

Patient Education Management™

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Target messages for annual breast cancer screening

Use community liaisons to help build confidence

Education about early detection of breast cancer through regular screening has boosted the number of women getting mammograms. About 10 years ago, older women were not getting mammogram screenings as frequently as younger women, even though older women are at higher risk for breast cancer. Now the numbers seem fairly even, says **Debbie Saslow**, PhD, director of breast and gynecologic cancer for the American Cancer Society in Atlanta. Also, it looks like the gap between African American women and Caucasian women has just about closed.

"I think the numbers are at a plateau because they are so high, and we have reached the easy-to-reach women. It is much harder to get those last 20% to 30%," she says.

One message targeted to a particular segment of the population — whether Caucasian, African American, Asian, or Hispanic women — does not work. There is diversity within every group, says **Zora Brown**,

EXECUTIVE SUMMARY

October is National Breast Cancer Awareness Month, and Oct. 15 is National Mammography Day. It is a time of year that draws much media attention to breast cancer and prompts health care facilities to host special events.

But does all the attention change behavior and increase early detection of breast cancer? What has been accomplished through event-driven education, and what needs to be done? Most experts agree that general messages no longer work. Education must be designed specifically for patient populations within a health care organization's service area.

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founder of the Breast Cancer Resource Committee in Washington, DC.

Brown reports that in recent years, breast cancer awareness efforts have been event-driven and, while women may get caught up in the activities, many have become lackadaisical when it comes to regular screening. Even though they

are knowledgeable about screening, they don't necessarily get the mammogram, she says.

"I think we have to freshen the message we have been delivering about early detection and eliminate some of the noise," says Brown.

Saslow says it is unclear which segments of the population are receiving the message but not acting on it, and therefore need to be reached in a different way.

It is important to determine the barriers to early detection within a patient population and target them. Strong predictors for the use of early-detection methods for breast cancer include poverty, insurance status, educational level, English vs. non-English-speaking, and the number of years a person has lived in the United States, says Saslow.

To reach women, a trusting relationship must be built between people within neighborhoods and the medical institution, suggests **Cathy Cole**, RNP, MPH, a breast health specialist at Cooper Sinkel Women's Health Center at City of Hope National Medical Center in Duarte, CA.

It's important to determine what it is about a particular culture or group that motivates them to come for screening, she says.

"It is a very long process. You have to build trust in the communities and continue to search for avenues to do this whether in print media, local radio stations, or through community based organizations, such as the YMCA or local chapter of the American Cancer Society," says Cole.

One way to connect is to determine where women congregate. For example, there may be a lot of mothers with school-age children who you would find at school-related activities such as PTA meetings.

"You have to go into the communities with language they understand, both in terms of sophistication of medical language, and in their native language, which may not be English," says Cole.

Design community specific programs

To provide easy access to mammograms after a relationship had been built between the medical community and its service areas, City of Hope initiated a mobile mammography program. To make the mobile mammography program successful, staff from the women's health center found women within the community to be their liaisons. They discovered one woman at a time by visiting churches, beauty shops, and markets as well as advertising in the local print media.

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Editor: **Susan Cort Johnson**, (530) 256-2749.

Vice President/Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@thomson.com).

Editorial Group Head: **Coles McKagen**, (404) 262-5420, (coles.mckagen@thomson.com).

Managing Editor: **Jayne B. Gaskins**, (404) 262-5406, (jayne.gaskins@thomson.com).

Senior Production Editor: **Nancy McCreary**.

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Editorial Questions

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

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SOURCES

For more information about targeting education to specific patient populations, contact:

- **Zora Brown**, Founder, Breast Cancer Resource Committee Inc., 2005 Belmont Road, N.W., Washington, DC 20009. Telephone: (202) 463-8040. E-mail: ZorBrw@aol.com
- **Cathy Cole**, RNP, MPH, Breast Health Specialist, Cooper Sinkel Women's Health Center, City of Hope National Medical Center, 1500 E. Duarte Road, Duarte, CA 91010. Telephone: (626) 256-4673, ext. 60020.
- **National Breast Cancer Awareness Month**, Susan Nathanson, National Coordinator, 233 N. Michigan Ave., Suite 1400, Chicago, IL 60601. Telephone: (312) 596-3557. E-mail: susan_nathanson@chi.bm.com
- **National Mammography Day**, American Cancer Society, 1599 Clifton Road, N.E., Atlanta, GA 30329. Telephone: (800) 227-2345. Web site: www.cancer.org

Potential liaisons then were invited to attend a meeting on the program.

The liaisons went to their neighbors to explain the importance of breast health screening and brought them to a community-based site where the mobile mammography van was scheduled for the day. Interpreters who spoke the languages of the women within the community also were on the van.

The message about screening for early detection of breast cancer always highlighted what was important within that particular culture or patient group. For example, in Hispanic communities, the nuclear family is very important; therefore, women were encouraged to remain healthy to take care of their family.

If follow-up was needed after the mammogram, a local clinician who understood the culture and income barriers was found to see the patient. "We had a whole network of community leaders, professionals, and clinical people working toward early detection, diagnosis, and treatment if needed," says Cole.

Women who have breast cancer or who have recovered from it make excellent spokeswomen, says Brown. Also, speaking to small groups of women at convenient times is a good way to deliver the message, she says.

However, the message to women is not that they should have a mammogram, but that they should be screened yearly after the age of 40.

Once women are brought in for screening, a secondary barrier or challenge is to get them to return year after year. "We need to create an

atmosphere where women will return many times, and hopefully to the same institution so we have historical evidence of what has gone on in her breast health over time," says Cole.

Getting physicians to recommend screening for early detection of breast cancer is an important factor as well as reminding them to have a mammogram each year, says Saslow.

Medical clinics and mammography centers should adopt a technique that many dentist offices use: Have women make appointments for mammograms for the following year after their screening, says Brown. At dental offices, people often make an appointment for their next exam after their semiannual teeth cleaning and screening. At that time, they fill out a postcard that will be sent later as a reminder.

Access to health care is another factor that keeps people from getting annual mammograms, says Saslow.

Cole says she never worries about the woman who has insurance and stability. She worries about the underserved or undertreated woman who is disenfranchised, who doesn't have the sophistication to know where her options are and what groups of professionals will continue to see her despite the fact that she might not have money or insurance. ■

Improve adherence to beta-blockers

Better physician/patient communication needed

The message that the long-term use of beta-blockers following a heart attack can decrease the risk of another heart attack and death from cardiovascular disease is not being delivered to patients.

A study conducted by the Council for Affordable Quality Healthcare (CAQH) based in Washington, DC, found that only 69% of the patients prescribed beta-blockers following a heart attack regularly took the medication during the first 30 days after their hospital discharge. Over the six-month period after the heart attack 52% of the patients regularly took beta-blockers. The first year after a heart attack, 45% of heart attack survivors continued taking the medication regularly.

Further investigation revealed that there were significant gaps between the patients' perception

about why they were taking the medication and the physicians' knowledge about the value of beta-blockers. The medications are prescription drugs that work by controlling certain nerve impulses that reduce the heart's workload. This protects the heart by decreasing its demand for blood and oxygen.

Information was gathered on patients through seven focus groups in three markets — Atlanta, Los Angeles, and Baltimore, says **Richard L. Snyder**, MD, vice president of Quality Management at Independence Blue Cross and chair of heartBBEAT for life (Beta-Blocker Education and Treatment), which is a public education campaign developed by CAQH. In addition, 20 physicians were interviewed to determine their perspective on the importance of beta-blockers and how they encouraged patients to remain on the drug following a heart attack.

The focus groups revealed that patients did not understand why they were taking beta-blockers or the benefit of staying on them. They often felt that lifestyle changes were more important and harder to do than staying on the medications. On the other hand, physicians thought that complying with lifestyle changes was something that patients couldn't do, even though patients thought they could.

Patients were often fearful of staying on beta-blockers for a long time; however, they were very willing to take aspirin for a long time. Physicians were not educating patients about the value of staying on beta-blockers for the rest of their life. Often they did not explain why patients were taking the medications or provide them with reasonable instructions about taking them, relying instead on the pharmacist providing information.

"In general, there were some major gaps in communication between the health care delivery system and the patients that we felt they could do

something about," says Snyder.

To help close the gap in communication CAQH recommends that hospitals participate in either the Bethesda, MD, based American College of Cardiology GAP Program (www.acc.org) or the Dallas-based American Heart Association "Get With the Guidelines Program" (www.americanheart.org). Both programs emphasize standardization of patient education during hospitalization and at the time of discharge, says Snyder. Also, they emphasize documentation of education on medications and providing patients with written materials that explain the importance of staying on the medications.

Under these programs, patients are verbally taught the importance of a beta-blocker and how it protects them from subsequent heart attacks and or sudden death.

"Patients take the medication during the hospitalization, and 95% go home on it; but the biggest drop-off is within the first 30 days. At the time that care is transitioning from the inpatient setting to the outpatient setting, the message isn't following the patient, so we wanted the stronger message to be delivered in the hospital setting," says Snyder.

To reinforce the message following discharge, a series of short informational items were prepared that can be delivered to patients via e-mail, postcard, letter, or by their physician. The messages sent to patients early on focus on side effects and what they should do if they experience them. Later messages focus on issues such as the cost of medication and communicating with their physician on long-term use of beta-blockers.

These messages also are available through pharmacists so they can be distributed with the prescription.

To educate physicians, a major vendor is creating three one-hour continuing medical education programs that are being promoted by health plans and the vendor. In addition, CAQH is preparing a set of presentations that health plans can give in meetings.

To measure the outcomes of the educational efforts, adherence to beta-blockers was made a measure of performance for the Health Employer Data Information Set, which is a measure of performance at the health plan level for many factors, says Snyder.

The same methods used to improve adherence to beta-blockers can be used to improve adherence to other medications such as those used in cholesterol management, says Snyder. ■

SOURCES

For more information about the study conducted by CAQH on beta-blocker adherence and its educational campaign heartBBEAT for life, contact:

- **Julia Gusakova**, Group Manager, Weber Shandwick, 640 Fifth Ave., New York, NY 10019. Telephone: (212) 445 8242. E-mail: jgusakova@webershandwick.com
- **Council for Affordable Quality Healthcare**, 601 Pennsylvania Ave., N.W., South Building, Suite 500, Washington DC 20004. Telephone: (202) 861-1492. Web site: www.caqh.org

EDUCATOR Profile

Good organization skills essential

Development, review and revision a full-time task

As program manager for consumer health education at The Ohio State University Medical Center in Columbus, **Diane C. Moyer, MS, RN**, is responsible for the development, review, and revision of the patient education materials.

The academic medical center has two locations within Columbus. The main campus has a 1,000-bed hospital, a comprehensive cancer center, a physical rehabilitation facility, and a psychiatric rehabilitation facility as well as several clinics. The medical center also partners with a number of small rural hospitals and is in the process of constructing a hospital for the care of cardiac patients on its main campus.

All written materials are available to staff via an intranet system, and members of the community have access to the information through the Internet. The patient education section receives the most hits on the web site, and each week Moyer receives e-mail messages and phone calls requesting to use the information from people throughout the United States and sometimes internationally.

Moyer works with one other person in consumer health education, a technical associate who is responsible for formatting all the patient education materials and putting them on-line. She oversees the technical associate and reports to the administrative director of network operations.

Patient education materials produced by The Ohio State University Medical Center have been on-line for almost a decade. The purpose is to provide readily available written information to support clinicians in their teaching.

"Throughout the system, a clinician can go to our intranet on the computer and pull up the most recent copy and [find that] the information is consistent across the spectrum. It saves us storage space, printing cost, and transporting the materials back and forth," says Moyer.

The date the material was developed or last

reviewed is on the copy as well as the department that initiated its development. That way, it can be updated every three years and, Moyer knows where to send the material for review. Each year, about 900 pieces must be reviewed.

Moyer has been in her current position for about 3½ years. Prior to being hired as program manager, she worked in patient education for about six years at another health care system in Columbus.

Much of Moyer's career was spent as a staff nurse in the medical-surgical area. For two years she was a med-surg clinical nurse specialist at Ohio State and during that time developed patient education materials.

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

Networking to build inventory

Question: What is your best success story?

Answer: "I have been working with my counterparts at two other health care systems in Central Ohio to translate patient education materials into foreign languages, and we received funding for the project at the end of May [2004].

"We will be hiring a part-time person who will work through me to do some community focus groups to get information about cultural beliefs and practices we need to be aware of while developing the materials. [This will help ensure the materials are] culturally appropriate and meet the needs of the community.

"We plan to make the materials available through an Internet site without copyright [restrictions] to anyone who wishes to use them for patient education. We hope to get funding for at least a couple of years so we can build a collective inventory of foreign language materials on topics beyond what we currently see in patient education such as vaccinations and women-infant care related to pregnancy and childbirth issues."

Languages that will be targeted include Somali, Spanish, Russian, and Asian (such as Chinese and Vietnamese).

Question: What is your area of strength?

Answer: "I tend to be able to juggle a number of projects. Keeping on top of things while having multiple projects at various points of development is essential in this type of position.

"It is important to come up with a system that

SOURCE

For more information about patient education methods at The Ohio State University Medical Center, contact:

- **Diane C. Moyer**, MS, RN, Program Manager, Consumer Health Education, The Ohio State University Medical Center, 1375 Perry St., Room 524, Columbus, OH 43201. Telephone: (614) 293-3191. E-mail: moyer-1@medctr.osu.edu

you can use. As far as filing materials, I tend to do better having active projects visible, so I have stacks on my desk. Anyone who came into my office probably would not think that I am well organized, but it's a system that works for me. I have a number of projects in the computer that I work from until they reach a certain point.

"If materials have been sent out for review, I make a notation on them and then look back through the stack periodically. And if I do not receive a response within two weeks, I send out a reminder."

Question: What lesson did you learn the hard way?

Answer: "While working in home care, I would find people doing dressings and procedures incorrectly because they misunderstood what had been taught. That was an eye-opener for me. I came to understand the importance of having patients repeat back what it was that you taught them.

"That was very important for me to pick up early in my career, and has been a piece that I have found very helpful through my years — both in the clinical setting and then in this role. I try to determine how people would interpret the written word, if it could be read in a different way that wouldn't be clear, and what we can do to make it better."

Question: What is your weakest link or greatest challenge?

Answer: "Every year, hundreds of publications must be sent to clinicians for review, and it is a struggle getting them back in a timely manner. I am not sure what we can do to streamline the process or make it easier.

"In many areas, we have a person who is designated as a liaison, or member of our patient education committee, so I tend to initially send the pieces to [those people] because they know me and are familiar with the process. In areas where we do not

have a liaison, I will contact the unit manager or unit director and ask if there is a member of their staff I can send it to, or I send it to them and let them disperse it. If I don't have a particular person assigned, it makes it more difficult for me to follow up.

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

Answer: "I would like to see patient education integrated into our clinical management systems so that, if a patient were being scheduled for a test, the computer would automatically generate the education materials for staff.

"I would also like to see more integration of our documents within our discharge planning process so, again, staff wouldn't have to back out of one computer system and go through another in order to print the material.

"Integrating those pieces into the documentation would be helpful as well, so there is less need for either duplication of efforts or wasting time in trying to figure out where something needs to be written down."

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

Answer: "One of the things we are working on, and continue to work on, is the documentation of interdisciplinary care including patient education. We, like many institutions, continue to struggle with how to get people to write what they are doing in the chart and where to document it so that surveyors can see there is integration of care throughout the disciplines."

The Ohio State University Medical Center will undergo a review by the Joint Commission in September 2005.

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

Answer: "I like to go to the group or person who is initiating the form, program, or document and talk to [that person] about its purpose and the audience they are trying to reach. I often find that they may think it is a good idea, but they haven't talked to any patients. I encourage people to discuss the idea with a few patients to get their feedback.

"It is important to know who your audience is and the purpose of the brochure or program. Then determine one or two key pieces that need to be

conveyed and use them as the focal point. It's important to ask what we want the person to walk away with when they read the document." ■

Educate public about HIPAA privacy rule

Explain privacy and access to patient information

Hospitals and health care workers have gone to great effort to understand the patient privacy rules, but more needs to be done to educate the public, according to some health care providers. The Health Insurance Portability and Accountability Act (HIPAA) became effective for all health care providers and health plans starting in April 2003, with full compliance required by April 2004.

The rule was met with concern and questions from the health care community when it first was introduced, but according to a hospital representative who addressed a Department of Health and Human Services (HHS) panel in July, health care providers have devoted much time and effort to educating themselves about the rule.

However, **Sara Howley**, director of corporate communications for North Broward (FL) Hospital District, told the HHS panel that the public and media need more education about the rule. She told the National Committee on Vital and Health Statistics' Subcommittee on Privacy and Confidentiality, "Hospitals have undertaken a great deal of effort to ensure that their staff, physicians, vendors, and volunteers understand the new rules and follow them," according to an HHS press release. "We believe that the HIPAA privacy rules are working, but there are areas where greater education is needed."

Patients who have been in the health care system previously are more likely to be familiar with privacy and information issues, says **Bob Norwicke**, director of corporate compliance and performance management for Magee Rehabilitation Hospital in Philadelphia.

Norwicke, who serves as Magee's privacy officer, meets personally with patients in his 96-bed facility when they have questions about privacy and access to patient information. He says the questions he most often gets have to do with patients' wishes to see their own medical records. "Before HIPAA, access to patients' own records

was kind of an unclear area with the public, and there seemed to be a cultural belief that you couldn't see your medical records, that it was secret," Norwicke explains. "So now that seems to be the thing we deal with most — people wanting to see their own records."

More complex are situations involving patients admitted with serious head injuries or who have been judged incompetent for other reasons, and determining who has the right to access those patients' records.

The suggestion that HHS provide more information to consumers in an easily understood format is not a bad idea, according to **Judy Colby**, RN, COHN, manager of Glendale Adventist Occupational Medicine Center in Burbank, CA.

"It's true, in the sense that patients who are more accustomed to a more streamlined, familiar approach, when they could just call up and say, 'Fax this to my other doctor,' might be having some difficulty with the new rule on privacy," Colby explains. "Or, for example, I have a 22-year-old child, and I might have a reason to ask [the child's physician] a medical question, and all of that is different now."

Recognizing the need for public education, the American Medical Association developed a template for a letter it suggests health care providers personalize with their individual facility's privacy practice and send or give to patients. (See **sample letter on p. 116.**)

One aspect of the privacy act that some patients don't fully understand is that there are limits to their rights to access their records, Colby says. Although a patient has the right to access, copy, and inspect his or her protected health care information within a designated record set, there are limits and the patient's request, if it falls within exceptions to the right of access, may be denied.

SOURCES

For more information about the HIPAA privacy rule, contact:

- **Judy Colby**, RN, COHN, Manager, Glendale Adventist Occupational Medicine Center, 2211 W. Magnolia Blvd., Suite 110, Burbank, CA 91506. Phone: (818) 526-1565. E-mail: colbyja@ah.org.
- **Bob Norwicke**, Director, Corporate Compliance and Performance Management, Magee Rehabilitation Hospital, 1513 Race St., Philadelphia, PA 19102. Phone: (215) 587-3000. E-mail: rnorwicke@magee rehab.org.

Sample Letter for Patients about HIPAA Privacy Rule

Dear Patient:

Physicians have always protected the confidentiality of health information by locking medical records away in file cabinets and refusing to reveal your health information. Today, state and federal laws also attempt to ensure the confidentiality of this sensitive information.

The federal government recently published regulations designed to protect the privacy of your health information. This "privacy rule" protects health information that is maintained by physicians, hospitals, other health care providers and health plans. As of April 14, 2003, your physician began to comply with the privacy rule's standards for protecting the confidentiality of your health information.

This new regulation protects virtually all patients regardless of where they live or where they receive their health care. Every time you see a physician, are admitted to the hospital, fill a prescription, or send a claim to a health plan, your physician, the hospital, and health plan will need to consider the privacy rule. All health information, including paper records, oral communications, and electronic formats (such as e-mail) are protected by the privacy rule.

The privacy rule also provides you certain rights, such as the right to have access to your medical records. However, there are exceptions; these rights are not absolute. In addition, we will be taking even more precautions in our office to safeguard your health information, such as training our employees and employing computer security measures. Please feel free to ask your physician or our privacy contact about exercising your rights or how your health information is protected in our office.

The Notice of Private Practices attached to this letter explains our privacy practices. It contains very important information about how your protected health information is handled by our office. It also describes how you can exercise your rights with regard to your protected health information.

Please let us know if you have any questions about our Notice of Privacy Practices. You may contact our privacy contact at _____, or discuss any questions you may have with your physician.

Sincerely,

Health Care Provider

Source: American Medical Association, Chicago.

"There are some times when patients do get frustrated," she adds. "They may think they have complete access to a record, when they don't."

And while patients have a right to amend protected health care information within a designated record set, that does not mean that they have the right to change a medical record. This is an area that bears further education, Norwicke points out.

Other suggestions that have been made to HHS by providers, besides giving patients easy-to-understand information, are to encourage law enforcement and rescue personnel to tailor their limits on information to those imposed on hospitals, to prevent private information from being divulged through those agencies during emergencies; offering training to media representatives who cover health care issues, for their own education as well as to help them educate the public; and to provide health care providers with

questions and answers pertaining to real-life scenarios involving aspects of the privacy rule that providers still struggle with. ■

Counseling, support aid Alzheimer's caregivers

Relieving harmful stress and depression is the goal

A combination of counseling and support services may reduce the risk of depression in people caring for a spouse with Alzheimer's disease, a new study says.

The study, published in the May 1 issue of the *American Journal of Psychiatry*, also suggests that giving spousal support might help people who

are not clinically depressed but who endure the chronic stress of caring for someone with the progressive brain disease. Other research suggests that chronic stress might damage the immune system and put caregivers at risk for diseases such as cancer.

The study began with the experiences of two elderly counselors who had started providing informal help to spouses in the hallways of New York University's (NYU's) Alzheimer's unit.

"We noticed that caregivers often looked very upset and bewildered," says NYU counselor **Emma Shulman**, who, at age 91, has both plenty of life experience and a degree in social work to help her provide guidance to others. Shulman and her colleague, 84-year-old Gertrude Steinberg, began to offer advice to spouses who were caring for a partner with Alzheimer's disease.

Those hallway-counseling sessions seemed to help, but epidemiologist **Mary Mittelman**, DrPH, and her colleagues wanted to measure the benefit in a scientific study. The team recruited 406 people who cared for a spouse with Alzheimer's disease at home. Half were assigned to a normal Alzheimer's support group and typically did not get formal counseling. The other half received intensive counseling services: Shulman, Steinberg, or one of the other geriatric specialists at NYU sat down with the spouse of an Alzheimer's patient to assess the spouse's situation and recommend services that might provide some relief.

The interventions provided by the counselors included help in arranging respite care to give the caregiver a break, or helping a spouse work through the complicated financial problems that crop up when a partner can no longer pay the bills or balance the checkbook. Another individual session and four family meetings followed that first counseling session. The NYU staff got calls every day from spouses dealing with problems that ranged from the physical demands of caregiving to financial problems such as how to pay for home health care, a service typically not covered by Medicare.

The researchers gave the caregivers a test that measured symptoms of depression at the study's start and at intervals throughout the five-year study. They found that after one year, slightly less than 30% of people in the group that received the extra help had signs of depression, compared with 45% of the other spouses. The extra-help group also had fewer symptoms of depression overall. The positive effect lasted for more than three years after the initial counseling sessions. The benefit

persisted even after a spouse died or had to enter a nursing home, according to the study.

Counselors can help caregivers minimize the behavioral difficulties caused by the disease. People with Alzheimer's can become aggressive and lash out at a family member. "This is a very difficult disease to live with," Mittelman says.

Alzheimer's disease can affect the entire family, but spouses can suffer the most, says **Sidney Stahl**, an Alzheimer's expert at the National Institute on Aging, which helped fund the study. He urges caregivers to seek help not just with day-to-day problems, but also with the emotional difficulty of watching the disease destroy their partner's mind.

"They're literally not the same person," Stahl says. "That's got to be heartbreaking for the caregiver." Tips for caregivers include:

- Learn all you can about the disease and caregiving techniques.
- Get help from family members, friends, and community services.
- Manage stress with relaxation techniques and time off.
- Get an annual physical and take care of yourself.
- Don't feel guilty if you can't do it all. ■

Communication plan needed for terrorist attack

Be prepared to ease stress levels

A terrorist attack involving a nuclear blast or a dispersion of radioactive material will cause significant mental health problems in both patient and health care workers, the Centers for Disease Control and Prevention (CDC) warns.¹

"There will be a significant psychological effect, particularly if it were a terrorist situation," says **Fun Fong**, MD, a CDC consultant and former director of radiation medicine at the medical sciences division of Oak Ridge (TN) Associated Universities. "Both victims and health care professionals will be under tremendous psychological stress. It is important to debrief people right after the event and identify those in need of counseling."

The initial reaction of many will be one of shock, immobilization, and fear, according to new CDC guidelines for hospitals. Most people will exhibit higher levels of anxiety rather than psychotic

behavior, and some also will experience post-traumatic stress disorder (PTSD). Long-term psychological effects, which could arise from 48-72 hours after the incident, include anxiety disorders, PTSD, depression, traumatic neurosis, insomnia, and acute stress disorder.

Since the situation is frightening to most people, hospitals should be proactive in reassurance and communication to reduce psychological issues. Hospitals should dispense timely and accurate information, including an accurate description of the incident and its location to the public, the CDC recommends. This will allow them to take appropriate actions before they come to the hospital. Counsel patients on both acute and potential long-term physical and psychological effects. Include this information in patient discharge sheets.

Hospitals also should ensure that trained counselors are on site, and screen persons who may be at higher risk for PTSD (i.e., people who have been previously traumatized or have been in other disasters). These individuals will require follow-up.

The CDC warns that health care providers — particularly those working outside of their areas of expertise — may experience a similar array of mental health effects. Health care workers also may have concerns about long-term risk of cancer and carrying radiation home to their families. Hard decisions may have to be made about who to try to save and who not to save. “Providers are likely to have a real sense of guilt when they cannot treat everyone and are not able to do as much as possible for each patient,” the CDC notes. “This concern could result in anger, feelings of helplessness, depression [potentially long term], and sleep disturbances. All of these will be aggravated by fatigue and exhaustion from response demands.”

Possible physical signs that staff may be experiencing psychological effects include vomiting, diarrhea, nausea, and headaches. Unfortunately, these also are physical signs associated with acute radiation exposure.

“Psychological effects are most likely to occur among staff who have the greatest amount of contact with the deceased and/or dying and those dealing with children or pregnant women,” the CDC warns. “These effects are more likely to occur with staff who are severely fatigued by being on duty for a long period of time.”

The critical incident stress management strategies should include having credentialed mental health providers in place at each facility. Hospitals should have mental health providers who can

dedicate time to staff support. Hospitals should screen for those who are at higher risk of psychological complications. Provider education and training are key components.

“Do not assume that practitioners know more about radiation than the general public,” the CDC advises.

Staff will be concerned about their own families, so hospitals should establish a communication liaison for them. Provide for rotation of staff to reduce fatigue. Hospitals should conduct tiered levels of debriefing after a mass-casualty event to gather data and address mental health concerns. The debriefing groups should not be cross-discipline (physicians with nurses, etc.). This allows participants to express concerns more freely, the guidelines advise.

Reference

1. Smith JM, Spano MA. *Interim Guidelines for Hospital Response to Mass Casualties from a Radiological Incident*. Atlanta: Centers for Disease Control and Prevention; 2003. Web site: www.bt.cdc.gov/radiation/pdf/MassCasualtiesGuidelines.pdf ■

NEWS BRIEFS

JCAHO to study hospital smoking-cessation practices

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) announced the implementation of an externally funded research study that will examine the counseling hospitals offer to patients to help them stop smoking.

A survey was sent to a random sample of 185 hospitals nationwide to assess the smoking cessation counseling provided to hospital patients admitted with diagnoses of acute myocardial infarction, heart failure, and pneumonia. The survey also seeks the perspective of institutional leaders on the effectiveness of smoking-cessation efforts.

The deadline for returning the survey was Sept. 8. Responses to the survey and findings from the research study will have no impact on

the accreditation status of organizations participating in this project.

Findings from the study will be used to identify best practices and develop educational strategies that health care organizations can employ to improve current smoking cessation practices. The initiative is being funded by the Smoking Cessation Leadership Center at the University of California, San Francisco, which is supported by the Robert Wood Johnson Foundation.

In addition to standards banning smoking at hospitals, the Joint Commission addresses the issue of smoking cessation as part of its standardized performance measurement requirements. Three of the core measure sets — acute myocardial infarction, heart failure and pneumonia — contain measures related to whether smoking cessation advice or counseling has been provided during a hospital stay.

For more information about the project, please contact Karin Jay in the Joint Commission's Division of Research at (630) 792-4940 or by e-mail (kjay@jcaho.org). To learn more about the Smoking Cessation Leadership Center, go to <http://smokingcessationleadership.ucsf.edu> or call (415) 502-1881. ▼

JCAHO panel to examine cultural, linguistic issues

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has appointed an expert panel to assist in a study of hospitals' efforts to address cultural and linguistic issues that affect patient care. The 2½-year study will attempt to identify best practices for providing culturally and linguistically appropriate care in hospitals, and could play a role in future JCAHO accreditation standards. The study will involve site visits to a sample of 60 hospitals starting May 2005.

The panel, which first met last month, will advise JCAHO in selecting hospitals for site visits, determining what information to collect, and developing

a survey tool and protocol for collecting information. The 23-member panel includes a representative from the Health Research and Educational Trust, which is an American Hospital Association affiliate. For a complete list of panel members, see the press release at www.jcaho.org. ▼

South Florida partners promote healthy habits in schools

The Joe DiMaggio Children's Hospital Foundation has received \$1.4 million in grants for a program that will promote healthy habits among fourth- and fifth-graders at 50 public schools in South Florida. The program seeks to decrease the rate of childhood obesity and improve health and academic performance.

Partners in the regional project include the School Board of Broward County, Health Care District of Palm Beach County, Joe DiMaggio Children's Hospital, North Broward Hospital District, School District of Palm Beach County, and YMCA of South Palm Beach County. The

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

■ Slowing obesity epidemic through education

■ Quick methods for program evaluation

■ The wisdom of prevention education

■ Creating a patient education culture

■ Jump-start discharge planning upon admission

CE Questions

13. Factors health care professionals should consider when educating women about early detection of breast cancer include which of the following?
- Motivation
 - Techniques for trust building
 - Understandable language
 - All of the above
14. In a study conducted by the Council for Affordable Quality Healthcare, researchers found that patients quit taking beta-blockers after they were discharged from the hospital following a heart attack for which of the following reasons?
- Physicians failed to provide a prescription.
 - Patients didn't have the money.
 - Patients didn't understand the benefits of the drug.
 - Patients forgot to take them.
15. According to our article, what do patients most often ask in regard to privacy and access to patient information?
- What are the HIPAA regulations?
 - Can I have access to my own medical records?
 - Can I see my adult child's medical records?
 - All of the above
16. Which of the following suggestions should people caring for loved ones with Alzheimer's consider to help prevent their own depression and reduce harmful stress levels?
- Learn all you can about the disease and caregiving techniques.
 - Get help from family members, friends, and community services.
 - Don't feel guilty if you can't do it all.
 - All of the above

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

initiative will phased in 16-18 schools a year over the next three years, reaching an estimated 18,000 students, according to a press release from Memorial Healthcare System, which includes Joe DiMaggio Children's Hospital.

In addition to local funding, the "Schools of Wellness Initiative" received a \$500,000 matching grant from the Robert Wood Johnson Foundation. ■

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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. ■