Patient Education Management™

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

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IN THIS ISSUE

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Message of prevention key in fight against heart disease

Work to get basic information out to the public about risks, lifestyle changes

Choosing February as American Heart Month is not coincidental. With Valentine's Day in February, it is a month in which people are heart-centric, in the spirit of honoring the emotional needs of the heart. So it is appropriate to extend that thought process from the emotional fulfillment to what is required physically to keep the heart healthy, says **Clyde W. Yancy**, MD, FACC, FAHA, FACP, medical director at Baylor Heart and Vascular Institute in Dallas and chief, Cardiothoracic Transplantation at Baylor University Medical Center.

While more and more medical interventions save people with heart disease, it is far better to avoid the disease than to treat it and education is key to prevention, he states. "The best way to treat heart disease is to never get it. I don't think that message gets out there. What gets out is the breakthrough discovery, the new technique and new strategy. It all sounds like we can fix anything," says Yancy.

In reality, heart disease shortens longevity, decreases economic pro-

EXECUTIVE SUMMARY

Since 1963 Congress has required the president proclaim February "American Heart Month." The American Heart Association works with the administration to draft and sign the annual proclamation.

As a longstanding and well respected tradition it provides an opportunity to target heart disease through community outreach and education. In this issue of *Patient Education Management* we ask experts in the field what educational strategies might be used to combat heart disease.

ductivity, and decreases quality of life. All these factors in turn disrupt families, disrupt society, and disrupt the economy, says Yancy.

To prevent heart disease, people need to know that there are lifestyle choices they can make to lower their risk. However, certain factors that put a person at higher risk cannot be altered, says Yancy. For example, people cannot pick new parents, change their gender, change their race, or change their age.

They can choose not to smoke, to lead an active vs. a sedentary life, what kind of diet to follow, and try to lose pounds if overweight. People with high blood pressure should be seen by a physician on a regular basis to get the problem under control and those with diabetes also need regular treatment.

"These are all things that are important in the consideration of heart disease, particularly diet, obesity, smoking, and hypertension — all of which can be modified by each individual's own activity, and that comes back to education," says Yancy.

People need to know that even modest changes in lifestyle can make a big impact on their risk for heart disease, and that how they currently live impacts their future. The message concerning future health can be difficult to convey. "In our culture we are often reactionary. What we are trying to do is get people to be proactive and take a preventive position," says Yancy.

For example, high blood pressure is a huge issue as people age. That is because about 90% of people over the age of 60 become hypertensive as a result of blood vessels getting stiffer and dietary intake patterns that take their toll. If people in their middle years can be encouraged to keep their weight down, exercise regularly, and refrain from smoking, the likelihood of delaying high blood pressure is much better, says Yancy.

More than head knowledge

Most health care professionals, however, realize it usually takes more than the message to create lifestyle changes. Knowing the steps for delaying high blood pressure with the onset of age and actually following them are two different things.

Creating a sense of community is a great way to tackle lifestyle changes, says **Maxine Barish-Wreden**, MD, an internist with Sutter Medical Group and the medical director for Women's Heart Disease Prevention at Sutter Heart Institute in Sacramento, CA.

The American Heart Association created an employer-based program called "Start" to encourage employees to begin an exercise and fitness program at work, such as walking, and not wait until the evenings and weekends when they often are too tired.

"The Start program is a way to make people feel that they aren't alone. It's a way to have people spend time every day during work getting exercise, and a more powerful way to stay engaged than trying to do it yourself," explains Barish-Wreden.

Lifestyle changes can be a community affair as well, she adds. A woman in Nevada City, CA, a small town in the foothills north of Sacramento, wanted to lose 40 pounds by her 60th birthday. A newspaper reporter showed up at the gym to

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chronicle her efforts, adding to her feeling she had to remain committed.

To stay on track, she partnered with the owner of the gym and they decided to invite everyone in Nevada County to get fit. They called the program the Nevada County Meltdown and fitness clubs offered free time for people wanting to start an exercise program. About 2,000 people got involved, so they formed teams that competed against one another. The group lost 8,000 pounds.

"Again, it was the power of getting a whole community involved and doing it together that made the difference," says Barish-Wreden.

Group approach effective one

The same group approach is helpful in addressing children who are obese and inactive, she adds. A healthy lifestyle needs to be a family affair; it doesn't do much good to teach children about good nutrition if their parents pick up fast food for dinner each night. "We can't expect children to shift their behavior. It has to be adults modeling good behavior, or there is no change," says Barish-Wreden.

Another way to motivate change is to provide a reward, she says. For example, the local newspaper company in Sacramento has a 24-hour fitness center onsite and offers financial incentives to employees who use the gym and take care of themselves, says Barish-Wreden.

It takes more than motivation

But she says it takes more than motivation to get people to put what they learn into practice. It also is important to address barriers to change, says Yancy. Some cannot see a physician on a regular basis or there is no money in their budget to add more heart-healthy foods to their diet.

Informing people of the dangers provides the foundation for change. Yancy encourages health care facilities to offer community awareness programs, such as blood pressure and weight screenings. "The kinds of things that are low tech and high touch make a big difference and make a big impact," says Yancy.

Sometimes the way to deliver the message must be considered as well. Yancy says that although many teens are at risk for developing heart disease at an early age due to poor dietary habits and lack of exercise, they function in an information overload.

"Public health messages are imbedded amidst so many other messages. It's not that they don't listen; I think we have to find a way to make the message important," says Yancy.

The American Heart Association develops campaigns to reach various at risk populations and encourage lifestyle changes. For example, to raise awareness that heart disease is the No. 1 killer of women, they developed the "Go Red" campaign. According to AHA statistics, one in 2.6 women die of cardiovascular disease while one in 30 women die of breast cancer.

Yancy says it is informative programs that made women more aware of their risk for breast cancer and the importance of early detection through screenings, and the same proactive attitude needs to be developed for heart disease as well.

"If we could simply get more people to embrace the prevention message and really understand the best way to treat heart disease is to never get it in the first place, we would be that much ahead of the game," says Yancy. ■

SOURCES

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Creating a culture of patient engagement

A clear vision provides basis for implementing tactics

In 2008, a workgroup at ProHealth Care in Waukesha, WI, will begin the process of select-

ing approaches to meet the goals of 16 tactics developed to create a culture of patient engagement.

For about a year, the workgroup, consisting of representatives from all divisions of the medical facility, met regularly to draft "The Partnership with Patients Work Plan."

The partnership, with patients' effort, evolved from the annual strategic planning process, says **Janet Schulz**, MBA, chief integration officer for ProHealth Care. There were a lot of tools in place to benefit the patient in terms of his or her health care, such as on-line immunization and appointment reminders. But she was concerned that the tools were not cohesive.

"My concern at that point in time is that we hadn't found a way to knit all those tools together in a way that really made the patients feel that ProHealth was their partner in their health care," explains Schulz.

The workgroup was formed to coordinate and develop tools for a true partnership experience for patients. Before the team could begin to shape the plan, they needed to determine what a patient partnership should look like. A literature search was in order. They also looked at information from the Institute of Family-Centered Care in Bethesda nd a book of case studies published by The Joint Commission, titled "Patients as Partners."

From the information, the group wrote a vision statement. It reads: "Through partnership, PHC will build and maintain trust with patients and families, respect and honor choices, and create a healing presence from the first moment of contact."

The major themes within the vision statement were used to form 16 tactics. "Once we had our vision statement we said, 'How does this really play out operationally,' and that is where we developed our tactics," explains Schulz.

"Communication and patient education are incredible drivers in building and maintaining trust, respecting and honoring choices, and creating a healing presence," she adds. **(For specifics on how patient education will be reworked to fit the patient partnership culture, see article, p. 5.)**

The group created a tactic for consistent patient and family communication and goal setting. They researched several strategies for support. For example, they are considering implementing the "Ask Me 3" program or doing multidisciplinary rounds. Patients were asked what type of communication they would like to have with staff during their hospital stay as well.

Clinics are also considering how to rewrite their pre-visit questionnaire to determine what might be important to patients in a partnership relationship with their physician.

Under the "respect and honor choices" of the vision statement, methods to help staff better understand patient choices, such as dietary preferences or wishes in regards to family involvement, will be implemented.

SOURCE

For more information about the workgroup, contact:

• **Janet Schulz**, MBA, chief integration officer, ProHealth Care, N17 W24100 Riverwood Dr., Waukesha, WI 53188. E-mail: janet.schulz@phci.org.

Creating the culture

A cultural training program called RAYS (Reinvigorating and Affirming Your Spirit) will be implemented this year. The program helps staff members learn how to support one another so they can better support patients and families.

The program bolsters the "healing presence" portion of the vision statement, says Schulz. It isn't always possible to fix what is wrong with the patient so health care practitioners must learn that the best role for them, from a partnership perspective and a healing presence, is to just be there for the patient and listen to him or her in such a situation.

As the concept for a patient partnership develops, staff members are being told the health care system is building on what is already established.

Woven into the work plan are methods for staff education as well as leadership education and orientation. This year the leadership orientations will begin in order to explain the work plan and the vision. Some education will take place through routine communication channels but when there is a significant education piece, training will be built around it. For example, if bedside rounds are implemented staff will receive training on this process.

In a patient partnership, staff start where the

patient is in the journey and walks with him or her, all the while communicating in a way that is understandable. In a patient partnership, staff don't try to pull the patient to their level, and if patients decide to stop walking it's their choice, Schulz says. ■

Patient education from a partnership perspective

Tools for teaching must become interactive

ProHealth Care in Waukesha, WI, is in the process of implementing its "Partnership with Patients Work Plan." **Susan M. Kanack**, BSN, RN, patient education coordinator, is determining how to make the patient education tools more interactive to fit with the new partnership culture that is being developed.

In a partnership, nurses and other clinicians will engage patients in their care from all aspects, whether it be a task or procedure or in decisions made concerning patient education.

Currently, the tools are script like, states Kanack. They dictate things to be covered such as what a patient needs to do and who he or she needs to contact if there are questions.

"That information is great, but a lot of times it is still the same as lecturing the patient. So changing the formatting of our patient education will help in that the patient might have to write on it and engage with the material, make it their own," explains Kanack.

Although no new tools have yet to be selected, Kanack plans to move away from the checklist of topics that must be taught to the patient. She concedes that sometimes certain topics are required by administration or a regulatory agency but other than mandated information, educators will determine what to cover by interviewing the patient prior to engaging that patient in formal education.

Kanack envisions more of a dialogue between patient and practitioner to customize the education topics to the patient's needs — more of a give-and-take interaction than a general needs assessment interview.

For example, a woman who has just given birth would have different concerns if she already had children at home than if she were a first-time mom. During dialogue a new mom might express a need to know how to bathe a baby while the woman with other children might want to know about juggling sibling care with the needs of a new baby. By engaging the patient, the education is more meaningful, explains Kanack.

Changes will evolve

The educational tools will not be changed to promote a patient partnership until the initiatives being implemented to create that type of culture are in place.

Kanack says the approach is similar to the one her health care institution has taken in regards to health literacy. First, the issue was presented and once staff understood the problem they began to ask for solutions. The same should hold true for patient partnerships. As care is changed little by little, staff will begin to ask how patient education applies.

Kanack does not want to introduce a new education process via an inservice, but have it evolve as the partnership initiatives become common practice. She says a more interactive approach to teaching will start to make sense as a partnership culture develops, and by the time the department is ready to really change how patient education is delivered, it will seem obvious to the staff and they will start to ask for more interactive teaching tools.

The process of education would not be extremely different from what currently happens in that staff conducts needs assessments before teaching. However, rather than an interview, the assessment would be more of a discussion, says Kanack. In a traditional needs assessment the nurse takes the information provided by the patient and formulates a plan. In a partnership, there is a dialogue that con-

SOURCE

For more information about creating patient education tools to fit a patient partnership culture, contact:

• **Susan M. Kanack**, patient education coordinator, ProHealth Care, Center for Learning & Innovation, Patient & Family Resource Center at Oconomowoc Memorial Hospital, Waukesha, WI. Office: (262) 928-2907. Resource center: (262) 560-4573. E-mail: susan.kanack@phci.org.

tinues beyond the needs assessment and the patient and health care practitioner set goals together.

It will be a culture change because health care providers have a desire to impart their knowledge on patients, providing information they think patients must know, says Kanack.

The development and selection of tools to promote partnership in patient education will be accomplished with the aid of the practice council, says Kanack. They will help define what is needed from a bedside standpoint. ■

Web sites with teaching sheets to aid education

(In 2008 Patient Education Management *will run more articles with suggestions for saving you time, which is a valuable resource. Time-savers will include references to educational materials, work tips such as juggling staff and patient education, or programs that can provide patterns for other institutions to follow.*

With this issue we begin with a list of resources for patient education materials.)

An important part of most job descriptions for patient education managers is the creation of teaching sheets. While many institutions elect to create material that is unique to their health care needs, those who do the work agree that it is easier to edit sheets with an author's permission than to start with a blank piece of paper.

Patient Education Management has collected a few web sites that provide access to teaching sheets. Contact information is available on the site for permission to use parts of the material.

In addition, there are web sites that provide teaching sheets in a variety of languages. Patient education managers know that translating materials from English to a foreign language can be costly, yet teaching sheets for non-English-speaking patients are vital for comprehensive education.

GENERAL EDUCATION SHEETS:

• Children's Hospital of Central California, Madera — A health encyclopedia with thousands of pages on pediatric diseases and treatments is found on the web site of this health care institution. There also is wellness and disease prevention information. To access this material: www.childrenscentralcal.org.

• Jackson Health System, Miami — The web site for this institution includes a health library with 4,000 health and wellness articles covering 1,500 medical topics. To access this material: www.um-jmh.org.

• Sutter Health, Sacramento, CA —The health information library has categories such as cancer, children's health, food and nutrition, heart and circulation, men's health, mental and behavioral health, pregnancy and reproduction, wellness and lifestyle, and women's health.

Each selection has topics listed in alphabetical order. For example, under heart and circulation topics include: ACE inhibitors for high blood pressure; angina, unstable; and beta-blockers for heart failure. This section also has a drug guide.

To access this material: www.sutterhealth.org.

• The Ohio State University Medical Center, Columbus, OH — This institution has a section of its web site devoted to patient education materials. Health topic categories include diagrams, diseases and conditions, medication/vaccines, and nutrition and diet. Included in the selection are Somali materials and Spanish materials. To access this material: medicalcenter.osu.edu/patientcare/patient_education.

FOREIGN LANGUAGE HEALTH EDUCATION MATERIALS:

• Health Info Translations — A collaborative initiative by Mount Carmel, The Ohio State University Medical Center, and OhioHealth to improve health education for limited English proficiency patients, posting materials in a multitude of languages. Each teaching sheet is written in the foreign language along with the English equivalent. Languages include: Arabic, Bosnian, Chinese, English, French, Hindi, Japanese, Korean, Marshallese, Portuguese Brazilian, Russian, Somali, Spanish, Tagalog, Ukrainian, and Vietnamese.

Topics include diagnostic tests, diseases and conditions, exercise and rehabilitation, food and diet, general information, health and wellness, home care, pain and comfort, pediatrics, pregnancy and baby care, safety, stress and coping, and surgeries and treatments.

To access this material: www.healthinfotranslations.com. ■

With rising rate of MRSA comes need for education

Identification of infection critical

Antibiotic-resistant infections are not new to the health care setting, but headlines throughout the country have increased public awareness of the potential risk of infection.

According to a study by the Association for Professionals in Infection Control and Epidemiology, methicillin-resistant *Staphylococcus aureus* (MRSA) accounted for only 2% of all *Staphylococcus aureus* health care-associated infections reported to the Centers for Disease Control and Prevention (CDC) in 1972. Today, MRSA accounts for more than 60% of *Staphylococcus aureus* infections.

Although there are no studies that have looked specifically at home care, infection control experts point to the need for home care staff members to be knowledgeable about these organisms in order to minimize risk. Unfortunately, even with increased publicity of MRSA in the community, not all health care providers recognize the infection.

"I went to visit my 90-year-old mother who lives on the East Coast and she showed me a wound that wasn't healing," says **Marcia R. Patrick**, RN, MSN, CIC, director of infection control at Multicare Health Systems in Tacoma, WA. "It was classic MRSA so we went to see her physician," she says.

Although the culture that Patrick had to insist upon did show the presence of MRSA, it became clear to Patrick and her mother that the physician did not know how to treat the infection. After visiting a vascular surgeon, then treating the wound with silver dressings, the wound healed, but not before it had grown from the size of a quarter to a 4-by-6 inch area that left a permanent scar, she points out.

"We don't always know who has MRSA or any other antibiotic-resistant infection because a patient can be a carrier without having an active infection," Patrick says. "Many hospitals are testing a wide range of patients upon admission to identify patients who may be carriers."

Although testing of all home health patients is not practical or necessary, Patrick recommends an increased awareness of the signs and symptoms of bacteria-resistant infections so that treatment can be provided early and so that home health staff can ensure good outcomes for patients.

SOURCES

For more information about antibiotic-resistant infections, contact:

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- **Shannon Quaritsch**, RN, MS, CPHQ, quality improvement specialist, Northwest Community Home Care, 3060 Salt Creek Lane, #110, Arlington Heights, IL 60005. Phone: (847) 618-7855. E-mail: squaritsch @nch.org.

For information about the methicillin-resistant S*taphylococcus aureus* study conducted by the Association of Professionals in Infection Control and Epidemiology, go to www.apic.org. Select "Research Foundation" on the top navigational bar, and then select "National MRSA Prevalence Study."

Patients at risk

Patients at highest risk for MRSA or vancomycin-resistant enterococci (VRE), the two antibiotic-resistant organisms seen in the community, are those with wounds, catheters, a history of boils, or patients on dialysis, says Patrick. It is critical to recognize these patients higher risk for infection and monitor them carefully, she says. "MRSA often appears as a spider bite that doesn't heal, or a wound that won't heal," she adds.

"We don't screen all patients for MRSA or VRE upon admission but we have an active staff education program designed to heighten awareness of these infections for all staff members," says **Shannon Quaritsch**, RN, MS, CPHQ, quality improvement specialist at Northwest Community Home Care in Arlington Heights, IL. Staff education includes guidelines that identify different organisms and describe the type and duration of isolation necessary to prevent spread of the infection, she says.

Inservices include case scenarios that give nurses a chance to discuss the challenges faced by home care providers when a patient must be iso-

lated, points out Quaritsch.

Although nurses use standard precautions in patients' homes, not all nurses were handling patient education in the same way before the awareness program, she admits. "Now, all of the nurses have a checklist that they use to ensure that patients and family caregivers are taught about laundry procedures, the need to clean the patient's area frequently, and the need for gloves or aprons when dealing with body fluids," she says.

CDC prevention recommendations

The most common methods to prevent spread of the infection in the home that are recommended by the Atlanta, GA-based CDC are:

- Caregivers should wash their hands with soap and water after physical contact with the infected or colonized person and before leaving the home.
- Towels used for drying hands after contact should be used only once.
- Disposable gloves should be worn if contact with body fluids is expected and hands should be washed after removing the gloves.
- Linens should be changed and washed if they are soiled and on a routine basis.
- The patient's environment should be cleaned routinely and when soiled with body fluids.
- Notify doctors and other health care personnel who provide care for the patient that the patient is colonized/infected with a multidrug-resistant organism.

One part of Northwest Community Home Care's protocol for antibiotic-resistant infections is the need to culture any unimproved wound at the two-week point, says Quaritsch.

"Pressure ulcers are more difficult to culture in the home so they generally have to be biopsied in the hospital," she adds.

Once MRSA or VRE are diagnosed, patients are started on antibiotics that are known to work on these infections and caregivers are taught how to keep the patient's area, linens, and clothing clean to prevent the spread of the infection, she says.

It is difficult to treat patients with MRSA in the home because you have to rely upon family caregivers who may not be able to take care of themselves, as well as a patient who requires additional care, says Quaritsch.

"They are also reluctant to ask for help so it is up to the nurse to notice if additional help is needed, or if the patient must be transferred to another provider until the infection is controlled," she says.

"It is not unusual for a home care patient with MRSA to go to an extended-care facility for a brief time to ensure proper treatment of the infection," she adds.

The best way to approach diagnosis of MRSA and VRE is to realize that MRSA is everywhere, says Patrick. "It all goes back to basic hygiene and washing hands," she says. "Teach patients and staff members to wash hands and the risk of infection decreases." ■

Uninsured patients benefit from ED referral program

Tucson center serves working poor

About 110 uninsured patients a month are being referred from a Tucson, AZ, hospital emergency department to a nearby primary care and specialty center, the result of a collaborative aimed at finding the individuals an ongoing medical home.

Between August 2006 and July 2007, there were 1,352 referrals for patients "who aren't emergencies, don't have insurance, and don't have regular medical care" from St. Mary's Hospital in Tucson to nearby St. Elizabeth's Health Center, says **Nancy Johnson,** RN, PhD(c), executive director of the health center.

Patients at St. Elizabeth's, which serves individuals who are not eligible for federal- or state-funded health care programs, are put on a sliding scale and pay whatever they can afford, Johnson notes.

The effort, which began as a pilot program, will be continued, she says, noting that of the patients referred to the health center, 252 "have established care" at St. Elizabeth's. "The definition of that is that they have actually shown up, registered, and had one appointment.

"Where the rubber meets the road is if they continue [to come to the health center] and we see that we don't have other hospitalizations," Johnson adds. "That is yet to be seen."

In addition to continuing the partnership with St. Mary's, she says, health center staff will be seeking out those in need of affordable care in other places. One of those locations, Johnson

notes, is a small volunteer clinic in south Tucson called Clinica Amistad.

"There is no outpatient care of any kind in that area, so it's not easy [to get treatment] if you wake up in the morning and aren't feeling well," she says.

Clinica Amistad is run by volunteers, Johnson adds, and is open only on Monday evenings. "Seventeen to 30 people show up who have no physician, no money, no insurance.

"We started sending one of the community health workers from our center there to let people know we're here and to do health education with whoever shows up," she says. The plan was to encourage them to enroll at the center, Johnson adds, "and start getting them involved in preventive health care as well as acute care — things like flu shots and PAP smears."

The message her staff want to get across, she says, "is that we can offer services based on what they can pay." As a result, it is anticipated that the hospital ED will see fewer uninsured people who are not emergencies, and there will be fewer hospital admissions.

Key to the success of St. Elizabeth's programs, Johnson notes, is the support of Tucson physicians. "Our great blessing is that we have over 150 volunteer physicians who help us." Physicians donated care worth $750,000 during the past fiscal year, she adds, including expertise, X-rays, and use of the vascular lab, among other services.

Reluctant patients

One of the challenges center staff face in their efforts to provide care to the uninsured, she says, is the reluctance of many individuals to seek treatment — no matter how crucial — that they know they can't afford.

"We have one woman in for breast cancer treatment who had a palpable lump," Johnson notes. "She said, 'I don't want to leave my family with a large medical bill. I'd rather leave my savings account to them.'"

St. Elizabeth's staff were able to tell the woman about funding that is available from grants and from the Komen Foundation, she says, as well as care from volunteer clinicians.

"The projects we work with are models that integrate family and neighborhood," Johnson explains. "If I'm hanging out with people who eat healthy and take a walk every morning, I'm not as likely to eat doughnuts and lie in front of the television. A lot of people are influenced by those around them."

The Monday night sessions that St. Elizabeth's community health workers conduct at Clinica Amistad, for example, include nutrition education and chair exercise sessions "with whoever happens to be there," she says. "It's very impromptu. They might say, 'We will talk tonight about protein and where to find it, or calcium and what foods it's in.'"

Staff might start a conversation with patients about the foods they like to prepare and suggest ways to make them healthier, or discuss stress management activities, Johnson says.

"Our education is twofold," she adds. "One [approach] is to provide health information, but another is to build trust and to convince people that [St. Elizabeth's] will be a comfortable place to get care."

Cooperation is key

Cooperation between health center and hospital employees is a continuing focus, Johnson notes "When one of our patients needs to have surgery for cancer, we call ahead to let the hospital know the person doesn't have insurance, so they can be prepared to help rather than have it be a traumatic experience."

St. Elizabeth personnel work with hospitals to set up packages and payment plans for uninsured patients, she says, including an arrangement with Tucson's University Hospital on obstetrics care.

The health center has obtained funding to establish an electronic medical record (EMR) system, Johnson says, and it is expected to be in place by the summer of 2008.

"That will help us tremendously," she adds. "We're building in some templates for all the education and health prevention [programs] we're doing."

In the case of patients who are referred from the ED, Johnson says, "we will be able to measure the power of these interventions. We might have a diabetic who has improved — his hemoglobin A1c has gone down, which is the gold standard we use for control of diabetes."

Using the EMR, she explains, the individual would be logged in as an ED referral, with notations in the record showing that he came to the nutrition class and did the chair exercise, and that those things actually impact clinical outcomes.

"Most EMRs are designed for what happens in the exam room, and that is certainly helpful, but the premise we have is that [the traditional] model of care needs adjustment and that some of the preventive intervention may affect everything else."

Physicians will be able to pull a person's record, she adds, and say, 'Oh, I see you've been going to this exercise class.'"

"We live in a really abundant society," Johnson points out, where a lot of money is channeled toward health care. "Money is spent on treatment and hospital care. It is a disease-based model. We reimburse hospitals and specialists for surgery, radiation, and chemotherapy, but we don't have a lot of funding on the front side for prevention."

If an uninsured person feels fine, she may not see spending $75 for a mammogram. "I believe there needs to be a shift to get money on the front side and help people who are working but who can't afford to pay $1,000 a month for insurance."

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

Program increases patient, family involvement

Patient safety initiative honors NPSG

Increased patient involvement in their own care is encouraged by The Joint Commission and other organizations as one of the keys to improving patient safety. In fact, "encouraging patients' active involvement in their own care" is one of the National Patient Safety Goals.

In recognition of the importance of such an approach, Community Health Network in Indianapolis has launched a new patient safety initiative, Call FIRST (Family-Initiated Rapid Screening Team), in all five of its hospitals.

As part of the program, patients and their family members are encouraged to make a phone call when there is a change in the patient's condition and they feel their concerns are not being addressed. A designated internal phone line has been established for the program at each facility.

When the number is called, a nursing supervisor or consult nurse will provide help within 15 minutes at the bedside to evaluate and stabilize the situation. The program is intended only for serious concerns in the change of a patient's condition. If there is confusion about the condition or treatment plan, Call FIRST also can assess the situation.

According to Community Health officials, the program is based on the "Condition H" program started by the University of Pittsburgh Medical Center in 2005.

SOURCES

For more information, contact:

• **Eleanore Wilson**, RN, MA, BSN, vice president of nursing, Community Hospital North, 7150 Clearvista Dr., Indianapolis, IN 46256. Phone: (317) 621-6262.

A culture of safety

"One of the reasons we started the program was because we are changing our culture to a safety culture," explains **Eleanore Wilson,** RN, MA, BSN, vice president of nursing at Community Hospital North. "We want to be sure our patients are safe."

The Community Health version of the program was developed by its senior leaders and safety trainers, she says, and it was launched in September.

To help prepare staff for the program, discussions were held during regular staff meetings, and "team days" were held where staff education was provided. During these half-day sessions, Wilson discussed the purpose of the program, and how it would increase patient safety.

As for the patients and their families, there are several vehicles of communication. For example, there is written information provided at admission and Call FIRST signs have been posted in the patient areas to make patients and families aware of the initiative. The sign says: "Please ask us — we want your involvement." **(For more details, see box, next page.)** "It also explains that we are dedicated to creating an exceptional experience, and that we want the patients and families to be our partners in care," says Wilson.

Informing patients about Call FIRST program

Signs are posted throughout the hospitals in the Community Health Network system in Indianapolis to remind patients about the Call FIRST program. Here are some excerpts:

As a partner we encourage you to do the following: Call FIRST (Family Initiated Rapid Screening Team) at 1-7699 (Internal Extension)

- If there is a change in your condition and you feel your concerns are not being addressed. Your family members can also Call FIRST.
- If after speaking with a member of the health care team there is confusion about your condition or treatment plan.
- When you Call FIRST a member of the team will provide help within 15 minutes.
- Please do NOT call for routing questions or concerns. Your care manager can address those directly.

SPEAK UP to your care team

- If you have any questions at all about your care.
- If you are unsure about any of the medications given you.
- If your armband is not checked, or your name is not confirmed before you are given a medication or treatment.
- If you are unsure if your caregiver has clean hands. ■

"When a patient is admitted, we give them a brochure that talks about the program," adds Wilson. "When the nurse admits them, she also explains the program to the patient and lets them know it is available."

The patient and family are told that if the patient does not feel they are being heard he or she should call the number, and that staff want to be sure a manager responds within 15 minutes. In the brochure itself the question, "When is Call FIRST appropriate?" is posed, and then answered as follows: "If there is a change in condition and you feel your concerns are not being addressed."

Since the program is so new, there are not yet much data available. However, Wilson says, the feedback from patients, families, and staff has been positive. "One of the hospitals received a call from a patient who was being discharged and did not feel they were ready to leave the hospital," she shares. "The manager went over the case and explained that it was time for the patient to go. In addition, she said if the patient

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

- ■ Strategies to save time on the job
- ■ Improve health literacy to improve bottom line
- ■ Most common areas for improvement identified by Joint Commission
- ■ Using pathways to make the patient connection
- ■ Educating unique populations

CNE Questions

1. To motivate the appropriate lifestyle changes to prevent heart disease, programs might offer which of the following?

A. A sense of community.
B. A reward.
C. Family support.
D. DAll of the above.

2. In a culture that supports a partnership between health care practitioner and patient, educational tools should be more interactive rather than script-like?

A. True
B. False

3. How does **Shannon Quaritsch**, RN, MS, CPHQ, quality improvement specialist at Northwest Community Home Care, ensure that nurses properly educate patients about the precautions to take in the home when MRSA or VRE is diagnosed?

A. She relies upon their years of experience.
B. She reminds staff wash their hands.
C. She provides a checklist to use in the home.
D. She covers MRSA in new employee orientation.

4. The Call FIRST program should be used by patients in which situation?

A. If there is a change in condition.
B. If the patient feels his or her concerns are not being addressed.
C. For routing questions.
D. A & B

Answers: 1. D; 2. A; 3. C; 4. D.

felt she needed any additional help, such as home care, that it would be provided." In short, says Wilson, "all her questions were answered."

There are a number of situations in which the program can prove beneficial, says Wilson. "For example, there could be a case of a woman who has been with her husband for 20 years and knows he is not acting normal," she says. "The family members might recognize something that we don't."

Because of this added level of communication, she adds, "we feel family involvement will increase patient safety." ■