Patient Education Management™

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

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IN THIS ISSUE

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Productivity measures point to funding needs, efficiency, and staffing changes

Make sure that the numbers tracked count for something

Generating productivity numbers on patient education programs, classes, and materials is not a worthless activity. Patient education managers have learned the data are valuable for a variety of reasons.

Each month, **Louise Villejo**, MPH, CHES, director of patient education at M.D. Anderson Cancer Center in Houston, issues a statistical report that shows the number of patient education materials that were distributed from various points including learning centers and those given out as part of a pathway.

The report also contains numbers on patient contacts at the learning center, in particular, classes such as side effects management, and computer-based education programs such as "Chemotherapy and You."

The number of people participating in focused interviews or focus groups is tracked as well as those attending health initiatives such as the Great American Smokeout or the Diabetes Fair.

New or revised materials added to on-line databases also are tracked.

EXECUTIVE SUMMARY

Many patient education managers are hesitant to track data that have been labeled "useless" — such as the number of brochures distributed — because they do not show that the material enhanced learning or resulted in behavior change. Yet such numbers can be valuable. In this issue, we look at the various ways patient education managers generate numbers and how they use them to prove to administrators that they are meeting job requirements and their services are worth funding.

"The numbers are valuable because they provide leadership some form of our productivity. A lot of what we do is program development and evaluation and that doesn't always show up in the numbers that are kept but you have to show some kind of productivity and people like numbers," says Villejo.

Proof that staff are doing the job is revealed in many ways. For example, the data on the number of people using the learning center help show that the education department is responding to patients' needs. This information is valuable during budget reviews in that it helps to justify the dollars spent on the service.

"Of course, numbers don't tell the whole story, but they tell some of the story," says Villejo. Needs assessments and evaluations also are routinely conducted with patrons of the learning center.

Numbers on focus groups and interviews show that the education department staff continually are looking for feedback from patients, family, and staff.

Comparisons of the numbers can show that new, more efficient methods are working. For example, as more educational materials go on-line at M.D. Anderson, the numbers for on-line material distribution increase while the numbers of print materials being distributed decrease, says Villejo.

Numbers help prove worth

Numbers help **Nancy Goldstein**, MPH, patient education program manager at Fairview-University Medical Center in Minneapolis make sure that the one-on-one instructional services offered at the patient learning center meet the needs of patient and staff.

"Data help make sure the learning center meets the needs of different departments, is doing what it was designed for, and is worth the money. By showing that it is an effective program, I can justify keeping it in existence in tough financial times because I have data to prove that it makes a difference to patients," she reports.

Goldstein uses the data she tracks in a monthly process report to show the value of the instruction at the learning center. Also, they help her determine where improvements might be made.

To generate the numbers she needs, Goldstein tracks how many patients are referred from each of the patient care areas and clinics, how many patients were placed on a waiting list distinguishing between those who gave a day's notice vs. a couple hours' notice, how many appointments were not filled, and the number of cancellations. A monthly phone survey provides data on the value of the service to patients.

In the report, she identified several of her expectations for the service and uses the data collected to determine if the program meets them.

For example, one expectation is that 10 or fewer people remain on the waiting list without being offered an appointment for one-on-one instruction, not including unrealistic requests for an appointment within four hours of the call.

In December 2003, the data showed that the learning center met this expectation with five people remaining on the list, all of whom needed

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their appointment the same day the center was contacted.

Another expectation is that no more than 25 time slots are not filled with patient appointments or 38 or fewer hours accounting for the difference between one- and two-hour appointments. In the December report, 10 time slots or 11 hours were not filled.

These numbers help to justify staffing and can point to a need for more staff, says Goldstein.

The expectation for the patient and family satisfaction survey is that 90% of those contacted received the information they needed to care for themselves at home; found that the information was presented in a professional, caring manner; found the information understandable and written materials clear and easy to understand.

On-line proof

Sharon Sweeting, MS, RD, CDE, patient and family education coordinator at Jackson Health System/University of Miami Medical Center, has found that the numbers generated by a web counter on the organization's web site can be valuable.

She is able to look at how many people are visiting the plain-language library of medical information on the web site, what pages are being hit, and how long people are spending on each page.

The popularity of this section, which has 250 of the health care institution's most frequently used materials in both English and Spanish, made it possible for Sweeting to approach the webmaster to ask for a link to the education section on the homepage to make access easier. The traffic on the site also helps to show the value of the patient education materials being offered.

"The data put me on the business side of the organization because I can give the marketing department insight as to what products we need to enhance," she says.

In addition to looking at the numbers generated by the web counter, Sweeting tracks revenue produced from a charge-back system for patient education print materials that are issued to the organization's units. When orders are filled, a budget code is used to bill that unit for printing costs or the costs of commercial materials.

The data reveal which materials are being used and justify the money allocated for the supply budget.

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Tracking class attendance is one way that Sweeting determines whether a class is working or not. If attendance is low, she can audit the class to evaluate such factors as the presentation of the material, the cultural sensitivity of the curriculum, and the amount of information covered so that the necessary improvements can be made to make the class more attractive.

Focus on outcomes

While patient education managers agree that statistics for easily measurable things can be valuable, data collection must be tailored to the needs of each institution, says **Fran London**, MS, RN, a health education specialist at Phoenix Children's Hospital. Also, they need to be combined with other measures.

"The most important measures of patient education relate to outcomes. A short-term outcome is, 'Did the person learn something?' and a long-term outcome is, 'Did the health outcome improve as a result of learning?'" she says.

Outcomes are easily measured too, London notes. For example, to evaluate understanding after teaching an educator can initiate a conversation with the patient in which they discuss situations pertaining to the teaching.

To determine if a class improved health outcomes, see if those who attend have fewer readmissions or fewer emergency department visits than people in that patient population who do not attend, she adds. ■

National publicity creates interest in observances

Opportunity for community outreach, education

A national health observance day, week, or month is a good opportunity for local community outreach, says **Valerie Eldred**, RN, community health representative at Winter Haven (FL) Hospital.

The national publicity these events generate captures the public's attention, making them easier to promote. Also, it is much easier to concentrate on one health topic at a time. In the past, Winter Haven Hospital held an annual health fair but it got too big. It was difficult to register and conduct lab work for 300-600 people.

"We thought that we would do better if we concentrated on the big diseases that we see in this area such as diabetes and cardiac disease," says Eldred.

February is "American Heart Month"; therefore, the hospital hosts a "Heart Smart Day" the first Saturday of the month. On this day, people who pre-register by calling the hospital's health connection phone line have blood work and a risk assessment completed for a fee of $30. The assessment includes body mass index, blood pressure, and pulse rate; and the blood work includes a chemistry and lipid profile. **(To learn more about national observance months, see source box, p. 29.)**

At the end of the month, people are invited back to get the results of the lab work, and a speaker or a panel discussion is scheduled. This year, a panel of physicians and a cardiac nurse discussed risk factors for cardiac disease in general and pertaining to women, minorities, and people with diabetes.

Before the education session, a nurse goes over the results of the lab work with each participant to discuss the areas in which he or she is doing well and where he or she might make some improvements. Everyone is encouraged to share the results with his or her physician, and at times referrals are made. Results are mailed to those who do not wish to attend the special session.

If someone's lab result reveals extremely high blood sugar or lipids, the lab notifies Eldred, who pulls the individual's paperwork and telephones him or her to make sure he or she is aware of the health problem. She does not wait to discuss the problem when results are distributed to all participants.

Education is not limited to the last Saturday of the month when a speaker is scheduled. On the first Saturday of the month, when people come to the hospital for the blood work and assessment, they have the opportunity to visit a variety of displays pertaining to cardiac health that are organized by various departments within the health care system. For example, behavioral health is on hand to do a stress assessment, the respiratory department brings a model depicting the lung of a smoker, and a nutritionist and diabetes educator are available.

On "Heart Smart Day," logistics are extremely important because space is limited. Approximately 300-350 people scheduled for blood work attend the event from 7:30 a.m. to 11 a.m; therefore, a system to move people through quickly had to be implemented. Paperwork is completed in one room, assessments in another, and blood work in a third room. The educational stations are set up in hallways along the exit route. Participants also have access to a breakfast buffet following their blood work that includes fruit, bagels, juice, and coffee.

Beyond prevention

While health observance months usually focus on prevention and early detection, Winter Haven Hospital stages an event during Diabetes Awareness Month in November that focuses on diabetes self-management. It hosts a diabetes health fair with the aid of in-house specialists, such as podiatrists who examine feet, as well as vendors demonstrating the latest products. Some vendors also conduct tests such as blood glucose measures.

The nutritionist usually is on hand to help with cooking demonstrations that teach people with diabetes how to fix foods that taste good and are healthy.

Also during November, a physician gives a community lecture on diabetes.

Screenings for prostrate cancer are conducted throughout the month of September, which is Prostate Cancer Prevention Month. To make these convenient for workingmen, they are scheduled at different clinics in the area as well as at the hospital on different days and at different times.

To publicize the various events tailored for health observance months, each is listed in the special events section of *Here's to Your Health,* a magazine published by the hospital twice a year and is distributed to about 100,000 readers. In addition, Eldred issues press releases, places ads

SOURCES

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- **Valerie Eldred**, RN, Community health Representative, Winter Haven Hospital, 166 Avenue E N.E., Winter Haven, FL 33881. Telephone: (863) 293-1121, ext. 3381.
- **American Diabetes Month** (November), American Diabetes Association, 1701 N. Beauregard St., Alexandria, VA 22314. Telephone: (800) 232-3472. Web site: www.diabetes.org.
- **American Heart Month** (February), American Heart Association, 7272 Greenville Ave., Dallas, TX 75231. Telephone: (800) 242-8721. E-mail: inquire@americanheart.org. Web site: www.americanheart.org.
- **Prostate Cancer Awareness Month** (September), National Prostate Cancer Coalition, 1154 15th St., Washington, DC 20005. Telephone: (888) 245-9455 or (202) 463-9455. E-mail: info@pcacoalition.org. Web site: www.pcacoalition.org.

in newspapers, and distributes flyers. In the past, she has sent letters to those who attended the event the year before.

"With so many health observances available, you need to evaluate your patient population and pick and choose what you want to do," says Eldred.

(Editor's note: A complete list of national health observances published by the National Health Information Center, Office of Disease Prevention and Health Promotion, U.S. Department of Health and Human Services, Washington, DC, can be found on the Internet at www.healthfinder.gov/library/nho/nho.asp.) ■

Create a solid foundation for patient education

Build an infrastructure to support teaching

Although **Zeena Engelke**, RN, MS, has multiple job duties as patient education manager of the University of Wisconsin Hospital and Clinics in Madison, she has managed to incorporate direct teaching into her position as well.

The teaching is done at one of five learning centers she oversees, and the patients frequently are in need of pre-surgical instruction or self-care management. For example, the patients learning self-care may be newly diagnosed with diabetes.

Engelke supervises nine registered nurses at the learning centers, one of whom is a clinical nurse specialist, and three program assistants. She also oversees student help.

However, patient and family education is not limited to the learning centers and neither is Engelke's oversight. She is responsible for helping nurses and other disciplines meet the standards related to patient and family education and ensuring they have the tools to teach, such as written materials and videos.

The academic medical center has 471 beds and includes an adult and pediatric hospital as well as several clinics. Four clinics are off-site.

Engelke has been in her role as manager of patient education for about 10 years; however, she has been with the University of Wisconsin Hospital and Clinics since 1986.

Her original clinical experience was in perinatal nursing. Also, she worked in staff development for about 10 years with part of that time shared with patient education. She has a bachelor's and master's in nursing.

The position of patient and family education manager is within the department of nursing at the University of Wisconsin Hospital and Clinics. Engelke reports to the senior vice president of nursing and patient care services.

In a recent interview with *Patient Education Management*, she discussed her job, her philosophy on patient education, the challenges she has met, and the skills she has developed that helps her to do her job well.

Question: What is your best success story?

Answer: "The emergence of the learning centers. I think they started as a bit of an illusive idea and have emerged into a very strong, vibrant service at five different sites with nurses practicing daily at those sites and modeling best practices in patient and family education."

It took a lot of work with a variety of disciplines to make the learning centers successful. The first center opened in 1995.

The working relationship between the learning centers and each clinic varies. Many have incorporated pre-op teaching into the work-up template for surgery along with lab tests.

Nurses and physicians also contact the learning center when patients have complex, time-intensive, learning needs. Often these patients have lots of learning barriers.

In addition to direct teaching, the learning

centers provide resources for teaching patients and families.

Creating a strong infrastructure

Question: What is your area of strength?

Answer: "We have developed a fine infrastructure to support patient and family education. We have a significant number of health facts available on-line for staff to print out on a variety of topics. Also, we have a lot of videotapes that match those health facts. We have set the stage for a good solid patient education effort."

Question: What lesson did you learn the hard way?

Answer: "You can never reach all the people you need to reach to let them know of all the resources and tools that are available. In huge organizations, it is hard to help people at so many different levels and locations understand what is available to support their teaching. Communication is nonstop. You can do it 24 hours a day and never reach everyone."

Question: What is your greatest challenge?

Answer: "The greatest challenge everywhere is documentation. It's helping nurses and other clinicians capture all the teaching they do and get it on paper."

It's important because it is a vital communication tool as well as a regulatory requirement, Engelke says. Effective communication will save a lot of time. Without effective communication, people always are reassessing before a teaching session and starting fresh rather than building on what the prior clinicians accomplished.

"A constant complaint is that there is no time to teach yet without communicating what has been assessed and taught more time is lost in the long run."

What's next?

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

Answer: "A much cleaner continuous path to learning would be incredibly helpful. Not just continuity from one site to the next but also consistency of information with documentation to support teaching."

Communication on patient educational efforts between inpatient areas, outpatient clinics, and home health often is fragmented, Engelke reports. Information on not only what the patients were taught but also how they responded to the teaching and what the priorities are for the next step of the learning process needs to be transferred from setting to setting so that there is a seamless delivery of patient education.

"Links and a crystal-clear message need to be in place so that teaching is constant from one location to the next. In some areas of the academic medical center, good models exist, but not in all areas."

Question: What have you done differently since your last Joint Commission on Accreditation of Health Care Organizations' (JCAHO) visit?

Answer: "We are more vigilant in tracking documentation. Learning preferences was a red flag for our organization, so I audit that. The managers need to work with their staff to get 100% compliance within 24 hours."

Rather than giving a 58% or 84% rating, managers receive specific data so that they can take corrective action to obtain 100% compliance on this issue. Assessing for learning preferences is a battle because staff not only have trouble asking people how they prefer to learn but also in the timing of the question. During a crisis situation, it is an awkward question, Engelke says.

JCAHO, based in Oakbrook Terrace, IL, surveyed the University of Wisconsin Hospital and Clinics in the fall of 2002.

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

Answer: "To get the best implementation, you have to work within the group that is implementing it. However, the group may or may not have all the latest ideas that are out there, so sometimes you feed in other models from across the nation."

Networking with colleagues via listservs or at conferences is one way to obtain best-practice ideas to bring to the group, but it has to be up to the core group working on the project to include the information. Without buy-in from this group, it wouldn't work anyway, Engelke advises. ■

SOURCE

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Program helps patients who take anticoagulants

Patient education helps avoid adverse outcomes

While an elderly man on the anticoagulant drug warfarin was waiting to get blood drawn at his physician's office, he was handed some educational materials about the drug. "The packet included warnings that the shape of the pill may change based on the manufacturer of the drug, but the color will never change," says **Kim Shields**, RN, clinical systems safety officer and team leader for the Virtual Anticoagulation Project at Abington (PA) Memorial Hospital.

After the prescription was filled, the man noticed that the pills, which always had been pink, were white. The pharmacy had mistakenly given the man 10 mg pills instead of the 1 mg he was prescribed, which could have resulted in a potentially fatal hemorrhagic event.

This near-miss scenario is just one success story from an innovative program at Abington Memorial, where a "Virtual Anticoagulation Clinic" has significantly reduced the morbidity and mortality of patients taking warfarin. As a result of this successful initiative, the organization won the 2003 John M. Eisenberg Patient Safety Awards, given jointly by the National Quality Forum and the Joint Commission on Accreditation of Healthcare Organizations, based in Oakbrook Terrace, IL.

The medical, pharmacy, physician network, and performance assessment departments at the facility implemented a web-based program for outpatients that improves primary care physician management of patients taking warfarin.

The pilot study data for the program show that patients in appropriate therapeutic range improved to 70% from 51%, reports **Keith Sweigard**, MD, the facility's chief of internal medicine. Here are key aspects of the program:

• Staff at physician offices are trained on an ongoing basis.

Staff at 29 physician practices have received initial training from the facility's performance improvement nurse, consisting of a three-hour class. Each coordinator is given a self-learning packet and passes a competency test, with ongoing education provided via newsletters and intermittent classes.

Additionally, office performance is continuously assessed and feedback given to the clinicians, Sweigard says. "Networks can monitor each office's performance and then use their resources to identify issues that may be causing less-than-optimal anticoagulation rates," he adds.

For example, when Sweigard noticed that one practice had failed to input patient international normalized ratio (INR) levels in a timely fashion, he arranged for one of the senior coordinators to work with the office to correct the problem.

Dosing instructions provided to the clinicians are standardized and based on national guidelines, Sweigard explains. "This has resulted in improved results with less risk of bleeding or clotting."

• Potential adverse outcomes are avoided with patient education.

Patients are educated on how to handle issues such as missed doses and drug interactions. While still in the hospital, patients receive an educational packet, including a one-page information sheet, available in English, Korean, and Spanish.

"We tell patients to put it right on the refrigerator because it lists the essentials they need to know to be safe," Shields says.

Patients also are given a sheet listing prescription and over-the-counter medications, herbal supplements, and vitamins that interact with warfarin. "One of the biggest problems with warfarin is that so many drugs interfere with the way it works by either raising the INR or lowering it," she says.

"So patients have a tool to bring with them to the pharmacy or other health care providers that informs them of drug interactions," Shields adds.

Patient education about warfarin often is sorely lacking, and this can have a devastating impact on patient safety since it is a difficult drug to manage with a narrow therapeutic index, she says.

If blood levels are too high, there is a risk of major bleeding; whereas, levels too low can fail to protect patients from blood clots, Shields explains.

"We promote that the patient has to be part of a team. They have to be very knowledgeable, because they are the first ones to alert us that something is not right," she says.

The web site allows patients to log in and see their own health record for warfarin therapy, Sweigard says. "At discharge, patients are told that their INRs and warfarin dosing will be faxed or entered into the program before discharge," he says. "Patients with mechanical valves may enter their own INR values and receive computerized decision support."

• Patient knowledge is routinely assessed.

Following a teaching session, patients are

asked 12 questions to determine their knowledge about warfarin, so that educators can "drill down" during future sessions on the areas that require reinforced education.

An education documentation record is kept in the patient's chart at the physician office. "When a patient is having blood drawn, the coordinators can refer to the documentation record that indicates where additional education is still needed," Shields says.

• Point-of-care testing is offered.

Dosage levels of warfarin are determined by blood test results reported as INR levels, and maintaining blood levels within therapeutic range is essential, as there is a narrow window of efficacy and safety, Shields emphasizes.

Therefore, the safest and best way to manage warfarin is with point-of-care testing, which is being implemented at one of the larger physician practices, she reports. "Instead of having venous blood drawn, it will be a finger stick with results available in one minute," Shields says.

The patient's dose can be changed immediately if needed, with no lag time or having to call the patient back, she says. "We can act on INR results 24 hours sooner than if we had to send the blood work to a lab. It also requires less blood and is a lot less painful," Shields continues.

• Patient care is individualized.

Patients are taught that foods high in vitamin K — such as leafy green vegetables — help the blood to clot and therefore can affect INR levels. "We tell patients, 'You can make modifications to your diet — just tell us in advance so we can adjust your warfarin dose as indicated,'" she says. "If patients have a glass of wine with dinner every night, we adjust the dose based on that."

This provides a better quality of life so patients don't feel that the drug controls their lives, Shields continues.

• Important information is pushed to the front page of the web site.

Patients who are late for follow-up blood tests and patients who should be off warfarin are listed on the front page of the web site, Sweigard notes.

"Patients have remarked that they feel more closely watched, which translates to improved patient satisfaction and safety," he says.

While many patients are on warfarin for life, others are only supposed to take the drugs for several months after orthopedic procedures such as total hip replacements. Sometimes, these patients would end up being on the drug longer than prescribed.

"We could have patients who didn't come back for months, and we didn't know it. Now with this new computer system, there is a screen that lists the patients, including the number of days late and their last INR results. This allows coordinators to contact the patient to schedule an appointment for overdue blood work." Shields adds. ■

SOURCES

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Educating staff on tracer methodology is a must

Survey results depend on it

Are staff at your facility skeptical that surveyors from the Joint Commission on Accreditation of Healthcare Organizations really will ask *them* the questions during your next survey?

You'll need to prepare staff for major changes in the survey process, including the new tracer methodology, which will be a key part of the 2004 surveys when Shared Visions — New Pathways goes live. In addition, the performance of organizations accredited after the beginning of this year, will be reported in the new Quality Report format, and all regular accreditation surveys will be unannounced as of January 2006.

"For several years now, we have told everyone that surveyors are going to be talking more to staff," says **Catherine M. Fay**, RN, director of performance improvement at Paradise Valley Hospital in National City, CA. "But in actuality, the numbers of staff who surveyors talked to in previous surveys were very small. So I don't think they really believe us this time."

But the Joint Commission's claims aren't just idle talk or empty promises, according to **Angie King**, BSN, CPHQ, quality management director

at Tift Regional Medical Center in Tifton, GA. "Unit staff are definitely the ones surveyors are going to be talking to," she reports.

King's facility participated in the pilot survey process for the Joint Commission's Shared Visions — New Pathways initiative. "We chose to participate because we wanted to have the opportunity to put our 2 cents in. Since we heard there were going to be sweeping changes, we wanted to have some live interaction to say what was good and what wasn't."

Overall, the new survey process is a definite improvement, King says. "It is, by far, a much more educational process," she says, adding that the process is a "real silo-buster," breaking down walls between departments and services within the facility.

"Hospitals are comprised of many silos, even within the nursing department itself," King notes. "With this type of methodology, staff get to see the whole continuum of care."

Here are key aspects of the pilot survey at Tift Regional:

• You'll have less control during the survey.

Due to the new tracer methodology's unpredictable nature, there is a loss of control for both the organization and the surveyors, King says.

This means that it will be more difficult to ensure key individuals participate in the survey process, she notes. "Our chief of surgery certainly did not put any patient at risk, but he chose to delay his start time because he wanted to spend time with the surveyors. Had he known when they were coming to the OR [operating room], he could have changed his schedule accordingly, because he wanted to participate."

Similarly, if you have one nurse manager who is responsible for two different departments, it could be difficult to ensure that individual is present, King adds. "If two different surveyors are there at the same time, and they are tracing back and forth, it's kind of difficult to coordinate schedules."

Since you can't predict exactly who will be in a given department when surveyors arrive, it's even more important that every staff member is ready to answer questions if needed, King says.

It also is tougher to ensure that you are present to step in if needed, she explains, and adds that it may be difficult to get used to the idea that you can't control where the surveyor is going next.

• Surveyors may not cover every area during the survey.

Since surveyors are tracing a patient's path through the facility, some departments or ancillary services may not come up during the survey itself, such as pharmacy, King notes. "They may not be able to see everything they need to in the hospital, so unless that is scheduled for a separate site visit, they will have to come back and do that after hours."

• Surveyors made good choices when selecting patients to trace.

The surveyors asked for a list of all patients, where they are, what their diagnoses are, and how long they have been there. "Based on that, they made their patient selections," she says. "I think that they made good choices. Those were also the patients they interviewed."

One of the chosen patients was a child who had come in through the emergency department (ED), spent time in critical care, and was on the pediatric unit. "They looked at the competency of staff since we had ICU [intensive care unit] nurses taking care of pediatric patients, but we don't have a pediatric ICU," King says. The questions asked of patients were focused on continuum of care, she states. "For example, they would say, 'Your care started in the ED; did you feel like that continued when you came up here? Was it explained to you? What happened when you got up here?'"

The pediatric patient had been given a nebulizer treatment, so surveyors asked the respiratory therapist who was responsible for teaching this to the patient. "The therapist said it was their function. So the surveyor asked, 'Can you show me how that's communicated so nursing knows you've done it?'" King adds. "The surveyor then asked the nurse the same question, 'How do you look to see that they have been successful in teaching it?' and asked to see where they would look for this in the record."

• Staff got more educational benefit from the survey.

King gives the example of a surveyor discussing a patient's care with a nurse on the pediatric unit. "There was a question that came up about the patient's care in the emergency department, and the surveyor asked, 'Is the ED nurse here today, and if so, can she come up here?" she recalls. "That was great, because that ED nurse sat there with the pediatric nurse and together they answered the surveyor's questions. Afterward, she said it gave her a much greater understanding of what happens outside the walls of the ED."

One of your top priorities to prepare for the new survey process is ensuring that every staff member understands how to answer surveyor questions based on the new tracer methodology; but many

managers feel they're flying blind.

"We have struggled with this. Since no one has actual experience with the tracer methodology, preparing the staff is difficult," Fay says.

In the past, getting ready for surveys centered around three things: standards considered to be hot-button issues with surveyors that year, new standards, and previous survey findings, she says. "That won't work this time because this year, we anticipate a process unfamiliar to any of the hospital staff," she says. "So we had to come up with a new way of preparing for our May 2004 survey."

The fact that the surveyors' whereabouts are unpredictable is another major change — a somewhat unsettling one for most quality managers. "Previously, a director or administrator would do their best to make sure a surveyor stays in one spot according to the schedule and doesn't go anywhere else." Fay points out.

As a result, the director typically answered many of the surveyors' questions, but that no longer will be the case, she acknowledges. "We are giving more and more information directly to the staff, because they are the ones the surveyors are going to be talking to."

Here are some effective strategies to educate staff about the new tracer methodology:

• Ask staff questions to reflect the new survey process.

At Tift Regional, staff were prepared by "walking ambassador" rounds and asked questions such as, "If you have a patient who complains of pain, what do you do?" and "Can you show me how you communicate with other departments?"

"My focus was to familiarize them with the type of questions that would be asked so they wouldn't be scared," King says. "If you can eliminate fear, staff will be able to answer the questions, because they know what they are doing. They might not know one way to answer it, but they will know another."

• Explain that staff should focus on processes.

Previously, survey preparation revolved around policies, procedures, and documentation, Fay says. However, with the new tracer methodology, processes have become very important, and surveyors will expect to hear staff talk about patient care in those terms, she explains.

"The intent of JCAHO is to determine what are our processes, how well they are implemented consistently, and how we measure the success of the process," Fay says.

Education for the new survey process is directed at the staff-level employees, she emphasizes. Fay says the goal is that staff understand the following:

— Processes they use in carrying out the responsibilities of their positions.

— How those processes are linked to other positions or departments.

— Matching policies and procedures for the processes.

— How the department measures the effectiveness of the processes.

For all the above, staff must address hospital-wide processes that apply to all departments, such as the National Patient Safety Goals, infection control practices, and emergency preparedness, Fay says.

Surveyors are not going to come to a department and say, "This is Mr. Smith — what did you do for him?" she says. "If a study is done on a particular person, they will ask, 'How do you go about doing it, how do you inform them about it, how do you document it, and how do you determine who is qualified to do it?' What they are looking for is consistent application of a process."

This means that staff no longer can use the excuse, "I didn't take care of that patient," Fay says. "The Joint Commission isn't buying that

SOURCES

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anymore. What they are saying is if you have these kind of patients, you need to know how to take care of them."

• Select your own patients to trace through the system.

Each month, department directors are choosing a patient to trace. The staff are walked through a "process identification exercise" to determine their level of understanding. Each director or manager pulls a patient's chart or a given procedure, based on the type of care or service provided in the department.

For example, on the surgical unit, staff must be ready to discuss the process for any surgical procedure, Fay says. Radiology staff may be asked to discuss how they do a computerized tomography scan with contrast, and dietary staff may be asked to talk about the process of nutritional intervention for a patient who has been NPO (nothing by mouth) for four days.

Staff are asked the following questions:

— **What do we do for this patient first?** "Staff then go through each process, including nutritional assessment or informed consent if they need it, and everything that is linked to whatever the diagnosis is," Fay says.

— **What is the policy for that process?**

— **Can you get me a copy of the policy?**

"Those are the steps that the Joint Commission is going to address," she adds.

• Identify problem areas.

Based on the results of the process identification exercise, managers identify areas where staff need improvement due to lack of knowledge or inconsistent answers, and these are addressed at the next staff meeting, Fay explains.

In addition, randomly selected department directors will report problem areas from their departments at the biweekly leadership team meetings, so that other directors can learn from their findings.

• Assess which types of patients are likely to be selected.

For the patient tracer exercises, Fay suggests departments select patients who are representative of the core measures the facility is collecting data on. "We believe that is where the surveyors will be going," she says. "We don't have the performance improvement overview, and we don't have the opportunity to talk about core measures. Congestive heart failure and community-acquired pneumonia are our top DRGs [diagnosis-related groups], and the surveyors will know that. So there is a pretty good chance that they will be asking about these patients."

Surveyors likely will base the patient selections on your services, census, and core measures, Fay says.

Surveyors also will consider patient populations at your facility, she adds. "We have a very small pediatric population, so they might look at that," she says. "The more you do things, the more you

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 to receive a certificate of completion. When your evaluation is received, a certificate will be mailed to you. ■

COMING IN FUTURE MONTHS

- ■ Obtaining pamphlets for various cultures
- ■ Strategies for timely project completion
- ■ Proactive patient education through community outreach
- ■ Jump-start discharge planning upon admission
- ■ The wisdom of prevention education thoughtfulness

CE Questions

9. Productivity numbers are valuable if used to show upper management which of the following?
A. Response to patient needs
B. Feedback from patients, family, and staff
C. Program meets expectations
D. All of the above

10. A national health observance day, week, or month is a good opportunity for local community outreach because the publicity it generates captures the public's attention, making them easier to promote.
A. True
B. False

11. Which is true regarding the new tracer methodology from the Joint Commission?
A. Patients will be selected based on core measures alone.
B. Questions about patient care processes will be directed to managers instead of unit.
C. Staff only will be expected to answer questions about patients they cared for.
D. Surveyors will expect unit staff to explain patient care processes for any patient.

12. Which is part of a program to improve outcomes for patients on anticoagulants at Abington (PA) Memorial Hospital?
A. Only venous blood draws are used.
B. Patients are instructed to avoid any modifications in diet.
C. All blood work is sent out to the laboratory.
D. Point-of-care testing is used.

Answers: 9. D; 10. A; 11. C; 12. D.

take shortcuts, and the less you do things, [the more] you tend to forget, so those are the two ranges of risk."

No matter what type of patient is chosen, all the processes should be the same, Fay emphasizes.

In the intensive care unit, you may have different competency levels depending on medications you are administering, and different procedures that you do, but the basic processes should be similar to other areas, she says. "So, I'm not as concerned about the diagnosis or how they select the patient. What is important is that the staff actually pick a patient and go through the process of learning — that they know the processes they use to care for the patient." ■

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. ■