

# patient education MANAGEMENT

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

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## Health reform promises improved access, more patients to educate

*What might patient education managers do to prepare?*

Although no one is sure what the new health care legislation will look like when fully implemented, all agree it will give more people access to preventive and medical care.

As a result, many health care professionals agree that reform will impact patient education.

Fran London, MS, RN, a health education specialist at the The Emily Center at Phoenix (AZ) Children's Hospital, expects that more patients will get screened, get care for chronic illnesses, get diagnosed with illnesses new to them, and get regular care.

"Each one of these will increase the need for effective and efficient patient education," says London.

It will be more important than ever for health care providers to evaluate understanding, because people who have not used the health care system for a while may not have the basic knowledge to understand instructions or an accurate view of how much self-care is required, she adds.

Health care reform will impact patient education because millions of currently uninsured people will be able to access health care when they fall ill and will need information about self-care and follow-up care, says Louise Villejo, MPH, CHES, executive director of the patient education office at the University of Texas M. D. Anderson Cancer Center in Houston.

## EXECUTIVE SUMMARY

Recent changes in health care law will most likely bring new demands for patient education. In this issue of *Patient Education Management*, we explore the various issues that could impact education and discuss possible changes in delivery of information.

“There will be an increased need for patient education in all areas, because people will be accessing the health care system throughout the continuum of care,” says Villejo.

Many hospital systems have focused on acute care; however, health care reforms will require systems to expand their inventory of resources to cover the preventive side of care and early disease management aspects, predicts Diane Moyer, BSN, MS, RN, program director of patient education for The Ohio State University Medical Center in Columbus.

Providing resources to physicians’ offices and

clinics will be essential, and helping those providers know how to select quality, easy-to-read and understand materials for use in educating patients will be very important, adds Moyer.

Mary Szczepanik, RN, BSN, MS, a breast health specialist at the OhioHealth Breast Health Institute in Columbus, says that because health care is a process, not a moment in time, needs will change as the person moves through the continuum of care. However, if more individuals are able to seek preventive care, such as well-child care and screenings, then there will be an increase in the diagnosis of disease, which suggests an increased need for education about the treatment.

What do patient education managers need to be doing in order to prepare for the changes in health care delivery?

“Become more involved in the preventive side of care by making sure that learning opportunities are provided by easy access to information,” advises Sandra Cornett, RN, PhD, director of AHEC Clear Health Communication Program Office of Outreach & Engagement, The Ohio State University College of Medicine in Columbus.

We need to communicate in such a way that preventive care is seen as meaningful to people with low health literacy, she explains.

According to Szczepanik, there are social and cultural norms associated with low health literacy that cannot be changed simply by providing better access to health care or improving health literacy. “We have to find a way to convince people that finding a health problem earlier, rather than later, is a good thing,” she says.

To reach a variety of people, education needs to be delivered in many different modalities, says Cornett. Social networking formats, such as Facebook, Twitter, texting, and podcasts, may help the younger population.

Patient education managers should explore ways to get their messages out to vulnerable populations, such as those with low health literacy. Also, they should explore settings where the message will be received, says Cornett. She encourages taking lessons on disease prevention into churches, beauty salons, barber shops, grocery stores, recreational areas, schools, adult education classes, and retail shops, as well as distributing information through ads and public service announcements. Patient education managers will need to do a thorough assessment of the patient population they serve, says Szczepanik. This assessment should include the socioeconomic status of the popula-

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#### EDITORIAL QUESTIONS

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tion, as well as existing comorbidities, health history, and health literacy level.

Villejo says there are already a lot of materials available through government agencies, disease-specific organizations, wellness organizations, health education vendors, and health care institutions that cover preventive services, such as diabetes screening. Processes are needed to provide preventive health information in the community, in schools, and in the workplace, as well as clinics, physician offices, and health care systems. “Simple print materials and multimedia materials should be available,” says Villejo.

## Thinking outside the box

**Cezanne C. Garcia, MPH**, adjunct faculty, School of Public Health and Senior Program and Resource Specialist at the Institute for Family Centered Care in Bethesda, MD, says, “Be wary of defining preventive care solely as those services that are provided/scripted by health care-based services.”

She advises support of community-based services, such as the delivery of fruits and vegetables to libraries in neighborhoods that historically have had no access to non-processed foods; participation in fitness activities in communities; construction of walkways and bike paths to encourage fitness in everyday life; support of fitness in schools for children; and meditation and exercise to tackle depression.

“We have been a sick-care system, rather than a health care system model, for so long, we need to help people understand how to stay healthy. It could be a big shift for providers and patients, but I think PEMs are positioned to help both parties be successful in the transition by helping to message content in a way that is easily understood by patients,” says Moyer.

To gain the greatest benefit from the recently passed health care legislation, which would be to improve health outcomes and hold down costs, patient education toward the goal of increasing health literacy is absolutely necessary, says **Jennifer Rho, MD, MPH**, co-founder, medical director, and volunteer physician at Hawthorne Health Services at Hawthorne Education Center in Rochester, MN.

A lot of emphasis within the health care system has focused on creating easy-to-understand written materials and improving patient-provider communication; however, improving the health literacy of

patients is equally important, says Rho.

“What I have found as a physician practicing in a health service for adult literacy students is that while they want health materials easier to understand, they are equally...eager to improve their knowledge of the health care system, healthy living, and common health issues,” she explains.

Assess what areas of health education are most important to the local patient population, then work directly with patients and community members to develop materials that meet the local needs, she advises.

Consumers will need information and education within their community about how to be an empowered consumer of health care, says Cornett. This might include information on how to prepare for a doctor’s/clinic visit; asking questions; understanding services available; appropriate use of the emergency department; knowing where to go to get resources and care; personal responsibility for getting care; and what to expect in the American system of health care, she explains.

According to Rho, people with very low health literacy, who have had limited access to health care in the past, may not understand what it means to have health insurance. Because this population is not currently reached by traditional patient education methods, which tend to be hospital-based, it is important that patient education managers step outside of the hospital and go into the community with their efforts, she says.

A patient education system where one person assists the patient in obtaining the care they need and deserve is an effective model, says Szczepanik. The assistant would help those inexperienced with the medical system make appointments, read schedules, and understand the steps and timelines for care, she explains.

In addition to teaching patients how to utilize the health care system, changes need to be made to make the system easier to navigate, says Cornett. Every health care system should do a health literacy environmental assessment on matters such as how well people can physically navigate the system. This would include an evaluation of the telephone system, entrance, lobby, maps, signs, information desk, staff assistance, color codes, and services and specialties, she says.

In addition, print communication and oral communication would be reviewed, as well as technology, staff orientation, and skill building in communication, says Cornett.

Although it is not yet clear how the legislative

changes will impact the health care system, patient education, or individuals, Szczepanik says she is optimistic. She hopes that cost barriers will no longer be an obstacle to preventive screenings and care — or compliance with the care recommended by health care professionals once a diagnosis is made. She is also hopeful that more people will understand the advantages of leading healthier lifestyles. ■

## SOURCES

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## Website aids caregivers in Alzheimer's

*Multimedia website assists with unique challenges*

It is estimated that Alzheimer's disease affects 5.3 million Americans, making it difficult for them

to function in some very simple, ordinary ways. Yet families are often caught off guard when the diagnosis is made, for they cannot imagine how the behavior of a loved one is altered as the disease progresses.

You can't imagine that your mother, who has been an excellent cook all her life, would forget to take the food out of a plastic container and put it in a pan to heat it, but would put the container on the stove and light a flame beneath it, says **Rosemary Bakker**, MS, ASID, research associate in gerontologic design in medicine in the Division of Geriatrics and Gerontology at Weill Cornell Medical College in New York City.

"There are a lot of missing pieces of information that are not processed or received by the person with Alzheimer's, so it can be daunting. You are not prepared for it," she adds.

Bakker has spent four years creating [ThisCaringHome.org](http://ThisCaringHome.org), an interactive, multimedia website for caregivers of Alzheimer's and other dementia patients. The website features videos, animations and photographs, and reviews of home furnishings and technology.

It is a valuable tool for educating caregivers and a resource for patient education managers and other health care providers who treat patients with dementia, says Bakker.

Caring for people with dementia is very different from caring for people going through the normal aging process, she adds.

To determine what to include on the website, Bakker relied on her own experience as a caregiver for 15 years to her mother, who had Alzheimer's. She also relied on her training as a gerontologist and interior designer, as well as her work with hundreds of family members at an assisted living facility for people with dementia and Alzheimer's.

In addition, she held focus groups in New York, Seattle, Texas, and Florida and asked her advisory board for input. Also, she did an extensive literature review to find out what some of the unmet needs were for those who cared for a family member with dementia.

The goal for families with loved ones who have

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## EXECUTIVE SUMMARY

Caring for family members with Alzheimer's is a trying experience, because meeting the needs of those with this disease is ever-changing as their ability to function normally.

Alzheimer's or dementia is to keep them in the home for as long as possible as the disease progresses and help them have a life worth living, explains Bakker.

Therefore, safety is one of the most important factors to address. Yet Bakker found during her caregiver experience that home safety checklists were mostly in text, and the concepts were difficult to understand without photos or illustrations.

"I wanted to create a visual website. I have hundreds of images on my website for fast, easy comprehension," says Bakker.

There is also help with the decision-making process, for the key to ensuring quality of life for people with Alzheimer's is to make changes at the appropriate time while thinking ahead to the future and what it might hold. Making lifestyle changes to match the stage of a person's disease can be a complex process, and many factors contribute to the complexity.

Caregivers must be vigilant about observing where changes are occurring so they can intercede at the right moment. For example, a person in the beginning stages of Alzheimer's would not need to have the cabinet with the cleaning supplies locked to keep him or her from ingesting the products. In fact, intervening too early can cause the person to lose the ability to complete a function.

Staging appropriate interventions is important. For example, in the early stages, reminder notes might be helpful. A note on the refrigerator might act as a reminder to take medications, and a note on the front door could prompt a person to turn off the stove before leaving the house — or the handle for the hot water faucet might be wrapped in red to remind the user which knob to turn.

To know what might be appropriate at any given time, caregivers must watch for signs. For example, one woman knew it was time to lock up the sharp knives when her mother tried to crack a walnut with the blade of a large knife.

It is important for caregivers to know that a solution that works for one person with Alzheimer's may not work for another. For example, purchasing an electric tea kettle that automatically turns off may seem to solve the problem of leaving tea kettles on a hot burner. But some people will not be able to learn how to plug the kettle in for a cup of tea, explains Bakker.

"It is very complicated knowing who can do what and who can respond — when there are changes in the environment — to learn a new way of doing things," she says.

## Addressing the issues

Bakker participates in the online forums for ThisCaringHome.org to help people figure out how to address problems.

"I can help them come to a solution or help them try out a few things and refer them to where the information is found on the website. A lot of it is trial and error, but you need to have your toolbox; and caregivers don't have an adequate toolbox," says Bakker.

One helpful tool is insight into how people with Alzheimer's experience the world differently. This helps the caregiver make the appropriate changes to the home. For example, their depth perception is altered, and if the same color tones are used in home décor, everything flattens out and they cannot distinguish objects, such as a brown chair placed on a brown rug. It is important to make sure seating contrasts with the floor, so the person can sit down safely. Or the edge of a step is highlighted with a bright color, so the person can see how high to raise his or her foot, thus reducing falls and increasing the person's ability to function.

People with Alzheimer's or dementia may forget some of the steps for completing a daily activity, such as cooking a meal, and caregivers must watch to see when it is wise to only allow kitchen access under supervision. Patients reach a stage where they forget how to initiate an activity, such as feeding themselves, and placing the spoon in their hand may trigger the long-term memory. They also lose skills and abilities that were once natural. For example, they may put their socks on over their shoes, forgetting the sequence of steps.

Learning what to expect and ways to address the issues is helpful, because families then have the ability to plan ahead and carefully analyze decisions. For example, knowing that people in later stages of Alzheimer's will lose memory of how to walk will help families determine when and if to remodel a home to accommodate a wheelchair. It may not be possible to install a ramp at a home entrance or enlarge a bathroom to accommodate a wheelchair, and alternate plans will need to be made.

There are many products on the market that can help families solve problems, yet there is not always good information available to help people make sound decisions. This was a problem Bakker struggled with during the period of time she cared for her mother, so the website has details about products. For example, she found safety covers for

stove knobs only worked on newer models, and with older stoves the covers actually caught the knob and turned the burner on rather than preventing the use of the stove.

Bakker also included more than 50 links to information the Alzheimer's Association has that either supplements her work or is out of her area of expertise but would be helpful to have available on the site.

"I wanted ThisCaringHome.org to be a little bit of one-stop shopping," explains Bakker. ■

## SOURCE

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# Telephone conversations provide education

*Follow-up important to ensure understanding*

About 9,000 patients at Marshfield (WI) Clinic learn self-care and disease management over the telephone from registered nurses. There are three telephonic care management programs that include the anticoagulation service, heart failure care management, and dyslipidemia care management.

Education can be very effective over the telephone, says **Melissa Mikelson**, RN, manager of care management at Marshfield Clinic. Because patient contact can be more frequent than office visits, information can be covered more than once to ensure understanding.

However, to be effective it must be done right, she adds. While there may be more time to discuss issues with patients on the telephone than in the office, nurses try to focus on one topic during their conversation, so they don't overwhelm patients

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## EXECUTIVE SUMMARY

Education can be enhanced and reinforced when follow-up care is scheduled on the telephone. Patients learn how to put the information they receive into practice.

with information.

With the aid of an education module, information is clear, consistent, repeated, and followed up on to ensure the patient understands. Written materials are usually mailed to a patient after a telephone conversation, and once the patient has had time to receive the material, the nurse calls the patient again to review it.

Scripts are available from a computer-based care management software program. The scripts are primarily written by Marshfield Clinic staff. Scripts guide the conversation and are required for nurses new to telephonic care management. On average, a nurse working in this area has 17 years of experience and has worked with patients face-to-face.

The scripts prompt questions and give examples in order to help patients set and meet goals. For example, if a heart failure patient is struggling to reduce salt in his or her diet, the script would direct the nurse to say, "I understand that you are looking at ways to decrease your salt intake. These are a few ways that we may help you reach that goal." The nurse then would give the patient the options from the script, such as eliminating a food that is high in salt from his or her diet, or not adding salt to foods on certain days of the week.

Scripts are used by all nurses during difficult situations, such as discussions about end-of-life issues with heart failure patients in stage four of the disease. They always ask permission before discussing sensitive issues with patients.

Patients in heart failure care management speak to the same nurse each time they are called. The frequency of calls depends upon the patient. All patients are contacted within 24 to 48 hours of discharge from the hospital, once care management staff are made aware of the discharge.

Once patients are in the program, contact depends on their symptoms, but can be weekly, every other week, monthly, or every three months. All calls are scheduled with the patient, so he or she is expecting to have the conversation, says Mikelson.

The focus of the phone calls in the heart failure care management program is management of symptoms, diet, and activity. The focus of the calls in the anticoagulation service and the dyslipidemia care management program is medication management, therapeutic lifestyle changes, and symptoms related to adverse events. Patients are called minimally on a monthly basis following lab tests. They are not always contacted by the same nurse.

“We do use policies and procedures, and our information is very structured; so the patient does not really hear anything different from nurse to nurse,” says Mikelson.

Although nurses call patients according to a schedule, those enrolled in the programs can call whenever they have a question.

## Perfecting telephone techniques

The cornerstone of telephonic care management is motivational interviewing, says Mikelson. This involves the use of open-ended questions that require more than a “yes” or “no” answer and active listening.

“Our nurses are experts in picking up cues over the phone, understanding what silence means, and what fear sounds like,” says Mikelson.

Nurses meet the patient where he or she is and try to assist the patient in setting goals. They are the patient’s coach.

To improve teaching techniques, conversations are frequently taped, so nurses can listen to them and provide feedback for one another. Nurses in care management also do a lot of role-playing with motivational interviewing to improve their presentation.

Motivational interviewing is a technique used to talk to patients at their own level in order to motivate them to change behavior, explains Mikelson. Patients often have a long list of things they want to change, so nurses help them set goals. During the conversation, the nurse helps them narrow the list, beginning with small steps and then celebrating achievements over the phone. Motivational interviewing challenges the status quo, says Mikelson.

Marshfield Clinic uses electronic medical records, so nurses in the care management programs know what was discussed at the physician’s office, what recommendations were made, and any changes in medication. Also, the physician can see the interaction patients had with nurses in the care management program. In this way, the patient is treated as a whole, says Mikelson.

The telephonic care management program increases contact with patients and makes it possible to intervene quickly. Nurses communicate with the physicians on behalf of patients and can help direct patients in their health care. They can support the physician’s instructions and make sure the patient is following through, says Mikelson.

“We can verify where the patient is at in regard

to the education they have received, and we talk to patients about many different things. We go where the patient goes in those conversations, and we feel that has been very successful for us,” she explains.

Conversations can last anywhere from 10 minutes to an hour. It depends on what the patient needs and how many questions he or she has.

One of the roles the nurse plays in all three management groups is telephone triage. Nurses talk to patients about their symptoms and help them decide whether they need to be seen by their physician. Patients enrolled in the care management programs have access to Marshfield Clinic’s 24 Hour Nurse Line.

“We can make sure patients are seen in a timely manner when it really warrants it. Also, we can help patients avoid unnecessary office visits or emergency department visits by helping them sort things out at home first,” says Mikelson. ■

## SOURCE

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## EOL video studied with cancer patients

*Viewers more likely to avoid CPR*

The latest in a series of papers published by researchers led by **Angelo Volandes**, MD, MPH, instructor in medicine at Harvard Medical School and documentary filmmaker, looked at the use of a video depicting real-life cardiopulmonary resuscitation, as well as other life-sustaining treatments often faced by patients at the end of life.

An earlier study tested a similar video in dementia patients, while this most recent study looked at patients with malignant glioma and was published in the *Journal of Clinical Oncology* last year.<sup>1</sup> Volandes believes that the use of video to describe in pictures what end-of-life options truly entail may one day be a “standard of care.”

Volandes, who also completed a fellowship in medical ethics and serves on the Partners Health Care general ethics committee in Boston, says that

during medical school, he “took a year off to do documentary filmmaking. After my third year, I realized that a lot of the discussions we were having on end-of-life were difficult to express using words. What I meant by those words and what my patient understood by those words were often two very different things.”

Physicians like Volandes and his team often realize, he says, that patients are more likely to look at today’s *Grey’s Anatomy* to gather an idea about what constitutes CPR, and what their chances are of surviving, however inaccurate that idea may be.

“[Patients] would think of these very different realities, because on those programs, over 90% of people actually survive CPR, where in the advanced state of various diseases, the vast majority of people do not survive,” Volandes says.

With regard to his interest in documentary filmmaking, Volandes went to film school during his fourth year of medical school to learn the art of documentary filmmaking.

“I felt like a lot of the clinical realities — the messy clinical realities in the details that clinicians see on a daily basis — are difficult to communicate solely with words,” he says. “There are many studies that showed that [physicians] are poor communicators; they often don’t adequately inform our patients. So, being a medical ethics type . . . I wanted to make sure that we not only guide decisions from our patients to respect their autonomy, but also make informed decisions.”

With the dementia study, his team randomized elderly subjects into two groups. One group received only a physician’s description of typical end-of-life care options; the other half of the subjects were randomized “to have the same verbal discussion, but to also see a 2-minute video. And then we asked them the same question: What sort of care would you want?”

“And, what we found was that in the group that saw the video, not only were they more informed about their decisions, but they also preferred more comfort-oriented measures,” he explains. “And we found that in a diverse group of people in terms of race, ethnicity, level of education, and health literacy.”

They also asked their elderly subjects in the dementia study if they would be interested in seeing an EOL video for cancer — and 95% of respondents said they would be interested.

In the current study, Volandes developed and filmed a 5-minute video on goals of care at EOL.

“We attempted in a short, brief video to offer a broad framework for patients to understand what their options are at the end of life when they have advanced cancer,” he says, noting that his team chose brain cancer because it includes all age groups.

“You have very young people, middle-aged people, and older people, and we really wanted to get a sense of: Would there be a difference [in response] in terms of age?” Volandes says. “Would the elderly, say, be less likely to be amenable to having a video be part of the patient-doctor relationship?”

The video for cancer patients went through seven different versions, and in addition to the filming, Volandes did all of the editing for the five-minute video. It took two and a half years to make, about which he jokes, “Spielberg makes five movies in two-and-a-half years!”

The reason for the long development of the video was that Volandes and his team were attempting to reach a consensus about the video’s impartiality among a group of oncologists, intensivists, ethicists, decision-making experts, and geriatricians.

“We wanted to make sure that everybody in the group felt this was a fair and impartial portrayal of options at the end of life,” Volandes says. “Now, you get a bunch of oncologists together and [try to] have them agree on anything, and they just don’t. So, the written script for the video went through 10 iterations — that was a year, just of itself.”

“It is exhausting and laborious when you have to re-film just for one word, but we wanted to make sure — we being the group of clinicians and scientists that I lead here — that we wanted to create something that oncologists would agree is impartial and unbiased and that oncologists would actually use,” Volandes explains.

He notes that his team has developed and published a set of guidelines to create such videos.

“We invite others to to make similar videos and see if there’s something that we did differently or that they do differently,” he says.

Already, certain health care networks are conducting pilot studies using the video in their end-of-life conversations. At the moment, there are pilot studies at four locations, but the team expects to have 10 in place at academic medical centers this year.

Volandes and his team are already studying the use of video in other cancers at Memorial Sloan-

Kettering in Boston.

“Just to be clear, this is not meant to usurp or replace the doctor-patient discussion and relationship; rather, this is meant to reinforce that discussion,” he says. “An ideal use of this would be having a discussion with your clinician, whether it be a physician, nurse practitioner, or social worker, and then viewing the video to reinforce what’s been discussed.”

Even though the video is thought to be “scary to watch” — even for Volandes — he thinks that “if patients are telling us they want this information, then this is one additional tool with which to empower [them],” he says. “And I think it’s incumbent upon the profession to equip them with those tools to make these decisions.”

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#### SOURCE

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## Ensure that patients are in the correct status

*Waiting 24 hours to review the case may be too late*

From the Centers for Medicare & Medicaid Services’ (CMS) perspective, the saying “ignorance is bliss” does not apply when it comes to a patient’s status. Hospitals are expected to get patients in the right status up front, not after the fact, says **Brenda Keeling**, RN, CPHQ, CPUR, president of Patient Response, a Milburn, OK, health care consulting firm.

“Across the nation, hospitals frequently do not have an order for the level-of-care assignment when patients are placed in a bed. If the order merely says ‘admit’ or ‘admission,’ the status automatically defaults to inpatient,” Keeling adds.

As hospitals struggle to get the level-of-care decision right, there is a lot of confusion about

inpatient status vs. outpatient with observation services, adds **Deborah Hale**, CCS, president of Administrative Consultant Services LLC, a health care consulting firm based in Shawnee, OK.

“The distinction between outpatient with observation services and inpatient status often is not addressed explicitly in the admission order because it’s irrelevant to the kind of care the physician will provide for the patient,” she says.

There are many reasons for the confusion about inpatient vs. outpatient, Hale says.

“There is a misunderstanding of the relative roles of physicians and other staff in determining the patient’s level of care, as well as confusion over the Medicare rules that guide the appropriate level-of-care selection,” she says.

In addition, the distinction represents a difference in billing and not medical treatment, Hale points out.

Using observation services as a default patient status is not the solution, she adds.

“CMS has been clear that it is inappropriate to use observation as a default patient status, and hospitals will be penalized for doing so. Placing patients in observation when they meet inpatient criteria penalizes the hospital, because the reimbursement is lower for observation services,” she says.

Patients also may be penalized financially if they are automatically referred for observation services when they meet inpatient criteria, because copays are higher for long outpatient services than for an inpatient admission, Hale adds.

In addition, if patients need post-acute skilled nursing care, their observation stay won’t count as an inpatient day or days, and they may not meet the three-day inpatient-stay criteria for skilled nursing care, she adds.

Observation services are appropriate for patients who need short-term treatment, assessment, and reassessment before a decision can be made about whether they will require an inpatient admission, or for brief stays following a procedure needed to manage a complication, Hale says.

Condition Code 44 is the billing code that indicates that the utilization review committee or physician advisor has determined that a physician’s inpatient order for a particular patient has been determined to be medically unnecessary, she says.

The order may then be changed to an outpatient order if the utilization review decision is made while the patient is still in the hospital, if the hospital has not submitted a claim to Medicare for

the inpatient admission, if the attending physician concurs with the utilization review committee's decision, and the concurrence is documented in the medical record, Hale adds.

### **When acute care is not substantiated**

If documentation doesn't substantiate an acute level of care, the case managers should discuss the issue with the admitting physician, involve the physician advisor and/or the utilization review committee, and give the patient written notice, Keeling says.

"A lot of hospital staff are not aware that if they convert the patient from inpatient to outpatient with observation services and implement Condition Code 44, CMS requires that patients be given information in writing about the change-of-care status," she adds.

When patient status is changed from inpatient to outpatient with observation services, there's often confusion about when the hospital can start to bill for observation hours, Hale says.

"Medicare requires an observation order and documentation that supports observation services before the hospital can bill for observation hours. The observation order must be present before the observation clock starts ticking. This validates even more why the patient status has to be correct up front," Keeling says.

For instance, a patient is admitted in inpatient status overnight but the case manager's review determines that the patient doesn't meet inpatient criteria. The case manager's process has to include discussing the issue with the attending physician and the physician advisor. If the attending disagrees with the physician advisor, the utilization review committee or a second physician advisor will need to look at the case.

All this time the patient is in a bed, receiving care, but the hospital won't get paid for an inpatient admission because the patient doesn't meet criteria and the facility can't bill for observation services, as the order hasn't been written, Keeling points out.

In some cases, by the time the case manager gets the order changed to observation services, the patient is stabilized and ready to go home. In these cases, an order for observation and an order for discharge are issued within a short time, and the hospital is in a position of not having any further medically necessary observation hours to bill, Hale says.

"Many times, the utilization review process takes place close to the time the patient is walking out the door. That means that hospitals can't bill for the time the patient is in the bed, but they can bill for the ancillary services ordered for the patient that was supported by medical necessity," she adds.

### **CMs should educate other staff**

Case managers should work with the physician and nursing staff in the emergency and admissions department to keep them educated on what constitutes inpatient vs. observation and the importance of getting it right from the get-go, says **Kimberly Gilbert, RN**, case management consultant, clinical advisory services for Pershing, Yoakley and Associates in Atlanta.

"The entire hospital staff have to understand that we're all in this together. It's not just the case managers' responsibility. Everybody has to know the regulations and get admission status right in order for the hospital to get paid," she says.

The process has to start from the minute the patient comes in the door, either in the emergency department or through the admissions department when patients are admitted directly, Keeling says.

"Cleaning up on the back end is a nightmare that causes redundant efforts and is confusing to the staff, physicians, and patients. Hospitals need to understand that getting the patient status right is a process and a system issue. It's not just the responsibility of case management. It's an overall hospital process," she says.

The solution at some hospitals has been to give emergency department physicians admitting privileges, a decision that often causes problems down the road, Keeling says.

"Giving emergency department physicians admitting privileges is not the best way to go. This doesn't fix the problem. It just puts a Band-Aid on it. When emergency department physicians have admitting privileges, it means that they will have to accept full responsibility for patients all night long, or until the attending comes to see the patient," she says.

Furthermore, if the utilization review committee determines that the level of care for the patient is not appropriate, it may be difficult to locate the emergency department physician to discuss the patient status, Keeling points out. She adds that CMS requires that the physician who wrote the original level-of-care order be notified when the

utilization review committee questions the level of care.

“In cases where the emergency department physician has admitting privileges, the case manager should clarify the patient status with the emergency department admitting physician, not the attending physician, which often is more confusing than helpful,” she says.

Just adding more case managers is not the solution to the problem of getting patient status correct up front, Keeling says.

“The best way is to implement a process that involves as many people as possible,” she says.

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## COMING IN FUTURE MONTHS

■ Education needed to balance cancer and careers.

■ Lessons on preparing children for surgery

■ Usability testing for better patient education

■ Better teaching strategies for the elderly

■ Incorporating pictures in lessons for visual learners

Hospitals should establish a process for case management review that starts when the patient comes in for preadmission registration — through the emergency department or as a direct admission.

“Most hospitals are not going to be able to have case managers in the house 24-7. This means a process should be established in which the bed coordinators and/or nursing supervisors are cross-trained for level-of-care status, where the medical staff are trained on level of care, and the admitting clerks are educated to look at the orders before assigning a patient a bed,” Keeling says.

The admissions clerk needs to be aware that he or she should look at the level-of-care order before assigning a bed to the patient. If there isn’t a level-of-care order, the clerk should notify the admitting physician for an order.

“Often, the registration or admissions clerk will register patients as inpatient admissions without looking at the order. Level-of-care status needs to be part of the orientation and the accountability for people working in the admissions office. If the

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## 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.

## CNE QUESTIONS

21. Some experts believe patient education managers should prepare to branch out from hospital-based education to teach patients about preventive care, which is a focus of the new health care reform law. Which of these do they suggest?

- A. Give lessons via Facebook.
- B. Teach in community venues like stores.
- C. Provide resources to physician's offices.
- D. All of the above

22. To improve health literacy, patient education managers might assess which areas of health education are most important to the local patient population, then work directly with patients and community members to develop materials that meet the local needs.

- A. True.
- B. False

23. Timing is not that important when making a home safe for people with Alzheimer's; therefore, caregivers should not consider the stage of the disease a loved one is at when making changes.

- A. True
- B. False

24. Which of the following techniques helps make educating a patient over the phone effective?

- A. Keep the conversation brief.
- B. Cover as much information as possible.
- C. Use motivational interviewing techniques.
- D. Rely on verbal communication, never mail written material.

**Answers: 21. D; 22. A; 23. B; 24. C.**

level of care is constantly wrong, a review to determine the root cause is indicated. The root-cause [analysis] may reveal an employee accountability or knowledge deficit or a competency problem, rather than a registration process problem. It may be as simple as the admissions clerk is not reading the orders," Keeling says.

Programs in which the house supervisor or whoever functions as an intake nurse is cross-trained in inpatient criteria work best, she says.

A proactive case management program should include representatives from registration, the busi-

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ness office, nursing, and ancillary departments. They should be a part of the daily case management meetings to reinforce the importance of ensuring that patients are in the appropriate level of care, Keeling says.

Gilbert suggests that hospitals staff the emergency department with case managers during peak hours to make sure the patient status is correct at the beginning. Case managers should make observation cases a priority when they come to work each day, she adds.

In addition, review the patients who are scheduled for surgery and identify those who are receiving inpatient-only procedures. Make sure that there is an order in place for an inpatient admission for these patients, Gilbert says.

"Case managers are going to have to review observation cases first thing in the morning to make sure the level of care is correct," Gilbert says.

Case managers should not limit their review of records to Medicare patients, adds **Joanna Malcolm**, RN, CCM, BSN, consulting manager, clinical advisory services for Pershing, Yoakley & Associates in Atlanta. ■

# Patient Education Management™

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

PEM060110TM

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**CNE Evaluation:** Please take a moment to answer the following questions to let us know your thoughts on the CNE program. Fill in the appropriate space and return this page in the envelope provided. **You must return this evaluation to receive your certificate.**

**CORRECT** ● **INCORRECT** ○

1. If you are claiming nursing contact hours, please indicate your highest credential: ○ RN ○ NP ○ Other \_\_\_\_\_

	Strongly Disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree
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2. Identify the management, clinical, educational and financial issues relevant to patient education.	○	○	○	○	○	○
3. Explain the impact of the management, clinical, educational and financial issues relevant to patient education on health care educators and patients.	○	○	○	○	○	○
4. Describe practical solutions to problems health educators commonly encounter in their daily activities.	○	○	○	○	○	○
5. Develop patient education programs based on existing programs.	○	○	○	○	○	○
6. The test questions were clear and appropriate.	○	○	○	○	○	○
7. I detected no commercial bias in this activity.	○	○	○	○	○	○
8. This activity reaffirmed my clinical practice.	○	○	○	○	○	○
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