Patient Education Management™

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

AHC Media LLC

IN THIS ISSUE

Financial Disclosure:
Editor Susan Cort Johnson, Associate Publisher Coles McKagen, and Managing Editor Mark Granger report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study. Consulting Editor Magdalyn Patyk reports a consultant relationship with Pritchett and Hull Association.

JULY 2007
VOL. 14, NO. 7 • (pages 73-84)

Qualified interpreters improve health literacy and patient safety

For proper use, establish policy and educate staff

To improve health literacy the use of trained interpreters must be common practice when health care practitioners are communicating with patients who are not proficient in English.

"The meaning behind health literacy is the ability for patients to adequately understand their health care and how to comply with treatment plans that are important for their well being. Having an interpreter communicating the self care plan, treatment plan, or simple instructions, such as 'take this pill two times a day,' is key to enhancing health literacy," says

EXECUTIVE SUMMARY

In the April issue of *Patient Education Management* we covered a new public policy white paper titled: "What Did the Doctor Say? Improving Health Literacy to Protect Patient Safety" that was issued by the Joint Commission. In that issue we focused on reading and understanding health information and promised to revisit other aspects suggested for improving health literacy that pertain to patient education.

One of those recommendations not covered in the April article was "The enhanced training and use of interpreters for patients." In another Joint Commission report titled "Hospitals, Language and Culture: A Snapshot of the Nation," recommendations for addressing language and cultural issues that increasingly pose challenges to hospitals seeking to deliver safe, effective care were discussed. There are two communication issues — one is language and the other is culture — that impact patient education. Therefore in the July 2007 issue of PEM we will target language issues and in the August 2007 issue we will cover cultural issues creating a two-part series.

Mursal Khaliif, RN, director of Community Health & Language Services at the University of Minnesota Medical Center, Fairview in Minneapolis.

Communication in general is an important element of patient safety, he adds. "When the patient doesn't understand the provider and vise versa patient safety is compromised at many levels," says Khaliif.

For example, getting an accurate medical history in order to determine a diagnosis is not possible when the patient does not speak the provider's language nor can patients be given clear instruction for disease management. When patients with diabetes do not understand how to administer insulin or monitor their blood glucose level they often end up in the emergency department, explains Khaliif.

If a qualified medical interpreter is not used when communicating with limited English proficient patients the result could be a misdiagnosis, says **Jose Sanchez**, coordinator of Interpreting and Translating Services at Children's Healthcare of Atlanta.

According to Sanchez there are a lot of risks involved when a person is not familiar with the medical terminology and steps into the role of interpreter.

Good interpretation and cultural competency has a positive impact on patient safety, says **Boris Kalanj**, MSW, LISW, director of Cross Cultural Care and Interpreter Services at Children's Hospitals and Clinics of Minnesota in Minneapolis.

"Most of patient safety hinges on the patient understanding what is going on at all levels and all points of care. If there is any misunderstanding there is more potential for unsafe care," he explains.

When Kalanj was hired six years ago interpreters were often seen by health care professionals as voice boxes, machines or tools.

"I wanted the organization to see interpreters as cultural resources, people who are steeped in two different cultures and can therefore build bridges," says Kalanj.

The department has mushroomed growing from a staff of four people to 24 full time employees as the number of interpreted interactions rise. In six years interpreted encounters have grown from 5,000 to 40,000 annually.

Children's Hospitals and Clinics are not alone in this growth. About 80 interpreter encounters are completed each day at Clarian Health in Indianapolis, IN, according to **Molly K. Smith**, manager of Language Services.

With the need for interpreter services increasing it is important for institutions to set in place policy and procedure for proper use, says Smith.

Policy will help to ensure the provision of equal access to health care for patients and their families who have limited English proficiency and the use of qualified interpreters rather than family and friends. Sanchez says, "It is important to have a policy because if you don't have structure or guidance there is no way for people to know what your department is committed to."

Securing an interpreter

At most health care institutions the patients pre-

Patient Education Management™ (ISSN 1087-0296) is published monthly by AHC Media LLC, 3525 Piedmont Road N.E., Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals postage paid at Atlanta, GA 30304. POSTMASTER: Send address changes to **Patient Education Management**™, P.O. Box 740059, Atlanta, GA 30374.

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291. Hours of operation: 8:30 a.m.-6:00 p.m. Monday-Thursday; 8:30 a.m.-4:30 p.m. Friday EST. E-mail: customerservice@ahcmedia.com. World Wide Web: www.ahcmedia.com.

Subscription rates: U.S.A., one year (12 issues), $489. Add $9.95 for shipping & handling. Outside U.S., add $30 per year, total prepaid in U.S. funds. Discounts are available for group subscriptions. For pricing information, call Tria Kreutzer at (404) 262-5482. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue date. **Back issues**, when available, are $82 each. (GST registration number R128870672.)

AHC Media LLC is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

This activity has been approved for 15 nursing contact hours using a 60-minute contact hour.

Provider approved by the California Board of Registered Nursing, Provider # 14749, for 15 Contact Hours.

This activity is intended for nurse managers, education directors, case managers, discharge planners, hospital clinicians, management, and other health care professionals involved in designing and/or using patient education/staff education programs. It is in effect for 24 months from the date of publication.

Opinions expressed are not necessarily those of this publication. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought for specific situations.

Editorial Questions

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

ferred language is identified upon registration whether for a clinic appointment, hospital procedure, or on an emergency or labor unit. In this way the need for an interpreter is identified in advance.

At the University of Minnesota Medical Center, Fairview patients are asked, "What language do you prefer to communicate your health care need?" If they mention a language other than English the follow-up question is, "Would you like to use an interpreter?"

In addition the policy states that a health care practitioner can ask for an interpreter even if the patient has not requested one. "Communication is a two way street. Providers and health care practitioners have a right to effective communication with their patients just as much as the patients have a right to that," says Khaliif.

There are some situations where the need for an interpreter is not accurately identified.

For example, one parent might speak English and the other struggle with the language, therefore an interpreter is not requested.

"We encourage the family to use an interpreter so better communication can take place even when one of the parents is bilingual. We want to make sure there is effective communication with all members of the family," says Sanchez.

Last minute requests are often an indication that a patient has not been flagged as needing an interpreter when he or she registers, says **Laura Rocha Nakazawa**, MA, program coordinator for Interpreter Services at Dana-Farber Cancer Institute in Boston, MA.

To remedy this problem the department creates two different listings each day. One is of all the patients who have requested an interpreter and the other is of the patients who have indicated their primary language is not English yet no request for an interpreter has been made. Often these patients have used interpreters in the past. A quick call to the clinic determines whether or not there is a need. Sometimes the patient is just coming in for blood work and doesn't need an interpreter.

In addition, when interpreters are working with a patient at a clinic and he or she makes another appointment they notify interpreter services so there is an early record of the need.

At Dana-Farber the list of scheduled interpreter encounters is completed on a weekly basis. "It is easier to schedule an interpreter beforehand and there is a greater chance we can provide one. We decided to do this to try to control last minute requests," says Nakazawa.

Making sure interpreters are used when needed and scheduled in advance whenever possible takes more than a written policy, it requires staff education.

At Children's Healthcare of Atlanta staff members can find information on interpretive services on their web site and there are instructions on how to access an interpreter posted on various units and in nursing stations.

To make sure interpreters are used for informed consent and written discharge instructions the forms have a place for the interpreter's signature.

During employee orientation at the University of Minnesota Medical Center, Fairview each new hire learns how to access and use interpreters. There is one number to call at any time day or night for an interpreter and their services can also be requested electronically when other services are ordered such as lab work.

"As part of orientation we also make sure folks understand the key situations or encounters where the use of an interpreter is required under our policy," says Khaliif.

These include the diagnosis process, discussion of treatment plans, communicating discharge planning, and providing social services or spiritual services.

In addition to knowing when to use an interpreter it is important for staff to know how, says Kalanj. During employee orientation at Children's Hospitals and Clinics of Minnesota a video is shown titled "Communicating Effectively Through an Interpreter: an Instructional Video for Health Care Providers" produced by the Cross Cultural Health Care Program in Seattle.

In the video there are three scenarios with one showing an interpretive encounter filled with problems, a second showing a good encounter, and the third showing how to correct the problems in the first encounter.

"The idea is that sometimes you will not get a qualified and super competent interpreter yet you as a provider have the responsibility of managing that person to work for you rather than against you or independently," explains Kalanj. **(To learn how to effectively use an interpreter during patient education encounters see article on pp. 77.)**

Last year the institution began a cultural competency training program for employed physicians and nurse practitioners that must be completed if they want their year-end bonus.

At Dana-Farber Cancer Institute the staff inter-

preters are considered part of the care team and not only interpret content but also clarify. For example, when they notice concepts are confusing for a patient they ask the provider to rephrase the information so it is more easily understood.

Also they may explain the peculiarities of a culture in relation to the health system, beliefs, and customs to assist providers in their decisions, says Nakasawa.

"The interpreter can play a role to facilitate the communication to achieve the maximum impact needed for that encounter," she explains.

Creating opportunity for best practice

While each institution sets standards for hiring interpreters good training is not necessarily enough. Kalanj says someone may have a sophisticated command of medical terms in two languages and still not be an ideal interpreter unless they are able to adjust the complexity to the level of the patient.

"Interpreters who have the ability to communicate and read the patient and persist with both parties to get things clarified and taught back if needed to make sure understanding is obtained, those people are the most valuable," says Kalanj.

For staff interpreters people are given screening tests for English and the target language and their ability to interpret is assessed by role playing. However there are so many requests for interpreters at Children's Hospitals and Clinics of Minnesota about 30 to 40% of the encounters are met by outside agencies.

Children's Healthcare of Atlanta requires their interpreters to have a bachelors degree, one year experience interpreting in a medical setting, and training in medical interpreting. Once recommended for hire they must take an extensive test and score 85 percent or better in order to join the staff.

At Clarian Health the interpreters must enroll in a course titled "Bridging the Gap" and complete its requirements, which include a written final exam and clinical evaluations with interpreting sessions.

Dana-Farber Cancer Institute requires all interpreters to have completed a medical interpreter training program. They must have a certificate of completion for one of these courses and also pass a test given by the cancer institute in order to be hired.

Linguistic skills, interpreting skills and training are all screened through a testing process before an interpreter is hired at the University of Minnesota Medical Center, Fairview.

"What is involved in interpreting is the ability to listen to what is said in one language that can be as short as three words or as long as five sentences, understand it, gather the underlying meaning, and then find a way to communicate that meaning all in a matter of seconds," says Khaliif.

All professional interpreters must follow a code of ethics for health care interpreters, adds Khaliif. These provide guidelines in situations when a patient seeks their advice or shares information withheld from the other members of the health care team.

Many barriers to the use of professional interpreters still must be addressed even though institutions are hiring interpreters to have on staff, contracting with outside agencies in their area to fill in the gaps, and using telephone interpreting services for those spur of the moment encounters or when the language is not common in the region.

A common barrier to the use of professional interpreters is taking the time to make the request, states Smith. It is easier to use family and friends, she adds.

Or sometimes practitioners who can speak a little Spanish try to communicate with the patient not realizing their level of understanding is too low to ask all the questions properly, says Nakazawa.

The way to overcome barriers to the use of professional interpreters is by education, says Khaliif. "Educate health care practitioners about the importance of using good, trained professional interpreters," he says. For example, family members cannot always effectively communicate what is being said in a medical situation. In addition they are not objective and impartial and will not alert each party when a situation is not conducive to effective communication.

There are many occasions when the use of an interpreter is needed to ensure that limited English proficient patients have full access to care, says Nakazawa. For example, an interpreter is needed during meetings with a nutritionist for lessons on how to prepare food for a restrictive diet or when patients are being trained on the use of medical equipment before they go home, she explains.

Currently the organization is trying to incorporate the use of interpreters into support groups. It has support groups for various types of cancer in

which limited English speaking patients rarely participate even though they would benefit from them.

"We are trying to make people aware that they can participate. It is like any other type of encounter," says Nakazawa. ■

SOURCES

For more information on the use of interpreters to improve health literacy and patient safety, contact:

- **Boris Kalanj**, MSW, LISW, Director, Cross Cultural Care and Interpreter Services, Children's Hospitals and Clinics of Minnesota, 2525 Chicago Ave., S., Minneapolis, MN 55404. Phone: (612) 813-7989. E-mail: Boris.Kalanj@childrensmn.org.
- **Mursal Khaliif**, RN, Director, Community Health & Languages Services, University of Minnesota Medical Center, Fairview, Minneapolis, MN. Phone: (612) 273-5850. E-mail: mkhalii1@fairview.org.
- **Laura Rocha Nakazawa**, MA, Program Coordinator, Interpreter Services, Dana-Farber Cancer Institute, Boston, MA. Phone: (617) 632-6961.
- **Jose Sanchez**, Coordinator, Interpreting and Translating Services, Children's Healthcare of Atlanta. Phone: (404) 785-2189. E-mail: Jose.Sanchez@choa.org.
- **Molly K. Smith**, Manager, Language Services, Clarian Health, Indianapolis, IN. Phone: (317) 962-2725. E-mail: msmith19@clarian.org.

Techniques for educating with the aid of an interpreter

Interpreters can improve understanding

There are many basic practices that improve teaching encounters between health care practitioners and patients with limited English proficiency (LEP). These are applicable in all interactions within a medical center when the use of an interpreter is required.

In addition to the basics, patient education requires a little more preparation and work with the interpreter to make sure the session is effective, according to some experts.

What are some of the basics that must be mastered? Learning to speak directly to the patient rather than to the interpreter is one. According to **Molly K. Smith**, manager of Language Services at Clarian Health in Indianapolis, IN, people have a tendency to speak to the interpreter rather than the patient. They will say, "Ask the patient if he has pain" rather than "Do you have pain?"

"The goal of health care practitioners is to make the patient feel they are the focus of the communication and act as though the interpreter is not there," explains Smith.

The person teaching should be positioned so that he or she can see the patient. It is important to make eye contact so that non-verbal communication can be observed.

"If a provider is not looking at the patient he or she won't see the facial expressions that might indicate confusion," explains Smith.

Before the education session begins the health care practitioner should introduce the interpreter and make sure the patient is clear on the perspective roles of everyone in the room. It is important to remember that everything said in the room will be interpreted so nothing should be said that the patient shouldn't hear.

It is best for anyone using an interpreter to pause after finishing a complete thought. This gives the interpreter time to interpret what was said.

When using an interpreter for patient education the best way to capitalize on his or her medical interpreting skills is to plan ahead and be organized about the teaching session, says **Susan Scritchfield**, MA, MSW, LISW, coordinator of consumer health education at the James Cancer Hospital, which is part of the Ohio State University Medical Center.

"You have to plan ahead to allow time to get an interpreter on sight and to make sure the caregivers or family members the patient wants to be present for the teaching are also available," she explains.

The interpreter needs to know the nature of the teaching in advance so he or she can prepare, says **Jose Sanchez**, coordinator of Interpreting and Translating Services at Children's Healthcare of Atlanta. If teaching protocols are to be used interpreters should be given a copy in advance.

"Make sure the interpreter understands what the training is about so he or she is familiar with the terminology," says Sanchez.

When teaching patients with communication barriers use the teach back method, having the patient demonstrate the skill or repeat back

what was taught, advises **Mursal Khaliif**, RN, director of Community Health & Language Services at the University of Minnesota Medical Center, Fairview in Minneapolis.

The use of the teach back method will give the practitioner confidence the patient fully understands. It will also help uncover misunderstandings so the information can be rephrased, explains Khaliif.

Relying on interpreter's observations

Sometimes it is the interpreter that observes that the medical terminology used is not clear to the patient and can ask the practitioner to use more family friendly terms, says Sanchez.

According to Smith the interpreter can serve as a "cultural broker" meaning if there are cultural practices or norms in either culture that might impede effective communication or lead to misunderstandings the interpreter will explain the differences.

For example some Hispanic parents might rub a tomato on a baby who has a fever leaving tomato seeds on the child's body. If staff in the emergency department are concerned that the baby has been abused the interpreter could tell the practitioner about the cultural practice and ask if they should find out if this is what the parents did, explains Smith.

Stephanie MacPhail, a Spanish interpreter and LEP Patient Advocate in the Hematology and Oncology Clinic at Children's Hospitals and Clinics of Minnesota in Minneapolis, says there are two schools of thoughts on interpreting. One is that interpreters only interpret what was said not actively participating in any education other than repeating what the other party said.

With the second model the interpreter is more of an integral part of the health care team and given an expanded role in terms of the input they can give the provider in a situation. This role is strictly for staff interpreters who have built a relationship with the health care practitioners, says MacPhail.

Interpreters can be instrumental in bringing the barriers out front but it is up to the provider to initiate the practices, she adds.

For example, in collaboration with the nurses at the clinic where she works, MacPhail came up with a system of calendars to help families with limited English proficiency manage confusing medication regimens during the course of their child's treatment.

The project was initiated because of a misunderstanding on dosage. A child's chemotherapy regimen was one half of a pill, yet instead of using numbers on the label the pharmacy had written the dosage in words. The family members, who could read a little English, saw the word 'one' but did not understand the 'half' therefore they had been giving their child a whole pill until the error was discovered.

Now families are given calendars to help with dosage and if the child is taking a pill there is a picture of the dosage whether a half pill or whole pill.

Liquid medicines are color coded and a sun and moon indicate whether or not the dosage is to be taken in the morning or at night. **(For information on providing translated educational materials to LEP patients, see article on pp. 79)**

"When I am in an encounter with a provider and patient I play a strict interpreting role, outside that role I do a lot of advocating and case coordinating working together with the nurses for purposes of education," explains MacPhail. ■

SOURCES

For more information on using interpreters during teaching sessions, contact:

- **Mursal Khaliif**, RN, Director, Community Health & Languages Services, University of Minnesota Medical Center, Fairview, Minneapolis, MN. Phone: (612) 273-5850. E-mail: mkhalii1@fairview.org.
- **Stephanie MacPhail**, LEP Patient Advocate, Hematology and Oncology Clinic, Children's Hospitals and Clinics of Minnesota, Minneapolis, MN. Phone: (612) 813-7706. E-mail: Stephanie.Macphail@childrensmn.org.
- **Jose Sanchez**, Coordinator, Interpreting and Translating Services, Children's Healthcare of Atlanta. Phone: (404) 785-2189. E-mail: Jose.Sanchez@choa.org.
- **Molly K. Smith**, Manager, Language Services, Clarian Health, Indianapolis, IN. Phone: (317) 962-2725. E-mail: msmith19@clarian.org.
- **Susan Scritchfield**, MA, MSW, LISW, Coordinator, Consumer Health Education, James Nursing Staff Development and Patient Education, Ohio State University Medical Center, Columbus, OH. Phone: (614) 293-3259. E-mail: Susan.Scritchfield@osumc.edu.

Back up education with translated teaching materials

Each person has a learning style. Some people are visual learners, some learn best hands-on, and others will understand information better if they read about the subject. However instructional sheets help to reinforce education for all types of learning styles. Therefore it is important to give patients with limited English proficiency information sheets to take home that are written in their native language, says **Laura Rocha Nakazawa**, MA, program coordinator for Interpreter Services at Dana-Farber Cancer Institute in Boston, MA.

Following are a few web sites that provide educational materials in languages other than English that can be used when teaching patients with limited English proficiency.

www.healthinfotranslations.org — This joint project of Mount Carmel Health System, The Ohio State Medical Center and Ohio Health, features translations in Arabic, Chinese, French, Hindi, Japanese, Korean, Russian, Somali, Spanish, Ukrainian, and Vietnamese. They cover a variety of topics such as diagnostic tests, diseases and conditions, exercise and rehabilitation, as well as food and diet. All translations have an English version.

www.hmonghealth.org — The goal of the Hmong Health Education Network is to provide access to health, education, and social services to the Hmong community. Content includes anatomy drawings labeled in English and Hmong, English-Hmong anatomy, medical phrase book as well as educational materials.

Don't overlook patients with low health literacy

Strategies to close communication gap

Patients are being put at risk because important health care information is communicated in medical jargon that exceeds their literary skills, according to a new white paper from The Joint Commission. (A copy of *What Did the Doctor Say? Improving Health Literacy to Protect Patient Safety* is available at no charge on The Joint Commission web site, www.jointcommission.org, under "Public Policy Reports.")

"I think this is a huge blind spot, and we in health care are just now waking up to it," says **Michael Leonard,** MD, physician leader for patient safety at Kaiser Permanente in Evergreen, CO.

The paper says that the communication gap between patients and caregivers involves literacy, language, and culture, and gives 35 recommendations including education and training of leaders and staff on health literacy issues. The paper also recommends use of established patient communication methods such as "teach-back," and assessment of the literacy levels and language needs of the communities served.

Ninety million Americans "have difficulty understanding and acting upon health information," according to an Institute of Medicine (IOM) report on health literacy.[1]

Originally, health literacy was seen as an issue relevant only to certain patient population groups, says **Rima E. Rudd**, ScD, MSPH, a health literacy expert at the Harvard School of Public Health in Boston. "Only recently are institutions paying attention to the IOM claim that health literacy is an interaction between the skills of individuals and the demands of the health sector," she says.

Many health care professionals have recently started looking at their often faulty assumptions about what patients actually know and can do, and the nature of the demands they make, says Rudd.

Low health literacy is associated with several adverse health outcomes, including increased incidence of chronic illness and poorer intermediate disease markers, according to an Agency for Healthcare Research and Quality (AHRQ) report.[2]

In the near future, we may be seeing new requirements from The Joint Commission to address health literacy of patients. "I think over time, some consensus will be reached about possible solutions or fixes," says Rudd. "Once a consensus is reached, then I think we will see standards." To address health literacy at your organization, consider the following interventions:

• **Assess commonly used forms, patient education print materials, signs and directions, informed consent documents, and discharge instructions.** "Evaluate signage and patient education materials to be sure they are clear to people with low reading skills," says **Patrice Spath**, RHIT, a Forest Grove, OR-based consultant and author of the book *Partnering with Patients to Reduce Medical Errors* (published in 2004 by the American Hospital Association).

Many hospitals use printed material to

encourage patients to speak up when they have a safety concern, but informational brochures used to communicate this are often written at a high grade level. People with low health literacy or non-English-speaking patients don't understand what is being stated in these brochures, says Spath. "Whenever possible, use pictures along with simple narratives to educate," she recommends.

• Provide a training and orientation program for all staff focused on health literacy awareness. "Develop a policy to address reading level of all in-house print materials for patients," says Rudd. "Train staff in use of plain language and how to avoid jargon."

• Ask about safety concerns verbally. Doctors, nurses, and patient advocates should be regularly asking the question, "Do you have any safety concerns?" says Rudd. "Avoid paper and pencil measures that only capture the opinion of those who read and write with ease," she says.

Consider the following "script" for a patient interview, says Rudd: "Many people point out that hospital staff often speak a 'foreign' language filled with medical and scientific words. We have been trying to use everyday words and clear explanations and directions as much as possible. We want to know what you think about our efforts."

• First, have you been here before?

• If yes: Have you noticed any change since you were here last?

• If no: Okay, now I will make some statements and want your response. Please use this scale to rate each of the following (1 means strongly disagree and 6 means strongly agree).

1. Staff people are very clear when they give directions.
2. When staff people use a medical or scientific word, they explain what it means.
3. Doctors/nurses are very clear when they talk to me.
4. When doctors/nurses use a medical or scientific word, they explain what it means.
5. Doctors/nurses always ask me if they are clear or if they have left anything out.
6. Doctors/nurses always ask me if I have questions.
7. I know who to talk to if I have a safety concern or question.
8. I know where to go if I cannot understand or use forms.

"We are continuously aware of the need to communicate to all our patients both in verbal and written messages that they can clearly comprehend and understand," says **Thomas C. Royer**, president and CEO of Christus Health, which has 40 acute care facilities, located primarily in Texas and Louisiana.

Administrators at Christus hospitals verbally ask these questions of patients and family members on their daily rounds: "Have the caregivers been identifying themselves to you? Is each person you encounter explaining what he or she is trying to do for you? Do you feel a trust or confidence in your caregivers?"

Similar questions are included in patient surveys conducted for inpatient and outpatient care, ambulatory surgery, and emergency departments, with written communications appropriately geared to the literacy level and language of the population each facility or program serves.

• Evaluate your progress.

To evaluate how well your hospital is doing at communicating with patients who have low health literacy, Royer suggests the following:

• Analyze the answers to the questions above and develop corrective action plans to address any deficiencies identified.

• Monitor re-admission rates to identify causes which might be related to the lack of understanding of discharge instructions.

• Have staff call ambulatory surgery patients or their designated contact to see how they are doing and to ensure they have full understanding of their post-operative instructions.

To identify patients with low health literacy, all patients at Christus are screened after triage for their financial insurance profile. The admissions clerks identify language barriers and obtain the necessary information with the assistance of an interpreter, and assess the patient and family's ability to comprehend and answer questions. "This information should be shared with the caregivers," says Royer. "It is important to note that the income level often parallels the health literacy level, making this process very useful."

References

1. Institute of Medicine. Health Literacy: A Prescription to End Confusion 2004, Washington, D.C. National Academies Press.

2. Agency for Healthcare Research and Quality. Literacy and Health Outcomes. Evidence Report/Technology Assessment Number 87. 2004. AHRQ Publication No. 04-E007. ■

Collaborative aimed at hospital communication

Important means of reducing care disparities

A new program from the Department of Health and Human Services (HHS) called "Effective Communication in Hospitals" is designed to aid hospitals in meeting the communication needs of individuals who do not speak English as their primary language, or who are deaf or hard of hearing.

The program will have both national and state-based components; the state-based initiative involves collaboration between HHS' Office for Civil Rights (OCR) and state hospital associations. At present, hospital associations in Kentucky, Missouri, New Jersey, New York, Oklahoma, Pennsylvania, Rhode Island, Utah, and Washington are slated to participate.

According to HHS, state-based efforts will be tackling such issues as:

- Developing a process for assessing the communication needs of patients and their families;
- Identifying tools and strategies for developing training, best practices, educational materials, technical assistance activities, and other resources;
- Responding appropriately and efficiently to the communication needs of individuals who are limited English proficient or deaf or hard of hearing;
- Sharing the results of efforts to assist other hospitals and state associations facing similar communication issues;
- Identifying potential resources and creative approaches to cover costs.

One of the 'chosen'

One of the participating organizations, the Kentucky Hospital Association (KHA), was actually enlisted by the OCR, explains **Pam Mullaney**, KHA's director of membership services.

"The OCR and AHA [American Hospital Association] brought it to us," she recalls, explains that there are 10 OCR offices in the country, with Kentucky falling within the jurisdiction of Atlanta's office.

Kentucky is unique in a number of ways, Mullaney continues. First, all 126 hospitals in the state belong to the KHA, which, she says, is unique. "Most states have more than one organization that represents its hospitals," she asserts. This means that in Kentucky, every hospital will be exposed to the program. KHA, adds Mullaney, "represents and facilitates collaborative efforts among Kentucky hospitals and is the source for strategic information about the constantly changing health care environment."

In addition, says Mullaney, "Because more than half our hospitals have fewer than 100 beds, we are considered a rural state. Urban hospitals probably are going to have programs in place already."

The program is important, she says, because "Patient care starts with communication; it's number one. Once you have a program in place that can assist these populations, you are on your way to delivering quality care."

So many of these people don't know how to find their way through the health care system, she explains. "In a lot of other countries, health care is provided by the government; they do not understand that we provide care for the indigent. They also do not understand, however, that this care should not start in the ED, but with a primary care doctor."

Starting pilot project

The KHA will begin its effort with a pilot program, says Mullaney, and it may even "go after" some grant dollars.

"Our idea currently is to come up with something like they've done in Illinois," she says. This involves the use of an oversized laminated board that employs dry erase markers, covered with many different symbols.

"So, if a person [who did not know English or who could not speak] came in and had a broken arm, they could point to it," Mullaney explains.

The board, she says, will have "maybe 100 different pictures, as well as the letters of the alphabet to spell out words." This will be done for the top five languages used in the state: Spanish, Somali, Russian, Arabic, and Vietnamese.

If KHA gets its grant dollars, it will investigate the different language line companies that could provide interpreters. "If a Vietnamese patient comes in, for example, you can call the phone line using two phones — one for the patient and one for the physician — and they can converse back and forth using an interpreter," she explains.

KHA will do due diligence on the top companies. "Since our endorsement could mean all the hospitals in the state would use this vendor, we could get a discounted rate," she suggests.

The OCR is doing a lot of population analysis for KHA "so we'll have a lot more arrows in our quiver when we go to grant writing," says Mullaney, adding that this collaborative "is all about patient care and patient safety," as opposed to a government-mandated activity.

"The nice thing about working with OCR," she continues, "is that they are not claiming to come to us with the answers. They recognized that we know your hospitals and our state, and they want to listen to us for guidance as to what would be of value in each hospital in each setting."

Still, she notes, one program will not be a cure-all. "I think this is a monumental problem, and we will not be able solve it with this one collaborative effort," she concedes. "But it *is* a step in the right direction; we'll try to give our hospitals a mechanism [for addressing the problem], and then spread the word from there."

[Editor's note: For more information, contact: Pam Mullaney, Director, Membership Services, Kentucky Hospital Association, 2501 Nelson Miller Parkway, Louisville, KY 40253. Phone: (502) 992-4363. Fax (502) 814-0363. E-mail: pmullaney@kyha.com.] ■

Change of shift high-risk for ED patients

Communication lapses can cause adverse outcomes

Both nurses and physicians are at high risk for communication lapses during change of shift, says **Francis L. Counselman**, MD, chairman and program director for the department of emergency medicine at Eastern Virginia Medical School. The departing physician often is anxious to leave and does not have the same degree of vigilance for that last patient of the day, he explains. As a result, all of the necessary information may not be communicated to the physician taking over the patient. "The arriving physician often never examines the patient, or does not really consider the patient 'theirs,'" he says. "There is often no sense of 'ownership' of the patient for the physician coming on."

Similarly, orders at the very end of a nurse's shift may not get done, yet the nurse coming on may assume they have been done. "The bottom line is that the order is not performed," says Counselman. "Another scenario is a compulsive nurse completes all of the orders on her patient such as hanging medications, but forgets to document these actions." The nurse coming on does not think the medication has been given and administers it, so the patient receives two doses.

The absolute worst scenario is when both physicians and nurses change shift at the same time, says Counselman. "There is then no caregiver who has a full understanding of the patient."

Improve communication

Information related to patient plan of care, diagnosis, and suspected complications is essential to safecare delivery, says **Pamela S. Rowse-Schmidt**, RN, quality/risk consultant and former ED manager at St. Rose Dominican Hospitals-Rose de Lima Campus in Henderson, NV.

Rowse-Schmidt gives a hypothetical example of a patient admitted from the ED as a rule-out acute coronary syndrome, with the first troponin level coming back negative. The patient is held for an admission to a medical/telemetry bed. While the patient is still in the ED, the next troponin level comes back critically elevated. "If it's a different shift, who communicated that very valuable information to the current caregiver? Probably no one," says Rowse-Schmidt.

After being admitted to the medical/telemetry bed, the patient's condition deteriorates and it becomes clear that patient is having an evolving myocardial infarction. As a result, the patient is transferred to the ICU in an emergent condition.

The delay in admitting to the appropriate level of care, based on the critical lab value, has the potential for resulting in additional myocardial damage and ultimately extending the patient's length of stay, as well as resulting in a further diminished cardiac functioning. "In this case, delay in identifying a potentially life threatening event could result in death," she says.

Particularly if the patient died, or suffered long-term affects from the event, the family would have a case for litigation, says Rowse-Schmidt.

Here are risk reduction strategies for change of shift:

• Have the oncoming physician sign the chart of all patients being turned over to them. "This

will often have the effect of making the oncoming physician more diligent in following up on results and rechecking the patient," says Counselman. "The patient is now 'theirs' without question."

• Have the oncoming physician examine all patients turned over to them, except for the most benign cases such as those waiting for a single, simple laboratory test, and write a brief note on their chart. "This gives the oncoming physician the opportunity to form their own impression of the patient, and also allows the patient to know who their doctor is in case they have questions," says Counselman.

This is much better than having a patient who has been in the ED for several hours and wants to talk to their physician to be told "your doctor has gone home," he says.

At George Washington University Hospital in Washington, DC, change of shift is viewed as "an opportunity rather than a risk," says **Robert Shesser**, MD, professor and chair of the department of emergency medicine. The physician leaving reviews all patients with the second physician who is coming on shift who asks the "hard" questions. "They generally ask the physician to explain any lab abnormalities that are already identified, what labs or X-rays have been sent and have not yet returned, and what the plan would be depending on what is found," he says.

Make every effort to have physician and nurse shift changes occur at different times, not the same time.

Schedule the physician going off service one additional paid hour to stay in the ED and help with the transition. "We also schedule our senior resident shifts to overlap the attending shifts so there is some continuity of care for the critical patients," says Shesser.

Some EDs have a culture of not signing out patients, which means that a physician going off service stops seeing new patients some amount of time before shift change. "Our culture has always been to see new patients right up until the last minute and feel free to check them out," says Shesser. The new physician always goes to see patients who have been checked out to them, so the patient gets two evaluations versus one. "I think over time, we have caught more problems with this approach than had things slip between the cracks because there was checkout," says Shesser.

Use an electronic medical record (EMR). Since an EMR is used at George Washington University's ED, there is very little chance of any key information getting lost, because the record is the repository for all information developed during the previous shift. "All lab and X-ray data are in one place and color coded according to whether it is normal or abnormal," says Shesser. ■

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

- Creating communication plans
- Educational needs of families coping with autism
- Making patient education part of your culture
- Revitalizing the patient education committee
- Effective pain control education

CNE Questions

25. To ensure safe health care to patients who are not fluent in English many health care facilities are taking which of these safety precautions?
    A. Flagging patients who need interpreters upon registration
    B. Asking staff to learn a foreign language.
    C. Encouraging use of family members.
    D. Only providing translated patient education brochures.

26. Which of these basic practices improve teaching encounters between health care practitioners and patients with limited English proficiency?
    A. Speak directly to the patient.
    B. Pause after finishing a complete thought.
    C. Explain role of interpreter to the patient.
    D. All of the above

27. Which is recommended to address health literacy?
    A. Written educational materials are always sufficient unless patients are non-English-speaking.
    B. Teach-back methods are not recommended.
    C. Providers should use pictures along with simple narratives when educating patients.
    D. Health literacy is a problem only for select patient populations.

28. According to **Thomas C. Royer**, one way to evaluate how well your hospital is doing at communicating with patients who have low health literacy is to monitor re-admission rates to identify causes which might be related to the lack of understanding of discharge instructions.
    A. True
    B. False

Answers: 25. A; 26. D; 27. C; 28. A.