Effectively Managing Patient Education
GOING BEYOND JOINT COMMISSION REQUIREMENTS

SUSAN KANACK

An effective patient education program saves lives—and reimbursement

A well-managed patient education program can be directly linked to better patient outcomes. As a function within a hospital, it requires full organizational support to succeed. A faltering patient education program can lead to a host of problems for your facility, including noncompliance issues, patient dissatisfaction, loss of reimbursement, and poor patient safety. But despite the importance of a streamlined patient education program, it can be difficult for patient education managers to make a case for proper funding and attention.

If you want to build an effective program, or improve your current program, the book and CD-ROM Effectively Managing Patient Education: Going Beyond Joint Commission Requirements is for you. This resource provides step-by-step guidance on how to bolster your own program, including methods to convince hospital leaders that patient education is important, techniques to engage staff members, and resources to incorporate health literacy, patient-centered care, and culturally based care into your program.

With this resource as your guide, you will learn how to:

• Gain buy-in from top leadership and prime your organization for change
• Assess a patient’s educational needs and abilities and create a care plan
• Train staff to communicate care plans to patients in a manner they will understand
• Comply with The Joint Commission’s National Patient Safety Goals (NPSG) and other standards concerning patient education
• Ensure your facility receives accurate reimbursement

Use the proven strategies in Effectively Managing Patient Education to engage everyone in your organization to provide excellent patient education today.

Also of interest
Build a strong patient safety committee and hospitalwide culture of safety with The Patient Safety Officer’s Handbook.

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Effectively Managing Patient Education

GOING BEYOND JOINT COMMISSION REQUIREMENTS

SUSAN KANACK
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About the Author

Susan Kanack, BSN, RN

Susan Kanack, BSN, RN, is the system coordinator for patient education at ProHealth Care. Based in Waukesha, WI, ProHealth Care is a healthcare organization comprising two inpatient hospital facilities, 27 primary care clinics, home health services, long-term care, and a health and fitness center. She manages patient education at a strategic and operational level for the organization.

Prior to ProHealth Care, Kanack worked as a labor and delivery nurse in several urban hospitals within the Milwaukee metropolitan area, as well as developed and coordinated educational activities at an organizational level for staff members and physicians. She obtained her bachelor of science degree in nursing from Carroll-Columbia College of Nursing in Waukesha in 1998, and has been an RN for more than 10 years.

Kanack is a certified Change Agent and has been instrumental in spearheading culture change within her organization related to patient education practices. She sits on the board of directors for the Literacy Council of Greater Waukesha and is a member of the Southeast Regional Health Literacy Committee for the state of Wisconsin. She is also a member of the Health Care Education Association.

She has contributed to several articles and publications on patient education and has spoken at several conferences.
**Dedication**

To my dad, Kenneth R. Strozyk, who always made me feel like I could do anything that I put my mind to.

To the loves of my life, Ian Parker Kanack and Sofia Grace Kanack: *Dream Big*. The world is yours.

**Acknowledgments**

I could not have written this book without the knowledge, assistance, and friendship of the following people who have mentored me and provided guidance, wisdom, talent, and encouragement:

- Janet Schulz
- Ann Woodward
- Rebecca Hay
- Christopher Scherer
- Monica Erdmann
- Tina T. Smith
- Jennifer Anderson
- Heather Comak
- Linda Oddan
- Vicki Kuenzi
- Patrick Mullen

And finally, my accomplishments mean absolutely nothing to me without the love and support of my best friend and husband, Aaron Kanack; my mom, Diane Strozyk; and my sister, Donna Wagner. Love you all.
Introduction

It’s time for patient education to enter the spotlight. It’s been lying dormant for too long; passed over in favor of other competing priorities; wrapped up in other initiatives; or simply laid at the feet of a patient education manager to analyze and execute on his or her own. Patient education, a concept that staff members often view as more of a task than a process, is one of the few responsibilities that is shared across healthcare disciplines and involves virtually all healthcare professions. It’s a process that often is minimized to a standardized checklist and a “one-size-fits-all” paradigm, an approach that is a tremendous disservice to patients and their families. Now is the time to take a step back, redefine your work, redefine patient education, and redefine what it means to provide this critical aspect of patient care in healthcare today.

Patient education means more than just meeting Joint Commission requirements; it means patient safety, patient and staff member satisfaction, marketability, and community image. It’s linked directly to and embodied in patient- and family-centered care, health literacy, culturally competent care, and linguistic services. In fact, in its broadest definition, patient education can mean just about any healthcare communication from provider to patient. Unlike a procedure, which may occur only once a month in the hospital setting, patient education and communication with patients and their families occurs on a daily basis. As a result, this critical element in healthcare needs to be examined, thoroughly, and within the larger context of the healthcare industry and your hospital. It’s time to engage your organization. Let the journey begin.

Analyzing Patient Education

Patients, their families, and regulatory agencies such as The Joint Commission and the Institute for Healthcare Improvement are demanding more from healthcare providers. Like healthcare itself, patients have evolved; thus, our care for them, including the education we provide to them, must evolve as well.

To better understand this evolution, it’s important to look at the history of healthcare.
Introduction

Understanding healthcare trends

The existence of hospitals in the United States date back to the eighteenth century. A hospital’s purpose in the 1700s was to shelter the dying, orphans, and seafarers, and to prevent the spread of communicable diseases. As the U.S. population grew, mental illness added to the burdens of the country’s inhabitants. Individuals whose behavior offended or frightened the general public were reported to the town board, which then ordered the individual’s family to build a “strong house” or cell in which to house the individual on their property. If family or friends were unavailable, the person was auctioned to the lowest bidder, who would then have to care for that person, many times in exchange for physical labor.¹

With the spread of contagious diseases, townships began to isolate infectious individuals. As that practice grew, “sick houses” (or isolation hospitals, as they were named) suddenly provided an ideal method for dealing with the homeless, petty criminals, and, eventually, the mentally ill. Hospitals during this period were never intended for the general population to use. Medical care was, for the most part, provided in the home.¹

It’s interesting to note that many hospitals today have a history that chronicles the evolution of healthcare quite well. The Poor House of New York City, established in 1736, was originally created to house the “poor, aged, insane, and disreputable.” Today, it is known as the prestigious Bellevue Hospital. The Public Hospital of Baltimore, established in 1789, was home to low-income earners and people with mental illness, disabilities, and other physical ailments. One hundred years later, in 1889, it became the renowned Johns Hopkins Hospital.¹

Understanding patient trends

As stated earlier, hospitals and healthcare delivery are not the only things that have evolved; patients have as well. The “sick role,” described by Talcott Parsons in 1951, refers to the paternalistic, authoritarian relationship between a patient and his or her healthcare provider.¹ This theory, described by Frederick Wolinksy as “an integral part of the sociocultural definition of health and illness,”¹ was the model for healthcare interactions in which a patient complacently listened to the advice of his or her doctor, following orders and taking whatever medicines or treatments were prescribed. Most healthcare practitioners have been taught, and subsequently practice, in this manner; they hold the answers, and the patient’s duty is to follow their recommendations to get better.
Today, encouraging patients to engage in their healthcare and promoting more of a “partnership” between providers and patients is the mainstream; patients tend to “prefer participatory medical decision-making in their treatment, particularly educated patients.” Additionally, many patients have identified that they prefer clear communication, an ongoing (as opposed to episodic) doctor–patient relationship, and the feeling of empowerment. Such trends, as well as the larger movement toward patient- and family-centered care, are bringing patient education into the spotlight.

About This Book

This book, targeted to individuals in centralized patient education roles, is designed to provide the insight, experience, and tools necessary to take patient education to the next level. Incorporating regulatory agency standards, patient safety organization recommendations, and tried and true leadership theories, this book will equip patient education managers with the tools and skills they need to evolve their patient education programs to a much larger initiative beyond simply providing patient education materials.

In healthcare today, many priorities are competing to gain the attention of senior leaders and staff members. The patient education manager needs to be politically savvy to navigate this situation and to advocate for patient education. In this book, I provide tips on how to talk to leaders, implement and navigate through the change process, obtain organizational support and buy-in, and understand what The Joint Commission and other organizations require; tips which I’ve gathered from my experience instituting patient education in my organization.

Like many things, evolving a program from point A to point B can be a challenge; often, such changes require many years, and sometimes leadership turnover, to come to fruition. But by being equipped with the right tools, you can jump-start those changes and pave the way for much larger accomplishments in the future. Change does not happen overnight; groundwork must be laid, and the patient education manager must lay that groundwork.

I hope you will learn from my experience in patient education and bring your organization to the next level of this important and necessary aspect of patient care.
Introduction

References


Hospital Accreditation Standards and Recommended Practices

Many organizations provide guidelines, standards, and recommendations that are designed to improve patient safety throughout the healthcare system. Several, such as the Joint Commission standards, are well-known among healthcare providers because most hospitals are subject to a Joint Commission accreditation survey roughly every three years (every 18 to 39 months), and nurse managers and directors often must “scramble” to prepare for an imminent survey. But, in addition to Joint Commission standards, there are several other standards and recommendations that are equally important and also represent best practices for improving patient safety. Patient education managers need to be familiar with all of these standards and recommendations and how they affect patient education practices, both directly and indirectly.

Understanding The Joint Commission

The Joint Commission is a private-sector, nonprofit organization that evaluates and assesses healthcare organizations’ compliance both with federal regulations and with its own standards. The Joint Commission’s published mission is: “To continuously improve the safety and quality of care provided to the public through the provision of health care accreditation and related services that support performance improvement in health care organizations.” Joint Commission accreditation is directly linked to the Medicare/Medicaid program, because if you meet Joint Commission accreditation standards, you also meet the Medicare Conditions of Participation, which is a requirement for receiving Medicare reimbursement from the federal government. This is referred to as “deemed status,” meaning that if a hospital meets Joint Commission standards, it is deemed to meet Centers for Medicare & Medicaid Services regulations as well. Despite this direct link to Medicare/Medicaid, The Joint Commission remains an independent, private-sector entity.
Receiving and maintaining Joint Commission accreditation is of utmost importance to hospital administrators and senior executives of healthcare organizations. Therefore, understanding the role The Joint Commission plays in patient education is important in determining the overall landscape of patient education in your healthcare organization. It is critical that every patient education manager is well versed in the Joint Commission standards, as well as in National Patient Safety Goal (NPSG) implications.

The Joint Commission addresses the importance of patient education in several of its standards and National Patient Safety Goals. These standards and goals serve as guidelines to high-quality healthcare. By no means, however, should organizations aspire to meet these standards and goals simply because The Joint Commission requires it; rather, they should do so because the standards and goals are evidence-based and encourage high-quality and safe care to patients. Basically, meeting the standards and goals is the right thing to do.

In 2008, three standards in the Comprehensive Accreditation Manual for Hospitals were intended specifically for patient education. Two of the standards, which appear in the Provision of Care chapter, address the need for patients to receive education that is appropriate to both their needs (PC.6.10) and their abilities (PC.6.30). The third standard, which appears in the Leadership chapter, requires leaders to support patient education initiatives and programming (LD.3.120).

In 2009, the standards were revised under the Standards Improvement Initiative, and those revisions included a few changes relative to standards PC.6.10, PC.6.30, and LD.3.120. Essentially, standards PC.6.10 and PC.6.30 were combined to form one standard (PC.02.03.01) that addresses that patient needs and abilities are attended to when providing patient education. In addition, standard PC.04.01.05 was added, which requires the organization to provide specific discharge instructions to patients in the event of a discharge or transfer, and to educate patients and their families about any and all follow-up care, treatment, and services.

It’s important to note that LD.3.120 was not replicated in the 2009 manual; patient education accountability specifically in the Leadership chapter was deleted. The implications of this are significant; in short, it means that more responsibility is placed on the patient education manager to keep patient education on the radars of senior leadership, through frequent and ongoing communication, demonstrated outcomes, and improvement initiatives. Unfortunately, this often happens only after the organization receives a requirement for improvement (RFI) related to patient education. This is why it is important to devise a proactive and anticipatory approach to identifying
potential problem areas for your organization, and to begin to work on action plans to address them. You can do this by ensuring an overall state of survey readiness in your organization.

In my experience, the term *survey readiness* often connotes negativity, because staff members get a sense that we are looking to implement these practices or improvements only to meet Joint Commission requirements. The “scrambling” often seen within organizations when they are preparing for an imminent survey can be exhausting for staff members. And honestly, it does not have to be that way.

We were able to change the way our organization handles survey readiness by taking a different approach. In the past, our centralized education department was responsible for initiating education across the system months before a survey was due. So, for example, a few months before The Joint Commission arrived, we would begin to put up posters and flyers and send e-mails highlighting patient education documentation and the importance of including discharge instructions for all patients. However, though our staff members were able to present well to surveyors, we noticed that they were unable to retrieve information from the electronic medical records (EMR), and thus it appeared that our continuity of care was weak.

In addition, our compliance with patient education documentation was also noted as being very weak. After we addressed these gaps, we worked to have a constant state of readiness in our organization by implementing tracer tools. These tools (see Figure 1.1) follow the Joint Commission tracer methodology and help staff members walk through what is expected of them from a Joint Commission survey perspective. In addition, the tools familiarize the staff members with the EMR and where to retrieve information in an efficient manner. It was surprising to learn that staff members had difficulty retrieving information, such as recent labs, results, progress notes from other care providers, and care plans. Although this could be the result of a particular EMR and its interface, anecdotal information from other organizations seems to suggest this is a common problem.

The tracer tool also proved to have a dual purpose. It not only assisted bedside staff members in being prepared for a survey, but also provided valuable data that could foreshadow problem areas in meeting Joint Commission standards, and thus allowed us to implement more proactive action planning. From this tracer tool, we identified gaps in patient education documentation, indicating that documentation was at 60% compliance.
### Inpatient Tracer Tool

**Date done: / / **  
**Done by: **  
**Department:**  
**Staff Participants:**  
**Patient label:**

**For each of the items listed below indicate a Yes if compliant, No if non compliant and NA if not applicable for this patient**

<table>
<thead>
<tr>
<th>Item #</th>
<th>Score</th>
<th>Description</th>
<th>Item #</th>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td>How do you give and where is the patients information about their rights?</td>
<td>25</td>
<td></td>
<td>Patients are reassessed per policy-systems review (detailed observations and monitoring of systems related to the chief complaint or change in clinical status is present)</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td>Hospital general consent form is completed</td>
<td>26</td>
<td></td>
<td>Fall risk - daily</td>
</tr>
<tr>
<td>3</td>
<td></td>
<td>Surgical/procedural consent is documented by the MD</td>
<td>27</td>
<td></td>
<td>Skin risk - daily</td>
</tr>
<tr>
<td>4</td>
<td></td>
<td>Advance directive information is documented by the MD</td>
<td>28</td>
<td></td>
<td>Summary note for each shift - Unit scope document for frequency Days PMs Nights</td>
</tr>
<tr>
<td>5</td>
<td></td>
<td>A copy of the advance directive is on the chart</td>
<td>29</td>
<td></td>
<td>Patient is reassessed after PRN or timed pain medication for effect.</td>
</tr>
<tr>
<td>6</td>
<td></td>
<td>End of life discussions are documented by the physician</td>
<td>30</td>
<td></td>
<td>Specific to population on unit (neruo, sheaths, Peds…)</td>
</tr>
<tr>
<td>7</td>
<td></td>
<td>DNR orders are written on admission</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td></td>
<td>Health Information profile is completed/updated on admission</td>
<td>31</td>
<td></td>
<td>Began on admission</td>
</tr>
<tr>
<td>9</td>
<td></td>
<td>Abuse screening is completed within 24 hours of admission</td>
<td>32</td>
<td></td>
<td>Individualize to the patients needs</td>
</tr>
<tr>
<td>10</td>
<td></td>
<td>Nutrition screen completed within 24 hours of admission</td>
<td>33</td>
<td></td>
<td>Appropriate for the patient (i.e. high risk areas from HIP – fall, pain, nutrition, skin, functional screen or disease process)</td>
</tr>
<tr>
<td>11</td>
<td></td>
<td>Functional screen is completed within 24 hours of admission</td>
<td>34</td>
<td></td>
<td>Multidisciplinary</td>
</tr>
<tr>
<td>12</td>
<td></td>
<td>Past Pain history is assessed on admission</td>
<td>35</td>
<td></td>
<td>Short and long term goals are established</td>
</tr>
<tr>
<td>13</td>
<td></td>
<td>Current Pain level (intensity) is assessed on admission</td>
<td>36</td>
<td></td>
<td>Plan and goals are revised when necessary</td>
</tr>
<tr>
<td>14</td>
<td></td>
<td>Medication reconciliation is completed on admission.</td>
<td>37</td>
<td></td>
<td>Involves the patient/family, significant others as appropriate</td>
</tr>
<tr>
<td>15</td>
<td></td>
<td>A handwritten H &amp; P/admit note is completed on admission</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| 16     |       | Physician admit H & P is dictated, transcribed and authenticated within 24 hours of admission (need all 3) | 38     |       | Patient Education Documented as appropriate on the Education Flowsheet Patient is educated about the following:
|        |       |                                                                             |        |       |                                                                             |
| 17/18  |       | RN initial assessment (systems review) is completed within 8 hours of admission | 39     |       | Basic health practices and safety (i.e. call light, bed check, wash hands, bed alarm, bed low position, smoking, vaccine, home environment) |
|        |       |                                                                             | 40     |       | Safe and effective use of medications (Does the patient understand the use of a medication – 1st dose) |
|        |       |                                                                             | 41     |       | All new medications started in the hospital (reason for, effects, side effects) |
### Figure 1.1 Inpatient Tracer Tool (cont.)

<table>
<thead>
<tr>
<th>Item</th>
<th>Score</th>
<th>Description</th>
<th>Item</th>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>18</td>
<td></td>
<td></td>
<td>42</td>
<td></td>
<td>Nutrition, diet or oral health (brush teeth, change in diet, …)</td>
</tr>
<tr>
<td>19</td>
<td></td>
<td>Fall risk assessment (Morris Scale) on admission</td>
<td>43</td>
<td></td>
<td>Safe use of medical equipment and/or medical supplies (any medical equipment used for patient care, discharge equipment to be used)</td>
</tr>
<tr>
<td>20</td>
<td></td>
<td>Aspiration risk assessment on admission</td>
<td>44</td>
<td></td>
<td>How to obtain further care or treatment if indicated (usually on discharge forms or summary note)</td>
</tr>
<tr>
<td>21</td>
<td></td>
<td>Skin assessment (Branden Scale) on admission</td>
<td>45</td>
<td></td>
<td>Understanding pain, pain management, and methods of assessment</td>
</tr>
<tr>
<td>22</td>
<td></td>
<td>DVT risk assessment on admission – Start in May</td>
<td>46</td>
<td></td>
<td>Rehabilitation techniques (PT/OT/Speech/CPR/Pulm Rehab)</td>
</tr>
<tr>
<td>23</td>
<td></td>
<td>Specific to population on unit</td>
<td>47</td>
<td></td>
<td>Critical test result notification of MD note in summary note (Summary note includes what the value is, interventions received, time of call to the physician) Notification of physician within 30 minutes of critical test result received</td>
</tr>
<tr>
<td>24</td>
<td></td>
<td>Specific to population on unit</td>
<td>48</td>
<td></td>
<td>Comprehension is assessed on teaching</td>
</tr>
<tr>
<td>25</td>
<td></td>
<td></td>
<td>49</td>
<td></td>
<td>Dietary/Nutrition/Oral health (diet type, eating certain types of nutrient, brushing teeth, dental care)</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Discharge Planning/Instructions</strong></td>
<td>50</td>
<td></td>
<td>Discharge instructions on activity at home</td>
</tr>
<tr>
<td></td>
<td></td>
<td>All handwritten orders are dated and timed</td>
<td>64</td>
<td></td>
<td>(Indicate % compliance on Page 3)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Discharge instructions on when to call the physician</td>
<td>51</td>
<td></td>
<td>Discharge instructions on diet at home</td>
</tr>
<tr>
<td></td>
<td></td>
<td>All handwritten progress notes are dated and timed</td>
<td>65</td>
<td></td>
<td>(Indicate % compliance on Page 3)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Discharge instructions on what to watch for</td>
<td>52</td>
<td></td>
<td>Handwritten entries are legible</td>
</tr>
<tr>
<td></td>
<td></td>
<td>All signatures in the record have name and title</td>
<td>66</td>
<td></td>
<td>a. MD</td>
</tr>
<tr>
<td></td>
<td></td>
<td>All ambulatory areas-problem list/summary list is complete by the 3rd visit</td>
<td>66b</td>
<td></td>
<td>b. RNs/Others</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Medication reconciliation list of take home meds</td>
<td>53</td>
<td></td>
<td>Medication orders - Name of the medication not abbreviated</td>
</tr>
<tr>
<td></td>
<td></td>
<td>All signatures in the record have name and title</td>
<td>67</td>
<td></td>
<td>(Indicate % compliance on Page 3)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Progress notes use few/common abbreviations so that the entire care team are aware of the notes meaning and intent.</td>
<td>68</td>
<td></td>
<td>All ambulatory areas-problem list/summary list is complete by the 3rd visit</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Medication reconciliation list of take home meds</td>
<td>54</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>All signatures in the record have name and title</td>
<td>69</td>
<td></td>
<td>Ambulatory areas-problem list/summary list is complete by the 3rd visit</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Are written in a form patients can understand</td>
<td>55</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>National Patient Safety Goals</td>
<td>60</td>
<td></td>
<td>Medication Reconciliation is done when the patient is transferred in-house to a different level of care</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Do not use abbreviations are found in the MR (Indicate how many and which one on comment page)</td>
<td>56</td>
<td></td>
<td>Medication Reconciliation is done when the patient is transferred in-house to a different level of care</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Critical test result notification of MD note in summary note Lab result, x-ray, …</td>
<td>57</td>
<td></td>
<td>Medication Reconciliation is done when the patient is transferred in-house to a different level of care</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The surgical/procedural site is marked</td>
<td>58</td>
<td></td>
<td>Medication Reconciliation is done when the patient is transferred in-house to a different level of care</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Final team time out is conducted and documented</td>
<td>59</td>
<td></td>
<td>Medication Reconciliation is done when the patient is transferred in-house to a different level of care</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Medication Reconciliation is done when the patient is transferred in-house to a different level of care</td>
<td>60</td>
<td></td>
<td>Medication Reconciliation is done when the patient is transferred in-house to a different level of care</td>
</tr>
<tr>
<td></td>
<td></td>
<td>On discharge a complete list of meds is given to the next provider of care</td>
<td>61</td>
<td></td>
<td>Medication Reconciliation is done when the patient is transferred in-house to a different level of care</td>
</tr>
</tbody>
</table>

Questions to ponder when doing a tracer:
Where would you report a near miss or a potential safety risk?

Describe the pain process for the facility.

**Answer:**

- **Admission**
  - Pain level (intensity) is assessed upon admission or outpatient visit
  - Pain history is assessed – worst pain experienced and effective interventions
  - Pain teaching is provided on the pain scale:
    - Pain teaching on the pain scale and resources given are documented in the educational flow sheet
    - Patient level of understanding based upon the teach back method (Rating 0-4)
  - Patient’s pain goal is documented as appropriate (esp. chronic pain)
  - Scales utilized are: 0-10, Wong, behavior.
  - If the patient is able to use the numeric 0-10 then that is the preferred scale

- **Ongoing**
  - Pain level is assessed with the nursing assessment (based upon unit scope) and by other disciplines (PT, RT)
  - Prior to giving pain medication the level is assessed with descriptors - location, severity, and quality
  - Pain medication is given
  - Patient is taught about the pain medication - reason for, effects, and side effects:
    - Pain teaching on the pain medication and resources given are documented in the educational flow sheet
    - Patient level of understanding based upon the teach back method (Rating 0-4)
  - Pain is reassessed after medication is given
  - Alternative pain relief measures are utilized and documented. (Repositioning, splinting, heat, cold…)

The Joint Commission is on your unit and wants to talk to you about your patient what do you do?

**Answer:**

1. Communicate to another nurse the needs of the patients you are taking care of
2. Ask for other disciplines that have been involved in your patient’s care to join you with the Joint Commission – dietary, pharmacy, case management, physical therapy…
3. These other disciplines can assist in answering questions that are specific to the patient and to the process of the coordinated care.

Where would you go to locate what steps to take for a Code White?

**Answer:** Code White = Emergency Preparedness Plan/Disaster Plan …. Quick reference Safety Flip Chart Located in the department

Locate the Policy on “Standards of Clinical Practice”

**Answer:** Find policy on line.

What is the value of the above policy to you, the bedside nurse?

**Answer:** Guide for the nursing care provided to patients. (Assessment, Plan, Intervention, Evaluation)

Comments/ Corrective Action Plan:
Addressing the gaps in patient education is a challenge, in part because ultimately, accountability for documentation of patient education rests with the organization’s bedside care staff. Patient education managers, although often the driving force behind patient education standards and mapping the direction an organization needs to take, lack the ability to truly enforce documentation standards. To address this, organizations need to put in place certain tactics that strengthen the standards and further drive accountability to the bedside staff and their reporting manager. Often, this comes in the form of a corrective action plan.

For example, our corrective action plan (see Figure 1.2) hypothesized what was causing our lack of documentation. By partnering with the quality department, both the information systems and human resources departments developed tactics to address our identified gaps. Including patient education in annual performance reviews and creating documentation standards and specific policies can provide more assurance that patient education documentation will be addressed. By including patient education documentation in performance reviews, you not only underscore patient education’s importance in a bedside care role, but also reinforce the idea that patient education documentation is an expectation, since staff members are evaluated based on meeting this requirement. This also places accountability where it belongs: with staff members and their reporting manager. A patient education policy is shown in Figure 1.3.
Corrective action plan for patient and family education documentation

**Problem:**
Inpatient tracer cumulative compliance report demonstrates inadequate compliance with all elements of performance of Joint Commission standard PC.02.03.01: *The patient is educated and trained specific to the patient’s needs and as appropriate to the care, and services provided.*

**Hypothesis:**
- Lack of patient education documentation standards and guidelines allow for variability in documentation (content and location).
- Staff perception of patient and family education as a task, rather than ongoing and continuous (i.e.: done but not documented).

**Corrective Plan:**
Establishment of Patient and Family Education Documentation Guidelines, Education and Accountability

<table>
<thead>
<tr>
<th>WHAT</th>
<th>Practice Standards</th>
<th>Staff Education</th>
<th>Accountability</th>
<th>Technical Infrastructure</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>WHO</strong></td>
<td>Nursing Practice Council</td>
<td>Central Education</td>
<td>Managers/directors</td>
<td>IS</td>
</tr>
<tr>
<td><strong>WHEN</strong></td>
<td>Within 45 days</td>
<td></td>
<td></td>
<td>July 13th</td>
</tr>
<tr>
<td><strong>NOTES</strong></td>
<td>Quality Council to monitor compliance</td>
<td></td>
<td></td>
<td>Pilot estimated to be favorable; will then implement house-wide.</td>
</tr>
</tbody>
</table>
I. PURPOSE:

To provide guidelines and standardization in the process for patient and family education delivery and documentation.

II. POLICY:

A. It is the responsibility of all healthcare providers to provide patient and family education that will foster patient self-management, promote patient safety and achieve the desired state of wellness as defined in partnership with the patient/family and care providers.

B. Utilizing the Patient Education Process, in partnership with patients/families and the multidisciplinary care team, the healthcare provider shall:

1. Conduct a thorough education assessment taking into consideration: patient/family education priorities, health literacy and other language barriers, cultural and religious practices, emotional barriers, drive and motivation to learn, physical and cognitive limitations, and financial implications of care choices.

2. Plan educational interventions and identify individualized learning goals, utilizing the data gathered in the assessment.

3. Teach utilizing approved patient education materials (handouts, TIGR On-Demand, etc) based upon the patient/family learning preference. Patient education materials should supplement teaching, not replace it.

4. Evaluate patient and family understanding of the new knowledge or skill utilizing the “teach-back” method of evaluation.

C. In addition to individualized learning goals, all patients and/or family members shall be educated about:

1. The plan of care, treatment, and services
2. Patient rights and responsibilities
3. Basic health practices and safety
4. The safe and effective use of medications
5. Nutrition interventions, modified diets or oral health
6. Safe and effective use of medical equipment or supplies when provided by the hospital
7. Understanding pain, the risk for pain, the importance of effective pain management, the pain assessment process and methods for pain management
8. Habilitation or rehabilitation techniques to help them reach the maximum independence possible.

III. PROCEDURE:

A. All patient and family education, including narrative notes, will be documented in the Patient Education Flow Sheet in the medical record, to allow for care coordination and interdisciplinary collaboration. Patient and family education goals shall be documented in the Care Plan.

B. Patient Education documentation shall include the following essential elements:

1. What was taught (i.e: new medication, indication, side effects)
2. What patient education materials were used (i.e: handout)
3. What additional follow-up instruction the patient/family may need

C. Discharge instructions will be completed and given to the patient and/or family prior to discharge. All discharge instructions shall include, but not be limited to, the following:

1. Activity
2. Diet
3. Medications
4. Follow-up appointments
5. When to call the doctor

REFERENCES:

The 2009 National Patient Safety Goals

The National Patient Safety Goals issued by The Joint Commission are requirements of care that all healthcare organizations must implement and be evaluated on during each accreditation survey. The Joint Commission reviews and updates the Goals annually, amending existing goals or adding others based on new initiatives or evidence. When the Goals were first implemented January 1, 2003, there were just six of them. Today, there are 16 Goals, with various elements of performance for each one. The Universal Protocol™ to prevent wrong-site surgery is also a part of the National Patient Safety Goals.

The Goals were originally developed by the Sentinel Event Alert Advisory Group, a nationally recognized panel of experts comprising pharmacists, physicians, nurses, and other patient safety experts. The Advisory Group first convened in April 2002 and developed recommendations after reviewing The Joint Commission’s Sentinel Event Alerts. From those alerts, the Advisory Group identified 44 recommendations that potentially might have a great effect in improving patient safety in hospitals across the nation. Of those 44 recommendations, the Advisory Group prioritized and presented their top six recommendations to The Joint Commission’s Board of Commissioners. Those recommendations were approved, and were implemented nationwide in 2003. The Advisory Group, now called the Patient Safety Advisory Group, continues to review the Goals annually and identifies upcoming topics for both future goal development and Sentinel Event Alert publications.

The first six Goals were announced in July 2002, and they were widely accepted by many practitioners, as they were topics that had been in discussion for many years. The Goals are evidence-based and extremely cost-effective, with practical strategies for implementation.

The Goals are designed to keep patients safe; they focus on problematic areas in healthcare and offer solutions to help resolve them. The solutions are generally system-focused in an effort to recognize that a truly safe environment is one that operates as seamlessly as possible. The Goals include all aspects of care, ranging from how to safely identify a patient before a procedure, to hand hygiene and central line infections.

Of particular importance is the role that patient education plays in these Goals. The 2009 National Patient Safety Goals have expanded to include more detailed Elements of Performance for certain Goals, with significant patient education or patient–provider communication implications for many of them. See Figure 1.4 for a list of the NPSGs that relate to patient education.
The National Quality Forum

The National Quality Forum (NQF), established in 1999, is a private, nonprofit organization whose purpose is to develop a national strategy for healthcare quality measurement and reporting. The NQF is composed of many organizations from all parts of the healthcare system, including consumers, employers, healthcare professionals, provider organizations, health plans, accrediting bodies, and labor unions. The group formed with a shared concern over healthcare quality and its effect on patient outcomes, patient safety, productivity, and rising healthcare costs. The NQF’s mission statement, published on its Web site, reads as follows: “To improve the quality of American healthcare by setting national priorities and goals for performance improvement, endorsing national consensus standards for measuring and publicly reporting on performance, and promoting the attainment of national goals through education and outreach programs.”

In addition, the NQF’s vision, taken from the NQF Web site, reads as follows:

- The NQF will be the convener of key public and private sector leaders to establish national priorities and goals to achieve the Institute of Medicine Aims—healthcare that is safe, effective, patient-centered, timely, efficient, and equitable
- NQF-endorsed standards will be the primary standards used to measure and report on the quality and efficiency of healthcare in the United States
- The NQF will be recognized as a major driving force for, and facilitator of, continuous quality improvement of American healthcare quality

<table>
<thead>
<tr>
<th>2009 National Patient Safety Goal</th>
<th>2009 Element of Performance Expansion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goal #3: Safe medication usage</td>
<td>Patients and their families are educated on standardized anticoagulants.</td>
</tr>
<tr>
<td>Goal #7: Decreased healthcare-associated infections</td>
<td>Patients and their families are educated on standardized multidrug-resistant organisms.</td>
</tr>
<tr>
<td>Goal #8: Medication reconciliation</td>
<td>Patients and their families are educated on their medication lists.</td>
</tr>
<tr>
<td>Goal #13: Patient involvement in care</td>
<td>Patients and their families understand that specific safety measures are evaluated and documented.</td>
</tr>
</tbody>
</table>
The NQF endorsed 30 Safe Practices in 2003 that should be “universally utilized in applicable clinical care settings to reduce the risk of error and resultant harm to patients,” recognizing the healthcare safety movement that by this point had become a national priority. Each of the Safe Practices, updated in 2006 and again in 2009 to include a total of 34, is specific, easily generalized, and evidence-based, ready to be implemented. Patient education managers need to be familiar with these Safe Practices, as a few of them directly involve patient education. All Safe Practices are organized into the following categories:

- Creating and sustaining a culture of safety
- Informed consent, honoring patient wishes, and disclosure
- Matching healthcare needs with service delivery capability
- Medication management
- Preventing healthcare-associated infections
- Condition- and site-specific practices

It’s important to note that the NQF intentionally does not prioritize or weight any of these practices, as each is considered to be equally important to implement. Each is critical to ensuring patients are kept safe.

Practices for creating and sustaining a culture of safety, although not as directly linked to patient education as in the Safe Practices, are important for everyone to follow, as doing so helps to meet an end goal which every department shares: patient safety. In my organization, we utilized a Culture of Patient Safety Toolkit that helped clinical managers prepare their bedside staff in creating and sustaining a culture of safety. This toolkit, located in Appendix Three of this book, was available for managers to use as activities during staff meetings or departmental inservices, since it is often a challenge to get staff members away from the bedside for any type of extensive education. This approach was successful for us in that it provided a resource to unit managers who were often in the best position to transfer information to the staff.

Of particular importance to patient education are practices that directly affect patient education. Safe Practice #2, under the broader category of Informed Consent, speaks to how practitioners need to assess comprehension, once instruction has been given, by utilizing the “teach-back” method. This method involves asking patients and/or family members to restate in their own
words key information about what they learned or were told regarding any treatments or procedures for which they need to give informed consent.

Although the teach-back method is recommended as a Safe Practice during the informed consent process, organizations should use this method for any patient education interaction, as it truly is an effective way to evaluate what the patient comprehends. You should avoid asking the classic question, “Do you understand?” as patients will rarely want to disclose that they didn’t understand, or they may not even be aware of any knowledge gap. Rather, reframing the question—as in, “Tell me what you’re going to tell your friends and family about how to manage your disease at home,” or “I want to make sure I taught you everything you need to know, so to help me know that I did that, explain to me how you would take your medication”—is a much better approach that will truly assess what the patient learned from the instruction. In addition, as related to consent, the patient will truly be able to provide informed consent, and staff members will have assurances that the patient is fully informed about his or her procedure and its risks and benefits.

Another Safe Practice recommends that the organization ensures that information is communicated to patients in a “clearly understandable form.” This means all aspects of communication with patients and their families, from verbal interactions to written handouts, are clear. But what does it mean to be “clearly understandable”? To be clearly understandable, information must be communicated in such a way that the receiver understands the message you are trying to convey.

The Plain Language Movement in the U.S. government is a perfect example of why this is necessary and how to go about speaking and writing in “plain language.” Plain language has been addressed at the government level in the United States since before the 1970s, starting with a publication called Gobbledygook Has Got to Go. From there, various initiatives throughout government have transpired. Plain language gained lots of momentum during the Clinton Administration, when Vice President Al Gore considered communications in plain language to be a civil right, and a practice that promotes trust in the government. In fact, the U.S. Securities and Exchange Commission’s (SEC) A Plain English Handbook remains a perfect example of a document that is written in plain language. Warren Buffett, a friend of the SEC chairman at the time the handbook was published, offered this definition of writing in plain language:

*Write with a specific person in mind. When writing the Berkshire Hathaway annual report, I picture my sisters, highly intelligent, but not experts in accounting or finance. They will understand plain English, but jargon may puzzle them. My goal is to give the information I would wish to receive if our positions were reversed.*
Clearly, communications from our federal government are important enough that all people should understand them; the same is true with healthcare. When speaking to a patient and his or her family about a new diagnosis or treatment the patient must undergo, or when writing and designing a handout that will be given to patients, consider Warren Buffett’s definition. More tips on how to prepare reader-friendly patient education handouts will appear later in the book.

**Culturally and Linguistically Appropriate Services (CLAS) standards**

The Office of Minority Health (OMH) developed the Culturally and Linguistically Appropriate Services (CLAS) standards in response to growing concern regarding the healthcare needs of minorities. The standards were developed by analyzing existing laws and standards, and were further refined by several project committees, with the aim of ensuring culturally appropriate care and cultural competence. The emergence of cultural competence as a method to close the gap in racial and ethnic disparities in healthcare\(^\text{10}\) came about due to the ever-increasing diversity of the United States. The goal of cultural competency is “to create a health care system and workforce that are capable of delivering the highest-quality care to every patient regardless of race, ethnicity, culture, or language proficiency.”\(^\text{10}\) Nurses and other healthcare professionals are faced with a global population, with varying beliefs, languages, and approaches to medicine. As a result, staff members need to be well-versed in how to provide care to patients with such diversity.

The OMH, a function of the U.S. Department of Health and Human Services, exists to develop health policies, programs, and standards to close ethnic and racial gaps in healthcare and to ensure that all minorities receive the care they need in order to stay healthy. As a result, the OMH developed the CLAS standards to assist hospitals in providing culturally and linguistically appropriate care. There are 14 standards, grouped by theme and falling under one of three stringencies: mandates, guidelines, or recommendations. Those that are deemed mandates are required actions by healthcare entities in order to receive federal funding.\(^\text{21}\) The themes in which the standards fall are: Culturally Competent Care (Standards 1–3), Language Access Services (Standards 4–7), and Organizational Supports for Cultural Competence (Standards 8–14). Of particular relevance to patient education is Standard 7 (a mandate), which speaks to how patient education materials not only must be easily understood, but also must be available in the patient’s language. So, if your hospital commonly sees Spanish-speaking patients, you are obligated to ensure that your materials are also provided in Spanish. We will discuss culturally appropriate care and patient education in more detail later in this book.
Chapter one

The guidance in Standard 7 is as follows:

*Healthcare organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.*

**The Institute for Healthcare Improvement (IHI)**

The Institute for Healthcare Improvement (IHI) is an independent, nonprofit organization dedicated to improving healthcare quality via various initiatives aimed at improving patient safety worldwide. By recommending key initiatives, building energy and enthusiasm to change, and providing resources for hospitals to deploy the initiatives, the IHI hopes to accomplish the following:

- No needless deaths
- No needless pain or suffering
- No helplessness in those served or serving
- No unwanted waiting
- No waste
- No one left out

Two of the largest improvement initiatives in healthcare are the IHI’s *100,000 Lives Campaign* and *5 Million Lives Campaign*, in which recommendations for saving patients from harm in one year’s time are shared and hospitals are called to action to participate. Each year since the inception of those initiatives, the IHI has added new recommendations and renewed energy. Thus far, patient education has had an indirect link to the IHI’s initiatives; however, it’s still important to stay abreast of what the IHI recommends each year. In late 2008, the IHI launched its newest campaign, *The Improvement Map*, which will focus on improving 100 processes within hospitals vital to great patient care.

**Reviewing the literature**

As with other clinical questions of inquiry, knowing “what’s happening” in the world of patient education is a must. This starts with a comprehensive literature review. Many librarians can assist you in this endeavor; however, knowing how to search on your own is a good skill to have. Many resources are available to help you learn how to search through databases and decipher literature findings; among the most helpful resources is *Essentials of Nursing Research: Methods, Appraisal and Utilization*, by Denise F. Polit and Cheryl Tatano Beck (Lippincott).
There are many reasons to conduct a literature review. For the purposes of managing patient education at the organizational level, it means analyzing study findings and assessing their applicability to your organization, determining any implications they may have, and developing subsequent recommendations. The literature can hold answers to these and many other questions regarding patient education:

- If your organization lacks a policy on patient education materials, how do you know what your policy statement should cover?
- What is a best practice on material development?
- What is the best way to measure comprehension after a teaching interaction?
- What are other organizations doing and what are some lessons learned?

Conducting a literature review will help guide your next steps, and also helps to ensure that your methods are best practices. In addition, the following resources are invaluable to new patient education managers and are considered a core collection for staying up to date and well-informed:

**Journals**

*Patient Education & Counseling* (Elsevier)

*Patient Education Management* (AHC Media)

**Books**

*The Joint Commission Guide to Patient and Family Education* (Joint Commission Resources)

*Teaching Patients with Low Literacy Skills* by Celia C. Doak, Leonard G. Doak, and Jane H. Root (Lippincott)

*No Time to Teach?* by Fran London (Lippincott)

*The Practice of Patient Education* by Barbara Klug Redman (Mosby)

*Patient Education: Principles & Practice* by Sally H. Rankin and Karen Duffy Stallings (Lippincott)

*The Illness Narratives: Suffering, Healing & the Human Condition* by Arthur Kleinman (Basic Books)
Assessing the environment

When you begin your career in patient education management, analyze your organization and collect some data to get a better understanding of the overall landscape. You need not be a statistician to collect data. Data can come from any number of avenues, both quantitative and qualitative in nature. Data can mean anything, from the number of patient education materials you have in foreign languages to dollars spent on patient education. Some topics lend themselves well to data collection; for example, if your facility has an on-demand patient education video system, you may be able to easily determine the usage rate of any and all patient education videos in your organization. Asking questions and knowing where your organization stands regarding patient education will help to guide your efforts and prioritize your energy. Use the following questions to understand the current state of patient education in your organization:

- How is patient education delivered?
- Are any competencies related to patient education?
• Are the patient education materials of high quality? Do they require only a low reading level?
• Is patient education documented appropriately?
• Is your organization meeting Joint Commission standards?
• What do clinical staff members think of the current state of patient education? Are their needs met?
• What does your chief nursing officer think is the greatest priority?

Suppose the answers to the preceding questions reveal the following: patient education appears to be delivered primarily via the nursing staff through handouts and verbal instruction. Usage of education videos is low to nonexistent, and the videos that are in the facility are more than 10 years old. There aren’t any competencies for patient education; documentation, however, appears to be good and your organization is Joint Commission–accredited and had minimal RFIs at the last survey. The staff thinks patient education overall is “fine,” but the chief nursing officer believes the staff is lacking basic skills in educating patients and shows you patient satisfaction reports that support this claim. What area would you focus on first? What would be your recommendation for action?

These findings, combined with the latest trends found in the literature, will provide valuable insights. Use the data gathered, as well as your interpretation of the data and subsequent recommendations, to prepare a formal assessment report. Collecting this data, preparing the report, and communicating your findings to senior leaders in your organization will assist in the buy-in process, particularly if you are looking for additional funding, full-time equivalent support, or expansion of existing services.

In many cases, only a quick “glance” by a patient education manager will reveal that improvement is required in all areas of patient education. Chart audits might reveal inconsistent charting with missing elements; comprehension is assessed via the classic “Do you understand?” and was validated by a patient’s signature on discharge instructions. Materials handed out to patients might lack unity and clarity and are decentralized in a way that costs the organization far more than it should. Resources for patients range from limited to nonexistent.

More likely than not, several areas need attention and organization. But you can’t change all of them at once. Keep in mind that too much change all at once can lead to “repetitive-change syndrome,” which can mean initiative overload, change-related chaos, and widespread employee
anxiety, cynicism, and burnout. To ensure that your changes are met with the least amount of resistance, find the one area that needs the most improvement and whose resolution would have the most effect; garner support for that first, and resolve that issue. And do it well.

**Navigating Through the Change Process**

Change is hard, and even harder to manage on your own. In fact, in organizations the world over, many change efforts fail before they even begin to take hold. Why? First, it’s important to recognize that any amount of change requires several phases that, in total, equal a large amount of time. Even though the change needed may be urgent or may seem relatively easy to execute, for the change to take hold and become part of the everyday business or culture in your organization, you need to invest in time.

Finding that one area to focus on and change for the better can be overwhelming. How do you decide? If you’re a patient education manager, everything about patient education is a priority. The reality, however, is that it can’t all be done at once; and if you’re new to the organization, you don’t want to come on board proposing sweeping changes. Instead, several great tools are available to help you prioritize your needs.

One such tool is the priority/payoff matrix (see Figure 1.5). You can use this tool to analyze an option from two different angles. If the issue falls into the “high payoff” and “easy to implement” categories, it is reasonable to infer that this is the issue toward which you should prioritize your efforts. In our organization, after we determined our current status through data collection and a subsequent assessment report, we placed problem areas on the payoff matrix. Actually deciding where something falls in the matrix often requires discussion and a group consensus. We identified several areas in patient education to work on, but on our payoff matrix, improving the education flow sheet for easier documentation in our EMR was believed to be “high priority/easy to implement.” “Easy,” of course, was relative, since we also had to partner with our information systems department to make this happen. But the payoff matrix proved to be a useful tool; we focused our energy on improving and implementing the flow sheet, and our caregivers’ perception of the usefulness of education documentation improved by 30% within two months.
Once you’ve identified the high-priority/easy-to-implement tactic you should work on, be cognizant of the change process and what it takes to create and roll out a successful change. John P. Kotter, a Harvard Business School faculty member who is highly regarded as the foremost authority on change, change management, and leadership, outlines eight crucial factors in managing change in his work, *Leading Change* (Harvard Business School Press). Understanding each factor is an important skill for any patient education manager to have, and is crucial to ensuring a successful transformation.

**Factor 1: Establish a sense of urgency**

It’s hard to implement a major transformational change when nobody in your organization believes there is reason to change in the first place. Getting people to buy into the need to change means demonstrating to them why change is needed. Literature reviews, benchmarking data, and competitor analysis are all valuable pieces of information that can lead to establishing a shared need to change. But it’s also important to include what will happen *if change does not occur*. For patient education programs, it could mean revenue loss, Joint Commission citations, a decrease in patient satisfaction scores, liability to the organization, or, worse, patient safety risks.
Don’t underestimate the amount of effort it may require to get people on board with your proposal. Even though the need for change may exist, getting people to move out of their comfort zone may take more effort than is realized. Often, people may start to tell themselves a story about potential horrible domino effects once a change has taken place, such as morale suffering as a result of new regulations, staff turnover, system problems, and the like. And many times, these concerns may be valid, and you should consider them within the larger context of the proposal. They should not paralyze leaders from taking action, however. Rather, it’s important to remember that “change, by definition, requires creating a new system, which in turn always demands leadership.”13

Factor 2: Create a powerful guiding coalition

As mentioned earlier in this chapter, change is hard to manage, especially alone. For a successful change initiative, having a core group of influential decision-makers guiding the process helps tremendously in ensuring that the change effort sustains over the long term and gains momentum. These influential decision-makers, in the most successful of groups, aren’t necessarily all senior executives, but rather are powerful individuals in terms of title, influence, reputation, and relationships.

A critical component is that the coalition has an executive sponsor, or a senior leader who can guide the process, remove barriers, and help foster and support change at the highest level of the organization. In our organization, this person was our integration officer. This was a new executive position designed to help our multi–health facility organization integrate into one system. Since patient education also needed to be integrated throughout the system, this executive seemed like a logical choice. I scheduled an appointment with her to discuss patient education, the current state of the organization, my recommendations, and the need for executive sponsorship.

This approach is also consistent with the experience of a Veterans Administration Medical Center, which found that “a strong linkage to the executive management team was necessary if patient education was to be an integral part of the medical center.”14 Recognizing that any amount of change requires the effort of other people is a critical factor to the success of any recommendation that is being proposed. For many organizations, a good step to take to begin that change process is to establish that guiding coalition with a systemwide patient education committee. Any system-level committee at the leadership level can be costly to the organization in terms of both time and money, so it’s important to outline a proposal for this to gain buy-in. Figure 1.6 shows an executive summary from a comprehensive proposal for a system-level committee.
Executive summary

State of affairs
The organization lacks a standard and unified process for the creation, implementation, and distribution of patient education documents and initiatives. Patient education occurs reactively as opposed to proactively, and without any strategic planning.

Although individual patient education documents may be of excellent clinical quality, collectively they lack consistency in the messages they deliver to patients. In addition, the materials given to patients are generally written at the graduate level, and most likely patients are unable to understand them.

The organization also lacks any archival process for its patient education documents. This continually puts the organization at risk because it is unable to determine what education was provided to a patient on any given health topic.

Risks and opportunities

<table>
<thead>
<tr>
<th>Strengths</th>
<th>Weaknesses</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Organizational willingness to align</td>
<td>• Consistency</td>
</tr>
<tr>
<td>• Executive support</td>
<td>• Organizational standards</td>
</tr>
<tr>
<td>• Many frontline staff members invested in writing materials</td>
<td>• Budget dollars</td>
</tr>
<tr>
<td>• “Homegrown” documents; allows for distinct customization</td>
<td>• Archiving</td>
</tr>
<tr>
<td></td>
<td>• Community image</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Opportunities</th>
<th>Threats</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Linkage to the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS): trending in qualitative patient perception of care</td>
<td>• Regulatory bodies</td>
</tr>
<tr>
<td>• Linkage to patient-/family-centered care approach</td>
<td>• Competition most likely will penetrate service area</td>
</tr>
<tr>
<td></td>
<td>• Patient safety</td>
</tr>
<tr>
<td></td>
<td>• Litigation</td>
</tr>
<tr>
<td></td>
<td>• Patient perception</td>
</tr>
</tbody>
</table>

The Journey Begins
Executive summary from a comprehensive proposal for a system-level committee (cont.)

**Recommendations**

1. Form a committee at the executive level (Patient Education Advisory Committee), which will direct and manage patient education activities at an organizational level. A subcommittee comprising expert clinicians (health education review group, or HERG) would serve to operationalize the vision put forth by the patient education advisory committee.

2. Fully implement Ask Me 3 ([www.askme3.org](http://www.askme3.org)) at an organizational level.

**Budget**

The following is a budget proposal for implementation of the patient education advisory committee and the HERG subcommittee. Implementation of Ask Me 3 requires no direct cost.

**Direct Salaries and Wages**

<table>
<thead>
<tr>
<th>Employees</th>
<th>Average hourly salary</th>
<th>Time per month (two hours)</th>
<th>Months</th>
<th>Amount per resource</th>
</tr>
</thead>
<tbody>
<tr>
<td>Managers and directors for the patient education advisory committee: total of 16 members</td>
<td>$22.64</td>
<td>1.28%</td>
<td>12 months</td>
<td>$543.36</td>
</tr>
<tr>
<td>Staff for HERG (nonmanagers/directors): total of 15 employees</td>
<td>$21.53</td>
<td>1.28%</td>
<td>12 months</td>
<td>$516.72</td>
</tr>
</tbody>
</table>

**Strategic goal alignment**

Implementation of the recommendations put forth in this assessment is consistent and in alignment with the following two major strategic initiatives:

- Patient-/family-centered care
- Cost and quality
Measures of success

Although currently neither national standards nor benchmarking data for patient education exist, you can use several metrics to measure success of patient education:

- Patient satisfaction scores:
  - Press Ganey
  - HCAHPS
- Patient feedback:
  - Focus groups
- Joint Commission standards and Core Measures
- Reading level of patient education documents
- Number of documents in Spanish
- Number of other foreign languages offered
- Online access of all patient education documents
- Consistent patient education document template
- Awards for patient education (National Health Information Awards; www.healthawards.com/nhia/details.htm)
Factor 3: Create a vision

It’s been said that one of the major reasons teams fail is the lack of a shared vision; goals may be unclear, leading to an uncoordinated effort that often results in duplicity, confusion, and, eventually, apathy. Creating that shared vision is a crucial first step once a powerful team has been assembled, to be certain that everyone is on track and is moving toward one agreed-upon and measurable goal. Creating a shared vision means coming together as a team with a shared understanding of the need for change, and determining together what the end result will look like. Later in this book, I will discuss specific tools that will help you to define what that vision is and to map it out within a group. See Figure 1.7 for an example of what a mission, vision, and goals for patient education can look like.
We support patients, families, and the community in their quest for health and well-being by providing quality health education that is informative and individualized. We believe in empowering patients and families, through education, to achieve and maintain health and safety, and encouraging an active partnership between our healthcare providers and the people they serve.

**Patient education vision statement:**
Providing an interdisciplinary framework for which patient education can be fully integrated throughout the organization and the healthcare continuum.

**Goals:**

**Ongoing:**
- Address the learning needs and preferences of people from all literacy levels, populations, and cultures we serve
- Support and promote patient education efforts within the organization
- Provide current, research-based patient and family education
- Utilize an outcome-based approach to patient education

**2007–2008 goals:**
- Develop and implement a process, along with criteria, for creating patient and family educational materials throughout the organization
- Develop a complete inventory of all current English and Spanish patient and family educational materials throughout the organization
- Develop and maintain an archival process for all patient and family educational materials throughout the organization
- Evaluate inventory of all current patient and family educational materials throughout the organization against the newly created criteria
- Identify additional patient and family education needs and prioritize development
- Identify other cultural language needs for our community
- Identify process for financial support of development and implementation of patient and family educational materials
Factor 4: Communicate!
Kotter notes that “in more successful transformation efforts, executives use all existing communica-
tion channels to broadcast the vision.” Kotter notes that “in more successful transformation efforts, executives use all existing communica-
tion channels to broadcast the vision.” When the vision isn’t strongly communicated, and, even more importantly, when leaders in the organization don’t model the new behaviors for change, momentum for change can be lost. Developing a comprehensive communication plan in partnership with corporate communications can enhance communication methods and ensure that all intended audiences are reached. See Figure 1.8 for an example of a communication plan.

Suppose, for example, that you are unveiling a new on-demand patient education video system. You decided to obtain this video system after your assessment report reveals that availability of patient education videos is lacking in your organization, and after the payoff matrix reveals that implementing this would bring a high payoff. In addition, it would probably resolve some of your patient satisfaction scores. Unveiling the system is great, but if its availability is not adequately communicated, it won’t take hold in the organization, and you will risk a failed implementation.
**Overarching communication message:**
In support of patient-/family-centered care, our organization will convert to a centralized, single online source for patient education throughout the organization starting in March 2009. The goal of this conversion is to provide the organization with a source for clear, consistent, and clinically current healthcare information that is readily available to patients and their families, hospital staff members, and physicians. In addition to improved access to the materials, the online source will enhance collaboration, efficiency, professionalism, flexibility, and comprehensiveness of the information being provided to patients on behalf of our organization. The resource will be available to anyone with a printer and access to the Web.

<table>
<thead>
<tr>
<th>Audience</th>
<th>Message</th>
<th>Message vehicles</th>
<th>Timing</th>
<th>Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians, PAs, MD, office staff, NPs</td>
<td>Overarching message, plus: Print what you need right in your office via the Web and a centricity link in EMR, Links and instructions, Resource to contact for live support, Conversion to this system is required throughout the organization. There will be an organizationwide effort to purge outdated educational resources by _______ (date).</td>
<td>Physician newsletter, Demonstrations and discussions at division meetings, outside of all staff conferences, Quick user’s guide</td>
<td>4 weeks prior to launch</td>
<td>Corporate editor, Patient ed manager</td>
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### Figure 1.8 Patient education project: Communication plan (cont.)

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<thead>
<tr>
<th>Audience</th>
<th>Message</th>
<th>Message vehicles</th>
<th>Timing</th>
<th>Responsibility</th>
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</thead>
<tbody>
<tr>
<td>Leadership</td>
<td>Overarching communication message: This is coming in March. As we are gearing up for the transition, please begin to use this process now to request new materials. Here are the details....</td>
<td>Leader e-mails, Leader e-mails, Fact sheet/talking points, Demo to leaders at site leadership meetings, Quick user’s guide</td>
<td>Four months prior, once ready to discuss, Start four weeks prior to launch</td>
<td>Communications strategist, Communications strategist, Communications strategist and patient ed manager, Patient ed manager</td>
</tr>
</tbody>
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**Patient education project: Communication plan (cont.)**

<table>
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<tr>
<th>Audience</th>
<th>Message</th>
<th>Message vehicles</th>
<th>Timing</th>
<th>Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>All employees</td>
<td>Overarching communication message: This is coming in March. As we are gearing up for the transition, please begin to use this process now to request new materials. Here are the details....</td>
<td>Huddle, Intranet, Manager discussion, Town halls</td>
<td>June/July as appropriate</td>
<td>Communications strategist</td>
</tr>
<tr>
<td></td>
<td>Overarching message, plus: Print what you need when you need it Links and instructions Resource to contact for live support Conversion to this system is required throughout the organization. There will be an organizationwide effort to purge outdated educational resources by ______ (date).</td>
<td>E-mail campaign, including IS newsletter, Huddles, Intranet</td>
<td>Start four weeks prior to launch</td>
<td>Communications strategist</td>
</tr>
<tr>
<td>Clinical employees</td>
<td>Launch messages, plus more detail about using new resources and procedure for creating new pieces</td>
<td>Training classes (?), Agenda item for key department meetings, Quick user’s guide</td>
<td>Four weeks prior to launch</td>
<td>Patient ed manager</td>
</tr>
<tr>
<td>Audience</td>
<td>Message</td>
<td>Message vehicles</td>
<td>Timing</td>
<td>Responsibility</td>
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<tr>
<td>Patients and families</td>
<td>Overarching message, plus: Resource is available to you and your family members online via easy access on hospital Web sites</td>
<td>Patient user’s guide</td>
<td>At launch</td>
<td>Patient ed manager</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Patient information materials and discharge instructions</td>
<td></td>
<td>Web strategist</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Consumer Web sites</td>
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Factor 5: Remove obstacles to the vision for patient education

Paradoxically, removing obstacles to the vision can be an obstacle in itself, and it can present the patient education manager with the single largest challenge in the change effort. Sometimes one of the larger, more destructive obstacles can be a key senior leader who is not on board with the change effort and who may actively work against the effort by allowing rogue behaviors to continue. In these cases, particularly when the person is a senior leader and the behavior isn’t addressed but is allowed to continue, the entire change effort can collapse. This is where having an executive sponsor who is a senior-level leader can assist to ensure that these barriers are addressed and/or removed.

For example, suppose a senior leader isn’t on board with the campaign to rewrite and reformat all of your organization’s patient education materials to be at a low reading level for patients, and this senior leader does not support the new process in place for patient education materials to be approved before use. Since this leader isn’t on board with the process, neither are the staff members. They continue to write and obtain renegade patient education materials and do not follow the process of having them reviewed or approved. Having such an obstacle in the way can seriously thwart the efforts of your initiative. Once aware of the obstacle, an executive sponsor can have those crucial conversations with that leader and can likely work to remove the barrier on your behalf.

Factor 6: Systematically plan for and create short-term wins

According to Kotter, “most people won’t go on the long march unless they see compelling evidence in 12 to 24 months that the journey is producing expected results. Without short term wins, too many people give up or actively join the ranks of those people who have been resisting change.” With this in mind, it’s important to build in some short-term gains that the staff can celebrate, but by no means should these gains equate to victory. The following represent some short-term wins:

- Mission, vision, and goals were developed and accepted by the executive team
- New processes were established to support the vision
- The organization reached its interim benchmarks

Celebrating these short-term wins demonstrates to the team that progress is being made and their efforts are paying off. Without this, it’s easy for the team to feel disillusioned and think they will not meet their ultimate goal.
**Factor 7: Do not declare victory too soon**

If your organization announces that all the goals have been met before the transformation has had a chance to really be embedded into the culture, there is a high risk that people's initial inertia and passion for the change effort will dwindle and they will return to their normal duties, which in many cases may mean the “old ways.” Furthermore, those people who were resistant to the change all along will use the victory celebration as evidence that no further change effort is needed: The battle is over and has been won. The risk is then very high that in two years, the processes that were set up could begin to unravel. In Kotter’s experience, he noted that in these cases “. . . the useful changes that had been introduced slowly disappeared. In two of the ten cases, it’s hard to find any trace of the reengineering work today.” This is why it’s important to build in those short-term wins, so people do feel a sense of accomplishment, but also make sure that these wins aren’t seen as the final victory celebration.

**Factor 8: Anchor changes into the organization’s culture**

You can ensure that changes are built into the organization’s culture in two ways. The first way is to connect the dots for people. When positive results are realized after a change has occurred, often people may associate the results with a new management team, the opening of a new hospital, or some other inaccurate link. You should make a significant effort to connect those dots and communicate how the change effort produced those results. For example, suppose that once patient education materials were reformatted to be patient-centered, patient satisfaction scores rose; there was a notable decrease in call volumes to the call center; and there were fewer readmissions for disease management lapses. Although certainly it could be argued that other factors may have contributed *overall* to these metrics, it is important to make the connection regarding how the patient education change effort influenced these results. Communicate this to staff via meetings, newsletter articles, and other common communication venues. If the connection isn’t made for them, they will make it themselves, and most likely it will be inaccurate.

The second way to ensure that changes are built into the organization’s culture is to ensure that any successors for senior positions buy into the change effort, so as to not undermine the culture years later when they are in a higher position of authority. Although this particular tactic may seem out of the scope and influence of the patient education manager, recognizing that having a strong, solid connection to senior leadership is crucial to minimizing this risk as much as possible. Establishing the connection to senior leadership happens primarily through ongoing networking. If your organization has quarterly “leadership retreats” or “leadership development institutes” or other types of forums where the organization’s leaders come together for a day of learning and development, you need to attend those as well. Not only do those forums provide a great venue for continuing education on various leadership topics, but also they typically provide a way for
people to interact with one another. Relationship-building and networking is a necessity to effectively do your job.

Understanding change and how to manage it in large healthcare organizations is a critical competency for any patient education manager. For patient education to remain a viable and important aspect of the healthcare continuum, patient education managers must advocate and plan for change; they must challenge the status quo and obtain the attention and support of senior-level executives. Once you have those skills, patient education can expand to the next level.

References


Chapter one


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