

## Education of Patients and Family: A JCAHO Requirement

### One Medical Center's Approach

Ruth A. Hartmann, EdD; Margaret Amato, CRRN; Jane Hendrickson, RN; and Mahendr S. Kochar, MD

#### **Abstract**

As part of the reorganization of the 1994 Accreditation Manual for Hospitals of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), an entire chapter was dedicated to the subject of patient and family health education. Consequently, healthcare providers throughout hospitals will be required to assume responsibility for the provision of patient health education. With the emergence of customer-focused, continuous quality improvement, healthcare organizations have adopted the goal of delivering the highest-quality, cost-effective care possible to patients and their families. The combined result of these two changes will necessitate the development of an overall, organization-wide patient education policy; as part of that policy, the staff and services involved in providing JCAHO-stipulated education and documentation will have to be identified. The Clement J. Zablocki Veterans Affairs Medical Center met this challenge by establishing a multi-disciplinary task force formed solely for that purpose. The draft document stemming from this effort assigned responsibility for patient education at the medical center and specified how the center would address key issues relating to JCAHO standards on patient and family education.

Historically, since its inception 40 years ago, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has strived to enhance the quality of care that hospitals and other healthcare organizations provide.<sup>1</sup> The delivery of patient education has been an integral component of that mission from the beginning. In 1986, with the introduction of an Agenda for Change, the JCAHO shifted the focus of its mission. Rather than asking whether an organization was able to provide

high-quality care, the JCAHO asked whether the organization *was* providing such care.<sup>2</sup> This focus was based on the concept of monitoring the quality of healthcare and of using measures to detect actual outcomes. Perhaps most remarkable has been the JCAHO's decision over the past 2 years to incorporate consumers' judgments into the process of gauging the quality of care.<sup>3</sup>

In 1994, the JCAHO revised its accreditation manual for hospitals. As part of the revision, the commission devoted an entire chapter to patient and family education. Previously, responsibilities relating to the topic had been incorporated into the various standards in the manual. One of the factors that influenced the JCAHO to create a chapter devoted specifically to patient and family education was a lack of consistency across standards for the same responsibility.<sup>3</sup> The new focus on provision of high-quality care also was a factor.

The recently revised accreditation manual emphasizes company-wide performance; the intent of this shift has been to "take a step back and ask people to be architects of how they think care should be delivered."<sup>4</sup> Under these new directives, healthcare organizations must begin to emphasize accountability and ongoing monitoring—changes that should produce continuous quality improvement. From this point on, in order to meet the JCAHO standards on patient and family education, every employee of an organization will have to become involved. The continuous quality improvement policy of the Clement J. Zablocki Veterans Affairs Medical Center (ZVAMC) states that such improvement "...is the responsibility of all staff and it is expected that an environment of continuous improvement will be fostered by all who serve the medical center's customers...."<sup>5</sup> Thus, the ZVAMC's continuous quality improvement mission is similar to the JCAHO's mission. Both are customer driven, and both strive to satisfy those who are served.

The JCAHO's revised standards cite "the need for a systematic approach to education throughout the organization."<sup>6</sup> The standards also emphasize the im-

From the Clement J. Zablocki VA Medical Center, Milwaukee, WI.  
Address correspondence to: Ruth A. Hartmann, EdD, Patient Education Center (14B), VA Medical Center, Milwaukee, WI 53295.

portance of removing barriers to quality improvement and of encouraging systematic assessment and improvement of performance.<sup>6</sup> However, they do not require that healthcare organizations develop a specific structure for the provision of education, such as an education department or patient education committee, nor do they require that an educator be hired.<sup>7</sup> It will be under the discretion of each healthcare organization to decide how it will meet the JCAHO's requirements on patient health education. Patient health education staff at the ZVAMC chose a team approach in their efforts to meet the revised standards.

The JCAHO encourages healthcare organizations to form informal linkages with each other as a means of disseminating information about efforts to meet the new requirements.<sup>8</sup> As a reflection of the spirit of that request, the purpose of this article is to share the ZVAMC's strategy with readers.

### Background

Patient health education is defined as any combination of activities designed to facilitate voluntary

change in patient behavior for the attainment or maintenance of good health.<sup>9</sup> Healthcare professionals who provide patient care have a responsibility to assist those who want to change their habits, or who need to do so, by directing these individuals to the appropriate resources. The goal of patient education management is to enable healthcare providers to work more effectively with patients and their families, thereby preparing them to cope with their diagnoses and to manage their conditions over time.<sup>10</sup>

The delivery of patient health education within the VA system is dispersed. The central office of the VA has supported such education strongly, through policies; guidelines; mandates; and the establishment of patient health education coordinator positions at the national, regional, and hospital levels. Some medical centers that did not receive funding for a coordinator from the central office have funded the position locally. According to a recent survey, 90% of the 171 medical centers within the VA system have established patient education committees. The ZVAMC has both a Patient Education Advisory Council and a

patient health education coordinator. The council was formed in 1979,<sup>11</sup> and the coordinator position was created in 1983.

Standards that measure patient health education outcomes are a fairly new phenomenon. No mandates enforced the limited standards that had been in effect, and adherence to them was voluntary. Within the VA system, the following four sources served as quality indicators: (1) VA systematic external review program indicators relating to patient health education<sup>12</sup>; (2) JCAHO criteria supporting patient education; (3) guidelines for the development of patient health education programs; and (4) the national

**Table.** Sequential Approach Used To Meet the JCAHO Standards

Action	Outcome
Present a memorandum to the Chief, Clinical Assessment and Risk Evaluation	Inquiry about the necessary steps for meeting the JCAHO standards
Meet with Chief, Clinical Assessment and Risk Evaluation; Patient Education Advisory Council; and patient health education coordinator	Establishment of a task force, involving managers from all affected services
Formulate objectives	Formulation of an umbrella policy; identification of how patient education currently is assessed at the ZVAMC; review and revision of the current patient education documentation form; and establishment of criteria to standardize patient education materials hospital-wide.
Review existing level of patient education	Policies deemed to be either acceptable or in need of revision
Identify high-risk pharmaceutical agents	Identification of eight agents for 91-100% documentation compliance
Install MedTeach software on Decentralized Hospital Computer Program (DHCP)	Access to data on 410 agents provided, either online or in hard-copy format
Plan JCAHO workshop	Clarification of issues by inviting JCAHO faculty
Document patient education records on DHCP	Data entry of patient education records on DHCP, with access by all staff
Assess which staff provide patient education, including how and where education is provided and documented	Distribution of survey to all clinical services/staff to obtain patient-education-specific data
Compile all relevant data	Production of binders containing information on each JCAHO standard relating to patient education
Consult with services	Guidance on meeting JCAHO standards provided by patient health education coordinator and task force to the services

standards and review criteria for diabetes patient education programs issued by the American Diabetes Association. All standards of the American Diabetes Association have been measured according to review criteria that have been pilot tested extensively to ensure an appropriate blend of stringency and practicality.<sup>13</sup>

The consolidation of patient health education standards into one chapter in the JCAHO's 1994 accreditation manual signals the importance of accountability, delivery, and continuous quality improvement in patient health education. In the future, regular assessment of quality improvement activities in this area will be critical, as will use of the assessment results in planning and actions based on the assessment.<sup>14</sup> To accomplish these tasks, all managers will have to become involved and will have to participate in a hospital-wide process that depends on teamwork, rather than on the individual efforts of staff in their own areas of responsibility.<sup>15</sup>

### The ZVAMC's Approach

The ZVAMC's patient health education coordinator responded to the issuance of the new JCAHO standards by seeking the involvement of the medical center's Clinical Assessment and Risk Evaluation Service and the Patient Education Advisory Council. The coordinator and staff of the two groups held a planning meeting to develop specific objectives and to identify the actions necessary to meet those objectives. After the meeting, the ZVAMC took a sequential, step-wise, team approach to the task of providing patient education in a way that would comply with the JCAHO standards (Table).

The deliberations behind the development of the station policy for patient and family education were lengthy, requiring numerous revisions and reviews by the Clinical Executive Board and the Nursing Executive Board. One of the issues that was subject to much debate was that of staff responsibility for medication counseling and documentation. Pharmacists, because of their knowledge, accessibility, and role in pharmaceutical care, are committed to remaining the stewards and gatekeepers of the drug-use process.<sup>16</sup> Therefore, as a compromise, pharmacists and nurses were assigned shared responsibility for counseling on and documentation of medication.

Revision of the patient education documentation form was another labor-intensive and time-consuming task. The end product of this effort was the document shown in the figure. ZVAMC staff are able to access the form through DHCP.

To ensure that the medical center staff understood the new JCAHO standards and their implications with

Figure. Interdisciplinary Patient/Family Education Record (PER) (front and back shown).

VA Medical Center, Milwaukee Interdisciplinary Patient/Family Education Record (PER)

Title/Group/Procedure: \_\_\_\_\_

**Patient's Initial Learning Assessment:**

1 Reading ability:  Able to read  Has difficulty  Does not read

2 Learns best by:  Hearing  Seeing  Doing  Reading

3 Barriers to learning:  None  Chronic pain  Cognitive/Memory  Speech  Vision  Hearing  
 Emotional  Dexterity

4 Communicates in:  English  Sign language  Other \_\_\_\_\_

5 Are there cultural/religious practices that may affect the patient's healthcare? Explain: \_\_\_\_\_

6 Motivation/readiness to learn:  Motivated  Not motivated  Ready to learn  Delay teaching

7 Educational goals identified and discussed with patient/significant other:  Yes  No

8 Knowledge of disease is:  Good  Limited  Preventive visit

9 Family/Other assistance provided:  Often  Sometime  Needed  Does not apply

**Teaching Needs** - including, but not limited to knowledge of:

\_\_\_\_\_ medical condition treatment plan tests, procedures, health maintenance

\_\_\_\_\_ medication including: purpose, dosage, side effects

\_\_\_\_\_ nutrition, modified diet and potential food and drug interactions

\_\_\_\_\_ rehabilitation techniques, including PT, OT, SP and exercise

\_\_\_\_\_ home medical equipment

\_\_\_\_\_ available community resources

\_\_\_\_\_ access to follow-up and emergency care

\_\_\_\_\_ others: \_\_\_\_\_

Received booklet on Rights/Responsibilities:  Yes  No

Signature/Title/Date \_\_\_\_\_

(Documentation/Evaluation on backside)

IMP/PRINT PATIENT DATA CARD (Name, Address and Social Security Number) DATE

MEDICAL CENTER SERVICE TREATMENT PLAN

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**Evaluation Codes:** 1 Able to perform/verbalize 2 Unable to perform/verbalize 3 Needs reinforcement  
4 Not receptive 5 Does not apply 6 Unable to determine

**Teaching Codes:** Ipt=Inpatient Opt=Outpatient I=Individual G=Group

Patient/Significant Others Education Goals		Changes in Learning Assessment/Comments
Date/Initials	Eval Code(s): _____ Teach Code(s): _____	Changes in Assessment: <input type="checkbox"/> Yes <input type="checkbox"/> No Comments:
Date/Initials	Eval Code(s): _____ Teach Code(s): _____	Changes in Assessment: <input type="checkbox"/> Yes <input type="checkbox"/> No Comments:
Date/Initials	Eval Code(s): _____ Teach Code(s): _____	Changes in Assessment: <input type="checkbox"/> Yes <input type="checkbox"/> No Comments:
Date/Initials	Eval Code(s): _____ Teach Code(s): _____	Changes in Assessment: <input type="checkbox"/> Yes <input type="checkbox"/> No Comments:
Date/Initials	Eval Code(s): _____ Teach Code(s): _____	Changes in Assessment: <input type="checkbox"/> Yes <input type="checkbox"/> No Comments:

Initials \_\_\_\_\_ Signatures/Titles \_\_\_\_\_ Initials \_\_\_\_\_ Signatures/Titles \_\_\_\_\_

IMP/PRINT PATIENT DATA CARD (Name, Address and Social Security Number) DATE

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respect to the operations of the center, all staff were invited to attend a JCAHO workshop. The following four points were among the key conclusions that emerged from the workshop discussions. First, senior management of the ZVAMC, rather than the JCAHO itself, would be responsible for deciding the direction that patient education would take. As part of that decision, medical center management would determine when and where patient education would be provided. Second, the JCAHO would be more interested in how the medical center organizes quality improvement monitors that measure outcomes than it would be in the outcomes themselves. Third, outcomes would be measured against criteria that the medical center identifies and chooses. Fourth, JCAHO staff would assess the center's progress, note areas requiring action, and examine the center's plans for future improvements.

### The Draft Policy

The ZVAMC's draft policy on patient and family education was developed to address the JCAHO's directive that healthcare organizations establish internal policies and procedures to conduct such education.<sup>17</sup> The policy also addresses the specification in the standards that healthcare staff provide patient education as a means of improving patient health outcomes, and that the staff should do so by promoting patient recovery, fostering a more-rapid return to function, encouraging positive health behaviors, and appropriately involving patients in their own care and treatment decisions.<sup>7</sup> The policy states that patient education at the ZVAMC will include the following areas: rehabilitation techniques, responsibilities in the treatment process, and availability of community resources. In addition, the medical center will provide patient education that is consistent with the patient's plan of care, and fully utilizes all education resources approved by the Patient Education Advisory Council, including patient education programs, materials, and other information sources.

*Areas of Responsibility.* According to the draft policy, the patient health education coordinator at the ZVAMC has overall responsibility for recommending policies and procedures, and for developing organization-wide patient and family education goals and plans. The Patient Education Advisory Council is directed to guide and assist the coordinator in these efforts, and to act as a resource. All clinical service chiefs, as well as chiefs of appropriate administrative services, are responsible for promoting patient education within their respective services or program areas.<sup>18</sup>

*Patient Education Procedure.* All interdisciplinary patient health education programs and activities will be coordinated through the patient health education coordinator, in accordance with the guidelines promulgated by the Patient Education Advisory Council. The appropriate professional-level member of the medical center staff will assess the patient's education needs as they relate to self-care; the assessment will include the following components, if indicated: the patient's cultural and religious practices, emotional barriers, reading ability, level of desire and motivation, physical and/or cognitive limitations, and language barriers. When the assessment has been completed, the staff member will identify patient education needs that have not been met and will take steps to address those needs.

When providing patient health education, medical center staff are directed to consider the patient's health status, problems, length of stay, treatment plan, and care needs. The staff also must take into account the capabilities, limitations, expected responses, and expected outcomes of both the patient and his or her family.

All patient education interventions will be recorded on the patient's medical record. According to the draft policy, medical center staff are encouraged to document the interventions on the hard copy of the patient education record or electronically, on the DHCP. If staff uses other methods, such as progress notes, flow sheets, referral/consultation forms, care plans, or discharge instructions, these methods of documentation must be in accordance with organizational policy. If the method does differ, staff must identify the difference, in writing, at the service level. The ultimate goal is to have only one documentation form to chart patient education.

Patient education about prescribed medications will be an ongoing process throughout the patient's hospital stay and a collaborative effort on the part of physicians, nurses, and pharmacists. This education will focus on, but will not be limited to, medications that the ZVAMC's Pharmacy & Therapeutics Committee identifies as commonly prescribed, high-risk medications. Medications given within the last 24 hours of a patient's hospital stay will be identified on the patient's discharge medication record. The patient's physician must provide education on those medications. Inpatients who present their prescriptions at the outpatient pharmacy window must receive counseling by the pharmacist. Physicians, nurses, and pharmacists are directed by the draft policy to instruct patients on the safe use of all medications that the patient is to take on an outpatient basis.

The draft policy instructs professional staff, including physicians, dentists, nurses, and therapists, among others, to provide patients with safe and effective training on the use of medical equipment. The level of training should be appropriate to each patient. Staff providing the education are required to document the nature of their efforts on the patient education record.

The ZVAMC dietician and pharmacist are instructed in the draft policy to identify food-drug interactions, and to provide appropriate patient and family education. The dietician is also responsible for counseling the patient on diet and for providing modified diet instruction. These actions are to be documented in accordance with medical center policy on food-drug interactions and patient education/counseling.

The draft policy directs the ZVAMC professional staff to provide patient health education so as to maximize the efficiency and effectiveness of care. To meet this goal, the staff are directed to help develop the patient's coping skills in a manner that is consistent with the plan of care (eg, by providing education before diagnostic tests that require preparation, before surgery, or in support groups).

At the time of discharge, the professional staff also will provide counseling on the patient's ongoing healthcare needs. The patient will receive information about relevant community resources and instruction on when, and how, to obtain additional treatment, if necessary. Any organization that is to be responsible for the patient's continuing care will receive a copy of the discharge instructions. All documentation will be in accordance with the ZVAMC's discharge policy.

Patient education will be individualized and ongoing. The Patient Education Advisory Council and the patient health education coordinator will act as an interdisciplinary forum for the continuing development of patient education programs and materials. Monitoring and evaluation of all patient health education will be conducted at the service level. The Patient Education Advisory Council will assist and guide this effort.

The education/counseling interaction between the physician and patient before surgery or diagnostic procedures qualifies as an intervention. Both the physician and patient sign the consent form at the end of the counseling session, and the patient has been given information in order to understand the scheduled procedure. In order to satisfy the JCAHO requirements, however, this practice, which many physicians consider to be routine, must be described in the policy of affected services.

### Follow-Up

After the policy was distributed throughout the medical center, the task force that had been established to create the draft was dissolved. Members of the Patient Education Advisory Council believed that a substantial amount of work required completion before the JCAHO visit. They therefore established a new JCAHO Committee, under the council's auspices. The committee was charged with identifying which staff members were responsible for the different components of patient education throughout the medical center, where the patient education was documented, and what patient education methods were being used. In order to obtain this information quickly and accurately, the committee distributed a patient education survey to all clinical services and staff. Although the survey was process-focused, rather than outcomes-focused, useful, factual data on outcomes were collected.

Two issues relating to the patient education record on the DHCP have yet to be resolved: (1) who will be responsible for printing a hard copy of the record on the patient's discharge form; and (2) who will be responsible for filing the record in the patient's permanent record. Discussions, including staff from the Medical Administration Service and Medical Information evolving around this filing issue, are currently in progress.

### Conclusion

After 12 months of deliberation by the task force, and after discussions with clinicians and management from the nursing service, the policy was accepted by all affected services at the ZVAMC. The document will provide guidance within the medical center on how the ZVAMC will meet the JCAHO's patient and family education standard. At the service level, individual staff who will be responsible for various components of the mandate must now be identified. The JCAHO Committee will provide assistance and direction to affected services. As part of its monitoring function, it also will ensure that the services identify their target goals, and that they address the goals by complying with organization-wide policy, creating a separate policy at the station/service level, or incorporating the goals into a preexisting goal. In addition, the committee will ensure that indicators or monitors comply with the 91% to 100% scoring requirements established by the JCAHO. The results of the patient education survey provided excellent feedback. Members of the Patient Education Advisory Council will communicate the survey data to the staff within their services.

In conclusion, if healthcare organizations are to comply with the JCAHO's new standards on patient and family education, the following organizational strategies must be established and made operational<sup>18</sup>:

- Provide a planned, coordinated approach to patient and family education
- Use a performance improvement framework to design, measure, assess, and improve the organization's performance of the patient and family education function
- Focus on how current organizational processes are implemented relative to the patient's care plan and to continuity of care
- Identify patient and family education responsibilities within the organization and provide the necessary education
- Establish a mechanism to present patient education in a way that both the patient and his or her family can understand.

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