

patient education MANAGEMENT

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

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Targeting the educational needs of cancer survivors takes many shapes

LIVESTRONG provides examples of program development

Clinical survivorship service is a new model of continuing care for cancer patients. The completion of treatment is not the end, and structured services are necessary to help a burgeoning population of cancer survivors deal with a multitude of issues that often are not addressed, says **Marci Campbell, PhD**, co-director of the Carolina Well Survivorship Program at the University of North Carolina at Chapel Hill Lineberger Comprehensive Cancer Center.

The Carolina Well Survivorship Program is part of a network of survivorship centers at leading medical institutions and their community affiliates that provide “essential direct survivorship services and increase the effectiveness of survivorship care through research, the development of new interventions, and sharing of best practices.”

LIVESTRONG Survivorship Center of Excellence Network members are selected by an appointed steering committee through a review process. The network is part of the Lance Armstrong Foundation, located in Austin, TX.

According to Campbell, the Carolina Well Survivorship Program determined which services to offer by surveying 200 patients and caregivers at the cancer center’s treatment clinics. There are categories of services people say they need, says Campbell. For example, they need to have some knowledge about what to do after treatment is over.

Patients need a treatment summary at the end of active treatment and a survivorship care plan. Also, they need help implementing that care plan, says Campbell. (*To learn more about survivorship care plans, see article on page 101.*)

“There is a wide range of education and support services that are important for cancer survivors when they are in that post-treatment phase,” says **Erin E. Hahn, MPH**, program coordinator at UCLA-LIVESTRONG

Survivorship Center of Excellence in Los Angeles.

For example, patients want to know about appropriate surveillance, which includes how often to schedule routine follow-up appointments and whether they should see their primary care physician or oncologist. Also, they should have a list of signs and symptoms, such as certain types of pain, that would trigger a call to their physician, says Hahn.

Education about what to expect psychologically in the post-treatment phase is important as well, says Hahn. People can feel lost once they have completed treatment, not knowing what to do next, and this heightens anxiety.

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EDITORIAL QUESTIONS

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Often, patients have symptoms that started during their treatment phase that they are having difficulty managing, says Hahn. They need help with strategies for such problems as chronic pain, anxiety, and depression.

Cancer survivors need a lot of information, agrees **Barbara Andersen**, PhD, program director of the Survivorship Center (member of LIVESTRONG excellence network) at The Ohio State University Comprehensive Cancer Center-James Cancer Hospital and Solove Research Institute in Columbus, OH. When diagnosed patients need information in order to cope with a cancer diagnosis, they need details on their cancer treatments; and when treatment ends, cancer survivors need to know what type of surveillance routine they should follow, she explains.

Information on health and wellness also is needed, as well as how to achieve a healthy lifestyle, she adds. This would include details on diet and exercise for overall good health.

Information about psychosocial issues and how to address them through counseling and other services is vital. Some people have difficulty coping with the anxiety, distress, and depression that may continue following treatment. This impacts their life in many ways, including a delay in returning to work, taking more sick days once they are back in the workforce, and causing difficulties in personal relationships, says Andersen.

The amount of education and support needed can depend on the stage of a person's cancer and type of treatment, says **Meghan Newcomer**, MPA, coordinator of the Cancer Survivorship Initiative Office of The Physician-In-Chief at Memorial Sloan-Kettering Cancer Center, which has a LIVESTRONG survivorship program.

It is important to address both physical effects and psychosocial effects, she says. Physical effects might be pain, neuropathy, osteoporosis, and sexual health, including fertility. Emotional effects might be difficulty communicating with family members, fear of cancer recurrence, uncertainty, employment difficulties, insurance problems, and need for financial assistance.

"For some people, cancer has a minimal impact, and for others, it impacts every area of life," says Newcomer. Frequently, the impact depends on the type of cancer and its stage, type of treatment, and the age of the cancer patient at diagnosis, she adds.

More than one delivery method

What is important to note is that there is more

than one way to deliver survivorship care, says Hahn. The UCLA survivorship center has three partner institutions that offer different programs, based on such factors as finances and patient population. They include a large county hospital, a primary care medical group, and a community hospital.

All three have decided it is important to provide information about what to do post-treatment. Some started with breast cancer patients and are using evidence-based guidelines for follow-up care available through the American Society of Clinical Oncology in Alexandria, VA.

“They rely on the guidelines to start the conversation with patients, filling them out, and giving the patient a copy,” says Hahn.

Also, the institutions are providing patients with a list of resources available within their organizations and within the surrounding community. For example, the community hospital is not able to offer a lot of support groups or one-on-one therapy, so it has partnered with the local chapter of the Cancer Support Community headquartered in Washington, DC. *(To learn about assembling a list of resources for a cancer survivor program see article on page 100.)*

One survivorship program is conducted via telephone and mail, because the medical facility did not have the resources to do a visit with a nurse or physician. The program is working well, adds Hahn.

To start a survivorship program, look at the literature, Hahn advises. Also, talk to providers within your institution, and survey patients formally or informally, she adds. Be realistic about financial restraints and work with community groups as well as patients to determine how to fulfill patient needs, says Hahn.

Providing resources to read and videos to watch can be helpful for both patients and caregivers. Hahn says that Patricia Ganz, MD, the program director at the UCLA survivorship center, did a study of a post-treatment video for breast cancer patients where women talked about their recovery. The study found that those who watched the video had an accelerated return to their normal quality of life. (The video is titled “Moving Beyond Breast Cancer” and is available at no charge from the National Cancer Institute, says Hahn.)

Conducting a needs assessment is the best way to determine how to develop a survivorship program, says Newcomer. In New York City, she said the needs of cancer survivors differ, depending on

the neighborhood in which they live. For example, in poorer neighborhoods, it is not support groups people want, but more concrete services, such as direction on obtaining financial assistance.

Cancer can impact quality of life at diagnosis, during treatment, and in the post-treatment phase, says Hahn. People can continue to feel apprehensive and frightened if they have new symptoms to deal with that are a result of the cancer treatment. For example, certain chemotherapy treatments can push women into premature menopause. Sometimes the cancer has a positive impact on a person, causing them to appreciate life more.

“Patients and family members need to know that things don’t just bounce right back; people talk about a new normal,” says Hahn.

Support services help people adjust to a new normal, whether offered through the hospital, medical group, community, or national organizations.

It is important to know there are a variety of issues to address when treating cancer survivors. These range from late physical effects, such as chronic fatigue, to long-term psychosocial effects from treatment, and financial burdens. Just as the problems can take many different forms, the solutions will differ depending on each patient’s situation, says Hahn.

SOURCES

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Create a resource list for contacts

Provide local and national contacts

Health care institutions do not always have the resources with which to provide special services for cancer survivors. However, all can provide direction about how to obtain support and information beyond the walls of the medical center, whether out in the community or from national resources.

Create a list with phone numbers and website addresses, so it is easy for cancer survivors to access the services they need, advises **Erin E. Hahn**, MPH, program coordinator at UCLA-LIVESTRONG Survivorship Center of Excellence in Los Angeles.

Patient education managers would provide a great service to cancer survivors if they would do homework on community resources to which patients could be referred, says **Barbara Andersen**, PhD, program director of the Survivorship Center (member of LIVESTRONG excellence network) at The Ohio State University Comprehensive Cancer Center-James Cancer Hospital and Solove Research Institute in Columbus, OH.

Generating resources would require a bit of research, telephoning, and meeting with people in the community, she adds. In smaller communities, look for resources within a 50-mile radius — whether support groups or rehabilitation professionals who know how to deal with issues, such as lymphedema, says Andersen.

There are many grassroots organizations, and in many rural areas there are volunteers who have been through treatment and want to help others, says **Marci Campbell**, PhD, co-director of the Carolina Well Survivorship Program at the University of North Carolina at Chapel Hill Lineberger Comprehensive Cancer Center. She advises patient education managers to contact health departments and churches to find volunteers involved in providing support services. She says that her center is training volunteers to provide support and help problem-solve via the telephone.

EXECUTIVE SUMMARY

There are many organizations that help cancer survivors deal with the issues they confront. Learn the value of providing a resource list so patients can make the connection.

The opportunity to connect with other survivors is very beneficial, says **Meghan Newcomer**, MPA, coordinator of the Cancer Survivorship Initiative Office of The Physician-In-Chief at Memorial Sloan-Kettering Cancer Center in New York City. People benefit when they can talk, e-mail, meet, or read a cancer survivor's blog online, she adds. Having the opportunity to be connected to people who have had a similar experience helps them see they are not alone, explains Newcomer.

She recommends CancerCare, a national non-profit organization that provides free, professional support services for anyone affected by cancer. The organization can be contacted at 1-800-813-HOPE or info@cancercares.org. Programs include counseling and support groups, education, financial assistance, and practical help. (*For complete contact information on all organizations mentioned in this article, see source box.*)

Also, Newcomer likes the nonprofit Cancer Support Community, which provides free emotional and social support services through a network of nearly 50 local affiliates.

For young adults, Newcomer suggests I Am Too Young for This! Cancer Foundation. This foundation connects young cancer survivors with age-appropriate support, forums and chat rooms, social networking, and coping literature.

Hahn notes that the Lance Armstrong Foundation offers LIVESTRONG Survivor Care, which provides free, confidential one-on-one support to cancer survivors at (866) 673-7205.

Also she recommends the Patient Advocate Foundation, which provides assistance on medical debt crisis, insurance issues, and health care access among other services. Its case management services, educational materials, and live chat services are free.

SOURCES

For more information, contact:

- **CancerCare National Office**, 275 Seventh Ave., Floor 22, New York, NY 10001. Telephone: (212) 712-8400. Web site: www.cancercares.org.
- **Cancer Support Community**, 919 18th St. NW, Washington, D.C. 20006. Telephone: (202) 659-9709. Web site: www.cancersupportcommunity.org.
- **I Am Too Young for This! Cancer Foundation**, 40 Worth St., Suite 801, New York, NY 10013. Telephone: (877) 735-4673. Web site: www.i2y.com.
- **Lance Armstrong Foundation LIVESTRONG Survivor Care**, 2201 E. Sixth St., Austin, TX 78702. Telephone: (866) 673-7205. Web site: www.livestrong.org.

• **Patient Advocate Foundation**, 421 Butler Farm Road, Hampton, VA 23666. Telephone: (800) 532-5274. E-mail: help@patientadvocate.org. Web site: www.patientadvocate.org. ■

Cancer survivorship care plans empower

Follow comprehensive guidelines

At the Dana-Farber Cancer Institute Lance Armstrong Foundation (LAF) Adult Survivorship Clinic in Boston, a nurse practitioner works with patients to develop a survivorship care plan.

According to **Karen Sommer**, NP, a nurse practitioner at LAF Adult Survivorship Clinic and Perini Pediatric Survivorship Clinic, these follow-up care plans take many shapes and forms, but most have certain key components.

All have recommendations for surveillance for the kind of cancer for which the patient was treated. That is particularly appropriate for patients within five years of having ended treatment and less of a concern farther out, she says.

As part of surveillance, plans include signs and symptoms patients should report to their physician. For example, something that might be ignored as heartburn could be a sign of esophageal cancer, says Sommer.

Plans also contain recommendations on management and screening for late effects a patient has experienced resulting from the past cancer and treatment.

A fourth piece would be identification of potential late effects for which a patient is still at risk and recommendation on mitigation or prevention of those late effects, states Sommer.

A plan would contain information on general health and disease prevention based on the recommendations of the U.S. Preventative Services Task Force in Rockville, MD, and cancer screening recommended by the American Cancer Society, headquartered in Atlanta.

General health and promotion measures would be identified with an eye to a patient's past cancer treatment, says Sommer. For example, everyone should get regular checkups that include cancer screening such as skin exams. However, for patients who have had radiation therapy to a large area of their body, skin exams are particularly important, for those patients are at increased risk

for skin cancer.

Survivorship care plans benefit patients in many ways, says Sommer. They empower patients, giving them some control with regard to their disease prevention — and certainly with regard to their general health. Patients can be educated about future late effects and take appropriate steps, she says. For example, the patient could be at risk for developing cardiac problems, and he or she could make lifestyle changes, such as following a heart-healthy, low-fat diet and exercising three to five times a week. A person who was not told he or she was at greater risk for heart disease might not be compelled to make healthy lifestyle changes and develop heart disease much earlier than would otherwise occur, says Sommer.

“Knowledge is power, and hopefully through knowledge you can effect change that positively impacts a patient's health going forward,” explains Sommer.

Care plans not for patients only

The information in survivorship care plans should be shared with family members and a person's primary care provider. The demand for oncologists and oncology follow-up is becoming far greater than the number of oncologists that currently exist. Therefore, a growing number of cancer survivors will return to their primary care physicians for ongoing follow-up, and these providers will need to learn about late effects.

“One of the first steps is empowering patients, so they can be advocates for themselves. Second to that is empowering the primary care providers, so they feel comfortable taking care of this increasing number of cancer survivors,” says Sommer.

Survivor care plans integrate a health and wellness program around a patient's prior cancer into primary care practice, along with a recommendation for the surveillance for potential late effects.

In addition to medical care, psychosocial health must be considered. At Dana-Farber Cancer Institute, every patient who is new to survivorship is seen by a psychosocial clinician with the option to follow-up with that clinician as needed or agreed as appropriate by the patient and clinician.

EXECUTIVE SUMMARY

Survivorship care plans give patients who have been treated for cancer concrete steps to follow, not only for surveillance, but also for general health.

To make recommendations about surveillance and follow-up, nurse practitioners at the LAF Adult Survivorship Clinic follow comprehensive guidelines published by the National Comprehensive Cancer Network based in Fort Washington, PA. This organization publishes surveillance guidelines for most cancers up to about five years from the end of therapy, says Sommer. The American Society of Clinical Oncology in Alexandria, VA, also publishes similar guidelines, she says.

When a survivor two years past his or her treatment is seen, the guidelines are referred to in order to make recommendations on clinical exams, blood work, and other follow-up measures. The recommendations are made in consultation with a patient's oncologist.

Because adult survivors of childhood cancer are often seen, guidelines from the Children's Oncology Group based in Arcadia, CA, are also used as a reference.

SOURCES

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- **American Society of Clinical Oncology**, 2318 Mill Road, Suite 800, Alexandria, VA 22314. Telephone: (571) 483-1300. Website: www.asco.org.
- **Children's Oncology Group**, Research Operations Center, 440 E. Huntington Dr., Suite 400, Arcadia, CA 91006-3776. Telephone: (800) 458-6223. Website: www.childrensoncologygroup.org.
- **National Comprehensive Cancer Network**, 275 Commerce Dr., Suite 30, Fort Washington, PA 19034. Telephone: (215) 690-0300. Website: www.nccn.org. ■

Environmental scan gives insight

Snapshot provides direction

To determine the state of survivorship across the United States and Canada, the Cancer Patient Education Network Survivorship Committee (CPEN) conducted an environmental scan in 2009 looking at the status of best practices at the institutions at which its members work.

At the time of its formation, the committee adopted the National Cancer Institute's definition of survivorship, which starts at the time of diagno-

sis and continues throughout the rest of a patient's life.

The Survivorship Committee clarified in their 2008 Tactical Plan, adding to the definition: "CPEN recognizes the important role of patient education intervention designed to educate, support, and empower survivors with their cancer experience through and beyond cancer. We believe that survivorship interventions should be guided by the principles of patient education and patient-centered care perspectives. The approaches may be clinical, formal, and informal, incorporating a whole person's perspective that addresses the physical, social, emotional, and spiritual needs of survivors and their caregivers."

The purpose of the environmental scan was to get some indication of where different organizations were in the process of recognizing, defining, or accepting best practices for survivorship care. For example, questions were designed to determine if cancer centers had adopted the Institute of Medicine's guidelines for survivorship care, if they followed other best practice guidelines, or none at all.

"This was a preliminary environmental scan. We were trying to get a broad sense of what is actually happening," explains **Scott Secord**, MSW, RSW, manager of the Clinical Survivorship Care Program at Princess Margaret Hospital in Toronto, Canada, and co-chair of the CPEN Survivorship Committee.

In the future, the information gained may be used to survey members on specific elements of survivorship care that indicates the need for further examination, he adds.

The survey was sent electronically to 237 individuals participating in the CPEN Network and 69 responded, or about 25%.

What did the environmental scan reveal?

About 50% of the respondents were familiar with the Institute of Medicine document on best practice for survivorship care. About 30% were unfamiliar or very unfamiliar. So, one-third of cancer centers were not aware of this guideline established for survivorship care, says Secord. About 20% reported their organization did not follow any guideline or best practice model.

Ninety-seven percent of the cancer centers are providing pamphlets and written materials. Education lecture style is being offered in 73% of the institutions, half use audio/visual tools, 47% use interactive workshops, and about 30% use electronic tools, such as Web casting, online information, or websites to aid in navigation.

EXECUTIVE SUMMARY

CPEN conducts an environmental scan to determine what resources are in place to educate and support cancer survivors.

“The primary method of intervention with patients is the provision of pamphlet materials and education sessions,” says Secord.

Eighty-seven percent of those answering the survey are interested in building online supports. This is an area to develop further, as this type of technology is important to serve isolated cancer survivors and their communities, says Secord.

While the education department is often the deliverer of information materials, survivorship care is more often delivered by social workers (88%), followed by dietitians, nurses, patient educators, chaplains or others providing spiritual care, and volunteers.

Psychosocial support is the most prevalent intervention at 86%, followed by nutrition, patient education classes, palliative care, and side-effect management.

About 60% felt providers were attempting to assess survivorship needs. Forty percent did not have a standardized way to look at how to meet the needs of that patient population, according to survey results.

Thirty-three percent of institutions were able to provide patients with a survivorship care plan. About 25% provided a clinical care plan. Secord says it would be helpful to further explore this issue with the CPEN network to better define a survivorship care plan and what components it should cover, as well as whether the plan should be developed at the beginning of a diagnosis or at the completion of treatment.

A majority of those responding to the survey — 75% — said they were offering programs to address the late effects of cancer treatment. The top five areas of late-effects management were identified by the survey group to be psychosocial distress, fatigue, nutrition, pain management, and body image issues.

“Our conclusions are that it will be important to look at some of the findings from the survey to help us determine if we could identify some benchmarks to monitor the efforts of cancer centers to be able to provide survivorship interventions — and even identify what needs to be considered a best practice model,” says Secord.

Only about 10% of respondents reported they have distinctive programs for each population, such as breast cancer patients or prostate cancer patients.

In future surveys, it would be beneficial to determine which organizations are engaged in work that has a patient education/e-health strategy, he says.

“The electronic platform is an area to be further explored to determine the benefits of organizational collaboration,” says Secord. “Few organizations can afford to build the elaborate platforms; there really needs to be more of a collaborative effort.”

SOURCE

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Oncology CMs guide patients through treatment

Program helps with symptom management

Capital BlueCross members who have been diagnosed with cancer are getting support during all phases of treatment through a new oncology case management program launched in the spring of 2010 by the Harrisburg, PA-based health plan.

The health plan added oncology case management to its specialty case management program after determining that 20% of the patients receiving case management services have a diagnosis of cancer, says **Jennifer Chambers**, MD, MBA, FACP, medical director at Capital BlueCross.

“Patients with a diagnosis of cancer have a unique set of issues. When they hear the word ‘cancer,’ they tend to shut down, and when they come out of the doctor’s office, all they remember is that they have cancer. We created this program to support them during this challenging time,” she adds.

The case managers who work with cancer patients are nurses with extensive case management, home care, and/or oncology experience. They work with Chambers, who is board-certified in internal medicine and palliative medicine, to coordinate care for patients who have been identified through hospital admissions, referrals from physicians, and self-referrals.

The purpose of the program is to help members

and families work through difficult issues such as treatment options, symptom management, and life-care planning, Chambers says. Case managers are trained to help patients understand their disease and their treatment options. They help them access educational resources such as the American Cancer Society and the National Cancer Institute and assist them in compiling a list of questions they should ask their doctor at their next appointment.

“We know from evidence-based data that there are five domains where case managers can make a difference: empowerment, adherence and compliance, coordination of care, knowledge, and safety,” Chambers says.

Empowerment is the portal to all the other domains, Chambers says.

“When members are educated and understand their treatment plan, they start to feel a sense of control. They may not be able to control the cancer, but they can control when and where they receive treatment, when to make the decision about palliative care, and who to see for a second opinion. We want members to feel educated and informed,” she adds.

Patients undergoing cancer treatment often are treated by multiple physicians, including a surgical oncologist, a medical oncologist, and a radiation oncologist, as well as their primary care physician, Chambers says.

Case managers often coordinate with the various treating physicians to make sure they are fully informed about other treatments the patient is receiving, and attempt to coordinate times and arrangements for numerous medical appointments.

They also may consult with treating physicians to advise them of concerns or challenges voiced by patients.

“A primary goal for case managers is to help patients navigate through the health care system and feel more comfortable in making decisions with their doctors. We don’t make treatment decisions for the members; we help the members with questions they need to ask to make the best decision for them,” Chambers says.

They address safety issues with patients, such as whether they have someone to provide transportation or assist with care at home. They advise them on how to prevent infection and suggest overall ways they can improve safety in the home.

Once patients say they are interested in participating in the program, the nurse case manager completes an assessment to identify the patient’s

needs and helps him or her develop individual goals and plans.

The case managers base their interventions and frequency of follow-up on the needs each member identifies.

They make periodic calls to check on the patients’ progress and work closely with the patient and the treatment team to address any concerns or questions.

“We find these phone calls are very helpful, because they provide a sense of confidence and empowerment for the member. They ask the patients about their goals and what they need to accomplish them. The case managers listen to the patients and offer their support and encouragement,” she says.

The case manager closes the case when the plan of care developed by the member and case manager is completed and no additional needs are identified. If patients need further treatment or support, they may become actively involved in case management again.

During their interventions with the patients, the case managers encourage them to have advance directives in place.

When a patient’s cancer progresses to the point that he or she needs palliative and/or hospice care, the case manager helps facilitate a discussion with the physician and gives the patient information about palliative care and hospice options and providers.

“Some patients never want hospice care. They want to continue treatment, even if the cancer can’t be cured. But they do want help with pain and nausea. What happens is always the choice of the member. If people are making a conscious decision not to have hospice care, the case managers help facilitate management of symptoms,” Chambers adds.

The oncology nurses meet with their supervisor on a routine basis to discuss their feelings and experiences in dealing with patients with a life-threatening disease.

“The case managers are either experienced hospice nurses or oncology nurses, but they often need support in coping with caring for terminally ill patients. They talk about when they are feeling sad and when they need to take a break and do self-care,” she says.

The health plan team spent about nine months developing the program and ensuring that everything the participants will need was in place.

“We like to start working with these patients as

early as possible or as soon as they're ready to participate," she says.

The health plan mines its claims data to identify patients who have been hospitalized with a primary or secondary diagnosis of cancer and makes an outreach call after the patients are discharged, following up with a letter asking if the patient would like to participate in the program.

"Some patients aren't ready to participate just after diagnosis. It's an individual decision. Our case managers are there to help them whenever they are ready for assistance," Chambers says.

Initial participants in the program range from patients who have just had surgery for cancer to those who are entering hospice, Chambers says.

"As the program progresses, we anticipate that we will be enrolling the majority of patients in the program much sooner in their cancer treatment regimen," she says. ■

Initiatives reduce readmission rates

Health plan partners with hospitals, PCPs

After two successful pilot projects aimed at reducing readmission rates, Capital District Physicians' Health Plan Inc. (CDPHP) has implemented a program aimed at ensuring that its Medicare Advantage members get the care they need after discharge to avoid a return trip to the hospital.

The pilot projects produced significantly improved readmission rates, dropping from an average of 13% to 14% for members in CDPHP's Medicare Choices plan to an average of 6% to 8% for patients in the pilot, according to **Kirk Panneton**, MD, medical director of senior services at the Albany, NY-based health plan.

"When our Medicare members are admitted to the hospital, we partner with the hospitals and the primary care physicians and follow the patient to their home to make sure their medication is reconciled and that they get back to see their primary care physician in less than seven days," he says.

The readmission rate nationwide for beneficiaries with fee-for-serve Medicare is 20%, while it's 15% on average for people who are in Medicare Advantage programs, Panneton points out.

"Right off the bat, Medicare Advantage plans touch people more effectively to keep them out of

the hospital. At CDPHP, we offer more than most Medicare Advantage programs and provide more support and education to help prevent readmissions," he says.

The health plan's readmission prevention program, which began in July, "takes the best elements of both pilot programs," Panneton says.

Pilot placed RNs in hospitals

In one pilot, the health plan placed RNs, called inpatient care coordinators, in local hospitals to assist the hospital-based case managers in coordinating care for all CDPHP members.

When a Medicare Choice member in the pilot project was going home, the inpatient care coordinator alerted the health plan's case managers, who called the primary care physician to arrange a follow-up appointment within seven days.

In the other pilot project, the health plan arranged for visiting nurses to see patients in the hospital and introduce themselves, then followed up within 24 hours after the patient was discharged. When the nurse visited these patients after discharge, he or she examined all the medications the patient was taking, evaluated the patient for care needs, and helped set up a follow-up appointment with a primary care physician.

For the pilot projects, the health plan focused on patients who received primary care at several big medical groups in the area with no regard to diagnosis.

"In the pilots, every Medicare Choice member who was chosen to participate received the services regardless of diagnosis. Going forward, we're going to provide the follow-up services for patients who can most benefit," he says.

The vast majority of Medicare members who are hospitalized have heart failure, chronic obstructive pulmonary disease, or coronary artery disease, Panneton points out.

The program focuses on patients with those three diagnoses and any others who the health plan's onsite inpatient care coordinators feel could benefit from the program.

For instance, a patient with a fractured hip may not need follow-up care unless he or she has limited support at home, has several chronic diseases, or is taking multiple medications.

The new program combines the best approaches from the two pilot programs, Panneton says.

While the new program will cover all lines of business that CDPHP serves, the majority of mem-

bers served will be within its Medicare population.

Members identified for the program will be seen by a nurse in the hospital, then receive a home visit from a nurse within 24 hours of discharge.

The home visit part of the program strives to reconcile medications, ensure that care needs are being met, and schedule a follow-up appointment with the patient's primary care physician. The nurse will then conduct a follow-up call seven days later to ensure that these processes, and the patient's recovery, remain on track.

Before the pilot projects began, representatives from CDPHP met with representatives of the hospitals in their area, the visiting nurse organizations, and primary care group practices to educate them about the project's goals and to get their buy-in.

"Everybody in health care is trying to reduce readmissions, but those who are the most successful are those that are collaborating with other organizations. When the payer, the hospital, and the primary care provider come together, they are able to make a program happen," he says.

It's a win-win situation for everyone, Panneton says.

"Hospitals have an interest in reducing readmissions, because they aren't going to get paid. The visiting nurse agencies are anxious to get more business. The providers are willing to participate, because we are giving them extra reimbursement for seeing patients within seven days of discharge," he says.

Capital District Physicians' Health Plan was started 26 years ago by a community of physicians in the greater Albany area, according to **Kevin Mowll**, vice president of Medicare products.

The health plan has about 25,500 members enrolled in its Medicare Choice program, a Medicare Advantage plan. The figure includes about 8,000 retirees who are part of an employer group, Mowll says.

CDPHP expanded its Medicare case management program when Panneton, a physician with years of experience in geriatric medicine, came on board in June 2008.

"At the time, we had only one case manager dedicated to our Medicare population. As the membership has grown, we have expanded the program and now have six case managers dedicated to Medicare beneficiaries," Panneton says.

The health plan created the CDPHP Health Ally program, a voluntary case management program for the health plan's Medicare Choice members and their caregivers, Panneton says.

The program was developed specifically for the Medicare population and takes into account the unique needs of that population and provides support, education, access to the health plan's benefits, and community-based services, he adds.

The health plan makes three outreach calls to Medicare Choice members shortly after their enrollment.

Program includes verification

When members enroll in Medicare Choice, they receive a verification call from the health plan's outreach staff to make sure they understand the plan. When they become eligible, the outreach staff call again to walk them through the benefits and ensure that they understand what benefits are available to them, Mowll says.

The third welcome call is from a case manager who completes an assessment that stratifies the members into three groups based on their likelihood of using health care services, Panneton adds.

"Our Health Ally program is designed to touch all new Medicare members by the telephone and to conduct a brief health survey," Panneton says.

Based on their response to the health survey and probability of needing health care resources, the members are referred to health plan programs that can meet their needs.

Members who are fairly healthy are referred to the health plan's SeniorFit program, a free health, exercise, and wellness program for older adults.

Seniors with one or two chronic diseases, such as a diabetic with hypertension, are referred to disease management, where they receive education on their chronic condition and how to keep it under control and are encouraged to see their physician regularly.

About 5% to 10% of beneficiaries in the program are among the most frail and sick members and are assigned a case manager who contacts them regularly and offers support and counseling and helps them find resources to meet their needs.

"Our case management program has grown significantly, and our Health Ally program has helped us stratify the members and help them get the services they need," Panneton says.

Health Ally advantages

The advantage of the Health Ally program is that CDPHP is able to identify the needs of members without waiting for claims data, Panneton point out.

“If we wait for claims to come in, we are always three to four months behind. Our program helps us find out more about the membership when they enroll and start working with them to help them avoid unnecessary hospitalizations and emergency room visits. Our case managers work with our members to help them keep their conditions under control and educate them so they can make informed decisions,” he says.

“The Health Ally program was a big strategic move to meet the challenge of finding out more about the membership so we can take a proactive approach to help them manage their health care,” he says. ■

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COMING IN FUTURE MONTHS

■ Making lasting lifestyle changes.

■ Helping patients make educated choices.

■ Tying patient education into organizational initiatives.

■ Better teaching strategies for the elderly.

■ Tailoring education on weight loss.

Dementia patients' spouses at higher risk

Husbands or wives who care for spouses with dementia are six times more likely to develop the memory-impairing condition than those whose spouses don't have it, according to the results of a 12-year study led by Johns Hopkins, Utah State University, and Duke University.¹

A few small studies have suggested that spousal caregivers frequently show memory deficits greater than spouses who aren't caregivers.

However, none examined the cognitive ability of caregivers over time using standard, strict criteria to diagnose dementia, a serious cognitive disorder characterized by deficits in memory, attention, judgment, language, and other abilities.

A study examined 1,221 married couples age 65 and older who were part of the Cache County

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

9. Once treatment has ended, cancer survivors need information on what to do next. This might include which of the following?

- A. When to schedule routine exams.
- B. How to address psycho-social issues.
- C. Developing a good health and wellness regimen.
- D. All of the above.

10. While health care institutions may not be able to offer services to cancer patients in the post-treatment phase, patient education managers can develop a list of community and national resources where many of these services could be obtained.

- A. True
- B. False

11. A survivorship care plan is helpful to patients in the post-treatment phase because it provides which of the following?

- A. A psychological evaluation.
- B. Symptoms to report to a physician.
- C. Information on potential late effects of treatment.
- D. B and C

12. A survey conducted by the Cancer Patient Education Network Survivorship Committee indicated most medical institutions follow best practice guidelines for post-treatment care of cancer patients.

- A. True
- B. False

Answers: 9. D; 10. A; 11. D; 12. B

(Utah) Memory Study, which began in 1995.

In the sample of 2,442 married people, the researchers diagnosed 255 individuals with dementia and discovered that individuals whose spouses had already been diagnosed were six times as likely to develop the condition themselves compared to those without an affected spouse.

Co-author **Maria C. Norton**, PhD, of Utah State University in Logan, says the long-term nature of the new research makes the results different from earlier “snapshot” studies showing memory loss

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in spousal caregivers. “We know that the declines in memory we saw were real and persistent, not just a point in time where they weren’t performing well on tests,” she says.

Researchers speculate that the stress of caregiving might be responsible for the increased dementia risk for spouses, although more research is needed to identify what that mechanism might be.

The researchers suggest that doctors who treat dementia patients should pay more attention to efforts to decrease stress for spousal caregivers.

REFERENCE

1. Norton MC, Smith KR, Ostbye T, et al. Greater Risk of Dementia When Spouse Has Dementia? The Cache County Study. *J Am Geriatr Soc* 2010; 58: 895-900. ■

Patient Education Management

Confidential Salary Survey

This confidential salary survey is being conducted to gather information for a special report later in the year. Watch in coming months for your issue detailing the results of this survey and the overall state of employment in your field.

Instructions: Select your answers by filling in the appropriate bubbles **completely**. Please answer each question as accurately as possible. If you are unsure of how to answer any question, use your best judgment. Your responses will be strictly confidential. Do not put your name or any other identifying information on this survey form.

1. What is your current title?

- A. vice president
- B. patient education coordinator
- C. director, health wellness
- D. director, staff education
- E. consultant
- F. other _____

2. What is your highest degree?

- A. LPN
- B. ADN (2-year)
- C. diploma (3-year)
- D. bachelor's
- E. master's
- F. PhD
- G. Other _____

3. What is your sex?

- A. male
- B. female

4. What is your age?

- A. 20-25
- B. 26-30
- C. 31-35
- D. 36-40
- E. 41-45
- F. 46-50
- G. 51-55
- H. 56-60
- I. 61-65
- J. 66+

5. What is your annual gross income from your primary health care position?

- A. Less than \$30,000
- B. \$30,000 to \$39,999
- C. \$40,000 to \$49,999
- D. \$50,000 to \$59,999
- E. \$60,000 to \$69,999
- F. \$70,000 to \$79,999
- G. \$80,000 to 89,999
- H. \$90,000 to \$99,999
- I. \$100,000 to \$129,999
- J. \$130,000 or more

6. Where is your facility located?

- A. urban
- B. suburban
- C. medium-sized city
- D. rural

7. In the last year, how has your salary changed?

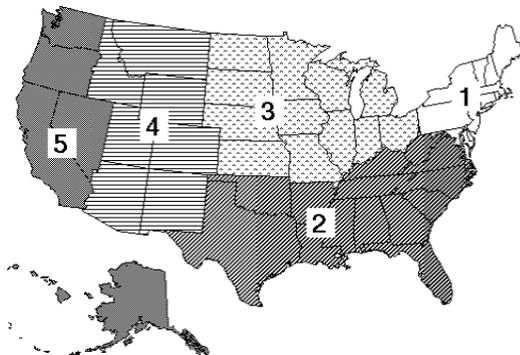
- A. salary decreased
- B. no change
- C. 1% to 3% increase
- D. 4% to 6% increase
- E. 7% to 10% increase
- F. 11% to 15% increase
- G. 16% to 20% increase
- H. 21% increase or more

8. What is the work environment of your employer?

- A. academic
- B. agency
- C. health department
- D. clinic
- E. college health service
- F. consulting
- G. hospital
- H. private practice

9. Please indicate where your employer is located.

- A. region 1
- B. region 2
- C. region 3
- D. region 4
- E. region 5
- F. Canada
- G. other



10. Which best describes the ownership or control of your employer?

- A. college or university
- B. federal government
- C. state, county, or city government
- D. nonprofit
- E. for profit



11. How long have you worked in patient education?

- A. less than 1 year
- B. 1-3 years
- C. 4-6 years
- D. 7-9 years
- E. 10-12 years
- F. 13-15 years
- G. 16-18 years
- H. 19-21 years
- I. 22-24 years
- J. 25+ years

12. How long have you worked in health care?

- A. less than 1 year
- B. 1-3 years
- C. 4-6 years
- D. 7-9 years
- E. 10-12 years
- F. 13-15 years
- G. 16-18 years
- H. 19-21 years
- I. 22-24 years
- J. 25+ years

13. What is your certification?

- A. RN
- B. COHN-S
- C. NP
- D. CIC
- E. FACOEM
- F. LVN
- G. CCM
- H. Other _____

14. How many hours a week do you work?

- A. less than 20
- B. 20-30
- C. 31-40
- D. 41-45
- E. 46-50
- F. 51-55
- G. 56-60
- H. 61-65
- I. 65+

15. If you work in a hospital, what is its size?

- A. <100 beds
- B. 101 to 200 beds
- C. 201-300 beds
- D. 301 to 400 beds
- E. 401 to 500 beds
- F. 501 to 600 beds
- G. 601 to 800 beds
- H. 801 to 1,000 beds
- I. >1,000 beds
- J. I don't work in a hospital

Deadline for Responses: Oct. 15, 2010

Thank you very much for your time. The results of the survey will be reported in an upcoming issue of the newsletter, along with an analysis of the economic state of your field. Please return this form in the enclosed, postage-paid envelope as soon as possible. If the envelope is not available, mail the form to: Salary Survey, AHC Media LLC, P.O. Box 740058, Atlanta, GA 30374.

