Patient Education Management™

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

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IN THIS ISSUE

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Documentation confirms educational needs met according to plan of care

Communicate what was taught, how barriers were addressed

Similar to teaching, documentation must meet the needs of a patient. While some documentation is better than no documentation, more detail benefits the patient because it directs staff members on the status of the education process.

With documentation as a tool, staff can better determine what to do next, says **Carol Ptasinski**, RN, MSN, MBA, associate director of standards interpretation for the Joint Commission on Accreditation of Healthcare Organizations in Oakbrook Terrace, IL.

A statement such as "medications reviewed with patient" is so vague other staff members wouldn't know what was covered; good documentation reflects what was done, including ways educational barriers were addressed, says Ptasinski.

The documentation sheet, which is part of the medical record, is a communication tool, agrees **Kathy Ordelt**, RN-CPN, CRRN, patient and family education coordinator at Children's Healthcare of Atlanta.

EXECUTIVE SUMMARY

Getting staff to document patient education is often a struggle. Frequently, if it is documented, it is noted only as a general statement such as "medications reviewed with patient." However, many patient education managers question the value of such a simple notation and wonder if general documentation is better than none at all.

In this article we explore the question: How much documentation is enough? In answering this question, the purpose for documentation becomes clearer; it isn't done just to meet standards and regulations or protect the health care institution from lawsuits — good documentation ensures better patient care.

"The medical record is the only communication tool we have for that patient. Certainly word of mouth doesn't do it and shift-to-shift reports don't do it — those are all verbal and they get lost and jumbled up. The medical record is the only thing we have that completes the picture of that patient's care," says Ordelt.

To make her point, Ordelt tells staff to imagine walking into a room and trying to take care of a patient without a medical record. She tells them to imagine having to go back and retake a history and physical, redo all the tests that have been done, and redo all the consults from all the therapists and physicians and everyone who sees the patient because nothing was recorded. Staff always respond that they could not care for the patient.

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"We document for a reason. The medical record is our guide for that patient's care; therefore what that translates into is safe, quality care for a patient when it is done properly. Documentation helps contribute to that safe, quality care," explains Ordelt. **(For information on how to make the importance of documentation clear to staff members, see article on p. 124.)**

Patient education is part of quality care, says Ordelt. Just as it is impossible to treat a patient properly without information about previous medical interventions, it is impossible to teach effectively without information on learning assessments, prior education, and the patient's comprehension of what already has been taught.

Teaching without regard to what patients have already learned or what they still need to know is unsafe, inconsistent, and frustrating for patients, says Ordelt.

Although it is helpful to create patient education documentation forms with check boxes and codes, such as "V" for "patient verbalizes understanding," in order to make the process quick and easy, some detail must be provided, says Ordelt.

For example, if a handout was used to educate the patient, it would not be enough to write "H" on the documentation sheet. The title of the

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resource would need to be written in the comment section as well so others would better understand what information was given.

While documenting that the education provided pertinent to a patient's plan of care is important, such as information about newly introduced medical equipment or supplies, it is not the only information needed.

To meet Joint Commission standards, documentation needs to reflect what was taught, when it was taught, whether the patient had any difficulties learning because of cultural, emotional, or cognitive barriers, and if the teaching was completed, says **Jodi L. Eisenberg**, CPHQ, CPMSM, program manager for accreditation and clinical compliance at Northwestern Memorial Hospital in Chicago.

When there are barriers to learning, a note on how they were addressed should be included. For example, when language is a barrier, stating that an interpreter was present during teaching would be appropriate.

If the teaching was not completed, there should be some sort of statement that the education needs to be reinforced or that the patient was unable to learn and the family was taught instead. The Joint Commission looks at evaluation of comprehension every time teaching occurs, and it needs to be documented, Eisenberg says.

Making a case for patient education

It is not only the Joint Commission that requires proof of comprehension. "While providing education is good, more important is that the patient was able to repeat back what was taught. That is the basics of informed consent. Unless the patient can repeat back what was taught, it isn't really consent and it is not education unless they get it; otherwise it is just people blabbering words at them," says **Geri Amori**, PhD, ARM, CPHRM, DFASHRM, senior director for education and professional development with the Risk Management and Patient Safety Institute in Lansing, MI.

Again, any documentation is better than no documentation, says Amori. However, when discussing what constitutes adequate documentation of patient education, the question is: Adequate for what? Adequate to be defensible in court or adequate to know it was done? To be defensible in court, the information documented must be as specific as can be provided. Anything that needs to be recalled in five years or more should be written down.

Documentation is important for defending a health care institution in litigation and ensuring that providers remember what happened, says Amori. And communication is important in preventing litigation in the first place, because it builds the relationship and the trust, she adds.

The literature indicates that when something goes wrong, medical lawsuits are triggered because patients feel there was a breakdown in communication. Patients believe they did not get adequate information or it was poorly presented. Also, they feel their perspective was dismissed.

Documentation that meets Joint Commission standards doesn't have to be as comprehensive as the records that would provide a good defense in court, as long as the health care institution has in place teaching protocols that are routinely followed and resources that are consistently given or used, says Ptasinski. As much detail as needed for patient education to be effectively completed is what is required.

"We would expect that if a patient was on a particular medication, he or she would be educated on that medication. We would say, 'Show us where you documented the patient received education,' and then see what process is in place," says Ptasinski.

With the new tracer methodology of surveying, the Joint Commission surveyor would interview staff and the patient to make sure an adequate educational process was in place. To ensure the same educational process was followed for each patient, the surveyor might trace another patient.

Adequate documentation for the Joint Commission means that any education needed as part of a patient's plan of care be documented. Documentation can be general as long as the resources are available that show the patient's educational needs were met, says Eisenberg.

"Our rule of thumb is that if it wasn't documented, it wasn't done. However, if you put down everything you educated a patient on, your medical records would weigh 50 pounds," she explains.

The expectation is not verbatim documentation but to cover the four basics: what was taught, when the teaching took place, the educational barriers, and whether the teaching was completed. If this information is included in the documentation of patient education, an institution should be covered from a regulatory standpoint as well as a legal one, says Eisenberg. ■

Reinforce good patient ed documentation practices

Review of techniques helps get the job done right

At Children's Healthcare of Atlanta, a special team called the documentation council routinely reviews a number of medical record forms, including the interdisciplinary patient and family education record.

In addition, the council completes chart audits monthly on each nursing unit and clinical department, such as nutrition or physical therapy. Certain staff members from these units or departments also are responsible for auditing charts.

Those who audit the charts have a list of particular items they look for, such as whether a patient's name and medical record number is on each page, if patient education is documented, and whether the handwriting is legible.

"They have a set of [Joint Commission on Accreditation of Healthcare Organizations] specifics and they go through those indicators and determine whether or not the medical records have them," explains **Kathy Ordelt**, RN-CPN, CRRN, patient and family education coordinator at Children's Healthcare of Atlanta.

The results of the audits from each department are given to the manager who addresses compliance issues. The system leaders also are given a report. At the department level, if a particular staff member has not regularly documented something that is required, the manager speaks with him or her.

If there is a problem systemwide education could remedy, the education department is notified so steps can be taken to teach staff.

"If we find something like handwriting legibility is a problem on all units, we do a big education push for it. If it is only a problem on one unit, a manager usually deals with it," says Ordelt.

Making sure documentation is complete is a process that includes system auditing as well as individual department auditing. The data from the audits are compiled into a report that is issued on a quarterly basis.

In addition to addressing problems identified by chart audits, Ordelt embraces opportunities to educate staff on the importance of documentation. She uses "Take Five," a short publication she distributes to staff to promote patient and family education, to provide a few lessons in good documentation practices.

In a three-part series, she told her readers the goal of education is to improve health outcomes by helping the caregiver learn how to care for the patient following discharge. Effective education is tailored to the patient or other caregiver by first conducting a learning needs assessment and documenting its results.

In one of her short articles she encouraged staff to determine each of the following:

- What does the patient and family want or need to know?
- How do they learn best?
- How much do they know already?
- What barriers are in the way, such as language, literacy, physical, emotional, or financial concerns?
- Are they ready to learn?

In the second article she covered what needed to be included when documenting teaching interventions. Her recommendations were as follows:

- Who was taught — the patient, parent, caregiver?
- Was the learner determined ready to learn when assessed for learning readiness?
- A short, concise list of the subject matter completed. For example, cast care, elevation; circulation and infection check; comfort measures and pain relief; positioning; and when to call the doctor.
- The teaching methods used, such as verbal, written material, video, class, or hands-on demonstration.
- Teaching materials used, such as the names of videos and teaching sheets.
- Information on whether or not the learner understood the teaching with such comments as "verbalized understanding" or "demonstrated skill." If the evaluation of learning revealed a lack of understanding, then the need to repeat the information must be documented.

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• The signature and title of the person doing the teaching, as well as the date, must also be included.

• Also important to document is any interventions taken to address learning barriers, such as the use of pictures when people can't read. ■

Education on certain birth defects a long journey

Cleft lip, palate a process from birth to age 18

Preparation for caring for a child with a cleft palate or cleft lip begins before a baby is born, when ultrasound reveals there is a problem.

It is a journey that lasts from infancy to 18 years of age.

"I tell people that cleft is not life or death; however, it is a long journey, and that is what I try to prepare my parents for. I tell them they will be doing cleft care until their child reaches adulthood," says **Alison Repass**, MSN, CPNP, a pediatric nurse practitioner in the Center for Craniofacial Disorders at Children's Healthcare of Atlanta.

A cleft lip results when the upper jaw and nasal area fail to close, resulting in one or more clefts in the upper lip. A cleft palate is a birth defect in which there is a hole in the middle of the roof of the mouth. Frequently, these conditions occur together. Both problems are repaired by surgeries.

Repass has found when parents come to the center they have no idea of the timing of the surgeries or the expected number. A lot of times parents think only one surgery will be needed, but often more are required. Therefore, she goes over a cranial facial care map with families.

Once the baby is born, Repass accompanies the surgeon to the birth hospital to visit the family and assess the severity of the cleft. At that time, the baby also is evaluated for other cranial facial anomalies such as a small jaw.

Feeding issues are discussed, as well, as part of a feeding and nutritional evaluation. Babies have difficulty sucking, so breast feeding often is impossible and usually a special cleft bottle must be used. Repass shows parents the different bottles available. After parents choose one, staff make sure they are using the bottles correctly so the babies are meeting their caloric needs, says Repass.

Often staff at the birth hospital are not skilled in feeding infants with cleft and rely on the center to help train the mothers and fathers in how to feed with the cleft bottles. Repass says that the parent feeding the baby must know where to place the nipple of these special bottles and how to manipulate them with their hands.

"It is hands-on practice. The feeding clinic is done by an occupational therapist and a nutritionist," explains Repass.

Parents also are told about pre-surgical molding that is made shortly after the infant is born. It is like a retainer used by orthodontists, but in this case it is used to bring the lip or palate closer together so they can be repaired more easily.

"The molding often allows us to create a better cosmetic result, because the tissues have grown closer over the months," Repass says.

The first few months before the repair of the lip or palate, the orthodontic appliance is manipulating the tissues so as to reduce the gap that must be closed surgically. Then, typically, the care team at the Center for Craniofacial Disorders repairs the cleft lip at three to five months of age and the cleft palate at six to eight months of age.

Several team members required

In addition to meeting with the occupational therapist and nutritionist for a lesson on feeding, the family meets with the cranial facial surgeon and if the baby is determined a candidate for the pre-surgical molding device they see an orthodontist. Also at this time, families are encouraged to meet with the geneticist to determine if the baby has a functional cleft or if the cleft is associated with a syndrome, which might mean he or she has other health issues, such as cardiac or pulmonary problems.

Children who have a cleft palate are evaluated by a speech pathologist when they are 1 year old and seen at the center every six to 12 months. They have weekly therapy within their local community.

Also, children with cleft palates have frequent ear infections and may need an ear, nose, and throat specialist. They also will need a dentist and orthodontist who are familiar with cleft lip and palate.

If the child has a complete cleft lip and palate, parents are told right away that future surgeries will be necessary. A lip and nose revision might be needed, which is done right before a child

enters kindergarten, and a bone graft will be done when the child is middle-school age.

During the teen-age years, rhinoplasty and some revisions to the mouth might be done. This work is done when skeletal growth is complete and is for better cosmetic results. By the time the teens are 18 years old, the problems have been taken care of; however, they may want more cosmetic dentistry or surgeries on their face, says Repass.

The first surgery to repair the cleft lip takes about an hour and a half and requires an overnight stay at the hospital. The baby wears arm restraints for about a week to prevent him or her from pulling out the stitches. Once the stitches are out, Repass gives the parents information on ways to help soften the scar.

"Parents want to hear what they can do to make their baby look more normal," says Repass.

Care instructions for surgery on the cleft palate include information on protecting the area that is healing. For example, parents are told not to give the baby any food that is sharp or to use straws because they could puncture the palate.

Repass lets parents know that future surgeries are common, as complications can occur. For example, the palate can open up again in certain places and more repair work must be done. In addition a surgical procedure to lengthen the palate may be required if the child continues to have speech problems.

When the children are middle-school age and teens, Repass works with them as well as the parents. She understands what it is like to go through the surgeries, as she was born with a cleft lip and palate.

"A lot of my education for these children is explaining how I think they may be feeling and the process of what I know professionally and what I know personally," says Repass.

Sometimes the conversation is about the child's feelings and their outlook on the upcoming surgery. The children often ask informal questions as well, such as how Repass reacted when other children made fun of her.

In the beginning there can be barriers to education. For example, the problem may not have been caught on ultrasound so the parents have not had prenatal education. However, most know about the birth defect before the baby is born, said Repass.

Often parents don't want to hear about the long repair process; they just want to know when the lip or the palate will be fixed. Repass says parents often are in denial about the longevity of the problem, so she tries not to overwhelm them and sticks with education on the infant's immediate needs.

Often small hospitals aren't familiar with the treatment process for cleft lip and palate and send the families to surgeons. Repass tries to outreach to local hospitals to provide staff education.

"I try to educate them on the technology of cleft today and how early we do repair," she explains. ■

SOURCES

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Changing behavior to make safety a priority

HCWs need to know safety is priority

Lift equipment sits unused in a closet. Safety needles are deposited in a sharps container without being activated. An employee fails to put on goggles when there's a risk of a body fluid splash.

As these common problems reveal, safety devices alone can't create safety. Rather, employees must "buy-in" to the safety program and believe that safety is a priority — for their managers, CEO, and themselves.

Both research and practice have demonstrated the benefits of a focus on the safety environment as a way to improve employee compliance.

An as-yet-unpublished study of 2,000 nurses in 13 health care facilities found a link between nurse-physician collaboration and nursing management and blood and body fluid exposures, musculoskeletal disorders, and lost workday injuries. Another study of 837 nurses in 39 intensive care units at 23 hospitals around the country had similar findings.

"Across the board, it's the systems approach that is most important," says co-author **Pat Stone**, PhD, MPH, RN, assistant professor of nursing at Columbia University in New York City.

"When you have employees who are committed to an organization and a work environment that is healthy for the employee, then a lot of other [positive] things happen," she says. "If people aren't feeling it's a supportive environment ... they're more likely to take shortcuts."

At Mercy Medical Center-North Iowa in Mason City, lift equipment once sat idle while nurses injured themselves in patient transfers. But then the hospital decided to focus on safety, with highly visible support from the CEO, an imperative to managers, additional equipment and hiring of an ergonomist, and a marketing campaign aimed at employees.

"We decided we needed to change the climate of the hospital," says employee health nurse **Jenean Wolterman**, RN, BSN, MA. "You can buy all the equipment you want and people don't use it. We decided to start focusing on safety."

In 2004, the hospital had 35 injuries related to patient transfers. In 2005, there were just 17. The severity dropped as well. In 2001, the hospital had 126 lost workdays due to patient transfer injuries; in 2005, there were just 13.

"We're trying to make a difference. It's really beginning to show," says Wolterman. "People are working safer; they're beginning to understand the importance of working in a safe environment."

Prevention means fighting human nature

Why is it so hard to get employees to use the safety equipment? After all, it's their health that you're trying to safeguard.

It's partly a matter of human nature, says **Robyn Gershon**, MS, DrPH, an occupational health researcher who has studied the safety climate. It took time for drivers to begin wearing seat belts even after being told they would prevent injury and death, she notes. Now, seat belt use is commonplace (though not 100%). Likewise, it took time for nurses, physicians, and dentists to get used to wearing gloves.

In that context, it's more understandable that nurses don't always activate sharps safety devices or use a lift. "There are many barriers to compliance," says Gershon, who is an associate professor at the Mailman School of Public Health at Columbia University. "One of them is time constraints. One is a cost-to-benefit ratio in the health care worker's mind that somehow is putting it in the negative column."

The best solution to compliance is "to engineer [the problem] out," Gershon suggests. A ceiling lift always is in the room. A needleless system won't cause a needlestick. Or, at least, make compliance as convenient as possible. One example: Providing pocket-sized hand hygiene gels.

In some cases, the injuries reveal a problem with a product. At Tampa (FL) General Hospital, needlesticks dropped but then hit a plateau after the hospital introduced safer devices. Employee health discovered problems with stocking; they provided a manual with the Pyxis numbers next to pictures of the devices, says **JoAnn Shea**, MSN, ARNP, director of employee health and wellness.

They also learned that nurses were being stuck by safety butterfly devices when they tried to attach the wrong Vacutainer. The hospital purchased butterfly devices with an attached Vacutainer, Shea says.

CEO puts weight behind safety

At Mercy Medical Center-North Iowa, president and CEO James FitzPatrick made it clear that safety was a key goal for the hospital. He wanted to create a climate with safety as a job expectation. No one was to lift more than 50 pounds without the use of lift equipment.

He put some heat behind that imperative. Managers' annual incentive pay is tied to improvements in patient handling injuries. A new safe lifting policy includes possible disciplinary action for employees who repeatedly fail to use lift equipment.

But the primary focus is on support, education, and encouragement of health care workers. "[Discipline] is in the policy in case we need it, but our goal right now is to show our employees that we care about them and we're trying to work in their behalf," says Wolterman.

Using a rebate from their workers' compensation premiums, the hospital purchased new lift equipment and patient transfer devices. "We interviewed all the managers and their charge nurses and asked them to tell us what type of equipment they thought they would utilize," she says.

Nurses had an opportunity to provide feedback on equipment during a safety fair. The hospital also hired a full-time ergonomics specialist, who reviewed jobs and job tasks to determine the physical demand.

"We made a decision tree to help people determine which equipment should be used [in different circumstances]," she says. "We also made a map of where all the equipment is kept in the hospital." For example, the hospital has bariatric lifts, but they aren't available in every unit.

The hospital has implemented other measures, such as functional ability assessments at preplacement exams and an office prototype with sample devices that enable computer-based employees to select the best chair and keyboard.

Feedback is an important component. In the monthly employee newsletter, Wolterman provides information about the type and number of injuries that have occurred. FitzPatrick also speaks about the hospital's safety record during employee forums.

Meanwhile, a "Simon Says" marketing campaign, using either a cartoon "Simon" or photos of a boy with his teddy bear, reminds employees that they need to use the safety devices.

"We're constantly putting safety issues in front of people," says Wolterman. "We're trying to maintain a focus on that."

Engaged employees are safer

Beyond safety initiatives, Mercy Medical Center has invested in wellness programs as a way to create more "engaged" employees. Engagement is "not just being satisfied with your job; it's being 100% committed to your job," says **Kelly Putnam**, MA, health promotion coordinator.

One nursing unit designated a room as a quiet, soothing space for stressed-out nurses. They decorated it with "healing" colors and comfortable furniture, and provided aromatherapy and soft music.

The billing department, with more than 120 employees at risk of repetitive injuries from their data entry jobs, takes a break twice a day and joins in group stretching. "They're anecdotally reporting that they have less numbness, less pain, and they love doing it," says Putnam.

The hospital measures the level of engagement among employees with a survey by Princeton, NJ-based Gallup Consulting. It asks about issues such as their relationship with their supervisor and whether they feel they have the tools they need to do their job. If employees are considering a job change, they are encouraged to look for another position within the hospital, says Putnam. "At the root of the compliance issue is engagement," she says. "If you've got an engaged work force, they're going to be compliant [with safety]." ■

Hospital seeks to boost staff's safety awareness

Needlesticks level off despite new devices

When needlesticks began to level off at BJC Healthcare in St. Louis, it was time to jumpstart the sharps safety program. Injuries occurred despite the health system's use of safety devices.

The solution: An educational PowerPoint program that could be accessed on-line or presented at teaching sessions.

"We want to keep working toward reducing needlestick injuries," says **Nancy Gemeinhart**, RN, BSN, CIC, manager of occupational infection control. "We wanted to make sure that our staff continued to receive proper education in how to use the devices."

Sharps awareness reminds employees of the importance of the safety features. Posters accompany the program to illustrate how to activate the devices — and what *not* to do. "Gemmy," a gem-shaped mascot that represents the many dimensions of occupational health, holds a target and urges employees, "Don't become a target."

Employees also take a post-test to demonstrate that they have mastered the material. Meanwhile, BJC continues to search for better devices that will be easier to use and more readily accepted by employees.

"It's a constant learning process," says **Carol Gavwiner**, RN, supervisor of occupational health and workers compensation at St. Louis Children's Hospital, a BJC hospital. "As the new devices come on board, whether it's something totally different or a newer, better version, we realize this is going to be a constant process." ■

Mad as hell and aren't going to take it anymore

Consumer advocate cites growing patient backlash

Fueled by anger and frustration often linked to the death or injury of a loved one, a grassroots consumer movement is arising nationally to demand more openness and accountability about hospital-acquired infections.

"There is a group of people all over this country

that are really motivated to work on change," said **Lisa McGiffert**, director of the Consumers Union's campaign "Stop Hospital Infections."

"They don't want to be pacified. They want to bring about real change in hospitals. They are very frustrated and some of them are really angry."

Known for its national publication, *Consumer Reports,* the union's campaign has included collecting stories from patients who were infected while receiving medical care. The group has collected some 1,200 patient stories and recently surveyed about 1,000 patients on hospital infection issues. The stories describe infections leading to repeated surgeries, rehospitalizations, job loss, and death.

"There is this sort of open-ended [feeling] that we don't know when they are ever going to get rid of this infection," McGiffert said in Tampa at the annual conference of the Association for Professionals in Infection Control and Epidemiology. "Everybody who talks to us says, 'I don't want this to happen to anyone else.' That is the single factor that gets people engaged in public policy. A lot of these people get very motivated. They want to do something in honor of a family member who died."

There is a prevailing sense that hospitals are not sensitive and responsive to the patient's plight. "Often people tell us that they tried to call attention to their problem," she said. "They felt like they knew what was going on with their body and nobody was listening to them. ...You cannot stop a problem if you are not acknowledging that it exists to the people who are experiencing it. The most common thing here is not [just] recognizing the signs of infection and problems that might come about; but also when nobody pays attention to your pleas, there is a feeling of callousness."

More hospitals have become more proactive on hand hygiene issues, but patients report a lack of information on their infection or confusion about whether they or a loved one even have an infection.

"In our survey, 85% of them said they were not provided full information about the source of the problem," she said. "That is a staggering percentage when you think about. It is common for families to say, 'I watched my mother, my child die a horrible, painful death, and no one would admit to me what was going on.'"

The consumer campaign is drawing national attention to the problem, letting the patients' voices be heard and urging consumers to take someone with them as an "advocate" when they are hospitalized. Though she did not cite specific incidents and provide documentation, McGiffert referred to accounts of blatant misrepresentation by hospitals discharging patients with methicillin-resistant *Staphylococcus aureus* (MRSA).

"One of the things that is most disturbing about this is that people are sent home from the hospital — the hospital knows that they have MRSA — but they are not told that's what they have," she said. "They take that home and infect their families. That is outrageous. They have no idea that they have something that is going to be passed on to their family. They might know that they have an infection but they haven't actually been told what it was and what they need to do to prevent the spread of it. So this is a really important public education issue."

While infection control professionals are dedicated to patient safety and infection prevention, they have sometimes been at odds with the union's aggressive campaign and consumer activism. While citing them as key allies, McGiffert also took them to task.

"I really don't know how engaged you are in patient education," McGiffert told APIC attendees. "We couldn't remember a story where somebody said that the infection control professional at the hospital came and talked to me about this. I think you need to be more visible. That might be kind of scary if you're an ICP with too much on your plate, but there has got to be some way for people to know that you exist, and I am not sure that they do. Of course, that is going to require acknowledgement about what is going on with the patient — bringing them up to speed and answering some hard questions. I'm not sure that hospitals are there."

There is common ground. For example, the consumer campaign is pushing for "zero tolerance" of infections, a mindset that already has

COMING IN FUTURE MONTHS

- Role of education family-centered care
- Effective pain control education .
- Strategies for improving pre-surgery teaching
- Education committees; not for review only
- Using consumers for material evaluation

been endorsed and emphasized as a major APIC goal. "I am an advocate for zero tolerance," said McGiffert. "The mindset that these infections are inevitable — can't be stopped — is one of the fundamental problems for preventing these. You have to have a mindset that this can be stopped. There is so much that can be done to reduce infections, focusing on what can't be stopped is focusing on the wrong end of it."

The consumer campaign is certainly putting a spotlight on ICPs, but in doing so gives them a unique opportunity to prove their mettle. "You are the change agents," she said. "You are the people who bring about change within hospitals. It makes a difference what you do." ■

Program improves Latino population compliance

Insurer collaborates with free clinic to improve care

As part of its commitment to eliminating racial and ethnic disparities in health care, CareFirst BlueCross Blue Shield has launched a diabetes disease management program in collaboration with a Washington, DC, clinic that serves a mostly Latino population.

"The Latino population tends to do less well clinically and tend to adhere less closely to treatment guidelines for diabetes. Even in a majority white population, people with diabetes are far from being compliant. With minorities, we are lucky if we get 30% compliance with evidence-based guidelines," says **Jon Shematek**, MD, vice president, quality and medical policy of the Owings Mill, MD-based health plan, which covers members in Maryland; Washington, DC; Northern Virginia; and Delaware.

The health plan is collaborating with La Clinica del Pueblo on a pilot project to find out effective ways of improving diabetes care in a Latino population.

"The clinic has a large Latino clientele, with 90% to 95% of the patients preferring Spanish as their first language. Many of them have no insurance or are covered by public funding," he says.

The program is targeted to the community as a whole, not just patients that CareFirst BlueCross Blue Shield insures.

"This program is part of our commitment to improve community health. Most of the participants in this program are uninsured. Our intention is to prove that this model will work and build on it," Shematek says.

The health plan has received national recognition for a program that is ahead of the curve in terms of disease management for minorities, he says.

"If health plans are looking at changes in the demographics of the community they serve, this kind of program is good business," he says.

A large number of patients at La Clinica del Pueblo have diabetes and are not doing well when it comes to keeping their disease under control and staying out of the emergency department, he adds.

When the staff at La Clinica del Pueblo entered the information on the 150 patients in the pilot program from paper-based records into the database, they discovered that almost 30% had a hemoglobin A_{1C} level greater than 8 and that 13% had a level that was greater than 10, a clear indication that diabetes is out of control. In the previous year, only 30% had an eye exam and 10% did not have a blood test.

In the first nine months of the program, before all of the components were in place, the number of

CNE 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 credit letter. When your evaluation is received, a credit letter 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** patient education programs based on existing programs from other facilities. ■

patients who had not had a hemoglobin A_{1C} test was cut in half and those with a good hemoglobin A_{1C} level had risen from 52% to well over 60%, Shematek says.

"We worked closely with the medical director and clinical staff to develop ways to improve compliance in the clinic's population," he says.

The project has a three-pronged approach that includes technology, culturally competent care, and community-based peer educators.

"Taking care of people with diabetes is complicated, and physicians have to remember an extensive list of things that need to be checked, including blood tests, eye exams, foot care. There's a huge laundry list, and it can't be done efficiently with a paper-based system. The team approach to caring for a patient with diabetes begins with the implementation of technology," he says.

The health plan funded a computer system that the clinic can use to implement the chronic care model for helping patients manage their diabetes.

"The model uses the team approach so that the moment a patient checks into the clinic, the staff is able to engage the patient immediately and start talking about what tests are needed and provide education. This allows the doctors to focus on specific aspects of care," he adds.

The health plan also is providing funding for the three-year pilot project that includes funds for a bilingual, bicultural health educator to work with the diabetic population.

"A key to compliance is having someone who not only speaks the language but who is culturally competent as well. It's not enough to translate the treatment plan into Spanish. There has to be someone who understand the culture and who can provide culturally competent counseling with individual patients," he says.

In addition to working with diabetics one-on-one, the health educator is using group counseling, a highly effective and efficient way for people to learn from each other, he adds.

The health educator has developed a curriculum for the third phase of the program — the use of lay health workers, called promotores, or health promoters, who will work with the most challenging patients in their home.

"This model has been very successful in other countries, and we think it will work well here. The promotores will visit the homes once a month and work with people who are having problems with compliance. This is a wonderful way to break down the barriers of mistrust that occur by having a peer reinforce the message of the clinic," he says.

The clinic recruited the promotores from among its patient population, looking for people who are well respected in the community. Many have some kind of background in health care in their native country but are not necessarily qualified as a health care professional in America.

The promotores were recruited and trained over the summer and made their first home visits in September, reporting their findings to the clinical staff, who will use the information to know where to focus on the patient's next visit.

"It's a comprehensive and focused program to meet the needs of the patient," he says.

The overall aim of the program is to increase the level of trust among clinicians and the immigrant population, ultimately resulting in changed behavior, Shematek points out.

"Disease management is about changing behavior. It is most effective when the education is done by someone who speaks the language, understands the culture, and generates a level of trust," he says.

For instance, since controlling diabetes largely

CNE Questions

17. For effective communication between staff, the documentation of patient education should include which of the following?
A. results of learning needs assessment;
B. copies of all handouts placed in record;
C. explicit details of everything discussed with patient;
D. patient's phone number for future contact.

18. Education on the repair of cleft lip and palate usually begins before birth and ends around 1 year of age.
A. True
B. False

19. According to a study involving 2,000 nurses at 13 health care facilities, what workplace organizational factors are linked to bloodborne pathogen exposures and musculoskeletal disorders?
A. staffing level;
B. size of the employee health department;
C. proportion of contract workers;
D. nurse-physician communication and nursing management.

20. CareFirst BlueCross Blue Shield's diabetes disease management program includes lay health workers called promotores.
A. True
B. False

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

depends on nutrition, diet, and exercise, the CareFirst program has the advantage of having someone doing the educating who is familiar with the types of food the Latino population enjoys. She can come up with recipes that the patients are likely to use, rather than steering them toward unfamiliar foods, he adds.

"There are a lot of issues around health beliefs that are culturally unique. For a disease management plan to be effective, it must be coordinated by someone who understand how health care is sought, to what extent it is sought, and how members of that particular population communicate with the physicians and nurses," he says.

Someone who is a peer and understands the culture can gain the patient's trust and find out why he or she may not be following the guidelines, he points out. ■

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PS Form **3526**, September 1998 *See instructions on Reverse)*

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d. Free Distribution by Mail *(Samples, Complimentary and Other Free)*	(1)	Outside-County as Stated on Form 3541	6	8
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	(3)	Other Classes Mailed Through the USPS	0	0
e. Free Distribution Outside the Mail *(Carriers or Other Means)*			25	25
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2006 SALARY SURVEY RESULTS

Patient Education Management™

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

Role of patient education manager continues to expand

Salaries can grow along with the importance of the position

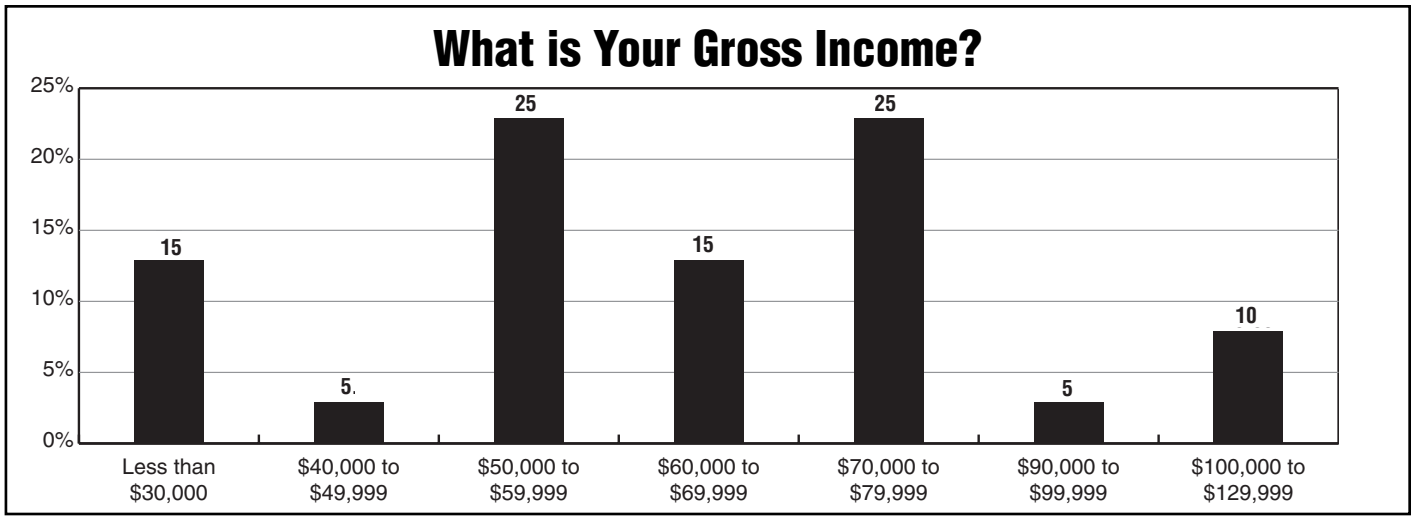
The demands of the job for a patient education manager or coordinator seem to be increasing.

The skills of the patient education manager are being drawn on more by others across a health care organization, says **Annette Mercurio**, MPH, CHES, manager of patient, family, and community education at City of Hope National Medical Center in Duarte, CA.

"We are being asked to lead multiple organization-wide initiatives, as well as address patient education responsibilities," she explains.

Diane C. Moyer, MS, RN, program manager for consumer health education at The Ohio State University Medical Center in Columbus, agrees. She juggles multiple projects with various departments, in addition to the routine tasks she is responsible for, such as updating materials in the patient education inventory.

New challenges occur when an organization grows, as many health care institutions are doing today, says **Kathy Ordelt**, RN-CPN, CRRN, patient and family education coordinator at Children's Healthcare of Atlanta. More staff members means



more people to train in the nuances of patient education and more resources are needed.

The ongoing changes in technology require diligence to stay abreast. This is important because technology is becoming more and more linked to resources, says Ordelt. For example, most institutions keep their inventory of teaching sheets on their Intranet. In addition, the web, video on demand, and computer-based education programs are becoming more common resources for educating patients.

With advances in medicine, more lives are being saved, but this can increase the demands for educational resources and strategies for teaching as more and more patients have chronic complex conditions, says Ordelt. As a result, there is more education to complete in the short time frame of a hospital stay and outpatient rehab visits covered by insurance.

Are the increasing demands of the job driving salary ranges higher? According to the 2006 salary survey conducted by *Patient Education Management*, there is no "average" annual gross income for people in the position, although many were in a salary range of $50,000 to $80,000.

"Salary seems most tied to the definition of the role. The job description defines the level of sophistication needed. Some patient educators are direct caregivers, others are managers and administrators. This also defines the education required for the position and contributes to the salary range the role fits into," says **Fran London**, MS, RN, health education specialist at The Emily Center, Phoenix (AZ) Children's Hospital.

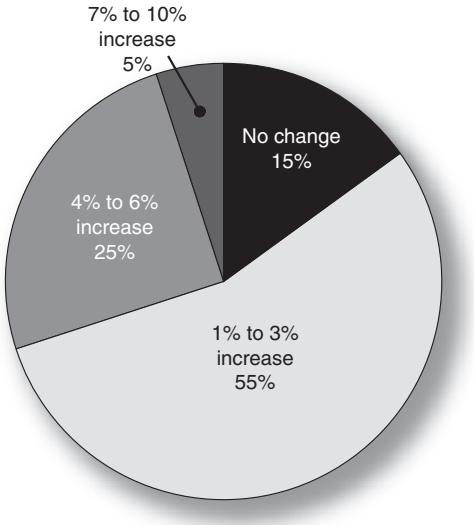
The amount of managerial responsibilities impact salary, says **Magdalyn Patyk**, MS, RN, BC, patient education program manager at Northwestern Memorial Hospital in Chicago. This does not necessarily mean the oversight of staff but the amount of work required in the position, she adds.

Yet, it is not job duties alone that drive salary. Geographic location has an impact as well. Salaries on the West Coast usually are higher than those in the Mid-Atlantic, but the cost of living is higher as well in the west, says Mercurio. The type of institution at which a person is employed would influence salary, with employees in a private hospital receiving higher pay than those in a state system, she adds.

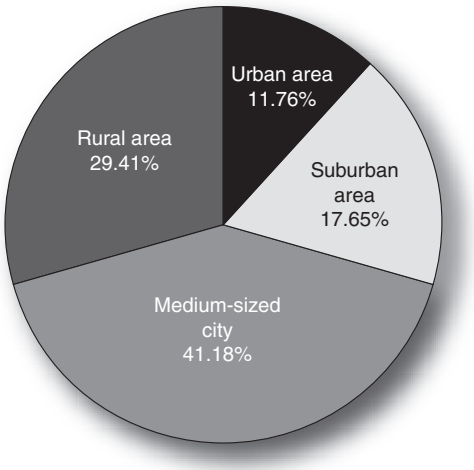
The majority of readers answering the salary survey worked at nonprofit hospitals vs. federal, state-, county-, or city-run facilities and for-profit hospitals.

As the importance of patient education grows, so

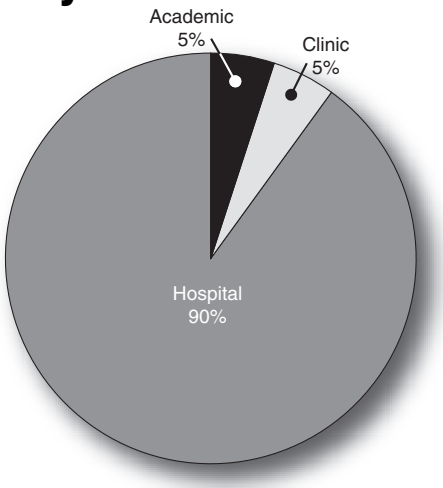
How has your salary changed in the past year?



Where is your facility located?



What is your work environment?



will the amount earned by those who work in the field, says Ordelt. The need for good resources and competent teaching becomes more apparent as health care professionals try to meet the needs of patients with complex chronic illnesses, she explains.

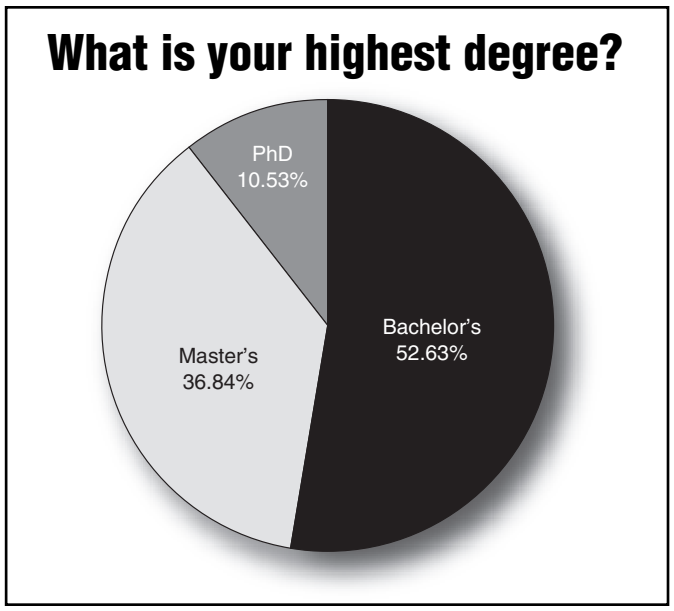
In addition, there is a growing need for foreign language resources as immigrant populations increase and for resources that are at a lower reading level to address health literacy issues, says Moyer.

Meeting the needs of a diverse patient population is key to achieving organizational goals, such as patient safety, better care outcomes, and increased patient satisfaction. In recent years more administrators are recognizing that patient education plays an important part, says Mercurio.

"I have an automatic Google search done weekly of patient education, and there seems to be more recognition of the connection between patient ed and health outcomes. Health literacy and medication compliance are coming up more often in these searches. Several research studies have come out recently showing individualized teaching improves health outcomes," says London.

Do increases in salary meet the increase of demands of the job and increased importance of patient education? According to the salary survey most who responded received a 1% to 3% increase in pay.

"The specific annual increase depends on a number of factors," says Mercurio. Generally, leadership establishes an average annual percent increase based on the organization's financial health. Ranges are established for increases according to whether or not an individual employee "meets expectations" or "exceeds expectations" and he or she is evaluated to determine which category is a good fit.

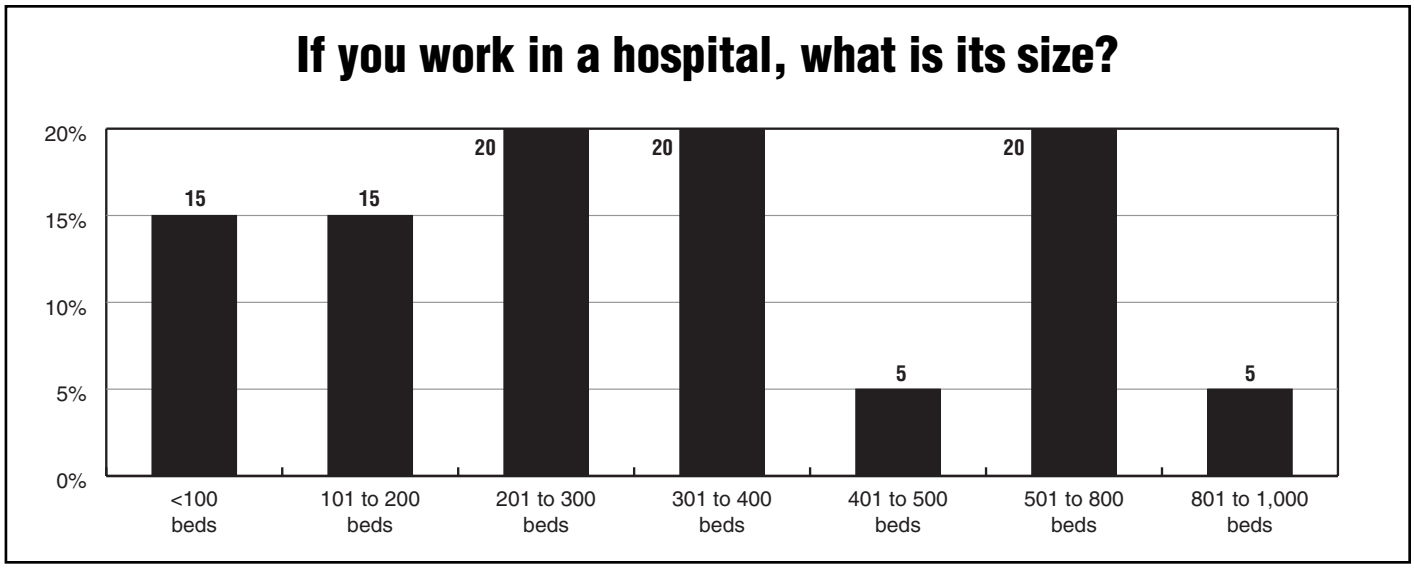


"For example, the organization may determine it can fund average increases of 3%. The range for 'meets expectations' may be set at 1%-3% increase and the range for 'exceeds expectations' at 2%-4%," explains Mercurio.

While salary is important and all want to be compensated well for the work they do, there are many factors that draw people to the field of patient education.

"The job has more rewards than stresses, and that is a big plus," says Moyer. Working with a wide range of clinicians in the health system and constantly learning about such things as new surgeries or treatments are plusses, as well as the opportunity to interact and network with a number of patient educators across the country.

For Ordelt, it is the marriage of nursing and teaching. As a child she had trouble deciding which field to choose, and her current job has allowed her to



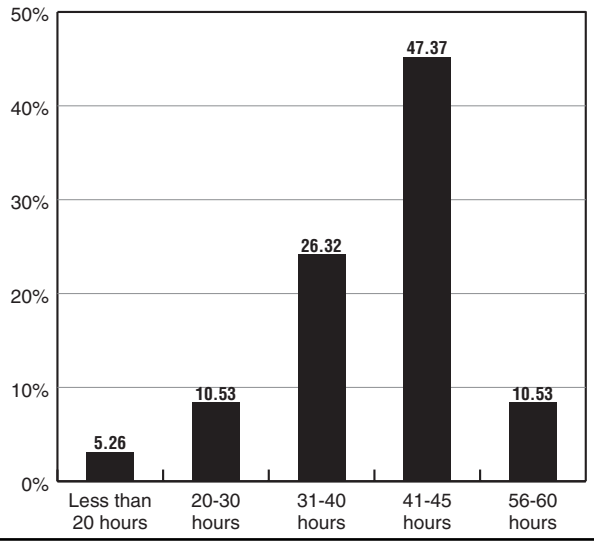
work both in teaching and education.

"When patient education is done well, we can positively impact patient outcomes, and there is nothing more rewarding than to do that," says Patyk.

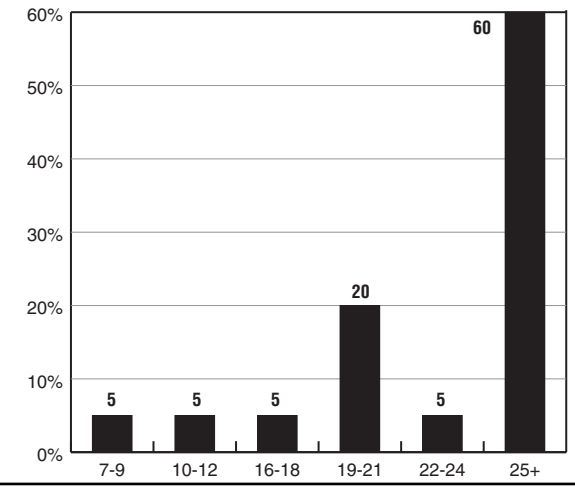
London agrees.

"After saving lives, patient education has the greatest potential for long-term impact on health outcomes. It is appealing to me because my work matters; it changes lives for the better. I can make a difference," she says. ■

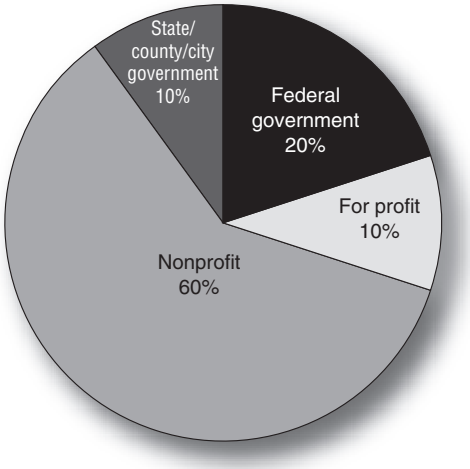
How many hours a week do you work?



How long have you worked in health care?



Which best describes the ownership or control of your employer?



SOURCES

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