Patient Education Management™

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

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IN THIS ISSUE

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Create criteria for interpreters in medical encounters and teaching sessions

Hiring properly trained interpreters and testing their skills improves quality

Harborview Medical Center in Seattle had more than 100,000 interpreted encounters in 80 languages last year. To meet this demand, the medical center has created a well-developed interpreter service with 50 interpreters on staff.

However, whether you have one interpreter on staff or 50, it is important to establish guidelines for hiring.

"As with any profession, there are people who do the job poorly, those who just do the job, and those who do the job in such a way it is clear that interpreting is an art," says **Bria Chakofsky-Lewy**, RN, supervisor of caseworker/cultural mediators and interpreters for Community House Calls Interpreter Services at Harborview Medical Center.

There are certain basic skills interpreters should have, says **Andrea Henry**, coordinator of Multicultural Translation Services at Children's Healthcare of Atlanta.

An interpreter must be proficient in both English and the target language. A good memory also is a must because interpreters need to repeat what the patient and health care provider said without eliminating or

EXECUTIVE SUMMARY

Hospitals and medical facilities encounter non-English-speaking patients no matter where they are located. While institutions in metropolitan areas have the need for interpreters more frequently than those in rural areas, all should be prepared with policies and procedures in place. This issue of *Patient Education Management* discusses the skills of a qualified medical interpreter and the policies many institutions have set in place for using them.

embellishing the information.

A good way to determine if interpreters have the appropriate skills is to have them take a test, says Henry. She recommends the tests provided by Language Line, a telephonic interpreting service, which tests for language proficiency and interpreting skills. The company also has a medical certification test that is very difficult; however, the simpler tests are adequate to provide quality assurance when hiring, says Henry.

Erika Shell Castro, manager of Interpretive Services at Grant/Riverside Hospitals in Columbus, OH, says part of the hiring process at her institution is for interpreters to pass the Language Line skills test with a score of 80% or higher and to have no more than three significant errors on the test. The cost of the test is $125 per person.

To make sure interpreters are qualified, training at the University of Texas M.D. Anderson Cancer Center in Houston lasts from one to three months. In addition to receiving a training manual that includes consent forms and medical center policy, newly hired interpreters are assigned to a mentor so they can observe the process until they are ready to interpret on their own. When the new interpreter is ready for an encounter, the senior interpreter observes the session and provides feedback, explains **Cecilia Garcia**, manager of Language Assistance at M.D. Anderson Cancer Center.

A good knowledge of medical terminology in the environment in which an interpreter works also is important. For example, if the interpreter works in the diabetes center, he or she needs to be familiar with medical terms pertaining to this disease. In addition, interpreters must have an understanding of the western medical model as well as physiology and anatomy, says Henry.

At M.D. Anderson Cancer Center, interpreters must pass an online medical terminology test within 60 days of being hired. In addition, each clinic specializing in a particular cancer has a manual and glossary of medical terms that are given to interpreters.

"Our interpreters have to be fully knowledgeable of the terminology used in the various clinics," says Garcia.

In addition, ongoing training takes place so, when there is a new treatment available to patients, an inservice is scheduled for the departmental meeting.

Knowledge of ethics a must

Knowledge of the ethical standards for an interpreter is extremely important, says Henry. "Most people who receive training learn the ethics of the role. These are the parameters that keep us from doing things that would negatively impact the encounter," she explains.

For example, interpreters must remain neutral

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at all times. Also, they must never make assumptions. If something that is said is unclear, they must ask for an explanation.

While patients may ask a medical interpreter to accompany them to an appointment outside the medical center, the national code of ethics for interpreters prohibits such an action. The patient should be referred to the social work department instead.

The principle of medical confidentiality needs to be stated at the beginning of every medical encounter, says Chakofsky-Lewy. In addition, patients need to know that everything said in the room will be interpreted. This way, patients will understand that they cannot provide information to the interpreter in confidence, and any discussion between the interpreter and medical staff will also be interpreted for the patient.

"It is important to remember that two people need training — the interpreter and also the person who is working with the interpreter. It's not rocket science, but a little bit of instruction on how to do it is very helpful," says Chakofsky-Lewy. **(To learn the most effective type of training to offer to staff, see "Train staff to work with interpreters" on p. 52.)**

Each institution sets policies for hiring interpreters, and some criteria is unique to that facility. At M.D. Anderson, people who have had a formal education are preferred because they have a better understanding of the language and the culture, says Garcia. **(To learn how cultural differences must be taken into account when teaching patients from other countries see "Consider cultural influences" on p. 52.)**

Completion of Bridging the Gap, a training program offered by Cross-Cultural Healthcare, is required at Harborview Medical Center**. (For information on this training program and others, see resources at end of article.)**

In Columbus, the community standard for interpreter skill training is 24 hours; therefore, that is the minimum required by Grant/Riverside Hospitals. In addition to a certificate of completion of a training course, interpreters must have one-year of professional experience. Volunteer work at free clinics in the area counts as experience, says Shell Castro. A person can have knowledge but not be able to put into practice what they know, she says.

While having interpreters on staff is ideal, it is impossible for health care facilities to have an interpreter for every language needed. In rural areas, it may be difficult to find a skilled interpreter for even the dominant foreign language spoken.

Many facilities contract with telephonic language lines that provide medical interpretation. However, when using a telephone interpreter, it is best to use a speakerphone to create the atmosphere of having a person in the room, says Henry.

If a rural health care facility had enough language needs to actually have a full-time interpreter, administrators might consider recruiting nationally. "The outcome of using interpreters can be so positive for the family and organization. It is worth having people on site; but if there isn't a large enough population for a skilled interpreter in a particular language, then use phone interpreters," advises Henry.

In large metropolitan areas, some health care facilities use local agencies to supplement their in-house interpreting staff as well.

No matter the size of the facility, it is important to use trained interpreters, says Shell Castro. It is not appropriate to use family members because they do not know medical vocabulary and often summarize and edit information, she explains. Contacting a telephonic interpreting service is a quick way to get a trained interpreter.

When patients insist on using a family member or friend to interpret, Grant/Riverside Hospitals has the patient sign a liability release.

"We reserve the right to have an interpreter present if we think it is necessary; and nine times out of 10, we do that. The interpreter only intervenes if information is inaccurate or incomplete. He or she is listening for us so we know what is being said," explains Shell Castro.

SOURCES

For more information about obtaining qualified medical interpreters, contact:

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- **Erika Shell Castro**, Manager, Interpretive Services, Grant/Riverside Hospitals, 3545 Olentangy River Road, Suite 001 Ground Floor, North Medical Building, Columbus, OH 43214. E-mail: ESHELLCA @OhioHealth.com.

Resources

• **Center for Cross-Cultural Health** — Information resource on cultural competency. Web site: www.crosshealth.com.

• **Cross-Cultural Health Care Program** — Helps bridge communities and health care institutions to ensure culturally and linguistically appropriate health care. www.xculture.org.

• **Ethnomed** — Information about cultural beliefs, medical, and other related issues. Web site: www.ethnomed.org. ■

Train staff to work with interpreters

Include pre- and post-sessions

When health care professionals work with interpreters to educate non-English-speaking patients, it is a team effort. While it is important that interpreters have the skills they need to convey the teaching to the patient correctly, health care professionals also need training to effectively work with interpreters.

"Often providers think they have a magic telephone where they speak English and it comes out the other end in the target language. That is not a helpful way to look at it. The interpreter is really the provider's partner in communicating," says **Bria Chakofsky-Lewy**, RN, supervisor of caseworker/cultural mediators and interpreters for Community House Calls Interpreter Services at Harborview Medical Center in Seattle.

As a partner, providers need to know that the interpretation is not always word-for-word because sometimes an English word does not exist in the patient's language; therefore, it must be described or explained.

In addition, the clinician doing the teaching should divide the session into three parts. The first is a pre-teaching session where the goals for the encounter are discussed. At this time, the interpreter can share some of the barriers to accomplishing the goals so the provider is prepared to address them, says Chakofsky-Lewy.

During the teaching session, the provider speaks directly to the patient in the first person as if a third party were not in the room.

When the teaching is completed, a post-session meeting should take place between the interpreter and the provider. At this time, both parties give each other feedback on the session. Also, the provider can ask questions about the patient's culture or traditions that he or she became aware of during the teaching session. This is an opportunity for health care professionals to increase their cultural knowledge.

The No. 1 skill practitioners need when working with an interpreter is patience, says **Andrea Henry**, coordinator of Multi-Cultural Translation Services at Children's Healthcare of Atlanta.

During a teaching session, educators must pause quite a bit to allow the interpreter to interpret. In addition, they may need to phrase things differently than they would when speaking to someone who speaks English for it to be understood by the patient.

It's OK to ask interpreters how to phrase information, says **Erika Shell Castro**, manager of Interpretive Services at Grant/Riverside Hospitals in Columbus, OH. Interpreters are not just linguistic bridges, they are cultural bridges, she explains.

When scheduling a teaching session, it's important to allow more time when working with an interpreter, says Shell Castro. It is not uncommon for a teaching session to take twice as long.

Good teaching strategies should be followed as well. For example, patients should be asked to repeat back information and instructions to determine if they understood the teaching, says Shell Castro.

The use of an interpreter needs to be documented in the medical chart. The documentation of the encounter should include the language spoken, arrival and departure time of the interpreter, and the interpreter's name.

People need to document how they got the information from the patient. For example, they need to write "per the bedside interpreter, the patient reports" if the information was gleaned with the aid of an interpreter, says Shell Castro. ■

When teaching, consider cultural influences

Negotiate when cultural beliefs create conflicts

When cross-cultural teaching encounters occur, health care providers, nurses, and other disciplines must be aware of barriers to education. While an interpreter can help get the message across, the fact that patients know and understand a regimen does not mean they will adhere to it.

Therefore, it is important to know something about a patient's culture in advance. At Grant/Riverside Hospitals in Columbus, OH, cultural handbooks are kept on each unit so staff can look up particular cultures as needed.

"This can help the staff understand aspects such as eye contact, touch, space, decision making, rituals, and health care beliefs," explains **BJ Wingert**, RN, BSN, MS, patient education specialist at the health care system.

Having a general understanding of a culture can help staff ask questions or assess what the individual patient believes and practices, she says.

"We need to ask questions so we tailor the teaching to the individual," says Wingert.

Questions might include what they do to heal themselves such as whether they use herbals or home remedies. Questions about the cause of their condition might be asked as well as who makes decisions and who helps with care in the family unit.

While it is important to understand a little bit about a patient's culture, a personal assessment is a must, agrees **Bria Chakofsky-Lewy**, RN, supervisor of caseworker/cultural mediators and interpreters for Community House Calls Interpreter Services at Harborview Medical Center in Seattle.

She advises making copies of *Culture and Nursing Care,* A Pocket Guide by Julienne G. Lipson available on each unit. In addition, it is important to teach staff to negotiate with patients. If instructions conflict with what patients think will make them well, they will not follow them, she explains.

To help staff negotiate with patients, they are taught the "Learn Model" (Berlin EA, Fowkes WC; 1983):

- **L:** The first step in an encounter is to ***listen***. "As long as you come to the encounter with respect for what your patient's worldview reality is, what their goals are, and you listen, then you will be very successful," says Chakofsky-Lewy.
- **E:** The second step is to ***explain*** the information you have for the patient.
- **A: A*cknowledge*** the differences and similarities in the patient and provider's beliefs. "Based upon having listened and acknowledged what the similarities and differences are, we can recommend a strategy and then negotiate," explains Chakofsky-Lewy.
- **R:** ***Recommend*** a plan.
- **N:** ***Negotiate*** an agreement. "We often think all we have to do is give the information. That is not the case. We have to find out what the circumstances are and how we can help adjust whatever it is we are teaching to those circumstances," explains Chakofsky-Lewy. ■

Asthma action plan acts as self-management tool

Green, yellow, and red zones aid troubleshooting

Ten years ago, nurse practitioners collaborated with pediatric pulmonary allergists at St. Louis Children's Hospital to develop a plan to manage asthma cases within the hospital setting.

The plan was necessary because there was not much continuity of care and asthma was, and continues to be, the No. 1 reason for hospital admissions. About 1,000 children per year are admitted to St. Louis Children's Hospital for asthma, says **Anne Borgmeyer**, MSN, RN, CPNP, AE-C, a nurse practitioner with the asthma intervention model.

An intervention model was developed and used successfully by the nurse practitioners. And an asthma pathway that was based on the intervention model was created to guide the care of all children admitted with asthma. Also, an asthma action plan was produced, which is the key education piece for families. Health care providers, school nurses and answer line nurses, and nurses who answer calls for community providers after hours all use the same action plan. Both the pathway and plan are patterned after national guidelines.

The asthma action plan is based upon the stoplight system, with a green, yellow, and red zone. When children are in the green zone, their asthma is in control. Those in the yellow zone are experiencing early signs of asthma. The red zone is the emergency zone when the child must contact their physician and seek medical care. **(See Asthma Action Plan on p. 54.)**

The most important piece of the action plan is the green zone, which provides guidelines for families on how to help a child stay well.

To help a child stay well, he or she is placed on proper medication according to national guidelines. Children who have asthma symptoms two times a week or nighttime coughing, or symptoms more than twice a month should be on a controller medicine, says Borgmeyer.

"Children with persistent asthma should be on

(Continued on page 55)

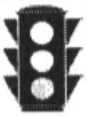
Children's
HOSPITAL • ST. LOUIS

Asthma Action Plan

Green Zone: Well

Peak Flow above _____
(80-100% of best)

- no signs of asthma
- able to do normal activities
- no problems while sleeping



- Check your peak flow.
- Take these medicines every day:

Name of Medicine	How much to take	When to take

Yellow Zone: Caution!

Peak Flow _____ - _____
(50-80% of best)

Early signs of Asthma:

- coughing
- wheezing
- tightness of chest
- shortness of breath
- unable to do normal activities
- unable to sleep at night
- cold symptoms
- _____
- _____

- First — tell an adult and take:

Albuterol	2-4 puffs or 1 nebulizer	1-3 times in first hour

- Next:
  - Check your peak flow.
  - Continue other Green Zone medicines.
  - If your signs of asthma return, you may take:

Albuterol	2-4 puffs or 1 nebulizer	every 4 hours as needed

- Call your Doctor or Nurse if:
  - You are not in the Green Zone after the first hour.
  - You need albuterol more often than every 4 hours.
  - You need albuterol every 4 hours for more than 1 day.

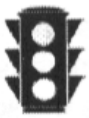
Red Zone: Danger!

This is an emergency!
You need help!

Peak Flow below _____
(below 50% of best)

Late signs of Asthma:

- very hard time breathing
- trouble talking or walking
- constant coughing
- use of neck or stomach muscles to breathe
- ribs show when breathing
- breathing medicines don't help
- lips or nails blue



- First — tell an adult and take:

Albuterol	4-6 puffs or 1 nebulizer	immediately

- Next:
  - Check your peak flow.
  - Call your Doctor or Nurse even if you feel better.
  - **If your child is still in the Red Zone or you cannot reach your Doctor or Nurse give your child:**

Albuterol	4-6 puffs or 1 nebulizer	immediately
		immediately
(oral steroid)		

- **Then: Go to the nearest emergency room or call 911. You must see a Doctor or Nurse!**

_____
Parent/Patient/Legal Guardian Signature

_____
R.N. or M.D. Signature *Date*

Phone Number of Doctor/Nurse:
Day: _____
Night: _____

Rev. 1/04

Copies: White–Chart Yellow and Pink–Patient

Source: Children's Hospital, St. Louis.

a controller every day in that green zone, and a lot of times it is overlooked," she explains.

In addition, older children are given a peak flow meter, which is a tool that is used to monitor their asthma. To determine their best peak flow reading, children blow into the peak flow meter when they are well for a period of two to three weeks. Guidelines are followed to determine the best peak flow number based on a child's height.

Peak flow helps identify zones

Children with moderate to severe asthma are encouraged to determine their peak flow on a daily basis. Those with intermittent or mild asthma are told to monitor their peak flow when they are beginning to feel symptoms. This way, the older children, ages 7 and older, can determine if they are in the green zone or yellow zone.

A peak flow reading in the green zone is 80% to 100% of the child's best, and a peak flow reading that would place a child in the yellow zone is 50% to 80% of his or her best.

Children in the green (well) zone have no signs of asthma, are able to do normal activities, and have no problems while sleeping. When a child begins to experience signs of asthma such as coughing, wheezing, tightness of chest, shortness of breath, cold symptoms, and the inability to do normal activities or sleep at night, he or she is in the yellow (caution) zone.

Parents of young children who cannot monitor their peak flow must be very aware of the child's symptoms so they can take steps to prevent the child from going into the red (danger) zone, says Borgmeyer.

When children are in the yellow zone, they are told to take two to four puffs of albuterol (an oral steroid) one to three times in the first hour and check their peak flow. If signs of asthma return, they are to continue to take albuterol every four hours as needed.

Those who are not back in the green zone after the first hour need albuterol more often than every four hours, or need it every four hours for more than one day, are told to call their doctor or nurse practitioner.

"The whole idea is to get them in contact with their health care provider quicker so they can be managed before they get into that serious emergency zone," says Borgmeyer.

Parents often mistake asthma for cold

Often, parents miss the first signs of asthma because they think the child has a cold. However, with the asthma action plan, they are advised to go directly to the steps in the yellow zone when the child does not feel well.

Parents are told, if their child is not feeling right, to think asthma first rather than last, says Borgmeyer.

When a child's peak flow is below 50% of his

Quick Facts about the Asthma Action Plan for School Nurses

1. **What is an Asthma Action Plan?** It is an individualized, written plan for asthma care developed by the health care provider that includes:
- Easy-to-read directions for everyday management and quick relief of symptoms.
- Information about medicines, signs of asthma, and peak flow.
- Phone numbers to reach the doctor or nurse.
- Signatures of the parent or guardian, student, and the doctor or nurse.
- Signatures signify understanding and willingness to take part in management.

2. **What does the Asthma Action Plan look like?** Three zones — red, yellow, green — similar to a traffic stoplight. Using the analogy is helpful when teaching the plan.

3. **How is the Asthma Action Plan used?**
- *Directions to help manage exacerbations that might occur at school.*
- *Directions for daily control.* Although control medicines usually are given at home, a list of home medicines enables the nurse to assess the chronic severity of the child's asthma and to observe for side effects of the medicines and signs of control or lack of control of asthma. The nurse may act as liaison between school and home or health care provider advocating for optimal care to promote health.
- *Tool for education.* The school nurse can reinforce education and adherence with the student by encouraging self-management in addition to educating all school contacts.
- *Tool for communication.* Copies can be provided to all caregivers including the classroom teacher, gym teacher, bus driver, and after-school care provider.

SOURCE

For more information about the asthma action plan, contact:
- **Anne Borgmeyer**, MSN, RN, CPNP, AE-C, Nurse Practitioner, Asthma Intervention Model, St. Louis Children's Hospital, One Children's Place, St. Louis, MO 63110. E-mail: anneeb@bjc.org.

or her best, and there are signs of advanced asthma such as difficulty breathing, trouble talking or walking, and constant coughing, the action plan indicates that emergency help is required.

Children are advised to take albuterol and contact their physician or nurse. Often when the steps are followed for the red zone in the action plan, children who go to the emergency department do not have to be admitted to the hospital, says Borgmeyer.

The asthma action plan is effective because families learn how to use it. Also, other key people in a child's life follow the plan.

Annually, St. Louis Children's Hospital sends an updated action plan to community providers within a 50-mile radius of the health care facility. School nurses also receive an action plan and education about its use. Through the Healthy Kids Express program, a van of health care professionals travel to schools and work with school nurses to provide asthma care to the children.

The hospital also works with the Asthma and Allergy Foundation in St. Louis to help educate day care providers about asthma.

The multidisciplinary Asthma Education Committee at St. Louis Children's Hospital keeps abreast of changes in practice and also develops resources for education. For example, they have written easy to follow instructions on medications and other asthma tools with the permission of the manufacturers. This way, baby-sitters or relatives have easy-to-follow instructional materials. They have also created a 20-page educational booklet for families.

When families leave the hospital with an action plan, they have a guide for self-management — not only for the routine days, but also for the times that symptoms indicate the child is in the yellow or red zone and needs to take quick relief measures. ■

Hospice patient handbook increases satisfaction

Patients, staff use book with each visit

A Florida hospice has created an education program that helps it handle its rapid growth while improving patient and family satisfaction. Each year, Covenant Hospice of Pensacola, FL, gives away more than 1,000 patient education handbooks that serve as a comprehensive guide to hospice for both families and hospice staff.

The hospice has given away about 5,000 handbooks since the education tool was created several years ago, says **Julie Patton**, LCSW, curriculum development manager for the hospice, which has more than 700 employees.

Covenant Hospice won an award of excellence in education last year for its patient and family education program. The award was sponsored by the National Council of Hospice and Palliative Professionals and presented by the National Hospice and Palliative Care Organization of Alexandria, VA.

Also, Covenant Hospice's family satisfaction with education increased from around the 40th percentile in July 2001 to the 70th percentile in December 2003 as a result of using the education handbook. The measure for family satisfaction in receiving adequate help in combating stress and anxiety increased from the 50th percentile in 2001 to about the 80th percentile in 2003, Patton says. "And we had 97% of caregivers [in a recent survey] say that hospice had increased their confidence in caring for their loved one as death approached," she adds.

In 2001, when Covenant Hospice's staff were preparing for re-accreditation by the Joint Commission on Accreditation of Healthcare Organizations of Oakbrook Terrace, IL, they decided their patient education program wasn't working as well as they wanted it to, Patton says. "There were a lot of different teaching sheets, and to make it successful, a nurse needed to have the right sheets in the home at the right time," she says.

Boosting education, improving care plans

The idea for an education handbook was a melding of the patient and family education goals with the hospice's latest project of improving the care plan process, Patton explains. "In talking about it, we felt the two would complement one another."

When hospice managers began to examine the

current care planning process, they realized it involved too much writing and too little interaction with patients, so they decided to reverse those trends, says **Dee Leslie**, RN, CHPN, director of the Partners in Care Program. Leslie was the one who spearheaded the changes to the care planning process.

"Now, when nurses select teaching sheets from the patient education handbook, they also are selecting teaching interventions," she says. "After finishing the teaching sheet, they review the interventions at the bottom to make sure they have covered those teaching interventions."

The handbook is nearly 300 pages long and is fairly inexpensive to produce since the hospice uses its own copying machines, but it does require about 20 volunteers to put it together, Patton says.

While the hospice could have the book published for sale to other hospices, the idea of making a profit from the book doesn't fit in well with the hospice's philosophy. "Our philosophy up to this point is that we are all, as hospice providers, contributing to a relatively new body of knowledge," says **Liz Stewart**, RN, BSN, CHPN, director of internal education.

Patton, Leslie, and Stewart describe how the award-winning handbook was created:

1. A needs assessment was conducted.

"What we found out was we had care plans that had been carried over from a number of different settings and were not terribly hospice-appropriate," Patton says. "So we did an extensive needs assessment."

Hospice staff decided they would need to improve both the care planning process and patient education materials. A committee that included clinicians was formed to develop hospice interventions for problems like pain and nausea or working with the patient and family to comply with around-the-clock dosing, Patton explains.

The result was the development of a care planning process that is simpler than what staff used previously, Patton notes. "In doing care planning, the staff doesn't have to do a great deal of writing," she says. "They can use a drop-down menu on the computer and select interventions that correspond with teaching sheets."

"What's unique about the care planning process is it came from the staff up to the management," Leslie says. "It's a method that makes it easier for hospice staff to do care planning and to do it effectively, without spending a lot of time writing out things."

Also, the care planning process is completely independent of hospice reimbursement and financial concerns, Leslie adds.

2. A separate committee developed the education handbook.

Initially, the hospice's committee was formed to improve the family education program, but it progressed into a committee to create the patient and family handbook, Patton says. "We were using a file box for teaching sheets, so it became a patient and family handbook," Patton says.

Committee members gathered new information while reviewing existing teaching sheets, and they e-mailed one another with suggestions for changes, Patton says. "I'd write something and send it to someone else to see if they would change anything or if there were things I'd left out or if there was anything that might be offensive," Patton explains. "They'd make comments and e-mail it back to me."

Many different people collaborated on the changes, including Stewart, Leslie, the director of operations, the director of special programs, a social worker, a health and safety officer, and a chaplain, Patton says. "Forty to 50 people contributed to it altogether, including an administrative assistant who prepared dividers and helped with formatting some of the sheets," Patton says.

Hospice staff also came up with ideas to reduce costs in reproducing the handbook. For example, it was begun as a loose-leaf notebook and now is a bound notebook that is printed entirely at the hospice, Patton says. The volume of printing was wearing out the hospice's copying machines, so the hospice invested in a larger copying machine that also inserts tab dividers, and volunteers assist with the printing and assembling, she adds.

3. Patient education materials were developed with psychosocial issues in mind.

One of the unique features of the handbook is that it reflects the holistic and psychosocial aspects of hospice care, rather than focusing primarily on nursing and medical interventions, Patton says. Many other care plans didn't reflect the breadth of hospice care, so Patton and others worked to develop many psychosocial teaching sheets. "We feel our program is very broad and reflects the work of everyone on the interdisciplinary team," Patton says. "The teaching sheets identify opportunities for growth at the end of life, and they facilitate growth in a variety of areas, including the spiritual."

4. The patient handbook contains alphabetized sections and teaching sheets.

Stewart recalls that when she was a case manager using the handbook, it was a wonderful tool for hospice families. "When a patient was approaching death and I wanted the family to be aware of the signs and symptoms, or when we had a conversation about hydration, the teaching sheets were there and readily accessible," Stewart says. "The family receives the entire handbook with teaching sheets, and the nurse will identify the sheets to which she refers the family."

Care plans prompt use of teaching sheets

Care planning works closely with the handbook, Leslie notes. "Care planning was integral to the patient and family handbook," she says. "In the electronic care plans, nurses can use a drop-down menu that says 'Review teaching sheet,' and there's a blank space to type in the teaching sheet that's reviewed."

Also, nurses do not have to repeat the interventions in the documentation because all of these are written in the handbook, Leslie says.

"I found it a very useful tool because, while I might remember some of the interventions, like how to request a volunteer, I may forget to go over what a volunteer can and can't do," Stewart says. "So I'd open the book to the page on volunteers, and it gave me a prompt of what I needed to say."

Previously, nurses would document teaching with a check-off in the nursing notes of "Teaching accomplished," and they would write on a small line what was taught, she recalls.

"Now, because of this tool and electronic care plan, we can better document what teaching has been done and whether it's a true intervention," Stewart adds.

The teaching sheets are listed alphabetically, and items are cross-referenced in the index, Patton says.

The handbook begins with a mission statement and covers such items as services, on-call system, safety issues, and nursing services before beginning the sections with education and teaching sheets. Also, there are sections devoted to medication, medical equipment, financial and insurance information, and discharge/transfer of hospice patients.

"It has an initial section that describes the organization and team," Patton explains. "Then a second section has the teaching sheets, alphabetically arranged, from advance directives to volunteers."

The handbook also covers hurricane preparedness, fire safety in the home, diarrhea and constipation, placement in a nursing facility, and unconventional teaching items, such as opportunities for growth, anxiety, anger and depression, end-of-life care, and a comprehensive description of what a patient might experience, she says.

The book is written at an eighth-grade education level and is in a clear font so it's easy to read, Patton says.

Patients who are admitted to hospice when they are very close to death are referred to a small section in the book for terminal patients, so they don't have to worry about reading the entire book if they choose not to, she says.

While the handbook has been a time-consuming and costly project, it has helped improve satisfaction among hospice staff and families of hospice patients, Stewart says.

"When the handbooks are put into facilities with hospice families, they're often left at the facilities, and we're actually spreading our mission in education by teaching families," Stewart says. "Research shows that, even when one person receives hospice care in a facility, all persons tend to benefit from the education that's provided." ■

CMS: Medicare to pay for seniors' smoking cessation counseling

The Centers for Medicare & Medicaid Services (CMS) announced it will cover smoking and tobacco cessation counseling to help seniors give up their tobacco habit. "Covering smoking and tobacco use cessation counseling for seniors has great potential to save and improve lives for millions of seniors," said CMS administrator **Mark B. McClellan**, MD, PhD. "This is another step in turning Medicare into a prevention-oriented health program."

The coverage decision, which was proposed for public comment in December, involves Medicare beneficiaries who have an illness caused or complicated by tobacco use, including heart disease, cerebrovascular disease, lung disease, weak bones, blood clots, and cataracts — the diseases that account for the bulk of Medicare spending today. It also applies to beneficiaries who take any of the many medications whose effectiveness is complicated by tobacco use — including insulin and

medicines for high blood pressure, blood clots, and depression.

Public comments generally supported the approach that CMS proposed, although some commenters preferred broader coverage of all tobacco users. CMS modified the proposal in response to comments by removing a requirement that providers have uniform training in smoking and tobacco-use cessation counseling, since no nationally accepted standards exist. When standards do become available, CMS plans to consider whether to add those requirements to its coverage policy.

The new coverage policy is effective immediately. The Centers for Disease Control and Prevention (CDC) has estimated that almost 10% of Americans ages 65 and older smoke cigarettes. About 440,000 people die annually from smoking related disease, with 300,000 of those deaths in those 65 and older. CDC estimated in 2002 that 57 % of smokers age 65 and older report a desire to quit. Currently, about 10% of elderly smokers quit each year, with 1% relapsing. CMS reports that smoking accounts for roughly 10% of the total costs of Medicare — more than $20 billion in 1997 alone.

The final Medicare coverage decision is available on CMS' web site at www.cms.gov/coverage/. ▼

CDC plans agencywide research agenda

The Centers for Disease Control and Prevention will develop an agencywide research agenda to target national health problems such as infectious disease, birth defects and obesity, and provide evidence to improve public health interventions to reduce risk factors associated with the leading causes of death and illness, the agency announced today.

It said the agenda will directly influence the selection and implementation of community and national programs that protect the health of children, adolescents, adults, and the public from terrorism, infectious, occupational and environmental threats. The agency will sponsor four public meetings to obtain public input on the agenda.

Interested people can register comments for the meetings on-line at www.maximumtechnology.com/cdcreg.htm. ▼

California awards $13 million for nurse training programs

California has awarded $13 million in grants to support initiatives to train current and future workers for high-demand nursing positions.

CE instructions/objectives

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.

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. ■

COMING IN FUTURE MONTHS

- ■ Innovative ways to use the intranet/ Internet in teaching
- ■ Assessing a child for readiness to learn
- ■ Strategies for evaluating education programs
- ■ Introducing non-English-speaking patients to American health care
- ■ Creating an effective closed-circuit TV system for educational purposes

CE Questions

17. According to the experts, a medical interpreter must meet which of the following criteria?
    A. Have a good memory
    B. Be a native of the target language country
    C. Have a college degree
    D. Have experience in a medical field

18. When working with an interpreter it is appropriate for a medical professional to ask questions of the interpreter about ways to explain a procedure to the patient without interpreting this conversation for the patient.
    A. True
    B. False

19. According to the St. Louis Children's Hospital Asthma Action Plan, why is the green zone the most important piece of the plan?
    A. It indicates the child is showing no signs of asthma.
    B. It indicates the child needs to be on a controller medication.
    C. It provides an ideal for the child to strive to achieve.
    D. It provides guidelines for families on how to help the child stay well.

20. What is the reading level of the patient education handbooks distributed by the Covenant Hospice in Pensacola, FL?
    A. 10th grade
    B. Fifth grade
    C. Eighth grade
    D. Third grade

Answers: 17. A; 18. B; 19. D; 20. C.

"Every effort must be made to help our hospitals and health care providers fill the nursing positions they need to deliver safe, quality patient care," said Gov. **Arnold Schwarzenegger**.

State has 14,000 RN vacancies

California hospitals have about 14,000 vacant registered nurse positions and need an additional 4,000 nurses under the state's current nurse-to-patient staffing regulations.

Eighteen organizations from throughout the state were selected for funding. Each recipient was awarded up to $800,000. The 18 nursing programs are each designed to prepare California's current and future work force for high-demand nursing positions ranging from licensed vocational nurses to RNs.

Examples of the projects include: increasing capacity in nursing education programs; creating awareness and interest among youth for careers in the health care industry; and training workers for nursing professions in rural areas that tend to serve the state's most vulnerable populations and experience more severe shortages.

California Hospital Association president **Duane Dauner** said, "With a majority of California's hospitals operating in the red and with nine hospital closures last year alone, the governor's proactive and results-oriented solution is an important step to make sure that we train enough nurses to keep hospitals open." ■