Patient Education Management™

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

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IN THIS ISSUE

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Create a paper trail to improve teaching, communication, and documentation

Methods should be tailored to needs of institution and patient population

In an effort to spur documentation, standardize teaching, and ensure patients will be ready for a safe discharge, many institutions utilize checklists, guidelines, and teaching plans. However, the implementation of these tools doesn't necessarily guarantee the desired result will be achieved.

It is important to implement such tools with care and be willing to replace or eliminate them completely if they are not working.

The Children's Hospital of Philadelphia had individualized teaching plans in place for almost every diagnosis and procedure with matching handouts for parents. The purpose of the plans was to prompt both teaching and documentation. These were tools to be used throughout the patients' stay to help nurses plan their day and communicate which teaching had been completed.

However, instead of using the tool day by day, they usually drew an arrow from the top of the page to the bottom of the page on the final day and signed the sheet.

"It was looked at as another piece of something to do," says **Linda S. Kocent**, RN, MSN, coordinator of patient-family education at The

EXECUTIVE SUMMARY

Tools to aid staff members with teaching and documentation of patient education seem to be a good idea; however, they are not always successful or even useful. It is important to determine the purpose or goal of each tool before it is implemented to be sure your teaching tools really are enhancing education. In this issue, patient education managers discuss teaching plans, guidelines, and checklists — and how each can be used to improve patient education.

Children's Hospital of Philadelphia. Children's Hospital now is phasing out the teaching plans as they come up for their three-year review if there is another tool such as the nursing standard, nursing procedure, or a teaching sheet that has the same information staff need to teach the family.

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Also, it is crucial to show the assessment, the education plan, and work being done in one place. Therefore, rather than have separate forms that never really show the plan, a teaching record called the Interdisciplinary Patient-Family Education Flowsheet was implemented for documentation.

The form has sections for documenting the assessment, the learners, their learning style, the method of teaching, and the outcome of the teaching session. Also, it is not for nurses only.

"The teaching plans could have been useful, but they weren't used correctly and the information was redundant — so why give nurses one more piece of paper to fill out?" asks Kocent.

Patient education managers need to make sure they are not duplicating documentation for staff, agrees **Mary Szczepanik**, MS, BSN, RN, manager of cancer education, support, and outreach at OhioHealth Cancer Services in Columbus. Also, when creating a tool its purpose needs to be very clear.

Teaching plans can be very valuable to your medical team, depending on your practice, says **Cezanne Garcia**, MPH, CHES, manager of patient and family education services at the University of Washington Medical Center in Seattle.

"In our case, we tend to have an extreme cross mix of types of patient groups — especially in our inpatient care areas where the patients from three to four services converge on one floor. The staff there not only need to know a wide range of clinical care practices and related expertise, but also what the teaching [needs are] for patients and family to successfully go home," says Garcia.

The patient education department helps the teams creating the teaching plans hone in on the essential "need-to-know" information for a safe discharge. The plans include a short list of teaching tools that can be used to reinforce one-on-one teaching such as videos.

Documentation of education is part of the plan so the medical team can easily see what has been covered and what needs to be reinforced. According to Garcia, patients who sit on the medical center's advisory councils tell them they prefer to hear complex information three or four times.

Plans never nullify good teaching

Some patient education managers are concerned that teaching plans give staff permission to skip the initial assessment and go right to the need-to-know information. However, Garcia says patient's concerns always must be addressed in

the education process. Patients do not always understand the complexities of a safe discharge; therefore, it is important to partner with patients and family members to help them understand the importance of using a piece of technical equipment correctly or how to care for a wound.

Without the assessment — teaching plan or not — barriers to learning will not be addressed, says **Nancy Goldstein**, MPH, patient education program manager at Fairview-University Medical Center in Minneapolis.

At the medical center's Patient Learning Center, about 50 guidelines have been created for educators to use to help patients achieve success in learning a technique for safe discharge, such as administering IV antibiotics. These guidelines have accompanying flowsheets for documentation that are sent back to patient units so bedside nurses will know which patients have been taught at the Learning Center and what information needs to be reinforced.

If the patient is not ready to learn, the teaching session is rescheduled for a later date. For example, if the patient is anxious, the educator will address the problem and postpone the education.

"If a patient can't get beyond a certain point, we make an assessment (Is it a bad day? Do we need to teach a family member? Do they need home care?), and then implement the plan," says Goldstein.

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One of the reasons the guidelines were implemented was consistency. A patient coming to the Learning Center on Monday should find no difference in the content or steps in education if he or she returns on Tuesday and is taught by another educator. The guidelines are given to the patient care areas so staff know how the Learning Center is teaching and can reinforce it, says Goldstein.

To be useful, teaching tools must focus on the outcome of the education, says Szczepanik. Often checklists are created as a tool for documentation of patient education, and while they may seem like a series of topics that need to be checked off, good teaching principles still are required. That includes completing a patient learning assessment before the topics on the checklist are tackled, she adds.

The initial assessment includes readiness to learn, preferred learning style, and a determination of what the patient knows and would like to know. The teaching is followed by an assessment to determine what the patient learned, or the outcome of the education, she explains.

There are many benefits to using a checklist, says Szczepanik. They decrease the amount of time the nurse and others spend writing, and provide a way for staff to communicate what the patient has learned and what still needs to be taught. Checklists can provide a paper trail for documentation and, because it is a quick read, it is more likely to be reviewed by staff. Reading narrative notes about what the patient was taught is not practical, explains Szczepanik.

"I teach staff nurses that you must document what you taught and you must be able to recreate by looking through the documentation in a medical record not only what was taught but how well you think the patient learned it. The last step I am going to look for (and probably any attorney would look for), if you didn't have time to teach everything or you don't think the patient learned it well enough to be independent at home, is an indication that some kind of home health referral was done to finish the teaching," says Szczepanik.

A teaching checklist is just a tool in the process of patient education. While a checklist is a good reminder of the topics that patients need to learn, it shouldn't be the purpose of the form. Checklists are not meant to prompt the teaching; they are meant to prompt the documentation, she explains. ■

Information at fingertips improves patient safety

Many applications available for PDAs

Although **Cheryl Burnette**, RN, MEd, an education specialist at Centra Health in Lynchburg, VA, purchased a personal data assistant (PDA) to track appointments, addresses, and telephone numbers, she quickly realized she was underutilizing the technology.

Her PDA had the capacity to store much more information, and she could download a multitude of databases from the Internet. As an RN educator, she now shows nurses how information at their fingertips improves patient safety. Often Burnette encourages students in nursing school to ask for a PDA as a graduation present.

"I realized there are a lot of things that a nurse needs at her fingertips. Because it is not easily accessible, it is very difficult to get to the reference material," she says.

For example, when nurses have to administer a drug to a patient, they have no easy way to check to see what a normal dose should be, the side effects, the contraindications, or the interaction with other drugs. The *Physicians' Desk Reference* usually is down the hall at the nurse's station. There are smaller books that can be kept on the medicine cart, but neither of these references is quick to access or easily updated.

Burnette read about a database called Epocrates (www.epocrates.com) that has free, up-to-date drug information that many physicians, nurses, and pharmacists use. She now pays a fee to subscribe to the advanced version that has more features. For instance, there is information on herbs, so it is easy to check to see if an herb a patient is taking will interact with the prescribed drug.

"With the enhanced version, if a nurse has a patient on 10 drugs, he or she can put in the names of all the drugs and the PDA will check for problems of drug interactions," says Burnette.

Checking drugs easy with PDAs

There are so many drugs available to patients, and it is impossible for nurses and physicians to know the indication for them all. Having the information on a PDA makes it much easier to check and cross-check, thus improving patient safety.

There are other applications that improve patient safety. PalmEKGn is a free database (available at www.pdacortex.com) that shows all the heart rhythms. Nurses working on the cardiovascular floor can quickly verify a heart rhythm if needed. There also is a database that allows medical professionals to check out unfamiliar diagnoses that Burnette has downloaded onto her PDA. With this application, she is able to show nurses, if they have a patient with congestive heart failure and Addison's disease and they have not have had a patient with Addison's disease in a while, they can look it up on their PDA.

Burnette also has an entire volume of clinical lab values and tests on her PDA she purchased to show her students the variety of information they can download on the system. With this database, if a test is not familiar, a nurse can quickly look it up. Also, on her PDA, she has the *Lippincott Manual of Nursing Practice*.

Many programs available

Even though Burnette is not in clinical practice she collects the programs to show nurses what is available. "It is not just one application — really, it is almost having the whole library at your fingertips," she says.

However, she advises those who have never used a PDA to get use to using it before downloading medical information. Burnette recommends first using the devise to track phone numbers and appointments for a couple of months.

"It is a learning process. I don't want people to load their PDA up with all the applications I have because it can be overwhelming," says Burnette. Once ready to start adding applications, she suggests it is good to start with Epocrates.

When medical professionals have the information on their PDA, it is much easier to validate decisions or to determine that the physician must be contacted for clarification or collaboration about the patient's care, says Burnette. ■

SOURCE

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EDUCATOR *Profile*

Build a solid patient education program

People skills and timeliness prove helpful traits

Laurel D. Spooner, RN, BSN, is one of five education coordinators at Winter Haven (FL) Hospital, which is part of Mid-Florida Medical Services. In her role, she oversees organizational patient education and coordinates continuing medical education. Other coordinators oversee other aspects of education such as diabetes education.

Patient education encompasses a variety of things including oversight of the corporate patient education committee, which meets monthly; a monthly chart audit of 10 open charts to determine adherence to the standards implemented by the Oakbrook Terrace, IL-based Joint Commission on Accreditation of Healthcare Organizations; overseeing the computerized patient education software used throughout the organization and the programming for the closed-circuit TV channel; and acting as a consultant to other health care professionals in developing patient education materials.

Oversight of the CME coordination includes the monthly agenda of educational offerings, the budget process, maintaining CME files, and compiling an annual report.

Spooner also teaches the basic cardiac monitor arrhythmia classes 10 times a year. She has been in her position for 13 years, and has worked for Winter Haven Hospital 34 years.

All education coordinators in the 527-bed hospital report to the director of education. The education department also has a secretary, an office manager, a media specialist, and a research specialist.

Before taking a position as education coordinator Spooner worked in med-surg and critical care, and she had been a certified critical care nurse (CCRN) for 16 years.

"Whether in med-surg or critical care, you are always teaching patients and families things they need to know to take care of themselves. The job of education coordinator gave me the leeway to grow and learn something different and still see that patients get what they need to know to be able to take care of themselves," she says.

In a recent interview with *Patient Education Management*, Spooner discussed her philosophy on patient education, the challenges she has met, and the skills she has developed to help her to do her job well.

Question: What is your best success story?

Answer: "The corporate patient education committee (we didn't have one before), the consumer health library, the closed-circuit TV with the patient education channels, and the MicroMedex Care Notes, which is the computerized patient education software.

"Inspiration for both the patient education committee and consumer health library came from colleagues I met at conferences of the American Society for Health Education, which is now the Health Care Education Association, based in Amarillo, TX. I talked to the administration, and both came about.

"Space for consumer information was earmarked in the medical library first, and currently space dedicated to a consumer library has been set-aside in the lobby, which is being renovated.

"We have two channels with educational videos and information on closed-circuit television [CCTV] and a third channel with soothing music and photos. During the night, only the care channel is available on CCTV so that those patients trying to sleep will not be disturbed.

"The patient education committee, with advice from pharmacy and other disciplines, selected the patient education software that makes it possible to distribute patient education materials via the intranet."

Question: What is your area of strength?

Answer: "People skills and timeliness. Obviously with a committee — whether the patient education committee or CME committee — you have to have skills to be able to compromise, negotiate with others, and yet still be able to facilitate and lead them in the right direction or come up with a solution that meets everyone's needs. Also, I am one of those [people who], if you tell me we need something by a certain deadline, do my best to get it done on time."

Question: What lesson did you learn the hard way?

Answer: "The one I am trying to learn is not to

sweat the small stuff. There are lots of different things that happen on a day-to-day basis that, if you keep thinking about them, they could do you in. Therefore, you need to put your efforts into things you can actually change.

"For example, if you are working on a project, you can't own it because it is not really yours. It belongs to everyone. Maybe my goals or expectations are higher than others, so I need to learn to compromise."

Question: What is your weakest link or greatest challenge?

Answer: "Documentation of patient education, which I do not think is unique. It is getting staff to take credit for what they do. In my heart, I think they do a lot of education, but then they just forget to take credit for it.

"Also, decreased staff in our department — over the years, our staff has been decreased, and then those who are left have to take on other duties."

Question: What is your vision for patient education for the future?

Answer: "Getting others to think global and not just about their department or their area. It makes sense that they focus in their area or discipline, but in order to get patient education done, you have to work with others. It is not one department or one person; it is everyone's job. Sometimes, it is hard convincing people that we all need to work together to get patient education done."

Question: What have you done differently since your last JCAHO visit?

Answer: "Since I have been on the chart review team, I have been reporting the patient education statistics to the patient education committee and also, through that committee, we are reporting them to other specific areas.

"For example, we are looking to see if there is evidence that education standards from the Joint Commission are documented in the chart. I bring the overall data back to the corporate patient education committee, and we look at both positive and negative examples. Some areas may be doing better than others, and we might be able to adapt their strategies to improve documentation someplace else.

"Also, we have been revising a form that provides cues to the staff to document patient education."

Question: When trying to create and implement new forms, patient education materials, or programs, where do you get information and ideas?

Answer: "Obviously, you have to think about the regulatory agencies — their standards that you have to comply with — and look at their resource materials.

"I get a lot of ideas from the patient education listserv because there are wonderful ideas and examples people share. I print the forms that I think may be of use to us. When we were revising the patient education form, I pulled a lot of the examples of forms that people had put out on the patient education listserv. We looked at those along with some of the resources from other regulatory places to come up with what we thought would serve our institution." ■

SOURCE

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Consider risks of sharing quality data with public

Address your liability implications first

If your organization is ranked as having lower mortality rates for heart attack patients than any other hospital in your community, your public relations staff probably would want to jump all over this for their next promotional campaign.

Indeed, many hospital web sites now include press releases using publicly reported data to trumpet how they compare to competitors.

But what if the data presented are potentially misleading, due, for example, to differences in patient populations that affect outcomes?

There could be increased liability risks if the organization boasted that its care was safer and this is shown to be unfounded during a malpractice lawsuit, warns **James W. Saxton**, JD, chairman of the health care litigation group at Stevens & Lee, based in Lancaster, PA, and chairman of the American Health Lawyers Association's practice group on health care litigation.

SOURCE

For more information on liability risks of publicly reported data, contact:

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Before using quality data in advertising and marketing campaigns, consider the potential impact on patient lawsuits, Saxton advises.

"We are in a crisis right now throughout the country, with medical liability rates literally driving physicians out of practice," he says.

Therefore, you must balance impressive-sounding quality data with maintaining realistic expectations, notes Saxton, adding that patient expectations right now are at an all-time high.

"Patients assume their providers will be able to cure their problems 100% of the time, that it's done with a smile and conveniently, and when that doesn't happen, that is often what drives patients to lawyers in the first place," he says. "When expectations are out of line with the reality of what is being delivered, we have a potential problem."

Attorneys are poised and ready to use any leverage they can, and that includes your organization's promotion of its comparative quality data, Saxton stresses.

"You need to understand that plaintiff's lawyers are downloading advertisements found on the web and in journals, are taking pictures of billboards that boast of this type of information, and are literally attaching this to the legal complaint they file and using it in the courtroom," he says.

"They literally blow them up the size of a movie screen and say, 'This is what this hospital told the patients in this community. Don't let them tell you that delivering anything less than that is OK,'" Saxton adds.

That type of evidence can be admissible despite the objections of defense attorneys, so juries can consider it along with everything else brought in as evidence.

"And it can be pretty powerful in the courtroom," Saxton explains. "Remember that you always get 12 patients on the jury; you don't get 12 doctors or 12 hospital administrators."

Take these steps to reduce legal risk:

- **Make sure the data are accurate.**

As a quality professional, you play a key role in ensuring that data are not easily subject to misinterpretation from the lay public.

"I think you have to be very careful that the spirit of what you are saying is not misleading," Saxton says. For example, saying that you give safer cardiac care may be a good sound bite, but an attorney can challenge that on a factual basis in court.

"A plaintiff's attorney may say, 'What was it about your organization that you felt was safer?' And if you mention the statistics, they will ask, 'Does that really mean that your hospital is safer for this patient than the health system down the street?' If the answer is no, could the jury get upset about that? Maybe it can affect your all-important credibility," says Saxton.

- **Balance boasting with realistic expectations.**

If you are proud of how you stack up against your competitor and have the data to prove it, it's not a bad idea to brag about it, says Saxton.

"I'm not suggesting that an organization shouldn't use this information for a marketing initiative, but you need to balance it with what I call 'expectation management,'" he explains.

Examples of this include patient education materials such as videos and brochures that explain the risks of medical procedures and a thorough informed consent about surgical procedures, says Saxton.

- **Collaborate with risk managers and public relations staff.**

As a quality professional, your input is essential before publicly reported data are used for a marketing campaign, since you know what will hold up under a microscope — and which statistics may fall apart upon closer inspection, advises Saxton.

"In the past, that collaboration is something that has not occurred, but clearly now that publicly reported data are becoming an important issue, quality professionals need to collaborate with public relations and marketing people," he says. "You will get a healthy tension between the two and will probably end up with about the right balance." ■

Strategies help HIV patients adhere to drug regimes

Management guidelines emphasize primary care

New HIV guidelines address long-term management in the context of a person's overall life and health — and emphasize the importance

of strategies to improve adherence to drug regimens.

The HIV Medicine Association and the Infectious Diseases Society of America, both in Alexandria, VA, developed the guidelines. The guidelines are more about comprehensive general medicine — the primary care of patients, says **Judith A. Aberg**, MD, an HIV/ADIS care specialist at New York University and lead author of the new guidelines.

"They are not specific therapy recommendations. It's more about the general care that a patient needs."

The guidelines cover information such as prevention and early diagnosis of chronic conditions that some patients with HIV may have high risk of contracting, including diabetes and heart disease. The guidelines also address HIV transmission, diagnosis, risk screening, and management. There are special sections on caring for women and children with HIV as well.

Primary care providers should educate patients

Other guidelines may recommend specific therapies but then just brush on drug regimen adherence, Aberg says. "They don't really spend any detailed amount on it."

Adherence, however, is a critical piece to the HIV guidelines. "That is why we emphasize it, she says. "The primary care provider should educate patients about whether they need to be on therapy. And if they should be, [providers should emphasize] how important it is for them to have appropriate follow-up and monitoring and for them to take their medicines."

Adherence is so important to HIV treatment because the long-term effectiveness of HAART (highly active antiretroviral therapy) is dependent on achieving a maximum and durable suppression of viral replication, the guideline authors say. In some clinical practices, however, as few as 40% to 50% of patients achieve this goal. "The primary reason for failure to achieve maximum suppression of virus load, particularly among patients taking initial regimens, is suboptimal adherence to medications."

HAART regimen characteristics can affect patients' adherence to their regimen, the authors explain. This includes the complexity of the regimen, side effects, and the fit with the patient's lifestyle and daily routine. Given this, they recommend the following regimen-focused adherence strategies:

- **Prescribe simpler HAART regimens.** Focus on constructing regimens that involve fewer pills and fewer doses and that minimize food-dosing restrictions.
- **Individualize HAART regimens.** Work with each patient to choose a regimen that is tailored to his or her lifestyle and schedule. Avoid adopting a "one-regimen-fits-all" philosophy. Get the patient involved in choosing and individualizing the regimen.
- **Choose regimens with fewer side effects.** Whenever possible, avoid prescribing medications known to frequently cause very unpleasant side effects.
- **Proactively manage side effects.** Let patients know what side effects may be experienced and how each side effect will be managed if it occurs.

No matter how simple or complex the regimen is, make sure patients understand exactly how to take their medications, the authors say. "Confusion is an important cause of suboptimal adherence. Providing a dosing schedule with photographs of the medications and helping patients to correctly fill a medication organizer with their new medications are two strategies that will help decrease confusion."

Health care providers can assess patients' understanding of the regimen by having them repeat back the regimen, the authors say. Providers also should be open to patients' requests to change their HAART regimen because of side effects.

Measuring adherence to HAART in clinical practice is important, too. "Clinicians should avoid making assumptions about patients' adherence, because these assumptions are usually incorrect," the authors say. "Ideally, the adherence measurement strategy should be easily incorporated into clinical care, be inexpensive, and be helpful in assessing both baseline adherence and the effectiveness of adherence interventions."

Adherence to HAART can be measured by a variety of methods, they continue. The most commonly used methods in clinical trials are patients reporting their own adherence and electronic medication monitoring devices, such as medication event monitoring systems. Other possible ways to assess adherence include pill counts and checking pharmacy refill records. "No single method has been established as the reference standard for measuring adherence; all have advantages and disadvantages. Once a method has been chosen, it should be used consistently to monitor each patient's adherence at each visit," the authors say.

The adherence component of these guidelines is particularly important to pharmacists, Aberg says. "One of the great movements in the past few years has been the pharmacist taking part in patient education."

When patients refill their medications, pharmacists can talk with them about the drugs, discuss side effects, and reinforce that it is critical that they take their medicines every day because of the risk of the medications failing, Aberg says. "Then [the patients] can develop resistance and could potentially lose options. If the pharmacist can [emphasize] the need for adherence, it's very important to the patients' overall care."

The guidelines were published in the September issue of *Clinical Infectious Diseases* and are available free on-line at www.journals.uchicago.edu/CID/journal/contents/v39n5.html. ■

Pilot project uses TV for self-management

Interactive TV gives patients control, reduces costs

"Must-see TV" could find itself with an expanded meaning — in the health care arena — based on an innovative communication program recently launched by Royal Philips Electronics (Andover, MA), Comcast (Philadelphia), and cardiovascular care provider Cardiovascular Associates of the Delaware Valley (CADV; Haddon Heights, NJ).

Focusing on patients with congestive heart failure (CHF) — and who also are likely to have a variety of comorbid conditions — the pilot project is evaluating the use of an interactive television platform to reduce the heavy costs traditionally associated with this demographic group, and, when standard management fails, their frequent hospitalizations or deaths.

Using a platform dubbed Motiva, the broader intent of this initiative is to encourage these patients to be more actively involved in maintenance of their conditions, according to **Jay Mazelsky**, general manager of the new ventures business unit for Philips.

Besides its interactive features, the Motiva system creates "a media-rich environment that allows an experience that the patient finds engaging and incorporates into their life," he notes. This should translate to important modifications of behavior that produce greater compliance with drug regimens, improved tracking of changes in disease status and greater use of relevant health care direction and information, Mazelsky adds.

The key components of Motiva include:

- Weight, blood pressure and other vital signs of the patient are sent daily to a data center so that they can be tracked by CADV clinicians, enabled by Philips home monitoring devices and a wireless set-top on the TV, and a modem supplied by Comcast. This information, especially the tracking of weight, is particularly important for this patient group, Mazelsky notes, since if CHF is not controlled it is characterized by an overload of extracellular water, thus additional weight.
- The vital signs data then are analyzed and tracked by what Mazelsky calls "a system of flags and alerts" that CADV clinicians can use to guide their contacts with the patient. They can either use the interactivity of Motiva to send messages reminding them to take their medications or to see their doctor at regular appointment times, or they can call the patient to better assess his or her overall condition, if that seems needed.
- Built into the system is a strong patient education component. Here, the patient can use his or her TV remote — featuring enlarged buttons designed for use by the elderly or those with difficulty seeing — to select from a menu of preprogrammed health topics, presented as video modules, the topics ranging from diet to smoking cessation to diabetes care. The Motiva program so far offers about 20 such modules, with more to come, says Mazelsky.

Jeffrey Kramer, MD, fellow of the American College of Cardiology (Bethesda, MD) and principal investigator for CADV at the Motiva project, says the system enables what he calls "a virtual house call" on a daily basis. "It has the potential to help us optimize clinical care . . . enhance the patient's quality of life while simultaneously reducing the cost of urgent clinic visits and emergency hospitalizations."

And **Mark Coblitz**, senior vice president of strategic planning at Comcast, points to that company's network investments "to securely deliver interactive targeted and user-friendly video, data and voice services" as an expanded offering to customers.

The key to Motiva's success, Mazelsky says, "is that when [patients] wake up in the morning, this becomes part of their routine and they want to make it part of their routine. You can't force compliance. You have to provide an experience and

activities that engages patients and allows some level of self-management."

The current study, which will involve around 60 patients, grows from an earlier project in Europe, Mazelsky explains, with a somewhat less sophisticated interactive technology, that project comparing remote patient and nurse-call management with what he termed "usual care."

The results of that effort were "exciting," he says. In particular, over a period of 400 days, investigators found a 26% reduction in mortality and nearly a 28% reduction in hospital stays for those remotely managed vs. the usual care group.

More long-range opportunities provided

The current effort is the first for the Motiva system, which he says is distinguished by being "broadband-enabled," thus offering "the capacity to send a lot more data in and out of the home." Additionally, this "very wide bandwidth will provide, down the road, the opportunity to do other things," he says. Those other things would include expanding the virtual house call to what he calls "virtual doctors' office visits — it provides that type of scalability."

Assuming the success of Motiva, Philips is poised to return to Europe with a fully commercialized program, Mazelsky says. "It's under discussion and there's a lot of interest there. Europe is less fragmented in terms of health care, so it makes sense to talk to that market."

The pricing for a commercialized Motiva hasn't been determined yet, he says, but he believes it will be comparable to less interactive, standard remote monitoring services in the $45-$100 per-month range per patient and should prove so cost-effective that it ill be broadly covered by Medicare and private insurers.

"Today, the typical heart failure patient costs the U.S. about $20,000 to $22,000 for hospital readmissions, pharmaceutical regimens, and facility services," he says. And with an annual cost of $226 billion in the U.S. alone, it is "one of the most expensive, very prevalent chronic conditions out there, with 5 million people suffering from heart failure."

Mazelsky makes no specific predictions concerning the market opportunity for Motiva ultimately, but says: "When you look at the tens of millions of the chronically ill, even a small percent being covered by a disease management component such as Motiva, it's a billion [dollar]-plus market in the U.S. alone, five years out." ■

Holistic wound care yields better healing rates

One nurse provides hands-on care, plus CM

The wound care center at Presbyterian Hospital of Plano (TX) takes a holistic approach to patient care by assigning each patient to one nurse who provides hands-on care and case management.

"We found that providing all aspects of patient care and case management was a really good change for us. The nurses have expressed more satisfaction, and we believe we provide better patient care by taking a holistic approach," says **Kathy Zeller**, RN, BS, director of the wound care center, who adds that wound care case managers typically aren't found in the outpatient setting.

The case management piece is unusual in the outpatient setting. The outpatient wound care case management program has paid off in outcomes that have improved steadily, Zeller adds.

In 2003, the hospital's healing rate was 96%. This year, it exceeded 97% in the first quarter and was 100% in the second quarter.

"It has to do with having a good team that works together well," she says.

The staff at Presbyterian Hospital's wound care center all are registered nurses, with the exception of office staff and a nursing assistant.

Nursing staff all are cross-trained to handle both wound care and case management.

"Everyone knows the whole case management philosophy. They can pitch in and take care of patients' needs, document on the chart, and handle all of the patient coordination," she says.

The RNs provide the wound care and work as case managers for their patients, coordinating home health services, durable medical equipment supplies, transportation issues, and making sure the patients get their prescriptions filled.

"They get into the entire realm of case management, including documentation and medical necessity questions as they arise," Zeller says.

Zeller joined the center in 1998. In 2001, she decided to involve all the nurses in the wound care center in case management activities.

"I felt it would work better if everyone was trained the same way to provide the full level of care," she says.

Each nurse case manager handles all the patients of the physicians to whom she is assigned. The case manager accompanies the physicians when they

see the patient and work with the primary care physician on any subsequent issues.

The nurse case managers make sure that everything the physician orders is carried out, that the patients get scheduled for the tests in a timely manner, and that the physician and patient are notified of test results.

The wound center runs 10 half-day clinics at Presbyterian Hospital of Plano, one all-day clinic in Allen, and one half-day clinic in Flower Mound each week. The clinics are staffed by physicians in individual practices, among them a vascular surgeon, plastic surgeon, and a podiatrist. The case managers typically cover patients in one to three clinics.

The rest of the time, she works as an intake nurse or a wrap-up nurse in other clinics, providing the patient education and making sure the patients understand what they need to do at home.

When patients are referred to the wound care center, intake staff handle the precertification or authorization process and send the patient a four-page detailed assessment form. The nurse case manager accompanies the physician on the preliminary examination.

"The physician and case manager are a team. They go from patient to patient during the clinic. The nurse case manager is the primary contact for the patient," Zeller says.

The nurse case managers give their patients business cards and encourage them to call them with any questions about their care at home.

The case manager also is available to the home health nurse or other providers that may be caring for the patient. The patients come every week for the first four weeks and call the nurses if they have any questions. The nurses follow up on biopsy findings and other medical reports.

If a patient has to be admitted to the hospital, the nurse case manager organizes the admission.

The average healing time for most patients is 10-12 weeks. Some heal in a few weeks, and others visit the clinic over a longer period of time.

Some patients with chronic problems are in conservative care and come in every four to six weeks to make sure their wounds aren't getting worse.

The wound center has a vascular laboratory to evaluate patients with circulation problems.

"We offer one-stop care. Quite a few of our patients are elderly, and we make sure they don't have to go all over the hospital," she says.

The hospital contracts with Curative, a Hauppauge, NY-based company that provides wound care management for more than 100 centers and maintains a database of more than 450,000 patients.

The company provides the hospital's wound center with a clinical pathway for the care of patients with chronic, nonhealing wounds, documentation support and other forms, policies and procedures, educational materials, and marketing materials that offer CME programs for physicians and CE courses for nurses. ■

CE 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 certificate of completion. When your evaluation is received, a certificate will be mailed to you.

After reading *Patient Education Management*, health professionals will be able to:

- **identify** management, clinical, educational, and financial issues relevant to patient education;
- **explain** how those issues impact health care educators and patients;
- **describe** practical ways to solve problems that care providers commonly encounter in their daily activities;
- **develop** or **adapt** patient education programs based on existing programs from other facilities. ■

COMING IN FUTURE MONTHS

- ■ Adapting teaching to learning styles in large groups
- ■ Innovative ways to use the intranet/ Internet in teaching
- ■ Creating good policy for interpreter services
- ■ Quick methods for program evaluation
- ■ Jump-start discharge planning upon admission

CE Questions

5. The benefits of creating a checklist to document patient education include which of the following?
   A. Less writing for educators
   B. Quick read for staff following through
   C. Creates a paper trail for documentation
   D. All of the above
6. PDAs improve patient safety in which of the following ways?
   A. Keeping physician phone numbers to call day or night
   B. Downloading databases for quick bedside references
   C. Tracking staff meetings
   D. Keeping notes on information to check at desk references
7. According to James Saxon, JD, which of the following is *not* a step you can take to reduce legal risk when developing patient communication material?
   A. Making sure the data are accurate
   B. Carefully choosing celebratory endorsers
   C. Balancing boasting with realistic expectations
   D. Collaborating with risk managers and public relations staff
8. How much does the typical U.S. heart failure patient cost, in terms of hospital readmissions, pharmaceutical regimens, and facility services?
   A. $50,000-$60,000
   B. $10,000-$15,000
   C. $20,000-$22,000
   D. None of the above

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