Patient Education Management™

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

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IN THIS ISSUE

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JCAHO reorganizes patient education standards, merged with provision of care

Some educators feel that integrating the standards obscures their role

It is difficult to predict what impact the revised patient education standards will have once they are implemented by the Oakbrook Terrace, IL-based Joint Commission on Accreditation of Healthcare Organizations (JCAHO). On Jan. 1, 2004, the majority of the standards officially will be included in a new chapter titled "Provision of Care" along with the assessment, care, and continuum of care standards.

"It is a little early to tell how the changes will impact us over the long run. I think it really helped in the past when they developed the education chapter because it helped us become a major focus," says **Louise Villejo**, MPH, CHES, director of patient education at M.D. Anderson Cancer Center in Houston. The downside to the changes is that patient education could become lost among the other standards, she adds.

To make sure that this does not happen, patient education managers may have to work harder to ensure that education is an integral part of patient care. They may need to keep bringing the standards to the attention of

EXECUTIVE SUMMARY

Many patient education managers are apprehensive about the Joint Commission on Accreditation of Healthcare Organizations' integration of patient education standards into the "Provision of Care" chapter of hospital accreditation standards for 2004. While the standards actually have not changed, they no longer will be as visible. According to the Joint Commission, combining the assessment, care, education, and continuum of care chapters into one new chapter reinforces the concept that the provision of care is a series of interrelated components of an integrated process.

leadership and clinical staff, working with them hand in hand to make sure they are met, says Villejo.

A separate chapter has given patient education a lot of visibility, says **Annette Mercurio**, MPH, CHES, manager of patient, family, and community education at City of Hope National Medical Center in Duarte, CA.

"When I heard that there was no longer going to be a separate chapter, I was a little concerned about whether the emphasis or prominence of patient education was going to decrease or not," she says.

Currently, in the introduction to the patient education chapter, there is a diagram showing the systematic approach to education that provides a good overview of the process. Mercurio says she will miss that tool because it shows the big picture. Sometimes people forget that it is more than handing out materials, she reports.

However, the integration of assessment, care, education, and the continuum of care does make sense, says Mercurio. For the patient, it brings together all these processes so that health care providers don't think of them separately. Ultimately, it could strengthen patient education, she says.

Goal of the Joint Commission

The changes made were in no way an effort to diminish the importance of patient education, says **Nancy Kupka**, BNSc, MPH, RN, associate project director in the Division of Standards and Survey Methodology at the Joint Commission. "One of the hallmarks of quality care is educating and empowering the patient," she reports.

Although patient education is no longer a standalone chapter within the 2004 accreditation standards, the requirements have not really changed; they are just formatted and presented differently, says Kupka. The standards were reworded and condensed, but no requirement for patient education was removed, she says. Overall, only a few standards that were outdated or obscure were eliminated.

"We really tried to retain all the existing requirements. We wanted to streamline the way in which they were presented," says Kupka.

The new format includes:

- a brief statement of the standard;
- a rationale for the standard, when appropriate, and background or additional information about the standard;
- elements of performance that provide specific information about the precise basis for scoring compliance with the standard;
- a self-scoring mechanism to help organizations determine compliance;
- elimination of compliance tips, also called examples of implementation. These tips instead will be found on JCAHO's web site allowing for more frequent updates that will help organizations meet standards requirements.

A pre-publication version of the new standards also can be viewed on the Joint Commission web site, www.jcaho.org. There also is something called a "crosswalk" on the site, which is designed to help health care professionals see how the language of the standards has been changed by comparing the

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former standard with the new version.

In viewing the crosswalk, **Cezanne Garcia**, MPH, CHES, manager of patient & family education services at the University of Washington Medical Center in Seattle, found much of the new wording incomplete. Many of the specific details have been removed, which leaves the standards open to various interpretations, she says.

The standards are more generalized now because it is impossible to create a list of requirements that fit every health care institution, explains Kupka. Education needs to be appropriate to the scope of services offered, the patient population, and the individual patient. For example, educational materials and teaching protocols for diabetes would be different in an outpatient diabetes center from a general medicine unit in the hospital, she adds.

Anyone who has trouble implementing the standards can contact the standards interpretation department at the Joint Commission either by telephone or e-mail. "We will work with the organization to see if they are meeting the standard," says Kupka. Once people begin implementing the newly organized standards they are welcome to offer comments on areas in which they see problems occurring as well, she says.

The good news is that there still is a primary focus on educating patients and families, says **Kathy Ordelt**, RN, patient and family education coordinator at Children's Healthcare of Atlanta. "[Former U.S. Surgeon General] C. Everett Koop said it best when he said, 'There is no prescription more valuable than knowledge.' This is even more important given our present health care environment," she says.

Kupka says that while some would argue that patient education is diminished by not having a separate chapter, others would say that because it is integral to caring for patients it shouldn't be in a separate chapter.

She is in the second group, as is **Dorothy Ruzicki**, PhD, RN, director of the Department of Educational Services at Sacred Heart Medical Center in Spokane, WA. "I've always believed that patient education is part of total patient care and by pulling it out it becomes more the responsibility of a single person. It should be integrated into nursing care not seen as a separate activity apart from all the care a patient gets," she says.

(Editor's note: As health care institutions begin to prepare for Joint Commission surveys in 2004, Patient Education Management *will print a follow-up article to discuss how they are structuring their committees and how patient education becomes part of the equation.)* ■

Where are you going for your medical information?

Be selective about Internet resources

As part of her job as a health education specialist at Phoenix Children's Hospital, **Fran London**, MS, RN, works as a nurse in The Emily Center, the consumer health library. Nurses at the center research answers to questions about child health and illness posed by parents from all over Arizona who either visit the library, call, or e-mail questions.

"As the Internet has become more accessible and has included more good information, the questions that are brought to us get more complex or difficult to answer," reports London.

To find the answers posed by consumers, she

and her colleagues search web sites open to everyone as well as health-related databases that Phoenix Children's Hospital has subscribed to, such as OVID and MD Consult.

The information provided to families depends on their questions, says London. It ranges from evidence-based clinical information, to scientific research, to reliable and valid practical advice from other families that have had the same experiences.

Some questions parents have come to the library with involve new diagnoses such as neurofibromatosis, irritable bowel disease with systemic juvenile rheumatoid arthritis, and a premature baby with a grade III intraventricular hemorrhage. Other families ask about ongoing problems, such as how to best manage the behavior of a child with bipolar disorder or what will be the course of recovery of a child who has had brain trauma. "The answers to all of these questions were found using our Internet resources," she explains.

Years ago when London researched her master's thesis, she did it manually looking through rows and rows of books such as the *Cumulative Index to Nursing, Allied Health Literature,* and *Index Medicus.*

"In comparison, search engines are a breeze," London points out. "I love searching PubMed, and within minutes finding research on my topic and immediately printing the article."

Good resources

For research London uses sites approved by the Health on the Net Foundation Code of Conduct for medical and health web sites and peer-reviewed journal articles as well as sources that she and other nurses at The Emily Center have found to be reliable.

The web sites she returns to time and again because they offer valid, reliable information include the following:

• MedLine Plus — www.nlm.nih.gov/medlineplus/sitemap.htm

This site accesses the U.S. National Library of Medicine with information on health topics, drugs, and a medical encyclopedia. Information also is available in Spanish.

• eMedicine — www.emedicine.com

This site offers patient handout material on more than 500 conditions and disorders. The clinical information is written in conjunction with the American Academy of Emergency Medicine.

• Medem — www.medem.com

Medem's medical library provides consumers with reliable health care information from introductory to advanced texts.

• PubMed — www.ncbi.hlm.nih.gov/entrez/query.fcgi

PubMed is a service of the National Library of Medicine, providing access to more than 12 million MedLine citations dating back to the mid-1960s and additional life science journals. PubMed includes links to many sites providing full-text articles and other related resources.

• MD Consult — http://home.mdconsult.com

MD Consult is a subscription web site aimed at physicians. Its purpose is to aid in patient education.

• National Guideline Clearinghouse — www.ngc.gov

The Clearinghouse is a public resource for evidence-based clinical practice guidelines.

• Centers for Disease Control and Prevention (CDC) — www.cdc.gov/health/default.htm

The Atlanta-based CDC has a section titled "Health Topics A to Z."

• Federal Drug Administration — www.fda.gov/advsearch.html

This is the advanced search page for the Federal Drug Administration web site on sections such as "Center for Food Safety and Applied Nutrition" and "Center for Drug Evaluation & Research."

• Healthfinder — www.healthfinder.gov/

Site includes a health library with information on prevention and wellness, diseases and conditions, and alternative medicine. It also has a medical dictionary, encyclopedia, and journals.

• Health Canada — www.hc-gc.ca/English/

This site's selections include healthy living, health care, diseases and conditions, and health protection.

• The Ohio State University — www.osu.edu/units/osuhosp/patedu/patedu.htm

This web site from The university's library for health information provides information on illness and attaining a healthy lifestyle.

The search engines London prefers are Google, www.google.com, and Vivisimo, http://vivisimo.com.

One downside to providing consumers information from Internet research is the reading level of the information.

"I wish there was more patient education material on the Internet that is written in keeping with SAM [Suitability Assessment of Materials]

SOURCE

For more information about Internet research, contact:

- **Fran London**, MS, RN, Health Education Specialist, The Emily Center, Phoenix Children's Hospital, 1919 E. Thomas Road, Phoenix, AZ 85016-7710. Telephone: (602) 546-1395. Fax: (602) 546-1408. E-mail: flondon @phoenixchildrens.com. Web site: www.phoenix childrens.com.

readability standards so our learners can easily understand what they need to do to get and keep themselves healthy," says London.

In addition to working in The Emily Center, she develops the teaching materials produced in house and helps staff improve their patient education skills as part of her job duties as health education specialist. London has found it more difficult to find information on the Internet that describes how to best provide patient and family education and how to assess learning needs or evaluate understanding than information on general health topics. There is information on health literacy issues, some on aspects of different cultures, and some on adult education principles, she says.

[Editor's note: Patient Education Management *would like to cover research on a more regular basis. If you find the Internet a vital tool for meeting your job duties please contact: Susan Cort Johnson, editor,* Patient Education Management, *P.O. Box 64, Westwood, CA 96137; telephone: (530) 256-2749; e-mail: suscortjohn @onemain.com. If e-mailing, please state in the subject section of the message that the information is on Internet research for a* PEM *article.]* ■

Identify smokers, then you educate

Smoking cessation intervention upon admission

Identifying smokers when they are admitted to the hospital and offering information on how to quit is good practice, says **Connie Graff**, RCP, AE-C, a respiratory therapist at Lake Region Healthcare Corporation in Fergus Falls, MN.

"This is an opportune time to reach patients because they are thinking about their health and no one can deny that smoking does not affect your health," says Graff. Their hospitalization may be a direct result of smoking; and if not, it still gets them in the frame of mind to consider their health. In addition, they go through days of not smoking while hospitalized so they might as well make it a permanent quit time, she says.

Smoking cessation intervention upon hospital admission is recommended by many professional organizations, says **Jennifer Robinson**, RN, MHS, patient education coordinator at Roper St. Francis Healthcare in Charleston, SC. "Often when your health is compromised, it is a wake-up call that you need to make a change in your lifestyle," she says.

Good opportunity to teach

While patients can't be forced to quit, it is important to at least provide the information and help if they choose to take the step, says Graff.

"While it doesn't work to nag people, if the health care professional doesn't say anything that sends a bigger message," she explains. "That bigger message is, 'my smoking must not be so bad if no one said anything to me about it.'"

To identify smokers, during the admitting process many health care institutions ask whether or not the patient smokes. A positive response will then trigger an educational intervention.

While some health care institutions are including smoking cessation interventions voluntarily to achieve best practice, others are participating in programs that mandate it. For example, hospitals that have elected to participate in one of three core measure sets (acute myocardial infraction, heart failure, or community acquired pneumonia) implemented by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) in Oakbrook Terrace, IL, must include smoking cessation intervention with certain patient groups, says **Virginia Reichert**, NP, director of the Center for Tobacco Control for the North Shore-Long Island Jewish Health System in Manhasset, NY.

To make sure that nurses document whether the patient smokes, the computerized admission system at this health care institution locks up and the nurse is unable to finish the admission process if information on the patients smoking habits have not been entered into the computer within eight hours after hospitalization, says Reichert.

Patients who smoke are given a self-help brochure on how to quit smoking that includes information on how to set a quit date and how to deal with the signs and symptoms of withdrawal.

The pamphlet also includes information about the free smoking cessation program offered at the Center for Tobacco Control.

Further intervention

In addition, if the patient was admitted to the hospital for congestive heart failure, acute myocardial infarction, or community acquired pneumonia the computer automatically triggers a printout on the patient at the Center for Tobacco Control. Reichert waits until the patient is stable and then visits him or her to discuss smoking cessation.

"Many are still not ready to quit. They swear they will call us when they get home and then they don't. However, we often find that they will call four months later," says Reichert.

When they do call they are enrolled in a six-week smoking cessation class that includes lessons on preparing for the quit date as part of the smoking cessation plan and nicotine replacement to help the smokers deal with withdrawal symptoms.

In addition to the general smoking cessation classes, the Center for Tobacco Control offers smoking cessation classes for cancer patients, pregnant women, and adolescents.

At Lake Region Healthcare, nurses document if the patient is a smoker upon admission and the unit clerk enters the information into the computer system. Respiratory care retrieves the list from the computer and therapists visit these patients. During the visit, the respiratory therapist assesses the patient's need for nicotine replacement and initiates the process for prescriptions if the patient is having withdrawal symptoms.

Also, the respiratory therapist provides the patient with information on the institution's smoking cessation program and leaves a business card with contact information.

The program entails individual counseling appointments with the patient returning for as many sessions as needed. During the first visit, the patient is assessed to determine where he or she is at in the process of quitting. Maybe the smoker has not had a cigarette since discharge from the hospital, or he or she may have started smoking again after returning home. A quit date is selected if needed and a plan is made with specific strategies for success.

For example, if the smoker is used to having a cigarette after dinner and the conversation following the meal triggers an urge to smoke, he or she will commit to leaving the table immediately after dinner and walking out to the mailbox and back.

After the initial visit, counseling sessions can take place either in person or over the telephone.

When patients admitted to Roper St. Francis Healthcare are identified as having smoked within the past year, the nurse asks if they would like education on smoking cessation. If the patient is interested, the nurse has the option of showing one of two videos on the closed-circuit television system or providing the patient with a one-page handout with steps for quitting, which was produced in house. The handout was compiled from several resources and can be printed from the computer.

Patients are asked if they would like to receive education as part of the assessment for their readiness to learn. "Timing can be everything for some people. Quitting smoking has to be their goal; it can't just be ours," says Robinson.

At discharge, patients are given the web site address (www.lungusa.org) for the American Lung Association's "Freedom from Smoking" program and also the association's toll-free number [(800) 586-4872] for continuing support. Shortly, the health care institution will be offering a smoking cessation program as well. In August 2003, several staff members attended a training program for QuitSmart, which was developed by Robert Shipley, PhD, at Duke University Medical Center in Durham, NC. This smoking cessation program consists of three one-hour classes offered during a three-month period.

According to the 2003 JCAHO Core Measure

SOURCES

For more information about initiating smoking cessation education by the admission process, contact:

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- **Virginia Reichert**, NP, Director, Center for Tobacco Control, North Shore-Long Island Jewish Health System, 225 Community Drive, South Entrance, Great Neck, NY 11021. E-mail: TobaccoCenter@nshs.edu.
- **Jennifer Robinson**, RN, MHS, Patient Education Coordinator, Roper St. Francis Healthcare, 316 Calhoun St. Charleston, SC 29401. Telephone: (843) 724-2130. E-mail: Jenny.Robinson@ropersaintfrancis.com.

Comparative Report for Heart Failure, Roper St. Francis Healthcare is scoring 10% above national standards for smoking cessation advice or counseling for at risk patients, says Robinson.

"The goal of our organization is that 100% of at-risk patients will receive smoking education if they are receptive to it," she says. ■

Great American Smokeout: How to kick the habit

Providing effective ways to quit for good

The Great American Smokeout sponsored by the Atlanta-based American Cancer Society is the third Thursday in November.

This national event not only challenges people to quit using tobacco for a day; it provides an opportunity for health care institutions to help people in their community who are contemplating giving up their cigarettes to successfully quit smoking. **(For more information on readiness, see Stages of Change Model as it relates to smokers, right.)**

According to the American Cancer Society, this is accomplished by educating smokers on effective ways to quit for good. Steps include selecting a date to stop smoking and creating a plan to support the effort. The plan may include the use of nicotine replacement products, enrolling in a smoking cessation program, joining a support group, or using self-help materials.

Giving up cigarettes is very difficult, says **Virginia Reichert**, NP, director of the Center for Tobacco Control for the North Shore-Long Island Jewish Health System in Manhasset, NY. This health care institution uses the Great American Smokeout to reach hundreds of people who are contemplating quitting smoking by holding an open house on the day of the Smokeout.

During the open house, smokers are introduced to the free six-week smoking cessation program, which is offered at the center as a community service, and about 600 people usually enroll.

Smokers are not encouraged to stop smoking on the day of the Smokeout, but to wait until the class starts, which usually is within a week. That's because preparation is part of the curriculum. If people aren't prepared, they usually light up a cigarette within a few hours of quitting, says Reichert.

"The key to our success is that we really prepare class participants. We spend two hours of class time in preparation, and we give them homework," says Reichert.

Smokers are taught to practice being a nonsmoker before their quit date so they know what to expect when they actually quit. For example, if they smoke while driving, they are told to smoke the cigarette before they get into their car so they can see how it feels to drive without a cigarette. If they are use to smoking while on the telephone, they are told to wait until they are off the phone before having a cigarette.

During the first two weeks of class participants are still smokers, making one-third of the class time the preparation period. The quit date is 48 hours before the third class meeting.

Assessing smokers' readiness to change

The Atlanta-based American Cancer Society put together a Stages of Change Model as they apply to a person's readiness to quit smoking. This model can be used to assess a smoker's readiness to quit.

- **Pre-contemplator**
  This is the smoker who is not thinking seriously about quitting at the present time.
- **Contemplator**
  This person is actively thinking about quitting smoking but is not quite ready to make a serious attempt. They often have excuses for not quitting such as "too much stress at work."
- **Preparation**
  Smokers in the preparation stage seriously intend to quit in the next month and often have tried to quit in the past 12 months. They usually have a plan.
- **Action**
  This is the first six months when the smoker is actively quitting.
- **Maintenance**
  A period of six months to five years after quitting cigarette smoking when the ex-smoker is in danger of relapsing and takes steps to avoid it. ■

SOURCE

For more information on the Great American Smokeout, contact:

- **The American Cancer Society**, Telephone: (800) 227-2345. Web site: www.cancer.org.

Once smokers quit, nicotine replacement products, such as gum or the patch, are used to control withdrawal symptoms and class participants also learn techniques for dealing with cravings. For example, students learn to take several deep breaths, leave the room immediately, drink a lot of water, or brush their teeth to help them resist giving in to a craving. If everything fails, they are told to call the Center for Tobacco Control.

"They have a step-by-step plan, and they are supported through the whole process. Quitting smoking is not a defining moment; it is a process because people slip up and they have to learn not to beat themselves up over it," says Reichert.

Societal changes

There are many reasons why people benefit from kicking the cigarette habit, according to the American Cancer Society. Smoking is a risk factor for several types of cancer, including lung, mouth, voice box, bladder, kidney, pancreas, cervix, and stomach. It also can cause progressive lung diseases such as emphysema and chronic bronchitis. Smokers have twice the risk of dying of heart attacks as nonsmokers, and smoking is a major risk factor for peripheral vascular disease.

People who quit at age 35 live on average 8½ years longer than those who don't stop smoking.

For more than 25 years, the Great American Smokeout has brought attention to the health risks of smoking in addition to methods for beating the habit. It also has helped to provide a climate for social change, according to the American Cancer Society. In 1977, Berkeley, CA, became the first community to limit smoking in restaurants and other public places, and this ordinance has now become commonplace in many states. In 1990, a federal smoking ban was implemented on domestic flights of six hours or less.

The California Division of the American Cancer Society sponsored the first Smokeout in 1976. In 1977 the event went national. The idea came about when a Massachusetts resident asked people to give up smoking for a day in 1971 and donate their cigarette money to the local high school. ■

Time efficiency paramount for one-person department

Finding efficiency amid the chaos

B.J. Hansen-Wingert, MS, RN, patient education specialist for OhioHealth in Columbus, is a one-person department with its own budget.

As such, she does not directly supervise any staff but works closely with clinical educators, such as those in the Women's Health Department that teach parenting classes. The clinical educators report to the service line in which they specialize, and Hansen-Wingert reports to the director of Employee Education Services.

The position, which she was recruited for in 1995, entails overseeing documentation related to patient education, helping to develop educational materials for patients and having written copy translated into other languages, and communicating with stakeholders on compliance with the patient education standards created by the Oakbrook Terrace, IL-based Joint Commission on Accreditation of Healthcare Organizations.

She coordinates activities and functions with other education services within OhioHealth and supports all disciplines to develop and coordinate programs across the continuum.

OhioHealth is a not-for-profit, faith-based organization providing a full range of care services. OhioHealth's Columbus hospitals include Doctors Hospital, Grant Medical Center, and Riverside Hospital. Within the city, it has 20 neighborhood health centers and also offers home health, long-term care, and hospice services. These central Ohio hospitals have 15,000 employees and 2,300 physicians that served 85,300 inpatients and 847,000 outpatients last year. In addition, there are four regional and six affiliate hospitals within the OhioHealth system, but Hansen-Wingert is not responsible for the patient education in these hospitals.

The educational requirements for the job include being a licensed RN in the state of Ohio, having a bachelor's degree in nursing, as well as a master's degree in nursing or a health-related field.

Hansen-Wingert has 10 years of nursing experience in transplant, renal, cardiac, and peripheral vascular care.

In a recent interview with *Patient Education Management*, she provided information about her job, which she described as chaotic at times. The

following are excerpts from that interview:

Question: What is your best success story?

Answer: "I like starting from scratch and creating a booklet with a very professional appearance that helps both the clinicians and the patients," says Hansen-Wingert. "I also love taking a complex, busy piece and making it easier to read and visually appealing."

A good example is the diabetes book she created for all three campuses with the aid of diabetes educators. Most of the content was written with the help of literature searches, however some information was taken from the existing folders being handed out at the hospitals. For example, there was a sheet that listed all the diabetes education programs in Ohio that had been kept up to date. Some copyrighted information, such as the diabetes food guide pyramid and diabetes activity pyramid, was added even though the committee had to pay money to the copyright holder to include the information.

The medication sheet was brought up to date now is updated once a year because diabetes medications change rapidly. A special section allows clinicians to individualize the instructions on care to each patient.

Question: What is your area of strength?

Answer: "I work well with chaos/multiple projects at one time, which is needed in my position," says Hansen-Wingert. "I also have a personality that can work well with a variety of clinicians. Another strength is my ability to decrease the reading level of material and make it easy to read and format it to make it visually appealing."

It is challenging in a one-person department to meet many needs in a time efficient manner. To help organize the multitude of projects, she is working on at any given time, Hansen-Wingert keeps all active projects in folders on her desk. They are organized according to priority with the tasks to be done during the current week in the prominent position.

Hansen-Wingert is able to write and revise patient education materials fairly quickly because she has fully grasped the concept of something that is easy to read. She knows that well-written educational pamphlets should have short sentences, bullets, words under three syllables, formatting that skips the use of all capital letters and italics and has short paragraphs with headlines that explain the topic.

Last year, she took the Health Insurance Portability and Accountability Act privacy notice that was created by a consultant team hired by OhioHealth and brought it from a 12th-grade reading level to an eighth-grade level. The legal department had to review it to ensure that none of the legal meaning had been changed. Hansen-Wingert always has the appropriate staff review the content of materials she has reworked to reduce the reading level. In this way, she can be sure that reducing the reading level has not changed the meaning of the material.

Question: What lesson did you learn the hard way?

Answer: "To try to take the politics out of patient education," Hansen-Wingert replies. "It is about the disease, condition, or test — not the doctor or hospital providing the care. Also, to negotiate clear objectives before starting a project or else you have a lot of rework."

It is very challenging at times to get people to agree on something and when the hospitals first merged and the written materials had to be the same across campuses there were turf wars, she says. To remedy this, Hansen-Wingert emphasized that the project was about educating patients about diabetes or heart disease. Often she would merge information from the pamphlets of each institution by selecting the portions that were worded the best.

Hansen-Wingert also uses national standards and research-based information to create material. Most people involved in the process of creating materials will not argue a point if best practice is followed.

An incident where she did not create clear objectives and explain good writing practices before beginning a project ended up taking a lot of extra time. Hansen-Wingert was working with a pre-existing committee on the revision of a booklet, and after making notes on what the members wanted in the booklet she merged information and reworked the material. However, when she presented it to the committee they said it was too much information. She had to rework the booklet because the objectives were not clearly understood at the start of the project.

Question: What is your weakest area?

Answer: "I am one person for three hospitals, and I can create and implement processes; but I can not communicate, provide inservices, and follow up on what the staff is working on," she explains. "It's very challenging to meet many needs in a time-efficient manner."

Without follow-up, it is difficult to know if teaching sheets are being used once they are created, she says. Also, it is difficult to improve teaching or documentation of patient education

SOURCE

For more information about the issues discussed in this profile, contact:

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without the time to conduct inservices.

Often, one of the hospital campuses will ask Hansen-Wingert to write a teaching sheet on a topic, such as trauma. Although it is specific in many ways to that particular campus, it is of benefit to the other hospitals so it will be distributed throughout the health care system. However, there is no time to offer assistance on how to use the new piece to raise patient satisfaction scores or improve patient education. Although e-mails are sent to managers and often the educators, communication is limited.

Question: What is your vision for patient education in the future?

Answer: "I'd like to see a computerized printout of written material when orders or clinical pathways are initiated and computerized documentation of education," Hansen-Wingert says.

The current project at OhioHealth is a computerized version of the discharge communication form and discharge instructions. This will help to solve the legibility problem for discharge instructions.

All in-house patient education materials are being redesigned, and once they are finished, they all will be downloaded onto the computer so they can be printed on demand.

While physicians can pull up preprinted orders from the computer system and clinical pathways are printed off, the process does not initiate the printing of complementary education materials yet.

Question: What have you done differently since your last JCAHO visit?

Answer: "Clinical pathways have been implemented on one campus where teaching is incorporated into care and there is true interdisciplinary documentation," she explains.

The Joint Commission will survey OhioHealth in June 2004.

Question: When trying to create and implement a new form, patient education material, or program, where do you go to get information/ideas from which to work?

Answer: "I collect examples from other hospitals and do a literature search on the topic. Also I get a team together to look at best practices and talk about the process."

She finds it easy to uncover information on the Internet and usually goes to such medical web sites as WebMD (www.webmd.com) or MedLine, the medical library to which her institution subscribes. ■

Language services tool for health care providers

The Access Project and the National Health Law Program have developed a resource to help health care providers and others ensure that people with limited English proficiency receive appropriate language assistance services in medical settings, which is called the Language Services Action Kit.

The kit, which costs $25, has information on obtaining federal funding for language services for patients covered by Medicaid and the State Children's Health Insurance Program.

Federal laws require health care providers to

offer language services such as interpretation and translation, yet these services can be expensive. In addition, the need for language services in the health care setting is on the rise because the number of people with limited English proficiency in the United States is growing.

The materials in the kit:

- explain the federal laws and policies that require health care providers to ensure access to services for people with limited English proficiency;
- describe models that some states have adopted to reimburse health care providers for language services;
- list resources for additional information about language services.

To place an order and find out more, visit www.accessproject.org/projects.htm. ■

Hmong STD education videos available

A Hmong language video on the prevention and proper treatment of sexually transmitted diseases (STD) now is available as a VHS cassette or CD-ROM to all health care facilities with Hmong clients. A single copy is available at no cost with additional copies available at cost, however the video may be copied for free educational distribution.

The video titled, "Sexually Transmitted Diseases: How to Protect Yourself and Your Family," was created by the University of Wisconsin Health Wausau Family Practice Center with funding from the Community Health Care Wausau Health Foundation and the Northern Wisconsin Area Health Education Center.

The program covers chlamydia, gonorrhea, syphilis, herpes I and II, human papilloma virus, hepatitis B, AIDS/HIV, with graphic illustrations used to show the effects of these infections. It also addresses the following questions:

- What is a sexually transmitted disease?
- Is there more than one sexually transmitted disease?
- Can I get more than one STD at a time?
- Can I get a STD more than once?
- How can I tell if I have a STD?
- Can all STDs be cured?
- How can I reduce my risk for getting a STD?
- Where can I get help if I think I might have a STD?

A second Hmong video on culturally relevant nutrition and health practices can be purchased for $35, which includes shipping and handling. Topics discussed on this video include reasons people may become overweight, what health problems can be associated with being overweight, as well as diet and activity tips for good health.

For more information and links to ordering forms, visit www.hmonghealth.org. ■

CE instructions

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

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

COMING IN FUTURE MONTHS

- Creating a patient education culture
- Strategies for timely project completion
- Must have books and resources
- Effective community outreach
- Getting the most use of educational resources

CE Questions

For more information about the CE program, contact Customer Service at (800) 688-2421, e-mail: customerservice@ahcpub.com.

13. Although the accreditation standards for patient education are no longer a stand-alone chapter as of January 2004, the Joint Commission on Accreditation of Healthcare Organizations has not really changed the requirements, just the way they have been formatted and presented.
A. True
B. False

14. Identifying smokers when they are admitted to the hospital and offering information on how to quit is good practice for which of the following reasons?
A. Patients are a captive audience.
B. Smokers are thinking about their health.
C. Family members are more likely to pressure them to quit.
D. Staff repeatedly can preach the hazards of smoking.

15. Pediatric services can ease the stress of a hospital stay for both parents and children by implementing which of the following policies?
A. Provide play areas in waiting rooms
B. Create easy-to-follow signage
C. Teach staff developmental differences in children
D. All of the above

16. Children would be less anxious about surgery if parents would keep the procedure from them until the day they are admitted to the hospital.
A. True
B. False

Answers: 13. A; 14. B; 15. D; 16. B.

CE objectives

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

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