Patient Education Management™

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

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IN THIS ISSUE

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TJC: Time is now to examine communication with LEP patients

New Joint Commission standards link with requirements of U.S. law

Now is the time for health care facilities to evaluate communication practices between patients and providers at the point of care to make sure they comply with new Joint Commission standards, says **Amy Wilson-Stronks**, MPP, project director in the Division of Standards and Survey Methods.

To aid staff in their efforts, The Joint Commission and the U.S. Department of Health and Human Services Office for Civil Rights released a video in Nov. 2009, titled, "Improving Patient-Provider Communication."

The video was produced to encourage health care organizations to determine the best methods for meeting communication needs. With 28

EXECUTIVE SUMMARY

The Joint Commission, based in Oakbrook Terrace, IL, initiated an 18-month project in August 2008 that explored how diversity, culture, language, and health literacy issues could be better incorporated into current standards or drafted into new requirements.

The changes in standards resulting from that project were unveiled in January 2010 and will be implemented in January 2011.

Since these issues pertain to effective communication — a key component of good education — *Patient Education Management* will explore them. In this issue, we interview Amy Wilson-Stronks, MPP, the principal investigator for the Hospitals, Language, and Culture study at The Joint Commission. She provides advice on steps hospitals should take to improve language access for patients with limited English proficiency.

million people in the United States experiencing hearing loss and 47 million people speaking a language other than English, language access is a matter of national importance, according to The Joint Commission.

"When we did our Hospitals, Language, and Culture research study and visited 60 hospitals across the country, we talked with administrators, as well as clinical staff. It became very apparent to us that many hospital administrators and clinicians are not aware there are laws and regulations that support the provision of language access service, both for people who are deaf or hard of hearing and those with limited English proficiency," says Wilson-Stronks.

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The study helped to shape the proposed standards, which were sent out for public comment in June and July of 2009. Following the field review, the standards considered to be the most vital were selected for implementation. An implementation guide was developed as the standards were finalized. The guide recommends that the practices identified in the larger set of standards released in the summer of 2009 be followed; however, only the smaller set will be part of the accreditation process, according to Wilson-Stronks.

"I don't think we put forward anything that is unreasonable. I think we put forward things that many hospitals in some way, shape, or form are already doing, whether or not they are doing them well," says Wilson-Stronks. **(To see what some hospitals are doing to provide language access, see article on p. 15.)**

What were some of the areas that hospitals needed to improve upon? When the researchers made site visits, they would follow a hypothetical patient through the system of care. Often, when clinicians were asked how they would communicate with that patient, there was a lack of consistency with hospital policy, available services, and the action of the clinicians, says Wilson-Stronks.

While all hospitals visited had access to the telephone interpreter services, clinicians relied on gestures, sign language, and the use of pictures with non-English speaking patients, she adds.

The questions asked by the researchers had to do with informing the hypothetical patient that he had acute appendicitis and would need to be transferred to surgery. In many cases, the clinicians were not aware that there were telephone services, and in some cases, interpreters or designated bilingual staff trained as interpreters available, says Wilson-Stronks.

She added that some people interviewed did not see a problem with relying on a family member, but that is not a recommended method for providing language access, because the clinician will not know what is communicated to the patient.

There should be more emphasis on good practices vs. poor practices, says Wilson-Stronks.

Assessment of policies a must

Hospitals also need to have in place systems that are working, she adds. While contracts with telephone interpreter services were common, not all clinicians knew the access code for their use —

SOURCE

For more information about new communication standards issued by The Joint Commission, contact:

• **The Joint Commission**, One Renaissance Blvd., Oakbrook Terrace, IL 60181. Telephone: (630) 792-5000. Web site: www.jointcommission.org.
[For access to video on communication and information on evaluation resources on The Joint Commission web site, go to Patient Safety, Hospitals, Language, and Culture. The Quick links accesses evaluation toolkit.]

or that there were special phones that were kept locked up, making them difficult to access. Also, there was some resistance among clinicians to using a telephone interpreter, because they weren't familiar with the system and felt awkward using it.

During the study, researchers learned from the administration what policies, practices, and resources were available and then went out on the floor to talk to clinicians. According to Wilson-Stronks, the hospitals that did best had administrators who thought about their approach and made an effort to understand the need and utilization of language services by patients. In some cases, hospitals found it more cost-effective to hire an interpreter because the need for a speaker of that particular language was so great that it was best to have someone on staff.

Currently, hospitals should be collecting data on race and ethnicity, as well as language and communication needs, says Wilson-Stronks.

"My recommendation to organizations is to look to resources that are currently available to help assess current needs in terms of language services, language needs, and communication needs within their community and to determine how they are meeting those needs," she adds.

The Office for Civil Rights has a guide for developing a plan for meeting the needs of limited English proficiency patients, and the link is available on The Joint Commission web site.

"It is a good way to make sure you are putting something in place that is comprehensive and complies with the law," says Wilson-Stronks.

Also, on The Joint Commission web site, there is access to the "Health, Research, and Educational Trust Disparities Toolkit," which walks an organization's staff through the steps of assessing systems, training staff, and using data to determine if there are health care disparities.

Communication is important for patient safety, accurate assessment, and accurate diagnosis, says Wilson-Stronks. Good communication also minimizes readmissions, because when patients are given discharge instructions in a language they understand and in a manner they understand, they are less likely to return to the health care institution, she adds. ■

Plan required to offer interpreter services

Make sure staff receives training once plan is set

Every medical facility needs to have a plan in place for accessing qualified medical interpreters when a patient has limited English proficiency. There are many ways to make sure there is good communication between medical staff and patients or family members with limited English proficiency.

At Wellspan Health in York, PA, there are four full-time and two part-time Spanish interpreters employed to provide services 24 hours a day, seven days a week, says **Christine Hess**, MEd, patient and family education coordinator. The AT&T Language Line is used for other languages, and there is a resource list of staff members who may be able to help with some languages in certain situations, she adds.

"Hispanics are the largest group in our community needing the interpretation services," states Hess.

The policy is specific about requirements. It reads:

"If a patient, designated family member, or significant other of a patient participating in treat-

EXECUTIVE SUMMARY

With new Joint Commission standards set to be implemented in January 2011 about communicating effectively with limited English proficient patients, now is the time to review and create policy.

ment discussions and decision-making for the patient is unable to effectively communicate except for using sign, or foreign language interpreter, all medical and psychiatric evaluations or discussions regarding a patient's symptoms, treatment, diagnosis, progress, and prognosis in which that person takes part must be communicated through the use of a qualified sign or foreign language interpreter.

"Additional situations in which an interpreter is involved include, but are not limited to: Obtaining informed consent or permission for treatment; discharge planning; explaining and discussing advance directives; explaining the administration and side effects of medication; explaining follow-up treatment; and discussing billing and insurance matters."

The "Communication Assistance Policy" at Cincinnati (OH) Children's Hospital Medical Center, specifies that any time medical information is exchanged with a family or patient with limited English proficiency, an interpreter must be present. Staff are required to arrange for interpreters in advance of a scheduled appointment or encounter, as well.

Although the health care institution has bilingual providers on staff from more than 60 countries, they are not allowed to act as an interpreter. Fluency in a language is not enough to qualify as an interpreter, explains **Mariel J. Broadus**, director of guest services at Cincinnati Children's Hospital.

"I know a lot of hospitals do allow for bilingual providers, but that is something we chose not to condone. Part of the reason for that is because we currently don't have any assessment in place for anyone who identifies themselves as bilingual," says Broadus.

To assist with communication, the children's hospital employs eight full-time Spanish-speaking interpreters and has three more on call. Three local agencies are used to provide interpreters for other languages, and also there is a contract with an agency for American Sign Language. A telephonic interpreting service is also available to staff.

Training essential

Although it is important to have policy in place, that alone is not enough. There must be ongoing staff education to make sure everyone understands how to comply with the policy.

Broadus constantly works with department heads and managers to make sure they can train their staff on the appropriate use of interpreters.

Also, when someone calls guest services with a question about policy concerning interpreters, Broadus has staff suggest someone from the department follow-up with a short in-service at a staff meeting. Information covered might include an overview of working with a medical interpreter, going through a mock encounter, and the steps for requesting an interpreter.

"One of the most important messages we try and give everyone is that interpreters are not just here for patients and families — they are here for providers, as well," says Broadus.

She helps providers learn how to politely tell parents who do not want an interpreter that they want one present in order to make sure everything said is communicated appropriately.

Interpreters on staff are also taught how to politely refuse to leave when a physician states that he or she can handle the encounter since he or she speaks the language. Often, the physicians realize the patient does not understand, and it is an opportunity for the interpreter to step in and clarify. It's a great teaching opportunity for providers, says Broadus.

At most health care facilities, the preferred method of communication is assessed at admission. At Cincinnati Children's Hospital, upon registration, parents or guardians are asked their preferred spoken and written method of communication, and patients are also asked.

Information on the electronic medical record can be flagged, and every time a patient or family with limited English proficiency is identified, the information is flagged. In that way, anyone who accesses the medical record will see the flag, says

SOURCES

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- **Christine Hess**, MEd, Patient and Family Education Coordinator, Wellspan Health, York, PA. Telephone: (717) 851-5859. E-mail: chess@wellspan.org.

Broadus.

Currently, additional methods for notifying providers are being considered, such as creating a magnet for the door of the patient's room, she adds.

Education about the importance of using medical interpreters is an ongoing effort, says Broadus. ■

Headline news creates need for patient education

Make sure education is consistent with media blitz

EXECUTIVE SUMMARY

A great deal of discussion took place among news commentators following the release of controversial guidelines on breast cancer screening, followed by new recommendations for cervical cancer screening in November 2009.

Such a media blitz can create an opportunity for patient education.

In Nov. 2009, recommendations for changes in screening guidelines for breast cancer made headline news. Shortly thereafter, new guidelines for cervical cancer screening also became news.

The new guidelines contradicted what was considered best practice by many health care institutions.

Such information can be confusing for both patients and professionals, says **Joanne Lester**, PhD, CRNP, ANP-BC, AOCN, a research scientist and oncology nurse practitioner at the James Cancer Hospital & Solove Research Institute in Columbus, OH.

Yet, when screening is news, there is an increased awareness and opportunity for education, she adds.

Any media coverage of a cancer-related topic will create questions on the part of the general public. As a result, a health care organization with any type of call-in or e-mail interface with the general public should be prepared with the facts, recommends **Mary Szczepanik**, RN, BSN, MS, a breast health specialist at the OhioHealth Breast Health Institute in Columbus, OH.

In the case of breast cancer screening, the U.S. Preventive Services Task Force of the Department of Health and Human Services in Washington, DC, recommended against routine screening mammography in women 40 to 49, with screening every other year for women 50 to 74 years of age. The task force counseled against teaching women to perform breast self-exams and questioned the usefulness of clinical breast exams. Also questioned was the usefulness of mammography for women 75 and older.

The recommendation that women should delay their first Pap test until age 21, regardless of sexual history, came from the American College of Obstetricians and Gynecologists (ACOG), based in Washington, DC. "Cervical cytology screening is recommended every two years for women between the ages of 21 years and 29 years. Evidence shows that screening women every year has little benefit over screening every other year," ACOG stated in a letter to its members.

When new guidelines for cancer screening become news, health care organizations need to have steps in place to make sure information from their staff is consistent, says Szczepanik.

"In the case of the recent announcements about mammography and Pap smears, it would be wise to research not only the full facts of the study and findings of the panel but also to contact the leadership of the cancer program at your institution for an official statement," she advises.

According to Szczepanik, such an approach reduces the risk of associates expressing their personal opinions and provides consistency and accuracy in all responses.

At M.D. Anderson Cancer Center in Houston, information was posted on its Cancerwise web site immediately after the news broke, advising women to get their first mammogram at age 40 and return every year for regular screenings. It stated that the guidelines would be assessed at the cancer center's annual evaluation in March 2010.

Educate consumers

The web piece also stated that physicians needed to educate their patients on the risks and limitations of breast cancer screening, so their patients could participate in the decision-making.

Patients must be treated on an individual basis, agrees Lester. She explained that practitioners should look at each patient's individual risks and

base what is done on the evidence, best practice, clinical intuitiveness, and patient preference.

"My first response to the news was that we had worked so hard to educate people, but it raised a lot of awareness and discussion; and it emphasizes again that you need to individualize your care for each person," says Lester.

Also important is education about the guidelines institutions choose to follow. Szczepanik says OhioHealth gets the word out via its web site, print materials made available to primary care physicians for use in their office, community education programs, and education of office staff, as needed.

Many institutions have a committee that reviews guidelines annually in order to establish policies for practitioners to follow. OhioHealth follows the recommendations of the American Cancer Society, in Atlanta; the American College of Surgeons in Chicago; and the National Cancer Center Network in Fort Washington, PA.

On the rare occasion when the medical staff committee identifies a difference in process, it creates a document indicating the exceptions to the standard, and that becomes part of the record via meeting minutes. If the difference is significant, then a letter to the medical staff would be sent, says Szczepanik.

Most of the physicians at OhioHealth are private practice physicians but are held to the standards set by the medical staff office, adds Szczepanik. "They are informed by section meetings, weekly ground rounds, cancer conferences, and at times in written form," she states.

At the James Cancer Hospital, guidelines issued by the ACS, the NCCN, and National Cancer Institute in Bethesda, MD, are used to form policy on screening. Also, the institution has disease-specific committees, including a breast disease committee, which discusses such issues as the new guidelines recommended by the task force.

Lester says it is important to discuss health information that has been on the news, because sometimes the information is misinterpreted. For example, ACOG recommended a Pap smear every two years, but women might assume that means they should have a pelvic exam every two years and therefore miss out on other important screenings, such as blood pressure and cholesterol.

Even if a screening test is not needed, it is important to educate women about seeing a physician on a regular basis, says Lester. ■

SOURCES

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2010 may bring new career opps for CMS

Value of care coordination is being recognized

Now is a good time to be a case manager, leaders in the field report. New opportunities are opening up for case managers as the country struggles with ways to provide optimal health care for everyone while minimizing soaring costs for care.

"Care coordination, case management, and safe transitions of care can only help save health care dollars. More and more, case management is being recognized as a valuable service, and people are beginning to understand how the care coordination piece benefits the bottom line," says **Margaret Leonard** MS, RN-B, C, FNP, senior vice president for clinical services at Hudson Health Plan in Tarrytown, NY, and president of the Case Management Society of America (CMSA).

All of the health care reform bills that were introduced in Congress include the concepts of care coordination, care management, and safe transitions of care as cost and quality essentials for health care, Leonard says.

In addition to giving input on health care reform proposals, CMSA has been asked to provide language for a model case management act, she adds.

The Case Management Model Act is not a bill, but rather a document that educates legislators and regulators to help them define criteria for care coordination, case management, and transitions of care. It includes case management standards of practice, which contain a list of criteria that must be met before someone can call himself or herself a case manager, Leonard says.

"I feel good about the health care reform measures as they apply to case management. I think they will open up new avenues of practice for us. I don't think primary care physicians or other providers who don't already have case managers on staff will not go start hiring them until something is decided about health care reform, including the realignment of incentives; but once we get past this hump, we're not going to see any problems with nurses and social workers getting positions," Leonard adds.

Nancy Skinner, RN, CCM, agrees that case managers will have new opportunities in the future.

"It's going to be a whole new world for case managers. The case manager is going to become a consultant who helps the patient, the family, and caregivers have quality of life through the end of life," says Skinner, a consultant for Riverside HealthCare Consulting in Whitwell, TN.

Some of the opportunities for case managers will depend on what the final health care reform legislation looks like, Skinner says.

For instance, the idea of a patient-centered medical home is under discussion and is likely to involve case managers in some way, Skinner says.

However, there's still no agreement on how physicians will be reimbursed for providing the extra services to patients, she points out.

"In today's economy, we truly need to focus on appropriate case management, but it all depends on the funding. I believe that case managers will become a part of primary care practices, but it may take as long as five years to determine how the patient-centered medical home is going to be organized and how case managers will participate," she says.

The incentives have to be aligned appropriately for primary care physicians to add case managers to their practice, Leonard adds.

"We can't ask primary care physicians to provide care coordination and not receive increased reimbursement. They're going to have to hire staff, and the government is going to have to reimburse for it," Leonard says.

The medical home model includes case managers who work with physicians to manage the care of patients, something that is sorely needed, adds **Catherine M. Mullahy**, RN, BS, CRRN, CCM, president and founder of Mullahy & Associates, a case management training and consulting company.

"The health care system has become so complex that people need someone to act as their advocate. As physicians are forced to decrease the time they spend with patients in their office, and more responsibility shifts to the patient and family members, people need someone to guide them in making the right choices and following their treatment plan," Mullahy says.

Case managers can help people understand their diagnosis, make informed choices about treatment options, prevent complications, and save money at the same time, Mullahy says.

"However, the average person doesn't understand how much help a case manager can be, and that's why we need to educate them," she says.

Case managers based in physician offices can help patients understand how to manage their condition, how it will improve their quality of life if they do, and what could happen if they don't, says **B.K. Kizziar**, RN-BC, CCM, CLP, owner of B.K. & Associates, a Southlake, TX, case management consulting firm.

"We hear so much about noncompliant patients who don't fill their prescriptions and don't take their medications correctly, but there is very little education that occurs at the doctor's office level when a new prescription is ordered or a new diagnosis is made. Patients need to be educated about how to adhere to their treatment plan, and case managers are the right people to do so," she says.

Sometimes patients can't afford their prescription and need help looking for alternatives, Kizziar points out.

"Doctors decide what is appropriate and rarely ask if the patient can afford it. I think people leave the doctor's office without the knowledge they need to make the kind of decisions they need to make. This is another opportunity for case managers," she says.

Whatever happens with health care reform, it is likely to be more and more difficult for middle-sized and smaller employers to continue to provide the same kind of health care coverage they

do today, and that is likely to create opportunities for case managers, Kizziar points out.

She sees opportunities for case managers either as consultants on a contract basis or as employees who can help employees navigate the health care system, she says.

"As more and more people shop for health care benefits, case managers have an opportunity to share their expertise and act as consultants to employees to help them make wise decisions," she says.

Being a health care educator and advisor to help employees navigate the health care maze is an opportunity case managers haven't had in the past, she says.

"I have believed for a long time that case managers should inform the health care consumer about how to make better decisions and how to be compliant. This is going to be even more important in the future," Kizziar says.

The complex health care system and the emphasis on efficient and effective care already is creating opportunities, Mullahy points out.

"More and more third-party administrators are bringing case management and disease management programs into their organization. Employers are starting to look at opportunities for case managers. Hospitals are advertising for nurse navigators to help patients navigate their way through the health system and to manage their care once they are discharged," Mullahy says.

With the current emphasis on readmission rates, case management responsibilities in the acute care setting are likely to expand, and extend into the community, Skinner says.

"The focus on readmissions is going to increase the value of case managers and create a greater need for case management," Skinner says.

Data compiled by the Centers for Medicare & Medicaid Services (CMS) show that about 20% of patients responding to the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) replied no when asked if anyone told them what they needed to do at the next level of care, Skinner points out.

"As health care reform rolls forward, I see case managers taking a role after patients are discharged from the hospital to help prevent an adverse event that could result in a rehospitalization," Skinner says.

For instance, heart failure is a major cause of rehospitalization within 30 days of discharge, Skinner says.

"Case managers can have a significant role in working with these patients to prevent readmissions. I predict that in the near future CMS will announce an intention to modify or discontinue payments for readmissions within 30 days. If and when this occurs, hospitals are going to have to develop a case management program for heart failure patients after discharge, or they're going to lose reimbursement from Medicare. Case managers in acute care are going to have to pick up a much greater role in transitions of care," she says.

Skinner predicts that in the future, case managers will work in every health care environment where there is a transition of care — skilled nursing facilities, long-term acute-care hospitals, home care agencies, and hospices.

"As patients move from one level of care to another, it's going to be the responsibility of the facility discharging them to give them the tools they need to be successful at the next level," she adds.

The aging baby-boomer population is going to be the catalyst for change, she adds.

"I can see case managers working in clinic environments and educating patients on what is wrong, what the patient needs to do, and why it is important," Skinner says.

For instance, joint replacement patients could benefit from having a case manager work with them before surgery, during the hospitalization, and after discharge, she adds.

Case managers can help with transitions of care by facilitating communication between providers and making sure providers at each level of care have all the information they need to treat the patient.

"Many times, patients are seeking care from many different providers who don't always communicate with each other," Leonard points out.

For instance, if a patient is hospitalized or sees a specialist, the family doctor may not know what has been going on.

With the current system, if the primary care physician refers a patient to a specialist, that doctor should get the information back to the primary care physician. It doesn't always happen because no one is responsible for sending the information or ensuring that the primary care physician receives it, Leonard points out.

"In the future, because of the economy, many different levels of providers are going to pop up. We've already seen patient navigators and care coaches," Leonard says.

The new types of providers may be less skilled and less educated than the clinicians who provide direct patient care, but they're also less expensive,

she adds. This means it will be more economical to hire a less skilled person to do jobs that don't need the expertise of a licensed clinician.

"Case managers are likely to be the people who will have oversight over the less expensive health care worker. The National Quality Forum has suggested in their work, which was published for public comment, that the care coordination team has to be led and overseen by a licensed health care professional. I don't think the public is going to let that idea die. They want to feel protected in what they are doing," she says.

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Want to spend more time interacting with patients?

Here are two opportunities to consider

Case managers went to nursing school to take care of people, something they find themselves doing less and less in most practice settings, **Catherine Mullahy,** RN, BS, CRRN, CCM, points out.

"Nurses like to feel like they are making a difference for patients, that they are part of the solution to their patients' health care issues. Case managers who spend a huge amount of time with their heads in a chart or talking to insurers aren't feeling good about what they are doing. Instead of spending time with patients, they're spending time on paperwork and business issues," adds Mullahy, president and founder of Mullahy & Associates, a case management training and consulting company.

In the future, as people need more and more help navigating the health care system, case managers are going to have the opportunity to have much more personal and face-to-face contact with patients, she says.

Direct-to-consumer case managers and guided care nurses already are providing face-to-face case management and developing a close relationship with their clients, she adds.

Guided care nurses

Guided care nursing gives RNs an opportunity to do what they went to nursing school for in the first place, says **Kathleen Trainor Grieve**, RN, BSN, MHA, CCM, a guided care nurse from Johns Hopkins Healthcare who works at Johns Hopkins Community Physicians at White Marsh.

The guided care model was developed by an interdisciplinary team of clinical researchers at Johns Hopkins University to improve the quality of life and efficiency of resource use for people with complex medical conditions.

Guided care nurses work in the primary care setting to coordinate care for patients with chronic conditions and complex needs, working side by side with the primary care physician, and interact with other health care providers who treat their patients.

"We are partners with the primary care physicians, the patients, the families, and the specialists. We take a holistic approach to patient care and are truly part of the whole team," she says.

Unlike nurses in other settings, guided care nurses never lose track of their patients after a brief episode of care because they work with their patients on a long-term basis, usually for life, Grieve points out.

They develop a close working relationship with patients and their caregivers and meet with them in their homes as well as accompanying them to physician visits and visiting them in the hospital. They coordinate transitions between levels of care and providers.

"Some patients have said that working with a guided care nurse is like having a nurse in the family. Someone they trust is looking out for them and getting them the care they need," Grieve says.

Following an at-home assessment and evidence-based planning process, the guided care nurse monitors patients proactively, promotes self-management, smoothes transitions between sites of care, educates and supports family caregivers, facilitates access to community resources, and coordinates the efforts of health care professionals, institutions, and community agencies.

"Self-management is an important aspect of the program. We don't do things for our patient that they can do for themselves. We focus on helping them take charge of their own health,"

she says.

Guided care nurses come from a variety of backgrounds, Grieve says. Of the seven nurses in a three-year trial of the guided care nurse program at Johns Hopkins, one nurse had geriatric experience, another was an experienced home care nurse, and another had been a hospital-based nurse for only four years.

"It's not so much the experience nurses have had that make them a successful guided care nurse. It's their personal attributes," she adds.

For instance, guided care nurses have to be assertive when they need cooperation from the physicians, especially when they are just starting with the practice.

"Doctors are all overworked and have limited time. You can't let it stop you when they tell you they don't have time to talk," she says.

Guided care nurses must complete a guided care nursing curriculum and pass a certification examination.

Direct-to-consumer case managers

Direct-to-consumer case managers are nurses who are independent business owners and contract with patients and/or their family members.

While the contract for the actual services may be with the patient, referrals may come from group medical practices, elder care attorneys, financial advisors, small employee groups, and others who are aware of the benefit of the services.

Their fees are paid by the person who hires them.

"There's a tremendous need for case managers to help consumers navigate the health care system. Direct-to-consumer case managers help patients understand their diagnosis, their treatment plan, their medications, and help when nobody else has the time to answer their questions. They are the patient's advocate and someone patients and family members can call on when they have questions and concerns," Mullahy says.

When patients are seeing five or six different doctors, they need a case manager who can go with them to their appointments, help coordinate the care, and ensure that all of the providers have the information they need to develop a treatment plan.

"This type of practice gives case managers an opportunity to work one on one with patients and to develop a close relationship with them. It goes back to the first generation of case management where the case managers spent time with their patients. Direct-to-consumer case managers can control their own caseload and decide the best way to handle their cases," she says.

Direct-to-consumer case managers are not employed by a managed care organization, a hospital, or another entity.

"They represent the patient's interest and only the patient's interest. They don't face the challenge that their employer may want something that conflicts with what they think is the patient's best interest," Mullahy says.

Geriatric case managers have been contracting with family members or elder care attorneys for a number of years and managing the care of elderly patients, often when their family members live in another state, Mullahy says.

Other case managers have gone into business to consult with patients who are undergoing cancer treatment or have complicated conditions, such as congestive heart failure or end-stage renal disease, she adds.

Direct-to-consumer case management is a growing field that is likely to increase in the future, but it's not for everyone, Mullahy says.

"Just because someone is a wonderful case manager, they don't necessarily have what it takes to become a business owner and market their own services," she adds.

Offering your services as a consultant to consumers is fulfilling but is challenging because many case managers can't afford to go out on their own and lose the security of a weekly paycheck, she says.

Mullahy advises case managers who would like to try direct-to-consumer case management to keep their job and build up their practice in their spare time.

"I wouldn't advise anyone to leave the security of a job unless they have savings and other income," she says.

(Johns Hopkins is offering a six-week, 40-hour online guided care nurse course through the Institute of Johns Hopkins Nursing. For more information, visit www.ijhn.jhmi.edu.) ■

Hospital created simple, effective discharge tool

Nurses helped create it

An effective and simple discharge checklist is the ideal tool for hospital nurses and others

who handle the patient discharge process.

The University of New Mexico Hospital in Albuquerque, NM, has developed one that meets both of these goals and has received high marks from nurses who use it.

The hospital developed the tool after becoming involved in Project BOOST (Better Outcomes for Older adults through Safe Transitions), which is sponsored by the Society of Hospital Medicine in Philadelphia, PA.

"One of the things we've had some success with is our discharge checklist for nurses," says **Percy Pentecost**, MD, assistant professor of medicine at the University of New Mexico Hospital.

"What we found is there is not a lot of consistency in the way discharges were done, so we tried to make that more consistent," he explains. "The way we've done that is to come up with a discharge checklist that all the nurses on our trial floor utilize every time they discharge a patient."

For example, if a patient has his prescriptions in hand or has a way to obtain his or her prescriptions before arriving home, this will improve the patient's discharge process.

"If you hand somebody prescriptions at 8 p.m., it doesn't do them any good because the pharmacies are all closed," Pentecost says. "So we're trying to anticipate the details needed for discharge."

Another example of a discharge detail involves making certain patients understand and can repeat back all of the warning signs of problems.

"So if they're admitted with pneumonia, they

CNE instructions/objectives

Nurses and other patient education professionals participate in this continuing education program by reading the issue, using the provided references for further research, and studying the questions at the end of the issue.

Participants should select what they believe to be the correct answers, then refer to the list of correct answers to test their knowledge. To clarify confusion surrounding any questions answered incorrectly, please consult the source material. After completing this activity each semester, you must complete the evaluation form provided and return it in the reply envelope provided in order to receive a credit letter. When your evaluation is received, a credit letter will be mailed to you.

Upon completion of this educational activity, participants should be able to:

- **identify** the management, clinical, educational and financial issues relevant to patient education
- **explain** the impact of the management, clinical, educational and financial issues relevant to patient education on health care educators and patients
- **describe** practical solutions to problems health care educators commonly encounter in their daily activities
- **develop** patient education programs based on existing programs. ■

COMING IN FUTURE MONTHS

- Online classes for better outreach
- Better teaching strategies for the elderly
- Ways to promote healthy lifestyles to patients
- Scripting follow-up calls for better education
- Providing written materials to LEP patients

CNE Questions

5. The Joint Commission uncovered which of the following problems in communication between health care professionals and limited English proficient patients during its research on new standards?
   A. Professionals unaware of interpreting services.
   B. Professionals hesitant to use telephone services.
   C. Professionals too willing to rely on family member.
   D. All of the above.

6. Even if hospitals provide access to a telephone interpreter service, clinicians often rely on gestures, sign language, and the use of pictures with non-English speaking patients, according to Joint Commission research.
   A. True
   B. False

7. When health issues become breaking news, hospitals should do which of the following?
   A. Ignore it.
   B. Let clinicians address it in their own way.
   C. Create an official statement.
   D. Ask news stations not to broadcast the story.

8. There are many ways to provide qualified language interpreters for patients with limited English proficiency. They include which of the following?
   A. Trained interpreters on staff.
   B. Contracts with local agencies.
   C. Contract with telephone interpreter service.
   D. All of the above.

Answers: 5. D; 6. A; 7. C; 8. D.

should be able to articulate to the nurse before the discharge that they know to call their medical provider or return to the emergency room if their breathing gets more difficult or if they develop a cough or fever," Pentecost says.

"The checklist is implemented on our trial floor, and the nurses are quite pleased with it, and they feel it adds consistency and helps them organize their thoughts," he adds.

The hospital's nurses helped develop content for the discharge checklist, which consists of one page.

"The nurses wanted to keep the checklist to one page," Pentecost says. "In fact, we gave them our trial version of four things, and they're the ones who said, 'That's a good start, but we also need this and this and this.'"

Based on that positive beginning, the checklist was revised and improved.

"The tool has helped us develop some unity and purpose in trying to improve discharges," Pentecost says.

The hospital plans to share its checklist with other hospitals through Project Boost, and Pentecost already has discussed it with peers in Project BOOST conference calls.

Project BOOST on its Web site already has a toolkit that includes a discharge checklist that has been used successfully by other hospitals, Pentecost notes. ■