Is That in the Budget? Technology and Patient Education (Keynote by Fran London)

Whether you are tech savvy or not, you need to know things are changing. Social media is being used by our patients so we need to learn about how we can tap into what they want and need.

With the large number of people who have cell phones, smart phones and computers, the technology is there. Content can be shared inexpensively to help our patients learn about their health. Choose the technology based on the information so you don't violate privacy or regulatory requirements.

Social marketing is here and things continue to change. There are many free apps and Fran shared many resources and thoughts and the discussion was engaging for participants. Meet your patients where they are engaged already.

Putting Patients Back into Patient Safety: Increasing Engagement to Improve Quality and Outcomes

Amy Wilson- Stronks

Structural barriers exist as we work with patients. Need to look at who our patients are and how we can help find health care that fits.

Language:

- Being aware of language barriers, how to access services within your organization, making yourself familiar with the services offered in your organization and community

Cultural:

- Be aware of cultural issues with families – don't make assumptions or apply generalities to patients simply because you think they fall within a certain group
- If we can't communicate effectively with families, how can we begin to understand their culture and the challenges they face within our hc system?
- Lack of communication is not limited to vulnerable populations. Even those with adequate health literacy may have health literacy issues
- Need to formalize a process to manage patient/provider communication at the patient level

Health Disparities:

- Study showed that over 50% of the LGBT population had experienced some sort of barrier to health care

Patient Centered Communication:

- Essential to patient safety
- Use of interpreters/translators

Innovative Approach to Improving the Continuum of Care through Community Partnerships

Anne Crowther and Michelle Copeland presented how hospitals can create links to community organizations to improve the continuity of care. Anne described the development of a school nurse advisory committee to improve their support of patients in schools. School nurses focus groups found that the complexity of care in schools has increased including trach care, g-tubes, diabetes care and others. School staff needed to be educated and most information comes to schools through parents. From feedback of school nurses, they found:

- Need to create standardization of processes
- Lack of relevant continuing education for school nurses that supported care coordination
- Had to negotiate school and HIPAA regulations to share information

We need to look at problems differently and build community partnerships and accountable care and non-payment is driving these programs. Work collaboratively with schools and school administrators to create and implement a training plan for school nurses, conferences and professional development days.

Do you mean Cookie or Cracker? Avoiding Pitfalls with Translations

Diane Moyer, Karen Guthrie and Becky Squires presented challenges and some solutions to translation of health education materials. This unique collaboration, HealthInfoTranslations.org, has the support of the 4 CEOs of the central Ohio hospital systems and the patient education specialists have shared their work with the world. The presenters challenged participants to consider sharing translated health education resources from their health systems as well to help expand the foreign language resources available.

The Convergence of Patient Education, Public Health Practices and Health Care Reform

Janette Helm presented an overview of health care reform legislation and the impact there will likely be on patient education on the horizon. Janette explained HCAPS and other measurements and evaluation tools that impact health care organizations.

Developing Evidence Based Practice Scholars

Cathleen Opperman presented this dynamic topic. She outlined the difference between quality improvement and evidence based practice. The development of an Evidence Based Scholar program and Mentor program were shared. The Scholar program includes pre-work and an 8-hour course that supports teams who are wanting to work on evidence based projects. Key points of the program—less than 10 people per class and there are 8 classes/year; whole team attends; manager training provided, and there is a website for resources.

Role of Patient Education in Specialty Certifications/Designations

Madge Patyk, Anne Findeis and Susan Ye discussed the process and role of the Patient Education Department had in hospital certifications, in particular VAD, stroke, and Baby Friendly. They outlined the need to be involved with Magnet and the Joint Commission to promote patient/family education, staff development and staff and family resources and documentation.

Hardwiring Health Literacy Strategies into Every Day Practice

Carol Klingbeil discussed the importance of having the whole team take part in the health literacy solution. Described the problems encountered in all areas and with all disciplines, departments and entities. Key points-Change the way we ask questions; Have people practice the skills; include this language in the electronic medical record.

The Language Game: Connecting Patients and Providers to Health Information

Dana Abbey shared her wealth of knowledge about resources available to help address learning needs of patients. Patients have multiple touch points throughout their hospitalization but there is seldom a coordinated effort. Many patients and families do not have English as a first language. Dana shared resources available for patients/families to learn more about their disease and care needs. Many online resources are geared at 10th grade readability when the average reading level is about 5th grade. Consider also aligning information to the patient's cultural lens. Several sites that provide foreign language resources were discussed.

Making Teach Back Visible with Journey Boards

Fran London presented the process of creating My Journey Boards at Phoenix Children's. These are a broad view of the patient's journey during the hospital stay and the education needed along the way. Journey boards have been developed for a variety of reasons and there are guide books associated with the use of the boards to access teaching resources available.

From Distress to Success with 5S

Elsie Nolan provided a detailed description of the cardiovascular program including operations, patients served, satisfaction scores, inventory of resources and more as the "before". Then she explained the LEAN process to get to 5S:

- Went to the experts
- Asked the LEAN coach
- Defined what LEAN was
- Process in learning about LEAN – self learning and attending a workshop

The 5S's included Sort (clean up); Set in Order (organize); Shine (regular cleaning); Standardize and Simplify; and Sustain and Elsie reviewed their process in creating a system wide inventory system.

Information Barrage: Helping Staff Absorb

Cathleen Opperman and Becky Thorne presented many signs of change fatigue. Lots of humorous examples were shared and the change fatigue acts a lot like alarm fatigue. Problems identified with information barrage included:

- Who set it and who can I ask about it
- What's the bottom line
- Do I need to know?
- Too much information

The key question- how do we empower staff without overwhelming them? The solution that resulted was a centralized newsletter. It combined all important information from emails, flyers and announcements in one place. It is put out every 10 to 12 weeks. Staff really like the newsletter and refer to back issues as well. All information shared had to be previously communicated. Each entry includes contact information to seek out the "expert" and get other questions answered. Entries are very concise and there is consistency in font and color used.

The National Action Plan for Health Literacy: Ideas from the Field

Sandy Cornett described and explained the 7 goals of the National Action Plan for Health Literacy (NAPHL) and shared many resources, such as:

- Healthliteracymissouri.org
- AHRQ: Questions and answers
- Ask Me 3
- American Medical Association – Improving Communication, Improving Care
- Easy to Read NYC
- Iowa Health System, Reach out and Read
- Health Literacy Study Circles from Harvard

The session wrapped up with small group discussions of ideas for implementing health literacy.

Eight Questions to Clarity

Charla Weiss presented to a full room of eager participants. This was a high octane presentation that included humor, stories, audience participation and electronic polling. Dr. Weiss provided an excellent informative session outlining the importance of culturally sensitive care. Would like to see this topic as a future pre-conference session. Thank you, Dr. Weiss!

Improving Cardiovascular Health in Children in Rural Communities

Suzi White and Vanessa Sammons presented a lively and descriptive presentation of their project targeting childhood obesity. The project took them into public schools to educate 5th graders about making heart healthy food choices. A 6-month post follow-up revealed huge numbers in retention of the materials taught to the students. Great job!

Bridging the Communication Gap Through the Use of Pictures

Jennifer Willoughby, Joan Morgan and Julie Schletker shared their project to improve communication to patients and families. They used the RCIP (Rapid Cycle Improvement Project) method. They had funding for their project from their organization's Center for Professional Excellence. The RCIP method included
1. Identification of the problem

2. Documentation of the current process- examples shared staff depended on verbal communication and did not use phone interpreters. When they did use phone interpreters, calls were less than 3 minutes in length.

3. Identification and Analysis of process failures

4. Identification of key drivers

5. Looked at root cause.

This thoughtful method to address the problem led to a change in direction and a focused implementation to improve communication using pictures. This was directed at English and non-English speaking patients and families. The presenters shared their communication improvement process, how they validated the steps and ended with lessons learned. The communication process began with IV insertion and once tested and validated, more pictures were added based on their main procedures and supplies their families encounter in the hospital. The ultimately hired a professional photographer and graphic designer to create a book of communication pictures.

Networking Session – HCEA Orientation

Conversation was lively about what HCEA could do to attract members and what HCEA members wanted from the organization.

- How can members get involved in HCEA but not get pulled into a giant commitment
- Provide resources to members to support patient education role as non-revenue generating- ie. Position papers; Statements to support FTE and manage FTE; value of work and assessment of work; and establishing value and outcomes.
- Suggested every other month teleconference to discuss topics –issues raised about taking time from work to attend
- Bringing new people on board—consider not implementing any new initiative unless "3 people on board"; Let the talent bubble up from the group—more willing to do the work if not alone.
- Provide presentation on how to build materials
- Discussed proving worth-"every hour is a work hour"—shared value of learning from other members
- Consider providing conference calls before work, over lunch or after work hours
- Construct 1-3 minute videos for teach back
- Consider using Smart phones to share communications with members
- How to coach to improve Teach-back as one person working part-time
- Develop a mission statement for patient education
- Describe meaningful use criteria and Affordable Care in relation to patient education
- Share business plans and outcomes to measure related to patient education
- How to control/manage vendor literature in EMR system and compliance issues
- How to get CEO support
- Legal issues if translated versions do not match English materials
- Who decides what are best practices?
- Patient education policy—what works, who has them and how do you make them work in your system?
- Policies related to sharing, permissions for use, repurposing materials

Beyond the Written Word: Innovative Approaches to Patient Education

Presenter: Nancy Posel

Objectives:

1. Explore critical issues that need to be aligned with the development of patient education material.
2. Examine secondary impacts of the development of patient education material.

Our clinical reality with changes to healthcare delivery was explored. These include: (a) aging demographics with increase in chronic diseases, multi-morbidities, multicultural and multilingual needs; (b) patients need to synthesize complex information while in crisis; (c) there are fewer teaching moments and misinformation on the internet; (d) fragmented health delivery; (e) shorter hospital stays with same day discharge; (f) teaching with less time and resources.

Basic foundational information presented included the following:

- Adult learning is self-motivated, self-directed, autonomous, and incorporates reflection on direct experiences and active learning methods.
- Experiential learning comes from direct experience.
- Situated learning if facilitated when material appears to be authentic, realistic, but non-threatening.
- Just-in-time learning is supported when integrated with real clinical experiences.
- Self-regulation theory promotes effective and collaborative self-management model of health and includes motivation as well as the ability to self-regulate.
- Elements of pedagogy: (a) facilitates knowledge transfer (b) encourages knowledge acquisition and synthesis (c) supports knowledge application (d) provides additional resources (e) individualized learning and align it with the need.
- Health Literacy- A constellation of skills: basic literacy; communicative literacy; critical literacy.

Patient Rights:

33 picture slides of materials were shown that supported the foundational information and the following patient rights. Examples of how to show numerical information were demonstrated.

- Information to support understanding of complex healthcare concepts
- Informed decision-making with the clinical team
- Knowledge for self-care management
- Ability to determine when to call healthcare team.
- Importance of adhering to care regimens
- Help navigating the system.

Steps of The Development Process:

1. Identify purpose and patient population
2. Check for existing resources
3. Establish an interdisciplinary team
4. Plan timeline and budget
5. Conduct a needs assessment
6. Develop content
7. Write in plain language
8. Apply clear design & layout
9. Translate into other languages

10. Evaluate patient education material
11. Obtain appropriate approvals
12. Produce, distribute and use

Issues to consider:

1. Level of the learner – Learner perspective
2. Complexity of the knowledge
3. Assessment and evaluation
4. Individualization
5. Interactivity
6. Navigation and design

Helping Families Make Informed Decisions: How Decision Aids Can Enhance the Process

Presenters: Anne Blackmore & Lisa Leesman

Objectives:

1. Define decision aids and their role in educating patients and families.
2. Discuss steps in creating a decision aid
3. Describe the application of decision aids in the clinical setting.

Patients make decisions through self-management and the shared decision-making process. Tools that are used to aid in decision making include literature and/or video presentations and using decision aids. Decision aids are tools to help provide objective, evidenced-based information, which empower patients and families to make informed treatment choices that support their lifestyle and values. They are used as part of a shared decision making process with patients and families. Decision aids (a) increase patient knowledge; (b) provides realistic view of benefits and risks; (c) decreases decisional conflict; (d) increases patient and family involvement in decision-making; (e) closes the gap between patient values and treatment choice; and (f) improves the relationship between the patient and healthcare provider. Decision aids should be used when there is a treatment choice; a decision for treatment or no treatment; end of life issues; to decide screening and testing options; and when there is conflict among patient/family members over treatment options.

To create a decision aid you must first decide on the format to use: paper; video; patient testimonials, or power point. Check the Ottawa Hospital Research Institute for more information. When developing the tool, decide who is to be involved in the development, such as content experts, literacy/education experts, and patients/families. Typical patient/family concerns or key determinants need to be identified, and then bias-free content created using literacy friendly language. The decision aid is tested using one-to-one interviews or a survey. Testing should be done with patients/families and with clinicians about the content, visual appeal, and whether the tool would help the patient make a

decision, and if the clinicians would use the tool. Revisions are made based on this feedback and tested with families who are about to make a decision.

The presenters helped the audience apply this information with an exercise about making a decision to buy and new or used car. Then they discussed a decision aid they created on the decision to use warfarin or enoxaparin for anticoagulation therapy. Lessons learned from doing the decision aid was on how important it is to garner physician support, ways to present it to the families, and how hard it is to be unbiased. The common pitfalls with decision aids includes: (a) imposing your bias; (b) using information that is not evidenced-based; (c) fearing how time consuming it is to develop one; (d) feeling uncomfortable if families' decisions are different their you own beliefs; and (e) determining what to do if there is no clear decision.

Innovations in Chronic Care: Health Literacy and Group Visits

Presenter: Lois Wessel

Objectives:

1. Recognize the concepts of chronic disease management.
2. Describe the role group visits can play in improved self-management of chronic disease.

Group visits is one way to meet the challenges in caring for patients in patient-centered medical homes. Group visits are used to: (a) enhance access and continuity of care; (b) identify and manage patient populations; (c) plan and manage care; (d) provide self-care and community support; (e) track and coordinate care; (f) measure and improve performance; and (g) to provide a template for the future. Low health literacy is a real problem in this environment, as well as the need to implement the Linguistically Appropriate CLAS Standards.

A shared medical appointment occurs when multiple patients are seen as a group for follow-up care or management of chronic conditions. These visits are voluntary for patients and provide a secure but interactive setting in which patients have improved access to their physicians, the benefit of counseling with additional members of a health care team (for example a behaviorist, nutritionist, or health educator), and can share experiences and advice with one another. Group visits are evidence-based as a proven, effective method for enhancing a patient's self-care of chronic conditions, increasing patient satisfaction, and improving outcomes.

Group visits usually last from 2- 2.5 hours with no more than 15-20 patients at a time. The visit format was described for the group:

- Patients are enlisted for the group, depending on type of condition or category of patient, such as older patients or those with numerous co-morbidities. Potential patients can also be identified based on ICD codes, registries, or available prescription data. Family members or caregivers are invited to attend.

- Staff spends time before each group visit reviewing and documenting medical forms for diagnostic tests/lab work and medications.
- The group visit begins with initial check-in and greeting, followed by self-care discussion and education about common problems encountered by participants.
- Refreshments are served and during this time the nurse(s) or physician(s) confers with each patient individually about specific health problems; getting vital signs; refills, etc.
- A question-and-answer period and group planning for next visit follow the individual visits.
- An individual visit with the nurse or physician after the group visit when needed.
- Some group visits can be focused on medications or healthy eating specifically.
- Consumer friendly materials written in plain language should be used.
- Sometimes incentives, like pedometers, are given to help patients meet self-management goals.