Patient Education Management™

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

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IN THIS ISSUE

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Promoting patient education vital to keeping it at the forefront of health care

Promotional methods must be uniquely tailored — not one size fits all

People in the field of patient education understand the concept of teaching and its impact on good health outcomes. Yet staff members and leadership do not always have the same point of view about the importance of education.

Therefore it is important for patient education managers and coordinators to get the word out.

Patient education must be promoted so clinicians will understand how to effectively teach patients and use the resources available to them to do a good job. Yet without support from leadership patient education initiatives often falter.

"Many of the initiatives that are patient education related need staff support to enact the principles, concepts, or ideas and administrative support is needed to remove barriers to organizational wide acceptance and to enforce it," says **Susan M. Kanack**, BSN, RN, the patient education coordinator for ProHealth Care, Center for Learning & Innovation, Patient & Family Resource Center at Oconomowoc Memorial Hospital in Waukesha, WI.

EXECUTIVE SUMMARY

To ensure that patients are taught in hospitals and clinics and the resources created to support the teaching are utilized, patient education must be promoted. When education is always at the forefront it is less likely to be forgotten and administrators are more likely to see its value. In addition a culture that supports education begins to develop at the institution.

In this issue of *Patient Education Management* managers discuss their best strategies for promoting patient education institution-wide.

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When staff and administrators buy into patient education it leads to a more cohesive approach that ultimately impacts the patient, she adds.

Patients have the right to receive information about how to take care of themselves once they are discharged, says **BJ Wingert**, RN, BSN, MS, a patient education specialist at OhioHealth in Columbus, OH. One of the biggest challenges is to get staff to use the resources available for patient education and to provide patients with information to reference at home.

"I think teaching takes place but because recall is difficult when people are sick they need something to take home to refer to at a later date," says Wingert.

Good patient education helps patients and family members feel more comfortable and less stressed, says **Carol Klingbeil**, RN, MS, CPNP, a clinical nurse specialist for education at Children's Hospital and Health Systems of Wisconsin in Milwaukee.

In addition, if patient education is not completed and documented misunderstandings can occur and patients might not comply with self-care instructions, medication regimens, or necessary lifestyle changes.

Documenting patient education as a part of the daily work routine helps to articulate how staff spend time, says Klingbeil. "People think you can do much more or take care of more patients when you are not really able to account for how much time you spend interacting and educating families," she states.

To help staff and leadership realize the importance of patient education and understand what constitutes best practice patient education managers need to determine what points they want to get across and the best methods for delivering the message.

Pinpoint a strategy

When many changes and improvements are necessary it is best to begin with something non-threatening, says Kanack. She chose health literacy and set about educating staff on the statistics of low health literacy and concepts of clear language. Soon they began to notice that many of the materials they used were at a 10th grade reading level.

"The organization began to ask for solutions and then I knew they were ready to hear what we needed to change," says Kanack.

She delivered the message on health literacy in a presentation format at leadership meetings and sometimes one-on-one. She offered to do in-services as well and used health literacy month to highlight the information.

Kanack says she also quickly learned that linking patient education to the organization's strategic goals helps it gain acceptance as well as importance.

For example, due to the fact that ProHealth Care is a multi-hospital, multi-clinic health care system, a strategic goal was to have what leadership called more "systemness."

"I explained that we wanted to function as a system and integrate our services so if we moved toward a system approach with patient education it would help meet our goal," says Kanack.

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Editorial Questions

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

Editor: **Susan Cort Johnson**, (530) 256-2749.
Senior Vice President/Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@ahcmedia.com).
Associate Publisher: **Coles McKagen**, (404) 262-5420, (coles.mckagen@ahcmedia.com).
Managing Editor: **Mark Granger,** (404) 262-5461, (mark.granger@ahcmedia.com).
Production Editor: **Ami Sutaria**.

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Taking part in committees within a health care organization gives patient education coordinators the opportunity to advocate for patient education, says Klingbeil. For example, when a new computerized system was being implemented Klingbeil asked how it would improve the distribution of teaching sheets.

According to Wingert promoting patient education initiatives to staff requires a different strategy then that used to reach leadership.

For nursing and other staff that teach the biggest challenge is to convince them that the initiative is worth their time, and saves time and money with fewer follow-up calls and readmissions.

With staff if some sort of prompter such as a flow sheet can be incorporated to make the process simple it is more readily embraced, says Wingert.

It is important to tell staff about patient education initiatives and resources once, then keep reminding them. Wingert finds newsletters helpful. "Often in our monthly newsletter we focus on something that might not be brand new but is a resource we want to keep on the forefront," she says.

Leadership has a different mindset and will be more supportive of patient education initiatives that are linked to patient satisfaction surveys, key admissions, standards set by accreditation agencies such as the Joint Commission on Accreditation of Healthcare Organizations, or key focus areas such as patient safety. Now that the Joint Commission has focused on low health literacy leadership is sending Wingert articles on the topic even though she has been talking about it for many years.

Penny Morgan Overgaard, RN, manager of the Trach & Airway Program at Phoenix (AZ) Children's Hospital agrees that strategies to promote patient education are not the same for leadership and staff.

For administrators to appreciate patient education initiatives link them to outcomes the healthcare organization is trying to achieve, advises Overgaard.

For example, patient satisfaction scores are important to administrators because it brings business to the health care facility. It's not just patients that need to be satisfied but insurance companies as well for they will want to place their patients at a hospital with good education for that equates to fewer readmissions.

"In this day and age when health care dollars are hard to come by it is not enough to say this is the right thing to do you have to be able to follow that dollar into outcomes," says Overgaard.

Currently the patient education committee at Phoenix Children's Hospital is focusing on educating patients, family members and staff on follow-up because the survey score in this area was declining. Patients need to know who to call if there is a problem and when to call. Also staff needs to make sure patients have this information upon discharge, says Overgaard.

"Frequently in patient education people think teaching someone how to do a skill is the education they will need to go home with but the truth is the most important thing you can teach might not be the skill but to problem solve," says Overgaard.

The secret to pulling staff into education is making them experts so they have absolute pride in what they do, adds Overgaard. They understand the importance and are able to teach and are so confident that if someone asked them a question they didn't know they could easily say they don't know but will find the answer.

"On our airways floor when people have specific areas they are interested in we try to encourage them to move ahead," says Overgaard.

For example, one nurse is working on a car seat project in regards to children with airway problems and ventilators and is sharing what she learns with her peers while at work. She has attended a couple workshops to help her in her pursuit of excellence.

Whatever method for promoting patient edu-

SOURCES

For more information about promoting patient education contact:

- **Susan M. Kanack,** BSN, RN**,** Patient Education Coordinator, ProHealth Care, Center for Learning & Innovation, Patient & Family Resource Center @ Oconomowoc Memorial Hospital. Phone: 262-928-2907. E-mail: susan.kanack@phci.org.
- **Carol Klingbeil**, RN, MS, CPNP, Clincial Nurse Specialist for Education, Children's Hospital and Health Systems of Wisconsin. Phone: 414-266-2210 E-mail: CKlingbeil@chworg.
- **Penny Morgan Overgaard**, RN, Phoenix Children's Hospital,Manager, Trach & Airway Program, 1919 East Thomas Road, Phoenix, AZ 85015. Phone: 602-546-0910. E-mail: povergaard@phoenixchildrens.com
- **BJ Wingert**, RN, BSN, MS, Patient Education Specialist, OhioHealth, Columbus, OH. Phone: 614-566-5613. E-mail: bwingert@ohiohealth.com.

cation is selected efforts need to be ongoing.

"Just as we constantly need to do campaigns about infection control and things like that we have to constantly keep patient education at the forefront and make sure people know it is just as important as medication safety or washing your hands. It needs to be continually highlighted," says Overgaard. ■

London expects education to be the center of care

Goal: To get staff to appreciate the longterm impact

As health education specialist at Phoenix (AZ) Children's Hospital, **Fran London**, MS, RN, develops teaching materials to give to the families of the children admitted to the 300-bed health care facility. Over a third of the beds, 130, are in the intensive care unit.

The content for the written handouts is provided by the clinicians who work directly with patients and families. London edits the copy, lays it out, finds illustrations and sends the final version through expert and family review.

Once completed she has the written material translated into Spanish and also makes it available to practitioners.

Patient education materials are distributed through a computer network that has a folder with all the teaching materials produced in-house. There is also a list of supportive materials, such as dolls and models that can be borrowed from The Emily Center, which is the consumer health library. All the handouts can be printed from the computer.

The larger booklets are preprinted ahead of time and can be ordered from The Emily Center.

London works in The Emily Center eight hours a week in the evenings and every other weekend because its hours of operation cannot be covered by one full-time employee. In addition to directing people to the material for which they are looking staff in the consumer library search the research and literature to fill specific requests for information. This service is available to everyone in the State of Arizona at no charge.

A few extra responsibilities London has taken on is to assist the people in staff education with lessons on how to teach patients and also instruction on how to find teaching materials. She also promotes patient and family education through committee work.

London works from The Emily Center, which is a donation funded consumer library. Phoenix Children's Hospital covers the rent, cost of utilities, and supplies computers. However, the director of the center must find grant money and other donations to cover salaries, books and other costs. London reports to the director of The Emily Center.

The first person to fill the job as health education specialist, London has worked in this position for 13-years. In the past she has worked a variety of nursing jobs. With a masters degree in psychiatric mental health nursing with a specialty in pediatrics she has worked as a staff nurse in pediatrics and psychology in both inpatient and outpatient areas.

Patient education a good fit

When her husband was transferred to Arizona she took a job as a school nurse before applying at The Emily Center for the job of health education specialist.

"In school nursing I did a lot of patient education and certainly as a staff nurse I did a lot of patient education. It has always been a passion of mine and actually when I was an undergraduate I got a little work study job where I was editing teaching materials for readability. So I guess I have always been working towards this job," says London.

In a recent interview, London, 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 helps her to do her job well. Following are the answers to the questions posed:

Question: What is your best success story?

Answer: "When I started there were not a whole lot of resources on how to do this job so I had to pull information together from whatever I could find in the literature. Out of that I determined there was a need for a book for people in jobs like me and that is why I wrote "No Time to Teach."

My best success story is that I took what I discovered, which was learning on the job, and turned it into something with which I could help people around the country know what to do."

Question: What is your area of strength?

Answer: "My strength is clarity. I can look at

and understand complex medical information and know how people who don't know the words and terms and don't have an anatomical background will be able to understand it. I recognize this as a strength because it took a while to recognize other people can't do this as well."

Question: What lesson did you learn the hard way?

Answer: "Don't let technology decide what you are going to do. We were given money to develop informational kiosks and after many years of struggling with them on many levels I came to the conclusion we were not looking at a problem, determining how to solve it, and finding kiosks were the answer. Instead we were handed kiosks and said 'what can we do with these?'

From now on we will always ask 'What is the point? What are we trying to accomplish and is this the best way to accomplish it?'"

Question: What is your weakest link or greatest challenge?

Answer: "To get staff to pay attention to patient education, to actually appreciate that the longterm impact is a challenge. I think we are looking at putting out fires and doing short term things that are necessary immediately and not looking at the big picture. Patient education is really a big picture solution. I think we will have to have some changes in mindset to recognize that ultimately the success of our entire health care system will depend on the quality of our patient and family education. I believe patient education is only going to get bigger and more important in the future."

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

Answer: "I can't see how patient education won't be the center of health care. It just seems to me given less funding, sicker people, and older people that we will need to focus more on patient education than ever before in order to sustain and maintain a healthy population.

Right now patient education seems in a lot of ways to be like the icing on the cake and I think it really should be the cake. People have to understand how to take care of themselves and patient education is the way to do that. I think it is the essence of health care."

Question: 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?

Answer: "With handouts I try to find out what needs to be taught and therefore go to the clinicians to ask what they are trying to communicate to patients and why they would need to provide a reference in writing for patients to take home.

Occasionally I get asked to look at forms that are being developed and again I try to find out what the users need. When you are creating anything new it is important to find out what the users plan to do with it and why it is needed." ■

SOURCE

For more information about topics discussed in this PEM profile, contact:

• **Fran London**, MS, RN, Health Education Specialist, The Emily Center, Phoenix Children's Hospital, 1919 East Thomas Road, Phoenix, AZ 85016-7710. Phone: (602) 546-1408. E-mail: flondon@phoenixchildrens.com.

Tips on redesigning the informed consent process

Joint Commission red flags issue for improvement

The public policy white paper on low health literacy released by The Joint Commission based in Oakbrook Terrace, IL, contains 35 specific recommendations on addressing this issue.

One recommendation is "The redesign of informed consent forms and the informed consent process."

In our article on The Joint Commission's call to action published in the April 2007 *Patient Education Management* we interviewed experts about ways to improve patient education materials so they could be read and understood more easily.

At that time many discussed ways to improve the informed consent process. Following are several suggestions they made:

Revise consent forms with patient/family advisor input for this is essential, says **Cezanne Garcia**, MPH, CHES, associate director for Patient & Family Centered Care and Education Services at the University of Washington Medical Center in Seattle.

"Our patient teaching sheets that accompany our consent forms reinforce the verbal conversation/teaching that takes place. These sheets are

based on preferred/ideal material development standards," says Garcia.

Good content and graphic standards include material that is written at a sixth to eighth grade reading level printed in a 12-point font. The text should be upper and lower case for information that is written in all capitalization is hard to read. Bulleted lists and headings make material easier to read and illustrations provide visual images of what is described in the text.

"It would be ideal if the informed consent was written by the patient in words he or she understands," says **Fran London**, MS, RN, a health education specialist at The Emily Center at Phoenix (AZ) Children's Hospital.

When patients are being asked to sign an agreement to an invasive procedure or treatment they should be asked to teach back what they are taught. When they are able to do this they are ready to make an informed decision. They understand what it is they are agreeing to, says London.

One of the biggest problems with informed consent forms is that staff in legal services is not willing to change the language so the forms are easy to read and understand, says **Sandra Cornett**, PhD, RN, director of the OSU/AHEC Health Literacy Program at The Ohio State University in Columbus.

"Of course the form is only one part of the informed consent process," she adds.

Clinicians must provide individualized explanations and clarification and make sure patients really understand what is taught and written by using the teach back method.

"Without that intense provider/patient communication effort consent is really not 'informed'," says Cornett.

She suggests institutions establish a multidisciplinary committee to set standards and guidelines or policies and procedures to ensure that the informed consent process is done in a way that helps patients clearly understand and that the forms are written in plain language.

The committee would monitor how the informed consent process is being implemented by conducting documentation audits, and surveying patients and staff.

The patient education coordinator should sit on this committee to provide expertise for writing in plain language.

This committee would also put in place staff education for all involved in the informed consent process. ■

SOURCES

For more information about creating an informed consent process that emphasizes clear communication, contact:

- **Sandra Cornett**, PhD, RN, Director, OSU/AHEC Health Literacy Program, Office of Health Sciences, The Ohio State University, 218 Meiling Hall, 370 West 9th Ave., Columbus, OH 43210-1238. Phone: (614) 292-0716. E-mail: cornett.3@osu.edu.
- **Cezanne Garcia**, MPH, CHES, Associate Director, Patient & Family Centered Care and Education Services, University of Washington Medical Center,1959 N.E. Pacific St., Box 356052, Seattle, WA 98195-6052. Phone: (206) 598-8424. E-mail: ccgarcia@u.washington.edu
- **Fran London**, MS, RN, Health Education Specialist, The Emily Center, Phoenix Children's Hospital, 1919 East Thomas Road, Phoenix, AZ 85016-7710. Phone: (602) 546-1408. E-mail: flondon@phoenixchildrens.com.

Loud and clear: Plain language protects patients

White paper on improving health literacy

As part of an increasing emphasis on patient empowerment and education, infection control professionals have seen arcane terms such as "nosocomial" de-emphasized in favor of clearer language.

That same trend is cutting across all fields of medicine, which has a long tradition of obscure nomenclature that seems increasingly out of touch with today's patient safety movement. In that regard, The Joint Commission warns that far too often, ordinary citizens are placed at risk for unsafe care because important health care information is communicated using medical jargon and unclear language that exceed their literacy skills, according to a call to action released by The Joint Commission in its newest public policy white paper, "*'What Did the Doctor Say?:' Improving Health Literacy to Protect Patient Safety.*" The paper frames the existing communications gap between patients and caregivers as a series of challenges involving literacy, language, and culture, and suggests multiple steps that need to be taken to narrow or even close this gap.

"Effective communication is a cornerstone of patient safety," says **Dennis S. O'Leary**, MD, president of The Joint Commission. "If patients lack basic understanding of their conditions and the whats and whys of the treatments prescribed, therapeutic goals can never be realized, and patients may instead be placed in harm's way." The detailed solutions developed by a special Joint Commission Expert Roundtable focus on making effective communications a priority in protecting the safety of patients; addressing patient communications needs across the spectrum of care; and pursuing public policy changes that promote better communications between health care practitioners and patients. Failure to provide patients with information about their care in ways that they can understand, The Joint Commission report warns, will continue to undermine other efforts to improve patient safety. "Breakdowns in communication between patients and caregivers can significantly impair the ability of physicians to diagnose and treat medical problems," says **Ronald M. Davis**, MD, chair of The Joint Commission expert roundtable on health literacy and director of the Center for Health Promotion and Disease Prevention at Henry Ford Health System, Detroit. "Everyone who has a role in health care — specifically including practitioners, employers, and regulators — must work together to pursue strategies for improving communications with patients that will result in safer, more effective care."

The Joint Commission already promotes the involvement of patients in their care through its ongoing Speak Up™ educational campaigns. In addition, expectations regarding patient engagement and involvement in care decisions are stipulated in Joint Commission accreditation standards and its National Patient Safety Goals. But health literacy problems, which often go unrecognized and unaddressed by health care practitioners, undermine the ability of health care organizations to comply with the intents of the accreditation standards and safety goals that seek to protect patients' safety.

"What is clear to you is clear to you," says **Toni Cordell**, expert panel member and nationally known speaker on the topic of health literacy, who struggles with dyslexia. "Every patient should be a full partner in his or her medical decisions. This requires crystal-clear communication that is done with compassion and mutual respect," she says.

The Joint Commission report on strategies for addressing health literacy and protecting patient safety contains 35 specific recommendations that cover a wide range of important improvement opportunities including, among others:

- The sensitization, education and training of clinicians and health care organization leaders and staff regarding health literacy issues and patient-centered communications.
- The development of patient-friendly navigational aids in health care facilities.
- The enhanced training and use of interpreters for patients.
- The redesign of informed consent forms and the informed consent process.
- The development of insurance enrollment forms and benefits explanations that are "client-centered."
- The use of established patient communication methods such as "teach-back."
- The expanded adaptation and use of adult learning centers to meet patient health literacy needs.
- The development of patient self-management skills.
- Health care organization assessment of the literacy levels and language needs of the communities they serve.
- The design of public health interventions that are audience-centered and can be communicated in the context of the lives of the target population.
- The integration of the patient communication priority into emerging physician pay-for-performance programs.
- The provision of medical liability insurance discounts for physicians who apply patient-centered communication techniques.

(Editor's note: A complete copy of The Joint Commission white paper, "'What Did the Doctor Say?:' Improving Health Literacy to Protect Patient Safety" is available at www.jointcommission.org.) ■

How accurate are patient satisfaction surveys?

'Continual monitoring' brings best results

When it comes to quality assurance in the customer service arena, those patient satisfaction surveys that have become ubiquitous in health care may not be providing accurate feedback, suggests **Michael Friedberg**, FACHE, CHAM, a manager with Besler Consulting in Princeton, NJ.

"My feeling is that patient satisfaction surveys

are potentially flawed," he says. "Many hospitals taint the process by preparing patients in advance of their receipt of the survey."

When he asked a recent gathering of health care professionals if they had a similarly negative opinion of such surveys, three-quarters of the hands went up, Friedberg adds. "I'm not convinced [patient satisfaction surveys] are an accurate representation of the service provided in patient access."

Among the more effective means of accessing managers and directors to measure customer service, he says, are to look at complaints to hospital administration and to create standard telephone scripts and then check to see if they are being used properly.

Since access is a 24/7 operation, that means calling late at night and early in the morning, Friedberg adds. "Many [access departments] have one or two access people on duty from 6 at night to 6 in the morning. If nobody is in charge, they can pretty much do what they want. You need to figure out a way to continually monitor them."

During his early years as a corporate director of access, Friedberg was also a new father. "When I gave the baby a bottle at 3 a.m., I also called all three hospitals. [Staff] used to hate that.

"Mystery shoppers also work very well for this," Friedberg adds. He recounts an example from his own experience in which a mystery shopper, pretending to be an existing patient, presented to his emergency department registration area.

"We expect our staff to re-interview [existing patients], especially in the emergency department," Friedberg says. "The mystery shopper reported that the registration representative did not speak to him during the process, except to ask his name, Social Security number, and date of birth."

The registrar then proceeded to hit the "enter" key all the way through the registration, asked the patient to sign in three places without any explanation, and then sent him on his way, he continues. "If a supervisor, manager, or director was in the area, [employees] would never show this behavior.

"Due to the 24/7 nature of patient access," Friedberg adds, "I would have to say that you must assume some of this is happening — especially on the third and first shifts, that is, 3 p.m. to 11 p.m. and 11 p.m. to 7 a.m. — but it is hard to prove." ■

Family-centered care enhances patient ed

Model takes the focus off the teacher

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.

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.

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.

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.

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.

"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.]* ■

Bariatric surgery patients need long-term support

Case managers follow them before and after surgery

Bariatric surgery works wonders, but it's not a miracle cure. That's why insurers and hospitals alike take pains to make sure their patients are prepared for the surgery and the lifestyle changes it requires.

"I make it clear to the surgical patients that they're not going to get out of diet and exercise. The surgery is a tool to allow diet and exercise to work for them," says **Pamela Davis**, RN, CCM, clinical coordinator for bariatric surgery at Baptist Metabolic Surgery Center of Baptist Hospital in Nashville, TN.

Davis, who underwent laparoscopic gastric bypass surgery in 2001, understands firsthand the challenges that her patients face.

Weight loss surgery can have a positive effect on the disease process, Davis points out. "We see patients who come in taking 60 to 100 units of insulin and they go home on a low amount or no insulin," she says.

Case managers working together on the payer and facility side help the patient ensure the long-term success of weight loss surgery, she says.

There are three types of metabolic surgery:

Laparoscopic adjustable band

This laparoscopic procedure is the least invasive form of surgery and involves placing a band around the upper part of the stomach. The patient receives an access port that is used to periodically inject saline into the inner portion of the band to restrict the amount of food the patient can take in. It typically takes three to four saline injections to achieve optimal results.

Gastric bypass

This surgical procedure, typically done laparoscopically, creates a small stomach pouch and bypasses part of the small intestine. This results in restriction and a mild degree of malabsorption of food.

Duodenal switch

This surgery, usually done by open incision, removes a portion of the stomach, leaving room for about eight ounces of food at a time and provides a higher degree of malabsorption of food.

"In the health care field, we tend to think that once we've fixed the problem, the patient doesn't need us. Patients with morbid obesity can flip into their old habits at any time. We need to support the patients for a lifetime to make sure they maintain the weight loss and prolong the health benefits," she says.

Davis works with bariatric surgery patients through the entire process, beginning with the new patient seminars the surgery center presents for patients considering weight loss surgery.

The session typically takes one to three hours and includes details from a surgeon on the various types of surgical procedures. Davis talks to participants about the steps they must go through, dietary and other lifestyle changes that will be necessary after surgery, and what is expected of them as patients to make the surgery successful.

For instance, patients who have weight loss surgery must give up carbonated beverages and must make changes in their eating behavior such as not drinking with meals and eating carbohydrates last.

Depending on the type of surgery they have, patients have to take vitamin and mineral supplements to compensate for what their body will no longer absorb.

Patients leave the seminar with packets of information about the criteria for eligibility and the process leading up to surgery, which can be lengthy depending on their insurance company's approval process.

At Baptist Metabolic Surgery, like other bariatric centers of excellence, patients are required to have a psychological evaluation before surgery.

"We need to make sure they are capable of understanding the lifestyle changes they must make and the long-term effects of surgery. If food is how they handle emotional issues, they may need help in developing other coping mechanisms," she says.

When the patient makes the decision to have surgery, Davis starts the educational process of case management and makes sure patients attend support groups and educational sessions before the surgery.

"It's important to take things slowly. It takes time for the patients to make the mental preparation and time for them to get used to the dietary changes," she says.

The insurance coordinator in the metabolic surgery program works with the insurance company to make sure the documentation is in place.

"Once we know the insurance company will cover the surgery, we help the patient collect the information to submit to the insurer," she says.

Typical requirements include a letter of referral

from the primary care physician, documentation of weight loss attempts in the past few years, and a five year history of morbid obesity.

Davis meets with the patients to educate them on the lifestyle changes required for an optimal outcome from surgery. She is available by telephone to answer their questions in between visits.

"We see our patients multiple times for the first two years after surgery and at least once a year after that," she says.

When patients move out of state, Davis continues to follow them by telephone. She gets the results of their annual check-up and discusses it with them.

"We help support the patients in maintaining their weight and other long-term outcomes. I work with them to make sure they're not struggling with weight gain," she says.

Davis encourages the patients to continue taking their vitamins and follow their treatment regimen to avoid side effects such as fatigue and itchy skin.

"Once they start feeling good, they may think they don't need their vitamins. These patients need long-term support," she says.

Case managers in the insurance field whose clients include bariatric surgery patients, should make their own resources book, Davis recommends. She suggests asking the centers of excellence within your state for educational materials to keep on file.

"If insurance case managers have all the educational materials from the hospital where the surgery was performed, they can better help patients follow the recommended treatment regimen," she says.

For instance, if a patient isn't taking iron, the case managers can point out where the requirement is listed in the educational material and find out if the patient isn't taking the iron because he or she can't afford it.

When members of BlueCross Blue Shield of Tennessee are referred for bariatric surgery, their care is coordinated by an insurance case manager certified in bariatric surgery, who reinforces the education the member is receiving from the surgical team, says **Jackie Flowers**, RN, CCM, manager in total health management.

The case managers spend a lot of time on the telephone with members before the surgery to make sure they understand the process and to help them prepare for the surgery and the lifestyle changes that must occur, she adds.

"We emphasize that bariatric surgery is not an easy fix. Members need a lot of education to make sure they are committed to being compliant with the diet and exercise program they must follow," Flowers says.

The health plan conducts extensive evaluations of the member to make sure that he or she is a good candidate for surgery, adds **Nancy**

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. ■

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Alsgard, RN, managing director of medical clinical strategy.

"Bariatric surgery is a major procedure and we take it very seriously. We are absolutely committed to assuring safety and success. We look at the members very critically to determine if they are prepared to make lifestyle changes in order to retain the long-term health benefit," Alsgard says.

The health plan's case managers follow the members by telephone for at least six months after surgery to make sure they understand their post-operative instructions and that they are complying with the exercise and dietary regimen. ■

CNE Questions

17. When promoting patient education initiatives system-wide efforts must be tailored differently when approaching staff versus leadership.

A. True

B. False

18. Which of the following help to get leadership and staff onboard with patient education initiatives?

A. Connect them to strategic goals.

B. Join committees to advocate for education.

C. Put information in newsletters.

D. All of the above.

19. According to **Sandra Cornett**, PhD, RN, without an intense provider/patient communication effort like the teach back method, consent is really not 'informed'.

A. True

B. False

20. When patients are able to teach back what they have been taught they are ready to make an informed decision.

A. True

B. False

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

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