Patient Education Management™

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

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IN THIS ISSUE

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Editor Susan Cort Johnson, Associate Publisher Coles McKagen, and Managing Editor Jill Robbins 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.

NOVEMBER 2007
VOL. 14, NO. 11 • (pages 121-132)

Improve patient education skills by making them part of annual competencies

Use the stand-alone method or weave them into other evaluations

For the best health outcomes, clinical staff need to have good teaching skills. One way to make sure they are competent educators is to develop patient teaching competencies that must be met when staff members are given their annual job performance evaluation.

A few years ago the patient education office at the University of Texas M.D. Anderson Cancer Center in Houston formed a multidisciplinary committee to look at patient teaching competencies and determine the minimum standard staff would have to meet.

Following brainstorming sessions, the group developed themes and came up with a list of competencies, says **Nita D. Pyle**, MSN, RN, associate director of the patient education office and head of the committee. **(To view list see story p. 123.)** They also developed teaching plans for each competency and a checklist that management used during the evaluation.

It is difficult to know if staff members who are involved with teaching patients practice good education methods unless their skills are evaluated.

During the annual employee assessment at Children's Healthcare of Atlanta staff members are tested via computer-based training modules on a variety of topics pertaining to regulatory standards, such as safety, and

EXECUTIVE SUMMARY

In the October issue of *Patient Education Management,* we discussed building a patient education culture within an institution. In this issue, we take a closer look at teaching competencies and how to design them.

patient education is included. Each topic has about 10 questions that change yearly. There is a booklet for each test that staff can read in advance.

The patient education module covers everything from doing a learning needs assessment to evaluation techniques and health literacy questions, says **Kathy Ordelt**, RN-CPN, CRRN, patient and family coordinator. Staff members must score 80% on each test in order to pass and retest on the modules when their score is lower.

"The module doesn't contain tons of information that will make staff experts, but it is a reminder that patient education is part of patient care, and it is important," says Ordelt.

This year The Children's Hospital of Philadelphia is creating a patient and family education on-line critical thinking module that addresses the key concepts of teaching a patient and family at the bedside. This is one of several on-line modules nurses work through at their own pace and take a post-test when finished.

In addition, teachable moments will be embedded in the skills revalidation portion of the competency review process, says **Evie Lengetti**, RN, MSN, director of nursing education, community programs and co-director for the Office of Simulation and Innovation at The Children's Hospital of Philadelphia.

For example, for the skills revalidation for caring for a patient with a central line, a manager would discuss the educational opportunities available when changing the dressing, such as the steps involved. "Wherever we see a teachable moment that is appropriate for patient and family education, we will embed that into the technical portion of our skills revalidation of the annual competency review program," says Lengetti.

Making patient education part of annual competencies and job evaluations helps staff members realize that education is part of good patient care. However, many health care institutions are discovering that a good way to incorporate teaching into clinical practice is to blend teaching into other competencies, rather than making it separate. That is the case at M.D. Anderson Cancer Center.

"We took about a year and a half to develop the patient teaching competencies. With the teaching plans, resources, and checklists, it was a whole notebook that was given to every unit and outpatient area. Once the validation was done, we began to incorporate the information into existing competencies so it would become part of the expectation," says Pyle.

Now the annual nursing competencies at M.D. Anderson are reviewed by a committee to make sure they include a teaching portion when appropriate. For example, part of the nursing competency for a patient-controlled analgesia pump would be to demonstrate how the patient would be taught to use the device in addition to demonstrating personal skills on its operation, explains Pyle.

Design and evaluation process

The best steps to take when developing a competency is to look at high-risk skills, says Pyle — those skills that could cause risk or harm to a patient if performed incorrectly. Also look at skills for which all staff must have a minimum

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 $12.95 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.)

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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.

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level of proficiency, she adds.

It is always good to look at available data, according to Lengetti. Work with the department for quality of care and patient safety review data to determine where people are having the most difficulty in practice or where people need to improve proficiency at a skill or technique.

"Those data are what drive the content and the focus of the competencies for the year," she explains.

In addition, it is good to look at key external drivers such as Joint Commission initiatives or in-house patient safety initiatives; also assess whether there are any critical thinking skills or technical skills that need to be addressed and then determine the best teaching method based on what needs to be taught.

"Competencies are very much driven by data and initiatives. We take pride in making sure our competency review program does that every year," says Lengetti.

Part of the incentive for the original patient teaching competencies at M.D. Anderson Cancer Center were chart audits that revealed problems that lent themselves to teaching as a solution but there was no documentation to support that the issue had been addressed, says Pyle. While teaching might have been done, it was not documented, so that prompted formation of a competency committee.

Establish evaluation process

In order to determine if people have mastered a particular competency, some sort of an evaluation process must be set in place. At M.D. Anderson the notebook of materials for patient teaching competency included a checklist for evaluation. For example, under communication skills a manager would check the "met" column if an employee demonstrated good listening skills when teaching a patient.

Observation is the best way to evaluate patient teaching skills, says Pyle. However, managers don't always have time to use this method. To give more evaluation options, a guided inquiry was provided with questions the evaluator could ask the staff person. These questions were related to a patient in that staff member's care. For example, the evaluator could pull a patient chart and ask how the staff member determined the patient had no barriers to learning.

The manager of clinical nutrition at M.D. Anderson took the time to observe staff once based on the checklist and then a second time to determine if the mistakes being made were corrected.

This manager determined that most of her staff talked too much and needed to listen more when teaching patients. Pyle says this is a common flaw because professionals have a lot of information; when they go into a patient's room, they usually want to share everything. Also the manager observed that the dietitians would automatically teach the female in the room about diet even if the patient was a male. They needed to learn to include the patient if possible.

Before implementing patient teaching competencies for a new year, step back to assess if past efforts have been effective.

"It's good to step back every year and ask if the competency improved practice," says Lengetti. ■

SOURCES

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Patient teaching competency for staff

Following is a competency list for evaluating patient teaching skills that was designed by a multi-disciplinary committee at The University of Texas M.D. Anderson Cancer Center in Houston.

Competencies integral to teaching

- communication skills

• shows respect
• demonstrates good listening skills
• reports to other members of team to ensure continuity of care

Diversity competency
• knowledge of how culture impacts patient teaching process
• demonstrates sensitivity and awareness
• demonstrates age-specific competencies

Content expert
• determines what needs to be taught to patients/caregivers

MDACC policy/standards pertaining to patient education
• locates the policies
• knowledge of content

Patient teaching competency
Introduction
Teaching/learning Process
• knowledge of teaching/learning process
• uses principles of adult learning and principles of learning for pediatric patients

Assessing patients and caregivers for learning needs
• uses the Interdisciplinary Patient Teaching Record as a guide for assessing the patients: barriers to learning; learning needs; preferred learning style
• provides opportunity for patient/caregiver to voice needs and concerns (What are the patient concerns?)
• asks the right questions through the use of open-ended questions
• identifies the patient's skills and current level of understanding and ability
• identifies the appropriate caregiver to teach

Other assessment tools: admission assessment, patient history database, follow-up progress note
Planning effective patient education
• determines what is important to teach
• formulates appropriate and measurable objectives for learning
• selects teaching resources appropriate for the objectives:
— teaching plan
— on-line education materials such as patient education on-line database
— videos such as those on MDA-TV
— consultation with other experts/disciplines
— department-specific resources

Identifies relevant resources for the patient/caregiver to access such as:
• the learning center
• place of wellness
• established patient-focused classes

Implementing the education plan for patients/caregivers
• provides appropriate learning environment
• reviews learning goals/objectives
• prioritizes content of teaching based on patient needs and readiness
• addresses the identified patient concerns and learning barriers
• demonstrates ability to use appropriate resources/media — use of mixed media to reinforce
• provides patient/caregiver with opportunity to demonstrate learning
• completes documentation in the Interdisciplinary Plan of Care and Teaching Record (IPOCTR)

Evaluating effectiveness of patient education
• assures that patient/caregiver can demonstrate required skills
• assures that patient/caregiver can verbalize required knowledge
• plans follow-up as needed
• reports status of teaching to interdisciplinary team, e.g. documents in the IPOCTR, shift reports, team meetings
• evaluates own teaching effectiveness
— patient/family
— peers ■

Educate the educator to ensure learning is occurring

For best results, offer a variety of opportunities

Writing patient education into job descriptions and making it part of annual job evaluations may help to make it part of patient care and not something separate that is completed when time allows, but it does not ensure the education will be effective.

"The basic premise is that teaching and learning are not equivalent, and just because we do a wonderful job setting up education and teaching our patients and families doesn't mean they are learning," says **Kathy Ordelt**, RN-CPN, CRRN, patient and family coordinator at Children's Healthcare of Atlanta.

In schools of preparation, students frequently learn what to teach about a disease, such as pneumonia, but not how to effectively deliver the lesson. It is important to provide opportunities for health care professionals to become skilled educators by offering a variety of classes and other resources.

"If we don't offer them the skills, they will keep teaching the way they have learned, either through a co-worker, a boss, or on the fly, and that may or may not be the best way to offer the information and to interact with that patient and family so that learning is actually occurring," explains Ordelt.

A good starting place for staff education on teaching skills is during orientation of new employees. "It sets the stage that patient education is part of patient care and cannot be separated from it," she says.

When included in orientation, it shows people that patient education is important enough to be included in the initial information such as the use of pumps and monitors. Within a 45-minute time slot Ordelt offers basic information on individualizing education, the use of available resources, and evaluating learning. The information is included in the orientation notebook all employees receive.

In addition, once employees arrive on their unit or department, they are given an individual in-service on things specific to their workplace, and patient education has been woven into this training as well. Part of the orientation checklist includes the location of teaching sheets, booklets, and manuals as well as how to access the computerized resources and operate the video-on-demand system. The documentation of patient education is also reviewed.

Helping staff develop their teaching skills is not limited to orientation. Opportunities for continuing education are available.

Six times a year Ordelt produces a one-page flyer titled "Take Five for Patient and Family Education."

"It is our quick in-service flyer that is supposed to take no more than five minutes to read through and gain little pearls about patient education," explains Ordelt.

For the past two years the patient education department has been writing about patient education related to various cultures such as Russian, Chinese, and Arab. Other topics have included conducting a learning needs assessment, tips on teaching children vs. adults, and documentation pointers.

A column also includes information on new patient education resources, such as a booklet, or newsworthy events such as a health education expo.

The flyer is loaded on the staff Intranet and also e-mailed to all educators and members of the family-centered care council so it can be posted on units.

Workshops improve skills

More in-depth learning opportunities are available through a corporate staff educational system. There is a database on the Intranet where employees can sign up for classes. Currently, there are three classes offered by the patient education department that are run several times a year.

Two, four-hour interactive classes are available. One covers writing for patients and families and the other using the computer for health care information, which includes the Intranet and also good web sites on the Internet. A shorter class covers the issue of health literacy. The interactive classes have a size limit but the literacy presentation can be held in an auditorium so more can participate.

Ordelt says while the classes are not always full, there is a good showing.

A new offering to be launched in the coming year is an interactive workshop on patient education skills covering such things as assessing for learning needs, clear teaching, and evaluating learning.

Ordelt participates in other system-wide programs as well. Graduates entering the nurse residence program at Children's Healthcare of Atlanta undergo an in-depth orientation and she provides an hour-long session on teaching techniques as well as information on health literacy.

At this time the nurses are introduced to the "Ask Me 3" campaign (AskMe3.org) used at the health care facility as well. This campaign encourages patients to ask three questions: What is my main problem? What do I need to do? Why is it important for me to do this?

During an annual nursing conference, Ordelt also offers a workshop on patient education and

either teaches it herself or finds an outside speaker.

Ordelt says she has not formally measured the results of the classes she offers to determine if they produce better educators. She does know there is a big difference in the skill level of people who take the writing workshop before drafting a teaching sheet or booklet and those who have been through the class. The material is much cleaner and the reading level is more appropriate, she says. ■

It is National Pancreatic Cancer Awareness Month

Teach public best prevention techniques

Pancreatic cancer makes headlines when someone famous dies of the disease such as Luciano Pavarotti, the world-renowned opera singer that lost his fight with the disease in early September 2007.

Otherwise, the general public does not pay much attention to the disease.

"Most people probably don't even know they have a pancreas and what their pancreas does," says **Michelle Duff**, DPT, director of patient and liaison services and medical affairs for the Pancreatic Cancer Action Network (PanCAN) located in El Segundo, CA.

To bring more attention to the disease and increase research funding, PanCAN has designated November as "National Pancreatic Cancer Awareness Month." According to PanCAN there is a great need for early detection and better treatment options for the deadliest of all cancers. Currently, 75% of all patients with pancreatic cancer die within 12 months of diagnosis. It is ranked as the fourth-leading cause of cancer death in the United States.

"We have so few answers and we understand so little about the disease compared to other types of cancer," says Duff.

While knowledge of pancreatic cancer prevention and detection is probably where breast cancer was 50 years ago, there is a lot of information the general public needs to know, adds Duff.

First, people need to know if they have immediate family diagnosed with pancreatic cancer, they should talk to their physician about their risk and the possibility of participating in a screening protocol.

"Those who have a family history of the disease can participate in some type of surveillance or screening protocol to see if the doctors can see types of changes to help determine if something abnormal is happening," explains Duff.

Also people need to understand there are treatment options and physicians who specialize in the disease, so if diagnosed they can choose treatment. While much research is needed, some patients do very well with treatment, according to Duff.

"We don't want people to think that because this is an uphill battle they shouldn't even try. We have a whole network of people who are surviving and talk with others that are diagnosed with this disease so they know there is hope," says Duff.

PanCAN works to not only raise awareness and increase funding for pancreatic cancer but also to support those diagnosed with the disease.

Best ways to prevent pancreatic cancer

The American Cancer Society predicts that in 2007 about 37,170 people in the United States will be diagnosed with pancreatic cancer and 33,370 of these patients will die of the disease.

Because pancreatic cancer is such a deadly disease, the best scenario is to prevent it in the first place. Yet there is not a lot known about how the disease develops. One risk factor for pancreatic cancer is smoking. According to the American Cancer Society, people who smoke are two to three times more likely to develop pancreatic cancer. Three out of 10 cases of this cancer are thought to be caused by smoking.

Other factors include a family history, obesity, and lack of physical activity. The risk of developing the disease goes up with age as well. The average age of diagnosis is 72, with 90% of the cases diagnosed in peopled older than 55.

There also seems to be some connection between diabetes and pancreatic cancer but it is not known if the diabetes is being caused by the pancreatic cancer or vice versa, explains Duff.

While there is no solid information on particular foods to eat to prevent pancreatic cancer, it is recommended that people eat a well-rounded diet with plenty of fruits and vegetables. The American Cancer Society recommends people cut back on red meat, especially meat that is processed or high in fat.

The typical symptoms that prompt people to seek a medical diagnosis are jaundice, unexplained weight loss, pain, and indigestion. Because warning signs are vague, the pancreatic cancer is usually more advanced by the time it is diagnosed.

SOURCE

For more information about pancreatic cancer or ways to commemorate National Pancreatic Cancer Awareness Month, contact:

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"We don't have good early warning signs and we definitely don't have good early detection tools for this disease. Occasionally, someone has a tumor in just the right location so it will cause jaundice when it is small and then people will go to the doctor when it is in an early stage," says Duff. ■

Disease management plan helps unfunded patients

Hospital system manages care of chronically ill

A disease management program implemented by nurse case managers helps chronically ill, unfunded patients cared for by the North Broward Hospital District avoid hospitalizations and emergency room visits.

The hospital system started the program eight years ago to help alleviate the number of unfunded patients with chronic illnesses who were coming to the emergency department because they didn't have a primary care provider and were not getting the care they needed to keep their condition under control.

The program focuses on patients in the community who may have access issues, financial limitations, and who may never have been to a primary care provider.

"It's a win-win situation for everyone. We get these patients established with a doctor or a nurse practitioner and make sure they get the right care. The patients are healthier and we keep patients who have no ability to pay out of the hospital and the emergency room. Our strategy was to ensure a healthier community and it has worked," says **Lori Kessler**, BSW, MHSA, district manager for disease state management programs.

The program illustrates the benefit of educating people with chronic illnesses about their conditions and helping them stay healthy, Kessler points out.

"We did a cost-avoidance analysis and the program has paid for itself. People with chronic illnesses who don't take their medications, monitor their conditions, or keep their appointments with their primary care provider are likely to be hospitalized. By monitoring these chronic illnesses, we are improving the quality of life for these patients and cutting down their medical costs at the same time," she adds.

North Broward Hospital District, with headquarters in Fort Lauderdale, FL, has five acute-care facilities and 11 primary care sites. The nurse case managers are located at the primary care site and coordinate care for patients with asthma, hypertension, congestive heart failure, HIV-AIDS, breast cancer, and high-risk pregnancies.

Patients without insurance and those with Medicaid are eligible for the chronic illness program. There is no charge to the patient for participating in the program.

The nurse case managers work face-to-face with patients, meeting them at the doctor's office and acting as their liaison and advocate.

"The nurse may accompany patients to doctor visits and may suggest that patients show the doctor their blood sugar log or peak flow log or prompt them to give the doctor information about symptoms or to ask questions about the treatment plan," Kessler says.

They educate the patients to help them gain control of their disease, to understand their disease and its complications and comorbidities. They also teach them about the importance of adhering to their treatment plan, seeing their physician regularly, and to act before their symptoms become severe enough to warrant hospitalization or an emergency department visit.

They teach their patients the importance of receiving recommended tests and procedures, such as eye examinations for diabetics. They call to remind patients of physician appointments and to get their medications filled.

"We take a team approach to managing care. We work closely with the providers to make sure that the patients follow the treatment plan. The providers are happy that our nurse case managers are there on site to provide patient education, like teaching the patients how to use a glucometer," she says.

About 60% of the patients are referred by the hospitals in the North Broward District. The rest are referred by the clinics and community agencies.

When patients are referred to the program, a case manager examines their records in the hospital system's electronic medical record to get clinical details, then calls the patient and develops a plan for managing the patient's condition.

Finding patients' medical homes

When a patient is referred to the program, the nurse case managers find out if the patient has a medical home. If patients have been hospitalized or visited the emergency department and don't have a medical home, the case managers help them find a physician at a convenient location and ensure that they get the follow-up care they need.

The nurses stratify the patients based on psychosocial issues, utilization of health care resources, and clinical indicators.

In addition to seeing them in the clinic, the nurse case managers contact the patients at regular intervals, depending on the patient's risk for a decline in health status and other factors.

"Even if a patient has a good control of her medical [condition] but may have just lost her husband, the case manager will call more frequently. Or, if someone has started a new medication, the nurse will call to make sure everything is going well," she says.

The nurse case managers slowly build relationships with their patients, working on the issues that are most important to the patient as they educate the patient about their disease and the importance of preventive care while being culturally sensitive to the patient.

"Sometimes the patient presents to the case manager and all she can think about is how bad her eyes have gotten. Before we can move into any other real [area] of her care, we get her eyes checked. This gives the nurse a starting point and over time she can expand to other health care problems or health-related issues the patient needs to address," she says.

Sometimes patients are in denial because they don't have symptoms and the case manager must educate them on the disease. "They may have hypertension but they don't feel bad or have symptoms until they have the first stroke. If they have no funds, they can't go for preventive care," she says.

They assess the patients' needs and work with community agencies to make sure eligible patients are receiving food stamps and other needed resources.

The case managers are assigned to patients by location, rather than disease.

"So many of these patients have comorbidities so it's better to have one nurse coordinating the care for all of the conditions. The nurses can always call on others for help and often co-manage patients with complicated diseases like HIV or cardiovascular disease," Kessler says.

Because the patient population is culturally diverse, most of the staff speak more than one language, including Spanish, Creole, and French.

In addition to conducting one-on-one education, the nurse case managers in the program arrange regular group sessions for patients with a particular disease, often partnering with other resources in the community. For example, the program organizes "Foot Days" and invites all the patients with diabetes to participate.

Kessler brings in a podiatrist from Nova University to help with the education sessions and to conduct foot examinations. She gives the participants small mirrors and encourages them to check their feet regularly.

"We get the patients educated and their feet checked for free and the Nova University students get good experience," she says.

*(For more information, contact **Lori Kessler**, BSW, MHSA, district manager for disease state management programs, North Broward Hospital District, e-mail: lkessler@nbhd.org.)* ■

Aortic dissection patients may have new hope

New way to predict post-hospital death risk

Survivors of aortic dissection may improve their odds of long-term survival with more aggressive follow-up care and more targeted discharge instructions, based on the findings of a new study in the *New England Journal of Medicine*.[1]

An international team of researchers, led by University of Michigan Cardiovascular Center experts, propose a new way to predict post-hospital death risk for aortic dissection patients, and a new model for the mechanism behind that risk. Their research focused on partial clotting in what is known as a "false lumen" — the channel created when the layers of the aorta separate like two lay-

ers of an onion. This channel runs alongside the "true" lumen, which is the hollow middle area of the aorta that acts as the pipeline for blood to flow out of the heart and down through the abdomen.

What made the researchers suspect partial clotting in the false lumen? "At our hospital we follow these patients in our clinic, and [some of these clots] just take a more aggressive course — the clot gets bigger much faster than others," explains **Thomas Tsai**, MD, MSc, of the University of Michigan Cardiovascular Center in Ann Arbor and lead author of the article. "We noticed the [MRI] scans would show partial clotting and that caught our eye, so we decided to investigate." No other researchers "had really looked at this before," he asserts.

The study involves data from 201 patients with dissections in their descending aortas, who were discharged from the hospital after treatment and followed for up to three years or until death as part of IRAD, the International Registry of Acute Aortic Dissection. (IRAD, which is headquartered at the University of Michigan Cardiovascular Center and supported in part by the university's medical school, the Mardigian Foundation, and the Varbedian Fund for Aortic Research, includes data from 22 large medical centers in 11 countries.)

The paper is based on retrospective clinical data from 114 patients who had a patent false lumen when they were admitted to an IRAD hospital, 68 patients who had a partially thrombosed (clot-filled) false lumen, and 19 who had a completely thrombosed false lumen.

By the end of the three-year follow-up period, nearly 25% of the patients had died. However, the researchers found a significant difference in death risk:

- 13.7% of the patients with patent (clear) false lumen had died, compared with 31.6% of the partially thrombosed patients and 22.6% of the completely thrombosed patients. This difference held up after other factors were corrected for.

A matter of survival

This research — and the findings — were of great import because of the high mortality rates among these patients, notes Tsai. "With aortic dissection of this type [Type B, in the descending aorta], most survive discharge, but once they leave the management is unclear as to what mode of action is best," he says. "The current protocol is to follow with imaging, and once the aorta becomes large enough [just how large, he says, is undefined] you may operate on it or take some other action."

With a three-year mortality rate of 25%, finding more targeted methods of follow-up could clearly make a big difference, he continues. "Our findings provide the possibility for physicians to look for other factors in the imaging tests above and beyond just how big the dissection is — like other features that either show the need for earlier surgery, or the safety of holding off."

A more sophisticated mode of treatment, he adds, would home in on the status of the false lumen. "At present we are not looking specifically at each lumen, whether it is false or true," says Tsai. "We should challenge ourselves to look at what happens within the false lumen: Is it clotted? Is it partially clotted? Where are the tears? We need a better understanding about the anatomy of dissection."

Current scanning technology enables such studies, he asserts, "but we still need experts who will be looking for this; most radiologists now will look at the size and don't know to look at anything else. You have to specifically ask for what you want, but if you do, they can do it correctly and get that information."

Should discharge instructions change?

While noting that the team's findings are "not yet completely substantiated," Tsai says it's not too soon to be considering an adjustment to discharge instructions and patient follow-up.

"Currently the implication is that we as physicians should be cognizant of what the anatomy of the dissection is when the patient leaves," he says. "If you see a partial thrombosis when the patient is leaving the hospital, you may say to them, 'Your dissection may be more risky for getting larger; we should make sure to image you again in one month,' and make sure to ask the radiologist what is going on with the false lumen."

Discharging physicians will recommend "frequent follow-up imaging," which could be every three, six, or nine months. "In addition to looking at more than just size, we should potentially try to refine how frequently we do follow-up imaging," Tsai suggests. "However, radiation exposure does not come without cost, so we need to better refine just what we are looking for."

Reference

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Collaboration accelerates safety improvements

Open communications help drive success

The Indianapolis Coalition for Patient Safety (ICPS), established in 2003, has made significant strides in a number of areas through collaborative initiatives, say its leaders. Among its successes to date are:

- The reduction of ventilator-associated pneumonia (VAP) cases in intensive care units;
- Improved identification of patients most at risk for heart or respiratory failure before they're in trouble;
- The establishment of rapid response teams.

The number of VAP cases in the city have dropped significantly, according to ICPS, with some local hospitals going more than a year without a case — and one going without a case of VAP for three years. After the institution of a rapid response team, one member facility reported that "code blues" had dropped 60% in 18 months.

The ICPS comprises chief executive, medical, nursing, and pharmacy officers from Clarian Health, Community Health Network, Richard L. Roudebush VA Medical Center, St. Francis Hospital and Health Services, St. Vincent Health, and Wishard Health Services. In addition, there is participation by entities such as Eli Lilly and Co., WellPoint Inc., Indiana University, Purdue University, and Regenstrief Institute Inc.

'Non-compete' agreement

The coalition got its start when the chief medical officers of the major systems, in concert with Eli Lilly, began talking about how to put on an educational program to heighten awareness of safety in the city, recalls **Glenn Bingle**, MD, PhD, FACP, chair of the ICPS and Community Health Network vice president for medical and academic affairs. "In planning for that, we realized we could do more than educate the public; we could share information and take on a project together," he explains.

They began studying out-of-state coalitions, and contracted with the National Patient Safety Foundation to facilitate their first meetings, which resulted in the formation of the coalition. "The CEOs all agreed they would not compete on safety issues, and that set in motion the establishment of our agenda," says Bingle.

The ICPS has a working group of CMOs, nursing officers, pharmacy officers, and safety officers that sets the operational and tactical agenda for the improvement projects. "They in turn charter working groups of leaders in each organization to take on the initiative," says Bingle.

"We figured out early on that the more we could cooperate and standardize the better our success would be," says **Kathy Rapala**, JD, RN, director of the ICPS and Clarian Health's director of risk management and patient safety. Part of what happened

over the first few years, she says, was creating a culture of cooperation among the members.

The first joint initiative involved the "do not use" abbreviations, says Rapala. "We added a couple of others [to those of The Joint Commission] based on our expertise and compared culture surveys around the hospitals," she recalls.

Following the model

That model of drawing on the experience and expertise of individual members has continued, notes Bingle — with help from outside organizations as well. For example, the VAP and identification of high-risk patient initiatives were part of the Institute for Healthcare Improvement's 100,000 Lives campaign, and "the coalition decided they would implement all six of the 100,000 Lives initiatives," he says.

"Some of our systems are major teaching institutions, while others are not," he notes. "So what is applicable to one is not applicable to another. For example, in teaching facilities, house officers and fellows are involved [on the teams]."

The work teams openly share the "how-to's" of the programs, says Bingle. They meet regularly, rotating the site. "The frequency depends on how far along we are with implementing the strategy," he says.

Results are positive

Since the ICPS is a collaborative, hospitals will start their programs and show improvement at different rates, with different baselines so it is difficult to state "collaborative-wide" rates of improvement. Still, says Bingle, "a lot of the effects" of the collaborative are already being seen.

"Some members of the coalition have had dramatic reductions in the number of codes in med/surg," he says. In terms of VAPs, "we saw improvement across our own ICUs; one of them has not had a VAP for three years and that continues today. That's pretty spectacular improvement; previously, in a given year we might have had six to 12."

[For more information, contact:

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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

- Tips on ways to keep patient education funding
- Using technology to improve patient teaching
- Self-care still a major focus for patient education
- Educating unique patient populations
- Most common areas for improvement identified by The Joint Commission

CNE Questions

17. To select an area to evaluate staff for competency, it is best to look at which of the following?
    A. high-risk skills
    B. hospital initiatives
    C. quality and safety data
    D. all of the above

18. Currently, there is not a great deal of information on what prevents pancreatic cancer, but there seems to be a connection between smoking and the cause of the disease.
    A. True
    B. False

19. The disease management program at the North Broward Hospital District covers patients without insurance and those with Medicare.
    A. True
    B. False

20. What percentage of patients in the study on aortic dissection in the *New England Journal of Medicine* died after the three-year follow-up period?
    A. 10%
    B. 15%
    C. 25%
    D. 35%

Answer Key: 17. D; 18. A; 19. A; 20. C.

United States Postal Service
Statement of Ownership, Management, and Circulation

1. Publication Title	2. Publication No.	3. Filing Date
Patient Education Management	1 0 8 7 - 0 2 9 6	10/01/07
4. Issue Frequency	5. Number of Issues Published Annually	6. Annual Subscription Price
Monthly	12	$489.00

7. Complete Mailing Address of Known Office of Publication *(Not Printer) (Street, city, county, state, and ZIP+4)*: 3525 Piedmont Road, Bldg. 6, Ste. 400, Atlanta, Fulton County, GA 30305 — Contact Person: Robin Salet; Telephone: 404/262-5489

8. Complete Mailing Address of Headquarters or General Business Office of Publisher *(Not Printer)*: 3525 Piedmont Road, Bldg. 6, Ste. 400, Atlanta, GA 30305

9. Full Names and Complete Mailing Addresses of Publisher, Editor, and Managing Editor *(Do Not Leave Blank)*

Publisher *(Name and Complete Mailing Address)*: Brenda Mooney, 3525 Piedmont Road, Bldg. 6, Ste. 400, Atlanta, GA 30305

Editor *(Name and Complete Mailing Address)*: Jill Robbins, same as above

Managing Editor *(Name and Complete Mailing Address)*: Coles McKagen, same as above

10. Owner *(Do not leave blank. If the publication is owned by a corporation, give the name and address of the corporation immediately followed by the names and addresses of all stockholders owning or holding 1 percent or more of the total amount of stock. If not owned by a corporation, give the names and addresses of the individual owners. If owned by a partnership or other unincorporated firm, give its name and address as well as those of each individual. If the publication is published by a nonprofit organization, give its name and address.)*

Full Name	Complete Mailing Address
AHC Media LLC	3525 Piedmont Road, Bldg. 6, Ste 400
	Atlanta, GA 30305

11. Known Bondholders, Mortgagees, and Other Security Holders Owning or Holding 1 Percent or More of Total Amount of Bonds, Mortgages, or Other Securities. If none, check box ☐ None

Full Name	Complete Mailing Address
Thompson Publishing Group Inc.	1725 K Street NW, Suite 700
	Washington, D.C. 20006

12. Tax Status *(For completion by nonprofit organizations authorized to mail at nonprofit rates.) (Check one)*
The purpose, function, and nonprofit status of this organization and the exempt status for federal income tax purposes:
☐ Has Not Changed During Preceding 12 Months
☐ Has Changed During Preceding 12 Months *(Publisher must submit explanation of change with this statement)*

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

13. Publication Name: Patient Education Management
14. Issue Date for Circulation Data Below: September 2007

15. Extent and Nature of Circulation			Average No. of Copies Each Issue During Preceding 12 Months	Actual No. Copies of Single Issue Published Nearest to Filing Date
a. Total No. Copies *(Net Press Run)*			500	500
b. Paid and/or Requested Circulation	(1)	Paid/Requested Outside-County Mail Subscriptions Stated on Form 3541. *(Include advertiser's proof and exchange copies)*	114	119
	(2)	Paid In-County Subscriptions *(Include advertiser's proof and exchange copies)*	1	1
	(3)	Sales Through Dealers and Carriers, Street Vendors, Counter Sales, and Other Non-USPS Paid Distribution	2	4
	(4)	Other Classes Mailed Through the USPS	8	4
c. Total Paid and/or Requested Circulation *(Sum of 15b(1) and 15b(2)*			125	128
d. Free Distribution by Mail *(Samples, Complimentary and Other Free)*	(1)	Outside-County as Stated on Form 3541	10	13
	(2)	In-County as Stated on Form 3541	0	0
	(3)	Other Classes Mailed Through the USPS	0	0
e. Free Distribution Outside the Mail *(Carriers or Other Means)*			20	20
f. Total Free Distribution *(Sum of 15d and 15e)*			30	33
g. Total Distribution *(Sum of 15c and 15f)*			155	161
h. Copies Not Distributed			345	339
i. Total *(Sum of 15g, and h.*			500	500
Percent Paid and/or Requested Circulation *(15c divided by 15g times 100)*			81%	80%

16. Publication of Statement of Ownership
Publication required. Will be printed in the November 2007 issue of this publication. ☐ Publication not required.

17. Signature and Title of Editor, Publisher, Business Manager, or Owner: Brenda 2. Moore, Publisher — Date: 9/27/07

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2007 SALARY SURVEY RESULTS

Patient Education Management™

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

The challenge of patient education oversight makes job rewarding

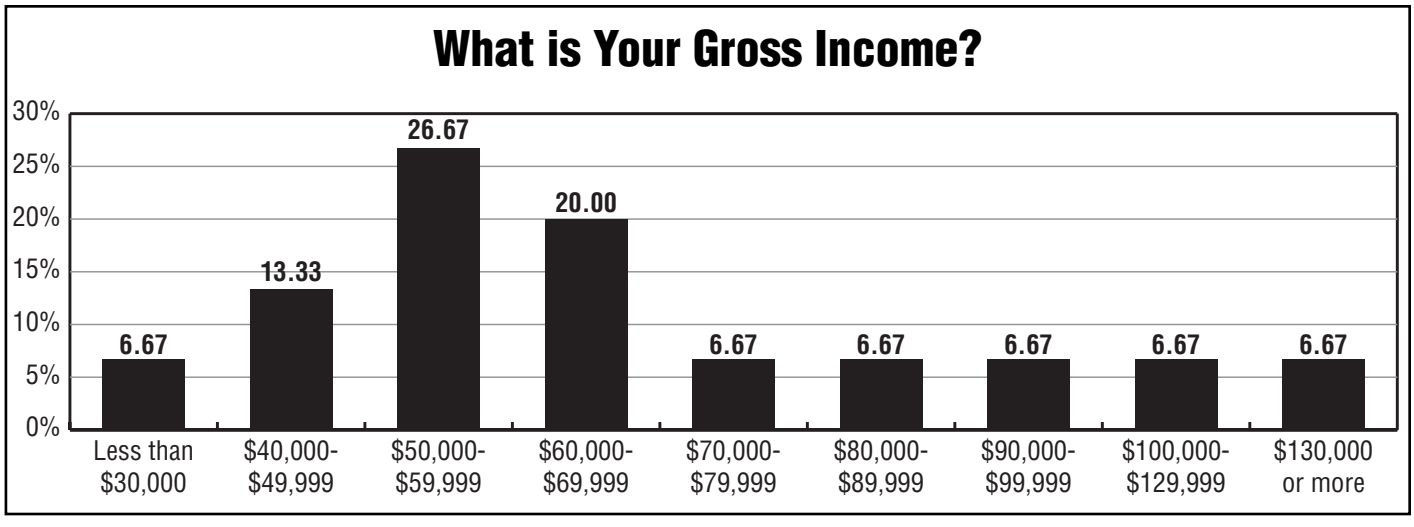
Salaries most likely based on job description

Work in patient education is both challenging and rewarding, say those employed in this field of health care.

"There is always some new way you can provide the resources for your patient population," says **Louise Villejo**, MPH, CHES, executive director of the patient education office at the University of Texas M. D. Anderson Cancer Center in Houston.

Whether creating print material or producing computer-based learning venues, making sure the different populations have resources in the way they need them is always a challenge, she says. The need can be basic, such as making sure readability is low or the resource is culturally appropriate, and it can be more complex.

Recently, a caregiver for a patient treated at M.D. Anderson said the self-care DVDs patients and caregivers bring home to help them with such tasks as wound care were helpful but a podcast (a digital media file that can be viewed on a portable media player) would be more beneficial. This caregiver explained that he did not have a television in the bedroom, but he could view the steps for the dressing change on a portable media play-



er as he completed the task.

More and more, interactive computer-based technology is used to reach patients at home, as well as in the health care setting, as a means of providing needed information, says **Nancy Goldstein**, MPH, patient education program manager at the University of Minnesota Medical Center, Fairview in Minneapolis. This is a trend that patient education managers can expect to continue.

The challenge is to consistently take a hard look at core services to determine if they are still the best or if it might be better to try something new, says **Cezanne Garcia**, MPH, CHES, associate director of patient- and family-centered care and education services at the University of Washington Medical Center in Seattle.

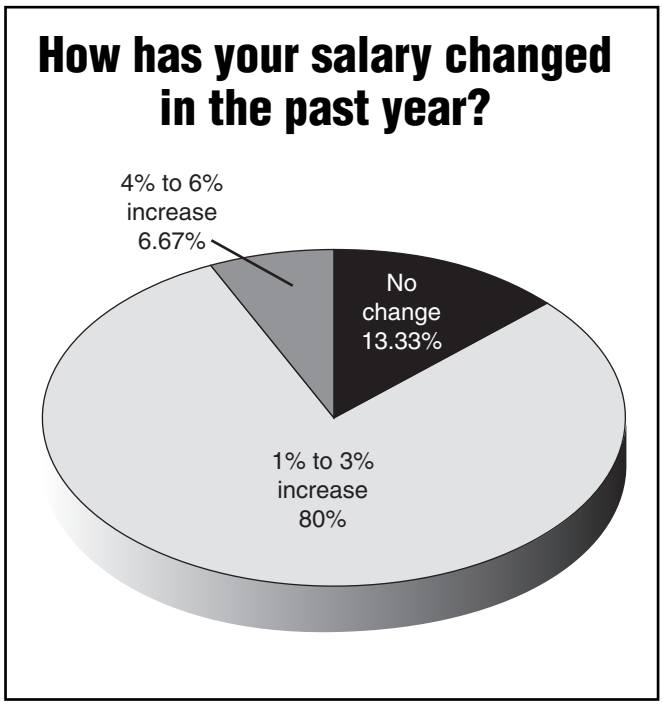
To nurture growth in a resource-limited environment demands creativity and innovation and a willingness to suspend services that tend to be more nice to do then necessary to do, adds Garcia.

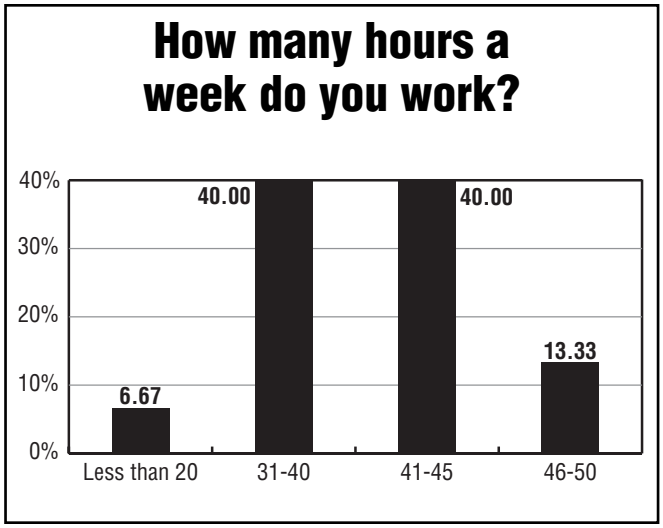
While the job is challenging, most agree that determining how to address these challenges and, thus, meet the needs of the patients is what makes the job rewarding.

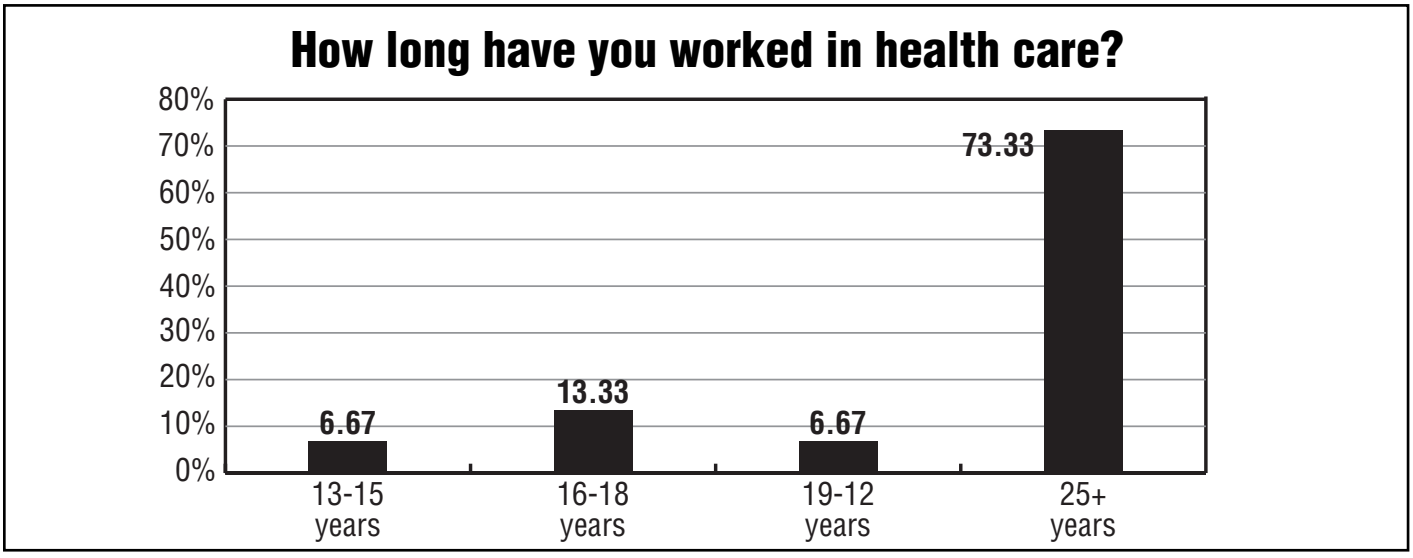
"It's rewarding because it puts the patient's mind at ease and helps them to be confident in their decision making," says **Mary Szczepanik**, MS, BSN, RN, manager of cancer education and support and outreach at OhioHealth Cancer Services in Columbus.

"Knowing you are making a difference by providing patients and families with the knowledge and skills they need to succeed on their own makes the job rewarding," Goldstein says.

The fact that the job is both challenging and rewarding is what keeps people in patient educa-







tion for years. According to the 2007 salary survey, most are not new to the job of coordinating patient education. Most readers who completed the survey indicated they had worked in the field for several years. According to Villejo, the field remains challenging so the job stays fresh and exciting.

"The job is always challenging and that is why it is rewarding. I just finished my 25th year at M.D. Anderson and I have more on my plate than I ever did and it is as challenging as it has ever been," says Villejo.

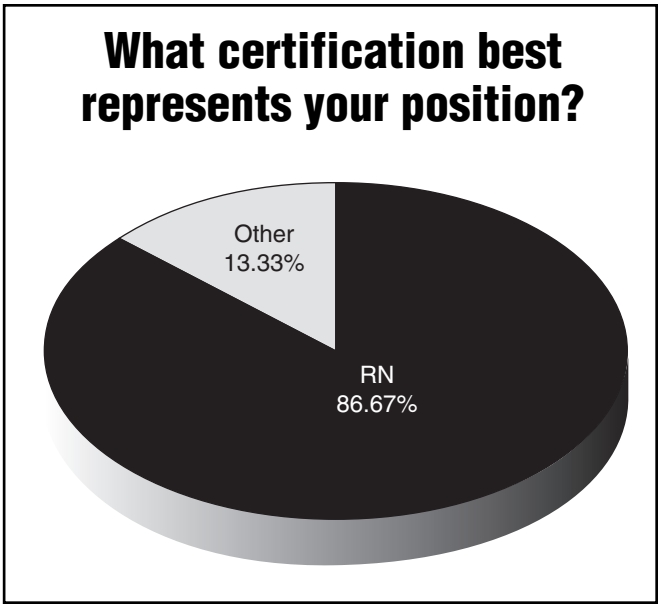
No matter how long a person has worked in the field of education, most are seasoned health care workers. The vast majority of readers had been in health care for more than 25 years. It is also a field that is dominated by RNs.

"Patient education is an integral part of nursing care so nurses will often fall in love with that aspect of their job and want to pursue it in a disease site in which they have experience," says Szczepanik.

For love or money?

A love for patient education may be the attraction for patient education managers but they don't always make the same amount of money as their colleagues with the same responsibilities make in other departments, says Villejo. There are two reasons why this is so. First, it is an education position, which tends to have lower wages, and second, the field is dominated by women and frequently women are paid lower salaries than men.

Readers who took the survey indicated their annual gross income ranged from $30,000 to $130,000. However many were in the $40,000-$70,000 range.

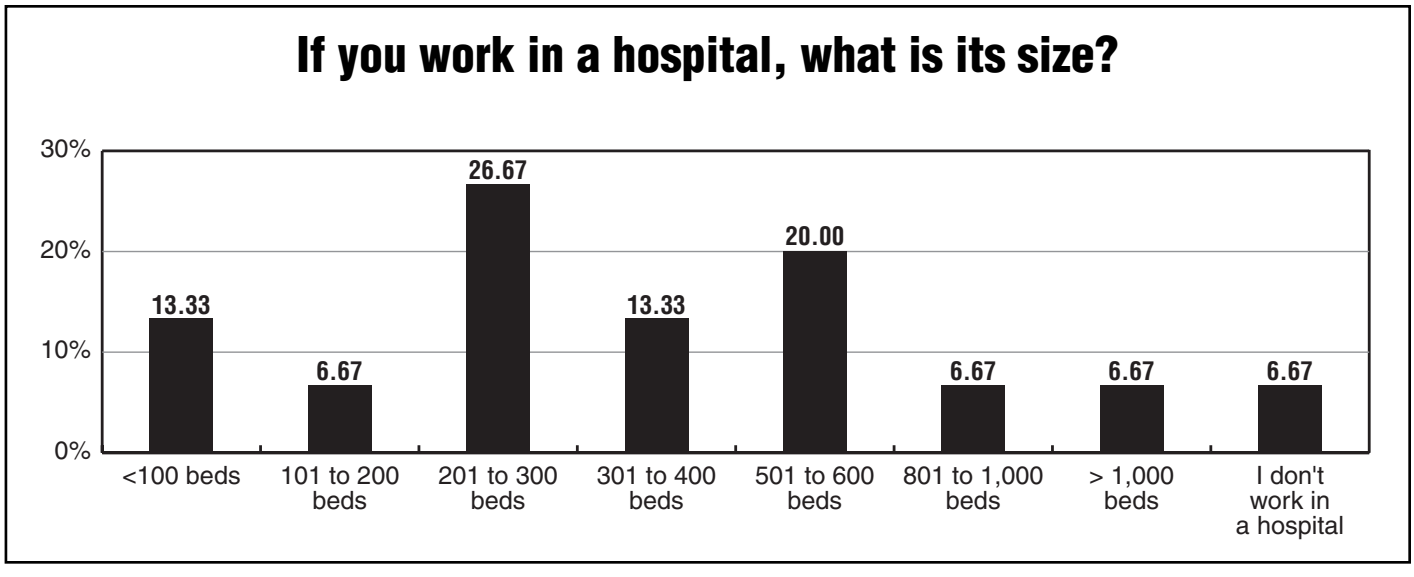


Villejo says M.D. Anderson conducts nationwide market surveys to determine the salaries of people in comparable positions when determining how much to pay an employee in patient education.

Other factors that could impact the salary offered for a patient education management position include the size of the organization, the number of staff members in the department, and the scope of the program, explains Goldstein.

From the reader responses it does look as if health care institutions of varying sizes are creating the position of patient education coordinator or manager. Hospital sites that employed a patient education coordinator ranged from 100 beds up to 1,000 beds. What makes such an employee valuable?

"I believe there is recognition that informed patients can make a huge difference in their health



outcomes. The sophisticated treatments and procedures patients undergo might not be successful unless patients know how to care for themselves upon discharge," says Goldstein.

In addition, there is a tremendous demand on the part of consumers for more information and involvement. There is also a Joint Commission requirement to demonstrate patient involvement in decision making that promotes having a patient educator on staff as well, she adds.

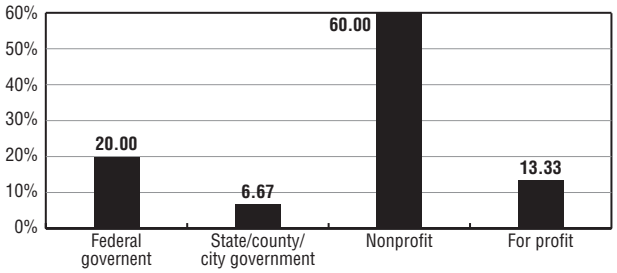
There are many benefits to having a patient education coordinator or manager at a health care institution. They know how to do the proper assessments to develop a comprehensive program that includes providing appropriate educational resources at the correct point of patient care and they know how to promote the program, says Villejo. They also will have a budget, whereas individual nursing units and other hospital departments won't have money for patient education, says Szczepanik.

Health literacy trends and the need for good communication in order to enhance patient safety are reasons for creating the position of patient education coordinator, says Garcia.

Education can promote patient satisfaction, adds Goldstein; also, a coordinated patient education effort is a good use of health care resources.

"With limitations on budgets, having a coordinated program can actually save the institution money by reducing duplication of efforts and streamlining available resources," she says. ■

Which best describes the ownership or control of your employer?



SOURCES

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