

# patient education MANAGEMENT

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

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## Make education a collaborative endeavor, including patients and staff

*Family-centered care model erases lines*

When Nick Masi, PhD, director of Family Centered Care at Joe DiMaggio Children's Hospital in Hollywood, FL, in 2002 began encouraging staff to obtain family input on health care issues, few saw the value of such teamwork. Finally, a family member joined the patient satisfaction committee to help review scores from patient satisfaction surveys.

Masi explains that the committee members kept asking how to address negative scores, and his suggestion was to add a family advisor to the committee. Six months later, a family member joined the committee. Now, it is difficult to fill all the requests from hospital committees to appoint family members.

"I think over the years, the staff has learned that they can learn from the patients and family, and they really see it in a different viewpoint," says Masi.

In addition to having family members on hospital committees, Joe DiMaggio Children's Hospital has a family advisory council that is involved in everything from architectural design to policy making.

The children's medical facility is one of seven hospitals within Memorial Healthcare System, the fifth-largest public health care system in the United States, that follows the patient- and family-centered care model, in which patients and

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## EXECUTIVE SUMMARY

Memorial Healthcare System in Hollywood, FL, has found that a patient- and family-centered care model is a good way to obtain consumer input about all aspects of care, including patient education. In this issue, we look at how the involvement of patients and family members helps make educational materials consumer-friendly.



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families are equal partners in health care.

Such a partnership is important in patient education, whether creating programs and materials to educate patients, or training staff to implement a pathway or educate on a topic, says **Susan Montgomery**, MA, director of Patient and Family Centered Care Services for Memorial Regional Hospital in Hollywood, FL.

Patients and family members can provide valuable input on educational materials. Staff at Memorial Regional are encouraged to submit educational materials to the advisory council before they are distributed for use, whether the

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materials were purchased or created in-house, says Montgomery.

Patients and family members are very good at spotting terminology that is difficult to understand. Also, patients and family members recognize jargon often used in health care -- and understandable to those in the industry -- that professionals fail to recognize patients will most likely not understand what certain terms mean, explains Montgomery. This can include acronyms, abbreviations, and titles that are not commonplace to patients and families, such as "charge nurse." The advisory council members continuously instruct those who create educational materials to keep them simple and to avoid wordiness, says Montgomery.

Learning preferences are also something patients and family members can address, she adds. More and more, the health care system's customers are saying they don't want to read information; they would rather turn on the television.

Because council members and family advisors are part of the health care team, they don't wait to be approached by the health care professionals. Often, members of patient and family advisory councils identify issues that should be addressed to improve patient safety, satisfaction, and care.

For example, patients and family members at Memorial Regional ask certain questions repeatedly; therefore, the council filmed a short video for the in-house television system that provides answers to these common questions. Named "Hospital Briefings," the TV show provides information on such issues as the discharge process and can be viewed in a patient's room.

Also, the council noticed that people did not seem to think about end-of-life issues. So, they drafted a brochure that prompts people to consider issues that may need to be addressed when an illness is terminal, such as options concerning medical care.

#### No preconceived ideas

When a medical system is patient- and family-focused, there are no preconceived ideas of how patient education should be created and delivered, says Montgomery. Have the audience present in the formative stages, she advises. It's good not only to start with the audience in mind, but to have the audience provide input as much as possible, because they are the ones who can determine if the material or program will be useful to them. (To learn about

## **usability testing, see article on page 75.)**

"I personally believe there is never a time when patients and families should not be involved in the design of just about anything that affects them. They don't have the expertise related to content, but they do about themselves and their families; and they bring that to the table in everything we do," explains Montgomery.

She adds that instead of shaping a program or educational piece and then having the audience review it, PEMs should bring them in when it has no form, and — through discussion — it will take shape.

When members of a patient and family advisory council are included in the process of staff education, they begin to get a clearer understanding of the point of view of members of the health care team. This viewpoint helps when family advisors are asked to work on patient education projects.

At a recent meeting of the family advisory council at Memorial Regional Hospital, members decided it would be a good idea to educate patients and families on how to interact with health care staff. The goal was to help them become more effective in asking questions, says Montgomery. "They understand the dynamics and want to contribute," she explains.

All educational activities should take the patient/consumer into consideration. That includes times when a physician or nurse is learning a new technique or procedure, says Masi. He says in health care, there is a silo mentality, with patient education in a different silo from nurse education or physician education. Yet when patients and family are included in staff training, it helps these staff members see situations from a patient's perspective. Also, it helps those selected as patient and family advisors see the point of view of the health care provider.

When an asthma care pathway was developed at Joe DiMaggio Children's Hospital, one of the council members, who had a child with asthma, observed its implementation. She spent a couple of days on the floor watching how it was used by staff to educate families. Afterward, the necessary revisions were made.

## **Virtual trauma staged**

Recently, Memorial Regional Hospital staged a virtual trauma that involved the trauma services team and a few family advisors who took part in the role-playing. The simulated incident began with a recent trauma patient of trauma services

telling his experience. Montgomery says these life-like educational sessions for staff members are much more effective than a lecture or video.

How should patient education managers involve consumers in the development and implementation of educational programs and materials if there is no family advisory council?

Form focus groups to obtain the voice of the customer, but note that it is not necessarily the voice of an educated customer, says Montgomery. Focus group participants should undergo a screening process, so there is a better understanding of their viewpoint.

The best way to get patient and family input time and again is to form a hospitalwide advisory council, says Montgomery. It doesn't have to meet monthly, but the council is available to work with staff. Definitely put patients and family members on the patient education committee, she says.

"If you break the term collaboration down, it means co-labor or working together, and that is what it is all about — collaborating to improve health care," says Montgomery.

## **SOURCE**

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## **Usability testing ensures clear info**

*Make sure instructions can be understood*

Consider evaluating educational materials, such as an educational sheet, self-care instructions, or an informational website, with a usability test instead of a focus group, says Dana Botka, manager of customer communications with the Washington Department of Labor and Industries in Olympia.

According to Botka, usability testing is a tool for determining if an instructional piece follows the rules of clear communication. A focus group will give you reactions to the materials, explains Botka.

The communication problems Botka helps solve within a state agency are similar to those that occur within the health care industry. These

## EXECUTIVE SUMMARY

Will patients and family members understand instructions given to prepare for surgery, or be able to put into practice information provided for self-care following surgery? One way to find out is to put the material through a usability test.

problems might include a form on which customers tend to make repeated mistakes that have to be corrected, or a letter providing instructions that people find confusing and thus inundate staff with telephone calls. Her job entails training and mentoring groups of state employees who have business problems, because their customers misunderstand what they are trying to communicate.

Patient education managers know that health care costs rise when patients are readmitted to the hospital, because they did not follow the discharge instructions, or a patient's surgery is postponed, because he or she did not prepare adequately.

Usability testing can uncover the following:

- terms patients and family members don't understand;
- words that can mean something else;
- basic information or context that is missing;
- information that is unimportant and distracting;
- a patient or family member's emotional reaction to what was developed;
- the unexpected, or something the developer had no idea would happen.

When designing a piece, make sure the process is centered on the people who will use it, says Botka. To correct a document that is not working, gather a team of subject-matter experts together. As a group, gather around a projected laptop screen and work together to develop a clearer, more usable document, she adds.

"The most important step is the one that follows. The second step is to test the product, which may be a form or letter, with a representative sample of the real people who would use the document in real life," says Botka.

Taking a medical example, Botka explains that by creating user-centered design, post-operation instructions for cardiac patients would begin by considering the demographics of the patients who undergo the surgery. It is important to have the typical users clearly in mind when creating the document, says Botka. To make sure the piece is on target, it would then be tested with a representative sample of the typical audience.

## Conducting the testing

To test the product, recruit four to six people who fit the description of your typical user, but who are not familiar with the material that is to be tested, advises Botka.

These people would be asked to come to a particular location for the usability test, and they would be scheduled at different times. Botka says offering money, or a gift card, provides incentive to follow through on the commitment.

Create a scenario that will allow the test participant to understand the situation. For example, for the post-op instructions for cardiac surgery, tell the participant that he is John Smith, a 56-year-old man who had a heart attack and underwent surgery three days ago. He is being discharged from the hospital with a set of instructions to follow.

Once the participant understands the scenario, he or she is given the instructions to read. Then, a series of questions prepared in advance are asked. These questions should be designed to get the person to do the tasks in the instructions, such as track daily sodium intake.

"If you want post-op cardiac patients to understand their diet, ask questions about that. You record the answers to see if they answer accurately, or see if they are missing something," says Botka.

Don't ask easy questions, she advises. For example, to determine if the medication instructions are easy to follow, ask what the patient's daily medication routine would be.

The test participants may use different words from those in the instructions, paraphrasing the information in their own words. This can give you clues as to phrasing the message, says Botka.

Also, in usability testing, you can use the "talk out loud protocol," which is to read a sentence or paragraph that you are concerned about and then ask the test participant to say it back in his or her own words. This helps you know how people would actually say something, says Botka.

The solution to misunderstood instructions may not be plainer language, but a chart instead of a paragraph, or information may need to be explained so there is context.

"The easier you can make it for people to understand the steps required in the task, the more likely it is they will do it," says Botka.

Usability testing is particularly popular with Web design, adds Botka. It helps site developers determine if users can find information, and once they find it, if they can understand it. Also, if they

can act on whatever task they need to do.

A survey or focus group does not test whether a person can do a task, says Botka. People will often say they "like" a document or website and yet not know how to use it. That's because they don't want to admit they had trouble or hurt the designer's feelings, explains Botka.

In addition, people may say they understand instructions, because they think they do; yet if asked to perform a given task, they are unable to do so, she adds.

"That is the advantage of a usability test; you get a better understanding of what people understand," says Botka.

## SOURCES

For more information about usability testing contact:

- **Dana Botka**, Manager of Customer Communications, Washington Department of Labor and Industries, P.O. Box 44050, MS 4050, Olympia, WA 98504. Telephone: (360) 902-5408. E-mail: BOTD235@LNI.WA.GOV.
- **Usability Professionals' Association**, 140 N. Bloomingdale Road, Bloomingdale, IL 60108-1017. Telephone: (630) 980-4997. Web site: [www.upassoc.org](http://www.upassoc.org). ■

## Education: Important in cancer treatment

*Knowing what to expect helps patients cope*

Cancer can be a life-altering disease, but Tammy Zeller, a mother with a career, wanted to keep her routine as normal as possible during treatment.

Diagnosed with stage-three breast cancer, she had a double mastectomy, 20 rounds of intravenous chemotherapy, six weeks of radiation, and four months of oral chemotherapy.

Education was one factor that helped Zeller continue in her job as an assistant principal at an

## EXECUTIVE SUMMARY

Education is important to prepare cancer patients for the treatment process and to move them through it. While patients don't always use the information provided immediately, they will refer to it as needed if it is available.

elementary school in Dallas and maintain family life as a wife and mother of three children ages nine, six, and four. She was educated to know what to expect. For example, she was prepared for the time she would lose her hair, and she knew which days she would not be able to go to work following treatment.

Also, she was taught how to keep the side effects of chemotherapy under control. Zeller says she followed the instructions of her oncologist, taking the prescription drugs to control side effects exactly as she was told, drinking plenty of fluids, and exercising.

Preparation for treatment is extremely important, says Dana Zager, MA, ATR-BC, MS-LISW, OSWC, an oncology counselor in private practice in Columbus, OH. Patients need to know what to expect during their treatment, and also they need to be made aware of services and resources they might need. While patients don't always make use of the resources given right away, it is good that they have them should they suddenly realize they do need help.

Zeller said she was given a large binder filled with information about her cancer treatment that she would go to when she needed answers. Especially helpful was the section on side effects she might experience from the medications taken during treatment. She would look up her symptoms to determine if they were normal.

Cancer patients may or may not be able to follow their usual routine during cancer treatment, says Lakshmi Naik, MA, LCSW, assistant director of the department of social work at M.D. Anderson Cancer Center in Houston.

Many factors play into it, she explains. Some cancer is disfiguring or disabling, and other types require months and months of treatment. Timing is also an important element. For example, a 65-year-old and a 27-year-old are in different positions as far as their occupational life. One is in the beginning stages, and one is in the ending stages, so the importance of remaining in a job might be different.

There are other critical factors, such as personality traits, the type of cancer, personal priorities, level of education, as well as the economic and financial status of a patient. "As we grow older, life changes with the natural course of things; cancer expedites it," she says.

When first diagnosed, people are so focused on getting treatment as swiftly as possible, they don't often come to a full realization of the fact

that cancer can be life-altering, says Zager. For many, a significant impact is missed work. People suffer from fatigue during treatment, or they cannot think as clearly during chemotherapy. If they undergo a stem cell transplant, there is a greater recovery time.

If these patients are single providers for a family, or on their own, it can be financially detrimental, says Zager. Therefore, patients must be made aware of financial assistance and other available resources.

## Assess for needs

Because a cancer patient doesn't know right away what the outcome might be and what resources he or she may need, it is a good idea to do an assessment, says Zager.

"The psychosocial assessment includes identifying what some of their life stressors are, or what their current situation might be, including their family unit, support system, and resources outside the immediate family," she says.

Naik adds, "Cancer is a life-changing experience which brings with it many issues related to adjustment, coping, and surviving."

Zeller says she had a very strong support system that included her family, friends, and her church. Her sister did her laundry, and she was told of an organization called "Cleaning for a Reason" that cleaned her house once a month.

Most patients feel fairly well supported during treatment, says Zager. At that time, they make friends with other patients going through treatment and develop a rapport with their health care team. Also, friends and family rally around to help. However, when treatment is completed, that support often vanishes, and people can feel abandoned, she says.

Therefore, education must also address this period of time. Zager refers to it as the "new normal."

"Their life is resuming, but it is different — and so are the resources they need. It is educating patients on how to reconnect with their lives and move forward," says Zager.

For some, their ability to complete tasks at work has been altered due to the chemotherapy treatment. Zager says she works with patients to come up with solutions to the problem, such as making lists or using oral reminders. "Whatever makes them more confident," she says.

A change in a person's stamina can linger for

a while following treatment, as well. Zager says she once worked with a woman who had run 14 miles every weekend to train for marathons before cancer treatment. The woman became frustrated, because she could not seem to get back her routine. Together, they worked out a plan to break the miles into increments while resting in-between. "She met the goal but did it differently," explains Zager.

Some cancer patients change the way they make decisions following cancer treatment, having had a close brush with death, she says.

Many patients think they will go back to life as it was following cancer treatment, only to discover they are different, and the people around them are different. For example, their children may be different, because they have taken on different roles during the cancer treatment, says Zager.

Education not only must address issues caused by cancer treatment, but also lifestyle changes that may have resulted from the illness. "For some people, cancer is really quite a dramatic and traumatic life change," she says.

## SOURCES

For more information about education before, during, and immediately following cancer treatment, contact:

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## Assistive technology can benefit clients

*Consider it for clients with mobility, cognitive, vision deficits*

Assistive technology can make life better for everyone and help people live independently in a safe environment, whether they have a catastrophic illness or injury or are elderly with cognitive and/or vision issues, says Hunter Ramseur, MEd, LPC, CDMS, ATP, principal of Atlanta-based Assistive Technology Consulting LLC.

As an assistive technology consultant, Ramseur gets referrals from the Veterans Affairs hospitals,

insurance companies, workers' compensation, life care planners, and others to help choose assistive technology that can help clients live safely at home.

"Assistive technology really plays a role in offering individuals maximal quality of life. It helps keep them safe and gives them a great opportunity to be self-directed in their own care," adds **LuRae Ahrendt, RN, CRRN, CCM**, nurse consultant, Ahrendt Rehabilitation in Norcross, GA.

Ahrendt and Ramseur suggest that case managers consider assistive technology when they develop a plan of care for patients who may need help with mobility deficits, cognitive issues, or poor eyesight.

"Technology today has so many applications that allow people to be independent. As a case manager, when I evaluate clients for the first time or re-evaluate them for changes in their physical, cognitive, and behavioral status, I look for ways that assistive technology can meet their needs for safety, independence, maximal community integration, and for them to achieve optimal self-direction," Ahrendt says.

The benefits of assistive technology often far outweigh the costs, Ramseur says.

"Technology can save money down the road. If you can get somebody to be more active, they'll be healthier and happier, and less likely to utilize the health care system," he says.

The addition of assistive technology can help people stay independent in their own homes and reduce the cost of care, Ramseur adds.

For instance, the installation of a lift system can help keep a patient with limited mobility out of a nursing home or assisted living center, because it helps caregivers with transfers from the bed to the wheelchair or the wheelchair to the toilet.

With a lift system, the patient has more control in getting in and out of bed alone, and the caregiver, who isn't strong enough to lift the patient, can assist with the transfers safely, he adds.

"Just the slightest amount of empowerment can make a huge difference, even if it doesn't seem significant at first. It builds on itself," he says.

For instance, many of his clients, who are veterans with combat injuries, also struggle with emotional factors and have lost the drive to do anything.

"Some of these clients are in pain and do nothing but sit around and watch television, because it's too painful to do otherwise. A lift chair is a

pretty simple way to get them up and going," he says.

If technology is appropriate and safe, it often saves money in the long run, Ahrendt says.

People who have assistive technology in their home environment may not need round-the-clock care, but may be able to stay alone a few hours a day and be safe, Ahrendt points out.

For instance, a spinal cord injury patient who can operate a wheelchair and has enough speech for voice-recognition technology can work on a computer, make telephone calls, and open doors using assistive technology for part of the day instead of having an aide 24 hours a day, she adds.

"Assistive technology is no longer the domain of the most catastrophically impaired individuals. People with chronic conditions, physical problems, cognitive and behavioral impairments that result from a wide range of disorders can also benefit from today's technology," Ahrendt adds.

For instance, personal digital assistants (PDAs) can be programmed to remind disease management clients to take their medication or weight themselves, saving telephone calls and home health visits.

Or, a desktop computer's calendar program can be used to set up a similar reminder system.

Voice-activated cell phones allow people with fine motor issues or those who are losing their eyesight to have a safer environment, Ramseur says.

When developing a plan of care, case managers should think outside the box as to what part assistive technology could play in improving clients' quality of life, and they should bring in technical assistance to help them decide on the right technology, Ahrendt says.

"Finding someone who understands the value of technology and its specific implementation for a specific client and family is a very important piece. No case manager should ever assume they have all the knowledge necessary to choose the right technology," she says.

Identify activities that are critical to what your client wants to do, and look at how the activities can be accomplished with the help of technology, Ramseur suggests.

When he evaluates someone for assistive technology, Ramseur starts by looking at the activities that need to be accomplished, then looking at what the client can or cannot do.

"For instance, the activity that needs to be accomplished may be to access the bathroom safely. Then I assess the person's function loss and

put the two together to decide what is needed to accommodate the activity," he says.

Don't just hook people up with technology. Make sure they know how to use it, Ramseur suggests.

"In almost every case, clients have a significant need for training, and it needs to happen in the home whenever possible. A lot of times, people are given equipment in the hospital and trained on how to use it, but they forget how when they get home. It's more effective to get them comfortable using assistive technology in their home environment," he says.

For instance, voice-recognition software for computers and cell phones is fairly straightforward when people are taught how to use it, but that process usually involves several orientation sessions to make sure the technology is being used correctly, Ramseur says.

PDAs are standard issue for patients with traumatic brain injury being discharged from a Veteran's Affairs hospital, Ramseur says. However, when he goes to the veteran's home for a consultation on other technology, he often finds that the PDA has been abandoned, because the client didn't understand how to use it.

Consider an ergonomic evaluation for your clients who spend a lot of time at the computer, Ramseur suggests.

"People who spend hours on the computer often have back and neck pain and repetitive stress issues in the upper extremities. If they have good ergonomics, it adds efficiency and comfort," he says.

Good ergonomics starts with a good adjustable chair with back support that fits the user's body dimensions. Other options include one-hand keyboards, ergonomic keyboards, and mouse variations, he says.

"There is so much technology out there that is becoming more universally available," Ramseur says.

Computers have opened up the world for people who have almost no function, Ramseur says.

Voice-recognition software for computers, which has been available for many years, is now in its 10th version and is 90% to 95% accurate, Ramseur says.

"This opens up a new world for someone like a quadriplegic who has limited use of his hands but his voice is still strong," he says.

There is even a product that combines hardware and software to allow someone to look at a com-

puter screen and activate what he or she sees using a sophisticated camera calibrated to his or her eye, Ramseur says.

For instance, the screen can be set up with a virtual keyboard and when the user looks at a key, it interfaces with a laptop or desktop computer and activates a key on the computer.

"They can create e-mail documents or go to an environmental control screen and turn on the lights by looking at a certain module," he says.

One scientist who has worked on developing the product can type 30 words a minute using her eyes, he says.

"Patients who have no function at all, such as high-level quadriplegics on ventilators or people with ALS or multiple sclerosis who are losing their speech, can communicate by using this type of program," he says.

Software programs developed for people with learning disabilities also can be helpful for people with traumatic brain injury or other cognitive defects who need help with concentration and memory, Ramseur says.

Some of the software has voice output that will speak what is on the screen and highlight the words as they are spoken.

Home automation technology offers safety and security to clients, Ramseur points out.

For instance, someone who is bedridden can use a computer to check to see who is at the door, then push a button that automatically lets the visitor in.

There are low-tech options available, Ahrendt points out.

For instance, retail stores sell monitoring systems that use live-view web cams that people can use to check on their loved ones or the person caring for them while they are at work.

In addition to grab bars and zero-step showers, devices such as bath lifts can help disabled people bathe in safety and comfort, Ramseur says.

"Getting out of bed or transferring in and out of a wheelchair or bathing chair is a struggle for a lot of people. An overhead lift system can give them independence. If they have some upper-body function, they can activate it themselves," he says.

One of Ramseur's clients was a veteran with a combat-related injury that left him a quadriplegic with head injuries. His mother and younger brother were struggling to take care of him but had trouble helping him transfer from the bed to a wheelchair and to the bathroom.

"The overhead lift system allowed him to get

himself out of bed and into the rolling shower chair or wheelchair. It gave him a measure of independence and gave his caregivers some relief," he says.

Ramseur recommends a global positioning system (GPS) for some brain injury patients and veterans who have issues with anxiety concentration difficulties.

"Sometimes people get distracted and forget how to get home. This is an example of how a simple thing can make a difference," he says.

Here are some links for more information about assistive technology:

- <http://www.catea.gatech.edu>;
- [http://seniors-health-medicare.suite101.com/article.cfm/aging\\_in\\_place](http://seniors-health-medicare.suite101.com/article.cfm/aging_in_place);
- <http://assistivetech.net>;
- <http://awarehome.imtc.gatech.edu/>.

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## Reform offers challenges for CMs

*Care coordination mentioned throughout legislation*

Once the details are ironed out, health care reform will offer great opportunities for case managers in a variety of settings, says **Margaret Leonard**, MS, RN-B, C, FNP, senior vice president for clinical services at Hudson Health Plan and outgoing president of the Case Management Society of America (CMSA).

Both the final Patient Protection and Affordable Care Act and the reconciliation bill contain half a dozen new buzzwords and phrases that have long been familiar to case managers, Leonard points out.

Among these are "case management," "care coordination," "transition of care," "disease management," "population management," "medical

home," and "hospital readmissions," she adds.

"We are mentioned throughout the bill in so many ways. The people who drafted the health care reform know that care coordination works, but now we have to decide who is able to do care coordination and who can bill for it," she says.

CMSA has opened an office in Washington to ensure that the voices of case managers are being heard on Capitol Hill, Leonard adds.

CMSA representatives are involved in developing a model act for care management based on the standards of practice the organization just revised.

"As the details of health care reform are being developed, CMSA is taking steps to get case managers at the table to help them define case management and design the regulations to make sure that everybody is using the same terms," Leonard says.

Once the government comes up with a payment process for case management services, more opportunities are going to open up for case managers, she adds.

Since there already is a shortage of nurses, case managers, and social workers, initially at least, health care reform is likely to result in more responsibilities for people who already are case managers, points out **Catherine M. Mullahy**, RN, BS, CRRN, CCM, president of Mullahy & Associates LLC, a Huntington, NY, case management consulting firm.

"Case managers are already concerned that they have too many cases. If more people enter the health care system, it's going to put more of a burden on them," she says.

No matter where they are working, nurse case managers will need another layer of administrative support to handle clerical duties to free them up to take care of tasks that need clinical expertise, Mullahy says.

"We in case management need to do a better job of stratifying patients according to their needs and identifying which people truly need a registered nurse or a social worker as their case manager," she adds.

The team approach for case management and disease management is going to become more important, Mullahy says.

For instance, trained paraprofessionals can perform health coaching if they use a script and call on licensed staff when complex clinical issues arise. In addition, the needs of some patients can be handled by LPNs, Mullahy says.

Mullahy suggests that case management departments perform studies to determine how each case

manager spends his or her time to demonstrate the need for additional staff that could increase the efficiency of case managers.

"If the nurses are spending a lot of time on paperwork or on the telephone, those are tasks that can be performed by others. Organizations shouldn't be paying the salary of a nurse to do jobs that an administrative assistant or paraprofessional could do," she says.

The medical home concept has gotten a lot of attention in the talks about revamping the health care system, Leonard points out.

"Here in New York, physicians who receive certification from the NCQA to be a patient-centered medical home are getting as much as an additional \$6 per member per month to provide care coordination," she says.

Primary care physicians and their case managers are going to be on the front lines when people who previously did not have insurance seek care, Mullahy says.

"The medical home model and guided care model will help people new to the health care system learn how to access care, but there have to be trained case managers to do so," she says.

Case managers in physician offices will be involved in coordination of care, transition of care, and everything else they're involved in now, but they're likely to be doing it with a larger caseload, Mullahy says.

Preventing hospital readmissions, another hot topic, presents another opportunity for case managers because of their role in transitions in care, Leonard adds.

CMSA convened the National Transitions of Care Coalition, which brings together the major players in the health care arena to develop ways to transition patients safely through the continuum of care.

When people are discharged from the hospital to a post-acute provider, then home with home care services, someone must coordinate their care to make sure that each level of care has the information it needs to provide the services that patients require, Leonard points out.

The primary care physician who sees the patient for follow-up after the hospital discharge also needs to know what happened during the hospital stay. If patients are seeing multiple specialists, someone has to be responsible for ensuring that each clinician knows what the other has determined and prescribed and that the patient is receiving coordinated care.

All of these tasks fall into the case management arena, Leonard points out.

"We already have the training and skills for all of the care coordination that health care reform is going to make essential," she adds.

When health care reform kicks in, physician offices will need more case managers to coordinate care for their complex patients, Mullahy points out.

There will be a need for more case managers to help the influx of beneficiaries on Medicaid learn to navigate the health care system, she adds.

On the payer side, insurance companies are going to need more case managers to ensure that patients receive the most effective and efficient care, Leonard says.

"We went from population disease management and sending out educational information to telephonic case management. Now, payers are developing tools to identify members who benefit from one-on-one case management in an integrated model that combines both behavioral health and medical management. We are moving toward more one-on-one care coordination in the hope that it makes people's lives better and reduces the cost of care," she says.

There also will be opportunities for independent case managers who contract with individuals, attorneys, or insurance companies on a case-by-case basis once there is a payment mechanism in place, Leonard adds.

To avoid losing reimbursement if patients are readmitted, hospitals will have to have care coordinators who work with patients after discharge to make sure patients have follow-up visits with physicians and follow their treatment plan, Leonard says.

She predicts that home care agencies will provide more care coordination to ensure that the primary care physician has information about the patient's home care episodes and vice versa.

"There is a great deal of opportunity for case managers. The medical home model is all about care coordination. Providers are going to have to have someone who is responsible for coordinating with other providers and services to make sure that patient gets everything he or she needs," she says.

But with the opportunity comes the challenge of making sure that people who are called case managers actually are performing the case management role and that people who move into the role have the kind of education they need to do the job, Mullahy adds.

"Employers in every practice setting seem to think that if you're a nurse or social worker, you can be a case manager. We need to make sure that people who are acting as case managers under-

stand the role and all that it entails," she says.

"The stimulus package will have to include additional money for scholarships to train more nurses, but if they finish school, they definitely will have a job," Leonard adds.

The need to educate clinicians on care coordination will lead to opportunities for case managers in the academic world where they can share their skills with people in other disciplines who want to become care coordinators, Leonard says.

She predicts that all health care disciplines will receive some basic training in care coordination, case managing, and motivational interviewing.

"The multidisciplinary curriculum will be for

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pharmacists, social workers, and therapists as well as nurses. We're talking to some schools now about this possibility. Case managers will have the opportunity to be instructors for these programs, or to train the trainers," she says. ■



## PAPRs end frustration of fit-test failures

*Hospital diverts funds to reusables*

**A**t DuBois (PA) Regional Medical Center, employees were failing N95 fit tests in alarm-

## CNE instructions/objectives

**N**urses 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

■ Lessons to prepare children for surgery

■ Incorporating pictures in lessons for visual learners

■ Addressing educational needs of cancer survivors

■ The impact of different cultural values on education

■ Better teaching strategies for the elderly

# CNE QUESTIONS

1. Patients and family members can help improve written educational materials by contributing which of the following?
  - A. Content expertise.
  - B. Identification of jargon.
  - C. Questioning acronyms.
  - D. All of the above
2. Usability testing can improve an education piece by uncovering which of the following?
  - A. A user's emotional reaction.
  - B. Distracting information.
  - C. Words with dual meanings.
  - D. All of the above.
3. Education for cancer patients should include information on readjusting to possible changes in life following treatment.
  - A. True
  - B. False
4. Creating patient and family advisory councils can benefit education in many ways, but patient and family initiated projects is not one of them.
  - A. True
  - B. False

**Answers:** 1. D; 2. D; 3. A; 4. B.

ing numbers. In the cardiology department, about 46% of employees failed fit-tests — even after trying a variety of models and sizes. Things weren't much better in anesthesia (35%), cardiovascular ICU (34%), or the emergency department (26%).

The most important number — the one that prompted the hospital to switch to powered air-purifying respirators (PAPRs) — was the cost: about \$37,000, mostly in loss of productivity of clinicians who had to spend an average of 35 min-

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utes to complete a fit-test.

By comparison, the investment in PAPRs and education cost about \$38,000, including about \$5,000 for education — the only annual cost.

"We were investing a significant time commitment and money every year, and the [fit-test] failure rates were higher than we were comfortable with," says Sue Miller, RN, COHN-S/CM, director of employee health at DuBois.

Fortunately, DuBois made the transition to PAPRs in 2008, a year before hospitals were faced with the novel H1N1 strain of influenza. That reinforced the benefits of reusable respirators, as the hospital avoided the scramble for supplies and massive fit-testing efforts.

"For us, it was a good return on investment. It made our life so much easier during the crisis," says Miller. "I'm definitely very happy we went with this solution." ■

Dear *Patient Education Management* Subscriber:

This issue of your newsletter marks the start of a new continuing nursing education (CNE) semester and provides us with an opportunity to review the procedures.

*Patient Education Management*, sponsored by AHC Media LLC, provides you with evidence-based information and best practices that help you make informed decisions concerning treatment options and physician office practices. Our intent is the same as yours - the best possible patient care.

The objectives of *Patient Education Management* are 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.

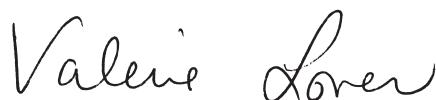
Each issue of your newsletter contains questions relating to the information provided in that issue. After reading the issue, answer the questions at the end of the issue to the best of your ability. You can then compare your answers against the correct answers provided in an answer key in the newsletter. If any of your answers were incorrect, please refer back to the source material to clarify any misunderstanding.

At the end of each semester you will receive an evaluation form to complete and return in an envelope we will provide. Please make sure you sign the attestation verifying that you have completed the activity as designed. Once we have received your completed evaluation form we will mail you a letter of credit. This activity is valid 24 months from the date of publication. The target audience for this activity is nurse managers, education directors, case managers, discharge planners, hospital clinicians, management, and other health care professionals involved in designing and/or using patient education/staff education programs.

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On behalf of AHC Media, we thank you for your trust and look forward to a continuing education partnership.

Sincerely,



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