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Multilayered DM programs help members stay healthy

Population-based initiatives win accolades for health plan

A series of award-winning population-based and multilayered disease management programs has resulted in high member satisfaction ratings, improved HEDIS scores, and decreased utilization over time by members in the program for Anthem Blue Cross and Blue Shield plans in Indiana, Kentucky, and Ohio.

The program involves mailing materials at least quarterly to members whose claims data have indicated a chronic condition, mailed and telephoned reminders for members who have not received recommended tests and procedures, and referrals to case management for members who have a hospital admission or emergency department visit.

"We have found that layered interventions are very effective, particularly with patients who have had a high hospital readmission rate. Sending outreach reminders, postcards, and automated phone messages has generated statistically significant improvement in their health care behavior compared to those who get only a few notices a year," says **Kim Byrwa**, RN, CPHQ, director for health prevention and disease management for Anthem Blue Cross and Blue Shield plans in Ohio, Kentucky, and Indiana.

In 2004, Anthem Blue Cross and Blue Shield, a subsidiary of WellPoint Inc., received "Leadership in Healthcare" awards for diabetes and chronic obstructive pulmonary disease (COPD) programs from the Bio-Tech Medical Management Association, a Gold Award from the Disease Management Association of America, and an e-Value8 Health Plan Innovation award for asthma disease management from the National Coalition on Business Health.

The Anthem disease management initiatives focus on conditions that are most prevalent among the plan's membership.

"Instead of focusing on small populations that may be high in cost, we tailored our program to conditions that are high in number," she says.

Multidisciplinary teams, led by a health care professional with expertise in that particular condition, designed the programs. The teams

include representatives from marketing, legal, data, and case management. They studied all claims, utilization, and member survey data to design the programs and produce the educational materials that are mailed to members.

"The teams study the data and look for opportunities for us to provide education. We got some feedback that externally produced materials were too difficult for members to understand, or they weren't culturally targeted, so we decided to produce our own materials," Byrwa says.

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Editorial Questions

Questions or comments? Call **Mary Booth Thomas** at (770) 934-1440.

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The materials feature health improvement information and tips such as reminding diabetics to take their shoes and socks off before the physician comes into the examination room, information on new technology and equipment, such as simpler glucose meters, new drugs for that particular condition, and information about the members' benefits at Anthem Blue Cross and Blue Shield.

"The materials are constantly evolving, and we are constantly updating them. Many are similar because they are built upon nationally recommended guidelines, but we try to put different twists on the information to continue to support the recommendations and keep it interesting for the reader at the same time," she says.

The team plans the disease management publications a year in advance, creating different materials for each quarter. One of the most popular features is a custom-produced calendar the health plan sends members in its disease management programs each December. Custom calendars are developed around pregnancy, chronic obstructive pulmonary disease (COPD), asthma, and diabetes.

The diabetes calendar won the Gold Award from the Disease Management Association of American last year.

The calendars are filled with information designed to help members control their disease. For instance, the diabetes calendar has information on how to log low blood sugar and develop a graph, tips and tools to take to the physician, reminders of tests and procedures diabetics should receive, and recipes.

The diabetes calendar is available in Spanish.

"We include a survey in the diabetes calendar and receive a lot of positive feedback from customers after they receive the calendars. They report that they use them every day and share the information with their doctors," Byrwa says.

The health plan has found that materials produced in-house are more cost-effective and better meet the needs of Anthem's own customers than if they purchased materials.

"We have almost half a million members in our disease management programs. Economies of scale make it economical for us to produce our own materials," she says.

Anthem's disease management initiatives are population-based and are offered to every member who has at least one claim identified with a condition for which there is a disease management program.

Members identified from claims data get an introductory letter about their condition and the

disease management program, followed by regular mailings of materials unless they opt out of the program.

"We mail the information to members at least quarterly. Every quarter, they get new and different information that helps them make lifestyle changes," Byrwa says.

The health plan analyzes claims data every month, picking out members who have not gotten the recommended care, such as eye examinations or cholesterol screenings. These are put into the second tier and receive additional information, such as reminder postcards, telephone calls, or voice messages related to what test or procedure they need to have.

Members who are in the disease management program and have a hospital or emergency department visit are referred to Anthem's case management program.

Nurses conduct a telephone assessment and make follow-up calls to make sure the members are complying with their treatment plans.

"The members are still in the disease management program and receive all of the literature and other information. This just adds another level of assistance," Byrwa says.

Anthem has disease management programs for childhood and adult asthma, COPD, coronary artery disease, congestive heart failure, hypertension, depression, childhood and adult diabetes, chronic kidney disease, and normal and high-risk pregnancy.

The prevention portion of the program includes information on smoking cessation, sending mammogram and Pap smear reminders and outreach for members at risk for colorectal cancer, and reminders for members to obtain proper immunizations.

The health plan uses member surveys to find out how they can best meet their members' needs.

For instance, one survey indicated that a number of members in the Appalachian region have a low literacy level. The teams have developed simple education materials geared to this audience that give them the same message as other materials but contain simpler language and more pictures.

When the plan analyzed data on immunizations for senior members, the study showed that African-American seniors with congestive heart failure (CHF) were receiving pneumonia and influenza vaccinations at much lower rates than other members in the CHF program.

The plan started outreach programs through community churches using pictures of African American patients and gearing the message toward "doing this for your loved one," based on research that showed this would be the best way to encourage action.

The health plan worked with Health Care Excel, the agency that has the Medicare contract in Kentucky and Indiana, to develop programs.

"Working with Health Care Excel, we went to churches across the Midwest and asked for help in displaying posters and giving out brochures to encourage these people to obtain immunizations," Byrwa says.

In Kentucky, where cardboard fans are staples in many churches, the health plan and Health Care Excel printed fans with a message reminding churchgoers to get their flu shots. ■

Plan rewards members for healthy behavior

On-line program encourages changes in lifestyles

Blue Shield of California is taking a different approach to cutting health care costs — rewarding members for engaging in activities aimed at improving their health.

Members who are participating in the two-year pilot project log onto the Blue Shield web site and complete activities at least once a week for a minimum of 20 weeks to earn a reward of $75. Members who participate for 28 weeks earn $150. At 35 weeks, the cash reward goes up to $200.

"It's a comprehensive, on-line program to help motivate, support, and reward individuals to work on their modifiable risk factors," says **Deborah Schwab**, RN, MS, director of new product development at Blue Shield.

At the end of the first year of its Healthy Lifestyles Rewards program in December, the San Francisco health plan mailed almost $200,000 to more than 1,100 members for adopting healthy behaviors.

Participants in the program can choose from more than 10 lifestyle modification modules designed to help them increase their exercise, develop healthful eating habits, reduce stress, and stop smoking.

Data from a comparison of the health risk assessments participants took before beginning the program and after a year of participation show:

- The participants in the program lost a total

of almost 5,000 pounds.

• The obese members who chose weight loss as a goal lost an average of 12 pounds.

• There was a 20% increase in exercising 30 minutes a day, three days a week.

• There was a 21% increase in participants who eat at least three servings of fruits and vegetables a day.

• There was a 12% increase in members who rated their ability to deal with stress more confidently.

• 92% of participants reported that they were successful in reaching their goals.

"Health care costs are escalating at a rapid rate, resulting in increases in premiums. When we conducted an analysis to look into the root causes of more expensive health care, lifestyle is by far the biggest contributor to the disease burden," Schwab says.

A multidisciplinary team at the not-for-profit health plan came up with the four focus areas for health improvement after studying the literature to determine which lifestyle changes would be most beneficial to its members.

"We knew that if we could encourage people to adopt healthier habits, it could make a difference in health care cost and claims," Schwab says.

The health plan looked for cost-effective ways to reach its members all over the state and ultimately decided on an on-line program to save administrative costs and channel the savings into providing awards.

Positive reception

Focus groups responded positively to the idea of a health plan rewarding members for staying healthy.

"They rejected the kind of goods, like t-shirts, visors, and water bottles, that traditionally are used in preventive health programs. They said that a premium discount would be great, but their No. 1 choice was giving members a cash reward at the end of the year," Schwab says.

Blue Shield of California worked with Miavita, an on-line wellness promotion company, to produce a customized web site with interactive modules that focus on the four components of the program: exercise, nutrition, stress management, and smoking cessation.

The web site includes interactive tools such as journals and planners, diet tips, recipes, and articles based on the members' interest.

Participants took a health risk assessment at the beginning of the program to help them identify what areas they should work on improving.

Following the program, the members take another health risk assessment to determine whether they have made lifestyle changes.

The company is working with researchers at Stanford University to conduct a claims study of participants in the program.

"The literature tells us that the members should show a modest improvement in claims the first year, and increasing improvements in years 2 and 3," she says.

The program relies on self-reported information about participation.

"We took the approach that we were going to trust people. We require people to participate and log in for 20 weeks. It's hard to lie for over 20 weeks. I'm sure there is a person here or there who didn't do what they reported. But the majority of people have reaped benefits from the program," she says.

The health plan offered the program to 25,000 subscribers, a randomly chosen cross-section of members from all of its products, for the pilot program. Blue Shield employees also are part of the pilot group.

Participation varied widely among the groups, from 2% of one group to more than 50% of another. The plan found that members were more likely to sign up if their employer had an active health promotion program and a health promotion officer or nurse who offered wellness programs.

"We had lower participation from members in sites where their employer prohibited them from accessing the Internet at work," she says.

"We were expecting that the majority of participants would get $150 and fewer would get the $75 and $200 rewards. When the results were in, we were surprised that the majority went the full way and got $200. Once they committed to the program, they kept going," she says.

The majority of people who joined up had goals of weight loss, healthy eating, and stress reduction.

The typical profile among participants was a woman who is overweight and stressed.

The Health Rewards program is loosely linked to the company's other health improvement, case management, and disease management programs.

"We wanted a broad-based program that would appeal to people who were well, but the focus areas we included are fundamental issues for people in a disease management program. They have better results if they exercise, eat well, reduce stress, and

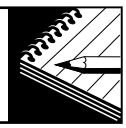
stop smoking," she says.

Case managers have referred some of their members to the program.

The web site refers members who have a question or need to the company's Lifepath Advisor nurse line.

More than 90% of the participants have reported on a survey that the program worked for them and they would do it again.

"We've gotten a lot of notes from people who say that the money reward jump started them to get motivated, but they also add that the real reward for them is better managing their health," Schwab says. ■

GUEST COLUMN 

Approach helps CMs show their effectiveness

Set goals and measure your progress

By **Michael Garrett**, MS, CCM
Commissioner, Commission for Case Manager Certification (CCMC)
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Case managers know that their services potentially can benefit their clients' health, wellness, and autonomy. That impact, however, may not routinely be measured against specific performance indicators. Case management services can produce improvements in health care quality and cost-effectiveness. Those beneficial results, however, may not be systematically tracked and analyzed.

In other words, case managers may not be taking an outcomes-based approach to case management.

Whether they work for an insurance company, a third-party provider of services, or for an employer, case managers may see increased emphasis being placed on documenting, reporting, and improving case management outcomes. In addition, case managers may find that a systematic and well-defined outcomes-based approach is being advocated across the board in benefits programs, from group health to worker's compensation benefit coverages.

While the focus on outcomes may be new to some case managers, the good news is this approach is very compatible with the practice of case management. Case management is, after all, a goal-oriented process.

Outcomes measures evaluate the results of interventions and performance (or, in some cases, nonperformance) of a function or process, which in this situation is case management. In health care, there are many variables that can affect the outcomes from case management, including:

- disease process and severity;
- process of care and treatment;
- patient adherence and abilities;
- competency, skills, and knowledge of the case manager;
- benefit system.

All of these factors must be taken into consideration when developing and implementing appropriate outcomes measures in case management practice.

For example, early on in the case management process, the case manager develops a goal-oriented plan of care by working with the client/patient, family members, and the attending physician. The objective of the plan of care is to move the individual toward health, wellness, safety, adaptation, self-care, and/or rehabilitation. These goals provide the road map for how the plan of care is carried out, including timeframes, assigned responsibilities, and expected outcomes. The success of the case management process is measured by comparing the results to these goals.

In addition, the case manager provides a range of services during the case management process that impact outcomes, including:

- establishing measurable case management goals that promote evaluation of the access, cost, and quality of the care provided;
- identifying the achievement of goals, and differentiating the goals that result directly from case management interventions;
- reporting quantifiable impact, including quality of care and/or quality of life improvements as measured against the case management goals;
- recommending referral sources based on evaluation of the provider's quality of care and ability to meet the needs of the individual;
- maximizing client outcomes through incorporating community-based and other services that are outside the benefit plan, whenever possible.

Outcomes in case management generally can be divided into three categories:

— financial or economic, focusing on cost savings and return on investment, or ROI;

— patient/client satisfaction, based on feedback

from individuals and family members receiving services;

— clinical/functional, looking at the patient's functionality in life, such as the ability to return to work or ability to live independently, depending on the benefit coverage.

These outcomes may be viewed as standalone results or as part of an overall assessment of the effectiveness of case management services. An employer, insurance carrier, or other referral source may place greater emphasis on one outcome over another, based upon its priorities and needs. For the purpose of this article, the outcomes will be discussed separately.

Financial outcomes relate primarily to cost savings from case management services in both workers' compensation and group health. These savings can be achieved in several ways. For example, case managers can contribute to cost savings by eliminating duplicate services and avoiding unnecessary services through timely and appropriate coordination and communication. Case managers also may direct or channel patients to preferred providers/vendors, such as centers of excellence with pre-established reimbursement rates that result in savings to the benefit plan. Typically, case managers report on the cost savings (both gross and net) as well as the ROI, which is calculated by dividing the gross savings by the cost of the case management services.

Patient/client satisfaction gauges the experience of individuals and family members receiving services. This may be accomplished through surveys or other standardized tools, or through grievance mechanisms that collect feedback from those who are unhappy with services received. Increasingly, employers want to ensure that their employees and their dependents have a good experience with the benefits and services provided by case managers. A positive experience can help reinforce the message that the employer cares for the health and well being of its employees and their families.

Clinical/functional outcomes can be measured by a number of different means. For example, in worker's compensation, this may be based on the success of a rehabilitation plan and whether or not the individual eventually was deemed employable and/or returned to his or her job. In group health, clinical/functional outcomes may relate to medical improvement, such as stabilizing the person's condition or returning the individual to his or her previous state of health.

Outcomes are very important to tracking the attainment of case management goals, including when milestones are reached and challenges or obstacles remain. Case managers, however, must be very clear about what their outcomes are based upon, particularly when reporting back to an employer, insurance company, or another involved third party. For example, if financial outcomes are being tracked, the case manager must specify what costs and/or avoided expenses are included in the analysis. There also needs to be an explanation of how the savings are calculated. In terms of patient satisfaction, how the information was gathered must be explained, and the tools that are used must be described. Because there is no widely recognized standard for determining and analyzing these outcomes, clarifying the criteria is just as important as reporting the final results.

Using outcomes to evaluate the impact of case management will help to quantify the process for all involved, from the client receiving the services to the employer and the insurance company. As a case manager, embracing an outcomes approach demonstrates a commitment to providing the best possible care for the patient, while taking into consideration the needs and priorities of all related parties.

[Michael Garrett, MS, CCM, is a commissioner for the CCMC, which is the first and largest certifying body for case management professionals to be accredited by the National Commission for Certifying Agencies. URAC has determined that the CCM credential is a recognized case management certification. Garrett also is vice president of business development for Qualis Health of Seattle, a private, nonprofit health care quality improvement organization that offers programs and services to improve the quality of health care delivery and health outcomes for individuals and populations.

For more information or to obtain an application for the CCM, contact the CCMC at (847) 818-0292 or visit the CCMC web site at www.ccmcertification.org.] ■

Communication is key to client satisfaction

Tips for communicating about pain management

Everyone who works in health care has a list of ideas for what needs to be done to improve client satisfaction, but one theme appears to be a common thread throughout: communication.

"Communication is always a challenge," says **Jan Jones**, RN, BSN, FAAMA, president and CEO

of Alive Hospice in Nashville, TN. "We're looking at how we communicate with the families and how to improve tools we use to communicate," she says. "Pain management is an area where we certainly perform well, but we also feel there are ways we can improve in terms of communicating with families about pain management efforts being made," Jones explains.

Honing employees' listening skills is a goal of Bayada Nurses in Moorestown, NJ, says **Mark Baiada**, president of the company. Bayada has more than 115 home care offices nationwide that work with hospices and care for patients with terminal illnesses. Nurses are trained to listen actively and observe clients' facial expressions to look for nonverbal communication, he says. "We teach them to look at the person's face to see if the person is communicating fear, discomfort, or worry. The patient may be fearful and cannot express how he's really doing," Baiada adds.

Putting the client first

Communication skills constitute an important aspect of coordinating patient care among a multidisciplinary team, says **Christie Franklin**, RN, CHCE, vice president of professional services, acquisitions, and start-up for AseraCare of Fort Smith, AR. When facilities coordinate care, it's important for the patient and caregiver to understand which services will be provided, she notes. "The case manager will review that with the patient and family, and with the facility staff if the patient is in a facility."

There are other important aspects of improving client satisfaction that health care facilities need to implement. Jones, Baiada, and Franklin offer these additional suggestions for improving client satisfaction:

• Focus on pain management, even if patients do not have complaints.

"Typically, we find that families perceive pain to be at a higher level than patients do," Franklin says. "This is something that we're working on, an area where we might be able to do something differently."

AseraCare has held a series of inservice training sessions on pain management this year, offering a focused approach to palliative care, she notes. After AseraCare began to use the family satisfaction survey promoted by the National Hospice & Palliative Care Organization of Alexandria, VA, pain management was one of the top three priorities identified in survey results, she says. "We always focus on pain management, and one of the indicators we are focused on is the amount of pain medication received," Franklin says. "We really look at pain management, how often the patient was treated with respect, and the overall rating of care."

Pain management education has included instruction by pharmacists, who join in conference calls with health care staff, she says. "We have some drug formularies that we review for educational purposes, and we give an overview of all the medications utilized for a facility," Franklin explains. "We had courses in Pain Management I and II, plus the overview of medications and how to use them."

• Improve staffing and access after hours.

"One thing that's always a challenge for us is how after-office care is delivered," Jones says. "As a result of information gathered on patient and family satisfaction surveys, we've made changes in our after-hours staffing." For example, several people surveyed said the facility didn't have someone to respond in a timely fashion after hours, she recalls.

"So that's our trigger to look more in depth at what's happening with our triage system and our after-hours staff and how we need to build it into our budget for more staff," Jones says.

This is how a quality improvement project should work once a problem is identified, she notes. "When we see a trend like that, we delve more deeply, and we certainly go to patient records and talk to family members and get specifics about what their issue was," Jones adds. "We talk to staff, including triage staff, to find out what it was they experienced; and from that, we begin to gather data and look at what needs to be changed, where the gaps are, and what our expectations are for what was delivered," she continues.

• Put the client first.

One speaker who trained Bayada's staff on pain management said to the nurses: "Remember one thing when you come to the door of a [patient]: Just remember to show love," Baiada recalls. "When you show love, you're helping patients with all of the needs they have, including the physical and emotional. So you have to prepare yourself to be of service in a loving and caring way, and to be reliable and have the skills in place so you can do a good job," he adds.

• Families must be able to trust staff.

Also, the client's satisfaction is more important than scheduling concerns, Baiada says. "If the family is dissatisfied with a nurse, then bring in someone new. Staff support is so important because it's a time of crisis for most families, and if one thing goes wrong, they lose trust."

• **Educate staff about client satisfaction surveys and quality improvement.**

AseraCare hospices provide short educational sessions through the lunch-and-learn training program, Franklin reports. These hour-long sessions are conducted by teleconference and are attended by executive directors and directors of clinical services first, she says. AseraCare held these training sessions to show staff how the company planned to use a new client satisfaction survey, including details about the scoring guide, frequently asked questions, and some sample information on the reports generated from the survey information, Franklin explains.

A second teleconference session teaches staff how to complete the survey's spreadsheet and provides them with data to enter during the call, she adds. "We go through the steps of entering data and have the information technologies department on conference call to answer any follow-up questions," Franklin says. "Then we go over the reports and how those are to be reviewed and utilized, and we continue with the training." ■

Do things right, and return to work won't go wrong

Employers can take steps to avoid mistakes

When an employee is out of work for an extended period with an injury or illness, his or her absence creates a physical and emotional void. The work needs to be done, and coworkers and supervisors look forward to the employee's return. That is, unless the employee isn't really wanted back.

While a boss might think that preventing an employee from returning from leave is a convenient way to terminate employment, it could be the first steep step into a lawsuit, according to **Jeffrey M. Tanenbaum**, JD, a San Francisco-based attorney specializing in employment law and occupational safety and health administration law.

Tanenbaum says his clients — employers — encounter problems not because they want to get rid of employees because of their injuries or illnesses, but because of performance problems that existed before the worker went on leave. "When you have someone who simply has not been a good performer, forgetting about the injury or illness, the employer needs to deal with [the poor performance]," he explains. "And the best way to deal with it is to have documented it before the employee ever went out on leave."

Otherwise, if the employee comes back and the employer chooses that point to tell the employee that his or her performance is not working out, "the timing looks suspicious to the employee and to any judge who might hear the complaint," Tanenbaum pointed out. "Even if the employer's intentions are good, you can get into trouble if you haven't documented."

Reasons to complain

Employees terminated during a leave, or who feel their right to return is not being honored, can lodge a grievance for several possible causes, including:

• The Americans with Disabilities Act prohibits adverse action against an employee who is able to perform the essential functions of his or her job "with reasonable accommodation," which can include a reorganized work station, reduced hours, or a flexible break schedule.

• The Family and Medical Leave Act prohibits employers' interfering with guaranteed family or medical leave, and prohibits retaliation against employees who take advantage of leave.

• An employee who files a workers' compensation claim cannot be terminated because of that claim. The penalties for such termination can be costly.

• Violation of the implied contract in the employer's internal policies.

• Violation of a written contract or collective bargaining agreement.

An offer the employee can't refuse?

An option an employer can use is to provide a severance package to the employee, in exchange for release of all claims against the employer, Tanenbaum says. On the one hand, an attractive severance package gives the employee the opportunity to find a new job while drawing a salary — "an extended vacation, if that's how they want to view it," he says. "The downside is the moment you start talking about severance, in their mind, they no longer have a job. They might very well start thinking about a lawsuit because they're not being provided with their rights to return under the law."

Disputes over wrongful termination relating to employee leave are common, but they commonly

are settled before ever going to trial. Proactive steps, which Tanenbaum says "are just good HR [human resources]," and can avoid disputes later on.

When the job or worker has changed

Another issue that can arise when it's time for an employee to return to work is when there's no job to come back to.

"What do you do when the workplace has changed while the employee has been off? For the most part, the law gives employers additional discretion if the job the employee left has been eliminated as part of a layoff," he adds. "However, the employer will still be scrutinized for a nook job that person could fill."

In other cases, it's the employee who has changed. "I recently had a case in which a senior executive was in a car accident and sustained a severe head injury," Tanenbaum recalls. "When he returned, his ability to concentrate was limited, his cognitive abilities were severely impacted, and he was no longer capable of serving in an executive capacity."

This person was fortunate — his company found another position for him and is supportive as he struggles with memory lapses that cause him to forget he's no longer a senior executive.

A situation like this could prove to be a hardship for some employers, but Tanenbaum says the law expects it to be. "It's a cost-shifting set of laws," he says. "They simply put the burden on the employer to bear that, and with more than 10 or 20 employees, it's hard to show that it's a hardship. Certainly, with larger employees — 100 or 200 employees — it would be incredibly hard to show hardship."

Employee policies

Employers inadvertently can give employees a wrongful discharge claim by making certain promises in their return to work policies and then violating them. "They have written extensive policies that go beyond the legal requirements, and then they don't follow their own policies," Tanenbaum says. "Handbook policies are as enforceable as some statutes."

He says employee policies, whether they address human resources issues or safety, should be written as required by law. "And if you add any extras, you'd best do what you say you are going to do," Tanenbaum says.

Another fairly common mistake employers make that can come back to haunt them when an employee goes on leave is neglecting to include a cutoff date for certain types of leave. Workers' compensation is not subject to preset cutoff dates, but other types of leave — maternity leave, for example — should have cutoff dates specified. "Sometimes the policy is not written well enough for employers to say, 'You have no more leave,' and you can't get them back to work; it's like the reverse of return to work," Tanenbaum says.

Another hot-button issue for employees and employers in return to work situations is when employers are required to make "reasonable accommodations" to allow the employee to resume his or her job. "The Americans with Disabilities Act or state law will say you must accommodate that employee, whether it is a change in the work station to accommodate a disability, a computer with dexterity assistance, aids for vision or hearing loss," Tanenbaum explains.

When faced with making accommodations for an employee's return to work, employers need to "engage in an interactive process to determine what a reasonable accommodation would be," he says. "There are a lot of reasonable accommodations readily available, and they are affordable — many cost less than $1,000. It's hard for an employer to say that's a hardship." ■

Tools to help improve teaching, communication

Tailor methods to needs of the organization

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 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.

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 valuable

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," she says.

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

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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.

Teaching tools

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

CE objectives

After reading this issue, continuing education participants will be able to:

1. Identify clinical, legal, legislative, regulatory, financial, and social issues relevant to case management.
2. Explain how those issues affect case managers and clients.
3. Describe practical ways to solve problems that case managers encounter in their daily case management activities. ■

CE *questions*

9. Members identified for Anthem Blue Cross and Blue Shield's disease management programs receive regular mailings about their condition how often?
A. Every month
B. Every six months
C. Annually
D. At least quarterly

10. Members who participate for 28 weeks in Blue Shield of California's pilot project to promote lifestyle modification earn how much money?
A. $150
B. $200
C. $75
D. $100

11. Which of the following communication strategies can be used to improve patient satisfaction in regard to pain management?
A. Focus on pain management, even if the patients do not have complaints.
B. Families must be able to trust staff.
C. Educate staff about client satisfaction surveys and quality improvement.
D. all of the above

12. If an employer does not want a problem employee to return to work after an accident or illness, a safe way to accomplish this is to avoid making reasonable accommodations, as defined by the Americans with Disabilities Act, to facilitate the employee's return.
A. True
B. False

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

CE instructions

Nurses 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 semester's activity with the **June** issue, you must complete the evaluation form provided in that issue and return it in the reply envelope provided to receive a certificate of completion. ■

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.

Benefits of checklists

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,she explains.

"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," Szczepanik says.

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. ■