patient education MANAGEMENT

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

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Hospital strives to allow childbirth decisions with family input

Opps for education abound during pregnancy and beyond

Childbirth at Evergreen Hospital Medical Center in Kirkland, WA, is viewed as a family experience, rather than a medical event.

To make it a positive experience, the family — rather than hospital protocol — determines the choices made for birth, says **Tamara Fitzgerald**, NAC, ICCE, LE, lead facilitator in childbirth education at Evergreen.

"There is this balance in the medical care to ensure the best outcomes possible with a focus on the family in terms of their wishes for the birth," explains Fitzgerald.

The balance is created through a comprehensive education program designed to help families make educated choices, and prepare them for childbirth and parenting. Education begins with prenatal classes, continues throughout the hospital stay, is provided directly after discharge with a postpartum visit, and continues throughout the first year of a child's life.

"It ensures that at every part of the parent's development, they have that base of information specific to their phase and the baby's phase," Fitzgerald explains.

Physicians encourage their patients, especially new parents, to attend three prenatal classes at Evergreen: a labor/birth series, an infant feeding series, and a one-day, hands-on class called "A Day About Baby."

"It is part of our collaborative process, for parents have less stress and

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Evergreen Hospital Medical Center was the first health care facility in the United States to be designated as a "baby-friendly" hospital by the World Health Organization and the United Nations International Children's Emergency Fund (UNICEF). The education that takes place throughout the continuum of childbirth is an important factor in its excellence. In this issue of *Patient Education Management*, we provide details on the curriculum that helps prepare families for childbirth and parenting.

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greater ease when they know what to expect ahead of time," Fitzgerald says.

During the labor/birth series, parents are educated about labor and delivery choices, such as pain medication and relaxation techniques, and they create a written birth plan. (*For details on how this process works, see article on page 3.*)

A Day About Baby is unique and fun, Fitzgerald says. During the day-long class, parents receive a life-like doll that is used for lessons about bathing and changing diapers, as well as how to hold a baby, and to calm and soothe a crying baby. Because the baby goes everywhere with parents, the couple must learn how to go through a lunch line in the cafeteria with a baby or use the restroom.

"It is a great role-play piece, and the parents really enjoy it and come away with a prenatal, hands-on experience," Fitzgerald says.

Parents who have children and who are attending the labor coping skill class, which is part of the labor/birth series, learn about any changes that have occurred since they had their last baby.

Also offered to families with children is a sibling class that parents attend with their children. The parents remain in the background while children age 2 to 6 learn about interacting with their new brother or sister and discuss how things might change at home. They learn how to help wrap a baby, play safe games with him or her, and tour the room where the baby will be born. Also, they draw a picture for the baby to hang on the crib when they come to meet their new sibling for the first time. According to Fitzgerald, the sibling class is very popular with families.

The curriculum is shaped by several factors. Recommendations from the Institute of Patient and Family Centered Care are incorporated, and the teaching follows standards on childbirth education issued by the State of Washington. Fitzgerald coordinates curriculum with a clinical nurse educator, and together, they stay abreast of current information.

"Birth doesn't change very much over the years, but certainly what is available to parents does change, and the research to support it; so we take new information and weave it into our curriculum," says Fitzgerald.

Prenatal education is timed to coincide with the various levels of adjustment that parents go through to the thought of a new baby, she adds.

Continuous education

Education is hands-on and continuous once the baby is delivered, because the Family Maternity Center at Evergreen Hospital has rooms where the labor, delivery, recovery, and postpartum stay occur. The value of having the baby room with the parents is that they are able to do the first diaper changes and give the baby his or her first bath. A postpartum nurse is there to answer questions. Also, a feeding specialist/lactation consultant visits every family to help with feedings based on the family's choices.

The hands-on care for the baby is very differ-

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ent from having the baby in a nursery during the hospital stay, and it gives the parents confidence to take the baby home, Fitzgerald says.

In addition to hands-on education, each family is given a DVD titled "Going Home with Your Baby" that was filmed at the hospital. In the DVD, staff and parents discuss all aspects of postpartum care for both the mother and baby. Parents review the DVD with a nurse before leaving the hospital; then, they use it as a reference at home. It contains answers to all types of questions that might arise, i.e., from when a parent should take the baby to the hospital to what a baby's first bowel movement looks like, says Fitzgerald.

Also during the hospital stay, mothers attend a class in their bathrobes with their newborn baby. It is taught by a registered nurse, who is a lactation consultant, and covers a variety of topics, such as umbilical cord care, eye care, and breast-feeding. The classes are small and take place daily. The curriculum follows guidelines from the American Academy of Pediatrics.

Learning continues after discharge with an appointment at the postpartum care center three to four days after the family takes the baby home. Parents and other family members can attend. "It is a clinical safety net for issues that might arise after the birth of the baby," Fitzgerald says.

Parent/baby classes are offered on a weekly basis for one year following the birth of the baby. Parents meet with a group that has babies of a similar age. Groups are divided as follows: families with babies 0-3 months; 3-6 months; 6-9 months; and 9-12 months. The classes are two hours and consist of an hour-long presentation by a parent educator, followed by a time for questions and discussion.

The 0-3 month baby class is offered to families at no charge, because the first three months is a crucial time for parent and infant development, Fitzgerald says. New moms, especially, are integrating the birth experience into their lives, and babies are still womb-oriented and don't yet perceive themselves as separate from the mother; also, they need warmth from a lot of holding, she adds.

According to Fitzgerald, the 0-3 month baby class helps mothers who might be experiencing postpartum mood disorder or depression work through these issues.

Fathering is recognized as a priority in childbirth education, as well, and the program offers a class called "Conscious Fathering."

The maternity education program is continually evaluated and improved through family input. Parents who participate in the prenatal classes together come to a reunion following the birth of their babies, and at that time they provide input on the program discussing what they would like changed — or if there was anything they would have preferred to know in advance.

Feedback is also obtained through a patient/advisory board that rotates members through. Board members share their birth experience at staff meetings with physicians, midwives, educators, and nurses.

The continuum of education works well, says Fitzgerald. Prenatally, families learn the clinical benefits of breast milk and learn the process of breast-feeding. At the Family Maternity Center, once the baby is born, the mothers learn to latch at the baby care class and also have hands-on lessons with a lactation consultant/feeding specialist in their room — and later at the postpartum care center. During the weekly meetings of the 0-3 month baby classes, mothers get further support and education about breast-feeding. As a result of this education, 90% of mothers who deliver at Evergreen Hospital breast-feed their babies.

SOURCE

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Let families write a birth plan

Education on choices helps

Families delivering babies at Evergreen Hospital Medical Center in Kirkland, WA, aren't told what to expect during labor. Instead, they are educated about their choices, so the birth is a positive experience.

Once decisions have been made, families create a written birth plan that is shared with their physician or midwife. Also, they bring a copy to the Family Maternity Center to show the labor nurse, who is exclusive to the family.

The birth plan helps parents clarify what they expect, says **Tamara Fitzgerald**, NAC, ICCE, LE, lead facilitator in childbirth education at

Evergreen. Articulating one's dreams and visions can be a real revelation to partners, she adds.

There are a variety of choices to make. For example, parents choose who they would like to have present during the birth of the baby, and they also set their own visiting hours; so any time day or night, they can choose to have their families visit.

The hospital provided education about the various ways women can seek relief from pain and discomfort during labor is provided. For example, women can sit or bounce on a physio ball to relieve back pain during labor.

Pain medication and relaxation techniques are covered during classes, so preferences can be included in the birth plan. The birthing rooms have showers and tubs that can be used by families during labor.

Also discussed are religious, cultural, and family traditions the couple may wish to follow. For example, what makes the birth special to a particular family may be an event that takes place at the time of the birth.

Fitzgerald says staff make note of what other parents have said made their birth special and use the information as examples in class.

Birth is not entirely predictable; therefore, sometimes a family's wishes must be adjusted. For example, a couple may want the lights dimmed or special music playing during the birth, but the mother must have a cesarean delivery. "We would try to preserve as [many] of their wishes as possible," says Fitzgerald. For example, they may wait until they return to the room with the baby in their arms and have the room dimly lit as they enter.

Without a menu of choices, it is difficult for families coming to the hospital for the first time to envision what kind of experience they would like to have. The education helps them form their ideas, says Fitzgerald. The birth plan ensures their wishes will be followed. ■

Respect cultural differences with care

Patient-centered discussion best

In a multicultural society, health care professionals must keep cultural differences in mind when trying to communicate clearly with patients who have immigrated to the United States from other countries. Teaching with an awareness of the cultural differences that may exist is essential for good medical outcomes.

During education, a full understanding of the information is important, and that requires good communication, explains **Heide Castaneda,** PhD, MPH, an assistant professor in the Department of Anthropology at the University of South Florida in Tampa.

Good communication begins with a medical interpreter to help with the discussion of symptoms, the prognosis, and proper treatment. "Without the aid of an interpreter, there can be a lot of frustration and misunderstanding," says Castaneda.

Even with an interpreter, it is important to be sure that both parties view the medical concepts and treatment instructions being discussed in the same way, because the meaning of a word or a term is not always the same in all cultures. For example, the word "liver" in the United States refers to a specific organ. Yet in other cultures, the term refers to a more generalized abdominal area.

People from different cultures may view the origin of illness and disease differently, as well, says Castaneda. For example, they may think something other than a bacterial infection is the cause of their health issue, such as the supernatural, being too hot or cold, or eating the wrong thing.

Also, something considered a standard diagnostic category in the United States may not exist in another culture. For example, several years ago, a colleague of Castaneda did work on menopause in Japan and found the word for hot flashes did not exist, because this symptom was not connected with the experience of menopause.

"If you were to suggest or talk about hormone replacement therapy to relieve a hot flash, that would make no sense to people in a culture that does not associate hot flashes with menopause," says Castaneda.

When educating about treatment methods, it is important to know that while someone may value a folk treatment or an alternative therapy, it is

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Clear communication when teaching is important in order for a patient to comply with the instructions. Yet cultural issues can deter that clear communication and result in noncompliance. An awareness of cultural issues impacting health care, which can be openly discussed during teaching, is the key to clear communication.

often used in conjunction with a traditional form of medical treatment and not an either/or situation between the two. Studies have determined that patient groups using different forms of treatment, such as herbs, use them in a complementary fashion, says Castaneda.

Another factor to consider during the education process is that it is not always cultural differences that prompt noncompliance. It can be life circumstances, such as labor and housing conditions, particularly for poor and undocumented immigrants. "I want to emphasize that educators should look beyond the notion of culture and look at the patient's life circumstances — and anything that might be impeding healthy living," says Castaneda.

Improving communication

Efforts to enhance clear communication between health care providers and patients from different cultures should be done in advance. Often, health care facilities treat patients from specific groups, such as Mexican immigrants or Hmong immigrants. In such cases, institutions should conduct as much research on the health practices of their patient groups as possible, says Castaneda. For example, discussions with key people in a cultural community should take place.

Also, health care professionals can read as much as possible and take college courses.

There has been a great deal of emphasis on cultural competency trainings, and while helpful, cultural issues can be oversimplified because of the limited time frame of the instruction, says Castaneda. People can leave with a list of 10 things patients from a certain culture believe about health care practices.

Certainly, background information is helpful, but a patient-centered approach works best, she adds. A dynamic interaction with the patient will bring greater understanding, because within each cultural group are individuals. Not everyone in a group acts the same way, especially when it comes to immigrant populations, says Castaneda. There are different levels of acculturation, and the only way to find out a person's beliefs is to have a patient-centered, one-on-one conversation, she explains.

"Ask about different cultural practices and be interested, open-minded, and respectful about those practices; ask patients in a straightforward manner," says Castaneda.

Health care professionals who are intellectually curious and open-minded will get a lot out of their everyday interactions with patients — maybe more than they would sitting in a classroom, she adds.

SOURCE

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Experts: Value of patient ed increasing

Not all positions are full-time

Many factors are increasing the value of patient education, according to experts in the field.

"As our health care system moves toward spending less and saving more, patient education will become more important," says **Fran London**, MS, RN, a health education specialist at The Emily Center at Phoenix (AZ) Children's Hospital.

Patient education is low-tech and low-cost with proven outcomes, she explains.

Education can equal cost savings to a health care institution, says **Nita D. Pyle**, MSN, RN, associate director of the Patient Education Office at The University of Texas M.D. Anderson Cancer Center in Houston. For example, cost savings can result from fewer hospital readmissions following discharge or fewer visits to the emergency department.

In addition, with health care reform, patient education may increase a health care institution's bottom line through reimbursement. With increased emphasis on such issues as the management of chronic disease, discussions on reimbursement for some education may be back on the table, says **Cezanne Garcia**, MPH, senior program and resource specialist for the Institute for Patient- and Family-Centered Care in Bethesda, MD.

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Each year, *Patient Education Management* includes a salary survey in one issue and tallies the data collected to track trends in patient education. In the following article, we try to give perspective to some of the findings through the eyes of experts in the field.

Other areas where the need for education is growing include medication adherence, healthy lifestyles, and obesity reduction, adds London.

Do salaries reflect PE value?

Our readers who completed the 2010 *Patient Education Management* Salary Survey indicated they made between $30,000 and $39,000 on the low end, and more than $80,000 on the high end.

There could be many reasons for such a wide variance. Salaries are determined in several ways, says Garcia. Some in the survey indicated they worked 20-30 hours, which could indicate the position was part-time. Also, it depends on the type of education programs and resources a patient education coordinator may oversee. The size of an institution could play a factor as well, she adds. A larger institution may have more departments and staff members asking for direction in program and resource development for patient education.

The survey indicated many readers working in patient education had worked in health care for 25-plus years, although they had not been in the field of patient education as long. Therefore, their salary would reflect their experience. "Seasoned health care workers usually don't take a salary decrease," explains Garcia.

To determine salary, administrators at Phoenix Children's Hospital look at the salaries of others in the region with the same skills and responsibilities, says London.

The majority of readers answering the survey had a master's degree, which indicates the position takes a certain skill set.

Increasingly, it is desirable to have a master's degree, so an individual has learned program development, implementation, and evaluation. In addition, the person who oversees patient education must view it as part of the total health care experience, says Garcia.

"These positions usually require someone to see the broad overview of the mission of the department and not get mired in the details," adds Pyle.

Managing groups of people, which often is taught as part of a master's program, is important, Pyle says. In addition, managers with a master's degree usually have planning and evaluation skills that are important to apply in patient education to gain visibility with upper management.

London agrees. Patient education is a sophisticated skill, and management of patient education even more so. Since it is integrated into the health care system, and helps other interventions work, it is not easily measured by itself. For example, unless a patient takes his medicine, or cares for a wound properly at home, the intervention is not effective. A master's degree is necessary to have the knowledge and skills to advocate for patient education, she says.

Benefits abound

Yet the benefits of having a patient education coordinator abound, adds London.

"It is to the organization's advantage to have a unified approach to patient and family education, in these days of market share and branding. All patients need access to the same information, no matter what their language, literacy level, or socioeconomic status," says London.

Implementing standards of teaching and developing standard content to make certain all patients receive what they need based on individual assessment is important, Pyle agrees.

A single contact person can coordinate and integrate efforts to reduce duplication, support standardization and reliable processes, and keep abreast of new developments and requisites, says Garcia.

There are many reasons to create a management position for patient education, she adds. The standards pertaining to patient education created by the The Joint Commission in Oakbrook Terrace, IL, have been a driving force over the years, says Garcia. Also, the growth in knowledge in the area of self-management of chronic conditions prompts the need for someone with expertise in education, she adds.

The continuing focus on clear communication impacts the field of education, says London. She points out that the U.S. government just passed the Plain Writing Act of 2010, which requires government communications to be clearly written.

Also, new Joint Commission patient-centered communication standards were implemented this month.

"Health literacy is not just written literacy. It is patients and families being able to know how to apply what they have learned to help them with their decision-making," says Garcia.

The amount of work required in the position of a patient education coordinator varies according to the job responsibilities assigned by each institution. At M.D. Anderson Cancer Center, there are many aspects of patient education to be covered,

which keeps managers and their staff busy, says Pyle. "Our health education specialists work 40 hours a week. We are a very large facility and have 13 disease site clinics, 13 support clinics, and 500-plus inpatient beds," she explains.

Our readers indicated they work at hospitals with a range of 100 beds to those with 1,000 beds.

Neither the size of the institution, nor the job duties or hours worked seemed to be impacting the amount of salary increases this year. Most received a 1% to 3% salary increase.

"Raises have been holding steady at 2% to 3% in our institution for the past few years. I expect it will remain the same this year," says Pyle.

The current state of the economy has led some companies to require that employees take cuts in salary to prevent layoffs, says Garcia. Therefore, a 1% to 3% raise is good, she adds.

SOURCES

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Iowa collaborative achieves improvement

Hospital-physician cooperation leads to success

Collaboratives have sprung up all over the country, and many boast impressive results. However, few can lay claim to as many accomplishments in a relatively short period of time as the Iowa Healthcare Collaborative (IHC).

On the occasion of its fifth anniversary, the IHC issued a statement summarizing those accomplishments, which included the following:

• 62% of Iowa hospitals have fully implemented rapid response teams;

• 84% of Iowa hospitals fully implemented the acute myocardial infarction (AMI) care bundle;

• 84% of Iowa hospitals fully implemented the surgical-site infection bundle;

• 76% of Iowa hospitals fully implemented the methods to high-alert medications;

• 79% of Iowa hospitals fully implemented the pressure ulcer care bundle;

• 90% of Iowa hospitals fully implemented the heart failure care bundle.

According to the IHC, fewer than 20% of Iowa hospitals had implemented any of these in 2006. And that's not all:

• In 2007, 68% of health care workers had received influenza vaccination; in 2010, that figure was 91%.

• Hysterectomy surgical-site infections have been reduced by 25%, and there has been a seven-fold reduction in central line infections variation.

• Compliance with the Centers for Medicare & Medicaid Services (CMS) AMI bundle of services has increased from 86% in 2005 to 94% in 2009, from 85% to 90% for pneumonia, and from 73% to 90% for surgical care.

• More than 50% of Iowa hospitals use Lean methodology.

A 'professionalism' model

How has the IHC been able to engender so much success in so many areas?

"We really have based our initiatives on a professionalism model," says **Thomas C. Evans**, MD, president of the IHC. "Our two founding partners, the state hospital association and the physicians, are about promoting 'hospital-ness' and 'doctor-ness.' They focus on their members, and we built a concept that...it's our responsibility as providers to be providing care. We took the tack of 'What if we assumed leadership?' — and we did."

With that "naïve" perspective, says Evans, a former CMO for the largest hospital system in the state and president of the state medical society, he began what he describes as an experiment. "We tried it out, and we said if it worked we'd roll it into a 501(c)(3) — and we did it in a year and a half," he reports.

Evans says the IHC has three cornerstones for improvement:

• **Aligning and equipping providers:** This involves assessing where Iowa hospitals are and where they need to be, looking at national challenges and opportunities for improvement, and offering information through tool kits, conferences, etc.

• **Responsible public reporting:** "We said from the beginning that if we're the ones to deliver care, then we really need to embrace transparency," says Evans. "As scientists we should assume responsibility for statistical reliability; we're the public reporting entity."

• **Raising the standard of care:** "We need to constantly improve care if we want to stay in the game," Evans says.

"We're one big PDSA [plan, do, study, act]," he continues. "We do small tests of change and look at what the data say. We have 100% reporting across the state for our 118 hospitals."

At present, he says, there are 74 measures for public reporting, "re-packaged" from Hospital Compare, the state inpatient data set, and tools from the Agency for Healthcare Research and Quality.

On all cylinders

A model is one thing, but it also requires action on the part of many hospitals to successfully improve in so many areas. Evans takes some of the "blame" for that. "I'm a little manicky. I'm a family doctor by training," he says. "It seemed like every time we started something, another imperative got added to the list. We started with the [Institute for Healthcare Improvement's] 100,000 Lives campaign. We looked at that and asked how much of that should we not be doing, and decided we should be doing it all, so we started a statewide initiative with the expectation that everyone would do everything." So, in March 2006, hospitals were asked to voluntarily report to IHC quarterly on their deployment of bundles. After that, six more bundles were added from the 5 Million Lives campaign.

"In the first campaign, 11% of the hospitals reported full deployment of all six bundles in the beginning, and we're now around 70%," Evans says. "The second campaign started at 22%, and now we're around 70%-80%."

There were times, he says, when he had to "chase" hospitals. "We'd tell them they hadn't reported and that they were, say, one of only 10 hospitals in the entire state that hadn't," Evans says. "No one wants to be an outlier."

Subsequently, he says, IHC added its hospital-acquired infection portfolios, a separate statewide project with an independent reporting vehicle. "Next, we adopted Lean manufacturing techniques," Evans says. The latest project is medical home. "With that, we can begin to work on transitions of care and re-admissions," he explains.

Working together

"We try to do these initiatives together," says Evans. "The hospital association does not lead these initiatives; they found it more effective to stay off to the side. We're the convener and PI coach across the state."

While IHC launches the initiatives, he continues, one of the founding partners is usually who communicates it to the hospitals. "They're told we're creating a statewide paradigm, and that they should be there," Evans explains.

Once an initiative has been selected, he continues, "We build the case for change — what is the current state, what should it be, and what penalties/incentives exist for getting there," says Evans. "Then we identify a series of actions, activities, or steps people should do, and we always try to tie in some objective measures of effectiveness." Wherever possible, he adds, IHC tries to build a return on investment (ROI) strategy as well.

IHC usually builds a "learning community" to help engender success. "We may build a toolkit available to all hospitals, to establish a general context; the learning community is where innovators can opt to participate," Evans explains. "We usually use the 'breakthrough series' model from IHI. We meet and discuss what we're going to do, folks go back to work, we give them more content, they go back to work, we talk about what we've accomplished."

The trick, says Evans, is finding and identifying innovators. "Sometimes we establish innovator workgroups and have them convene regularly by phone," he says.

As initiatives begin moving forward, Evans notes, there are different levels of engagement. "For example, our HAI work group is made up of a few well-equipped infection control professionals who do strategic thinking. Then, we have a monthly conference call for all infection control professionals; we have 70 people on it." The conferees learn about state-of-the-art approaches to preventing HAIs and where things currently stand; then they are given a set of action items. "We have discussions where people share what they've done and how they did it," notes Evans. "Those little huddles keep everyone

on the same page."

"There are a number of different ways to participate," adds **Steve Gibson**, RN, manager of clinical performance improvement at Trinity Regional Medical Center in Fort Dodge, IA. "You can be fully involved in all conference calls, which occur at different intervals depending on the nature of the collaborative. You can meet in person at least once, sometimes twice a year, and always communicate by telephone at least once a month. Everyone has the opportunity to relate what happened in their independent institutions, going around the table, or call in and share what they do, how they managed the program, and what kinds of processes they're following. They share checklists, and talk about what has and hasn't worked for them." This has proved successful, says Gibson, because "you learn from each other."

In addition, he says, the collaborative provides the opportunity to formally benchmark with the other hospitals. "You can see who's doing well," he notes. "Tom might pick up the phone and say that you're at the top on a certain initiative, and ask if you'd like to give a presentation at the next meeting. If so, that becomes part of the agenda for the collaborative."

Inside an initiative

Gibson offers a closer look at an initiative with which his facility has had "pretty good success" — ventilator-associated pneumonia (VAP). "We've not had one incident for two years now," he reports.

The VAP initiative at Trinity Regional started a little more than three years ago, says Gibson. "It came out of an IHI bundle adopted by IHC," he says. "They took the initiative statewide and offered hospitals the opportunity to participate. We focused on the bundles, implemented them, and monitored our process to make sure we were following the bundle until we were up to 100% bundle use."

The progress was monitored in a number of ways, says Gibson. "Part of the process is behavioral driven; for instance, the way you provide oral care, or a ventilator 'vacation,'" he notes. "We had the charge nurses on the [critical care unit] monitor the performance of the nurses caring for the patients to make sure those bundles were in place for each patient on a ventilator. That was the key."

Gibson says he has learned some valuable lessons about getting staff on board. "If you approach things from the standpoint that when you take into account the human characteristic side of the equation, you try to eliminate all variables a practitioner would face when trying to do the right thing," he shares. "You try to put processes in place that make it very natural and easy to do the right thing."

So, for example, if the barrier to providing proper oral care is that it is done at a difficult time of day, "maybe you have to move that to a different time of day," Evans says. In fact, he says, that lesson came out of the VAP initiative.

Checklists are valuable, he continues, because "people can't remember everything, so you say, 'Here are the four, five, or six things you need to do for this bundle. We even went so far as to have reminders on the ventilators themselves that the bed should be in a certain position, so when you walk in the room, if the bed is not at a 45-degree angle, you have a reminder. We actually had little gauges built into the beds eventually."

Another key to success, he says, is that "the lab is actually the bedside, and in a collaborative you have shared, real experiences — results of processes are shared, and you can adapt and adopt processes from different hospitals. In fact, I think the sign for bed elevation was developed by someone else."

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Readmission rates for HF reduced by 30%

Transitional care model, self-management keys

DMC Sinai-Grace Hospital in Detroit has been recognized by the Institute for Healthcare Improvement (IHI) for reducing its heart fail-

ure readmission rate by 30% this past year. Sinai-Grace was one of the first hospitals to participate in the IHI's State Action on Avoidable Rehospitalizations (MI STAAR) initiative.

"We received a letter in 2009 stating that IHI and the Michigan Hospital Association were doing a joint venture on reducing hospital readmissions," says **Peggy Segura**, FNP-BC, nurse practitioner and the day-to-day leader for the STAAR project. "Our president and my boss decided this was something they were interested in."

While the initiative offered guidelines, she says, "we picked what we wanted to work on first." The project leaders looked at the highest-impact areas, processes that were in place, and what could be improved upon with the greatest impact. "For us, congestive heart failure had a significant readmission rate; in fact, most participants have selected it because it's one of the highest DRGs," says Segura.

Transitional care focus

The key component of the initiative, says Segura, was the transitional care model. "That involves providing a high level of service — whether from the acute facility to home or rehab, or back to the primary care provider," she explains. The other key element, which supports the first, involved improving the self-management of patients with chronic diseases.

"We found the most important activity was finding who the learner was; sometimes it's not the patient, but a family member or caregiver; sometimes it's a combination," says Segura. "If the patient is not the one who's going to the store and purchasing food or meds, we need to make it a joint venture."

Within the first 24 hours of admission, an advanced learning assessment is conducted by the nursing staff, the case management staff, or Segura herself. "We educate the patient by teach back; we identify the key points we want to teach them about their disease process and communicate with them at a 5th grade reading level," she says.

The goal, she says, is to make sure the patient/learner understands who the primary care provider is, what his or her medications are, and how frequently they should be taken. "We also teach them what they're used for, and that they have to have two lists of medications — one with them and one at home," Segura adds. "For this disease process, we also wanted to teach signs and symptoms of their condition worsening — identifying when they are going into heart failure, and what they need to do if it happens. And, we teach them about follow up."

Teach back, she explains, is a "non-shaming" way of teaching patients. "Studies have found if you ask close-ended questions, they give you close-ended answers," says Segura. "We tell them at the end of the session that we want them to teach the information back us to be sure we both have an understanding."

Other improvements implemented

The program involved several other process improvements, including post-discharge follow up. "We have a call center in the hospital, so upon discharge we provide patients with a request for a follow-up appointment to be made within five days," says Segura. "We make sure they have available transportation, and that it works within their schedule."

Initially, she says, her team would call the patients on days seven, 14, 21, and 28 post-discharge to make sure all was going well — that they had followed up with their primary care doctor, and that they were taking their medications. "We also verified the teach back," Segura adds.

However, they found that a number of readmissions were occurring within the first 13 or 14 days, so the call program was rescheduled for days three, eight, 13, and 25. "At the end of 30 days, we turn the patient over to the corporate call center nurses, who call the patients at home twice a month for six months," says Segura.

Improved coordination of care, she continues, goes hand in hand with the post-discharge follow up. "We make sure to facilitate getting the patient back to their primary care provider," says Segura. "If they're from another system outside of ours, we still make every attempt to do follow up. We also work closely with home care and we partner with the Visiting Nurse Association on telephone monitoring, and they call me if the patient is in trouble."

If patients do not have a primary care provider and they are insured, the team asks them who they want to follow up with. "Most of the time they choose to see their [Sinai-Grace] doctor if they have an office outside the hospital," she says. "If

they're uninsured, I see the patient in our primary care clinic, and they see me at no charge."

Finally, says Segura, medication reconciliation also has been improved. "We have an EMR, and the medical history is obtained by a nurse at the point of entry," she explains. "Then, whoever provides the care will reconcile the medications. We do an admission reconciliation, and they verify with the patient that those are the meds they're on. If they're transferred to another unit, a transfer reconciliation is obtained, and a discharge medication reconciliation is completed at discharge on a written form."

COMING IN FUTURE MONTHS

- Evaluating videos according to health literacy standards
- Using the latest technology to teach patients
- Educating to reduce obesity
- Expanding resources for preferred learning methods
- Be ready to educate the deaf

As most prescriptions come with a label, she continues, "I try to teach my patients to take that label and put it on a loose-leaf piece of paper along with the name of the person who wrote the prescription, where it gets filled, and the last time it was filled."

Keys to success

The project could not have succeeded, says Segura, without the support of top administration. "It had to come from the top down," she says. "Once they decided to support the initiative, they allowed my boss to hire 1.5 people and a QI specialist [Segura came on board about three weeks before the project was implemented]. Once the plan was formulated, I worked with a unit to pilot on, along with unit managers and the administrative director." The team, she says, included a member from pharmacy, primary care clinic managers, social workers, two QI specialists, and a nurse educator, all of whom went to the "kickoff"

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

1. At Evergreen Hospital in Kirkland, WA, new mothers are educated about baby care before discharge in which of the following ways?
A. A DVD they can take home.
B. Visit with a feeding specialist.
C. Attending a baby care class.
D. All of the above

2. To create a good birth plan, couples must be educated about their choices in advance on such matters as pain control and relaxation techniques.
A. True
B. False

3. For clear communication, cultural differences must be understood. These differences might include:
A. The origin of an illness or a disease.
B. Understanding of a standard diagnostic category.
C. Use of a particular term.
D. All of the above

4. Immigrants from the same country usually have the same cultural beliefs, which can be learned through classes and reading of literature.
A. True
B. False

Answers: 1. D; 2. A; 3. D; 4. B

to get educated on the total program.

When she came on board, Segura went through the process herself. "I went to the floor and educated patients for a month," she recalls. "Then I started bringing in nurse champions for each unit; I educated them, and we worked with the patients. Once they were comfortable, we expanded to teaching on the floors."

Another key to success, she says, is having someone who is very knowledgeable and practice driven — in this case, her boss. "She looked at the project and defined the process, and developed a process map," she says. "We looked at who was responsible for each process; it's really a matter of putting the right people in the right place."

Segura says she is convinced that facilities that have not been as successful "did not have a defined process, or a defined leader." ■

Dear *Patient Education Management* Subscriber:

This issue of your newsletter marks the start of a new continuing nursing education (CNE) semester and provides us with an opportunity to review the procedures.

Patient Education Management, sponsored by AHC Media LLC, provides you with evidence-based information and best practices that help you make informed decisions concerning treatment options and physician office practices. Our intent is the same as yours - the best possible patient care.

The objectives of *Patient Education Management* are 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.

Each issue of your newsletter contains questions relating to the information provided in that issue. After reading the issue, answer the questions at the end of the issue to the best of your ability. You can then compare your answers against the correct answers provided in an answer key in the newsletter. If any of your answers were incorrect, please refer back to the source material to clarify any misunderstanding.

At the end of each semester you will receive an evaluation form to complete and return in an envelope we will provide. Please make sure you sign the attestation verifying that you have completed the activity as designed. Once we have received your completed evaluation form we will mail you a letter of credit. This activity is valid 24 months from the date of publication. The target audience for this activity is nurse managers, education directors, case managers, discharge planners, hospital clinicians, management, and other health care professionals involved in designing and/or using patient education/staff education programs.

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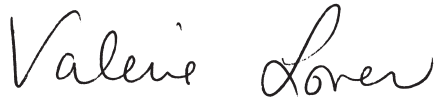

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