

Patient Education Management™

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



Core concepts of family-centered care enhance patient education

Steps for good teaching take prominence with focus on patients and family

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List the components of patient- and family-centered care and many would think it was the formula for good education. The four core concepts include "dignity and respect," "information sharing," "participation," and "collaboration."

The family-centered care model takes the focus off the teacher, whether the nurse or another discipline, and places it on the learner. Patients and family members are seen as partners rather than as pupils, says **Kathy Ordelt**, RN-CPN, CRRN, patient and family education coordinator at Children's Healthcare of Atlanta. "It helps us to individualize the teaching a little better," she adds.

With the focus on the patient and/or caregiver, a good learning needs assessment to determine how they would like to be taught and what they would like to know becomes vital, says **Linda Broz**, RN, MS, patient/family education coordinator at Children's Hospitals and Clinics of Minnesota in Minneapolis. The information gathered from the learning needs assessment is used to individualize the education.

EXECUTIVE SUMMARY

Patient- and family-centered care is good for patient education; people learn best when health care professionals respect the needs and desires of patients and family members. Education is also enhanced when the plan is designed in a collaborative way, in a partnership between the professional and patient. In the third article in a three-part series on patient- and family-centered care, we focus on the impact this model has on education.

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Individualized education is important in all situations, says Broz. Frequently, education is delivered in the same way for everyone, especially during a short length of stay, but that is not ideal.

When patients say reading is not their preferred learning style, yet written materials are used anyway, the educator is being disrespectful, says Broz. There are many ways to make sure the education is delivered in a way that is dignified and respectful.

Visual learners can be taught in a variety of ways including videos or with the aid of models, pictures, or hands-on demonstration.

Providing interpreters for patients and families that do not prefer to learn in English as well as

giving out written materials in the appropriate translation shows respect, says Broz.

"It is a mind shift. You are looking at what they need and what is the best way to get that information to them," agrees Ordelt.

During a learning needs assessment, a family member or patient may say he or she learns best with a video but if there isn't a video on that topic then the health care professional must find the next best way to teach and present the information, she explains. If a less effective teaching method is used, the information may need to be repeated or other methods of teaching also incorporated into the process, she adds.

If patients and family members are not learning, one reason may be that the education has not been individualized enough so that learning can take place. Another reason might be that there are barriers prohibiting them from learning. When this is the case, the medical team needs to determine how to address them, says Ordelt. **(To find out how to do a family-centered care self assessment that includes patient and family education see note at end of article.)**

Patients and family members are part of the actual educational planning process in a family-centered care model. While there are certain skills that must be taught for a safe discharge, the determination of how and when the information is delivered should be collaborative. Also, patients and family members should be able to request additional information that would be added to the teaching plan. Of course, if their questions require in depth research, they might be referred to the learning center or advised to ask their physician.

Ordelt explains that a nurse may only have the time he or she is on shift to educate a caregiver or patient about a topic; Ordelt tells the family about the time constraints so they can work out the details. While scheduling the teaching session, she also can find out if family members would like any additional information.

"Sometimes in an emergent situation you have to teach immediately, but it is the attitude and the way the information is delivered and the way it is negotiated based on the mutual respect and trust you develop in those relationships; it is also seeing people as partners rather than us as the professional expert telling them what is and what is not going to be," says Ordelt.

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Editorial Questions

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Bringing patients in at the beginning

To deliver patient education in a respectful and collaborative way, patients and family members need to be a part of the organization-wide planning of educational materials, programs, and processes through committee work, as part of task forces, and other means, says Broz. **(Learn how one health care organization uses patient and family advisors to review written materials in article on p. 17.)**

When Children's Hospitals and Clinics of Minnesota decided mechanical lifts needed to be used with some children with weight problems, families were involved in determining how these new patient lift procedures would be introduced to families. "They also helped write an education piece that would be given to families," says Broz.

Sometimes staff members think including patients and families in the planning will slow the process. However, the result is a better product in the end and it better meets the needs of patients and families, she says.

Ordelt says patients and family members can also provide insight into topics for new teaching sheets. "A family member might say 'I would have liked to have had a resource on this topic in the beginning; a teaching sheet would be helpful,'" she explains.

Another key component of patient- and family-centered care — information sharing — is directly related to education. Many health care institutions have added resource centers, an invaluable resource Ordelt says, because family members can get information there they are not given at the bedside. **(For information on how to**

use patient and family advisors to design and run a resource center, see article at the bottom of this page.)

"At resource centers they can go on the web and also find different books on various topics. It is supplying a resource that will meet the needs of people who choose to use it to enhance their learning," says Ordelt.

However information sharing is more than providing good educational resources. It also involves good communication between patients, family members and the health care providers. Often family members will wait and wait to get information from the physician and as soon as they leave the patient's room the physician comes, says Broz. Methods to remedy this problem might be to give family members a pager so the physician can notify them when he is available to see the patient, she adds.

Also it is important that the medical team communicate clearly by defining the medical terms they use and also pausing during the discussion often enough so family members or patients can ask questions.

"In patient satisfaction surveys a lot of the pieces that have to do with satisfaction relate to information sharing and that is a piece of education," says Broz.

[Editor's note: Kathy Ordelt recommends an 18-page "Family Centered Care Self Assessment Inventory," found in the back of a book produced by the Society of Pediatric Nurses and the American Nurses Association (ANA) titled Family-Centered Care: Putting it Into Action. It is published by the ANA.] ■

SOURCES

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Best resource centers shaped by user advice

Include patients, families in design and operation

To make the health information resource center at the University of Washington Medical Center in Seattle an inviting place, it was designed with input from people who had been patients, as well as their family members.

Ten patient and family advisors joined 10 staff members to form an oversight committee.

The resource center is only about 350 square feet, so much of the information is computer based. There are four computers with book-

marked web sites broken down by subject area so people can easily navigate their way through the information.

“My committee played an important part in picking which web sites we wanted to feature,” says **Andrea Dotson**, a health educator with patient and family education services at the medical center.

It was the advice of patient and family advisors that resulted in breaking down the health information by subject matter as well. In addition, committee members provided greater insight into certain health topics or issues. For example, one of the committee members ran a support group for people with diabetes and knew a lot about the resources available and which would be most valuable to those with diabetes.

“It is great to hear from the experts. Those who are dealing with diabetes on a day-to-day basis know what other people who have the disease are looking for. That helps me figure out what information we should have,” says Dotson.

Advisors in wheelchairs helped to make the space handicap friendly. For example, one computer station has adaptable equipment that includes such things as an adjustable table that moves up and down.

Family members knew it was important to have information on how to be a caregiver available, so a brochure — titled *50 Things Every Caregiver Should Know* — is stocked.

While all ideas are heard, there were certain system-wide policies and procedures that had to be adhered to, says Dotson. For example, resources from pharmaceutical companies cannot be used; when evaluating credible web sites, committee members did not look at those established by drug companies to promote product.

In the beginning, the purpose of the advisory committee was to get the resource center up and running. Now the committee looks for ways to expand services and promote the center in all departments. Because there is no longer such a time crunch on projects, meetings are scheduled every other month rather than monthly.

“A lot of my volunteers are willing to spend time at home doing research on individual projects reporting at the next meeting,” says Dotson.

To help facilitate work during the hour-and-a-

SOURCES

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half meetings, Dotson has divided the 20 members into three subcommittees, each with an equal number of staff and volunteers. They include evaluations and outcomes, materials and selections, and operations and staffing.

“We try to stick as close to the agenda as possible during meetings. Some of the time is spent in subcommittee groups discussing individual projects, and each group reports to the team at the end of the meeting. In that way it is easier to get work done,” explains Dotson.

Members of the committee are mailed an agenda one week before the scheduled meeting and also are called to see whether or not they can attend. Those who attend the meeting are given a \$15 stipend to help with childcare and/or transportation expenses.

Patients and family advisors at the University of Washington Medical Center are asked to make a commitment of at least one year. Volunteers for various committees and projects are identified in two ways. A brochure about volunteering as a patient and family advisor is distributed throughout the medical center so people can offer to participate; also staff members make recommendations.

Once a person is identified, he or she is invited to attend an information forum to learn more about the various roles. Those who volunteer are given an orientation for the role selected and also attend a general volunteer orientation that covers such issues as patient confidentiality.

Having patient and family advisors involved in the decision-making process of the health information resource center is extremely beneficial, says Dotson. “We are here for patients and family members, so we want to hear what will make this place successful and user friendly and a place where people want to come to find credible health information,” she explains. ■

Advisor input makes for user-friendly forms

Feedback forms make review process simple

A method for reviewing written materials provides a way for staff at the University of Washington Medical Center in Seattle to get input from patients and family members to help ensure signs, forms, patient education handouts, and web site content are user friendly.

A group of about 15 people have volunteered to read and provide input on written materials and are given copy that requires a patient/family perspective, says **Laura Seuferling**, MPH, a health educator in patient and family education and coordinator of the review committee.

If people who become patient or family advisors at the medical center are interested in reviewing written materials, Seuferling contacts them to set up a face-to-face meeting as these volunteers work from home. In the meeting, she can evaluate such things as disabilities a volunteer might have that would impact the answers they provide in their review (i.e., a brain injury).

"That helps me to understand why they may have responded the way they did. If the information is provided in a way that is not helpful I will go back to them to find out what they mean. That gives me a little more of a friendly foundation having had direct contact," says Seuferling.

Copy for review is usually sent via e-mail and a hard copy is mailed. Volunteers have a week to complete the review and all know if they are too busy to participate at a given time that is OK. Seuferling says there is around a 50% return rate.

SOURCES

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All forms that will be included in the patient record must be submitted to the education department to be reviewed by the patient and family advisors. However, patient education material and other types of written copy don't have to be submitted for review.

General guidelines are that written material with broad distribution should be reviewed. Also recommended for review is technical clinical information, as well as material that has socially or ethnically sensitive content, says Seuferling.

Feedback made simple

Feedback forms have been created to make the review process simple. They provide a scale of one to three for grading. The criteria for grading forms that go in patient records includes the following: instructions for completing the form are clear; the form is clearly presented and well organized; the form is easy to read; medical terms are explained; and overall, what the reviewer thinks of the form. One question requires a written answer. It is: "What could be improved to make the form easier for patients and families to complete?"

The criteria for the review of patient education materials includes the following: the title describes the content of the handout; the introductory paragraph speaks to the content of the handout; the information is clearly presented and well organized; the material is easy to read; the diagrams, drawings, tables or checklists are easy to understand; medical terms are explained; and overall, what the reviewer thinks of the handout. Additional questions include: Would you recommend the material to your family and friends, if not, why not?; do you have any suggestions or comments?

Reviewers are not required to use the feedback forms, says Seuferling. Some leave e-mail or voicemail messages, while others write comments in the margin of the copy.

"Some like the form and only check the boxes offering very little feedback on open-ended questions, and others only write a narrative about what they think," says Seuferling.

To get more detailed information from specific patient populations, Seuferling on occasion has additional people review handouts. For example, to determine if a manual for patients having a laryngectomy was on track, former patients who had the procedure were asked to read the manual

and give feedback based upon their experience.

To find these additional reviewers, she will look at patient records to see who fits the diagnostic group or ask clinicians to handpick patients.

Once input from reviews is submitted, a health education editor takes the information and writes a summary report of the handout for the author. This would include such information as “three patients said you should have an illustration.”

In addition, Seuferling and her staff will edit the document applying the changes the advisors suggested. About 90% of the authors accept all the changes, says Seuferling.

“Most of the time they are very grateful for the edits and suggestions because they want their handouts and forms patient friendly and they are glad we do this,” says Seuferling. ■

PEM says standardized teaching materials best

Educating nurses on best way to teach cancer patients

As manager of cancer services at Riverside Methodist Hospital, an 800-bed institution in Columbus, OH, **Mary Szczepanik**, MS, BSN, RN, oversees cancer research, cancer registry, and cancer education support and outreach.

“About 10 years ago, I went from being a patient education manager for the entire hospital to working just in cancer. A new department was created called cancer education support and outreach and I managed that department. The research and registry department started reporting to me in October 2006,” says Szczepanik.

She now oversees about 20 employees. These include two research nurses who help select patients for one of about 140 trials available at the hospital and manage them.

“There is a huge patient education component to clinical research for cancer because those patients have to be extremely well informed and they have to understand even before they start the study what they are agreeing to, and then the education continues,” says Szczepanik.

This area also has a person who assists the nurses and a person who tracks the regulatory requirements for all the trials.

Certified registrars collect data on each cancer patient that comes into the system for treatment at Riverside Methodist Hospital. Each year about 2,500 people are diagnosed with cancer at the institution.

In education support and outreach, Szczepanik supervises a nurse educator who provides orientation and continuing education to oncology nursing staff and other clinicians. These job duties include a monthly continuing education program, ethics discussions, weekly multi-disciplinary rounds on the oncology unit, and teaching core curriculum to new oncology nurses during their eight-week orientation.

Also in education is a lung health nurse who educates all lung cancer patients throughout their treatment and connects them and their family members to community resources. Two community education representatives staff the cancer hotline. They provide cancer information, coordinate referrals to support services, and also take requests for community presentations.

Other staff members include a licensed massage therapist, social worker, and a master’s-prepared art therapist.

Hands-on work as well as oversight

The oversight of employees is just one aspect of Szczepanik’s job. “I write all the policies and procedures for cancer patient education and I write the patient education materials, which we review on a regular basis. I teach a class on educating patients primarily to nurses, both on the two oncology units and throughout the hospital because our patients are on so many units,” says Szczepanik.

As a manager on the cancer service line, Szczepanik reports to the director of operations for cancer services. She obtained her BSN from St. John College in Cleveland right after graduating from high school. She began her work as a nurse in pediatrics in 1971 and went to work for Riverside Methodist Hospital in 1979.

“I first worked in nursing education and then a patient education manager position was created and I took that,” says Szczepanik.

In a recent interview, Szczepanik, who also sits on the editorial board for *Patient Education Management*, discussed her job, her philosophy on patient education, the challenges she has met, and the skills she has developed that help her do her job well. Following are the answers to the

questions posed:

Q: What is your best success story?

A: It is the standardization of our teaching materials and the quality of our print materials followed by the education of the nursing staff on how to use them effectively and how to know when a patient is ready to learn.

Our standard is that for disease-specific information, we use the National Cancer Institute materials. If a person is diagnosed with lung cancer they get the NCI book on lung cancer. If they are to receive chemotherapy, they get the NCI booklet on chemotherapy and the Riverside drug sheet I write with the help of our clinical nurse specialist who works on the unit. Our sheets are all standardized and have the same type of information.

I wrote something called "Your Cancer Planner" that is a small three-ring binder divided into chapters and it is individualized by adding all the materials patients receive. The print shop puts holes in the NCI booklets so they fit, and the planner was designed to match the size of these booklets.

Q: What is your area of strength?

A: I am a good writer, a good problem solver, and I like developing new programs, taking new ideas and making them happen.

One program we developed ourselves is called "Kid Share." It is a monthly program where we meet with parents who have cancer to help them learn how to communicate and educate their children about their cancer. A few times a year we do a kid component of that which is an all-day retreat.

Q: What lesson did you learn the hard way?

A: As a nurse it was how to get organized, especially in terms of patient care and prioritizing what had to be done first.

The other lesson is that you can be a really

good educator or manager, and it doesn't always mean the people under you or the patients will learn what they need to learn or do what they need to do.

As far as patients, I may be a really excellent patient educator but if the patient is too sick to learn, isn't willing to learn, or is willing but doesn't have the resources they need, you can fail because the patient is really the one who has to follow through.

So whether you are an educator or manager you can only provide a person with the tools they need and somewhat influence their motivation and then it is up to them.

Q: What is your weakest link or greatest challenge?

A: Having the resources I need, whether they are human resources or financial funding for programs and projects; that is the hardest part.

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

A: Once we know for sure a person has a cancer diagnosis, I would like to get to them earlier with both our education and our support services, providing the opportunity for them to be on a trial and so forth. I think we would be more effective.

I would like to get to a point where the patient loses as little function during treatment as possible so their rehabilitation, their ability to get back to a normal role in their families, their work, their church and their community involvement isn't such a huge struggle. We have about 10 million cancer survivors walking around this country now that we didn't have 10 to 20 years ago.

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

A: We have a cancer-disease-site-specific certification from the Joint Commission as well as the general survey; so we have yearly assessments and accreditations for that. A multidisciplinary team selects measures to demonstrate we have a superior cancer program.

What we have decided to report relating specifically to my areas of responsibility are the cases presented at tumor conferences. For example, once a week a team of physicians and other clinicians get together to talk about our lung cases presenting the pathology and radiology reports or the diagnostic studies and come to an agreement on what the stage of the cancer is and what next step in treatment should be offered to the patient.

We report that as something we think we do a

SOURCES

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great job of and also our pain management initiatives. Also we always have quality improvement projects in progress. For example, with cancer patients who are neutropenic, we are trying to get them on an antibiotic within two hours of the time they come to the hospital with a fever whether they come through the emergency department or a physician's office. That is really tough, so that is a quality improvement project on which we are working.

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

A: The ideas usually come internally because we have a great group of people who are members of their professional organizations and keep very well connected both in the community and their professional groups. But if we want to benchmark or find out the standard of care, certainly we look to such organizations as the National Conference of Cancer Network, as well as state and federal legislation. We always look at the HIPPA perspective and the Oncology Nursing Society. ■

Award winner engages all sectors to improve quality

MAPS helps pass legislature on public reporting

Many health care quality proponents are under the impression that, while there is much they can do within the hospital setting to improve patient safety and quality, their impact is limited when it comes to much-needed changes in public policy. However, the Minnesota Alliance for Patient Safety (MAPS), one of the 2006 winners of the John M. Eisenberg Award for achievement in patient safety, has demonstrated the ability to engender important changes across a wide range of public and private sectors.

The other 2006 Eisenberg Award recipients, announced in October by the Washington DC-based National Quality Forum and the Oakbrook Terrace, IL-based Joint Commission on Accreditation of Healthcare Organizations, were: The IHI's Don Berwick, MD; Dr. Jerry H. Gurwitz, geriatric medicine and drug therapy expert (research category); the Pennsylvania

Patient Safety Authority (second winner in the category of innovation in patient safety and quality at a regional level) and the Wichita Citywide Heart Care Collaborative (innovation in patient safety and quality at a local level). The four-year-old awards program honors Dr. John M. Eisenberg, former administrator of the Agency for Healthcare Research and Quality in Washington, DC.

Changing safety culture

MAPS is a partnership of the Minnesota Hospital Association (MHA), Minnesota Medical Association, Minnesota Department of Health, and more than 50 other public and private health-care organizations.

"MAPS started as a way to change the culture of safety outside the clinical setting," explains **Bruce Rueben**, a founding member and MHA president. "Going all the way back to the 1999 IOM report, there have been calls for collaboration and a change to a systems approach. What we felt at the MHA was that change certainly needed to occur inside the clinical setting but that change would not be as helpful if all stakeholders — lawmakers, the general public, the business community, health plans — all still looked at improving safety as something you did in a punitive way."

In order to get everyone moving on the same priorities, he continues, "We had to engage all those stakeholders in an effort to improve safety and move to a just culture." Apparently they succeeded: The Eisenberg judges cited MAPS for its "unique collaborative approach to improving safety through multiorganization cooperation and coordination."

The three driving forces behind its formation, says Rueben, were the MHA, the Minnesota Medical Association, and the Minnesota Department of Health, which, along with a few others, formed the executive committee.

"We first convened the group in 2000, and initially started with some priorities that were pretty easy to get agreement around — like educating patients about how to participate in their own safe care," Rueben recalls.

But the really significant achievement, which "truly coalesced this thing and created a bond," says Rueben, was the need to streamline a law in the state called the Vulnerable Adults Act. "Under this act, providers were expected to report all types of adverse events," he explains.

Too open-ended

The problem with the law, Rueben continues, was that “it was open-ended, subjective, and very poorly thought out, because depending on where you were in Minnesota any one of a half dozen bureaucrats made the decision as to whether an event was reportable or not; there was no uniform standard applied.”

As the various MAPS stakeholder groups began to work together and developed a successful track record on things like patient education, they developed enough trust in each other to agree to use a national safety standard, says Rueben. “We agreed on the National Quality Forum’s 27 so-called ‘never’ events,” he relates. “At the same time, we developed technology that allowed hospitals to capture root cause analysis and corrective plans of action, and share them in a non-punitive way.”

After two legislative sessions, MAPS succeeded in creating an opportunity — by law — for hospitals to share best practices and create a public reporting approach, which would engender accountability. “The Adverse Health Care Event Reporting law has become a national model,” Rueben asserts.

Under this law, a report is issued by the Department of Health every January. “Any of these adverse events are listed by the facility, according to type of event; the accountability is very public,” says Reuben. “And the hospitals are able to go into this web-based patient safety registry where they can see the root cause analyses and corrective action plans.”

This reporting, he stresses, is not voluntary. “If a hospital has an adverse event occur, by law they must file a root cause analysis and corrective action plan. All other hospitals can have access to this and can put changes in place to prevent such events from occurring at their facility.”

System flaws uncovered

Since the enactment of the law, MAPS has focused on identifying best practices around areas the reports have shown to be challenges. “We’ve had two public reports, so we’re still trying to develop some experience and track record to show how helpful it is, but there is plenty of early anecdotal evidence that it’s very useful,” Rueben asserts.

One example, he shares, involved wrong-site surgery. “We had put into place protocols for correct-site surgery, but when we looked at the data in

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six different hospitals, each had had one adverse event involving wrong-site surgery on the vertebrae,” he relates. “If you did not look at these hospitals all together, and it happened just once in one hospital, you might consider human error. But since we saw six in one year, it was clear the protocol in place was not adequate with respect to the spine.”

The hospitals went back to their clinicians and put in an additional step — taking an image of the patient on the table — “and that seems to have substantially corrected the problem,” Rueben asserts.

This would not have been possible without the collaborative model engendered by MAPS, he continues. “Working through MAPS stakeholders and being able to develop common goals has been a very bold step,” he concludes. ■

ED, primary care clinic pilot program for uninsured

‘Working poor’ are focus of services

A pilot program under way in Tucson, AZ, aims to direct uninsured patients who show up for care in the hospital emergency department to a nearby primary and specialty care clinic where they can find an ongoing medical home, says **Nancy Johnson**, RN, PhD(c), executive director of St. Elizabeth of Hungary Clinic.

The clinic, which is celebrating its 45th anniversary, was recently recognized by the Arizona Department of Health Services as the “gold standard” for care of the uninsured in southern Arizona.

People who come to the St. Mary’s Hospital ED for conditions that are not emergencies because they have no regular provider and those who end up there because they are at the crisis point of an illness are the project’s target population, adds Johnson, who also operates a consult-

ing business called Quality Health Consultants with her physician husband.

"[ED staff] fax us every day a list of anybody who has come in for care that is uninsured, doesn't have a physician, and isn't an emergency," she says.

"That's usually 12 to 15 people in a 24-hour period."

A staff member at the clinic calls the patients, explains how their names were obtained, and says something like, "We'd like to invite you over to establish St. Elizabeth as your medical home, a place to get care when there is not an emergency."

Patients at the clinic, which serves individuals who are not eligible for federal or state-funded health care programs, are put on a sliding scale and pay whatever they can afford, Johnson notes. "As a result, hopefully, the ED is seeing fewer uninsured people who are not emergency [cases]. ED care is very expensive and we want to make sure we have that for people who really need it.

"It's that idea of 'right person, right place, right service,'" she says.

"We're tracking what percentage of those people we can register for care, and what percentage actually keep their appointments," Johnson adds.

Cooperation between clinic and hospital staff is an ongoing focus at St. Elizabeth of Hungary, she says. "When one of our patients needs to have surgery for cancer, we call ahead to let the hospital know the person doesn't have insurance so they can be prepared to help rather than have it be a traumatic experience."

Clinic personnel work with hospitals to set up packages and payment plans for uninsured patients, Johnson adds. "It's a collaborative effort. We don't want people in the position of not seeking care because of fear of the system, that the cost will wipe them out [financially]."

One example is an arrangement with Tucson's University Hospital on obstetrics care, she explains.

Pregnant women without health insurance who don't qualify for government assistance are set up with a "package," whereby they make payments throughout the pregnancy, Johnson says. By the time the child is born, she adds, the payments are completed.

"It's a discounted total, but the flip side is that otherwise these women would just show up at the ED in labor with no [prenatal] care," Johnson points out. "The message here is that our staff work collaboratively with hospital registration and business staff, rather than letting things fall where they may."

Johnson says experience has shown her that

most people — including many in the health care field — have a number of misconceptions regarding the uninsured population.

"People think [the uninsured] don't work, but in fact eight of 10 are working," she says. "These are the working poor. There are 46 million people in the country without health care coverage, and here in Arizona, there are usually at least a million people without it at any one time."

Another thing many people believe, Johnson notes, is that it doesn't really matter if one has health insurance because necessary care will be provided regardless.

In fact, the uninsured are much less likely to get care, even with serious symptoms, she says, citing a woman with breast cancer who knew she had a lump but delayed seeking care because she was concerned about her inability to pay.

Children without health care coverage, Johnson says, don't get care for things like asthma, ear infections and sore throats.

At a recent presentation on uninsured care she made to a group of case managers, she notes, many had some of the same misconceptions as the general public.

Exacerbating the situation, Johnson adds, is the fact that health care insurance premiums were expected to rise between 6.7% and 9.9% in 2006. The average increase in Arizona was 10%, she says.

The web site (www.covertheuninsuredweek.org) is an excellent resource for health care professionals, Johnson says. "If you go there, you can click on your state, and it tells you, in English and Spanish, what services are available for the uninsured, how to find health insurance, and how to get both public and private coverage.

"This is something we all need to be knowledgeable about," she adds, "if we want to keep our health care system as effective and efficient as possible."

(Editor's note: Nancy Johnson can be reached at njohnson@ccs-soaz.org.) ■

New NY regulations govern language assistance

Hospitals must designate coordinator

The state of New York has taken a step toward ensuring consistency in the provision of language assistance services to hospital patients

with limited English proficiency (LEP).

New state regulations that took effect recently require hospitals to designate a coordinator to oversee language assistance services and conduct annual needs assessments to identify English-speaking populations in their service areas. They also specify requirements for ongoing education and training concerning cultural and linguistic competence for employees with direct patient care contact.

The state health commissioner, meanwhile, has proposed patient interpreter services as part of the new regulations, including a requirement that hospitals statewide create and implement formal Language Assistance Programs (LAPs). The programs, according to the proposal, will assure appropriate communication with patients on treatment options, informed consent, discharge plans, and health care proxy decisions.

Under this expanded process, hospitals will discourage the use of family members, as well as individuals under age 16, as interpreters, except in emergency situations.

While many of New York's hospitals have implemented policies and protocols to provide communication assistance to patients, the new regulations will bring uniformity to the process in hospitals statewide, proponents say.

A proposal by state Health Commissioner **Antonia C. Novella**, MD, MPH, aimed at ensuring that the standard of care is being met and that patients' rights are being protected, would require the state's hospitals to do the following:

- Create LAPs and name a language assistance coordinator who would oversee communication assistance services in the hospital and report to hospital administration;
- Implement policies that will assure the patient's communication needs and language preference are identified, confirmed, and documented in the front page of his or her medical record during the initial hospital visit;
- Post signage in entrance ways and common areas of the hospital offering free interpreter services;

- Provide continuing education and training to staff on the importance of delivering culturally and linguistically competent services, as well as how to access interpreter services on behalf of patients; and

- Conduct annual assessments of the linguistic needs of the population in the communities the hospital serves and evaluate whether those needs are being met.

Title IV of the Civil Rights Act and state regulations require hospitals to provide interpretation services to patients with difficulty speaking English or who have disabilities affecting their communication. ■

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. ■

COMING IN FUTURE MONTHS

■ A look at family advisory councils

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■ Effective pain control education

■ Educating about herbal supplement/medication interaction

■ Strategies for improving pre-surgery teaching

CNE Questions

5. The family-centered care model can improve patient education because it does which of the following?
- A. focuses on the needs of the patient
 - B. seeks to individualize teaching
 - C. allows patients to dictate education plan
 - D. A & B
6. To get good feedback on written materials from patient and family advisors, the University of Washington Medical Center does which of the following?
- A. provides evaluation forms
 - B. allows people to respond in many formats
 - C. uses diagnosis-specific patients on occasion
 - D. all of the above
7. Under the Adverse Health Care Event Reporting, disclosure is voluntary.
- A. True
 - B. False
8. Under new New York state regulations, hospitals will discourage the use of family members as interpreters.
- A. True
 - B. False

Answers: 5. D; 6. D; 7. B; 8. A.

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