Patient Education Management™

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

THOMSON™
AMERICAN HEALTH CONSULTANTS

IN THIS ISSUE

- Resource centers becoming important tools for patient education . . . . . cover
- Field-test education materials for easy reading 64
- Tips from those in the know. 66
- How to's of field-testing . . 67
- Program keeps AIDs patients out of the hospital. 68
- Screening, intervention for postpartum depression. . . . 69
- Getting around rebound headaches 71

Financial Disclosure:
Editor Susan Cort Johnson, Editorial Group Head Coles McKagen, and Managing Editor Jill Robbins report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study. Consulting Editor Magdalyn Patyk reports a consultant relationship with Pritchett and Hull Association.

JUNE 2006
VOL. 13, NO. 6 • (pages 61-72)

Making resource centers an extension of bedside and clinic education process

Assemble collection of resources and work to reach people

Most bedside education in hospitals provides patients and family members with what is frequently referred to as "survival skills" for a safe discharge.

However, there is much to learn about diseases and conditions that resource centers can provide. "We have some very educated clients that are interested in a lot more information than a preprinted pamphlet on heart disease, for example," says **Susi Frederick Miller**, MLIS, director of the medical library at Riverside Hospital in Columbus, OH.

Patient and family resource centers can complement bedside teaching in many ways. In addition to allowing patients to explore a topic in as great a depth as they desire, patients can learn on their own time and at their own pace not when staff have the time to answer their questions, Miller says.

The information patients and their family members get at The Learning Center at M.D. Anderson Cancer Center in Houston supplements the teaching received at bedside or at clinics, says manager **Elaina J. Cundiff**, MPH. Often patients have questions about their disease and treatment

EXECUTIVE SUMMARY

Resource centers can be a valuable education tool providing opportunities for patients and family members to gather information that time constraints prevent them from obtaining during clinic or hospital teaching sessions.

This month we look at ways to make resource centers effective tools for patient education by examining how to best meet the needs of the population served.

options — questions they need answers to in order to make an informed decision.

"Patients receive customized service. The information is customized to their learning ability, their learning needs, and where they are in their disease continuum," Cundiff explains.

For example, a newly diagnosed cancer patient would need different information than a patient who has had a recurrence of cancer after 25 years.

Resource centers are comfortable places to learn, says **Patsy Rann**, CRTT, RCP, CHIS, family library coordinator at Children's Healthcare of Atlanta Max Brown Family Library at Scottish Rite. Often, parents are scared or intimidated yet try to put on a good face in front of their child. Going to the library is a normal experience during a stressful time, Rann explains.

Patient Education Management™ (ISSN 1087-0296) is published monthly by Thomson American Health Consultants, 3525 Piedmont Road N.E., Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals postage paid at Atlanta, GA 30304. POSTMASTER: Send address changes to **Patient Education Management**™, P.O. Box 740059, Atlanta, GA 30374.

Subscriber Information

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

Subscription rates: U.S.A., one year (12 issues), $489. Outside U.S., add $30 per year, total prepaid in U.S. funds. Discounts are available for multiple subscriptions. For pricing information, call Steve Vance at (404) 262-5511. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue date. **Back issues**, when available, are $82 each. (GST registration number R128870672.)

Thomson American Health Consultants is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation. Provider approved by the California Board of Registered Nursing, provider number CEP 10864. This activity is approved for 18 nursing contact hours per year.

Opinions expressed are not necessarily those of this publication. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought for specific situations.

This activity is intended for nurse managers, education directors, case managers, discharge planners, hospital clinicians, management, and other health care professionals involved in designing and/or using patient education/staff education programs. It is in effect for 24 months from the date of publication.

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: **Jill Robbins,** (404) 262-5557, (jill.robbins@thomson.com).

Editorial Questions

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

In addition, families often feel they aren't being heard at the bedside, and rather than being told what they want to know they are being told what they need to know. In the resource center they can ask their own questions. And knowledge, Rann says, empowers parents to advocate for their child.

Resource centers provide more teaching tools than those that would be presented at bedside, says **Magdalyn Patyk**, MS, RN, BC, patient education program manager at Northwestern Memorial Hospital in Chicago. For example, while there are many educational videos on the patient TV station it is impossible to include everything there is to show on closed-circuit television.

At consumer libraries, there can be many other resources that aren't available at bedside.

Gear resources to patient population

The selection of resources will depend on the amount budgeted and the patient population served. The majority of resources at M.D. Anderson are on cancer topics; however, because it is promoted as a consumer health library about a third of the collection relates to chronic conditions such as heart disease, says Cundiff.

The resource center at the Scottish Rite campus of Children's Healthcare of Atlanta has materials for all age levels and reading comprehension levels including material for children, says Rann.

It's important to deliver information in a variety of formats to adequately address various learning styles, says Cundiff.

Staff members at the M.D. Anderson consumer library have access to everything from basic print materials from the National Cancer Institute to 4,000 medical journals and about 80 medical databases.

"We are fortunate to piggyback with our research medical library on site and we belong to a consortium of libraries. Therefore, we are able to provide more sophisticated levels of information than an average consumer health library," explains Cundiff.

Rann says the Max Brown Family Library has models, posters, and a color copier to print pictures from books, which parents can use to gain a greater understanding of their child's health condition. Also, there are books and videos that can be checked out for use during the hospital stay.

Parents receive bookmarks on which to write information and the library staff will make single

copies of pages from the book if parents ask. Rann says she encourages parents to start a notebook if their child has been diagnosed with a chronic illness as their knowledge base will grow. There are also interactive tutorials on-line for children to learn about their disease.

Providing access to various databases is important, says Miller. At the medical library at Riverside Hospital consumers can obtain information from consumer health-oriented databases, such as the Mayo Clinic Resource Center, and medical research databases such as MD Consult.

With Internet access it is wise to post information at each computer that explains how to evaluate a web site to determine if it is reputable, says Rann. Also post disclaimers, she advises.

"Everything that comes out of my hand that I research is stamped with a disclaimer that says: This is for your information only and does not reflect the opinions or policies of Children's Healthcare of Atlanta. Please consult your doctor or staff if you have any further questions," Rann says.

Whatever resources are offered, it is important to do your homework before making the purchase, says **Mary L. Gillaspy**, MLS, MS, manager of the Health Learning Center at Northwestern Memorial Hospital in Chicago.

SOURCES

To learn more about how resource centers might complement bedside teaching, contact:

- **Elaina J. Cundiff**, MPH, manager, The Learning Center, M.D. Anderson Cancer Center, 1515 Holcombe Blvd-Unit 312, Houston, TX 77030-4009. Phone: (713) 745-8064. E-mail: ecundiff@mdanderson.org.
- **Mary L. Gillaspy**, MLS, MS, manager, Health Learning Center, Galter 3-304, Northwestern Memorial Hospital, 251 East Huron St., Chicago, IL 60611-2908. Phone: (312) 926-9693. E-mail: mgillasp@nmh.org.
- **Sandy Keno**, MEd, librarian, Sacred Heart Medical Center, 101 W. Eighth Ave., Spokane, WA 99220-2555. Phone: (509) 474-3094. E-mail: kenos@shmc.org.
- **Susi Frederick Miller**, MLIS, director, medical library, Riverside Hospital, Columbus, OH. Phone: (614) 566-5740. E-mail: SMILLER5@OhioHealth.com.
- **Patsy Rann**, CRTT, RCP, CHIS, family library coordinator, Children's Healthcare of Atlanta Max Brown Family Library at Scottish Rite. Phone: (404) 785-2166. E-mail: patsy.rann@choa.org.

When purchasing books that are not standard text or reference works find two positive reviews before adding them to your collection, she advises. "If you don't have time to do that you can go with one really solid review from a reputable source such as the *New England Journal of Medicine*," says Gillaspy.

To find basic resources, she suggests patient education managers purchase "Introduction to Reference Sources in the Health Sciences," published by Neal-Schuman.

In addition to reference materials, many resource centers offer recreational materials, such as novels, magazines, and movies, to help families ease the stress of having a loved one hospitalized.

Other important resources include trained staff and a private place to talk with people about their information needs should they have a sensitive health issue.

Assessing patient needs

Whether patients and family members are willing to discuss their needs at the information desk or require a secluded area, with so many choices available at most resource centers some guidance is usually required.

"It's important for library staff to be very aware of the different levels of interest and education and not to overwhelm folks but really gauge the amount of information they want by asking direct questions and looking for indirect cues," says Miller.

Consumers are asked if they would like to look at medical textbooks, read current research articles, or search medical databases. Find out what questions people have, Rann says, and then work with them to find the answer.

While Sacred Heart Medical Center in Spokane, WA, does not have a resource center specifically for patients, the staff medical library is open to the public. **Sandy Keno**, MEd, the librarian, encourages staff members to ask patients and family members if they already have basic information and then probe further about more in-depth details.

It's also important to find out how much time they have to spend researching the topic. When information is given let people know that what is described in the material may not exactly mirror the diagnosis and should be discussed with the patient's physician. It's important that patients don't jump to conclusions about worst-case sce-

narios, explains Keno.

Cundiff recommends that staff initiate conversation by asking people how they can be of help. Often people will ask for specific information, such as details about a cancer treatment. Sometimes the request is for everything available on breast cancer, which would be an overwhelming amount of information.

To accommodate this staff members must help the patient determine exactly what information might be helpful. For example, they might ask what the specific diagnosis is and follow this answer with a question about the treatment options the physician discussed with the patient.

A helpful tool developed at M.D. Anderson is the pathfinder, which is available via the cancer center's web site. These pathfinders list books, pamphlets, audio-visual materials, and evaluated web sites that provide information on certain topics such as breast cancer.

"Pathfinders give patients an opportunity to look at what we have and pick and choose from the list what medium would work best for them," says Cundiff.

At Northwestern Memorial Hospital a referral system makes the educational needs of patients clear. They show up with a paper script from their physician or an advance practice nurse and when possible are referred via an electronic patient record.

"What really makes our program work is that we close the loop and give the provider documentation of the patient visit within five working days. We send a paper letter if the patient is referred on paper or an electronic e-mail through the electronic medical record. Whether paper or electronic it is put directly into the patient's chart," says Gillaspy.

While patients and family members who walk through the doors of a resource center can be provided with information to complement what is taught at the bedside, one of the limiting factors of this method of education is that people must show up.

Many centers look for ways to distribute information to people who cannot physically make it to the site.

Volunteers at Children's Healthcare of Atlanta take book carts to patients. At Riverside Hospital the resource center will send staff to a patient's room to discuss what information they are interested in receiving. They also will mail material to patients' homes at no charge.

M.D. Anderson recently began an e-mail reference service. People can send questions to the resource center staff electronically. The e-mail is on the health care system's web site — www.mdanderson.org/departments/tlc.

It is equally important to publicize the center to patients, family members, and the public so they will know about the resource.

Miller sends physicians throughout the community library brochures and bookmarks and also sends these promotional materials to the hospital units. She also works with public libraries, encouraging them to send patrons to the medical library when they need information that is not available at the community site.

Cundiff invites nurses to come to the learning center for a scavenger hunt. She provides them with a set of questions about their patient population; for example, if the nurse works at the prostate cancer clinic the questions would pertain to prostate cancer. Learning center staff guide each nurse through the process of identifying the resources available.

"Nurses get hands-on experience and see what we have available for teaching patients and that raises their awareness level," Cundiff says.

Rann says she has announcements on the overhead public address system throughout the day at Children's Healthcare of Atlanta and also advertises on the closed-circuit TV and in the information guide to services at each bedside. She also presents at various staff meetings and has many advocates in the chaplain's, social work, and child life specialist departments.

Miller says resource centers have an important place in the community helping people find detailed, reputable medical information. ■

Field-test materials to gauge effectiveness

Create focus group or one-on-one evaluation

Health care educators know that easy-to-read materials are a must for patients with limited literacy skills but also work best for skilled readers.

There are many elements that distinguish an easy-to-read booklet including writing style, the organization of information, and an uncluttered layout. **(To learn more, see *PEM*, May 2006, p. 52.)**

However, the only way to be sure the material has met its goal of being easy to read is to field-test it.

Material can be field-tested in focus groups or in one-on-one interviews. For best results the intended audience must be used to determine if the material works.

During the field-testing phase recruit individuals who have similar characteristics as the target audience in knowledge, attitude, skill, and accessibility, says **Sandra Cornett**, RN, PhD, director of the OSU/AHEC Health Literacy Program at The Ohio State University in Columbus.

"The more specific you make your criteria the more specific your audience is the better you will be," says **Aracely Rosales**, president of Rosales Communication in Philadelphia, a company that specializes in plain language and culture, and a member of The Clear Language Group.

When Rosales field-tested material on breast cancer via focus groups, the target audience was women who had been affected by the disease and their caregivers.

Rosales recommends asking focus groups who should be asked to review the material. The groups providing information on breast cancer suggested spouses since they are involved in the treatment process. So some of the groups Rosales field-tested the material with were mixed, patients and spouses, and some were only partners of breast cancer survivors.

To find the appropriate people for focus groups or one-on-one evaluation contact community based-organizations or hire a company that has expertise in recruitment. Rosales says if the piece is bilingual make sure the focus groups are bilingual.

To recruit a focus group for a booklet targeting pregnant women Rosales partnered with organizations in the community that work with pregnant women such as family-planning clinics.

"There are many ways to recruit. You can approach organizations directly, partner with organizations, distribute flyers as well as advertise in the newspaper," says Rosales.

Test clear language individually

Wendy Mettger, MA, president of Mettger Communications in Takoma Park, MD, a consulting firm that specializes in health literacy and plain language projects and a founding member of The Clear Language Group, checks to see if materials are truly easy to read by working with adult learners.

"In making sure the materials you are preparing are attractive and appealing and understandable to many different individuals we have found that working with adult learners is a great way to measure that because these are people who have marginal skills and are struggling to learn how to read and write effectively," she explains.

Mettger likes to work with individuals from this group because one-on-one field-testing provides people with limited literacy skills an atmosphere of confidentiality and safety.

To find adult learners contact local literacy programs, she advises. **(For more information on finding adult learners and other tips on field-testing from members of The Clear Language Group, see article on p. 66.)**

Teachers can identify the appropriate students, and recruiting can take place during class. One of the key advantages of adult education programs is that the students have undergone a reading assessment to determine their reading level. If the material to be tested is at a sixth-grade reading level the appropriate students can be identified.

It's important not to give people material in advance but have them read it during the focus group or one-on-one evaluation. In this way it is possible to observe the participants discretely to see how quickly they read through the material and if they seem to be stuck on any pages. Often people who are learning to read will read the material out loud so it is easy to see if they struggle with any of the words or skip words they can't pronounce.

Mettger has a script she reads through before

SOURCES

For more information about field-testing contact:

- **Sandra Cornett**, RN, PhD, director, OSU / AHEC Health Literacy Program, The Ohio State University, 206 E Atwell Hall, 453 W. 10th Ave., Columbus, OH 43210. Phone: (614) 293-7396. E-mail: sandy.cornett@osumc.edu.
- **Wendy Mettger**, MA, president, Mettger Communicaitons, 129 Grant Avenue, Takoma Park, MD 20912. Phone: (301) 270-2774. E-mail: wmettger@mindspring.com.
- **Aracely Rosales**, president, Rosales Communication, Philadelphia, PA. Phone: (215) 849-0545. E-mail: aracely@rosalesc.com.

getting started that explains the process of letting people know there are no right or wrong answers, and it is their opinion she wants so the more honest they can be the better. **(To learn what types of information field-testing should uncover and what questions to ask, see article on p. 67.)**

The testing process, whether one-on-one or in focus groups, should help identify areas that are problematic. Look for patterns, says Mettger. For example, during field-testing of a pamphlet on Alzheimer's disease it was clear that people with low literacy skills struggled with the words. So a phonetic guide was inserted into the text.

Generally about 10 interviews are appropriate. If the pamphlet is on a specific disease, such as diabetes, Mettger might do half with people who have diabetes and the other half with adult learners.

With focus groups Rosales recommends running about four groups with a trained facilitator. Always work with prepared questions that help determine if the point of the pamphlet is understood, such as accessing treatment for cancer.

Testing tips from those in the know

Advice on improving field-testing techniques

The Clear Language Group is a consortium of communication specialists whose aim is to create clear, plain language materials.

In this piece three members provide a few simple tips on field-testing, bits of wisdom they have learned through experience.

***Audrey Riffenburgh**, MA, president, Riffenburgh and Associates in Albuquerque, NM, former adult basic education administrator, tutor, and tutor trainer.*

"Wondering how to find readers with limited skills to consult about your materials? Contact your local adult literacy organization or adult basic education program. Not sure how to find *them*? You can start your search at ProLiteracy Worldwide's web site www.proliteracy.org and click on "Find a Program." This will usually lead you to local adult literacy programs, which typically serve the low- to intermediate-level readers as well as adults learning English as a second language.

Or you can call your local school district or community college to find out whether they offer instruction to adults with less than a high school education. The sponsorship of these programs varies from state to state as does the terminology used to describe them.

Some of the terms often used to describe programs are: pre-GED, adult basic education, adult education, adult literacy, basic skills, English as a second language (ESL), and English as a foreign language. The best class level for testing materials with native English speakers is pre-GED. And the best class level for testing materials with ESL students is intermediate."

***Sue Stableford,** MPH, MSB, director AHEC Health Literacy Center University of New England, Biddeford, ME.*

"Use the same testing groups (representative of or actual users) several times to progressively shape materials. This has been especially useful for longer (12 page) booklets. The feedback during successive efforts to address both text and graphic concerns has been invaluable and resulted in a sterling new booklet. Additional testing should be done near the end with people and/or groups who have not helped in development.

The groups that help with development take real pride and ownership in their contributions. And they get a product that's truly useful to them as well as others."

***Jann Keenan,** EdS, president, The Keenan Group Inc., Ellicott City, MD.*

"Offer participants cab fare or bus tokens to and from your focus group site along with the incentive gift. Choose a site that is easy to find and put up signs or have a greeter at the front entrance to lead participants to the room. People with limited literacy can have challenges navigating buildings. When working with ethnic groups, consider placing a few cultural artifacts around the room and post a sign with 'Hello' written in the participants' native language.

*In the room, s*erve healthy snacks before the group starts so you won't need to break mid-way through to keep up the group's momentum.

Place a tent card with the participant's first name, a note pad and pen, the easy-to-read consent form, and a handwritten thank you note at each place setting. These small efforts set a welcoming tone."

[To learn more about The Clear Language Group: Phone: (410) 480-3723. E-mail: clg@clearlanguagegroup.com. Web site: www.clearlanguagegroup.com.] ■

"When you see a pattern in the beginning focus groups when people have trouble with content or a specific piece of information make sure to review this with other focus groups," she advises.

Once all the information is collected it is often clear what changes need to be made. Rosales says she prefers to make the changes and test the material one more time just to make sure the changes are right on target. ■

How to get the most from the field-testing process

Ask the right questions

Whether using focus groups or individuals to field-test materials the object of the exercise is to determine if the material has audience appeal, if people comprehend what it is they are reading, if it is relevant to the culture for which it is written, and whether the reader will put the information into practice.

It is important to determine if the cover and title will make a person want to pick up a booklet and read it.

"If your cover design and text aren't appealing then no matter how well written the booklet you are not going to keep your reader," explains **Wendy Mettger**, MA, president of Mettger Communications in Takoma Park, MD, a consulting firm that specializes in health literacy and plain language projects.

Eliciting appeal depends on such things as the size of the words on the pages, as well as the number of words, the colors used, whether there is too much color or not enough. For example, Mettger determined a booklet was too dark during one-on-one interviews.

It isn't enough that people are able to read the words on the page; it is important to determine if they understand the message. It's good to begin with a general question, asking what the reader thinks the booklet is about, says Mettger.

Follow up with specific questions, such as asking the reader for the three main messages. "It is a way to see if the writing is clear enough so people can easily pick out the main messages," says Mettger.

Also ask for information that can be gleaned by the booklet. For example, in a pamphlet on Alzheimer's disease the question might be why it is important to see the doctor early when experiencing memory loss. "We want to know if the message resonates and if people can recall it," Mettger says.

Often she encourages people to re-read the text if they can't quite remember exact points. "If people go back through and can't find the information that is a clue that we may need to clarify it, make it more visible, or provide a better definition. It is very helpful to me to see people trying to scan, which is a difficult skill for some marginal readers," says Mettger.

To determine cultural appeal, ask if the way the pamphlet looks or if the words used are offensive to the reader.

Finally, it is important to determine if the reader can envision using the information. For example, can people see themselves talking to their physician about the information provided in the booklet?

Sandra Cornett, RN, PhD, director of the OSU/AHEC Health Literacy Program at The Ohio State University in Columbus, suggests field-testing include the following questions:

- Begin the discussion with general questions such as: What are some words you would use to describe this pamphlet? What do you like best/least about this brochure?
- Questions about content might include: What are some of the major ideas? Are any ideas confusing to you? Are there any important ideas left out? Are people with similar problems likely to be concerned about these ideas?
- To determine if the reader will use the information ask: Can a person reading this booklet do what it recommends? If you were given this booklet, what would you do with it? Describe how you would use this booklet in the future.
- Questions to evaluate the writing style might include: Are there words you don't understand? What do you think about how the ideas were presented? What do you think about the length of the booklet? Do the words sound similar to the way people talk?
- Layout and design might be evaluated by asking these questions: What do you like or dislike about the way the material looks? Do the pictures help get the ideas across? Are there pictures you would change or add? Is the print large enough? Is it organized in a way that helps you understand the key points? ■

DM program keeps AIDS patients out of hospital

One-on-one education is the key to success

An intensive one-on-one case management program helps people with AIDS stay adherent to their medication regime, avoid hospitalizations and emergency department visits, and learn to self-manage their disease.

Positive Healthcare Florida, the disease management program of the AIDS Healthcare Foundation, is the only National Committee for Quality Assurance-accredited disease management program for HIV-AIDS in the country. The program received a score of 98.4% out of a possible 100% during the survey.

RN care managers with extensive HIV-AIDS expertise oversee the care of 10,000 Medicaid patients with AIDS across the state of Florida.

"We've been successful because of the intense one-on-one and face-to-face work with the patients. The nurses follow them closely and develop a wonderful rapport. The core of our program is education and one-on-one coaching to improve the patients' quality of life and to keep them out of the emergency department and out of the hospital," says **Gene Bundrock**, MS, RN, CCM, statewide director for AIDS Healthcare Foundation's Positive Healthcare Florida.

The field-based care managers work out of their homes and manage the care of patients in the counties in which they live. They work closely with the patients' physicians, often accompanying patients to their office visits, and working with them to coordinate care.

"Positive Healthcare takes a different approach to disease management. We do a lot of face-to-face assessments. The care managers get to know the provider and work closely with them. They meet with social service agencies in the community and incorporate them in the plan of care," says **Donna Stidham**, chief of managed care for the AIDS Healthcare Foundation.

Publicly supported patients with AIDS present a challenge to providers. They are poor. Many don't have telephones. They often live with relatives and move around a lot, Bundrock says.

The program uses representatives from the community who help find patients and call the care manager. The representative makes an appointment for the patient with the care manager, who sees him or her within three days.

"Our care managers will meet with them anywhere — the home, the doctor's office, in a restaurant, or even under a bridge. We'll go anywhere the patient feels comfortable and where their confidentiality won't be breached," Stidham says.

When new patients are identified for the program, the nurse contacts them and makes an appointment to see them, preferably at their home.

"It helps the nurses manage the care if they can see their patients in the home environment and become aware of their living conditions. Some don't have electricity. Others may not have a refrigerator or cooking facilities. It helps us tailor a care plan when we can see firsthand what the patient is facing," Bundrock says.

Patient assessments

The care managers conduct an extensive assessment that categorizes patients by severity level and acts as a guideline for the number of interventions the patient received. They determine the patients' needs and barriers to care, such as transportation, and get a consent form allowing them to go into the physician's office and examine the patient's medical record.

"These patients are not good historians on previous hospitalizations. They may know they had a cough but not whether it was pneumonia. Our nurses examine the medical record to find out what we need to know to manage the disease," Bundrock says.

The care managers zero in on patients with a high acuity level who are frequently hospitalized, not adherent to their medication regime, and are substance abusers.

"Once the nurse has seen the patient in person, some of the work can be done telephonically. She might not need to see patients every month if they are doing OK, the lab work looks good, and she knows they are being adherent with their medications," Bundrock reports.

The disease management nurses remind patients if they have physician appointments, check to see that the appointment has taken place, and visit the physician's office to review the chart. They give the patient a pillbox to help them organize their medications and stress the importance of taking the medication until the physician discontinues it.

Because confidentiality is an issue with AIDS patients, Positive Healthcare mails AIDS-related educational materials only to patients who have

given their permission. Otherwise, introductory and follow-up letters are very generic.

The care managers know their community well, often serving on local health planning councils. They know the practitioners in the community and know how to guide their patients through the complex medical system to get help.

The care manager can mine the database for claims data and talk to the physician if a patient is making frequent trips to the emergency department.

"These patients have a lot of mental health issues as well. Depression is a huge problem, and many are on psychiatric medication. Physicians can't get the patients interested in caring for themselves until their mental status is stable," Bundrock says.

Dental care is another problem for AIDS patients on Medicaid.

"The state doesn't pay for dental work of any kind, but Medicaid patients still get toothaches. We try to get them access to dental care so they won't go to the emergency department or hospital with an infection that's the result of a dental problem," he says.

A team of nurses and an LPN care partner manage the care of the population in each area. The LPN takes care of telephone calls and other reminders for patients who are at severity level 1, allowing the care manager to concentrate on the more complex patients who are in and out of the emergency department, helping them avoid admissions.

For instance, AIDS medications often cause adverse reactions until the patient gets used to them, causing trips to the emergency department for pain and nausea. The care managers encourage them to try alternatives.

Working with physicians

"Now instead of going to the emergency department when they start a new medication and have cramps, they call the care manager who helps them understand that it might be a side effect of the medication. They suggest that they use an over-the-counter medication rather than going to the emergency department," Bundrock explains.

The care managers work closely with the physicians and nurses in physician offices to make sure that the patients are getting the recommended care. They refer any problems they spot to Bundrock or the medical director, who contacts the physician and educates him or her about evidence-based guidelines for the treatment of HIV-AIDS.

Positive Healthcare holds six educational programs a year in each region, informing physicians about the latest information from the scientific community.

"We stay up on new treatment regimes and make sure the physicians know about them. A bad regime can have a bad outcome, which in turn can cost hundreds of thousands of dollars," Bundrock says.

Physicians in the AIDS Healthcare Foundation's disease management programs work with the physicians who care for the patient.

"They don't want to interrupt the physician-patient relationship but they do want to enhance the physician's access to knowledge about the condition," Stidham says.

In California, the AIDS Healthcare Foundation began operating one of the first Medicaid managed care programs specially designed for people with AIDS in California in 1995. The foundation has received approval to operate a Medicare Advantage plan, allowing the patients to get their drugs through Medicare Part D.

The Medicaid program covers the sickest of the sick, only people with AIDS. HIV-positive patients are not eligible.

The state of California compares the foundation's costs to the fee-for-service Medicaid program and splits the savings with the foundation on a 50-50 basis.

"Our patients have always had better outcomes, shorter lengths of stay, and less cost than the fee-for-service patients," Stidham says.

Patients in both the Medicare and Medicaid programs are assigned an RN case manager who has HIV expertise. All of the primary care physicians and specialists in the network have experience working with people with AIDS, and the formulary is designed with people with AIDS in mind. ■

Program screens members for postpartum depression

Info, follow-up calls, referrals prevent other problems

Members of Blue Cross Blue Shield of Missouri's Postpartum Depression Screening Program consistently give the St. Louis-based health plan patient satisfaction scores in the 90th percentile.

Since the program was launched in November 2001, more than 25,000 women have been screened for postpartum depression and received information and resources about the illness and treatment options.

Postpartum depression is common and affects between 10% and 13% of all women who have given birth or experienced an adverse obstetrical outcome to a pregnancy, but treatment for women suffering from the condition often is underutilized, reports **Pat Jones**, RN, BSN, project manager for the postpartum depression program for Blue Cross Blue Shield of Missouri (BCBSMo).

"Postpartum depression doesn't affect a huge number of members, but can have devastating effects on the mother and those around her. Even though the volume of cases is small, we felt we had the tools and the ability to develop a program that could make a difference in the lives of our members," says **Kathleen McDarby**, RN, MPH, senior health service analyst for BCBSMo.

If left untreated, the condition can last for at least a year. Treatment includes a combination of medication, talk treatment, and self-help strategies. With treatment, the symptoms improve more quickly. Women who have postpartum depression have trouble with daily activities of self-care and child care. Postpartum depression potentially can affect the infant, other children in the family, and the couple's relationship.

The health plan has developed an algorithm to pull medical claims to identify women who qualify for the program. The process is performed on a weekly basis.

"We examine claims from every woman with any type of medical claim that has an obstetric background, whether it's a normal birth, a premature birth, a stillbirth, or any other condition. This makes our program unique because many programs do not include women who have had an adverse outcome to the pregnancy or a premature infant," McDarby says.

Members who are identified from claims data receive a letter explaining the postpartum depression program, a brochure listing the causes and symptoms of the condition, with a section on grief and loss, and the Maternal Mental Health Survey, a 10-question screening tool.

About 33% of the women who receive the survey completed it and sent it back in the self-addressed, postage-free envelope supplied with the survey.

An outreach specialist scores the surveys and gives the names of members whose scores are positive to Jones, who contacts the members by telephone.

Members who screen negative for postpartum depression also receive a letter informing them that their score is normal at this time, but should they develop any of the listed signs and symptoms, they should contact their medical provider promptly.

"We thank them for participating and remind them not to ignore the symptoms if they do occur in the future," Jones says.

"There is no formal script for my outreach calls. Instead, each member is approached as a unique individual. The questions I ask are determined by how they answer the survey questions and my general impression from talking with them. However, with every member, I assess for their own safety and the safety of their child," she explains.

When she calls a member who screened positive for postpartum depression, Jones has a list of three behavioral health providers at hand. The providers have been contacted by the outreach specialist to make sure they have appointment slots available.

If Jones' assessment determines that the members need professional help, she encourages them to accept a referral to a behavioral health provider.

"I give them options to choose from a list of behavioral health providers so they are involved in the decision-making process," she adds.

About 40% to 50% of the members choose to go back to an established provider, either their primary care physician or their obstetrician, because they feel more comfortable with a known provider, Jones adds.

"Some members recognize the extent of their depression and will accept a referral. Very few of these members are already in treatment, so it's usually a starting point for them," she says.

Jones asks the members to call her back after they make an appointment, and many of them do. She makes a follow-up call three months later to see how the treatment is going and to see if the member needs more referrals for behavioral health services.

"Once I've made that three-month call and the member is not in need of further behavioral health services, I consider them graduated from the program. I leave the member with the knowl-

edge that they can call me if they feel like they need further assistance with referrals," Jones says.

In most cases, within three to six months of treatment, the member's symptoms have lessened or may have resolved.

"Most members will remain in treatment for six to 12 months. At that point, most members have had their medication titrated down to a lower dose and therapy visits are less frequent. In general, postpartum depression is usually easily resolved when identified and treated early," Jones says.

The postpartum depression program was developed by Blue Cross Blue Shield of Missouri's quality management department in collaboration with behavioral health.

They worked with Blue Cross Blue Shield of Missouri's internal communications and graphics department to produce the brochure.

The content of the brochure was reviewed by the plan's quality improvement peer review panel, which includes network physicians, obstetrician/gynecologists, psychiatrists, family practitioners, and pediatricians.

"We received positive feedback from all of them. The psychiatrists were particularly complimentary about the brochure," McDarby says.

The program has been accredited under disease management standards for URAC. It's been so successful that it's been expanded to other programs and Blue Cross Blue Shield plans in other states. ■

Learn how to get around rebound headache

Duration not related to time of drug in body

Giving preventive medications to a patient who is overusing acute medication for headache may be a waste of time, according to a presenter at the American Society of Health-System Pharmacists Midyear Clinical Meeting.

In fact, the six to eight weeks that the preventive medications take to become effective does not begin until the patient is no longer using the headache medications, says **Carla R. Rubingh**, PharmD, assistant professor of the department of pharmacy practice, University of Nebraska Medical Center in Omaha. Rubingh's presentation, "Getting around rebound," was part of the meeting's "Clinical Pearls" section.

Medication overuse is the No. 1 cause of chronic daily headache, she says. Chronic daily headache is defined as headache that occurs

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** patient education programs based on existing programs from other facilities. ■

COMING IN FUTURE MONTHS

- Addressing changing patient education needs
- Education committees; not only for review
- Using personal health journals to aid in patient education
- Using consumers for material evaluation
- Must-have research materials for the office

CE Questions

21. Which of the following best explains why resource centers provide an opportunity to give patients information beyond what is learned during bedside teaching?
A. Patients learn on their own timetable.
B. Atmosphere is more comfortable.
C. More resources are available.
D. All of the above.

22. One important reason for field-testing easy-to-read materials with adult learners from literacy programs is that they have had their reading level assessed and will be more closely matched with the target audience.
A. True
B. False

23. At Positive Healthcare Florida, once a patient has an appointment with a care manager, the care manager sees the patient within what length of time?
A. The same day
B. Three days
C. Five days
D. One week

24. If left untreated, postpartum depression will last no longer than six months.
A. True
B. False

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

more than 15 days in a month. Medication overuse headache can present as a dull, squeezing pain, usually in the frontal region of the head.

All acute medications used for the treatment of headache can cause rebound, with the possible exception of nonsteroidal anti-inflammatory medications, Rubingh says. To avoid this, no acute medication should be used more than three days per week. "This is not the number of doses. This is the number of days."

Patients may wonder why they quit taking a medication such as Excedrin for two weeks, and their headache did not get any better. The duration of rebound headache is not related to the duration of the drug in the body, Rubingh says. "You cannot calculate how long it should take for the drug to wash out of the body."

Physiological changes occur in the brain depending on what drug the patient is overusing, she explains. "Rebound can last anywhere up to a year."

Because of this, all patients should be monitored for the frequency of the use of these medications and the doses it takes to get relief. Administration of preventive therapy should be done at the time you start to taper the overused medications, Rubingh says. Support medications can be started at that time, too.

Most important is patient education. Patients, she says, should be told at the beginning that these drugs should not be used more than three days a week. ■