patient education MANAGEMENT

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

vol. 17, no. 12 December 2010
pages 133-144

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Financial Disclosure:
Editor Susan Cort Johnson, Executive Editor Russ Underwood, Managing Editor Karen Young, and Consulting Editor Magdalyn Covitz Patyk report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study.

Education a must for safe delivery of pain management therapies

Health care professionals and patients need to work as a team

Chronic pain sufferers want relief. To achieve their goal, they may misuse pain medication.

"We cannot safely give patients any treatment, let alone medication, that can reliably eliminate their pain if it is a chronic disorder. One of the major problems is the unrealistic expectations many patients have in regard to treating their pain," says **Lynn Webster**, MD, FACPM, FASAM, a leading expert in the field of pain medicine and addiction and advisor to PainSAFE.

This message needs to be clear for physicians as well. Webster says that when he began his career in the field of pain medicine, he realized he could not always give patients everything they needed for pain relief. He began to redefine realistic expectations for patient safety and best outcomes.

These same issues are addressed by PainSAFE (Pain Safety & Access for Everyone), a new education program available on the website of the American Pain Foundation (www.painsafe.org). The information focuses on the role of health care consumers, as well as health care professionals, in the safe use of pain management therapies. Information on opioids and implantable pain therapies is available on the website, and a section on

EXECUTIVE SUMMARY

Patient safety can be improved with good education and clear communication. In this issue, we look at a new education tool to reduce the risk of some pain management therapies. PainSAFE (pain safety & access for everyone) is a Web-based initiative offering programs, tools, and resources designed to improve communication between provider and patient, reduce pain management risks, and improve access to pain care. The program was launched by the American Pain Foundation, based in Baltimore, in September 2010. Currently, there are teaching modules on opioids and implantable pain therapies with more modules in the works.

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over-the-counter pain medication will be ready in January. Educational resources on complementary and alternative medicines are also in the works.

"The website will be evolving — not only in the areas of pain management and the different treatment modalities, but also in regards to providing more resources, tools, and education for the two audiences; the website will continue to expand," says **Samantha Libby-Cap**, director of PainSAFE.

The mission of PainSAFE is to provide education surrounding the appropriate and safe use of pain management therapies for people affected by pain and health care professionals, thereby helping to reduce risk and improve access to quality pain care. By educating both the consumers and the health care professionals on safety issues, patients will get better care, explains Libby-Cap.

Educational issues addressed

A look at the opioid education modules provides insight into the education provided. For example, the section on the safe use of opioids within the education module for health care professionals advises: "Assess the risk for opioid misuse, provide close monitoring, dose judiciously, and continually reevaluate the benefit of potentially dangerous medications." Eight guidelines are given to minimize safety concerns.

These guidelines include:

— assessing patients for risk of abuse before prescribing a medication and recommended tools for conducting the assessment;

— watching for and treating comorbid mental illness when it occurs, and coordinating care with experts in the field of mental health;

— the cautious use of conventional conversion tables when switching from one opioid to another;

— ways to avoid using benzodiazepines with opioids, especially during sleep hours;

— starting methadone at a very low dose and titrating slowly regardless of whether the individual is opioid-tolerant or not;

— assessing for sleep apnea in patients on high daily doses of methadone or other opioids, and in patients with a predisposition for the sleep disorder;

— providing details to patients on long-term opioid therapy about reducing their opioid dose during upper respiratory infections or asthmatic episodes;

— avoiding the use of long-acting opioid formulations for acute post-operative or trauma-related pain.

A link to safety tools and resources to aid in the education and prevention of addiction or substance abuse is available, as well as six opioid safety steps to give to patients. Information on creating a favorable balance between analgesia and side effects is included, as well as details on what constitutes a legal prescription.

Consumer information includes what happens when patients increase their dosage on their own; try to lower their dosage; or combine opioids with certain medications or alcohol. Also, the safety section includes details on topics to discuss openly with the physician, such as side effects to expect and

Patient Education Management™ (ISSN 1087-0296) is published monthly by AHC Media LLC, 3525 Piedmont Road N.E., Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.

POSTMASTER: Send address changes to Patient Education Management™, P.O. Box 740059, Atlanta, GA 30374.

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Customer Service: (800) 688-2421 or fax (800) 284-3291. Hours of operation: 8:30 a.m.-6:00 p.m. Monday-Thursday; 8:30 a.m.-4:30 p.m. Friday EST. E-mail: customerservice@ahcmedia.com. World Wide Web: www.ahcmedia.com.

Subscription rates: U.S.A., one year (12 issues), $499. Add $17.95 for shipping & handling. Outside U.S., add $30 per year, total prepaid in U.S. funds. Discounts are available for group subscriptions, multiple copies, site-licenses or electronic distribution. For pricing information, call Tria Kreutzer at 404-262-5482. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue date. Back issues, when available, are $82 each. (GST registration number R128870672.)

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This activity has been approved for 15 nursing contact hours using a 60-minute contact hour.

Provider approved by the California Board of Registered Nursing, Provider # 14749, for 15 Contact Hours.

This activity is intended for 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. It is in effect for 24 months from the date of publication.

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when to report problems. Patients are educated to discern the differences in tolerance, physical dependence, and addiction to opioids, as well as how to recognize an opioid emergency and take action.

Logs and worksheets for patients to track the use of opioids are available, as well as information on how to safely store the medication so it cannot be accessed by someone who does not have a prescription.

The focus is on safety, risks, and how a patient can properly manage the medication, says Libby-Cap. "I guess the two words you can use to describe PainSAFE [are] 'educating' and 'empowering,'" she adds.

A handout the size of a business card gives consumers six steps for safe opioid use. The card opens to reveal the eight prescribing guidelines for professionals. "The combination builds that communication between the patient and the health care provider, so they both have knowledge," says Libby-Cap.

The focus on providing education on the roles of both the health care professional and the consumer is important, according to Webster. The problem with addiction and overdose deaths is multifactorial, he explains. Patients have ignored the potential danger of the powerful analgesics and fail to follow instructions, taking the medication as they feel they should take it, because they want to get out of pain, says Webster.

"The general attitude of most people with regard to pain medicine is that if you take one and it works, taking two is even better," he says.

Also, with mild analgesics and anti-inflammatory medications, people have grown accustomed to taking one and, if it does not work, taking another. While these medications are reasonably safe, the same practice does not translate to the more powerful pain killers like opioids, explains Webster.

PainSAFE helps educate patients about their responsibilities and provides direction on how to hold them accountable for using the medications as directed and in a safe way. According to Webster, patients and physicians must work together if pain therapies, such as opioids, will continue to be available to treat all the patients who have severe pain.

Based on successful prototype

According to Webster, PainSAFE is a program that evolved from a zero-deaths campaign in Utah launched in 2005. It was started because newspapers reported an epidemic of opioid overdose deaths from prescription drugs.

Webster determined that health care providers in the field of pain medicine needed to address the issue, especially if it was related to their attempt to help patients. Also, at the time, he was president of the Utah Academy of Pain Medicine, and he thought he had a moral responsibility to understand the problem and reverse the trend.

He talked to a wide array of people, read the literature, and conducted clinical research. He learned there were a number of physician errors in prescribing and managing patients using opioids. Also, patients were being harmed, because they were not following instructions and were overusing the medications in an effort to get out of pain. A third problem uncovered was the fact that some medical conditions were particular risk factors for patients who could be harmed from opioids — something not previously known.

He wrote a paper about some of the common problems associated with the overdose deaths and also lectured. This information became part of a program backed by the Utah Department of Health called the "Use Only as Directed" campaign.

"We educated physicians about some of the potential harms of prescribing, how to better manage and monitor our patients, and to instruct them on the appropriate use of medication," says Webster.

The next year, the department of health reported a drop in the death rate from opioid overdose. However, there was no money to support the education program. Therefore, the American Pain Foundation was approached. This organization determined the program should be expanded beyond opioids to ensure that all therapies provided in the field of pain medicine are safe. Webster embraces the concept of looking at what harm has occurred, potential harm, and how to prevent problems in the future. Once the research is completed, physicians and patients must be aware of the problems and how to correct them. In this way, patients will continue to have access to a full, broad spectrum of pain management therapies, says Webster.

SOURCE

• **Samantha Libby-Cap**, Director of PainSAFE, American Pain Foundation, 201 North Charles Street, Suite 710, Baltimore, MD 21201. E-mail: slibby-cap@painfoundation.org. ■

Give guidance on proper diagnosis

Treatments must be carefully selected

Education on pain is multifaceted, according to **David Kloth**, MD, national spokesman, board member, and past president of the American Society of Interventional Pain Physicians (ASIPP), headquartered in Paducah, KY.

He advises educators to teach consumers that early diagnosis and treatment is essential for preventing acute pain from becoming chronic pain and from the affected areas losing functionality.

Also, medical expertise in properly diagnosing and treating pain is important. He adds that pain specialists not only know how to properly treat pain, but also diagnose the cause of the problem. "As with any problem, if you don't make the right diagnosis, it does not go away," explains Kloth.

After taking a comprehensive patient history, doing an examination, and reviewing tests that have been ordered, a pain specialist determines the cause of the problem. Diagnostic steps might be an injection that selectively blocks a nerve to prove that is the cause of the pain, says Kloth.

Patients should make sure they have all the facts before considering surgery, he adds. While surgery should be done for very specific and correct indications, not all surgeries to treat pain are going to be successful, says Kloth. He advises that patients with back, neck, and spinal problems try appropriate, conservative management first to see if that corrects the problem. This may be physical therapy, medication management, injections, or chiropractic treatment. Every patient is different, he adds.

Kloth says that the vast majority of pain management treatments are totally reversible, and if they don't work, they have not caused any harm or long-term problems, except with surgery where scar tissue can form.

Pain management is not a shot in the dark, says Kloth. While a chiropractor or acupuncturist may be beneficial, a pain specialist will determine if such treatments are appropriate and advise patients which to explore based on their particular condition.

Patients should use the following criteria to find the right pain specialist, according to the ASIPP:

— Make sure the physician has a track record in interventional pain management.

— Ideally, the physician should be practicing pain management full time.

— Training is important. Find out where the physician did his/her residency and what their specialty was. Also, ask if he or she did a fellowship in pain management.

— Find out if the physician holds a certificate in pain management from a board, such as the American Board of Medical Specialties (www.abms.org), or the American Board of Interventional Pain Physicians (www.abipp.org).

— Ask if the physician has credentials at a local hospital or surgery center to practice interventional pain management.

— Use peer recommendations. Patients can ask their personal physician to refer them to a physician who specializes in pain management.

SOURCE

• The American Society of Interventional Pain Physicians, 81 Lakeview Drive, Paducah, KY 42001. Telephone: (270) 554-9412. ■

EXECUTIVE SUMMARY

According to the American Society of Interventional Pain Physicians, about 75 million Americans suffer from acute and chronic pain. Desperate for relief, pain sufferers need guidance on how to select physicians for the right diagnosis and treatment.

Satisfaction data zeros in on areas to improve

Low scores could affect future reimbursement

If you're not using your patient satisfaction data to develop process improvement projects, you're missing a chance to improve patient care, says **Quint Studer**, CEO of Studer Group, a health care consulting firm based in Gulf Breeze, FL.

Studer particularly recommends paying close attention to your hospital's scores on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), which he says will transform the way hospitals do business.

"To raise your HCAHPS scores, you have to identify and fix the core underlying causes of low patient satisfaction. Patients aren't going to perceive your quality any better than it actu-

ally is — you can't fake it. If you have quality issues like readmissions or high rates of hospital-acquired infections, that's where you need to focus to move both HCAHPS and quality results. HCAHPS helps you know how to focus," he says.

HCAHPS is a 27-question survey created by the Centers for Medicare & Medicaid Services (CMS) and the Agency for Healthcare Research and Quality. It is designed to measure patients' perception of the care they received while in the hospital.

HCAHPS is far superior to patient satisfaction tools of the past because of its focus on quality, Studer says.

"The HCAHPS includes questions like pain management, responsiveness of the staff, communicating the side effects of medication, and understanding home care instructions," he says. "No clinician can say those items are not important."

In addition to measuring issues that affect clinical quality, HCAHPS measures the frequency of how often something happens, Studer points out.

Answers to the survey questions include "never," "sometimes," "usually," and "always."

"For instance, many other tools ask if someone explained the side effects of medication. This is different from asking if the side effects are always explained. To do well in today's health care environment, hospitals can't be content with responses of 'usually.' If they want to be a stellar performer, they should move to 'always,'" he says.

HCAHPS gives hospitals an accurate snapshot of how well they are performing in comparison to their peers, Studer says.

The drawback of patient satisfaction tools in the past was that a hospital could compare its ranking only with other hospitals that were using the same measuring tool.

"HCAHPS creates a level playing field. It allows hospitals to see how they really stack up against the competition in the eyes of patients," he adds.

The issues covered by the HCAHPS are crucial ones that hospitals must address in order to be able to produce good outcomes in a tight money situation, he adds.

CMS announced its intention in 2007 to include HCAHPS scores as part of its value-based purchasing initiative, points out **Carolyn Scott**, RN, MEd, MHA, vice president of performance improvement and quality for Premier, a health care performance improvement alliance.

Although the details of how and when value-based purchasing will be rolled out have not yet been announced, it's clear that how patients score a hospital on the HCAHPS will affect reimbursement, she adds.

"CMS is building the voice of the consumer into the quality equation. Hospitals are paying more and more attention to HCAHPS scores," Scott says.

Scott recommends that in addition to reviewing their HCAHPS scores, hospitals dig deeper into the results for specific questions to find out where the problems lie.

"Vendors often are able to segment results by hospital unit, which helps hospitals identify the specific departments where issues may reside," she says.

That's what happens at Integris Baptist Regional Health Center in Miami, OK, according to **Alice Hunt**, MBA, the hospital's director of service excellence.

The hospital's patient survey integrates the HCAHPS data with the standard Press-Ganey patient satisfaction survey, she says.

"When we look at the HCAHPS data and something doesn't look right, we dig deeper using the Press-Ganey questions to see if there are any underlying issues. We can identify more specific problems and focus on areas where we can make a difference," Hunt says.

If patients give the hospital a low rating on the HCAHPS global questions that measure the overall rating of the hospital and their willingness to recommend the hospital, Hunt uses the Press-Ganey data from the same time period to see if there are specific areas where patients expressed dissatisfaction and comes up with process improvement projects to address the issue.

The hospital administration looks at HCAHPS data to determine if the percentage of "always" or "usually" answers changes in any category.

"It's difficult to meet the expectations of 'always' but some hospitals are doing it, and that is what we are working toward," Hunt says.

Newton-Wellesley Hospital in Newton, MA, uses its HCAHPS and Press-Ganey data to identify gaps in processes and procedures and to develop initiatives to correct the situation, says **Patrick Jordan**, senior vice president, administration, and COO.

Every month, the hospital administration produces a leader report card that goes to every manager who, in turn, takes the information to his or her staff.

The care coordination report card includes information such as staff turnover, timeliness of completion of annual evaluations and orientation, number of thank-you notes written to the staff, employee satisfaction, customer care activities, productivity, response to patient and family complaints, and budget performance.

"We track to see if there [is] a pattern of complaints and take this as a signal to look at opportunities to bring together a small group of people to look for solutions," says **Elaine Bridge**, RN, MBA BSN, senior vice president patient care services and chief nursing officer.

For instance, patient satisfaction data had shown that patients were unhappy about the length of time it takes to be discharged.

"The scores are not troublesome, but there always is an area for improvement," says **Monica Ferraro**, RN, MS, manager of care coordination.

The hospital created a work group that includes staff nurses, RN case managers, and hospitalists to analyze the discharge process for nurses, physicians, and discharge planning staff and identify improvement opportunities. The multidisciplinary team has looked at all aspects of the process from the time the physician writes the order until the patient is out the door.

"The discharge process frustrates the staff as well as patients at times. Each step of the process is dependent upon another clinician completing a part of it. The delays in discharge are not intentional delays. They are directly related to the complex processes. We have a motivated group of people on the team who are looking for rapid cycle improvements as well as long-term solutions, such as leveraging technology," Ferraro says.

Meanwhile, as part of a statewide initiative to reduce avoidable readmissions in collaboration with the Institute for Healthcare Improvement, the team on some patient care units is analyzing whether patients receive discharge education, whether the right person to receive the education is identified and involved in the teaching, and what kind of information is being communicated to the next level of care, she adds.

For instance, the orthopedic unit is looking at the key items patients should be educated about and who is the appropriate person to receive the information.

"We are trying to find ways to be sure that the patient is able to process the information using the teach-back method. We want to make sure they completely comprehend what they are supposed to do after discharge," Bridge says.

Take proactive approach to HCAHPS

Take a proactive approach to the HCAHPS questions and ask patients the questions while they are still in the hospital so you can address the issues and make changes before the patient leaves the facility, Scott suggests.

For instance, if a patient reports being confused about his or her medication or discharge destination, the nurse or case manager can spend more time making sure the patient understands, she says.

"There's not a lot a hospital can do to improve its rating once the patient leaves. But if things aren't going well, paying attention to the gaps in information can turn the tide, especially if the patient sees that the hospital staff are interested in them as people," she says.

Some hospitals participating in Premier's QUEST: High Performing Hospitals collaborative engaged in practices to assess the patient experience prior to the time of discharge. These hospitals have reported that when they ask questions before patients leave the hospital and address the issues identified, they begin to see some improvement in patient experience statistics.

Scott suggests overlaying HCAHPS with other data, such as readmission rates and clinical quality scores, to identify trends that may be parallel to patient experience scores.

In addition, look at staff satisfaction and see how it trends with the patient experience, she adds.

"Typically, when staff satisfaction goes up, so does the patient experience," she says.

Studer suggests calling patients 24 hours after discharge and going over the home care instructions.

The phone calls have paid off for Integris Baptist Health Center by raising HCAHPS scores as well as potentially avoiding readmissions, Hunt says.

An analysis of the HCAHPS data determined that patients who get a post-discharge phone call usually rank the hospital in the 90th percentile or above on whether they'd recommend the facility to family and friends. Those who don't get a phone call rate the hospital much lower, Hunt says.

"The phone calls have helped us catch potential problems, such as when patients have a reaction to

their medication, when they haven't gotten their prescriptions filled, and when their symptoms indicate that they should see their doctor. All of this filters back to the case managers, and we work to ensure that there are no gaps in care," adds **Linda Hollan**, RN, BSN, CDE, ACM, director of case management.

Make your focus improving clinical outcomes, not just raising patient satisfaction scores, Studer advises.

"People are not likely to be motivated by a project with the goal of raising scores. Instead, hospitals need to determine where they need to focus their process improvement efforts to remove the barriers that get in the way of quality care," he says.

For instance, look at your answers on the pain control measures of HCAHPS. If the patient answers include mostly "sometimes" and "never," look at what your team is doing to deal with patients' pain, he suggests.

Correcting the problem could pay dividends in a number of areas, he adds.

If a patient's pain is controlled, the patient isn't hitting the call button to ask for more medication and the family isn't rushing out to the nurse on a regular basis to say that patient is in pain. This leaves the nurse free to deal with other issues, Studer adds.

"One in every five patients discharged from the hospital [has] adverse events. About 60% of these are because they aren't taking their pain medications correctly and have side effects, so they call in or go to the emergency department. If you're doing things right while patients are in the hospital, keeping their pain under control and teaching them about their medication, you can avoid these adverse events," Studer says.

Include all departments in the hospital in your process improvement initiatives, Scott suggests.

"It's not just doctors and nurses who affect the patient satisfaction scores. HCAHPS measures issues like cleanliness and noise [that] are often impacted by non-clinical staff. Every employee has the potential to impact the patient experience," she says.

When the HCAHPS scores indicated that patients at Newton-Wellesley Hospital were disturbed by noises on some units, the unit staff met to brainstorm ways to reduce the noise. In some cases, the solution was to put up a glass partial partition in the nursing station. On one unit, the hospital moved the ice machine away from patient doors. On the obstetrical unit, the hospital set up a two-hour quiet period where no one but a significant other could visit in order to give the patients a chance to rest.

"We received wonderful feedback on those changes," Bridge says.

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Communication key to patient satisfaction scores

Let patients, families know staff are there for them

As part of its efforts to create an excellent patient experience, Newton-Wellesley Hospital has made constant and comprehensive communication with patients and family members a key part of the hospital's culture.

"We want to create an environment where every patient and family member feels comfortable speaking to the staff. That means it's critical for the front-line caregivers, the doctors and the nurses, to learn to communicate effectively with our patients. We developed key words that the staff can use at key times to educate the patient on what they are doing and why," says **Patrick Jordan**, senior vice president, administration and COO for the 250-bed hospital located in Newton, MA.

For instance, some patients have commented that they didn't understand why the nurses or case managers kept closing the curtains and doors when they came to examine, treat, or talk to them.

"Some thought it was because their condition was too gruesome for other people to see. Now we tell them upfront that we are closing the door for patient privacy," he says.

"If you leave a void in information, people have a tendency to fill the void with something worse than reality," adds **Elaine Bridge**, RN, MBA, BSN, senior vice president for patient care services and chief nursing officer.

Before staff leave the room, they ask the patient,

"Is there anything else I can do for you?"

"They often get an answer. This is a great way to increase communication between the patients and the staff. If the staff find out patient needs and things that they can fix immediately, that reduces call lights," Jordan says.

Patients have said that they didn't want to hit the call button, because the nurses seemed busy so they waited until someone came to the room to ask to sit up or be taken to the toilet, says **Monica Ferraro**, RN, MS, manager of care coordination.

"We want the patient to know that the staff are here for them, and we work with the staff to identify phrases that get that idea across," Bridge says.

Members of the hospital leadership team spend time each month in the lobby, greeting patients, families, and visitors; answering questions; and giving people directions.

CMs developed formalized process

The case management department developed a formalized process that staff use to introduce themselves to patients and/or family members.

"We actually role-played this during a staff meeting to create some fun around the script. The goal is to reassure the patients by introducing ourselves and explaining our years of experience in coordination care, as well as how we can help them prepare for discharge," Ferraro says.

The case managers and social workers may vary what they say based on the needs and conditions of the patients, but, according to Ferraro, a typical statement may be:

"Good morning. My name is Monica. I'm your case manager today, and my role is to help you with discharge planning. I've been a case manager for 20 years, and I feel comfortable knowing that we can work together to make sure you have a safe discharge."

"We always end the conversation by thanking them," she adds.

The team uses the same type of script to reassure patients that their treatment team is experienced and will provide first-rate care.

"There's a lot of activity going on in the operating room, so when a patient is in pre-op, we use that opportunity to reassure people about their surgery. Everyone who talks to the patient mentions their own credentials and the credentials of the anesthesiologist and the surgeon. This often helps to reassure patients and reduce their anxiety," Bridge says.

The hospital has gone so far as to develop scripts for the staff to use when answering the telephone on the unit.

"In a busy day, people can move away from the basics very quickly. We want the staff to treat people the way they or their loved ones want to be treated. These are basics, but they have a big impact," Bridge says.

When they encounter someone in the hallways, all members of the staff are expected to stop and ask if they need help finding something and offer to take them there.

"A single individual in a unit can have a profound impact on the experience of patients and visitors. Offering help to someone you see in the hall is basic, but it can have an impact on the patient experience," Jordan says.

All of the top leaders in the hospital meet once a week and examine every negative patient comment from the Press-Ganey and HCAHPS surveys. The person in charge of the particular section where the complaint originated calls the patient to find out what happened, Jordan says.

"The hospital has a huge commitment to patient satisfaction. This includes more than just case managers and nurses. It involves everyone in the hospital," Bridge says.

Following the weekly meetings, the team members address the negative comments with patients. Depending on the situation, they may send a letter of apology, flowers, or a coupon for the hospital gift shop, Bridge says.

For instance, a patient complained that she was given the wrong information about the home care nurse's appointment. When she looked into the situation, Ferraro determined that the social worker was clear about the appointment; however, the home care nurse failed to show up.

"The home care agency dropped the ball. We acknowledged the problem with the patient, sent a letter of apology, and included a coupon for free parking for her return visit. This is just one example of how we made a patient feel like her complaint was taken seriously," Ferraro says. ■

CM redesign promotes care coordination

Patient satisfaction rises, avoidable days decrease

A new case management model that establishes hospitalwide care coordination and pro-

motes collaboration among disciplines is paying off for Alamance Regional Medical Center in Burlington, NC.

In the new model, traditional case management duties are shared by clinicians in the separate roles of admissions nurses, care coordinators, social workers, documentation specialists, utilization review staff, and the patient care nurses.

The admissions nurses review each admission for medical necessity and level of care required. Care coordinators are responsible for ensuring that patients' needs are met efficiently and effectively. The social workers handle the complicated discharges and other social issues while the documentation specialists work with coders to ensure that documentation is accurate and complete, and the utilization review staff are responsible for UR for commercial patients.

Already the new model, which is still being rolled out throughout the hospital, has reduced avoidable days and increased patient satisfaction, says **Beve Butler Smith**, RN, MSN, CHCC, director of care management for the 238-bed regional hospital.

"In addition, communication between the staff is much better. In the units where the new model is fully rolled out, I can see an excitement between the care coordinators and the rest of the staff that wasn't there before," she says.

When patients come into the hospital, the admissions RN reviews the admission for medical necessity and patient status using InterQual criteria and assigns a DRG before the patient is admitted. The nurse puts the data into the hospital's electronic system, which assigns a geometric length of stay.

If the patient record doesn't support medical necessity criteria for the admission, the nurse contacts the physician and asks for additional information.

If the admissions nurse and the physician can't agree on inpatient admission versus observation, the nurse refers the case to a physician advisor who reviews the medical record and either affirms the admission or contacts the admitting physician for more information.

If the additional documentation still doesn't support an inpatient admission, the nurse informs the patient and family and makes sure they understand what their financial responsibility is likely to be.

"The nurse talks to the patient and family while they still are in the emergency department and explains the difference between inpatient and observation services. We give them a written notice that they are in observation and what it means, including the fact that they will have a copay," she says.

If the nurse suspects that the services the patient will receive may not be covered, she gives them a Hospital-Issued Notice of Non-Coverage (HINN) letter and explains what it means.

The admissions nurses go through the same process with patients coming in from the emergency department, patients being directly admitted, those receiving same-day surgery who aren't ready to be discharged, and patients from the cancer center who may need inpatient treatment.

"Any patient who needs a room goes through an admission review," Smith says.

During the admissions process, the nurse talks to the patient about his or her expectations for the hospital stay and goals for discharge.

"Patients are becoming more involved in their care and often want to talk about their discharge goals and destination up front. If it appears they may need post-acute services, we discuss it with them and ask them to think about what they want and where. This gives us the beginnings of a discharge plan as we admit the patients," she says.

Admissions nurses cover the hospital from 7 a.m. to 11 p.m., seven days a week. If patients come in after 11 p.m., the nurse reviews the records immediately at 7 a.m.

"During the times the admission nurses are not in the house, it's often obvious that the patient needs to be admitted. If it's not clear, they are placed in observation and the record is reviewed by the nurse when she arrives," Smith says.

Under the new model, RN care coordinators are responsible for coordinating care for the patients, performing utilization review and continued stay review for Medicare patients, and handling simple discharges. Social workers assist with the utilization review for Medicare patients and handle all the complicated and challenging discharges.

The care coordinators no longer are responsible for patient status, assigning DRGs and anticipated discharge dates or performing documentation assurance.

Each care coordinator is unit-based and manages the care for about 25 patients. The hospital is staffed with one social worker for every 40 patients.

Having unit-based care coordinators gives the nurses an opportunity to become familiar with the patient population on the unit, and to develop a

close working relationship with the physicians and the rest of the staff on the unit, Smith points out.

"With this model, the care coordinators spend a great portion of their time with the patients, doing rounds, and keeping everything going smoothly. They coordinate all the ancillary services so everything gets done in a timely manner," she adds.

The care coordinators are responsible for tracking patients who are receiving observation services and making sure they are either discharged or admitted within 24 hours.

They make rounds on each patient four times during the day.

Every day at 10 a.m., the care coordinator and shift coordinator (charge nurse) make "touch-base" rounds, usually at the nursing desk or in the break room.

They talk about each patient on the unit, looking at the reason for admission and the anticipated discharge date, and set goals for the day, then determine who will be responsible for ensuring that the goal is met.

The care coordinators use an electronic care coordination review tool that guides them during the rounds to ensure consistency.

"Our rounds are very structured. We don't just look at a patient, say they're doing well, and move on. The care coordinators and shift coordinators thoroughly review the patient record, looking at the core measures, and the major systems on every patient every day. It helps us develop our goals and work through what we need to do to accomplish them," she says.

Right after the touch-base rounding, the care coordinator visits the patients. They identify themselves, write the goals for the day on a white board in the patient's room, and discuss the goals with the patient, including what he or she needs to do to participate in meeting the goals.

For instance, if one of the goals for the day is removing the patient's Foley catheter, the care coordinator tells the patient he or she should drink a lot of water to prepare.

Later in the day, the care coordinator rounds with the physician in the patient's room and brings up the goals for the day and what the patient is doing to help meet the goals. The care coordinator and the physician also talk about the discharge plan for the patient and what has to happen before the patient can go home.

The shift coordinator and care coordinator meet again for touch-base rounds at 2:30, review each patient again, and make sure the goals were met.

The care coordinators handle the simple discharges and refer patients who have complicated discharge plans to the social worker as early in the day as possible.

"The number of challenging discharges has tripled in the last two years. The number of patients who have no place to go is huge. The social workers handle the discharges for patients who need IV therapy after discharge, who have no insurance coverage for medication, who are homeless, or have other social needs," she says.

The case managers and social workers handle utilization review and continued stay review for the Medicare patients.

The hospital created a separate department to handle utilization review for commercial payers. Documentation specialists, who are RNs or social workers, work with the coders to ensure that the documentation is complete and accurate.

"There's so much money riding on documentation these days that we felt like we needed a separate staff whose sole responsibility is documentation assurance," she says.

The documentation specialists and coders funnel all queries to the physician through the care coordinator, who brings up the subject during rounds.

"We didn't want to overwhelm the doctors with questions, so everyone sends their queries to the case manager, who already has a good working relationship with the physicians," she says.

Before the redesign, the hospital had an integrated model of case management and social work.

"The case managers and social workers worked together in tandem, and there wasn't much difference in their jobs. Both did discharge planning. The social workers had been cross-trained to assign DRGs and to perform admission and continued stay reviews using InterQual," Smith says.

But as regulations changed dramatically, the Centers for Medicare & Medicaid Services (CMS) rolled out the Recovery Audit Contractor (RAC) program and other initiatives to scrutinize hospital reimbursement, and the hospital administration realized that the work of the case management department needed to be realigned in order to continue to get optimum reimbursement under pay-for-performance initiatives.

"The RACs started looking at our efficiency in a new way. We know that we are doing a

good job and providing high-quality patient care, but if we can't document it, we could come out on the losing end. The challenge in today's health care environment is making sure that we are providing care efficiently and in the correct environment, and at the right time, and that we are carefully describing it in the medical record. If we don't carefully document everything we do and the services aren't provided at the right level of care, we are not going to realize the reimbursement we deserve for the great services we provide," Smith says.

The core group that developed the new model included the directors of patient financial services, health information management, case management, the medical director, and the head of the hospitalist team. Representatives from human resources and patient relations were called in as needed.

The team put together a timeline and worked with patient relations to coordinate education on the process.

The hospital leadership met with the entire case management staff and described the new model. The existing staff were given the option to choose where they wanted to work.

Working with the human resources department, the leadership team wrote job descriptions for the new roles. They set up interviews with the staff to help them make choices about which job they preferred.

The hospital leadership team spent a lot of time educating everyone at the hospital on why the emergence of pay for performance makes it necessary for everyone to change the way they work, Smith says.

"If hospitals are going to survive all the regulations and reimbursement challenges of today, we have to look at patient safety, quality, efficient throughput, and documentation as universal challenges, and not just the responsibility of care management or a single department. The staff in ancillary services need to understand that when a patient needs a consultation, test, or procedure in order to move along the established plan of care for discharge, we need to work together and get it done even if the schedule is full. Physicians need to understand that with the MACs [Medicare Administrative Contractors] and MICs [Medicaid Integrity Contractors], documentation is everybody's problem because they are going to be penalized financially if we don't tell the patient's story in the medical records," Smith says.

"Care coordination is the process to help the acute care environment share a goal with a patient and make it happen," she says.

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COMING IN FUTURE MONTHS

- Evaluating videos according to health literacy standards
- Educating to reduce obesity
- Patient centered maternity education
- Be ready to educate the deaf

CNE instructions/objectives

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

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

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

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

CNE QUESTIONS

21. Several patient safety issues need to be addressed when prescribing opioids. Patients need to know which of the following?
A. Importance of taking as prescribed
B. Reportable side effects
C. Details on safe & secure storage
D. All of the above

22. PainSAFE is an education initiative to teach patients about the responsibilities they have for the safe use of pain management therapies. Also it provides direction to health care professionals on how to hold patients accountable for using the medications as directed and in a safe way.
A. True
B. False

23. Free mobile phone applications can be a good way to get the word out about risk factors for certain medical conditions. One on risk for hereditary breast and ovarian cancer is helpful because it does which of the following?
A. Covers a topic difficult to discuss.
B. Provides database for providers and mammography centers.
C. Gives suggestions on addressing hereditary risks.
D. Answer A and B

24. Research does not show that exercise and activity is beneficial to the elderly, and therefore they should not be encouraged to continue to pursue personal interests and get out of the house.
A. True
B. False

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

Patient Education Management™

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

PEM120110TM

PLEASE NOTE: If your correct name and address do not appear below, please complete the section at right.

Please make label address corrections here or PRINT address information to receive credit letter.

Account # _____

Name: _____
Company: _____
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State: _____
Zip _____
Fax: _____
Phone: _____
E-mail: _____

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

CORRECT ● **INCORRECT** ✓ ✗ ⊖ Ⓜ

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

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

If so, how? _____

10. How many minutes do you estimate it took you to complete this entire semester (6 issues) activity? Please include time for reading, reviewing, answering the questions, and comparing your answers to the correct ones listed. _____ minutes.

11. Do you have any general comments about the effectiveness of this CNE program?

_____

I have completed the requirements for this activity.

Name (printed) _____ **Signature** _____

Nursing license number ***(required for nurses licensed by the state of California)*** _____

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