patient education MANAGEMENT

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

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IN THIS ISSUE

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AHC Media

For healthy behavior change, take the message into the community

Strategies for successful disease prevention programs

In September 2011, world leaders held the first General Assembly at the United Nations to address chronic disease, which caused an estimated 36 million deaths world wide in 2008. The declaration written by these leaders identified unhealthy behaviors such as smoking, excessive drinking, lack of exercise, and poor, diets dominated by fast food as the leading cause of cancer, diabetes, and heart and lung disease. The U.N. hopes to have a plan of action to promote healthy lifestyles by the end of 2012.

In the United States the Centers for Disease Control and Prevention reported this summer that education that results in healthy behaviors is needed to improve the lives of Americans. According to the CDC, people who don't smoke, exercise regularly, eat a healthy diet, and drink moderately are 63% less likely to die at an early age. When people practice the four behaviors, the risk of death from cancer and heart disease is about two-thirds lower.

Healthcare institutions should be leaders in delivering messages on healthy behavior because they have the expertise, says **Barbara B. Mintz**, MS, RD, assistant vice president, wellness at Newark (NJ) Beth Israel Medical Center. However, the education cannot be completed within the four walls of the hospital because people only come there when they are sick.

"The challenge is to execute successful programs that reach our community to prevent disease," Mintz says. "Treating disease is so much easier because they come to us. To prevent disease we have to be in the community."

EXECUTIVE SUMMARY

Research shows that healthy lifestyles equal long life, but many people never learn how to prevent disease. To reach your patient population, go beyond the hospital walls to churches, schools and worksites.

- Bring tried-and-true programs to the community.
- Consider the culture to determine how to engage.
- Find ways to teach the hard to reach.

This step is done at Beth Israel Medical Center by taking programs piloted at the healthcare institution out into the community. For example, a weight loss program with education on lifestyle changes named the Beth Challenge was first offered to employees. Now it is being used in the community setting offered through churches and worksites. The KidsFit program developed to address childhood obesity was first implemented within the medical center and is now part of school curriculum.

Because children within the community can weigh 300 pounds or more at 12 years old, treating obesity after the fact was not the answer, says Mintz. Now two dietitians are teaching school children how to eat healthy in the environment in which they live where access to fresh fruits and vegetables is limited. Also, they are teaching children how to exercise within their home when streets are not safe, by creating indoor obstacle courses or using stairs.

Children bring messages home

Children in schools are a captive audience, agrees **Olajide Williams**, MD, MS, chief of staff of neurology and associate professor of clinical neurology at Columbia University Medical Center in New York City and founder and director of Hip Hop Public Health. This organization has an office at Columbia University Medical Center and at Harlem Hospital and works within school curriculum to change health behaviors. For example, a school-based educational program on healthy eating and living aimed at children in middle school also engages parents by involving them in homework activities, such as tracking meals or learning about daily caloric expenditure.

"It is very hard to engage this group [working parents], but we think we have a way to do it through their children. They don't have time to manage their risk factors because they are so busy and challenged, but through their children, we can bring a lot of things to their attention," says Williams.

Children need to be excited and motivated about the intervention in order to follow through with the parental engagement, he says. The program generates this level of excitement by engaging children through hip hop music and culture using a multi-media approach that includes short, animated features, a series of comic books that complement the animation, and video games. The resources and curriculum are produced in-house. *(To learn more about this program, visit the web site at hiphoppublichealth.org.)*

"Piggyback on what is already a part of their life and culture," advises Williams. "Use what they are comfortable with and what they already love as a tool to empower them. I don't really see this as rocket science; we are basically using what the youth are already crazy about and use it effectively." *(For additional education strategies, see article on p. 127.)*

Look at popular forms of delivery

At MD Anderson Cancer Center in Houston, TX, technology is used to deliver prevention messages beyond the hospital walls. Messages are delivered via an online subscription newsletter called "Get Focused on Health" (www.mdanderson.org/focusedonhealth), a Facebook page (www.facebook.com/mdanderson.focusedonhealth) and Twitter (@focusedonhealth).

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Adelina Espat, communications program manager in the Public Education Office at MD Anderson Cancer Center, says, "Its purpose is to educate people in a very consumer-friendly way on the various things they can do to make healthier choices in order to avoid getting cancer. We cover a lot of topics regarding nutrition, exercise, avoiding tobacco, obesity, and sun safety."

Delivering a message on healthy lifestyles through technology provides a way to reach a lot of people on a small budget, Espat says, and it's affordable. "Research shows people are looking for health information online by doing Internet searches. Also, people are going onto social networking sites discussing health questions with friends. We want to be present to proactively offer good information," she says.

To draw consumers to the web site, news releases are distributed to national and local media every month promoting the online issue. Also, the Public Education Office has partnerships with other web sites that repost articles, such as Everydayhealth.com and kevinmd.com. "Our online educational programs are geared to larger numbers and are more to increase awareness," says Espat.

Education is the spark that gets people thinking about their health behaviors, says **Jason L. Bittle,** community health improvement coordinator at Hanover (PA) Hospital Wellness and Education Center. In the Stages of Change Model, health education can take a person from a place where they don't realize certain behaviors are unhealthy to a later stage of behavior modification and lowered disease risk, Bittle explains. *(See description of Stages of Change Model, below.)*

"If health education can inform the person before disease sets in, we can save a tremendous amount of resources and energy rather than treating the disease," says Bittle.

SOURCES

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Relevant messages made relevant

Discuss, show, and model information

To reach the public with education messages, avoid lectures, says **Barbara B. Mintz,** MS, RD, assistant vice president of wellness at Newark (NJ) Beth Israel Medical Center.

It is best to engage people, Mintz says. Question-and-answer sessions are good because this format provides a way to address participant's personal issues, she explains. Models also are engaging. Show people what a pound of fat looks like, Mintz advises. Also fill test tubes with sugar to show people how much sugar is in a 20 oz. bottle of soda or that juice actually can have more sugar in it than soda.

Active listening and open dialogue works best, says **Jason L. Bittle,** community health improvement

Stages of Change Model

The stages of change model was developed by James Prochaska, PhD, director of the Cancer Prevention Research center and professor of Clinical and Health Psychology at the University of Rhode Island in Kingston, and Carlo DiClemente, PhD, professor and chair of the Department of Psychology at the University of Maryland in Baltimore. The stages are based on the idea that people progress through different stages at their own rate before successful behavior change. The stages include:

• **Precontemplation:** There is no intention to change behavior in the foreseeable future. Often people in this stage are unaware or not fully aware of the problem.

• **Contemplation:** People are aware that a problem exists and are seriously thinking about overcoming it but have not yet made a commitment to take action.

• **Preparation:** People have made a commitment to change and are trying to determine how. Often this is a time of research.

• **Action:** A time when individuals take steps to change their behavior or overcome a problem.

• **Maintenance:** Successfully avoiding any temptations to return to the bad habit. ■

coordinator at Hanover (PA) Hospital Wellness and Education Center. "Patients really don't get it when you talk 'at' them, but when you talk 'with' them and ask open-ended questions, they feel more comfortable building a plan of action," he says.

Know the population with which you are working such as their age, gender, culture, and economic status, Mintz says. Economics can be a big barrier to making healthy lifestyle changes. While grilled chicken and fresh vegetables might be the healthier choice, it is more affordable and much easier for a mother in a single family home to feed her children a box of macaroni and cheese when she works three jobs to make ends meet, she explains. If the patient population eats at fast food restaurants, teach them how to make healthier menu selections. If they eat certain unhealthy cultural foods, teach them how to modify their recipes, says Mintz.

Many factors are necessary to get an audience to lend an ear, including relevance, buy-in, trust, and being able to relate and understand the message, says **Adam Bennett**, MSW, LSW, tobacco cessation coordinator at Hanover (PA) Hospital Lung & Sleep Center. If an individual cannot relate a message to their existence, it doesn't mean much at all, Bennett explains. "Education has never been and never will be one size fits all," he says.

While proven programs have been developed for tobacco cessation and prevention, they must be tailored to each individual, Bennett says. *(To learn more about the programs used at Hanover Hospital, see Resource, right.)* Those who use the programs must teach clients how to apply the methods to their own life so they work for that individual. For example, patients in smoking cessation programs are taught that engaging in physical activity is an excellent coping strategy to use when quitting smoking. However, if an individual cannot take a 20-minute walk due to severe emphysema, he or she might be taught how to do chair aerobics in order to be physically active, explains Bennett. In this way, the instructor is sensitive to the limitations the patient is experiencing.

Using members of the community, or lay leaders, to deliver the message often works well, says Bittle. The person already is trusted and understands the struggles of the target population.

Also, the message is better embraced when teachers are willing to model, says Bittle. He provides physical activity instruction to children as part of after-school programs and school health days, and he actively participates. Bittle has done Zumba with third graders, yoga with kindergarteners, and cross-country skiing with middle and high school students.

Remember that often your population has been influenced by the marketing ploys of food, alcohol, and cigarette manufacturers. Mintz says people will drink juice instead of soda because an ad said it was healthier, yet their beverage choice results in weight gain.

Stay abreast of the marketing trends, says Bennett. Those staff who handle tobacco prevention and cessation look at current trends in tobacco marketing. They then adapt counter-marketing efforts, prevention education messages, and cessation promotion to make messages relevant to what children and adults see in the media and communities where they live. Help adults and youth develop discrepancy identification skills, he adds.

"This allows them to discern between the messages they hear and perceive about tobacco use and the reality of it all for their life," explains Bennett.

SOURCE/RESOURCE

For more information about smoking prevention and cessation, contact:

• **Adam Bennett**, MSW, LSW, Tobacco Cessation Coordinator, Hanover (PA) Hospital Lung & Sleep Center. E-mail: bennetta@hanoverhospital.org.

• **American Lung Association of the Mid-Atlantic**, Camp Hill, PA. Web: www.lungusa.org/associations/charters/mid-atlantic/programs/smoking-programs.html. Telephone: (717) 541-5864. Youth tobacco prevention program Teens Against Tobacco Use (TATU) instructs teens how to go out and educate kids younger than themselves about the real dangers of tobacco. Freedom from Smoking is an adult cessation program. Both programs allow the messages to be adapted to the populations being served. ■

There is no need to reinvent the wheel

Use technology to uncover best practice

Technology is beneficial to people designing programs to impact the health behaviors of their patient population base, says **Jason L. Bittle**, community health improvement coordinator at Hanover (PA) Hospital Wellness and Education Center.

"We can look at best practices in similar community settings, contact those key people who can help replicate the program, and facilitate best practices in our own communities," says Bittle.

He advises people in the field of community education to check out this web site from the Department of Health and Human Services: http://www.communityhealth.hhs.gov. This web site provides

community health status indicators so healthcare professionals in "peer counties" might be able to uncover reasons for rate differences in such matters as risk factors for premature death and share information about model programs. *(Select state and county in the table on the left side of the page, then select the category you would like data on such as access to care or preventative services use.)* In addition with the ability to do an Internet search, you can find complete narratives of programs and their contacts, then replicate in your own program without reinventing the wheel, says Bittle.

Best practices can be found with a computer-based literature search that uncovers the articles with the best research protocols. For good information look to the web sites and journals of accrediting agencies, says Bittle. For example, with a background in fitness, he often uses information disseminated by the American College of Sports Medicine. Technology can help with how clean the research is, says Bittle. For example, you can find who out paid for the study, whether the authors have a conflict of interest, if they are considered creditable in their fields, or if they have other work that can build upon the subject matter. ■

Palliative care comprehension

Dispel idea that it is end-of-life care

Patients and caregivers are not often familiar with palliative care, or they misunderstand its purpose. Therefore, education on the reasons to make use of a multidisciplinary palliative care team and the benefits provided is important.

For most, the word does not have a lot of meaning, or they worry that palliative care is end-of-life care, says **Steven Z. Pantilat**, MD, FAAHPM, SFHM, professor of clinical medicine and director of the Palliative Care Program and Palliative Care Leadership Center at the University of California, San Francisco. It is care focused on improving quality of life for people with a serious illness such as heart failure, cancer, dementia, Alzheimer's disease, chronic lung disease, and chronic liver disease.

"People who may not understand what palliative care is can certainly relate to what palliative care does," says Pantilat. *(See resources for educating patients on palliative care, p. 126.)*

Anyone with a serious and complex illness that needs help with pain or other symptom control such as fatigue, anxiety, sleeplessness, or shortness of breath benefits from palliative care, says **Nathan Goldstein**, MD, associate professor of the Brookdale Department of Geriatrics and Palliative Medicine, Hertzberg Palliative Care Institute, at Mount Sinai Medical Center in New York City. Palliative care also helps patients better understand their disease, develop goals for medical care, and tailor treatment to those goals.

Clinicians help patients and family members make decisions all the time, but the way a palliative care team helps is different, explains Goldstein. While physicians might ask patients if they want to continue with chemotherapy, members of a palliative care team work with patients to understand what is important to them at a given point in their illness. Also team members ask what their hopes and fears are, and they use the information to help patients make decisions. A palliative care team includes doctors, nurses, and other specialists such as social workers and chaplains.

Expertise in multiple issues

Often what is different about palliative care is the interdisciplinary nature of the team addressing medical, social, psychological, emotional, and spiritual issues that impact a patient's care in a comprehensive way.

"Experts who know how to talk with patients to help understand what their goals are and help ensure their treatment matches their preference," says Pantilat. *(To learn how the palliative care team addresses gaps in education, see article on p. 126.)*

When a medical team focuses on disease management, issues that aren't addressed by this approach often get missed, he adds. Waking up in the middle of the night short of breath for someone who lives alone might have psychological implications. Adjusting medications is important

EXECUTIVE SUMMARY

Patients might shy away from palliative care because they do not understand its benefits. Therefore, educate patients who are unfamiliar with its purpose. Its benefits include:
improves quality of life for patients with serious illness;
helps with symptom control; matches treatment preferences to patient's goals.

but might not be the entire answer, says Pantilat. The patient might need someone to telephone or even someone to stay overnight.

It's important for staff to be educated on palliative care as well so the team can be set in place at the appropriate time, says Goldstein.

"The earlier we are called in, the better we can help patients cope with serious illness. The talking points of palliative care is not end-of-life care, it is care much earlier for patients to help them make complex decisions as well as support them during these really difficult medical situations," Goldstein explains.

SOURCES/RESOURCE

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• Web: www.getpalliativecare.org. Web site offers educational materials that help explain palliative care to patients, including answers to the six most frequently asked questions. Select "What is Palliative Care," "How to Get Palliative Care," or "Is Palliative Care Right for You?" The Web site is sponsored by the Center to Advance Palliative Care at Mount Sinai School of Medicine in New York City. ■

Palliative care teams enhance education

Devoting time to quality-of-life issues

Physicians and nurses helping patients learn to manage disease such as heart failure often have no time to talk about patients' preferences for care; if continued interventions are consistent with their goals, and what is hampering their quality of life.

A discussion about a patient's goals and preferences can't be done in five minutes, says **Steven Z. Pantilat**, MD, FAAHPM, SFHM, professor of clinical medicine and director of the Palliative Care Program and Palliative Care Leadership Center at the University of California, San Francisco.

A palliative care team can fill this gap in education. Team members can take time to discuss options and gain an understanding of what is important to patients, what they value, and what kinds of outcomes and states of health are acceptable to them and which are not. Once this information is understood, the treatment can support their goals, he says.

"Gaps in education may be helping people understand goals of care and letting them know about the opportunity to document their goals and preferences for care," says Pantilat.

In addition, at University of California, San Francisco, a palliative care team assesses a broad range of symptoms that include emotional and psychological issues as well as physical. Patients who are not taking their medication successfully might not need instruction on the medication regimen but need help with depression, says Pantilat.

Members of palliative care teams have special training in communication to help determine what a patient knows about their condition, what they understand, and what they want to know, says **Nathan Goldstein**, MD, associate professor at the Brookdale Department of Geriatrics and Palliative Medicine, Hertzberg Palliative Care Institute, Mount Sinai Medical Center in New York City. "We figure out where patients are in their understanding and then help them move along in terms of their understanding and their education," explains Goldstein. ■

Templates don't ensure copy is easy to read

Patient ed departments may need to assist

Templates often are created to help make sure patients with low health literacy understand information. The National Cancer Institute published a template for consent documents with an eighth-grade reading level for participants in clinical trials. *(To learn how to access this template, see resource at the end of the article.)*

To determine how effective these templates were in keeping consent forms understandable, a study assessed these forms once the local institutional review boards (IRBs) at various institutions added specific clinical trial details. The hypothesis was that the local IRB-approved consent forms would have a lower reading ease

EXECUTIVE SUMMARY

Templates to keep consent forms for clinical trials easy to read often lose their reading ease once details from local institutional review boards are added. To remedy this:
• Patient education departments can consult.
• Show institutional review boards the inconsistencies in forms for same clinical trial.

score, a higher reading grade level score based on Flesch-Kincaid statistics, and be longer than the sample oncology group trial consent. The lead researcher was **Shlomo Koyfman**, MD, associate staff, departments of radiation oncology and bioethics, Cleveland Clinic Taussig Cancer Institute in Ohio.

Lorianne Classen, MPH, MCHES, senior health education specialist at the Patient Education Office, MD Anderson Cancer Center in Houston, TX, says "Researchers were trying to see the impact the IRB has on the process." Classen and her colleague, **Chesley Cheatham**, MEd, MCHES, a senior health education specialist, took part in the research project by assessing the clinical trial consent forms from oncology cooperative groups, such as the radiation oncology group, at MD Anderson Cancer Center. The trials were going on at multiple institutions across the United States.

At MD Anderson, a total of 141 consent forms were assessed. The assessment was completed with the aid of a chart and included the page count, reading level, and reading ease of the document. The IRB inserts information in the template such as a description of the medicine and the side effects.

Cheatham says, "There was a large fluctuation between some forms we studied and the NCI templates." Often the text was scientific and difficult to comprehend without any medical background or advanced education, she says.

According to Koyfman, the research study found that the consent forms tended to get longer and less readable when following the additions made by each local IRB. "There are lots of potential reasons for this," he adds. "Part of it is that each local IRB has their sense of what is and is not appropriate language." Also, many do not have skills in making copy easy to read. "It is important for each institution to keep in mind how their modifications impact the length and readability of these forms," says Koyfman.

The Patient Education Office at MD Anderson would like to use the study results to show IRBs or cooperative groups there could be a big difference between consent forms at various institutions participating in the same clinical trials and try to get some consistency. Also, the department would like to assist in the writing of the forms whenever possible within their institution.

Classen says staff with a health education background can provide their expertise as a consultant on clinical trial consent forms.

NCI is revising the template for clinical trial consent forms in an effort to shorten and simplify all consent forms used, says Koyfman.

SOURCES/RESOURCE

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• **Shlomo Koyfman**, MD, Associate Staff, Departments of Radiation Oncology and Bioethics, Cleveland (OH) Clinic Taussig Cancer Institute. E-mail: koyfmas@ccf.org.

• National Cancer Institute template and process for consent documents. Web: www.cancer.gov/clinicaltrials/patientsafety/simplification-of-informed-consent-docs/page1. ■

Education, follow-up reduce readmissions

Use of Heart Failure Zones is a key

A pilot project providing coaching and follow up for heart failure (HF) patients who are readmitted frequently resulted in a 50% drop in the readmission rate at Indiana University (IU) Health Ball Memorial Hospital in Muncie, IN.

The pilot project focused on patients admitted by the hospitalist team, which admits most patients at the 350-bed hospital, says **Traci Strauch**, RN, BSN, RN case manager. Strauch and **Patty Williams**, RN, BSN, CCM, lead RN case manager manage the care of patients being followed by the hospitalist team.

Williams says, "We were pulled off the unit two years ago when the hospital-based hospitalist program was begun."

The project originated when **Pat Gorman**, RN, MSN, CPHQ, administrative director for the hospital who oversees case management, asked Strauch and Williams to develop and carry out a project to focus on heart failure patients who were readmitted frequently. Based on the success of the pilot, the hospital has since hired a full-time heart failure coach, **Wilma Carrier**, RN, BSN, case manager. In the future, the hospital will roll out the program to include patients on the cardiac telemetry unit, regardless of who admits them. Strauch and Williams act as back-up coaches and fill in when Carrier is on vacation.

The program provides intensive education throughout the patient's stay, follow-up within 48 to 72 hours after discharge, and weekly calls for the next four weeks for patients who are discharged to home, as well as those going to skilled nursing facilities or assisted living facilities.

Williams says that when a patient with heart failure is admitted, the case managers meet with them, discuss the reasons for admissions, and begin the educational process. "They visit the patient throughout the stay, teaching them about their medication and diet, determining their home situation and support system, and assessing their need for medication assistance. Then they start educating the patient on the plan to follow after discharge," she says.

Strauch adds, "In every encounter, we use teach-back questions to make sure they understand the disease process and their treatment plan. We ask if they're following their diet and if they are having any problems."

After discharge, the case managers call the patients within 48-72 hours to make sure they have filled their prescriptions, to make sure that they have a follow-up appointment with their primary care physicians and/or specialists if needed, and to reinforce the discharge teaching they began on the unit. After that call, they call the patients on a weekly basis and go through the treatment plan.

A key component of the program is teaching patients how to use the Heart Failure Zones, a one-page tool that uses the colors of the stoplight to help patients learn to manage their condition. *(For more information on the Heart Failure Zones, see Source/Resource, right.)* The Green Zone means symptoms are under control. The Yellow Zone lists shortness of breath, swelling in feet and ankles, some weight gain, and other symptoms, and it instructs patients to call their doctor. Symptoms in the Red Zone alert patients to seek emergent care and include difficulty in breathing, chest pain, and confusion.

Everyone on the treatment team educates the patients on the heart failure zones. The nurse caring for the patients has them explain each day how they feel and correlate it to the zones and the patient's weight. Williams says, "This way, when they go home, they know what symptoms to look for and what to do if they occur, which helps them avoid an exacerbation that could bring them back to the hospital."

Strauch says the project gave the hospital case managers a chance to develop close working relationships with home health agencies and skilled care facilities. "We don't limit telephone calls to patients who go home," she says. "We also call the skilled care or assisted living facilities."

The hospital invited home care agencies with telehealth and heart failure disease management programs to become part of the team and learn about the zones so the patients receive the same information after discharge as they receive in the hospital. "We educated our skilled care facilities on the zones and send a Heart Failure Zones sheet with the patients who are discharged to nursing facilities," Strauch says.

The team revised its skilled nursing facility order sets, adding one for heart failure that specifies weighing the patients every day, putting them on a low sodium diet, and giving them a rescue dose of furesomide if they gain 2 pounds in 24 hours.

Willliams says: "We're continuing to looking at going outside the hospital walls to coordinate patient care. We have placed social workers in some of our clinics and assigned an RN case manager to the at-risk population in the hospital's insurance group."

SOURCE/RESOURCE

• **Patty Williams**, RN, BSN, CCM, Lead RN Case Manager Indiana University Health Ball Memorial Hospital in Muncie, IN. E-mail: pwilli10@iuhealth.org.

Heart Failure Zones were developed by Improving Chronic Illness Care, a Robert Wood Johnson Foundation program housed at the MacColl Institute for Healthcare Innovation in Seattle. For more information, visit www.improvingchroniccare.org. Click on "Resource Library," then on the left side of the page, select "Critical Tools" and "Red-Yellow-Green CHF tool." ■

Communicating with patients encouraged

The Agency for Healthcare Research and Quality (AHRQ) has launched an initiative with the Ad Council to encourage clinicians and patients to engage in effective two-way communication to ensure

safer care and better health outcomes.

For nearly a decade, AHRQ has encouraged patients to be more involved in their health care, and this new initiative builds on previous public education campaigns AHRQ has conducted under contract with the Ad Council around the theme "Questions are the Answer." This phase of the initiative features new public service ads directed at clinicians with the message that a simple question can reveal as much important information as a medical test. Research shows that better communication correlates with higher rates of patient compliance with treatment plans. This improved compliance can lead to better blood sugar control for patients with diabetes, for example.

"We know that when patients and clinicians communicate well, care is better. But in today's fast-paced healthcare system, good communication isn't always the norm," said AHRQ Director **Carolyn M. Clancy**, MD. "This campaign reminds us all that effective communication between patients and their health care team is important and that it is possible, even when time is limited."

An original series of new videos on the AHRQ web site (www.ahrq.gov/questions — select "Patient and Clinician Videos") features real patients and clinicians discussing the importance of asking questions and sharing information. Several patients discuss how good communication helped them avoid medication errors or obtain a correct diagnosis. Clinicians emphasize the benefits of having their patients prepare for medical appointments by bringing a prioritized list of the questions they wish to cover.

Bill Lee, a patient from Baltimore, who is featured in one of the videos, said, "I used to think, he's a doctor, who am I to ask a question?" Lee, who has suffered 10 heart attacks since 2004, noted that good communication is the key to successfully managing his heart disease and diabetes. "If I had not started asking questions of my doctors, I honestly think I'd be dead today," he said.

The web site also features new resources to help patients be prepared before, during and after their medical appointments. The resources include:

- An interactive "Question Builder" tool that enables patients to create, prioritize, and print a personalized list of questions based on their health condition.
- A brochure, titled "Be More Involved in Your Health Care: Tips for Patients," that offers helpful suggestions to follow before, during, and after a medical visit.
- Notepads designed for use in medical offices to help patients prioritize the top three questions they wish to address during their appointment.

The brochure and notepads are available for co-branding. Organizations that wish to promote patient and clinician communication and safer and better health care may use the materials for their members, employees, and patients. Materials can be found at www.ahrq.gov/questions in the "Tips and Tools" section.

The new ads for clinicians will run in donated space this fall in a variety of print and online medical and allied health journals, including "The New England Journal of Medicine," "The Journal of the American Medical Association," "American Family Physician," "Annals of Internal Medicine," "Journal of the American Academy of Physician Assistants," and "The Journal for Nurse Practitioners." The print ads, which were created pro bono by the advertising agency LLNS, will reach a combined audience of more than 2 million clinician readers, can be found at www.ahrq.gov/questions/psas.htm. ■

Simulation found to be effective in training

Simulation-based training is an effective way to teach physicians, nurses, dentists, emergency medical technicians, and other health professionals, according to an analysis led by Mayo Clinic researchers.

The team reviewed more than 600 studies evaluating the use of technologies such as virtual reality computers, mannequins, and training models to teach skills and procedures including surgery, trauma management, obstetrics, and team communication. Their conclusions were published Sept. 7 in *The Journal of the American Medical Association*.[1]

Lead author **David Cook**, MD, of Department of General Internal Medicine at the Mayo Clinic Rochester (MN), worked with researchers from Mayo, the University of Ottawa (Canada), the University of British COlumbia, Vancouver, Canada, and the University of Toronto in Ontario, Canada. They concluded that training with simulation is consistently better than no instruction, as measured in controlled settings and in practice with actual patients.

"We reviewed hundreds of articles, and, with extremely rare exceptions, we found improved outcomes for those who trained with simulation," Cook says. "This held true across a wide variety of learners,

learning contexts, and clinical topics."

However, "we need more effective, more efficient, and safer ways to learn," says Cook citing the increasing volume of medical knowledge, rapidly changing practice environments, and evolving physician-patient relationships. "Simulation-based instruction has unique advantages, including the opportunity to practice without harming patients, repeat training to become more proficient, and structure training for more effective learning."

The study also found a lot of variation in the quality and results of the simulation activities. "Not all training was equally effective," Cook says. "Now that we know that simulation works, the next step is to understand how to use simulation-based instruction effectively and efficiently." He and the others on his team are researching how to use simulation-based teaching most cost-effectively.

The other researchers were Benjamin Zendejas, MD, Jason Szostek, MD, Amy Wang, MD, and Patricia Erwin, all of Mayo Clinic; Stanley Hamstra, PhD, University of Ottawa; Rose Hatala, MD, University of British Columbia; and Ryan Brydges, PhD, University of Toronto.

REFERENCE

1. Cook DA, Hatala R, Brydges R, et al. Technology-enhanced simulation for health professions education: a systematic review and meta-analysis. JAMA 2011; 306:978-988. Doi:10.1001/jama.2011.1234. ■

Hospital puts focus on workforce

(Editor's note: This article is reprinted from the Sept. 19, 2011, issue of AHA News Now *from the American Hospital Association.)*

The answer is: attracting, retaining and developing the best workforce. The question: What is one goal of Avera McKennan Hospital's Keys to Excellence initiative?

The 545-bed tertiary hospital and university health center in Sioux Falls, SD, plans activities like Jeopardy and the Operation board game to educate employees about the organization and help every employee feel connected to patients and to his or her larger role in the hospital. Onboarding activities are targeted for employees of three months and also those of nine months.

"If people understand the bigger picture, they stay connected and stay longer," says **Mary Sand**, PhD, director of service and organizational development.

Two other Avera programs keep employees engaged. During the past two years of the Bright Ideas program, employees have submitted more than 1,800 ideas for improvement, and nearly 700 of them have been implemented. The Emerging Leaders program offers a nine-month curriculum for employees identified by their managers as having leadership potential.

For more information, contact Sand at Mary.Sand@avera.org. Visit *Hospitals in Pursuit of Excellence* at www.hpoe.org for more workforce and culture case examples. ■

National training center targets LGBT care

The Health Resources and Services Administration (HRSA) recently awarded $248,000 to the Fenway Institute in Boston to create a National Training and Technical Assistance Center to help community health centers improve the health of lesbian, gay, bisexual, and transgender (LGBT) populations.

The Fenway Institute is the research, training and policy arm of Fenway Health, a community health center. Since 2000, the Fenway Institute has provided medical, academic and community institutions with training, education, and technical assistance in LGBT health. Their work is based on "The Fenway Guide to LGBT Health," which is the only clinical textbook on LGBT health that was published in collaboration with the American College of Physicians in 2008.

"This award is an important step in HHS' continuing effort to provide health care services to all people recognizing that different groups of people may have distinctive health care needs," said Health and Human Services Secretary Kathleen Sebelius.

Fenway will work to:

recruit leading experts in LGBT health to lead seminars and provide consultation to health center staff;

develop curricula specifically targeted to LGBT populations;

work closely with state primary care associations to maximize the geographic reach of the project.

HRSA Administrator **Mary K. Wakefield**, PhD, RN, said, "Significant health disparities exist for sexual and gender minorities. This award will help

to expand access for the LGBT community to ensure that patients who need care can receive it in a safe, welcoming, and respectful environment."

This award to Fenway represents the first time that HRSA has entered into a National Cooperative Agreement that focuses on LGBT health.

In other news, the Centers for Medicare and Medicaid Services (CMS) has released guidance for enforcing new rules that give all patients, including those with same-sex partners, the right to choose who can visit them in the hospital as well as the right to choose who will help make medical decisions on their behalf. All hospitals that participate in Medicare and Medicaid must comply with these rules. For more information, see the press release "Medicare steps up enforcement of equal visitation and representation rights in hospitals" at http://www.hhs.gov. Select "news." Under "Latest News Releases," go to "September 7, 2011." ■

CNE QUESTIONS

1. To best educate the public on disease prevention, a healthcare institution might do which of the following according to patient education experts?
   A. Take lessons into the community.
   B. Identify culturally appropriate delivery methods.
   C. Pursue avenues of technology.
   D. All of the above.

2. According to healthcare professionals who teach disease prevention within communities, which of the following techniques work best?
   A. question and answer sessions
   B. Lecture
   C. Active listening/open dialogue
   D. A&C

3. Palliative care is most beneficial to patients who are at the end of life.
   A. True
   B. False

4. According to a research study, additions to easy-to-read templates created for consent to clinical trial participation can make them difficult to understand.
   A. True
   B. False

CNE INSTRUCTIONS/OBJECTIVES

To earn credit for this activity, please follow these instructions.

1. Read and study the activity, using the provided references for further research.
2. Log on to **www.cmecity.com** to take a post-test; tests can be taken after each issue or collectively at the end of the semester. *First-time users will have to register on the site using the 8-digit subscriber number printed on their mailing label, invoice or renewal notice.*
3. Pass the online tests with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.
4. After successfully completing the last test of the semester, your browser will be automatically directed to the activity evaluation form, which you will submit online.
5. Once the completed evaluation is received, a credit letter will be e-mailed to you instantly.

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.

COMING IN FUTURE MONTHS

■ Resources for multi-language teaching sheets

■ Steps for educating caregivers

■ Directing cancer patients on road to wellness

■ Addressing communication issues

United States Postal Service

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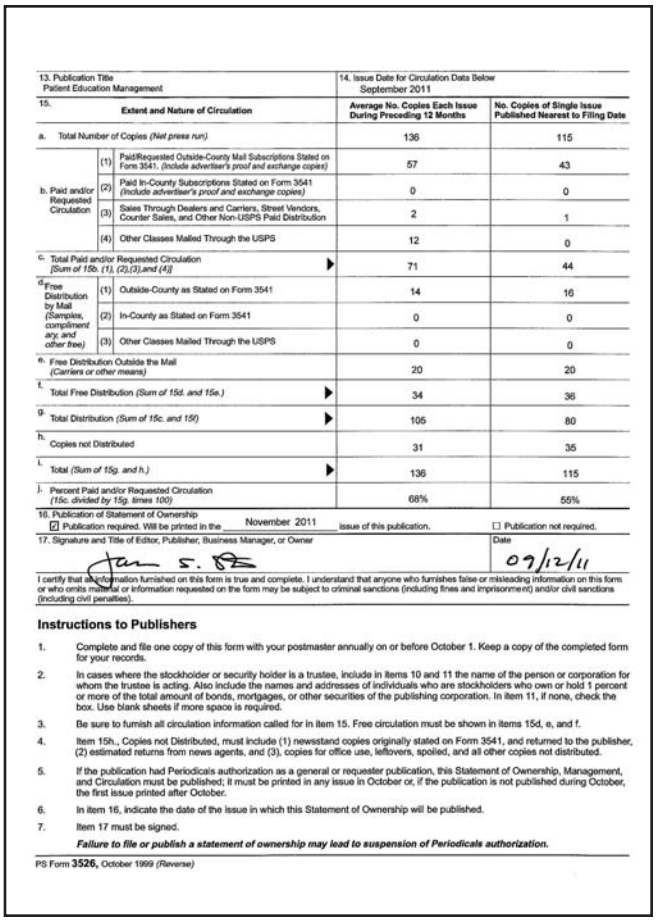

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f. Total Free Distribution *(Sum of 15d. and 15e.)* ▶	34	36
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