Patient Education Management™

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

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IN THIS ISSUE

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Improve classroom education with student dialogue

The least effective way to deliver information is to tell it

To improve classroom education, create dialogue. That's the advice of proponents of dialogue education, or learning by dialogue. This approach requires that 50% of the time the instructor is not talking and the students are having dialogue in small groups or in partnership with another person, says **Joye Norris**, MS, EdD, an adult education consultant, curriculum designer, and speaker with Learning by Dialogue, based in North Myrtle Beach, SC.

Designing for dialogue is designing a conversation if it is one-to-one teaching or multiple conversations in a group. The most difficult part for the educator is to let go of a lot of the information usually taught because it is impossible to have a dialogue approach and keep the same level of content in the classroom curriculum, says Norris.

Adult learners must be given an opportunity to take the information and wrestle with it so to speak until they determine how to make it their own, explains **Jane Vella**, EdD, founder of Global Learning and adjunct professor at the School of Public Health of the University of North Carolina at Chapel Hill. "Learning is always active," she says.

EXECUTIVE SUMMARY

Many times, people go to classes and return home with a binder full of notes and nothing more because they have not learned to take the information and make it useful. They have not learned how to put it into their context. To do this, students must actively participate in the learning process.

In this issue, we will look at dialogue education, a form of teaching that requires full participation from students in the classroom that results in learning.

In regular classrooms, the educator determines what to tell the students and how to transmit the information. However, in learning by dialogue, the educator determines what students need to do to learn. This shifts the focus from the instructor to the adult learner, Norris explains. **(For an example of this process, see article on p. 111.)**

Educators do not create a lesson plan; they design a class, says Norris. Design principles are used such as sequence or starting with the simple and moving to the more complex.

Dialogue education is carefully designed. It takes about three hours of preparation for every one hour of class time, Vella reports. There is a seven-step process that can be used to help develop a class designed to foster learning, she explains.

The process begins by asking, "Who are the learners?" They may all be people with congestive heart failure who need to learn how to manage this chronic disease, but that alone is not enough information to design a class tailored to the participants. Get the names and e-mail addresses of a sampling of the students and find out what they expect to gain from taking the class, advises Vella. This is called a learning needs and resources assessment.

Participants may be resources. For example, if a new mother in a parenting class is a nutritionist, she could be made a resource for information.

"You have to know what resources learners bring and also what their expectations of learning are. You don't need to talk to everyone, but you need to get a sample. If 10 are in the class, talk to at least three or four," Vella suggests.

The second step in class design is to determine "why" the participants need to learn the skill selected to be taught.

Norris says to select something from the content that allows participants to practice a skill that will make a difference as they manage a particular health issue. In that way, they will leave with a skill rather than with a lot of notes from a lecture they have difficulty remembering.

The third and fourth steps in the design are to determine the "when" and the "where." The when is the amount of time allotted for the class, and the where is the environment in which it will take place.

It's important to evaluate the time allotted for the class. If there are a series of classes, break the information into teachable segments. If there is only one class, the educator must determine its objective and select the appropriate point or points that fit the timeframe.

Less is more. Educators should be teaching half as much in twice the time if they are serious about wanting people to remember the information and be able to use it, Norris says.

Although there often isn't a lot of choice in classroom facilities, it is important to consider the environment in which the class is being taught. Norris says she once placed a 99-cent plastic tablecloth on the table to improve the atmosphere, and people noticed.

In the fifth step, the educator names the "what" of the course content. In the time allotted, participants must learn how to do a skill; therefore, the course instructor would determine what information was needed to perform the task. Vella says it is important to remember the only way to learn a skill is by putting the information into practice. To learn to ride a bicycle, one must

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Editorial Questions

For questions or comments, call **Susan Cort Johnson** at (530) 256-2749.

Editor: **Susan Cort Johnson**, (530) 256-2749.

Vice President/Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@thomson.com).

Editorial Group Head: **Coles McKagen**, (404) 262-5420, (coles.mckagen@thomson.com).

Managing Editor: **Russell Underwood,** (404) 262-5521, (russ.underwood@thomson.com).

Senior Production Editor: **Nancy McCreary**.

get on and ride it.

Also, instructors need to know that information is only one element of the dialogue approach, Norris says.

The sixth design step is the "what for." In this step, learning objectives are created. For example, in a class for new parents, participants may leave the classroom having properly installed an infant car seat in their automobile.

The final step in design focuses on "how" participants will learn a skill. A good way to teach a skill is to design a learning task, Vella says.

A learning task has four parts that Vella describes as inductive work, input, implementation, and integration. Norris describes these parts as anchor, add, apply, away.

During the inductive work, participants are brought into the content through personal experience, Vella explains. This might be accomplished by having them pair up to discuss a question that connects them to the content, then having a few of the pairs share their answers with the entire group.

The key is to make a connection and ground the topic in the participants' lives. Otherwise, they won't be interested or they will struggle to figure out how the information applies to them, Norris says.

The input, or second part of the learning task, is the points that are to be made. In the implementation, participants are invited to select the point that they think is most relevant and determine how they can implement it. Although they focus on only one aspect of the teaching during the implementation portion, by working energetically on one item they will have learned them all, says Vella.

"During the implementation period, they have learned how to learn the content," she explains.

The fourth part of a learning task is integration. This focuses on what people will do when they leave the classroom. "Often, I like to have the fourth part open questions to the group and say, 'How will you use this when you get home.' They have to be explicit about this projection; it is not just good intentions," says Vella.

It's important to have some indication the participants know they know the information before they leave the room. The indicator of adult learning always is behavioral, says Vella.

When designing learning tasks for a group, make sure each of the different learning styles is addressed. For example, there are visual aids for the visual learners and handouts for those who like to read, says Vella.

Making personal meaning of new information is a key element in learning by dialogue, Norris notes.

To design this type of lesson, the educator must ask the right questions, such as: "How can I create a learning environment that makes them feel more safe?"; "How can they connect this topic to their own lives right away?"; "What at the very least should they know how to do when they leave this session?"; "How exactly is that going to happen?"

Learning by dialogue is connecting with the participants, says Norris. Whether one-on-one or in a group and typically around open questions, it is engaging participants in how the information pertains to their lives. ■

SOURCES

For more information about using dialogue to improve education, contact:

- **Joye Norris**, MS, EdD, Founder, Learning by Dialogue, P.O. Box 3413, North Myrtle Beach, SC 29582. Telephone: (843) 281-8832. Web: www.learningbydialogue.com.
- **Jane Vella**, EdD, Founder, Global Learning Partners. Phone: (866) 284-4572 (toll-free).Web: www.globalearning.com.

Using dialogue in mandated nutrition classes

Participants make content relevant to their lives

Following a nutrition class using dialogue education at a center that oversees the California Women Infants and Children (WIC) Program, participants applauded.

This act of support was quite a transformation from the "I don't want to be here, so let's get this over with" attitude many people generally had when attending the mandated classes.

In addition to receiving coupons to purchase nutritional foods for infants and children, program participants must periodically attend teaching sessions on breast feeding, physical activity, food safety, sanitation, nutrients, and other health topics. The problem was, most of the classes were not working, says **Michael Elfant**, MS, RD, a

public health nutritionist with the California Department of Health Services WIC Program.

To improve classes, the principles of dialogue education now are incorporated into the curriculum design. Rather than teaching nutrition, the instructors teach adults, and that is a big difference, says Elfant. "Education that results in behavior change is very different from just recounting the benefits of a particular food," he explains.

At the beginning of a class, instructors try to have a good open-ended question that invites dialogue between participants and helps them think about their life experiences and how they are connected to the information being taught.

For example, if the topic is on developmental cues for starting infants on solid foods, the instructor might ask participants to turn to the person next to them and discuss two amazing new things their infant did in the last couple of weeks.

The topic then is introduced with good visuals of developmental signs, and participants are asked to recommend different foods that would be appropriate for the various stages. In this way, they learn to apply the information.

"Finally, we try to end with a way for them to visualize and anticipate what they will do when they get home, because it doesn't really matter what goes on in our classrooms; what matters is what they do when they leave," says Elfant.

The classes are only about 20 minutes, so one or two important items are covered rather than lots of information the participants have trouble remembering.

"We try to have the learner do 50% of the talking and the doing so the teacher is doing half the talking or less," says Elfant. ■

Learning centers can be cost-effective

Prove worth through tracking

Learning centers or labs that provide individual teaching opportunities on various health care topics and skills needed for a safe hospital discharge have been proven cost-effective.

According to **Nancy Goldstein**, MPH, patient education program manager at University of Minnesota Medical Center, Fairview in Minneapolis, when the Patient Learning Center opened in 1987, it was able to bill insurance companies for reimbursement. However, with managed care currently covering so many patients, this is no longer possible because the companies pay the hospital a set fee for services.

EXECUTIVE SUMMARY

In our September issue, we ran an article on learning centers or labs, describing how and why they are implemented at health care facilities. When one of our editorial board members reviewed the copy, she wanted to know how the learning centers pay for themselves, especially in this time of very tight resources. She also wanted to know if there was a significant return on investment that justified their existence/continuation.

To find out, we went back to our sources and asked.

Although the learning center no longer receives funds that directly cover the teaching costs, it has proven cost-effective because of the dollars it saves elsewhere.

"When we received reimbursement, we were able to pay for ourselves. We no longer receive reimbursement for this service due to managed care and how reimbursement is handled. The program does save the institution dollars as demonstrated by our research. We have relied on our research findings and performance improvement [PI] data to demonstrate that it is a cost-effective program," says Goldstein.

One study showed a reduction in readmissions for reinsertion or complications with central lines. Another study demonstrated an increase in compliance with a home monitoring device for lung transplant patients.

PI data regarding joint replacement pre-op classes showed a half-day reduction (from a three-day hospital stay) for people who attended the classes.

In a study that looked at discharge planning and included anecdotal feedback from inpatient and home care staff, the staff members said it took half as long to prepare patients for discharge if they went to the Patient Learning Center.

Goldstein has a budget for the center that includes staffing and supplies. The budget is based on her projections for the coming year, and she submits it to administration annually.

The cost to run the patient learning center at University of Wisconsin Hospital and Clinics in

SOURCES

For more information on gaining financial support for patient learning centers, contact:

- **Zeena Engleke**, RN, MS, Patient Education Manager, University of Wisconsin Hospital and Clinics, 3330 University Ave., Suite 300, Mailbox Drop 9110, Madison, WI 53705. Telephone: (608) 263-8734. E-mail: zk.engleke@hosp.wisc.edu.
- **Nancy Goldstein**, MPH, Patient Education Program Manager, University of Minnesota Medical Center, Fairview, 420 Delaware St. SE, Minneapolis, MN 55455. Telephone: (612) 273-6356. E-mail: ngoldst1@fairview.org.

Madison is included in the organizationwide budget for the patient and family education department. The hospital covers salaries and other expenses such as printing, office supplies, and building rental, reports **Zeena Engelke**, RN, MS, patient education manager.

"I submit an annual budget in February just like all other hospital managers and directors. Monthly, I receive department operating expense reports, which reflect our expenses and revenues. The reports also tally the number and variety of sessions provided [i.e., 60 minutes diabetes, 30 minutes Peds ENT pre-op, etc]. This allows us to track growth at the various sites and/or troubleshoot any negative variances," she explains.

Although day-to-day operational expenses are part of the budget, any special projects are funded by grant money. For example, grant money was used to create a box of materials, called a pain kit, filled with items to decrease pain and anxiety.

Engelke says the Friends of University of Wisconsin Hospital and Clinics have been very generous. They provided $15,000 in start-up funds in 1995 and recently gave $50,000 for special projects. Also, the center received $8,000 as part of the Quality through Safety grant program at UWHC.

It is important to prove the worth of the learning center in terms of its clinical value, says Engelke.

"When you consistently provide services that help the patient care delivery to be more efficient or effective, you become an undeniable service. Support from nursing colleagues and other disciplines becomes hugely helpful in articulating your worth to the organization," says Engelke. ■

A patient education model others want to emulate

Provides pre-op education for successful surgeries

Hospital for Special Surgery, a 142-bed acute care surgical orthopedic facility in New York City, has developed a patient education model that others want to duplicate. Most recently, Great Britain's National Health Service asked staff from this New York hospital to help them design a similar program for a new orthopedic center that includes pre-op teaching.

This educational model makes sure the patient has all the information he or she needs for a successful surgery. Patients are taught everything from A to Z in a pre-op class so they know what will occur during the course of their hospitalization. At that time, they meet their health care team and discharge planning is begun, explains **Suzanne Graziano**, RN, MSN, ONC, CNA-BC, director of patient education programs.

Education is part of clinical pathways developed by interdisciplinary teams for orthopedic populations. A 10-chapter manual for patients that covers every topic pertaining to surgery and recovery is given to all patients.

At the helm of these efforts is Graziano, who oversees and provides direction for all patient education programs and initiatives at the hospital.

"As part of my role in this position, I take a look at different trends and patient issues that we may need to develop an interdisciplinary response to in regards to patient care needs," she says.

There are several committees that she either chairs or sits on as a regular member. These include the Executive Nursing Council, Fast Track Total Hip Team, Patient Education Council, Arthroplasty and Spine Team, Nursing Practice Council, Discharge Utilization Review Team, and Quality Improvement Committee.

About 5,000 patients attend the pre-op education program annually. Patient educators conduct the classes with the aid of a physical therapist. Graziano oversees three full-time patient educators, two of whom are RNs and one who is a social worker; one part-time educator; and a secretary. She reports to the vice president of nursing.

Graziano came on staff at Hospital for Special Surgery 19 years ago as a new graduate. Within a year she was promoted to a head nurse position, and a year later she became a nurse manager. She

SOURCE

For more information about the educational process at Hospital for Special Surgery, contact:

- **Suzanne Graziano**, RN, MSN, ONC, CNA-BC, Director, Patient Education Programs, 535 E. 70th St., New York, NY 10021. Telephone: (212) 606-1263. E-mail: GrazianoS@HSS.EDU.

has been director of patient education programs for 12 years.

In a recent interview with *Patient Education Management*, Graziano discussed her job, her philosophy on patient education, challenges she struggles with, and the skills she has developed that help her in her profession. Following are the answers to the questions posed:

Question: What is your best success story?

Answer: "We are celebrating our 10-year anniversary of our interdisciplinary pre-op patient education program. During that 10 years, the team and I have provided patient education to over 30,000 patients and their family members. That is a huge milestone and an unbelievable success story.

Our model is a program that works again and again. It really features the patient and how we can best provide his or her care and educational needs."

Question: What is your area of strength?

Answer: "I have very strong leadership qualities. I am not a procrastinator; I get the job done. Also, I am a quick thinker and I look at the whole picture.

Really, I am very compassionate in regards to the care and the needs that outpatients go through. I'm a good listener and very organized, and I think those are all strengths in regard to this position."

Question: What lesson did you learn the hard way?

Answer: "Everything is a process. It takes time to do things right, especially when you use a team approach and you are depending upon other interdisciplinary team members. You need everyone's input and you need to take a look at the whole picture."

Question: What is your weakest link?

Answer: "I try to do too much in a given day. When your schedule is so full you tend to lose focus. In order to be creative and again to see the whole picture you need to have balance in your life, not overloading the day but approaching it from a more holistic view."

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

Answer: "Education is a critical part of patient care and I believe all health care providers need to keep that as a top priority and stress its importance. Every health care organization needs to put patient education as their top priority, and it is something that definitely needs to be budgeted. If you want patient satisfaction to be high and compliance to be high, there needs to be budgets developed to help improve patient education. Technology is very important, but we can't lose that human communication, that human touch."

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

Answer: We were surveyed in June of 2004, and in preparation for that visit we needed to implement an interdisciplinary patient education record for the whole hospital. We now have a division in the patient's record, a tab titled specifically for patient education, on which the staff documents. It is easy to use, and you can see exactly when the education was provided and the response from the patient or family member.

"Creating the form was a process that took three years."

Question: When trying to create and implement a new form; patient education material; or program where do you go to get information/ideas from which to work?

Answer: "First we do a literature search to see what is out there already. In addition, at the Hospital for Special Surgery, we have experts from all areas so whenever we are developing something we pull together the experts and we listen to our patients. Overall a literature search, pooling together the staff as experts, and listening to our patients gives us the information we need to build or work on." ■

Redesign cuts LOS, reduces denials, improves care

Model integrates case management, social work

A clinical redesign project partnering social work and case management has resulted in a 15% drop in length of stay and a 66% reduction in denials during a period when the average number of cases increased by 24% at Children's National Medical Center in Washington, DC.

"Our denial rate now in terms of total patient days is very low. It's 1.5%. We have reduced our denials because, with our redesigned model and intense focus on moving patients through the plan of care, we have been able to reduce medical unnecessary days," reports **Mary Daymont**, RN, MSN, CPUR, manager of case management.

New department created

The redesign created the clinical resource management department, combining the previously fragmented utilization management, case management, and social work functions.

Before the redesign, the case managers were under the performance improvement department, utilization was part of medical records, and social workers were in the department of family services.

"Each department had the family at its core, but each had a different vision statement. We didn't have good interdisciplinary teamwork, and discharge planning accountability was variable," says **Brenda Shepherd-Vernon**, MSW, LICSW, director of social work, child life, language services, and pastoral care.

In 1998, the year before the redesign was implemented, the hospital was facing a tough managed care market and competition from other facilities in the region.

"Denials were way out of control, totaling more than $8 million a year. The managed care payers perceived our facility as providing inefficient and very expensive care," Daymont explains.

High-risk and high-dollar cases were a problem for the hospital. One case that grabbed the attention of management was a patient who accrued more than $1 million in charges but did not meet medical necessity.

When the administration mandated a clinical redesign, the team began looking at ways to improve inpatient care coordination.

Working with **Karen Zander**, RN, MS, CS, CMAC, FAAN, principal and co-owner of the Center for Case Management in South Natick, MA, the team integrated the case management, utilization management, and social work functions into one cohesive department.

Kathleen Chavanu, the hospital's executive director of quality and clinical support services, led the effort to redesign the hospital's clinical resource management model.

"Our goals were to reduce denials and length of stay, to improve care coordination, to hold all team members accountable, improve our relationship with external payers, and to change their perception of the hospital," Shepherd-Vernon says.

Two case management positions

Under the redesign, there are two case management positions:

- **Case Managers I** have a bachelor's degree and are responsible for utilization review and denials management, working with the on-site review nurses, interfacing with the health care team and insurance company, and managing reviews of observation and admission status.
- **Case Managers II** have a master's degree and are responsible for family meetings, discharge planning, and coordination of care while the patient is in the hospital.

A Case Manager II and a social worker are assigned to each unit, typically covering 26 to 28 beds. The exception is the neonatal intensive care unit, with 40 beds.

The team can cover the extra load because the patients have a longer length of stay and there is more time to arrange post-discharge services, Daymont explains.

"We had to educate many of the people in the Case Manager II positions. They were strong clinical nurses and educators but were not familiar with utilization management. We had to educate them to start thinking about resource management," she adds.

Social workers are on site at the hospital from 1 a.m. to 8 a.m., Monday through Friday.

The unit-based social workers are on duty from 8 a.m. to 5 p.m. In addition to their duties on the unit, they respond when called to work with the outpatient services team.

A social worker covers the emergency department from 4:30 p.m. to 1 a.m., responding to trauma codes and handling other issues in the emergency department.

Two social workers split a part-time position, covering the hospital for 10 hours a day on weekends. Working hours for case managers are 8:30 a.m. to 5 p.m., but the Case Manager II staff often work longer. Case Manager IIs are on call for their unit Monday through Friday after hours.

A weekend case manager is on call but comes to the site if the census is high.

To increase communication and facilitate patient care, the hospital implemented interdisciplinary clinical resource management teams that

make rounds on all units. The team includes the physician, social worker, case manager, and nurse.

"The rounds were added in after the initial implementation of the program. When we first redesigned the model, we had people who were together on a team but who were engaging in parallel play. There was not a formal process for sharing information, and there was a lot of distrust between the different groups," notes Shepherd-Vernon.

The team holds clinical resource management rounds every day after the physician rounds. The nurses, social workers, and case manager on each unit establish a plan of care for the day and for each patient's stay.

"Everybody leaves the rounds with an understanding of what they have to do that day," adds Daymont.

Goals of the project

The goals of the redesign project were to reduce length of stay and denials and to establish clinical pathways with outcomes.

The department installed a computerized documentation system and developed databases to make it easy to run outcomes reports and analysis.

The unit-based teams focused on looking at denials, how they were being managed, and why they were happening. They provided those data to the clinical resource management team.

"We looked at where the areas of problems were. We can provide information on length of stay by unit and by diagnosis. The high volume diagnoses seemed to be the area where we didn't have a good handle on coordination of care and length of stay," Daymont explains.

The hospital uses the Pediatric Health Information System (PHIS) database — a collection of data from a number of freestanding pediatric academic medical facilities — to benchmark its outcomes.

"If the length of stay was above the PHIS average, it indicated we were not providing efficient services and that was an area where we needed to focus," Daymont continues.

Implementing clinical pathways

Each clinical resource management team chose clinical pathways to implement, ultimately implementing 52 clinical pathways hospitalwide with the goals of facilitating coordination of care and improving length of stay and clinical outcomes.

The hospital's new onset diabetes pathway dramatically reduced the length of stay and improved coordination of care to the point that a large payer contracted with the hospital to be its disease management entity for children with diabetes.

Under the new system, the social workers begin discharge planning at the beginning of the stay, anticipating any psychosocial issues or other problems that could affect the patient and be a barrier to discharge.

"We have become more proactive as opposed to reactive to discharge and family issues as soon as the patient is hospitalized," Shepherd-Vernon says.

The team developed the social work initial assessment and risk tool, a communication tool that clearly states the pertinent information that all team members need to make assessments.

Barriers to discharge are identified

The social work assessment identifies barriers for discharge, providing a clear understanding for all team members what the impact of the patient's condition and hospitalization is likely to be on the family, Shepherd-Vernon says.

"We get an idea from admission what the potential problems may be for the family and document it clearly in the medical record," she adds.

For instance, the social worker may find out that the patient's mother uses a walker and may have a problem taking care of the child upon discharge. The social work assessment communicates this to the case manager, who may not have met the mother.

The department's family service associates assist the social worker and help identify resources needed to plan for the patient and family.

"Families of hospitalized children often have a lot of different things going on in their lives, and we don't always get the correct information at admission. We were spending a lot of time learning about the family and what kind of support they need. This role is critical in helping stretch social work resources," Shepherd-Vernon points out.

The social work team developed a computerized data collection tool to help track how many families they assist and what they do for them.

"We needed to know more about our families and to be able to work with families at a greater level than in the past," she adds.

"This tool helped us compile information about what the staff are actually doing. It also

includes readily accessible resource information that helps us move from a passive, traditional social work model to a proactive, efficient, and streamlined work force," Shepherd-Vernon explains.

In 2001, social workers performed an assessment on 26.9% of patients who stay in the hospital 48 hours or more. By 2004, the figure had jumped to 73.9% of patients who are assessed by social workers. The family services associates and the computerized data have enabled the department to increase the figure with the same 10.5 full-time equivalents, Shepherd-Vernon says.

The case management department developed the Interdisciplinary Patient and Family Education and Discharge Planning Record, called the "pink sheet" because it's printed on bright pink paper.

The case managers record discharge planning activities, what has been done, and what the next step is. If the case manager is working with another family or the discharge takes place after hours, the nurse or physician handling the discharge readily can see the plan.

"One of the benefits for the entire team with the pink sheet is that it makes clear what needs to happen when patients are discharged," Daymont explains.

"It the patient is discharged after hours or in the evening, the hospital staff have the phone number for the post-acute care provider, what services the patient needs, and the information the agency needs," she adds.

Interdisciplinary review board established

The hospital established an interdisciplinary complex case review board that includes representatives from business operations, legal, admission, financial, as well as social work and case management.

The team meets monthly or twice a month if necessary to review complicated and complex cases and come up with interventions that will help move the patients through continuum.

For instance, the hospital frequently has patients who are on a social hold, waiting for a child protection agency to make the next move.

"In the past, staff who were working directly with the patient got frustrated because they felt that nobody was listening. The complex case review board gives them a forum in which to discuss the options for these patients," explains Shepherd-Vernon.

Since implementation, the hospital has been able to retain 40% of total charges.

"The legal department has been instrumental in having discussions with the legal representation for the District of Columbia Protective Services agency and, in some cases, the family court superior judge," she adds.

"We've had local agencies reimburse us for charges that are being denied because they don't meet medical necessity, thanks to their intervention," Shepherd-Vernon says. ■

New hospital uses tried-and-true CM practices

Collaborative approach includes daily rounds

Daily multidisciplinary rounds, a full-time medical director who is part of the clinical resource management team, and a clinical resource manager who acts as an additional resource for the case managers on the floor were chosen carefully to promote better patient care when the case management model was developed at the new Memorial Hospital Miramar (FL).

Although the 128-bed community hospital, which opened in March, doesn't have enough data for definitive outcomes, so far staff have been successful meeting the CMS Quality Indicators, keeping avoidable days to a minimum, and earning high scores for discharge planning on patient satisfaction surveys, says **Patricia Wilds**, RN, BSN, CCM, director of clinical resource management.

The hospital, part of Memorial Healthcare System in South Broward County, FL, based its integrated CM model on tried-and-true practices from the other hospitals in the system.

"The case management model has been ongoing at other facilities in the health system and has evolved over the past four to five years. It includes the director of clinical resource management and the clinical resource manager, and a physician. Bringing a physician on board to direct the process is something the entire system started doing several years ago," reports **Eric Freling**, MD, director of medical affairs for the hospital.

The clinical resource management team at Memorial Hospital Miramar includes six RN case managers, one full-time master's-prepared social worker, Wilds, the director, and **Anna Carter**, RN, MS, manager of clinical resource management.

The case managers and social worker stagger their arrival time to cover the hospital from 7:30 a.m. to 6 p.m. They rotate being in the hospital for eight hours a day on Saturdays and Sundays and on call 24 hours a day. Case management duties include utilization review, discharge planning, screening, resource consumption management, and patient education.

A case manager staffs the emergency department Monday through Friday, screening to make sure patients meet admission criteria, starting the discharge planning if patients need it, and initiating some of the protocols for the core measures.

Carter's role is to be an extra resource for the case managers on the floor and the admissions nurse. In addition to attending the daily rounds, she monitors the discharge planning process and double-checks to makes sure everything is in place when it's time for the patient to go home.

"The case managers call me when they're not sure if the patient meets the InterQual criteria. I identify any high-risk and high-cost patient and assist in ensuring that they are getting the care they need in a timely manner," she says.

Freling is an integral part of the clinical resource management team and spends 50% of his time working with them to make sure patients meet criteria and helping move them through the continuum of care, a role that Wilds and the rest of her staff welcomes.

"Since this is a new hospital, many of us came from other facilities where we didn't have a medical director or physician advisor who devotes so much time to the program. We have found it to be very helpful in providing top-quality patient care and moving patients through the continuum as quickly and safely as possible," Wilds says.

Daily rounds

Daily rounds on all patients by a multidisciplinary team are a key component of the hospital's collaborative approach to patient care. A core team, which attends daily rounds on all units, includes Wilds and Freling, along with representatives from dietary, physical therapy, pharmacy, and infection control.

The core team moves from unit to unit, attending rounds on all patients every day with the nurses and case managers assigned to that particular unit. The hospital's chief financial officer accompanies the team on rounds as a way of finding out what is going on in the hospital.

"She's very receptive to learning about the medical processes and how the case management department works. This is an asset to our department because we have support from the administration," Freling says.

The team looks at the patient's diagnosis and demographic information, progression of care, where the patient is in the continuum, whether the treatment is following standards of care, and makes sure the core measures are being followed, if applicable.

"Our walking daily rounds emphasize team management of patients. We talk about the progress of the patient, based on their diagnosis and symptoms and make sure the standard of care for that diagnosis is being followed," Carter explains. For instance, the pharmacist may make sure the antibiotic prescribed is appropriate for the diagnosis, or the dietitian may determine whether a stroke patient needs a swallowing evaluation.

"We look at the patient's age and social issues, discharge plans for the patient, and what we need to do, so that when they become stable from a medical standpoint, they'll be ready to go home," Wilds says. For example, if the patient needs a dietary consultation or labs before discharge, the team facilitates that taking place.

"We look at whether these services could be done in another setting and look every day at the level of care to see if the patient is ready to be moved through the continuum," Carter says.

If the patient needs a test to be discharged and the schedule is full, Freling talks to the department head to make sure the test gets done.

When the team conducts rounds on the intensive care and telemetry units, it looks at whether the patient can be weaned from the vent or the drip, and whether there are end-of-life issues or reasons to call a family conference on the patient's condition. "We are very proactive. If we see something that needs to be done, we assign a member of the team to call the physician," Freling says.

The team has found it useful for the nurses who care for the patient to accompany them on rounds. "Sometimes, they have an emergency and can't give us information. When they can be there and give us a report and talk about the case, it helps us come up with ideas about how to best manage the patient's care," he adds.

For instance, the team may suggest to the nurse ideas to discuss with the physician, such as a need for wound care or physical therapy or a dietary consultation. "When the nurse is right

there and involved, the result is more efficient patient care," Freling says. If the case managers are having trouble getting documentation or ensuring that the CMS Quality Indicators are in place, they can call on Freling to intervene with the physician.

Attending physicians find the clinical resource management team a valuable resource that helps them coordinate their patients' care and make sure that tests and other procedures are carried out in a timely manner, he says.

"This team gives us the ability to have an overview from 30,000 feet of what is going on with the case. We can make suggestions when something might have been overlooked, allowing interventions to be made in a more timely manner so discharge planning can move ahead more quickly," Freling adds.

An admissions nurse reviews all the patients who are admitted to the hospital and handles preauthorization and screening for InterQual criteria. The admissions nurse is part of the admitting and registration department and works closely with the clinical resource management team to ensure that all patients meet criteria for being in the hospital.

"There is ongoing communication between the admissions nurse and the case manager on the unit. We are always looking at criteria and getting the clinical information needed to document that the patient meets criteria," Wilds says.

For instance, if a patient with congestive heart failure comes into the hospital as a direct, the admissions nurse asks the admitting physician if he would like to use the standing order sets for congestive heart failure and then initiate them. The emergency department case manager will do the same if the patient comes in through the emergency department.

Both communicate with the case manager as well as the nurse on the unit that the patient is coming and that they should begin implementation of the orders when the patient arrives.

The admissions nurse applies InterQual criteria for severity of illness and intensity of service based on information given by the physician's office or the emergency department.

If more information is needed, such as a chest X-ray performed in the doctor's office or further documentation, the admissions nurse gets in touch with the physician's office. The resource management team does the follow-up review the next day during the daily rounds.

"Because there is constant communication between the admissions nurse and the case manager on the floor, we've been successful in obtaining the documentation needed to ensure that the patients meet criteria," Wilds says.

During rounds, the team makes sure that the patients meet criteria for continuing to stay. If the

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

- Lung cancer prevention education
- The education continuum between bedside and home
- Education's role in reducing health disparities
- The wisdom in creating readable consent forms
- Writing vs. purchasing intranet teaching sheets

CE Questions

13. A class design based on dialogue education would have which of the following?
A. At least 50% learner participation.
B. A learning task.
C. A way to help participants connect with the topic.
D. All of the above.

14. To prove the worth of its Patient Learning Center the University of Minnesota Medical Center, Fairview in Minneapolis did several studies including one that showed a decrease in readmissions and another that showed an increase in compliance when patients were taught at the center.
A. True
B. False

15. A clinical redesign at Children's National Medical Center resulted in a 15% drop in length of stay and a 66% reduction in denials.
A. True
B. False

15. What percentage of his time does the medical director at Miramar Memorial Hospital spend on case management issues?
A. 50%
B. 25%
C. 40%
D. 10%

Answers: 13.D; 14. A; 15. A; 15. A.

patient does not meet InterQual criteria, the case manager calls the physician to ask for additional information and to talk about whether the patient is stable enough to be discharged.

If the physician doesn't have additional information or is resistant to discharge, Freling gets in touch with the physician and makes sure the documentation is in place or plans are made for the patient to be discharged.

Having a physician on the clinical resource management team is an asset to the success of the department, Wilds says.

"He adds credibility to what we are saying and can clarify our concerns from a medical standpoint. It's a great advantage to have him on the team," she adds. ■