Patient Education Management™

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

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IN THIS ISSUE

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Call centers provide vital information after hours

Patients get a one-stop resource for information and services

Parents in Georgia don't have to guess whether it is appropriate to rush their child to an urgent care center in the middle of the night. When they telephone the Children's Healthcare of Atlanta Call Center, they speak to an experienced pediatric nurse who, through a series of questions based on a protocol, helps them determine the suitable level of care for their child.

"We do a lot of teaching as we go through the protocol. Then, if we get to the home care page and they haven't fallen out as far as needing additional follow-up immediately, we teach there as well," says **Pennie Graham**, RN, MS, director of the call center, which receives 325,000 calls from consumers each year.

The mission of the call center is to make sure everyone in the Atlanta metro area has access to the best possible advice and care and is making the best choices they can about the care their children need, she notes.

The Children's Healthcare of Atlanta Call Center was launched 12

EXECUTIVE SUMMARY

The need to for health care information doesn't always arise during office hours. That's why health care institutions provide call centers where consumers can find out if they should rush to the emergency department or get information on ways to treat the problem at home.

In addition, call centers provide a one-stop resource for information on services offered at health care facilities as well as connections to specialists. This issue of *Patient Education Management* explores the educational services offered by call centers and the staff training required to effectively meet the needs of consumers.

years ago with two nurses at a counter in the back of the emergency department. Originally, its purpose was to make sure people calling the emergency room for advice were getting good information and being sent to the appropriate place for their care. It also was a way to help the underserved patient population connect with the resources that they needed.

Today, about 60% of the calls are from patients of subscribing pediatricians. The answering service transfers those patients who call after office hours to the center for triage and education where they learn how to care for the condition.

While the purpose of call centers varies, generally they provide an opportunity for consumers to get information when they need it.

The Help Line in the Women's Health Center at Sacred Heart Medical Center in Spokane, WA, has been so beneficial to new mothers that they continue to call for advice and information as their children continue to grow.

An employee in the technology department originally created the Help Line for the obstetrics department, but it now is used for other women's health issues. However, one of the key purposes is to support the women who deliver babies in the hospital's Birth Place.

About a month before delivery, mothers come to the Birth Place to learn about baby safety and infant care as well as how to care for themselves following the birth of their child. At that time, the medical history sent by the physician's office is reviewed. This information is entered into the Help Line database so registered nurses can educate mothers on issues they may struggle with once discharged from the hospital, such as sore nipples while breast-feeding.

"We can talk them through anything they may have problems with once the baby is born," says **Julie Emery**, RN, assistant nurse manager of the Women's Health Center.

A nurse from the call center telephones mothers 24 hours after they go home to see if they are having any problems. At that time, they ask several questions based on the protocol, such as whether the baby is eating and in what position the baby is sleeping.

Seventy-two hours after the mother and child go home, a second phone call is made in which another set of questions from the protocol are asked. Any problems discussed during the two phone calls are entered into the computer so additional follow-up calls can be made, as needed.

New mothers can call with questions 24 hours a day. After hours, calls from the Help Line are forwarded to the Birth Place. A call log is kept and sent to the Help Line so the information can be entered into the database. Also, each time a protocol is used, the information given to the patient is automatically recorded in the database along with the date and time the call was made

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and the name of the educator.

"People love it. They know that there is someone there to help them if they need it. It is good public relations for the hospital," reports Emery.

Training is essential

Training staff to handle the calls received at a center is often extensive. At Children's Healthcare of Atlanta, applicants must have three years of pediatric nurse experience. Also they need good communication skills and very good listening skills because information is gleaned by what is not said as well as what is said, explains Graham. **(For more information on good telephone teaching techniques, see article on p. 100.)**

"Because you cannot see the child, and you are talking to people who have no medical background, for the most part it takes a certain set of skills to convey the information in a way they will understand," says Graham.

When a nurse is hired he or she undergoes a 90-day formal orientation that includes listening to calls and working with the computers. Following that, training nurses receive nine months of supportive orientation. During this time, they learn the 80 protocols and take tests on them.

While information given on the M.D. Anderson Information Line in Houston is not clinical, training is essential for staff. Job qualifications include a college degree and a background in health or communication. Because the institution is one of the leading cancer treatment centers in the United States, training covers both the phone service and also cancer information.

"Each health information specialist spends a good deal of time in the first four or five weeks studying booklets and taking many tests on the different types of cancer. We also have them shadow other specialists on the phone and listen to how they take calls," says **Darren Skyles**, director of the M.D. Anderson Information Line.

If a caller has lung cancer, the information specialist explains M.D. Anderson's standard treatment for that type of cancer and explains some of the clinical trials for the disease currently being conducted at the health care institution. The specialist then advises the patient to discuss the information with his or her physician.

Callers are generally looking for additional cancer treatments as well as information on how to be admitted to M.D. Anderson for treatment.

"Information specialists can direct callers to resources and counsel them in a way that tells them the benefits of coming to M.D. Anderson, but we aren't nurses or doctors," says Skyles.

As the Internet increases in popularity, the calls on the information line have decreased and e-mails are on the rise. In the 1998-99 fiscal year, the call center received 32,564 calls and 8,685 e-mails. And in the past year, there were 24,005 calls and 21,869 e-mails, thus indicating that e-mails now are a substantial part of the M.D. Anderson Information Line service. **(For information on providing information via e-mail and web sites to support call centers, see article on p. 100.)**

When a health care system includes 13 hospitals, creating a call center that distributes information for all facilities can be cost-effective.

"It is certainly a more cost-efficient way to provide the service. There is one set of overhead costs vs. [multiple] overhead costs for each of the hospitals," says **Julie Bruns**, call center manager for BJC HealthCare in St. Louis.

People call for a physician referral, to schedule a screening mammogram on the mobile van, to enroll in a childbirth class, to ask about parking at a particular facility, or to inquire about obtaining their medical records.

"When the hospitals are promoting a service, or providing an educational program, or just letting customers know they can call for a physician referral, they use the phone number that rings into our call center. We have 10 or 12 different numbers that ring in here," says Bruns.

Because the calls are nonclinical, the phone lines are staffed by customer service representatives who receive six weeks of training before taking calls on their own. A couple of nurses are available to provide assistance when a customer

SOURCES

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- **Darren Skyles**, Director, M.D. Anderson Information Line, 1515 Holcombe Blvd., Unit 213, Houston, TX 77030. Telephone: (713) 745-9212. E-mail: dskyles @mdanderson.org

calls with a particular condition and wants to be referred to a specialist.

A call center similar to the one at Children's Healthcare of Atlanta is operated at one of the hospitals within the BJC HealthCare system. When parents call the St. Louis Children's Hospital Answer Line, they talk to a registered pediatric nurse.

In addition, the Answer Line provides an asthma management service. There is a process in place where the nurse recommends asthma treatment and then follows up with phone calls. By using more aggressive management practices, fewer children are sent to the emergency department and, when they are sent, they are not admitted to the hospital as often, says Bruns.

"We have come up with a model that follows standard practice and, even though it takes our nurses more time for the calls, it has proven to be better for the children in that they get the rescue treatment more quickly and may not have to go to the ER," she reports. ■

Health education goes electronic

E-mail and Internet preferred by many patients

Most call centers are developing a closer link with their hospital web sites, says **Julie Bruns**, call center manager for BJC HealthCare in St. Louis.

"In our case, the people will e-mail questions and requests for physicians. What might have been a phone call in the past is now an e-mail, so the call center is providing support for that," she says.

Also parent-friendly protocols on the St. Louis Children's Hospital web site (www.stlouischildrens.org), which is one of the 13 hospitals within the health care system, help to support its Answer Line.

"Parents can go on-line and look up information about fever and follow a set of protocols written by the same physician who wrote our telephone protocols. They can get some basic information there and, if they still have a question, they can call," says Bruns.

Children's Healthcare of Atlanta has an e-call center on its web site to complement the call center.

"Our e-call center has a number of our most asked for protocols in a format that most parents would understand. They include behavioral issues and chronic illness like asthma and reflux. Parents can read the information at their leisure," says **Pennie Graham**, RN, MS, director of the Children's Healthcare of Atlanta Call Center.

The information line at M.D. Anderson Cancer Center in Houston, gets almost as many e-mails as phone calls. Staff answer most e-mails within 24 hours.

"E-mails are more difficult from a customer service perspective because when you give them an e-mail answer it is in writing and there is no interaction. There has been some dissatisfaction with the answers we gave because patients didn't feel like they got the answer they were looking for," says **Darren Skyles**, director of the M.D. Anderson Information Line.

Staff for the information line attended a seminar to learn how to format e-mail messages so the answer showed more understanding of the patient's request.

Now Skyles searches for the "question" that the patient is asking and addresses that first in his return message.

"What we have started to do is to categorize our answers. If, for example, they are asking about our treatments for pancreatic cancer we might have a category in bold letters that says "treatment information" and then give them the information so they don't get lost. We are trying to make our e-mails more user-friendly," says Skyles. ■

Improve communication with good phone skills

Use clear speech with nontechnical words

By **Kathy Ordelt**, RN-CPN, CRRN
Patient and Family Education Coordinator
Children's Healthcare of Atlanta

Clinical staff and physicians routinely use the telephone for triage, patient education, and follow-up care. Although the phone is both necessary and vital in any health care setting, it can create a barrier to communication because it prevents us from seeing facial expressions and body language. The impression the patient or

family receives depends on what they hear — using good phone skills and proper phone etiquette can help make the phone encounter more productive and enjoyable.

Whether you're doing the dialing or the patient is calling you, here are a few tips for using the telephone that can help you maximize your communication efforts:

First impressions

- ***Smile.*** Even though the caller can't see your expression, your smile communicates a caring and compassionate attitude. It shows — even over the telephone.
- ***Add a personal touch.*** Answer with a friendly greeting and use the patient's name when possible during the conversation. This shows the patient that you are interested in him or her.
- ***Be polite and focus on the caller.*** Put yourself in the listener's place and act accordingly. Avoid distractions such as chewing gum, eating, drinking, or having secondary conversations with others in the room.
- ***Lower your voice if it is normally loud.*** Keeping the phone about two-finger widths from your mouth may help as well.

Communicate effectively

- ***Be an active listener.*** This is simple advice, but often overlooked. The patient may express important information informally during your conversation, and not even realize it. Take notes, if necessary, so you can recall information correctly.
- ***Speak slowly and clearly.*** The caller may be confused, upset, or need clarification of something he of she does not understand. Pause occasionally to let the listener digest what you have said and to ask questions. If you leave a message on an answering machine, say your name and phone number slowly, and spell your name if needed.
- ***Use "living-room" language.*** Try to assess the caller's level of understanding within the first minute or two of the call. This will help you decide how to present information. Communicating medical information in an understandable way is important for both the spoken and written word.
- ***Express interest and address the patient's concern first, even if it's different from yours.*** Let him or her know that you care and want to help. Once you discuss the patient's concerns, he or she can relax and answer your questions.
- ***Don't expect patients to have good assessment skills.*** They really don't know the significance of symptoms or what is serious. Ask open-ended questions to explore any problems that need to be addressed.
- ***Stay calm and stay focused.*** Patients who are angry, upset, or difficult to communicate with are those who need your patience and compassion the most.

Hold and transfer

- ***Say please and thank you.*** Before you put a caller on hold, ask permission and provide a reason if needed (e.g., "Would you mind holding while I get your chart?"). Be sure to return to the call within a reasonable length of time, or provide updates to let the patient know you haven't forgotten about them. When you pick up the call again, thank them for holding.
- ***Keep them informed.*** When transferring a call, tell the patient what you are doing, and give him or her the new phone number in case you get disconnected. If possible, stay on the phone until the transfer is completed.

A great finish

- ***Evaluate understanding.*** Before you hang up, make sure the patient understands the information you have given and that you have answered any questions to his or her satisfaction.
- ***Let the patient know when to call back, if necessary.*** Provide information about who to contact, what symptoms to watch for, and whether to call immediately or during regular operating hours.
- ***End on a positive note.*** Saying, "Have a nice day," or "It was nice talking with you," is a nice way to end the conversation.

Write it down

- ***Document.*** Finally, remember to document your telephone conversation and educational efforts on the appropriate medical record form. ■

SOURCE

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How to choose and work with translators

Accurate translations result from team effort

The translation process of educational materials from English into Spanish or another language will be a successful project if several steps are followed, says **Lynn Gordon**, MPH, a health education writer in Los Altos, CA.

Everyone has a limited budget. Therefore, a patient education manager must first decide what is appropriate to translate, she says. Factors to consider include how many people within a patient group speak a particular language, whether they are literate in that language, if the subject is appropriate or of interest to the population, and if this audience likes to receive medical information in a written format.

If a translation project is approved, the next step is to find a qualified translator. Get recommendations from colleagues, advises Gordon. Translators can also be found on association web sites. For example, the Northern California Translators Association has a list of translators with a description of the projects they have worked on. If a translator has worked for the court system or fashion industry, but has no experience related to health, he or she would not be a good choice, says Gordon.

Also, if the Spanish-speaking patients served by a health care system are from Mexico and the translator is from South America, the translation may not be appropriate. Spanish varies from country to country, explains Gordon.

"That doesn't mean that the translators aren't qualified for the job. However, you would want to make sure they have a lot of experience with people of Mexican descent living in the U.S.," says Gordon. The same word in Spanish will mean something completely different. For example, the word for baby that Chileans use is the word that Puerto Ricans use for bust, she explains.

It is important for the translator to be familiar with health education. Many medical translators are more accustomed to doing technical work, and use a level of language that is not appropriate for patients, says Gordon. Also, certification is not a good criterion for selection because there are almost no certification programs in the United States, she adds.

When determining whether to work with an agency vs. an individual translator, be aware that there are pros and cons to both. Consistency can be a problem with an agency. If a project is extensive, several translators may work on the piece and, if they don't coordinate the work, the terminology within the material may not be consistent.

Also, although a project completed by an agency may be good, there is no guarantee that the same translator will work on future material submitted by a health care institution. "The next time you may have a different translator working on your materials who may not do as good a job, so you don't always know what you are getting," says Gordon.

An agency usually is quicker than an individual, especially on a large project, she says.

Location doesn't really matter for it is easy to work with translators electronically. Gordon has several out of state clients. "The nice thing about a person being local is they are more likely to be familiar with your local population to the extent that is needed," she says.

Working with translators

Before hiring a translator, ask for references. Also ask to see samples of his or her work so it can be reviewed for spelling, grammar, and writing technique. And be sure to discuss price as well.

"There are three different ways to charge. The translator could charge by the word, the hour, or the piece," says Gordon. If the charge is per word, find out if it is according to the English words or the language in which the material will be translated, she advises. The translated version is usually longer than the English version.

If possible, get an agreement for a price per English word so the cost is clear. Anyone on a budget should get an estimate per piece, says Gordon. "If you are trying to see if you can afford a translation, you can ask for a range of what might be charged," she says.

Once a translator is selected, do a trial project, advises Gordon. Have that project back-translated, or at least have a native speaker review the material.

Word-for-word translation is never appropriate for educational materials. Frequently, the material is difficult to read and doesn't sound natural because the syntax is different from English. For example, in German, the verb is at the end of the sentence; therefore, if translated word-for-word into English it would be difficult to read and distracting.

"A person needs to be a good writer to produce

a good readable translation," says Gordon.

No matter how skilled the translator, the project should be a team effort and include the patient education manager. It's important that translators know that they can call with questions.

"As a person who does some translating, I think it is very important and helpful to have your materials prepared properly for translation," says Gordon. If something is well written in the first place, it is easier to translate and it is more likely that the translation will be accurate and of high quality.

Some translators will lower the reading level, including Gordon. However many translators are not able to do this. Therefore, it is wise to make sure the document is at an appropriate reading level for the target population in the English version.

Is it culturally appropriate?

Consider cultural adaptations as well. For example, when discussing exercise in the English version, skiing might be suggested. But if the brochure is for people from Mexico, another sport might be substituted, such as soccer or dancing, because many Mexicans would not be familiar with skiing, says Gordon.

If the translator is asked to culturally adapt the material, ask to see what was substituted before the final version is completed, advises Gordon. For example, if the pamphlet discusses nutrition, foods appropriate to the particular ethnic group should be substituted.

When there are references in a brochure such as hotlines, books, or classes, let the translator know if they are available in the language of the target population, such as Spanish. "If they are, then you need to get their official names in the language that you are translating into and the correct phone numbers," says Gordon.

When the resource is not available in the reader's language, mention it, but indicate that it is only in English and find alternatives in the language, or omit the reference, says Gordon.

Encourage the translator to use the most generic terms when translating the piece. There may be several words for one item, but one word might be more mainstream than all the others, says Gordon. If there are one or two alternate words that might be understood by some people exclusively, they can be put in parentheses after the other term, she says.

Titles of publications often have a play on words or slang in them. In this case, work with the translator to come up with a title that would be appropriate in the other language, advises Gordon. Also, let the translator know if there is anything in the brochure or pamphlet that needs to be left in English, such as a funding credit or cataloguing information. Some English words that the reader might find on a product label in the United States might be left in as well.

The translator may need to provide keys in the material so the graphic designer knows which piece corresponds to the English version. "For some jobs, that is important or your graphics people will be confused," says Gordon.

When working with a translator on a piece, it is important to find out if the translation will take up more space. For example, Spanish can take up 25%-30% more space than English.

"If you need to fit something into a certain space and you are going into a longer language you may need to figure out what you want to cut before you hand the material over to a translator. In that way you won't spend money having something translated that won't be in the final product," says Gordon.

When the accuracy of the information is of vital importance, it is a good idea to have it back-translated before the final copy is submitted for publication, says Gordon. For example, if the material contains critical information, such as post-op instructions, you need to be sure the patient clearly understands the signs that would prompt him or her to call the physician immediately. ■

SOURCE

For more information about the translation process, contact:

- **Lynn Gordon**, MPH, Health Education Writer, Los Altos, CA. Telephone: (650) 941-5672.

Build trust with home health care patients

Sharing food shows interest and compassion

Anyone listening to news programs in recent months will say that we are a nation obsessed with food and eating. If the news report isn't talking about overeating and obesity rates, it's focusing on the latest diet program to find favor with the public.

Resources on cultural diversity and health care

- ***Culture & Nursing Care: A Pocket Guide*** is published by the UCSF Nursing Press. The book discusses cultural differences that can affect nursing care. Contact UCSF Nursing Press, University of California, San Francisco, School of Nursing, Box 0608, Two Koret Way, #N-535C, San Francisco, CA 94143-0608. Telephone: (415) 476-4992. Fax: (415) 476-6042. A description of the book and an order form can be found at http://nurseweb.ucsf.edu/www/book4.htm. The book costs $21.95 plus shipping charges that range from $6 to $15, depending on quantity ordered. There is a 25% discount for prepaid orders of five books or more.
- ***Henry Ford Health System Multicultural Resource Guide*** contains background, family, social, food, spiritual, and health practice information on more than 20 cultural, racial, and religious groups. Copies of the book can be purchased for $29.95. For more information, or to order the book, contact Karen Giovannini at (313) 874-3766 or kwierci1@hfhs.org. The most recent issue will be available in September.
- **Diversity Rx** is a clearinghouse of information on how to meet the language and cultural needs of minorities, immigrants, refugees, and other diverse populations seeking health care. The web site (www.diversityrx.org) offers sample models and practices, resources, overview of legal issues, and networking opportunities.
- **The Education Center for Texas Health Steps** offers an on-line continuing education course on cultural competency for health practitioners. To review the material, go to: http://thsteps.org/cultural_index.htm. ■

While the media may focus on food and our culture, home health managers may overlook the social importance of sharing meals or food with patients, says **Gottfried Oosterwal**, PhD, director of the Center for Intercultural Relations in Berrien Springs, MI. "Universally, eating together is a way to form a bond, build a sense of community, and develop trust among people," he explains.

"In different parts of Africa, strangers are not allowed into a village until they have shared a meal with someone from the village and, in Mexico, a business lunch may last two to three hours with no business discussed at all," Oosterwal points out. "We don't want to do business or share our personal information with strangers, but if we've shared a meal, we aren't strangers," he adds.

Patients' culture can affect food sharing

Unfortunately, many home health agencies have policies that prohibit a home health employee from eating or drinking in the patient's home, says Oosterwal. Adherence to this policy can make it difficult, if not impossible, to establish a trusting relationship with members of different cultures, he adds.

It is important to understand how the different cultures represented by your patients view food. Home health employees need to be aware of the differences and know how they can make the first visit a step toward a trusting relationship, as opposed to an offensive experience for the patient, says Oosterwal. "There are many resources that explain cultural differences, and you can also rely upon your own employees who share the same cultural background as that of your patients," he says **(see box, left, for some cultural resources)**.

Even with resources that are available to help you understand cultural difference, remember that immigrants do become "Americanized," says Oosterwal. For this reason, be prepared to follow the patient's lead in terms of how they want the visit to begin, he suggests.

Staff members don't have to completely ignore a policy about sharing food with patients, but they should be able to have a cup of tea or coffee and a few cookies with a patient on the first visit, suggests Oosterwal. A trusting relationship is an important part of providing good patient care in home health, and the first visit is the point at which that trusting relationship is begun, he points out.

Keep conversation light

While drinking the tea, the nurse should not discuss "business," says Oosterwal. "Although we are very task- and time-oriented, it is important to take a few moments to make the visit personal rather than businesslike," he says. "It doesn't take much time to ask questions that put the patient at ease," he adds. For example, asking patients how long they have lived in the city, admiring a garden in their yards, or commenting

SOURCE

For more information about food and culture, contact:
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on pictures of grandchildren that are displayed, are all ways to show that you are interested in the patient as a person rather than a chart that needs to be completed.

To really strengthen the trust you are building, be sure to share something about yourself, says Oosterwal. You don't have to share personal secrets, but you can refer to a spouse or a sibling who shares the same career as the patient, or you can mention a vacation trip to the city in which a patient's child lives, he adds. The information you share should be simple and demonstrate that you've been listening to the patient and that you have something in common with him or her, he explains.

Once you've spent a few minutes getting to know the patient and letting the patient get to know you as you've had tea together, you can begin with assessment questions and completion of forms, says Oosterwal. "The key to developing a trusting relationship is to show interest in the patient, and the sharing of food along with nonbusiness talk for a few minutes is the best way to demonstrate your interest in the patient," he says. ■

Cardiac education program reduces readmissions

Education of patients and staff improves outcomes

What do you do when you find that more than 20% of your new admissions are for cardiac-related reasons and about 33% of your patients have cardiac disease, even if it wasn't the reason for admission? If you are the staff at Visiting Nurse Association of Central New York (VNA) in Syracuse, you put together a special team of employees who work only with cardiac care patients and call it Heart Smart.

The Heart Smart program increased the agency's exposure as an expert in home care for heart patients and also decreased hospital readmissions for congestive heart failure patients, says **Mary P. Hussain**, RN, MSRN, CNS, clinical nurse specialist for Heart Smart. Staff members on the Heart Smart team undergo intensive training related to cardiac disease to help them become experts on their patients' care, she says. Comprehensive patient education is used to teach patients to recognize signs that indicate changes in their condition and take steps to improve their condition, she says.

Heart Smart patients see the same staff members each visit except in cases of staff vacation or illness, says. "This continuity improves the effectiveness of patient teaching because the nurse knows what has been taught," she points out. The continuity also strengthens the relationship between the nurses and the patients and family members, Hussain says. If a staff member is unavailable, another nurse who is member of the cardiac team makes the visit, she adds.

Staff continuity improves compliance

The strong relationship improves a patients' desire to follow instructions on daily weight monitoring and other activities to control and monitor their condition. It also results in the patients' being less likely to go to the physicians' offices or emergency departments for changes that might be controlled at home, Hussain points out.

"Our patients are comfortable calling us to report changes in their condition," she explains. For example, each patient monitors weight on a daily basis and is given parameters for weight control, she says. If a patient's weight exceeds those parameters, the patient knows to call the nurse, she adds. This call gives the home health nurse a chance to talk with the patient to determine what might have caused the weight gain, and to make a home visit to assess the patient. "Our immediate intervention can usually prevent a hospital admission," she adds.

The Heart Smart program focuses upon patient education to keep patients at home and out of the hospital. "We follow a clinical path that includes skilled nursing, physical therapy, and nutritional evaluations as our approach to improving the patient's quality of life," says **Diane Nanno**, RN, BSN, clinical nurse manager for VNA. "We've also developed a teaching manual that not only explains how to monitor with pulse oximetry and

daily weight, but also gives the patients and nurses a place to write the information, including vital signs taken at visits, as it is obtained," she says. This informal medical record serves as an excellent method of communication for a nurse or therapist who might fill in for a staff member on vacation as well as for family members, she adds.

A nurse visits a new Heart Smart patient three times in the first week of admission. The nurse next makes two visits for two weeks, and then weekly visits up to six weeks, reports Hussain. "Between visits we check on patients by telephone and we add visits as needed," she says.

Because the program relies heavily on education, a patient must be teachable or must have a teachable in-home caregiver to be eligible for Heart Smart, says Hussain.

First year brings positive results

Although the program is just over one year old, there have been some positive results in terms of recognition for the agency, says **Amor Bango**, RN, BSN, director of clinical operations. "In February 2004, we were asked to provide the home care component for patients of a local hospital that developed a clinic for heart patients receiving nesiritide, an intravenous medication to treat symptoms of patients suffering advanced heart failure," she says.

The patients receive the infusion at the hospital clinic, then Bango's staff are responsible for patient education, monitoring any side effects, and assessing the patient's condition, she explains. "We would never have been contacted if we had not developed the reputation as an agency that specialized in care of cardiac patients," she adds.

"I've also noticed that communications between cardiologists and our nurses are greatly improved because there is a new level of respect for these nurses who have become experts on heart patients," says Hussain. And the fact that there is one nurse who knows the patient very well is another advantage for the physician, she adds.

The best thing about the program is the fact that focusing on this group of patients was relatively easy, says Hussain. She points out, "We were already providing excellent care. This program just enhances that care and gives the nurses a chance to increase their knowledge and expertise." ■

Audio conference prepares you for influenza season

Brace yourself: Flu season is right around the corner. Are you prepared? If an influenza pandemic hits, the entire U.S. population could be at risk.

The annual impact of influenza on the United States is staggering: 10%-20% of the population will get the flu. Some 36,000 people will die. And 114,000 will be hospitalized. Most of those who die will be older than 65, but children 2 years old and younger will be as likely to be hospitalized as the elderly.

Thomson American Health Consultants is offering an audio conference with the information necessary to help you diagnose and treat patients with flu symptoms and, as important, prepare for an influenza pandemic.

Get Ready For Influenza Season: What You Need to Know About the Threat, Diagnosis and Treatment, which will be held on Tuesday, Sept. 28, 2004, from 2:30-3:30 p.m. ET, will be presented by **Benjamin Schwartz**, MD, and **Frederick Hayden**, MD.

Schwartz, who is with the National Vaccine Program Office and is spearheading the development of the National Pandemic Influenza Preparedness and Response Plan, will discuss the potential impact of an influenza pandemic.

Hayden, a professor of Internal Medicine and Pathology at the University of Virginia School of Medicine in Charlottesville, will discuss current methods of diagnosis, and the latest information on treatment with antivirals.

This program will serve as an invaluable resource for your entire staff. Your fee of $249 includes presentation materials, additional reading, and free continuing education.

For more information, visit us at www.ahcpub.com, or contact customer service at (800) 688-2421 or by e-mail at customerservice@ahcpub.com

When registering, please use reference code **T04118-61332**. ■

Tool helps pediatric flu immunization programs

The National Foundation for Infectious Diseases has developed a free on-line resource designed to help health care providers conduct influenza immunization programs for children.

The "Kids Need Flu Vaccine, Too!" program aims to increase immunization rates among children 6 to 23 months of age and those with chronic medical conditions; facilitate implementation of pediatric influenza immunization recommendations issued by the Centers for Disease Control and Prevention, American Academy of Pediatrics and American Academy of Family Physicians; and help educate parents and health care providers about the importance of preventing influenza among children. The tool is supported by the National Influenza Vaccine Summit, and can be found at http://64.242.251.230/ ■

Communication key to reduce delivery risks

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) issued an alert to accredited hospitals about the key role caregiver communications plays in preventing infant death and injury during delivery. In a review of 47 cases of perinatal death or permanent disability reported to JCAHO since 1996, it said the majority of reported root causes related to problems with organizational culture and with communication among caregivers.

In the alert, JCAHO recommends that organizations conduct team training in perinatal areas to teach staff to work together and communicate more effectively. It also recommends hospitals conduct clinical drills to help staff prepare for high-risk events such as emergency cesarean delivery and maternal hemorrhage when they occur, and debriefings to evaluate team performance and identify areas for improvement, among other steps. For more information, see *"Sentinel Event Alert:* Issue 30" at www.jcaho.org ■

Health care leaders urged to promote prevention

Noting that chronic diseases account for three-quarters of U.S. health care costs and 70% of deaths, Centers for Disease Control and Prevention director **Julie Gerberding**, MD, urged the public health community and health care providers to help promote healthy lifestyles and prevention.

While data clearly show the risks of such things as obesity and smoking, the challenge is getting patients to change their habits, Gerberding told attendees at the Health Forum and American Hospital Association Leadership Summit in San Diego, which was held July 25-27.

To help frontline caregivers promote healthier lifestyles to patients, she said the agency is working to give them population-specific data on lifestyles and health. She urged health care leaders to press lawmakers for changes to the reimbursement system that encourage prevention as well. "We have a business case, we have a health case, and we believe we have a moral case (to do so)," Gerberding said. ■

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

- Creating policy for interpreter services
- Best methods for evaluating programs
- Addressing timely education issues
- How to effectively get the point across to patients
- Taking it to the streets — the best in health fairs

CE Questions

9. Call centers are designed to meet specific patient needs. Which of the following patient needs might a call center address?
A. "My child fell. Is an emergency department visit appropriate?"
B. "Which cancer treatments do you offer?"
C. "Where do I park when I come in for surgery?"
D. All of the above?

10. When hiring new translators, it is a good idea to give them a small project and have the finished product back-translated to make sure their work is accurate.
A. True
B. False

11. Why should home health managers evaluate their agency's policy prohibiting employees from eating or drinking in a patient's home if the agency serves clients from a variety of cultures, according to Gottfried Oosterwal, PhD?
A. Sharing food is a method of building trust in many cultures.
B. The visit will be lengthened considerably if the nurse has a cup of tea.
C. Employees can skip meal breaks if they eat with patients.
D. The assessment form can be completed while the nurse and the patient eat.

12. What is one of the key benefits of the teaching manual developed for the Heart Smart program offered by the Visiting Nurse Association of Central New York, according to Diane Nanno, RN, BSN?
A. It guides inexperienced nurses through the teaching process.
B. It serves as a marketing tool.
C. It replaces the medical record.
D. It serves as a communications tool between home health personnel, patients, and family members.

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

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. ■