patient education MANAGEMENT

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

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Patient/provider communication critical — Pick the best method

Avoid misdiagnosis, inappropriate treatment, and med errors

A series of patient testimonies videoed for a new initiative launched by the Agency for Healthcare Research and Quality (AHRQ) in Rockville, MD, this fall shows the benefit of two-way communication between clinicians and patients. For one patient, the conversation resulted in a correct diagnosis and a reduction in medications. Another realized that if he had discussed with his physician the side effects he was experiencing from his high blood pressure medicine, he would not have ended up in the emergency department.

Called "Questions are the Answer" (www.ahrq.gov/questions), this effort one of many initiatives and tools introduced in recent years to improve communication. With The Joint Commission evaluating institutions to determine if they are working to improve patient/provider communication, it's time to make sure plans are in place. What steps might you take to enhance patient/provider communication?

Choose tools that have been identified as a best practice or promising practice, says **Jen Kimbrough**, PhD, executive director of the Guilford Coalition

Patient Education Management features staff education article and awards Gold Star

This month we are adding new features to *Patient Education Management (PEM)*. We want to recognize healthcare professionals who go "above and beyond" to dramatically improve patient education through unique and create approaches. From time to time, we will formally recognize their excellence by bestowing a "Gold Star Award," which will be indicated at the top of their story.

In this issue, we have given our first Gold Star to Matthew Ballo, MD, professor of radiation oncology at MD Anderson Regional Care Center in the Bay Area, Nassau Bay, TX, for the "Road to Wellness" program. If you have a suggestion for a "Gold Star Award" recipient or a good staff education program to share, please send the information to Susan Cort Johnson, editor, at suscortjohn@frontiernet.net.

Also newly added this month is a feature on staff education pertaining to the field of patient education. See p. 136.

on Adolescent Pregnancy Prevention in Greensboro, NC, a faculty member at the University of North Carolina at Greensboro, and a founding member of the Guilford Health Literacy Forum and NC Health Literacy Council in Greensboro, NC. Best practice is something that repeatedly has been shown to be effective in any setting where promising practice is supported by emerging evidence.

Kimbrough recommends the Health Literacy Universal Precautions Toolkit for primary care released by AHRQ. It contains some proven communication strategies, such as teach-back and information on how to do a brown bag medicine review. In that review, providers request that patients bring all their medications and supplements to medical appoints for patient/provider discussion on their purpose and how to take them correctly. *(To download a copy, visit www.ahrq.gov/qual/literacy.)*

At WellSpan Health, a healthcare system in York, PA, the discussion about tools to improve patient/provider communication within physician offices took place within the Health Literacy Task Force set in place by the Healthy York County Coalition, which is affiliated with the healthcare institution. The work is part of the Aligning Forces for Quality grant funded by the Robert Wood Johnson Foundation. Input also came from the patient advisory councils at WellSpan Health. The interventions selected include brown bag medication education and teach–back, says **Christine Hess**, MEd, patient and family education coordinator at WellSpan Health.

It is always good to include the people impacted by communication tools in the discussion, says **Cindy Schlough**, director of Strategic Partnerships for the Wisconsin Collaborative for Healthcare Quality (WCHQ). in Middleton. Therefore, when discussing communication strategies that impact clinicians and patients, include them in the process, she says.

Do the research

When committees are assembled to examine communication tools, it is important for members to gather as much information as possible, says Schlough. Before implementing the "Ask Me 3" program at local clinics, the group Schlough worked with performed a literature search to find research on the tool, which they listed in their report on the project. Also, they held conference calls with clinics that had implemented the program.

"We need to look at each program to determine where it has been successful and then what made it successful," says Schlough.

Also important is an assessment of your facility

EXECUTIVE SUMMARY

According to The Joint Commission, ineffective communication between patients and providers can result in misdiagnosis, inappropriate treatment, or medication errors. There are many initiatives and tools designed to help healthcare institutions improve patient/provider communication. When making decisions on what to put into place, consider:

- which methods have been identified as best practice;
- the weaknesses identified in an assessment;
- input from patients and providers.

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EDITORIAL QUESTIONS

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AHC Media

to determine what you do well and where there are weaknesses, says Kimbrough. Create a plan based on the evaluation, she advises. She recommends "The Health Literacy Environment of Hospitals and Health Centers" produced by The National Center for the study of Adult Learning and Literacy in Boston. (To obtain a copy, see list of resources at the end of this article.)

Schlough says the research on "Ask Me 3" revealed that patients did not feel comfortable asking questions of the physician. One physician realized early on that regardless of the best efforts of the clinic staff, patients were uncomfortable asking the questions, so he used the "Ask Me 3" format to provide information to the patient. He told patients their main problem, what they should do about it, and why it was important. "He found this really changed his interactions," says Schlough.

Staff at WCHQ began to look at programs based on culture change, such as informed or shared decision-making and teach-back, which changes the behavior of staff within the organization, she adds. "Ask Me 3" is excellent for building awareness of the need for better communication, and some health care organizations are using it as an introductory tool before implementing something more complex, says Schlough.

Whatever methods for improving communication are selected be sure to include staff training, says Kimbrough. Practicing is a good way to improve communication skills, she adds.

Staff members at WellSpan Health were alerted to the tools being implemented via web sites, e-mails, and fliers, Hess says. "The two tools were rolled out to our medical groups during staff meetings, and training was provided," she adds.

A practice support specialist from Planned Care at WellSpan Health organized training. The specialist, along with the medical group administrators, attended an inservice conducted by **Darren DeWalt**, MD, MPH, an advisor for Improving Performance in Practice at the University of North Carolina Chapel Hill Center for Health Promotion and Disease Prevention. This university was commissioned by AHRQ to develop the Health Literacy Universal Precautions Toolkit. DeWalt presented the health literacy background and tools. Training was conducted at the medical group practices upon request by **Robin K. Rohrbaugh**, MSW, executive director of the Healthy York County Coalition.

Now there is a new endeavor at WellSpan Health to teach communication skills to patients through a train-the-trainer program. The training is based on the Patient Empowerment Training curriculum of the Washington, DC-based National Partnership for Women and Families, and program oversight is through the Healthy York County Coalition. *(For information on Patient Empowerment Training, see article below.)*

SOURCES/RESOURCES

For more information about setting in place tools to improve patient/provider communication, contact:

- **Christine Hess**, MEd, Patient and Family Education Coordinator, WellSpan Health, York, PA. E-mail: chess@wellspan.org.
- **Jen Kimbrough**, PhD, Executive Director of the Gilford Coalition on Adolescent Pregnancy Prevention, Greensboro, NC, Faculty Member, University of North Carolina at Greensboro. E-mail: jbkimbro@uncg.edu.
- **Cindy Schlough**, Director of Strategic Partnerships, Wisconsin Collaborative for Healthcare Quality, Middleton. E-mail: cshlough@wchq.org.

For more information about the resources mentioned in this article, contact:

- **"Ask Me 3."** Information on this communication program is available at www.npsf.org/askme3.
- **WCHQ -- Improving Patient-Provider Communication.** The full report on the effectiveness of the "Ask Me 3" program assessed by The Wisconsin Collaborative for Healthcare Quality and Wisconsin Department of Health Services can be accessed at www.wchq.org/about/askme3.php.
- **Health Literacy Environment of Hospitals and Health Centers** produced by The National Center for the Study of Adult Learning and Literacy is available at www.ncsall.net/index.php?id=1163. ■

Teach patients to communicate

Shared information is for their benefit

A program initiated by Healthy York County Coalition in York, PA, trains any interested party to teach a program titled "It's Your Health, Take Charge."

The curriculum is based on the Patient Empowerment Training of the Washington, DC-based National Partnership for Women and Families.

"We have done a lot of work to augment some of the different topics that are covered in that curriculum," says **Robin K. Rohrbaugh**, MSW, executive director of the Healthy York County Coalition.

The curriculum is based on the concept the patient is the most important person on the healthcare team. Therefore, the patient learns their role as a team member. They learn that in order for the physician to be fully helpful, they must share information with him or her, such as whether they can afford the medication prescribed or adhere to the exercise regimen.

Also consumers learn how to prepare for a visit to their physician. For example, they are taught to identify two or three things they want to get out of the appointment with their doctor and write down questions they have. Also they are encouraged to take a friend or family member to the appointment if they have trouble understanding the physician due to language or cultural barriers.

While physicians provide education, those attending the class learn it is their responsibility to learn about their condition, and they are taught how to do a little research. Also, they learn how to evaluate information to determine if it is reliable. For example, they are encouraged to visit web sites sponsored by credible organizations, such as the American Diabetes Association.

Steps taught to physicians are also being taught to patients. For example, those taking the class are told to bring their medications to the appointment with the physician so he or she can see the medications and find out if they are being taken correctly. Also, they are taught to initiate teach-back by stating, "This is what I understand I am supposed to do" and repeating what they thought was taught.

"It provides a way to correct misunderstanding," says Rohrbaugh.

SOURCE

For more information about patient empowerment training called "It's Your Health, Take Charge," contact:

• **Robin K. Rohrbaugh**, MSW, Executive Director, Healthy York County Coalition, York, PA. E-mail: rrohrbaugh@wellspan.org. ■

staff education
CORNER

Orientation covers teaching/learning process

Hands-on workshop provides practice

Knowing how to develop an individualized teaching plan for patients is a skill each newly hired nurse must know at Massachusetts General Hospital in Boston. Therefore, a two-hour orientation gets them up to speed on how to access online resources to support the plan and document the teaching outcomes.

This hands-on workshop is scheduled monthly and taught by a masters prepared patient education nurse who works in the hospital's Maxwell & Eleanor Blum Patient and Family Learning Center. Teaching is a mixture of didactic presentation illustrated with real life examples; hands-on computer experience with available online resources; and a case study example, explains **Brian M. French**, RN, BC, manager of the learning center and The Knight Simulation Program. The class includes computerized graphics with the talking points, and there are instructions for the teacher that explain the content to be covered.

EXECUTIVE SUMMARY

A two-hour nursing orientation at Massachusetts General Hospital in Boston covers the teaching process staff members are expected to follow. Participants learn:
• how to complete an assessment;
• how to use the assessment to create a teaching plan;
• best practice for effective teaching;
• how to evaluate and document teaching.

The instructor begins with a discussion of the teaching/learning process, then the steps to effective patient education including the following:

• **Assessment.**

The instructor covers the process of patient education and discusses the need to find out what the patient already knows, what the patient wants or needs to learn, what he or she is capable of learning, and if there are any factors that might impact the learning.

Also covered is the Nursing Dataset Form, which is to be filled out within 24 hours of admission. That form documents issues that could impact a patient's learning such as language barriers, pain, cultural beliefs, and vision and hearing problems.

Assessing readiness to learn is the final point in this category, which includes looking for cues in verbal and nonverbal behavior and then verifying your assumptions, says French. For example, the nurse might ask: "So what I am hearing you say is that you are very anxious about your diagnosis?"

• **Planning.**

In this category, the instructor covers the need to review the assessment to determine how best to teach the patient, identifying appropriate resources and whether an interpreter is needed to overcome language barriers. Also covered is the need for the instructor to set mutual goals with the patient and family, says French.

• **Intervention.**

Many tips for effective teaching are reviewed in

this category. They include using plain language, involving a family member or friend, and making sure the content of printed materials is reviewed with the patient.

• **Evaluation.**

Staff members are encouraged to use the teach-back or show-back method for evaluation. *(To learn how more details on effective teaching are offered to staff following orientation, see article below.)*

• **Documentation.**

Nurses are taught to document the problem, what the knowledge deficit is related to, the assessment of a patient's readiness to learn, who was taught, the teaching method, the patient's response to the teaching intervention, and what progress the patient has made toward an expected outcome.

The instructor goes over the content covered with a practice scenario using a patient who has been prescribed warfarin, a medication to prevent blood clots.

SOURCE

For more information about the nursing orientation on patient education at Massachusetts General Hospital, contact:

• **Brian M. French**, RN, BC, Manager, The Maxwell & Eleanor Blum Patient and Family Learning Center and The Knight Simulation Program, The Institute for Patient Care, Patient Care Services, Massachusetts General Hospital, Boston. E-mail: BFrench@MGHIHP.edu. ■

Venues supplement orientation instruction

Staff learn with in-services, modules, tip sheets

While a two-hour orientation on patient education provides a good introduction to resources and teaching methods at Massachusetts General Hospital in Boston, it is difficult to provide all the details in such a short time period, says **Brian M. French**, RN, BC, manager of The Maxwell & Eleanor Blum Patient and Family Learning Center and The Knight Simulation Program at the hospital.

Therefore, the patient education nurse from the learning center conducts unit-based in-services upon request and one-on-one coaching or small group sessions on how to find information on the hospital's intranet.

Two modules for Healthstream, the hospital's online learning management system, are being developed. One is on teach/show-back technique, and the second covers online resources. Because Massachusetts General Hospital has a decentralized patient education system, resources are not found in one online location but in several places.

When the patient education committee was planning the curriculum for the orientation, it performed a brief survey of staff. It found there was a lack of awareness of available resources for teaching patients, and even when staff members were aware of the resources, they lacked the ability to find them online, says French.

A sub-group of the patient education committee creates tip sheets or articles for the Patient Care Services' newsletter as well. One tip sheet was on teach-back. *[A copy of the tip sheet is included with the online issue of* Patient Education Management *available to subscribers on the Internet at http:///www.ahcmedia.com/public/products/Patient-Education-Management.html. On right side of the page, select "Access your newsletters." You will need your subscriber number from your mailing label. For assistance, contact customer service at (800) 888-2421 or customerservice@ahcmedia.com.]*

"We try to do multiple things to raise awareness, help staff know the resources better, and improve their teaching technique," says French. ■

Gold Star
AWARD

Patients learn skills for cancer survivorship

Interventions occur during radiation therapy

An education program to convert active cancer patients to cancer survivors called "Road to Wellness" has lofty goals, according to its author, **Matthew Ballo**, MD, professor of radiation oncology at M.D. Anderson Regional Care Center in the Bay Area, Nassau Bay, TX.

Although lofty, the achievement of these goals garnered Road to Wellness an Excellence in Patient Education Award from the Cancer Patient Education Network in 2011

The components of the program are designed to equip patients with the skills needed to be cancer survivors. It might be a new normal, because patients learn how to eat healthy and exercise, which might not have been part of their lifestyle prior to cancer, says Ballo. Also they learn skills for coping with stress and smoking cessation, if needed.

EXECUTIVE SUMMARY

A program titled "Road to Wellness" gives patients undergoing radiation therapy for cancer treatment the skills they need to be cancer survivors. Interventions include:

- a consult with exercise physiologist;
- recommendations on nutrition from a dietitian;
- stress management lessons from a social worker;
- smoking cessation if needed.

When Ballo first sees the patients, they are in the middle of their cancer treatment, beginning radiation. At that time, he introduces the program to get patients to think of themselves as prostate cancer survivors, breast cancer survivors, or colorectal cancer survivors. What is unique about the program is that it is an intervention, explains Ballo.

Instead of just telling people to start eating well and exercising, hands-on instruction is provided. Patients meet with a dietitian who recommends diet modifications or creates a personal diet plan. Also they attend nutrition classes for continued support.

An exercise physiologist assesses a patient's fitness level and designs an exercise plan. A social worker teaches patients stress management skills, such as deep breathing exercises and guided imagery, and offers a stress management class. Finally, if patients smoke, they are referred to the smoking cessation program on the main campus of M.D. Anderson Cancer Center in Houston.

The nutritionist and social worker are provided by M.D. Anderson Cancer Center. The exercise physiologists who participate in the program work at St. John Hospital in a neighboring building. They have an exercise facility where patients can work out for 45 minutes to an hour for a minimal fee when they come for their radiation treatment.

Many reasons for success

"Our program has been a huge success here in the Bay Area because of the collaboration we have with St. John Hospital and the dedication of our nurses, social worker, and dietitian," says Ballo.

Also important is the fact that Ballo as the physician introduces the program, goes over the importance of the four components, and lets the patients know it is important to him that they participate. It is a six-week program, coinciding with their radiation treatment schedule.

The four components of the program were chosen for several reasons. Ballo says he knew what to include from the information gathered in lectures he attended as a physician, a comprehensive literature search, and information from a report published by the World Cancer Research Fund in London, England, titled "Policy and Action for Cancer Prevention — Food, Nutrition, and Physical Activity: a Global Perspective." *(To learn how to obtain a copy of this report, see resource at the end of this article.)*

The program was first launched on a small scale in 2007. In 2010 grant money was used to create a polished packet of materials for the program, rather than distributing photocopied handouts. **Desiree Gonzales Phillips**, MCHES, a senior health education specialist within the Patient Education Office at M.D. Anderson Cancer Center, worked on the project. Some of the information was rewritten to a sixth-grade reading level, and additional documents were included from the cancer center's education database.

An evaluation form was created as well, to be mailed to patients a month after they complete treatment. The forms that have been returned indicate that patients find the program very useful in their treatment. Phillips says most continue the interventions.

SOURCE/RESOURCE

For more information about the Road to Wellness, contact:

- **Matthew Ballo**, MD, Professor of Radiation Oncology, MD Anderson Regional Care Center in the Bay Area, Nassau Bay, TX. E-mail: mballo@mdanderson.org.
- **Desiree Gonzales Phillips**, MCHES, Senior Health Education Specialist, Patient Education Office, M.D. Anderson Cancer Center, Houston, TX. E-mail: ddgonzal@mdanderson.org.
- **World Cancer Research Fund report**: The report can be viewed or downloaded at www.dietandcancerreport.org. Click on "Resource Centre" which displays a page with photos of each report and titles beneath them. Click on "Policy Report." ■

For better access, bring the library bedside

Use volunteers to fill patient requests

To make sure patients have their questions answered and obtain the information they need, **Jackie Davis**, MLIS, consumer health librarian at Sharp Memorial Hospital in San Diego, CA, started a Health Ambassador Program.

The program is a partnership between the consumer health library and the volunteer department at the hospital. The volunteers involved in the program have a discussion with Davis about consumer health. They then are given forms to fill out as they visit patient rooms to ask if additional health information is needed. When patients and families have ques-

EXECUTIVE SUMMARY

A Health Ambassador Program implemented at the consumer library at Sharp Memorial Hospital in San Diego, CA, helps patients and families gain access to information on their condition and other health issues.
- Volunteers fill request forms at the bedside.
- Information is provided with reading difficulty in mind.
- Contact information is given to encourage future use.

tions or concerns, the volunteer fills out the form and brings it back to Davis, who fills the request.

Davis says she tries to find information at the most basic level because she does not know the literacy level of the patients. Also, she reviews the material with the volunteer so he or she can go over the items with the patients and families. For example, an article might contain an answer to one of their questions, so she places a sticky note on the section with the information and provides the details to the volunteer.

When patients and families say they have no questions or health concerns, the volunteer leaves information on how to contact the librarian should they change their minds. People can text Davis, e-mail her, telephone, or come to the resource library. Patients can use the library at any time, even after discharge, says Davis. The use of the library is free and open to anyone in the community.

When patients and family members tell the volunteers they already have done computer research to find information, they are given a bookmark about the Medline Plus web site. This bookmark is a way to "gently" direct consumers to quality, trustable, online health information, says Davis.

"The Health Ambassador Program takes the health information accessibility to a whole different level," says Davis.

SOURCE

For more information about the Health Ambassador Program, contact:

• **Jackie Davis**, MLIS, Consumer Health Librarian, Sharp Memorial Hospital, San Diego, CA. E-mail: Jackie.Davis@sharp.com. ■

Parents' literacy screen helps reduce costs

Alerts when parents need extra education

A pilot program in which parents or caregivers of patients were screened for health literacy reduced healthcare costs and emergency department use for patients at Cook Children's Medical Center in Fort Worth, TX. Parents and caregivers who did not successfully screen received additional comprehensive education on caring for the children during the pilot program initiated in March 2008.

The program generated an average savings of $3,545 per patient when costs were measured against those incurred by select group of members in the Cook Children's Health Plan, according to **Margie Dorman-O'Donnell**, RN, MSN, director of case management.

"We believed that poor literacy among the parents played a role in lack of compliance to the treatment plan following discharge, but we didn't know how to address the problem," O'Donnell says. "Our answer came when Cook Children's created a new 10-bed unit for children who need short stay observation or extended treatment, such as for asthma."

Working with their three physician advisors, the case management team researched ways to screen for healthcare literacy and selected the Newest Vital Signs screening tool to determine the literacy of the parents. Parents of every child admitted to the short-stay unit are assessed for healthcare literacy.

"Good literacy skills are paramount if we expect parents to understand the discharge plan," Dorman-O'Donnell says. "Parents need to follow at home what they learned in the hospital. For instance, they need to be able to read and understand prescription labels and to know that their children need to take their medicine at a certain time and how many pills or milliliters of liquid they need to take."

Parent and caregiver education at Cook Children's incorporates the teach-back method, which asks the parents to repeat what they have been told and the "Ask Me 3" tool to further determine parents' understanding of their child's hospital stay and discharge instructions. "Ask Me 3" questions are: "Do you know why your child is in the hospital?" "What do you need to do when you get home?" and "Why do you need to do that?"

Everyone on the unit, including the nurses, the interpreters, the pharmacist, the respiratory therapist, and the RN case manager, is trained on "Ask Me 3" and teach back. The two tools are used to assess each family's level of understanding, but the amount of time they spend teaching each family varies significantly. Those who did not successfully screen for healthcare literacy are enrolled in a special case management program that includes more focused teaching and post-discharge follow-up to assess their understanding and compliance with discharge instructions. The education is repeated frequently throughout the

stay and again at the time of discharge.

"We want to make sure that the parent understands the child's condition and how to take care of it," Dorman-O'Donnell adds.

The unit's RN case manager calls the parents who did not successfully complete the literacy screen 5-7 days after discharge to determine if they are following the discharge instructions. During the call, the case manager reinforces hospital teaching, checks on follow-up appointments with primary care physicians, and arranges transportation if the family needs it.

"Initially, we called them back one or two days after discharge, but we determined that it was too early to get an accurate assessment of compliance with the medication regimen," Dorman-O'Donnell says. "A lot of parents stopped giving the children their medication after they started feeling better. Since most prescriptions are for a seven-day supply, by waiting, we can determine if they have taken all or almost all of the medication."

Simplifying teaching materials is an ongoing process, she says. "Medication administration is one area of improvement in Cook Children's discharge teaching process," Dorman-O'Donnell adds.

Working with the hospital pharmacists, the short-stay unit team developed a color-coded tutorial to instruct parents on how to give their children their medication. The instructions have a colored dot for each medication that corresponds with the color on the prescription label. Instead of using "morning," "noon," or "evening" to designate when the medication should be taken, the hospital uses a rising sun for early day, a full sun for mid-day, and a moon for evening. When patients fill their medication somewhere other than the hospital pharmacy, the case manager calls the pharmacy and asks that the label be color-coded as well. In special cases, such as when parents are color blind, the pharmacist pastes one pill on the bottle and another on the instruction sheet.

When members of the unit team use "teach back" and "Ask Me 3," they are not evaluating how much information the parents know. They are evaluating how well they are teaching the information, Dorman-O'Donnell says.

"Parents want to do what is right and what is best for their child," she says. "Some of the parents learn by seeing, some by hearing, and some by doing. Our challenge is to figure out the best method for delivering information to our parents at their level of understanding."

RESOURCE

The Newest Vital Signs tool, available in English and Spanish, is based on a nutritional label from an ice cream container. The parents (or in the case of adults, the patients) are given the label and asked six questions about the label. Their answers enable the healthcare professional to determine their ability to read, understand, and act on healthcare information. For more information, see: http://www.pfizerhealthliteracy.com. Select "Physicians & Other Providers," then select "Risk Assessments & Screening," and "The Newest Vital Sign." ■

Coaching helps cut readmissions

Face-to-face encounters included

A year after Saint Joseph-London Hospital in London, KY, began a heart failure readmissions program, 30-day readmissions dropped from 27.7% to 15.9%. A similar program for patients admitted for acute myocardial infarctions (AMI) reduced the readmissions rate from 23% to 10% in a short time.

A study of the reasons for readmissions showed that variation in discharge plans and lack of patient preparation for managing their care were the main reasons for the readmissions, says **Mary Osborne**, RN, MSN, MBA, executive director of Innovative Cardiac Solutions, a management company with which the hospital contracts to manage its cardiac service line. The hospital serves five counties in the Appalachian region of southeast Kentucky. Those counties are in a rural area with low income levels and high rates of obesity, coronary artery disease, and diabetes. Cardiology represents about 65% of hospital business, Osborne adds.

The program includes face-to-face encounters with patients by **Shalan Gibbs**, RN, BSN, the hospital's heart failure and AMI transition coach, who visits them in the hospital, calls them after discharge, and sees them in the heart failure and AMI clinics within a week after discharge. The clinics are run by mid-level providers who see patients only once or twice during the 30 days following discharge.

"We aren't trying to replace the primary care physicians or cardiologists in the community," Osborne says. "The clinic supports patients through the acute phase of recovery."

Gibbs attributes the success of the program to meeting patients face-to-face and getting to know them. "We establish rapport before the patient leaves the hospital," she says. "They know I'll call and see them at the clinic, and they know they can call me any time. I still get calls from some patients who have questions months after discharge."

The hospital started the program in mid-2010 and focused on heart failure patients initially, then

rolled it out to include AMI patients. Each day, Gibbs reviews the entire hospital census to identify heart failure patient and AMI patients. She visits them, usually on the second day of the hospital stay, to educate them on their disease process and to review their diet, medication, and other parts of the treatment plan. With AMI patients, she usually waits to see what kind of intervention they are having so she knows what kind of education they will need. She often sees patients having a coronary artery bypass graft before discharge.

"I work hand in hand with the case managers to get patients ready for discharge," Gibbs says. "The difference is that I have the time to sit down and talk to them for as long as needed, whereas the case managers have other jobs to do as well as educating patients. I stress to them that they can call me when they get home if they are having any problems or have questions."

If patients qualify for home health services, Gibbs follows up with the patients to make sure services are coordinated. "If they don't have a primary care physician, I make sure they have one before they are discharged," she says. Gibbs sets up an appointment with the heart failure or AMI clinic within a week of discharge. "Many patients who are readmitted come back within the first seven days. We like to see them in the clinic to take care of any issues that could cause a readmission," she says.

Gibbs calls the patients within 72 hours after discharge and goes over their treatment plan and their medication regimen, and she makes sure they have scheduled an appointment with their primary care physician in addition to the clinic visit. "If they aren't following their discharge plan, I determine what the barrier is and work to overcome it," she says. Many times, patients didn't fill their prescriptions because they couldn't afford it. In those cases, Gibbs helps them sign up for the hospital's pharmaceutical assistance program, which helps patients who qualify obtain heart and diabetic medicines.

According to Osborne, about 90% of patients who visit the heart failure clinic need a medication adjustment. "We can get the medication adjusted early and avoid problems down the road," she adds.

With heart failure patients, the biggest roadblock to compliance is diet. Gibbs says, "I pull up a footstool and sit next to the bed and talk about what they like to eat. By making small talk, I usually can pick up where the problems are."

Gibbs gives heart failure patients a list of foods they should avoid. She urges them to get rid of their salt shaker, and she shares recipes and seasonings that can substitute for salt. "Many patients are elderly and eat things that are quick and easy to prepare but are chocked full of sodium," Gibbs says. "Canned soup is what lands a lot of people back in the hospital. I suggest that they look for low sodium soup. It still has a lot of sodium, but at least they are cutting back."

A year after the program started, most of the heart failure readmissions are patients with end-stage disease, Osborne says. "We are working to get them referred to hospice care if that is appropriate," she says. "It's been a challenge because thinking about hospice is so difficult for patients and their families."

Many of the heart failure patients already have Medicare and/or Medicaid. AMI patients frequently are younger and many have no insurance. About 80% of the AMI patients did not know they had a heart problem until they came to the hospital. Gibbs says, "It's a totally new experience for them. They tend to be more compliant about that than heart failure patients because of the fear that comes with having a heart attack, but they need far more resources."

Many of the patients are self-pay and don't follow up with their physician or get their prescriptions filled because they can't afford it, she says. A hospital social worker is called in and gives them a voucher for two weeks supply until the medication from the pharmaceutical assistance program is available.

Gibbs visits them after their interventions and goes over their treatment plan with them. She discusses the need to exercise, and she educates them on a heart healthy diet. Gibbs asks them to sign a contract agreeing to take their medication and follow their treatment plan.

"I educate them on why it's important to take their medication and urge them to call me if they run out and can't get it," she says.

SOURCES

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Infection prevention aimed at cancer patients

Vulnerable population needs attention

Each year more than one million patients receive cancer treatment in an outpatient oncology clinic. Despite advances in oncology care, infections from community and healthcare settings remain a major cause of hospitalization and death among cancer patients receiving chemotherapy.

To help protect this vulnerable patient popula-

tion, the Centers for Disease Control and Prevention (CDC) is launching a program featuring tools to help clinicians and patients prevent infections.

"Cancer patients receiving chemotherapy often have weak immune systems and need to be kept safe against germs," said CDC Director **Thomas Frieden**, MD, MPH. "These new resources help patients take an active role in protecting themselves against infection and give doctors, nurses, and other clinicians necessary tools to better prevent infection."

CDC's Preventing Infections in Cancer Patients program is a comprehensive initiative focusing on providing information, action steps, and tools for patients, their families, and their healthcare providers to reduce the risk of life-threatening infections during chemotherapy treatment. These resources include an interactive web site (www.preventcancerinfections.org) for cancer patients and caregivers, as well as a Basic Infection Control and Prevention Plan for use by outpatient oncology settings. (http://www.cdc.gov/hicpac/basic-infection-control-prevention-plan-2011).

The new web site, named "3 Steps Toward Preventing Infections During Cancer Treatment," includes a questionnaire that helps cancer patients understand their risk for developing a condition called neutropenia, a low white blood cell count during chemotherapy. Neutropenia is a common and potentially dangerous side effect of chemotherapy that reduces a patient's ability to fight infection. Cancer patients and caregivers can answer a few questions about their risk factors and receive information about how they can prepare, prevent, and protect themselves from getting an infection during their cancer treatment:

Prepare: Watch out for a fever during chemotherapy.

Prevent: Clean your hands.

Protect: Know the signs and symptoms of an infection and what to do if you develop any signs or symptoms.

For health care providers and facility administrators, The Basic Infection Control and Prevention Plan for Outpatient Oncology Settings includes key policies and procedures to ensure the facility meets or exceeds minimal expectations for patient safety, as described in the newly released "CDC Guide to Infection Prevention in Outpatient Settings." That guide is available at http://www.cdc.gov/HAI/settings/outpatient/outpatient-care-guidelines.html. The elements in this plan are based on CDC's evidence-based guidelines and those from professional societies.

Alice Guh, MD, medical officer and co-lead of the initiative at CDC, said, "Outpatient oncology facilities' attention to infection prevention varies greatly. Repeated outbreaks resulting from lapses in basic infection prevention practices, such as syringe reuse, have put patients at risk. In some of these cases, the implicated clinic did not have written infection control policies and procedures or regular access to infection prevention expertise."

It is critical that care of this vulnerable patient population be provided under conditions that minimize the risk of healthcare-associated infections, the CDC says. This responsibility should be shared by clinicians, to follow best practices and facility administrators, to ensure that staff has appropriate resources and training, the agency says. A combined approach will help to emphasize the importance of creating a culture of infection prevention at all healthcare facilities, it says.

The CDC recommends that outpatient oncology facilities use the plan in one of the following ways:

Facilities that have a plan in place should ensure that its policies and procedures include the elements outlined in this tool.

Facilities without a plan should use this resource as a tool to draft and implement a plan for their facility.

Facilities can use this plan as written or modify it with facility-specific information.

"Preventing Infections in Cancer Patients" was developed by oncology and infection prevention experts from the CDC in partnership with external experts and the CDC Foundation. To access the plan, checklist, clinician and patient education materials and additional information, please visit http://www.cdc.gov/cancer/preventinfections. ■

Smoking cessation is focus of publications

The Sept. 28 issue of the "Health Care Innovations Exchange," available from the Agency for Healthcare Research and Quality (AHRQ) at http://www.innovations.ahrq.gov/issue.aspx?id=113, includes the following.

- The "featured Innovations" describe two programs that led to increased use of smoking cessation resources and higher quit rates.
- The "featured QualityTools" provide practical approaches for treating tobacco dependence in the clinical setting and for achieving tobacco-free hospitals and health systems.

More innovations and tools related to smoking cessation are available on the Innovations Exchange Web Site (http://www.innovations.ahrq.gov), which contains more than 650 searchable innovations and 1,625 searchable QualityTools. Search for "smoking

cessation."

In other news, the "Tobacco-Use Cessation Counseling Services" brochure is available in a hard-copy format from the Medicare Learning Network. This brochure is designed to provide education on tobacco-use cessation counseling services.

To place your order, visit http://www.CMS.gov/MLNGenInfo. Scroll down to "Related Links inside CMS," and select "MLN Product Ordering Page." ■

Best practices in patient safety

Guide for educators to teach providers

The World Health Organization has published the "Multi-professional Patient Safety Curriculum Guide" to help educators around the world train health professionals to bring about improvements in patient safety.

In a foreword included in the guide, **Sir Liam Donaldson**, WHO's envoy for patient safety, writes that patient safety became a global movement following the Institute of Medicine's "To Err is Human" report in 1999 and a 2000 report from Britain's Chief Medical Office.

"Yet, the current state of patient safety worldwide is still a source of deep concern," he notes. "As data on the scale and nature of errors and adverse events have been more widely gathered, it has become apparent that unsafe care is a feature of virtually every aspect of health care."

The guide includes teaching slides on 11 topics ranging from improving medication safety to effective teamwork and infection prevention and control. Its slides explain why patient safety has become an urgent concern: Patients can't rely on antibiotics; there is an increased rate of nosocomial infections; and infected patients stay in hospitals longer, might die, and are prone to surgical site infections). It also discusses causes of infections and strategies for preventing them, including hand washing, housekeeping, and personal protective equipment (PPE).

WHO wants facilities to start with Part A of the guide, which is an educator's guide containing advice on how to introduce and build patient safety courses. The organization has posted endorsement letters from the International Council of Nurses and the International Pharmaceutical Federation.

The guide is available at http://www.who.int/patientsafety/education/curriculum/Curriculum_Tools/en/index.html. ■

COMING IN FUTURE MONTHS

- Update on Joint Commission communication standards
- Are Facebook/Twitter good education venues?
- Resources for multi-language teaching sheets
- Unlikely resources for chronic disease management

Drug communications available in Spanish

The Office of Communications at the Center for Drug Evaluation and Research has launched a pilot program to provide Spanish language versions of the agency's Drug Safety Communications (DSCs). The Spanish versions

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.

are available at http://www.fda.gov/Drugs/DrugSafety/ucm263010.htm.

Given various time and review constraints, the Spanish version DSCs generally will follow the English version by about 1-2 weeks. Recent Spanish version DSCs:

Celexa Update: Comunicado de Seguridad de Medicamentos de la FDA: Ritmos cardíacos anormales asociados con dosis altas de Celexa (bromhidrato de citalopram) ■

CNE QUESTIONS

1. When determining strategies for improving patient provider communication, some experts in the field of health literacy recommend which of the following?
   A. Choose best practice.
   B. Obtain input from clinicians/patients.
   C. Look at the research.
   D. All of the above.

2. Curriculum to improve a patient's ability to communicate with the physician created by the Healthy York County Coalition teaches that patients are the most important person on the healthcare team.
   A. True
   B. False

3. An orientation class on the patient teaching process at Massachusetts General Hospital includes elements for basic instruction. These include which of the following?
   A. Writing plain language materials
   B. Accessing an interpreter
   C. Assessing readiness to learn
   D. None of the above

4. The "Road to Wellness" program at M.D. Anderson Regional Care center in the Bay Area teaches health practices, such as nutrition and stress management, once radiation therapy is complete in order to foster cancer survivorship.
   A. True
   B. False

Collaborative Governance

"promoting excellence every day"

Patient Education Committee

Teachable Moments
Teach Back/Show Back Method

What is the Teach Back/Show Back Method?

- The Teach Back/Show Back method is a patient teaching technique used to determine the patient's baseline knowledge and to evaluate the patient's understanding of the content that has been taught.

Steps for Teach Back/Show Back:

1. Assess what the patient already knows about the topic.
2. Provide teaching on any new medication, test, skill or treatment.
3. Ask the patient to repeat in his/her own words what was you have taught or demonstrate the new skill (see tips below).
4. Identify and correct any misunderstandings.
5. Repeat steps 3 and 4 until comprehension and safety are ensured.

Teach Back/Show Back Questions:

- Use open-ended questions to assess understanding:
  - Don't ask: "Do you understand?" or "Do you have any questions?" or "Do you think you can do this?"
  - Do ask/say: "I want to make sure I explained your meds correctly, could you tell me, in your own words, what you need to know about this medication?" or "Please show me how you would test your blood sugar at home."
- Consider asking questions such as "If you had to explain what you just learned to your husband, how would you explain it?"

Resources:

1. The Maxwell & Eleanor Blum Patient and Family Learning Center (http://www.massgeneral.org/pflc/)
2. Healthstream module:
   "Improving your Patient/Family Teaching Skills Through the Teach Back/Show Back Method"

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2011 Index

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