

Patient Education Management™

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



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Streamline documentation for outpatient education

Examine the process as well as the form

Documentation is becoming a routine part of patient education in inpatient settings. However, many health care providers have not yet formed this good habit in outpatient areas.

Documentation of teaching in outpatient settings is important for all the same reasons that support it at a patient's bedside within the hospital, says **Marjorie Schirado, RN**, patient education coordinator at Medcenter One Health Systems in Bismarck, ND.

Proper documentation establishes a paper trail showing that education took place. This is important for the legal department should litigation occur.

Schirado says the risk management department has determined that the most common patient complaint is that the patient was not told something important or that the patient did not have enough information. With proper documentation, it is easy to trace the name of the educator, what was discussed, and what literature was provided, she says.

EXECUTIVE SUMMARY

For many years patient education managers (PEMs) have struggled to create the perfect form to document patient teaching within the inpatient setting. This same form can be used also in the outpatient setting because the standards for education do not change depending on the area. However, many PEMs find that the inpatient form is too long.

Patient education managers are now stepping back to look at the process of education in outpatient areas before designing a form. This month, *Patient Education Management* reviews the steps taken by a few PEMs to design forms to fit the unique needs of their outpatient areas.

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Documentation of patient education is required by the Joint Commission on Accreditation of Healthcare Organizations, and must be completed if an institution is to become accredited.

Most importantly, documentation of patient education allows providers to build on the education

given by others on the health care team. "If we can see what teaching has been provided, where that person was in the learning process, and build on that, then he or she receives more continuity of education," says Schirado.

At Roswell Park Cancer Institute in Buffalo, NY, treatment takes place in many settings, which makes it important to trace education across the continuum of care, says **Megan D. Battaglia**, patient education facilitator.

It is not as if all the members of the team treating the patient are in the room at the same time. Therefore, it is important to document a patient's educational needs and barriers to learning, says Battaglia.

While reasons for documenting remain similar in both inpatient and outpatient settings, many issues make documentation of education different in each setting. For example, an outpatient clinic sees more patients, says Schirado. Also, educators don't have the option of coming back in an hour or two to finish a conversation or evaluate a patient's learning, as they do when a patient is in the hospital.

On the inpatient side, education will include diagnosis, procedure, possible complications, medications, equipment, supplies, and diet. However, education in an outpatient setting focuses on one or two areas that are new for the patient, such as a change in medication or diet, says Schirado. Due to these subtle differences, patient education documentation forms for outpatient areas work best if geared to the outpatient setting, she says.

Tailor forms to the setting

Medcenter One Health Systems began as a single hospital and then acquired clinics. While some of the clinics are close to the hospital, others are up to 100 miles away. When determining how to document education in these clinics, Schirado considered using the inpatient form, but she knew that only one or two areas would be marked during a visit. That would result in a lot of wasted paper, she says. Also, it would be difficult to follow the continuity of education if a separate sheet was used to document teaching at each visit.

Therefore, Schirado implemented a multi-visit form that provides space for documentation of education at four clinic visits. (See **Clinic Patient Education Record**, p. 63.)

(Continued on page 64)

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Editorial Questions

For questions or comments, call **Susan Cort Johnson** at (530) 256-2749.

Centers for Disease Control and Prevention, and the Arthritis and Rheumatism Foundation. Board member Mercurio is a steering committee member of the NCI Cancer Patient Education Network.

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Source: Medcenter One Health Systems, Bismarck, ND.

Each section has a column to document which topic is being taught (such as medication) as well as columns to note barriers to learning, the literature provided, verification of learning, and referrals made for further education, such as a class on diabetes.

When designing documentation forms for outpatient areas at Kishwaukee Hospital in DeKalb, IL, patient education coordinator **Andrea Diedrich**, RN, MS, and her colleagues patterned the forms after the general patient education flow sheet used in the hospital. The standards for documenting patient education are the same no matter the setting, she says.

However, the forms for the physical therapy area, cardiac rehab, pain clinic, and sleep lab are streamlined.

“Our forms are shorter, more specific to the needs of each area, and designed for the shorter, quicker visits that are typical in outpatient areas,” says Diedrich.

Education noted in outpatient assessment

During multidisciplinary rounds at Roswell Park Cancer Institute, the educational needs and barriers of each patient in the hospital are discussed and documented. However, in the outpatient setting, the patient is not seen by a team of health care workers from social work, nutrition, physical therapy, and occupational therapy along with physicians and nurses at the same time.

To ensure that all team members know what education takes place outside the hospital, Battaglia incorporated all the aspects of the two-page inpatient documentation form into the nursing assessment in the outpatient area. Education is assessed along with blood pressure, medications, and a patient’s medical history.

“We wanted to make it a part of a form that everyone uses, sees, and reads,” explains Battaglia. Everyone who sees the patient will look at the assessment and see the education. They don’t have to search for it on a separate form, she says.

The short section inserted into the nursing assessment includes barriers to learning, learning needs, the patient to whom education was provided, the method of teaching, the patient’s response, and the required follow-up.

To determine which method of documentation to use in outpatient areas, Battaglia went to staff to discuss the issue. She was told it would be difficult for staff to document consistently if a new form

was introduced into the medical record. “You can’t expect cooperation unless you ask how to make the documentation process easier,” she says.

By examining how patients were seen in the outpatient setting, Battaglia was able to devise a way to make documentation of education more natural.

“It is part of the process, and it has increased our documentation tremendously because it is part of the natural order. They don’t have to seek out the form, and we don’t have to prompt them to document; it just happens automatically,” says Battaglia.

At Kishwaukee Hospital, Diedrich found that, if forms are similar in all areas, it is easier for staff to read and understand them. The outpatient forms in this hospital are therefore patterned after the inpatient forms.

When designing the documentation form for the clinics at Medcenter One Health Systems, it was important to keep real time in mind, says Schirado.

If a provider sees 40 patients in one day, the result could be an overwhelming amount of documentation, because every patient receives some education. In addition, there is only a short amount of time to assess a patient’s learning needs, plan an education strategy, implement it, and evaluate that education. It takes about 15 seconds to document education on the outpatient form, says Schirado.

While it would be nice to have all education documented, Schirado encourages staff to at least document anything new that is taught. For example, if a patient has a new diagnosis, is undergoing a new procedure, or is receiving a prescription for a new medication, it is important

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that the staff educate the patient and provide written materials to reinforce the teaching.

Compliance with documentation requirements is higher if it is monitored on a regular basis, says Schirado. Providing a way to test staff competency in this area also helps, she adds.

This year she put together a two-page information sheet on patient education along with a ten-question posttest. She distributed the information sheet and test to everyone who teaches patients, including disciplines such as respiratory therapy. Schirado asked staff members to return the posttest to her along with a copy of documentation of the education they provided to an actual patient.

"This helps me to get a look at all the different ways that people actually do document so that I can determine what education to provide staff," says Schirado. ■

Library of valuable resources for PEMs

List of books, web sites, and organizations

Every professional has a library of books and resources that provides insight into his or her specialty, and patient education managers are no exception.

There are many titles that patient education managers (PEMs) keep on their bookshelves, as well as resources provided by organizations dedicated to helping PEMs do their jobs effectively.

Patient Education Management asked several PEMs to recommend a list of helpful books and other resource tools providing aid on such topics as low-literacy patients, preparing written materials, adult learning theory, designing disease management programs, and general information on patient education skills.

Books

Fran London, MS, RN, a health education specialist at The Emily Center, Phoenix (AZ) Children's Hospital, says the book she uses the most is *Teaching Patients with Low Literacy Skills* by Doak, Doak, and Root, published by J.B. Lippincott.

"It gives specific information about how adults

learn, how to teach, and how to evaluate understanding, whether or not they have low literacy skills," says London.

For information about designing a disease management program, London reaches for *Patient Education: A Practical Approach*, written by Kate Lorig and published by Sage Publications.

For general information about patient education skills she refers to *Patient Education: Principles & Practice*, written by Sally H. Rankin and Karen Duffy Stallings, and published by Lippincott Williams & Wilkins.

London recommends the web site www.westone.wa.gov.au/toolboxes/equity/site/staff/f.htm for specifics on how to apply adult learning theory.

Mary Szczepanik, MS, BSN, RN, manager of cancer education, support, and outreach for OhioHealth Cancer Services in Columbus, OH, finds these books very helpful:

- *Handbook of Patient Education* by Ann Haggard, published by Aspen Publishers.
- *Client Education: Theory & Practice* by Dorothy Babcock and Mary Miller, published by Mosby.
- *No Time to Teach? A Nurse's Guide to Patient and Family Education* by Fran London, published by Lippincott Williams & Wilkins.
- *Effective Patient Education: A Guide to Increased Compliance* by Donna Falvo, published by Aspen Publishers.

Professional Organizations

In addition to books, organizations are good resources when patient education managers are focusing on a specific disease, says Szczepanik.

"Now that my focus is oncology, I rely heavily on the Oncology Nursing Society for standards, recommendations, texts, and other publications as a resource for patient teaching," she says. "Also, the American Cancer Society, the National Comprehensive Cancer Network, Association of Community Cancer Centers, and the professional organizations for each disease site and medical specialty are helpful."

The following is a list of oncology organizations recommended by Szczepanik:

- American Cancer Society, based in Atlanta, with local offices throughout the United States. Telephone: (800) 227-2345. Web site: www.cancer.org
- Association of Community Cancer Centers, 11600 Nebel St., Suite 201, Rockville, MD 20852-2557. Telephone: (301) 984-9496. Web site: www.acc_cancer.org

• National Comprehensive Cancer Network, 500 Old York Road, Suite 250, Jenkintown, PA 19046. Telephone: (215) 690-0300. Web site: www.nccn.org

• Oncology Nursing Society, 125 Enterprise Drive, RIDC Park West, Pittsburgh, PA 15275-1214. Telephone: (866) 257-4667 or (412) 859-6100. Web site: www.ons.org

Kathy Ordelt, RN-CPN, CRRN, patient and family education coordinator at Children's Healthcare Atlanta, finds the videotape *Health Literacy — Help Your Patients Understand* quite useful. The tape, which deals with clear communications between health care providers and patients, was produced by the American Medical Association. For more information, contact the AMA at 515 N. State St., Chicago, IL 60610. Telephone: (800) 621-8335.

For information on health literacy, Ordelt visits a web site produced by Pfizer Pharmaceuticals (www.pfizerhealthliteracy.com). "It has an amazing amount of information on the problems with

SOURCES

For more information about resources on patient education, contact:

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health care communications and literacy in the United States," she says. ■

EDUCATOR Profile

Teaching and nursing skills a winning combination

Work with staff to educate patients

Terry Chase, ND, RN, patient and family education program coordinator at Craig Hospital in Englewood, CO, received her nursing degree in 1996. She had been teaching in public schools for ten years, but her experience as a patient following a spinal cord injury prompted her to change careers.

"I felt that I could make some contribution to the field of nursing around patient education," says Chase.

She has been in her position at Craig Hospital, an 80-bed model rehabilitation center for patients with brain and spinal cord injuries, for eight years. Before Chase started at Craig, she earned a master's degree in exercise physiology and a doctorate of nursing (ND). She is currently working on a master's degree in spiritual psychology.

Patient education is part of nursing administration at Craig Hospital. Chase reports to the vice president of patient care services. She is responsible for the overall education program and must make sure it is compliant with the standards set by the Joint Commission on Accreditation of Healthcare Organizations.

Chase also is responsible for ensuring that staff members have the resources they need to do their jobs, such as written materials, videos, or classes. Chase revises and updates written materials and most recently rewrote the handbook for patients with spinal cord injuries. She helps create new videos by writing the scripts and directing the filming.

"Basically, I see myself as the support to the staff, who are the front-line patient educators," says Chase.

Teaching is part of her job at Craig Hospital, and she can often be found in the classroom as well as working one-on-one with patients and their family members to reinforce the teaching that other staff members have provided.

In the classroom, Chase teaches some of the curriculum on her own, but she also partners with other disciplines at times. For example, she teaches about medications with the pharmacist, and partners with the psychologist to teach coping skills.

Patients are not always physically, mentally, or emotionally ready to learn when they arrive at

Craig Hospital. At the same time, there is a limited amount of time to complete the patient's rehabilitation. Therefore, educators must begin giving the lessons as soon as possible and deal with barriers to education as they arise.

"As health care has changed, we are getting people earlier and earlier. We have had people within three days of their injury," says Chase.

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

Q: What is your best success story?

A: "In this hospital, where I was a patient, I have been able to create a patient education program," she says. "No one was really directing it, so I have been able to move our patient education program toward excellence, always looking for ways to improve, expand, and be innovative. I have integrated our patient education classes into the therapy schedule, and therapists now come to me to get their patients into classes."

The institution has three series of classes. The first is basic education for patients with a spinal cord injury or a spinal cord injury combined with a brain injury, which includes instruction on bladder, bowel, and skin care; medications; stress and coping; and air travel.

A second series is called "tetra" topics, which is short for tetraplegia. These are interdisciplinary classes designed for patients with high-level spinal cord injuries. A third series of classes focuses on re-entry issues for spinal cord injury patients, such as getting a job and sexuality.

"The classes for brain injury patients are a work in progress," Chase says. "It is difficult to determine exactly what to teach when learning is so individual and based upon the extent of the injury."

Q: What is your area of strength?

A: "I have good organizational skills for project planning. In addition, my gift is teaching. I really brought a lot of experiential education components to our program.

"From a personal standpoint, I have a spinal cord injury and have been a patient here. I have insight into what is needed in a program, and I can talk to the patients from that perspective."

Q: What lesson did you learn the hard way?

A: "That I needed to form relationships with

other professionals at Craig Hospital so that we were working toward the same goal, and I was not going against them but working with them.

"I had to build rapport with other departments, letting them know that I was reinforcing what they were doing . . . that working with me would be beneficial and would reinforce what they are doing with their patients as opposed to them giving up their rehabilitation time to send their patients to class."

Q: What is your weakest link or greatest challenge?

A: "The greatest challenge for me is to work at the same pace as that of the organization. I want to be more innovative, and I have to temper that and wait for things to evolve so I am more in pace with the organization's ability to grow."

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

A: "I would like to see health care providers develop skills that would make them excellent educators. We have the content for teaching, and we know what will keep people healthy. But we fall short in health care because we can't get the message across very well.

"I have been developing staff inservices and training around communication, listening skills, and teaching skills, as well as on how to be more caring educators.

"In order for patients to learn, it is important for health care workers to spend time with them even though it is easier to show a video. Patients really want someone to be interested in them and have personal contact. That makes a big difference."

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

A: "We are trying to put our patient education documentation form into electronic format. We know the form is good because the Joint Commission put it in their book of examples, the *Joint Commission Guide to Patient Education*. Also, I am working on a way to document the kind of patient education we are doing around pain management."

Pain management is a large factor in a patient's education and recovery at Craig Hospital, where patients often have multiple injuries. For example, a spinal cord patient might have fractured ribs, and this could slow his or her rehabilitation progress because upper-body strength is important for recovery.

SOURCE

For more information about patient education at Craig Hospital, contact:

- **Terry Chase**, ND, RN, Patient and Family Education Program Coordinator, Craig Hospital, 3425 South Clarkson St., Englewood, CO 80110. Telephone: (303) 789-8211. E-mail: ChaseT@CraigHospital.org

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

A: "I do look to the Joint Commission for examples, but I also belong to a patient education listserv, so I collect information off that. If I see an example of something that I think I will be able to use in the future, I print it off and put it in a file." ■

Health 'illiteracy' may cause disparities in care

Many people do not understand health information

Nearly half of all American adults — 90 million people — have difficulty understanding and using health information, and there is a higher rate of hospitalization and use of emergency services among patients with such limited "health literacy," states a report released April 8 by the Institute of Medicine (IOM).

The report, titled *Health Literacy: A Prescription to End Confusion*, represents almost two years of work by an 11-member panel of experts in public health, primary medical care, health communication, sociology, anthropology, adult literacy education, and elementary and secondary education.

The panel was formed in October 2002 and was charged with determining the scope of the problem of health literacy in the United States. Panel members conducted extensive reviews of the published studies on literacy issues related to health care, interviewed experts researching the impact of literacy on health care access and outcomes, and convened public workshops to get input from a variety of sources about how easily Americans are able to understand the health

information provided to them and participate as decision-makers in guiding the care they receive.

"Health literacy is fundamental to quality care," says **David A. Kindig**, MD, PhD, professor emeritus of population health sciences at the University of Wisconsin-Madison and chair of the committee that developed the report. "The public's ability to understand and make informed decisions about their health is a frequently ignored problem that can have a profound impact on individuals' health and the health care system. Most professionals and policy-makers have little understanding of the extent and effects of this problem."

The IOM report defines health literacy as "the degree to which individuals have the capacity to obtain, process, and understand basic information and services needed to make appropriate decisions regarding their health."

More than a measurement of reading skills, health literacy also includes writing, listening, speaking, arithmetic, and conceptual knowledge, the report indicates.

At some point in their lives, most people will encounter health information they cannot understand. Even well-educated people with strong reading and writing skills may have trouble comprehending a medical form or doctor's instructions regarding a drug or procedure, the report says.

Health information is particularly difficult to understand for people with limited overall literacy skills, Kindig notes. Attempts to improve health education in grades K-12 have met with substantial barriers over the years. As a result, many people lack the ideas and concepts they need to be health-literate.

But that's not the only problem, he adds.

"Another reason is that health professionals often lack education and training about how to communicate with patients and how to help improve the health literacy of their patients," he says. "During the evidence-gathering phase of this project, our committee heard from individuals who have been ill-served by the health care system as a result of limited health literacy — which means limited reading or writing ability — but also a limited capacity to navigate a complex health care system and to advocate for themselves within it."

For instance, the committee heard testimony from a woman who signed a consent form to undergo surgery without understanding that she was going to have a hysterectomy.

"It isn't [the woman's] fault that she did not know she had a hysterectomy," Kindig says.

“Problems with limited health literacy such as [hers] arise from a confluence of factors and failures in the health care system, the educational system, and culture and society. For instance, an individual may have a different idea of what being healthy means than his or her doctor does, may have trouble understanding the medical jargon that we in the health professional sometimes use without thinking, or may speak a different language. These are all common problems that are related to health literacy.”

Literacy and bias may coexist

Communication problems may be particularly harmful for immigrants and members of racial and ethnic minorities, many of whom have limited access to care and are further disadvantaged by cultural and systemic biases.

A 2002 IOM report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, concluded that minorities experienced disparities in quality of care and access to care that were not attributable to socioeconomic status or the severity of their medical condition.

That report demonstrated that health care providers often have biases and preconceptions about certain groups of patients without even knowing it, says **Alan Nelson**, MD, MACP, the former chair of the IOM Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care, which issued the 2002 report.

Compound that with the problems of low literacy and a complex health system, and you have a recipe for disaster.

“We also need to have a better understanding of the communication problems that may lead the minority patient to have difficulty communicating with the providers and making wise choices about their treatment,” Nelson said in an April 5 teleconference on racial and ethnic disparities in health sponsored by the Kaiser Family Foundation. “And, on the other hand, we found that bias and stereotypical behavior on the part of the physicians and other clinicians may very well be a factor.”

The medical community needs to do a better job of teaching cultural competence and understanding why biases exist, Nelson said.

The American Medical Association recognized in 1998 that limited health literacy was a problem and has since taken several steps to begin to address it, said AMA president-elect **John C. Nelson**, MD, in a statement accompanying the

release of the IOM report.

Low health literacy presents problems for the entire population, not just the individual patients who don't get the care they need, Nelson said. “Excess hospital stays, multiple doctors' visits, expenses incurred by misunderstanding and miscommunication — all of these create costs borne by everyone through higher premiums, higher taxes, and the higher inefficiencies low health literacy brings to the process.”

The AMA and the AMA Foundation have sponsored a multi-year effort to study how physicians and others are experiencing low health literacy and to develop tools to help turn the tide, he said.

They have developed a health literacy kit, *Health Literacy: Help Your Patients Understand*, which is available at www.amafoundation.org. The kit contains a 48-page manual for health care professionals, a videotape, and patient information.

The IOM report details ways in which low health literacy affects the delivery of health care and makes several recommendations about how the situation might be improved.

A concerted effort by the public health and health care systems, the education system, the media, and health care consumers is needed to improve the nation's health literacy, the report says. If patients cannot comprehend needed health information, attempts to improve the quality of care and reduce health care costs and disparities may fail.

The report recommends also that health care systems develop and support programs to reduce the negative effects of limited health literacy. Education in health knowledge and skills should be incorporated into existing educational curricula from kindergarten through 12th grade, as well

SOURCES

For more information about health literacy, please contact:

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as adult education and community programs, the report says.

Furthermore, programs to promote health literacy, health education, and healthy lifestyles should be developed with involvement from the people who will use them. And all such efforts must be sensitive to cultural and language preferences, the report states.

Copies of *Health Literacy: A Prescription to End Confusion* are available from the National Academies Press. Visit www.nap.edu or call (202) 334-3313 or (800) 624-6242. The cost of the report is \$47.95 (prepaid) plus shipping charges of \$4.50 for the first copy and \$.95 for each additional copy. ■

Improve communication with surrogate decision-makers

Alleviate burden by focusing on patient's wishes

Recent studies in intensive care units have found that critical care specialists often try to base decisions about withdrawal of advanced life support measures on their perception of the patient's wishes and the likelihood of survival in the ICU.¹

But making accurate decisions about a patient's wishes in such situations often requires clinicians to communicate effectively with surrogate decision-makers — members of the patient's family or others empowered to make decisions should the person become incapacitated.

Unfortunately, this is one of the most difficult tasks faced by physicians caring for patients at the end of life, says **Paul Hofmann**, DrPH, FACHE, a consultant on clinical and health care organizational ethics and vice president of Provenance Health Partners in Moravia, CA.

"In trying to come to a decision, physicians frequently ask family members, 'What do you want me to do?' instead of, 'What would your family member want under these circumstances?'" Hofmann says. "Asking the question this way can put an unnecessary burden on the surrogate decision-maker."

Physicians and family members may understandably have their own values and wishes to consider, and this often leads both groups of

people to make decisions that don't reflect the true wishes of the patient, he says.

Numerous studies performed over the years have indicated that most terminally ill Americans hope to die at home in the care of their families, as opposed to a health care setting. Yet, as a recent study published in the journal *Critical Care Medicine* finds, most Americans still die in hospitals — with the largest percentage receiving care in ICUs.²

"In that study, based on discharge data received about more than 500,000 deaths nationwide in 1999, 38 percent of deaths occurred inside a hospital, and 22 percent of those in the ICU," Hofmann says. "Extrapolated nationally, more than half a million patients die annually in ICUs. This is all the more reason to emphasize the need to find better ways to honor the patient's wishes at the end of life."

According to Hofmann, patients and family members can be better served if physicians phrase their question as, "What would your family member want under these circumstances?"

One doctor, he explains, puts the question another way. "He asks the family members, 'If I could give your family member a magic potion that could make him or her conscious for five minutes, what would your family member say they wanted under these circumstances?'" Hofmann says. "It is another way of lifting the burden from the family member and saying, 'This is the opportunity to honor and respect what your family member would want.'"

Physicians also should be careful when talking to family members about the patient's condition.

Too often, he says, physicians go into extensive descriptions of the patient's condition or prognosis without first determining what level of knowledge and understanding family members already have.

"If the physician were to begin by asking the surrogate decision-makers and other family members to describe what they understand the patient's condition to be, then the physician can be better positioned to explain and describe the circumstances within the context the family understands," he explains. "This can be very helpful in terms of minimizing misunderstanding and listening to the family."

Family members may have misconceptions or concerns about their loved one's condition that they do not reveal unless asked, or, conversely, they may understand more than the patient's physicians realize.

"There may be a high degree of understanding

or a low degree of understanding, and there may be complete consensus among the family, or, as is often the case, there may be disagreement among family members about what they understand the prognosis and the patient's wishes to be," he says. "I encourage physicians to think about the whole communication process and how it can be enhanced to best serve the needs of the patient as well as the family members."

Hospitals also periodically need to re-evaluate any policies they have on caring for patients at the end of life, especially those that concern substituted judgements — a situation in which someone other than the patient is making decisions about the patient's care.

For example, Hofmann says, hospitals are required by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) in Oakbrook Terrace, IL, to have a policy on do-not-resuscitate (DNR) orders.

Although JCAHO does not stipulate what the policy should contain, the organization does require each accredited hospital to have a DNR policy. Consequently, many institutions have policies that are out of date and not useful in many areas of common practice.

"For example, many do not stipulate what should happen in the event that a patient with a DNR should return to the operating room for surgery," he notes. "Many clinicians feel that, in some circumstances, it is appropriate to suspend a DNR when a patient is undergoing surgery for a procedure that is expected to improve their condition." But a suspension may not be appropriate for all circumstances. An up-to-date DNR policy should indicate when, if ever, the DNR would be suspended if the patient is scheduled to undergo surgery.

Other institutions Hofmann has worked with have developed their own policies regarding difficult issues at the end of life. One has a specific policy on incapacitated patients who do not have surrogate decision-makers available, he says. Another has developed a policy on administration of non-beneficial treatments.

"These are policies that were developed and

SOURCE

For more information about communicating with family members, contact:

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reviewed by all of the hospital committees and approved by the board of directors," he says. "So, both were very long, thoughtful processes that allowed the hospital to develop policies that honored its institutional values."

Many hospitals are reluctant to have such specific policies because they believe in the value of having an ethics committee make an individual decision about cases in which a conflict or question arises, Hofmann says.

However, it is important to develop such policies because they allow for a more relaxed, thoughtful discussion of the issue by different groups of health care professionals at the institution, rather than a last-minute, pressured decision by an ethics committee on each case.

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

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CE Questions

21. Patient education should be documented in the outpatient setting for which of the following reasons?
- A. Provides evidence for legal department
 - B. Required for accreditation
 - C. Functions as a communication tool among educators
 - D. All of the above
22. In addition to books and web sites, organizations can provide a wealth of information on various aspects of teaching to help patient education managers create programs and educate patients.
- A. True
 - B. False
23. According to the report from the Institute of Medicine, the term "health literacy" means
- A. The ability to understand a certain level of clinical or scientific information.
 - B. The ability to read and write alone.
 - C. The degree to which individuals have the capacity to obtain, process, and understand basic information and services needed to make appropriate decisions regarding their health.
 - D. None of the above
24. Clinicians discussing a patient's condition with a surrogate decision-maker should
- A. Ask the person what he or she believes the patient would want, given the circumstances.
 - B. Ask the person and other family members, if they are present, what they understand the patient's condition to be.
 - C. Attempt to focus the decision-making process on honoring the needs and wishes of the patient.
 - D. All of the above

Answers: 21. D; 22. A; 23. C; 24. D.

"With regard to patients at the end of life, a hospital should not only develop appropriate policies, but it should also make sure its existing policies are reviewed," Hofmann concludes.

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1. Cook D, Ricker G, Marshall J, et al. Withdrawal of mechanical ventilation in anticipation of death in the intensive care unit. *N Engl J Med* 2003; 349:123-131.
2. Angus DC, Barnato AE, Linde-Zwirble WT, et al. Use of intensive care at the end of life in the United States: An epidemiologic study. *Crit Care Med* 2004; 32:638-643. ■

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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. ■