Patient Education Management™

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

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Advance planning eases care for elderly and caregivers

Seniors and close relatives should prepare for aging process

Planning is something Americans do on a regular basis. They plan their vacations. They plan for the birth of a new baby. They plan for retirement. And they even plan for death. Yet few plan for the aging process.

"It is good for people to start to think ahead," says **Marilyn Rantz**, PhD, RN, director of the Center of Excellence in Aging and a professor at the School of Nursing at the University of Missouri in Columbia.

Families need to consider the various scenarios that could take place as people age such as not being able to drive or maintain a house. Then they should research the services and options available within their community, and work with close family members to develop a plan.

Rantz has talked to seniors and family members who volunteered at nursing homes, assisted living, or senior centers to help them become familiar with the services available to seniors in their community.

"That saved so much stress in those families who were proactive and

EXECUTIVE SUMMARY

As Americans grow older, their ability to care for themselves decreases and family members must step into the role of caregivers. It is not a role for which many people currently are preparing; however, a little preparation can mean the difference between a pleasant aging process and one that is chaotic and stressful for all members of the family.

This issue of *Patient Education Management* addresses caring for older adults, including the educational resources needed to help families transition into this period with the knowledge of what is required and how to develop plans for success.

took the time to understand what services there were in their community," says Rantz.

Michael Doran, CSW, coordinator of Caregiver Services at Health Outreach at New York Presbyterian Hospital in New York City often meets caregivers who are overwhelmed with the responsibilities of caring for an elderly loved one while trying to meet work and family obligations. "Quite often when people present for help they feel things are out of control," he says. **(For more information on fostering a realistic view of caregiving, see article on p. 75.)**

To help families prepare for the care of aging relatives, patient education coordinators can provide information on what types of resources might be needed by seniors and their family members, how to determine when it is time to make use of such services, and how to find services that meet budget constraints and family requirements.

A list of community outreach centers would be very useful to families looking for help with the care of aging family members, says **Collette Schelmety**, RN, assistant nurse manager on the Acute Care for the Elderly (ACE) unit at New York Presbyterian-Cornell Hospital in New York City.

These centers have access to the resources that families may eventually need for an aging relative, she says. For example, some have social workers who can help explain which services Medicare might cover, or they might offer home safety evaluations.

Local, state, and national agencies provide resources for older adults, says **Jennifer S. Browning**, MS, RN, CS, gerontology clinical nurse specialist at The Ohio State University Medical Center in Columbus. Senior centers within communities are also an important resource. They often have classes for older adults as well as social activities and meals.

Associations and organizations are good resources for disease-specific information. For example, the local chapter of the Alzheimer's Association headquartered in Chicago provides services for caregivers of elderly relatives diagnosed with this disease.

Preparing for potential problems

As relatives age, it is important for family members to foster their independence, but the family also should stay involved and supportive as needed, says Browning.

For example, social isolation could become a problem if an elderly person cannot drive or is not physically able to get out much. "They need frequent contact, even if it is just a phone call," says Browning. Relatives also can encourage visitors. Interaction with other people and the stimulation of talking about current events and things of interest is important, she says.

Caregivers need to be aware of the mental and

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physical changes that take place as people age so they know when to intercede, says Schelmety. For example, some forgetfulness is common as people age. Therefore, it would be wise to take steps to prevent potential problems by putting a list of emergency numbers next to the telephone.

It's also important for caregivers to encourage elderly relatives to participate in activities that stimulate their minds. "Seniors can improve their memory by continuing to be active in such recreational activities as Scrabble or cards," she says.

Watch for signs of dementia

Caregivers should note that signs of dementia include consistent loss of memory that affects activities of daily living and a person's ability to participate in social events, and to take care of him or herself, says Browning. In this case, an elderly relative would need more assistance and may need to be moved to an assisted living facility.

Older adults also are at risk of depression, which is underdiagnosed and undertreated, says Browning. It is important for caregivers to know the signs of depression in the elderly. "Older adults present differently. Their only complaint may be physical symptoms such as fatigue," Schelmety says.

As people age, there is a decrease in strength and balance, and bones become less dense so they are more susceptible to fractures, says Schelmety. Therefore, home modifications may be required to improve safety. For example, better lighting might be installed, and throw rugs removed. "One out of three persons age 65 and older fall each year, and fractures are the most serious consequences of the falls. Many of the injuries can be prevented," she explains. People can obtain environmental safety checklists to evaluate their homes. **(For a list of Internet resources for educating caregivers and seniors about the changing needs of aging adults, see p. 76.)**

Medications can cause confusion as well as falls. Caregivers should review all medications an elderly relative is taking and learn the side effects of each as well as the proper dosage and method of taking them. Medication containers need to be clearly marked for older adults, says Schelmety.

Certain immunizations and screenings are required for good health as people age; therefore, it is a good idea for people age 65 and older to begin seeing a physician who specializes in geriatrics, says Schelmety. Older adults should be vaccinated against pneumococcal pneumonia and influenza because these illnesses are in the top 10 leading causes of death for this age group. **(To learn more about education on immunization, see next month's issue of *Patient Education Management.)***

While good health practices are vital at any age, there are many things the elderly can do to improve the aging process. For example, to increase strength, flexibility, and balance, they need to make exercise a part of their daily routine. Good nutrition and hydration is important as well, says Schelmety.

Communication between the aging adult and his or her caregiver is very important as long as interaction is possible. Good health practices, living situations, and care should all be discussed and advance directives should also be set in place.

"Caregivers should find out what the older adult wants — they shouldn't assume anything. [Caregivers] need to communicate well with their loved one," advises Browning. ■

Fostering a realistic view of caregiving

Time, energy, and emotions often underestimated

Caregivers often underestimate the responsibilities of caring for an elderly relative. Frequently they have conflicting feelings about what they have undertaken, and it is hard for them to work through this and set limits on what they can accomplish, says **Marilyn Rantz**, PhD, RN, director of the Center of Excellence in Aging and a professor at the School of Nursing at the University of Missouri in Columbia.

"Sometimes people make promises to loved ones, and when they get into the reality of the situation they can't handle it," she says.

If an elderly relative needs help for a few weeks or months due to an injury or illness, families often can put other obligations on hold and provide assistance. However, it is difficult when the care is needed for years.

People need to be realistic about getting help and accepting help, says Rantz.

Most people know about agencies that deliver a hot meal to homebound seniors. However, there are many other services available. When Rantz lost her father, the family needed to find a transportation

Elder care Internet resources

Find agencies, print handouts, and services

Families with aging parents and other relatives need resources to help them address problems that arise as family members take on the role of caregiver.

A source of support and information is important, says **Michael Doran**, CSW, coordinator of Caregiver Services at Health Outreach, New York Presbyterian Hospital in New York City. In his position, he gets calls from families looking for advice on legal issues, home safety, how to set in place advance directives, and other issues.

Following is a list of on-line resources to help patient education coordinators assimilate a source of support and information for the families that utilize their health care facilities.

- **Administration on Aging: www.aoa.gov**

  The Administration on Aging is a division of the U.S. Health and Human Services, which is headquartered at 200 Independence Ave., S.W., Washington, DC 20201. The web site on aging has an Alzheimer's Resource section and a Caregiver's Resource section. Information for caregivers includes how to find help, how to cope with the role of caregiver, and how to find support groups. It also has a resource directory of names, addresses, phone numbers, and fax numbers of organizations that provide information and resources on the needs of older adults.

- **Alzheimer's Association: www.alz.org**

  The Alzheimer's Association National Office maintains a web site that provides information on Alzheimer's including the risk factors and warning signs, as well as connections to local chapters, resources, and services. Contact: Alzheimer's Association National Office, 225 N. Michigan Ave., Fl 17, Chicago, IL 60601. Telephone: (800) 272-3900.

- **Best Caregiver Information: www.bestcaregiverinfo.com**

  This web site contains articles, connections to organizations and associations that provide help, and information on standards of excellence. Articles on the site include tips on identifying depression in older adults, home modification and repair for safety, and how to find transportation services. Telephone: (561) 212-5297.

- **Consumers' Guide to Quality Care: www.nursinghomehelp.org**

  The Consumers' Guide to Quality Care was produced by the school of nursing at the University of Missouri in Columbia. It offers advice for families searching for quality nursing home care and includes suggestions about what to look for inside nursing facilities, how to identify quality nursing staff, and links to other resources on the Internet. ■

service for her mother to get around. Her mother learned of a van service while getting her hair done at the beauty shop. This enabled her to go to the drugstore for medications, shop, and go for walks at the mall on her own. It helped her remain in her home an additional three years after the loss of her husband, Rantz recalls.

She also had the opportunity to use a home care service when her mother was recovering from a fall. This service is frequently covered by insurance and provides home care workers to care for seniors while the family is at work and school. These workers can give baths, prepare meals, help with exercise, and keep seniors company.

People who take on the role of caregiver also need to accept help for themselves, such as finding a support group and a good source for information, says **Michael Doran**, CSW, coordinator of Caregiver Services at Health Outreach at New York Presbyterian Hospital in New York City.

"Given the emotional challenge and the time and energy of maintaining one's own life, work, and family responsibilities, caregiving can be overwhelming — especially if someone is doing it all by themselves," says Doran.

What is tricky about the situation is that often the caregiver is the son or daughter, and it is difficult to relate to one another in a different way. No matter the age of those involved, the daughter still is the daughter and the mother still is the mother, he adds.

The elderly adult may refuse to agree to something such as hiring a home care service to help attend to his or her needs. When this happens, it is important to get an outside party involved, preferably someone the elderly adult trusts such as their minister or health care provider, says Rantz. This scenario also can be avoided if families make plans in advance with seniors fully involved in the decision making, she says.

It often is difficult for adult children to see their elderly parent's health deteriorate and to see them losing the ability to do things for themselves such as grooming. It can be an emotional time for families, says Doran. That is why a support system is important.

Information that can help families make the best decisions can be helpful as well, says Rantz.

SOURCES

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That is why her organization created a guide on how to select a quality nursing home.

"If people have to use a nursing home or assisted living facility, I encourage them to make the decision based on quality of care — not just on price or location. It is quality of care that will make the difference," she says.

At the University of Missouri School of Nursing, research is being conducted on how to help the elderly age in place, says Rantz. The model of aging in place means that seniors are able to remain in their preferred place of living as they age by contracting with services as needed so they do not have to move to a more restrictive environment. ■

Shared position proves two heads are better than one

Coordinators tell how to job-share successfully

To balance work and family, **Cindy Latty**, BSN, RN, and **Maureen Battles**, BSN, RN, share the role of patient education coordinator/clinical educator at Riley Hospital for Children in Indianapolis, which is a part of Clarian Health Partners.

Latty and Battles were looking for part-time opportunities when the job was created 3½ years ago, so they decided to work in tandem. One day a week they both are on site, and the remaining four days they take turns, creating their work schedules four to six weeks in advance.

Both work about 24 hours a week, leaving detailed phone messages about the tasks they have accomplished during their shift so each can pick up where the other left off. They also make copies of their notes and the minutes from any meetings they attend.

The two women are active participants in many groups, and they sit on councils as one person — Latty/Battles. If both are working, they attend the meetings together, otherwise, one or the other attends.

The job summary for their position at Riley states that they are to coordinate the planning, implementation, promotion, and evaluation of patient education at Clarian. The two adult hospitals within the system, University Hospital and Methodist Hospital, each have a patient education coordinator with whom Latty and Battles work.

"We focus more on the pediatric population, and our counterparts at IU and Methodist focus more on the adult population. If we come across something that applies to the pediatric patient as well as the adult, we work together," says Latty.

As coordinators, Latty and Battles assist health care professionals with the development of patient education materials and other projects pertaining to the education of patients. In that way experts develop the content, and Latty and Battles make sure it adheres to the policies created for patient education at Clarian. Materials are updated every three years to ensure that information is current and accurate. The two women also co-chair the interdisciplinary patient education council.

Both women have been with Riley Hospital for Children their entire nursing careers. Latty has worked at the pediatric facility for 20 years where she mostly cared for infants before taking on the job as patient education coordinator. Battles has been with Riley for 15 years, working with preschool-age children as a bedside nurse and as a care coordinator for 2½ years.

Clarian has 349 pediatric beds and 985 adult beds. Of those pediatric beds, 230 are at Riley. Methodist Hospital has three pediatric floors that include an intensive care unit and rehabilitation unit, while University Hospital does pediatric transplants. Recently, the health care system installed an overhead railway between the hospitals, which

makes it easier for Latty and Battles to attend meetings at the other hospitals in a timely fashion and meet the needs of the other facilities.

In their joint position, Latty and Battles report directly to the senior vice president of pediatric nursing and patient care services. However, one year ago a director of education was hired for the health care system to oversee both staff and patient education. Latty and Battles consider this a matrix relationship.

In a recent interview with *Patient Education Management*, Latty and Battles discussed their philosophies on patient education, the challenges they have met, and the skills they have developed that help them to do their job well.

Perfecting education, step-by-step

Question: What is your best success story?

Answer: "We don't have one success story. When we were selected for the position of patient education coordinator at Riley it was difficult to know the source of many of the materials given to patients and health care providers didn't know what was available," says Latty.

"We started a pediatric-parent patient education council with parent members and representatives from all the inpatient units, clinics, and disciplines.

"Now staff are taking the initiative to focus on the patient education needs of their areas when they differ from the institution as a whole and some are developing their own councils. We feel success in the fact that we are mentoring people to see what they need for their areas and how to achieve that. We are ad hoc members of all these councils, and attend on a regular basis to encourage the development of these areas.

"We assisted with the creation of a patient education department site on our intranet and have electronic versions of our materials. Units can order a supply to have on hand or they can pull up documents and print them as needed.

"We have a long way to go, but we think these are some of the primary things that we have done."

Question: What is your area of strength?

Answer: "Communication, dependability, and flexibility are our strong points. Each of us can pick up where the other left off because we leave detailed explanations on the telephone. It is truly continuity. Also, we can depend on each other, we know that the task will get done," says Latty.

"We call each other sounding boards. Sometimes we look at something the exact same way, and other times we have different viewpoints. It can give us a different focus and that is good. A lot of times, two heads are better than one.

"We have helped with communication of patient education throughout the facility. There used to be isolated groups doing their own things, and now they contact us when they need something that falls in the category of patient education."

Question: What lesson did you learn the hard way?

Answer: "That organizationwide, there is red tape, and it can take a long time to complete projects or create change. Even though we are definitely making a difference, it takes a long time to move forward with things in a large organization," says Battles.

Question: What is your weakest link or greatest challenge?

Answer: "Because Clarian is such a large organization, we want to make sure we are contacting all the appropriate stake holders, and we don't know everyone in every hospital. We are learning. Our pediatric knowledge base has grown, and we have wonderful contacts throughout the organization. Yet it is a challenge to get the word out. We have broadcast e-mails that we use but not everyone reads them, so this is something we are slowly working on. [We] feel it is a weak link in that it is not exactly where we want it to be, and is something on which we are improving," says Battles.

"The organization has acknowledged that this is a weak link, and recently formed a task force to partner with a communications company to plan and implement some strategic communication improvements."

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

Answer: "We recently opened a new family resource center and are working with our clinical staff to develop curriculum for classes. We are looking forward to evaluating outcomes of patients and family members educated in the classrooms vs. those at the bedside," says Latty.

"By developing curriculum that is evidence-based, we will teach staff what it is they are supposed to teach. They will have standardized information and education for all our families on a lot of different topics. Our new education process in the family resource center will help with

the standardization of care."

The center has four components that include a chapel, a family library, a Ronald McDonald House with six sleeping rooms and an adult lounge area for inpatient families, and an education center where Latty and Battles now have their office.

Question: What have you done differently since your last Joint Commission on Accreditation of Healthcare Organizations' visit?

Answer: "The biggest thing we have done is to modify our patient education record. When we first took the position, we tried to determine why people weren't documenting and why the education wasn't being completed, and we found the biggest challenge was time. Also, the forms weren't user-friendly. So we took suggestions from staff and worked on a new record and guidelines on how to use it," says Battles.

"We want the teaching record to be a communication tool of exactly where the patient is with education. [This way], anyone can look at it and see what has been completed and what needs to be done [so] the patient and or family is taught what they need to know in order to be discharged."

The first Joint Commission visit Latty and Battles were involved with took place six months after they took the position of patient education coordinator, and these changes are in progress. The most recent Joint Commission survey was in May.

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

Answer: "To determine what is needed we get information from staff and patients. When we are looking for information we go to our clinical content experts. We rely on them because we want to make sure that what we create not only adheres to Clarian practice, but is evidence-based information. We not only format patient education materials making them colorful and user-friendly, we make sure that any layperson can understand the terms." ■

SOURCES

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Communicate with the baby boomers

Aim to reach the decision makers

Educating physicians about the cost-effective, high-quality care provided by your facility is only half of the marketing equation. Patients are the other half, and in many ways they are a tougher nut to crack.

While most elderly hospital patients are older Medicare beneficiaries, they can be a diverse lot, especially if you account for the fact that their middle-aged children may be the decision makers for medical care.

As the nation's population grows older, baby boomers — the proverbial cow making its way down the python's gullet of U.S. health care — will be faced not only with their parents' mortality, but their own as well.

Boomers have been characterized as a group that is accustomed to being in control. It was the boomer-aged women who prompted hospitals to rethink their approach to labor and delivery. They demanded more choices and greater power in the process, and changed an industry as a result.

Baby boomers are poised to change the health care industry in much the same way. They will watch their parents go through the dying process, and that experience will provide the basis for their own choices regarding health care. Health care facilities have every reason to make that experience as good as possible.

According to **Kristen Wolf**, president of Spitfire Strategies, a Washington, DC-based communications consulting firm that helps organizations affect social change, targeting marketing efforts toward health care decision makers within a family and those who have influence on family decisions can go a long way.

The traditional health care marketing approach can be summed up simply: "Get the word out." That usually entails producing brochures and videos explaining the facility's philosophy. At its best, this approach is a rational way of increasing awareness. But it's less effective as a way to reach

a middle-aged daughter confronted with the declining health of a parent.

"These are emotional times," says Wolf. "Your marketing cannot be rational."

In other words, brochures or nurses explaining health care may not be enough. In a time of crisis, the health care message will be lost if it is not delivered by a figure of trust. You have to target marketing to those who have an emotional connection to the patient or family. For example, clergy can have a tremendous influence on families in times of crisis.

A targeted marketing approach begins with understanding exactly whom you are trying to reach. Look for the gatekeepers, Wolf advises. These are the people who are advisors to patients and their families.

Once you determine who your target is — women in their forties, for example, because they are the primary medical decision makers for elderly parents — ask yourself this question: What motivates this population to seek a health care facility for a family member? There may be a number of answers, such as guilt, fear of watching loved ones suffer, or dissatisfaction with current medical care.

Targeted marketing is nothing new. It's omnipresent. Just look at the wide variety of television ads. Fast-food companies aim their messages at a variety of different audiences. Cereal boxes are designed to appeal to children because producers know children can affect the buying habits of their parents.

"If you want to grow your customer base, you'll have to target your marketing," Wolf says. ■

Use health education as a marketing tool

Form partnerships with other organizations

As the population ages and the needs of seniors change, home health managers are looking for ways to make their services more applicable to today's senior population. One way to expand services and increase the visibility of your home health agency is to form partnerships or relationships with other organizations in the community.

It's much easier for private-duty agencies to establish partnerships with assisted living facilities because rules related to anti-kickback statutes don't apply, says **Karon Austin**, MPA, RN, CHCE, a home care consultant and owner of Healthcare Concepts in Avon, CO.

"During my 21 years as an owner of a private-duty home care company, I was able to establish several relationships with assisted-living facilities," she says. Her arrangements actually specified her agency as the preferred provider when the assisted-living facility needed to refer to a home care agency. While Medicare-certified agencies are unable to establish the same type of formal agreement, there are a number of ways that all home care agencies can establish relationships, she explains.

"One of the services we provided to our assisted living facility partners was a monthly educational program in which we provided speakers on a variety of topics of interest to the facility's clients," Austin continues. "We would present topics on health issues such as osteoporosis and Medicare coverage topics, such as benefits for wheelchairs, canes, or other durable medical equipment," she says. "We also provided cholesterol screenings and coordinated annual health fairs," she adds.

Speakers for the educational programs and the health fairs can be a mix of agency nurses with expertise in certain areas, representatives from vendors such as durable medical equipment providers, and medical personnel such as podiatrists or dentists from the local area.

"We never charged the clients for the seminars, and we never paid fees to any of the speakers," Austin says. There was, however, never a lack of willing volunteers to speak, especially when local health care providers and physicians learned about the program and saw it as an excellent way to establish a connection with an audience that would most likely need their services at some point, she adds.

Before finalizing any agreement to provide health fairs or educational programs at an assisted-living facility, be sure to have an attorney review the agreement for violations of state and federal anti-kickback regulations, suggests **John Gilliland**, JD, an Indianapolis-based attorney.

Basically, a home health agency cannot promise a free service such as an educational program in exchange for a promise of referrals, he explains. The laws differ from state to state, with some state regulations being even tougher than federal regulations, so each agency needs to have its agreements evaluated, Gilliland says.

It also is important to make sure the assisted

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living facility has a policy that gives preference to patient choice when choosing a home care agency, and that the facility follows its policy. This gives a Medicare-certified home health agency an extra measure of protection against charges of kickback violations, he says. ■

Lost in translation? Helping LEP patients

Interpreter errors are common

A Spanish-speaking mother brings her infant daughter to a hospital emergency department because of a skin rash on her baby's face. Because a professional interpreter is not available, the woman's older child first translates the mother's information about the patient. Then, the child translates doctor's instructions on treatment to the mother.

The recommended treatment, however, will likely never be delivered because the young girl, asked to quickly interpret complicated medical information, instructs her mother to spread the prescribed hydrocortisone cream across the baby's entire body.

Such misinterpretation may seem comical in this case, but the actual consequences of mistaken translations in health care can be deadly.

Although federal regulations require health care providers to provide assistance to patients with limited English proficiency (LEP) — including translation and interpretation services when necessary — there are no objective standards or guidelines for who may work as an interpreter for health encounters.[1]

As a result, most hospitals and primary care providers have sketchy programs for communicating with non-English-speaking patients.

"What often happens is they ask a bilingual employee, who may not be fully fluent in both languages, to step back and serve as interpreter," says **Beverly Treumann**, a state-certified Spanish interpreter at the University of California at Los Angeles Medical Center and president of the California Healthcare Interpreting Association (CHIA). "For a lot of people, Spanish-speakers for example, Spanish may be their first language and the language they hear at home. But that is not the language they learned in school, if they grew up in this country, and they don't have formal knowledge of the language, both written and verbal, [as well as] its grammar and structure."

Translator can compromise privacy

Asking bilingual employees to serve as interpreters during health care encounters raises important questions about patient privacy and confidentiality as well. But Treumann and others say they are primarily concerned because inaccuracies in translation can lead to dangerous medical mistakes.

Interpreters not only have to be conversational in both languages, but they also must be able to understand complex medical terms and a great deal of technical vocabulary in both tongues.

In addition, nontrained interpreters are unlikely to use the basic professional practices of trained interpreters to ensure accuracy, Treumann adds. Medical interpreters, for example, know to restate what each party said, verbatim, if possible, and minimize any shadings of the meaning.

"This may sound like common sense, but you'd be surprised how many people, when asked to interpret for someone else, will not understand that they are to repeat, in exact detail as possible, what each party says," she notes.

Professional interpreters often are trained to pause after translating to allow each person to respond, and also are trained to ask for more time to "catch up" in the conversation without disturbing the interaction between patient and physician or inserting themselves into the visit.

"You are always going to get behind . . ., no matter how good you are," Treumann says. "You have to be able to acknowledge that and ask people to slow down, or repeat what they said to ensure you are accurate."

Even when professional interpreters are used, the results are not always perfect, says **Glenn**

Flores, MD, associate professor of pediatrics, epidemiology, and health policy at the Medical College of Wisconsin in Milwaukee and director of the school's Center for the Advancement of Urban Children.

Study shows many translator mistakes

In 2003, Flores and colleagues conducted a study aimed at evaluating the accuracy of medical interpreters working during clinical visits.[2] They audiotaped 13 clinical encounters in a pediatric clinic where Spanish interpreters were used. Investigators then used trained interpreters and documentation of the visits to evaluate the accuracy of the interpreters' work.

Of the 13 visits, there were a total of 396 interpreter errors, an average of 31 errors per encounter, ranging from as few as 10 errors in one visit, to as many as 60.

Most were errors of omission, Flores says, where the interpreters left out information stated by either party. In 16% of the visits, "false fluency" was a problem — interpreters simply invented words that did not actually exist in the language. In 8% of the visits, interpreters added incorrect information that the physician or patient did not state. Other problems emerged when the designated interpreters frequently inserted their own opinions.

Of the errors, 63% were deemed to have potential clinical consequences, Flores says.

"These were errors in interpreting information about the history, past medical history, the history of present illness, or their understanding of treatment instructions and follow-up," he explains. "The average was 19 errors of potential clinical consequence per encounter, ranging from five to 49."

Flores and colleagues also found that "ad hoc interpreters," friends, fellow patients, social workers, clinic personnel, or relatives who spoke Spanish but were not trained interpreters were significantly more likely to make errors of potential clinical consequence than the trained hospital interpreters, he adds.

"Their rate was 77% vs. 53%, for the trained interpreters, which is highly statistically significant," he notes. "As an example, there was an 11-year-old girl used as an interpreter for her mother and an infant child, and 84% of the 15 errors she committed had potential clinical consequences, including some pretty impressive ones. "The most pressing ones we saw, were omitting questions about drug allergies, omitting key information about the past medical history, omitting crucial information about the chief complaint or symptoms, and errors about the antibiotic dose, frequency, and duration.

The interpreters working for the clinic often had other difficulties, Flores states.

One interpreter, a social worker, actually turned to the patient and indicated that the doctor was going to ask detailed questions about sexual history and drug use, and advised the patient not to answer the questions. And another interpreter told the patient an antibiotic was prescribed for the flu, which is never done.

"Then, there was a mom who clearly said to the interpreter that her child had already had a rectal swab for culture and the interpreter did not tell the doctor, so the child got another swab," he adds.

Since that time, the hospital has improved training for its professional interpreters, and their rate of errors has dropped significantly, he says.

In many cases, it is unfair to ask bilingual employees to serve as interpreters, as often is the case in many health care settings, adds Treumann.

Hoping to avoid the cost of professional interpretation and translation services, some providers hope to kill two birds with one stone and hire personnel who are bilingual in the hopes they will serve as interpreters.

Just because someone is bilingual, it does not mean they will be an accurate and reliable interpreter. And, the pressure from one's employer to do something they have not been trained to do can be acute.

"They may not feel comfortable serving as an interpreter for a person who speaks the same language because of concerns about how well they know the language, and [also may be uncomfortable] taking such a personal role," she says.

If bilingual health care personnel are adequately trained and want to serve in that capacity — that's another story, she notes.

"Many physicians from other countries, while awaiting licensure here, want to serve as interpreters. They can be ideal because they have usually had a high level of formal education in their native language, and they have the medical background as well," she says.

Enormous potential for disaster

Today, more than 47 million people in the United States speak another language and 21.4 million people have LEP.

SOURCES

For more information on preventing interpreter errors, contact:

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- **Beverly Treumann**, The California Healthcare Interpreting Association, One Capitol Mall, Suite 320, Sacramento, CA 95814. Telephone: (916) 669-5305. E-mail: chia@chia.ws

"There has been a tremendous growth over the last decade in those populations. It is not an inconsequential number of patients seeking care in U.S. hospitals," Flores explains. "And, the available data suggest that lack of available trained interpreters is not uncommon for millions of these patients. One study found, for example, that no interpreter was used for 46% of LEP patients and when an interpreter was used, 39% of the interpreters had no training."

Currently, there are no objective certification processes, licensing bodies, or training programs for health care interpreters, says Treumann. Most professional certification comes from learning to interpret and translate for the legal system.

However, health care interpreting has its own set of unique challenges that warrants special training.

Court legal proceedings are adversarial in nature, and the interpreter is not required to be an advocate for the patient. However, in health-care settings, the interpreter may have certain ethical and moral obligations to the person presenting for care that he or she would not have working in the legal system, Treumann says.

Standards of practice for interpreters

Health care interpreters not only need training in how to serve as accurate and reliable interpreters, but also must receive education about the ethical complexities of the patient encounter as well — information about privacy and the principles of informed consent are particularly compelling.

CHIA has developed standards of practice for health care interpreters, and they can be found at www.chia.ws/index.php on the organization's web site.

The results of Flores' study and others like it also provide ample justification for third-party reimbursement of translation and interpretation services, he says. The potential reduction in increased health care costs due to preventable medical errors and unnecessary care should more than offset the costs to the health care system, he notes.

Currently, only 10 states require third-party payer coverage of interpreter services.

References

1. 68 *Fed Reg* 47,311 (Dec. 16, 2003).
2. Flores G, Laws MB, Mayo SJ, et al. Errors in medical interpretation and their potential for clinical consequences in pediatric encounters. *Pediatrics* 2003; 111:1,495-1,497. ■

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

- ■ Best practices for getting the word out on immunizations
- ■ Tips on educating via the telephone
- ■ The best in translation practices
- ■ Addressing timely education issues
- ■ Creating policy for interpreter services

CE Questions

1. To help families prepare for the care of an aging relative, patient education coordinators can:
A. Provide a list of senior centers
B. Educate on signs of depression
C. Offer checklist on home safety
D. All of the above

2. When a nursing home or assisted living facility is needed to help care for an elderly relative, family members should make their selection based on the quality of care rather than location or price.
A. True
B. False

3. When marketing your health care facility's services for the elderly, you should target your messages to which of the following audiences?
A. The elderly person who will be using the services
B. Younger family members who may be heavily involved the decision
C. Trusted advisors such as clergy
D. All of the above

4. Which group of people do NOT make ideal translators in health care settings?
A. Family members of the patient
B. Bilingual physicians from other countries
C. Trained and certified interpreters
D. None of the above

Answers: 1. D; 2. A; 3. D; 4. A.

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. ■