Patient Education Management™

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

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IN THIS ISSUE

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Strategies for improving education competency among staff members

Research can uncover targets for improvement through instruction

To improve patient education, institutions must develop competent teachers. Some patient education coordinators have found that a survey tool is a good strategy for improving patient education competency among staff members.

Not your average tool, but one that measures "personal skill level" and the "importance of the skill."

Doris Doherty, BSN, RN, patient/family education coordinator at Franciscan Skemp Healthcare in LaCrosse, WI, helped implement such a tool in the fall of 2005 after returning from a Health Care Education Association conference.

She says while her institution would look at different competencies each year, they had not surveyed nursing staff to find out what the nurses wanted to know. The survey helped identify a focus for creating a plan. Also the use of a survey adhered to the adult learning methods. "If adults can identify what it is they would like to know more about, they will easily learn it," she says.

A survey with nine statements was mailed to about 800 RNs and LPNs in the health care system that includes multiple clinics, three hospitals, sub-acute

EXECUTIVE SUMMARY

Nurses and other disciplines that teach are expected to be competent. Each year health care facilities determine what they might look at for competency. In this month's cover article, *Patient Education Management* looks at strategies patient education coordinators have used working with others in their organization to identify gaps in competence and curriculum to address the problem.

and rehabilitation facilities, and nursing homes.

The statement that showed measurements of lowest proficiency and highest importance was: "Determines the patient's ability to read, understand and act on health care information (health literacy), and adjusts teaching methods accordingly."

Those responding were asked to rate the importance of each statement in the survey by marking one of the following: not at all; of little importance; important; very important; critically important. They were also asked to rate their personal skill level for each competency that included: little or none; basic; adequate; proficient; expert.

The presentation that prompted Doherty to form a task force to conduct a survey to identify competencies for nursing staff was delivered by **Jean Just**, RN,C, MSN, director of staff development and patient education at The Ohio State University James Cancer Hospital and Solove Research Institute in Columbus, OH.

Just was part of a professional development committee initiated within the Cancer Patient Education Network (CPEN). One of its charges was to identify competencies for cancer patient educators.

To develop the survey tool, the CPEN committee looked at the literature to see what staff members needed to know to facilitate learning among cancer patients.

"Based on our review of the literature, we compiled the competencies and then we had the competencies further reviewed and refined by the members of our professional development committee. We came up with 38 competencies," Just says. *(For information on the competencies, see editor's note at the end of the article.)*

The task force that Doherty helped form at Franciscan Skemp Healthcare included members from the staff development and patient education committees and a market analyst who had expertise in setting up a survey tool and analyzing data. This team chose eight statements from the 38 identified by the CPEN committee. It created one statement of its own pertaining to diagnosis-related patient care standards.

The task force determined that 38 statements were too many because they did not have staff to handle the analysis of extensive data and some of the statements were unique to cancer nurses.

The purpose of the CPEN survey was to identify competencies for those who provide education for cancer patients. "We thought there were perhaps some things that were a little different with educating a patient with a cancer diagnosis," says Just.

The survey was distributed via a listserv to cancer patient educators. When the results were evaluated, the CPEN committee found the most important competency for cancer patient education is to consider the impact of a cancer diagnosis on learning.

Patient educators must be able to assess where the patient is emotionally and then take steps to reduce the emotional impact so the patient can retain information.

"We all know anxiety is a big barrier to taking in and retaining information," Just says.

Creating a plan for competency

Once the results of a competency survey have been tallied, a plan to target the learning needs identified is the next step.

Doherty says the task force at Franciscan

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Editorial Questions

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Skemp Healthcare is in the process of putting together an education plan for 2006 and will follow up with an evaluation in 2007 to determine if the plan was successful.

The team used the statement from the survey that showed lowest proficiency and highest importance to form a focus, which is "nurses will demonstrate assessment skills in determining the patient's ability to read, understand and act on health care information, and adjust teaching methods accordingly."

In the process of assembling a self-learning packet the committee has looked at a lot of information and is developing education around a video produced by the American Medical Association titled "Health Literacy, Helping Your Patient Understand."

A plan to improve patient teaching competency can be simple or quite extensive. The work at University Health Network, a large health care organization in Toronto, began in 2002 and is still a work in progress.

It began with a competency survey to establish baseline teaching skills, similar to the one CPEN created. **Audrey Jusko Friedman**, AC MRT(T), MSW, director of oncology patient education and survivorship at Princess Margaret Hospital within University Health Network was part of the CPEN committee creating the competency survey.

In addition to a survey, committees established to work on the program as part of an interdisciplinary task force benchmarked evidence-based practices and competencies about patient teaching. They also looked at identifying a target audience, developing a curriculum, determining how to provide delivery of information or a strategy for teaching staff, and evaluating patient teaching competency.

Several strategies have been put in place to improve patient teaching competency. One committee did an extensive literature review, and from the information gathered, developed annotated bibliographies and summaries of all the material they found. From these findings they created a document titled "Teaching Effectively to Advance Care and Health by Educating Staff."

These evidence-based guidelines provide six steps for creating a teaching plan and are available via the institution's Intranet to people throughout the organization. The steps include identifying a problem, conducting a needs analysis, developing goals and educational objectives, sequencing instruction, instructional strategy design, and evaluating learning outcomes. Each step has a detailed bibliography on the evidence to support the execution of each step, says Friedman.

Curriculum also was developed to improve patient teaching. "Maximizing Your Patient Education Skills" has three parts and people can enroll in one or all of the sections.

The first part of the course is designed to enhance the delivery of patient education by focusing on principles of adult learning and identifying communication styles. It helps staff become competent at recognizing the different learning styles of patients and families and adjusting their teaching style to those different learners.

While part of the class is a lecture, the students also do an exercise that provides hands-on learning. During this exercise class participants are divided into small groups and they take turns working with four different patients, portrayed by trained actors, who have a particular learning style and communication preference that must be identified. The groups must interact with each patient and develop a teaching plan.

The second part of the course is based on the six-step strategy for developing a patient teaching plan. Participants in this course receive a sample teaching plan and learn how to identify educational objectives, the sequence of instruction, the instructional message including materials that could be used, and ways to evaluate the instructional message.

The third part of the course focuses on leadership development and mentoring skills to facilitate patient education competency amongst one's colleagues. People participate based on the recom-

SOURCES

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mendation of a supervisor or manager.

Friedman says the first two courses will eventually be delivered on-line as well as face-to-face instruction so those who cannot find the time to attend a class will be able to participate.

The next step in the process to improve patient teaching competency across the organization is to develop a way to evaluate whether the curriculum is on target. Some have suggested conducting a pre- and post-test using the trained actors posing as patients. They could interact with the "patient" in a preplanned scenario before taking the course and then after they have taken the course and worked in the field for six months.

Another evaluation strategy being considered is to look at changes in patient behavior after teaching. For example, with more competent teaching is the patient better able to use a particular device or participate more successfully in a treatment plan?

"This is a work in progress. Intuitively we believe it is improving patient teaching but, we now need to know more about that," says Friedman. ■

Help nurses find model for teaching

Techniques can address stage of readiness to learn

To help oncology nurses determine what type of education model might work for them when teaching patients, **Mary Szczepanik**, MS, BSN, RN, manager of cancer education, support, and outreach for OhioHealth Cancer Services in Columbus, conducts a one-hour class that provides information on two models of teaching.

Szczepanik says there are different ways of teaching, and nurses should determine what works best for them whether they use one of these models or another they have read about.

The theories she covers in a class to help nurses educate patients in a hospital setting where there is little time to teach are the Adaptation to Illness Theory and the Situational Leadership or Education Theory.

"What I try to do is talk to the nurses and help them understand what is possible and practical in a hospital setting and how to determine not only what the patient has to learn before he goes home but the best way to teach it to him based on how ready he is to learn," Szczepanik says.

The Adaptation to Illness Theory has three stages. The first addresses a patient's readiness to learn when they do not yet have a definitive diagnosis. Szczepanik says in this stage patients are most interested in the present and are pretty tense and anxious.

Teaching would focus on the tests and treatments patients are actually having and some basic information on how they could get more information.

"At the first stage they are not going to remember very much or comprehend very much so you are really going over the basics and teaching about the tests and treatments," explains Szczepanik.

In the second stage the diagnosis has been confirmed and the patient has accepted his or her illness and agreed to a particular treatment or care. It may be they are in the late stages of cancer and go right into hospice but the model works no matter the circumstance, says Szczepanik.

The impairment to education at this stage is that the patient is in a state of forced dependence on both medical personnel and family members. Because of this their ability to retain information is limited.

"It is one of the main reasons we use print materials as backup, so they can go back and read the information again after we have taught it to them," says Szczepanik.

At this stage she tells nurses to do all they can to help the patient feel more independent. For example, the nurse could encourage the patient to bring family photos to place around his or her room so the environment is more familiar or the nurse might arrange a visit from the art therapist.

"Anything to help them feel normal will improve their ability to comprehend and retain information," explains Szczepanik.

The third stage is the convalescent period when the patient is at a higher level of health. This stage doesn't necessarily mean the patient is being cured; it could be a hospice patient who has his or her pain under control. Regardless, patients are more receptive to teaching at this stage. This last stage usually does not apply to teaching in a hospital setting, Szczepanik says.

When using the Adaptation to Illness Theory continuous assessment is important because the facts of the case with cancer patients often change. A person might be at the second stage of adaptation one day having agreed to a treatment and then is given new information the next day and is back to the first level, says Szczepanik.

Adapt teaching to learner's readiness

The Situational Education Theory helps the nurse adapt his or her teaching style to the learner's readiness.

"You do that by adjusting the amount of instruction you give, the amount of supervision you give, and the support you give in teaching a patient based on their level of readiness to learn," says Szczepanik.

To determine a patient's readiness to learn the nurse should get answers to three questions.

First determine if the patient has had recent education and experience specific to what needs to be taught. If so, the patient will know what equipment is needed to perform the task and what type of environment is needed to safely complete it at home. The second question is if the patient has set clear goals. The final question determines if the patient is able and willing to take responsibility.

To answer these three questions the nurse would have a conversation with the patient, read the chart, and talk with the nurse that cared for the patient on the last shift.

Szczepanik says if the patient is at the lowest level of readiness to learn the nurse will educate by giving very specific instructions and supervising very closely. At this point the nurse is doing the task, such as a dressing change, while the patient watches. This is called a telling style of education, according to the theory authors Paul Hersey and Ken Blanchard.

At the second level of readiness to learn, while the patient might know the type of equipment needed to perform a task, he or she is still dependent on the supervision and specific instructions of the nurse. At this level the nurse is explaining and clarifying the task the patient is completing.

"The authors of this theory call this a selling style. You are still protecting the learner from error because you are directly supervising him, but you give him more to do and you are explaining more," says Szczepanik.

The patient does more and the nurse explains in more detail the task at hand. Szczepanik encourages nurses to ask open-ended questions with this teaching style. For example, the nurse might ask what the patient would do if he or she dropped the piece of equipment on the floor.

Once patients have had experience and their confidence has increased they are more likely to move to the next level of readiness to learn, which would be the ability to do most of the task on their own. The teaching style at this level is called participating, says Szczepanik.

"You only move to the third level if you know the patient really knows how to do the task," says Szczepanik.

At this stage the nurse would verbally review the procedure with the patient and then provide lots of support, encouragement, and clarification if needed.

When the patient reaches the final level, he or she has the skills to complete the task with very little supervision or instruction.

"What I try to remind the nursing staff who attend these classes is that we rarely get patients to this level before we send them home," says Szczepanik.

At the beginning of the class Szczepanik asks the nurses to select a patient they cared for during their last shift and identify the patient's educational needs. For example, the patient might be going home on a complicated medicine regimen. Szczepanik then uses these specific patients as examples while teaching.

She has been teaching this class for about 10 years and although she currently focuses on oncology nurses, she says, the class is beneficial to nurses on any hospital unit. ■

SOURCE

For more information about teaching nurses how to adapt teaching style to a patient's readiness to learn using a teaching model, contact:

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To reach children strive for interactive, fun

Make the activity fun as well as educational

The Teddy Bear Clinic sponsored by Browns Mill, NJ-based Deborah Heart and Lung Center was interactive, fun, and educational.

These three factors helped make it a successful outreach at an event called a Kid's Fest that had

activities such as headline entertainment, helicopter water rescues, and booths located at various pavilions. The booths were organized by categories such as the learning lab, youth and the arts, kid's spaces, kids in sports, family health, pampered moms, and the exceptional child.

While signage identified the Teddy Bear Clinic and its sponsor, the opportunity to make a handprint on the canvas walls surrounding the booth by dipping your hand into a tub of bright finger paint proved very attractive to the children. Two teen hospital volunteers helped children put on a vinyl glove, select a color, and make a handprint.

"As the day went on we were creating a beautiful display of many colored hands all different sizes," says **Laura Gebers**, BSN, RN, BC, patient care services programs health education coordinator.

A volunteer from the Deborah Heart and Lung Center Foundation signed children in at the entrance by obtaining the parents' name and address for future promotional activities. As families entered they were given a teddy bear dressed in a T-shirt that had the name of the medical center along with contact information including the web site address.

Children with their Teddy Bears in tow progressed through three stations in groups of 10. At the first station they gave the stuffed bear a name, which was written on a pink or blue patient identification band by a pediatric nurse. Each child took a turn placing the bear on a baby scale to weigh it and its height and weight were also printed on the band before it was placed around the bear's neck.

This personalized the bear for the child, says Gebers.

At the next station children had an opportunity to learn about nutritious foods with the help of physician assistants. Gebers selected this topic for the educational component because of the obesity problem in the United States and its impact on heart health.

To make this section interactive Gebers had the media department at the center create pictures of different types of healthy foods, including fruit, vegetables, meats, and dairy products, as well as foods that didn't have nutritional value such as soda and potato chips.

"The children were asked to select which foods were good for you and which were bad and how many of each they should have in a day," explains Gebers.

A poster of the new food pyramid was hung in the booth for the parents to review. Children also received a nutritional coloring book so they could continue to learn about healthy foods at home.

At the last booth children met Deborah Heart and Lung Center's pediatric cardiologist and a nurse manager. They could put an isolation mask on the teddy bear and ask medical questions about themselves or their bear. If the children were afraid to ask a question about themselves they frequently attributed the problem to the teddy bear, says Gebers.

In addition, the physician would ask who wanted to be a nurse and who wanted to be a doctor. Children received either a nurse's or physician's hat based on their career choice and each had the Deborah Heart and Lung Center logo. Gebers says children wearing these caps and carrying their teddy bears could be seen all over the festival grounds.

Organization is extremely important when trying to reach a large audience at a children's event like the Kid's Fest, says Gebers. Otherwise participants may not spend the amount of time needed to hear the message at the site or they will be distracted. By creating stations and rotating children through in groups of 10 there was structure.

"If you don't have some kind of control by going through the exhibit station to station a lot is lost. Parents and children are willing to abide by the guidelines you set," says Gebers.

It's important to get the message across when spending money on an outreach. The cost of the Teddy Bear Clinic was just less than $6,000. Expenses included the cost of the teddy bears with the Deborah logo and information, the nutritional coloring books that also had the medical center's logo, canvas sewed into side panels for the canopy, and other supplies. Gebers was able to have the fee for the booth waived because the center is a nonprofit organization. Everyone who helped in the booth volunteered, so there was no labor cost.

Gebers says when so much time, effort, and resources are invested it is important to get the message across. Children and adults left the

SOURCES

For more information about creating a Teddy Bear Clinic as a children's outreach project, contact:

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Teddy Bear Clinic knowing more about nutrition, Deborah Heart and Lung Center, and the medical field as a career choice. ■

Video conferencing streamlines ASL service

Hospitals can access it 24/7

Caregivers at Hamot Medical Center in Erie, PA, are using a video interpreting program that allows deaf patients "to be treated as quickly as anyone else," says **Barbara Magee,** RN, patient education coordinator.

With only two certified American Sign Language (ASL) interpreters in the area — one of whom lives 30 minutes away — it had often been difficult to make sure an interpreter was available to assist deaf individuals on a timely basis, she notes.

"Our staff would get very frustrated when they attempted to call and couldn't reach the small supply of interpreters," Magee says. A Pennsylvania law effective in July 2005 requires that hospitals use only interpreters certified by the state, she adds, which further limited the options.

With DT Interpreting, a service of DeafTalk LLC, hospital staff can access ASL interpreters 24 hours a day, seven days a week, Magee says. A recent collaboration with Sony Electronics involves that company's compact, all-in-one video conferencing system, which makes use of IP-based communications technology, she notes.

"We get the DeafTalk equipment cart and take it to the bedside, where someone dials an 800 number to set up an interpreter on the screen," Magee explains. "The voice of the person calling is picked up and transferred [to the interpreter] and there is a small camera on the patient.

"The interpreter and the patient sign back and forth, and the interpreter voices what the patient has said," she says.

Most rooms in the hospital's emergency department (ED) are wired for the service, with a special jack to connect the equipment, Magee notes. If the person needing the interpreter is in an inpatient bed, she adds, a second cart can be taken from floor to floor.

The service is actually more cost-effective than using in-person interpreters, Magee says, because it can be accessed precisely when needed.

"Any time you're trying to arrange for an [in-person] interpreter, you don't always know exactly when the physician will be there, so you often need to keep the interpreter on hand for hours at a time," she points out. "Now, whenever the physician is there to give discharge instructions, discuss a surgical consent for an immediate procedure or talk about a diagnosis, the family comes in and they can talk immediately."

A community education meeting was held to help ensure that deaf individuals in the area would be comfortable with the service, Magee says. "We wanted to emphasize that we were not saying that we would not continue to find an actual interpreter, if that was what they preferred."

In some cases, deaf patients do want face-to-face interpretation, she adds, particularly if the person has a long history of working with a particular interpreter. Many times, however, they are more agreeable to using the video service because it allows a faster interpretation, Magee says.

"We just try to meet their requests and let them know we aren't mandating," she says. "Once they know it's a comfortable experience, some actually feel better not knowing the interpreter personally."

With so much emphasis in hospitals on patient safety and meeting the standards of the Joint Commission on Accreditation of Healthcare Organizations, Magee points out, "It's very important that patients who are deaf are treated as anyone else would be.

"They need to be able to pick pertinent information from the nursing or physician assessment so they can be given the most appropriate care," she adds. "With a form of communication that is quickly available, we're much better able to assess patient needs accurately and deliver that care in a timely manner." ■

Creative approaches help members control asthma

Costs of disease top $11.6 billion a year

Health plans across the country are coming up with innovative ways to tackle asthma, a disease that costs $11.6 billion a year in direct health care costs, according to the American Lung Association.

Strategies run the gamut, from working with local agencies to improve air quality in the community to visiting patients in the intensive care

unit following an asthma attack.

More than 20 million Americans suffer from asthma, according to the Centers for Disease Control and Prevention's (CDC) National Center for Health Statistics.

Asthma was the primary cause for 12.7 million physician office visits, 1.2 million hospital outpatient department visits, 1.9 million emergency department visits, 484,000 hospital visits, and 4,261 deaths in 2002, the latest year from which statistics are available, according to the CDC.

The condition accounts for 12.8 million lost school days and 24.5 million lost workdays every year, according to the CDC's statistics.

Asthma is one of the few chronic conditions that appear to go away for a period of time. The lack of ongoing symptoms prompts people to stop taking their medication, thus precipitating an asthma attack, says **Janis Sabol**, RRT, team coordinator for the asthma program at Optima Health, a Virginia Beach, VA, insurer.

The American Lung Association's National Asthma survey revealed that although patients and parents of patients say asthma is easy to control, most have a high tolerance for recurring asthma symptoms, lifestyle accommodations, and negative family impact.

Among those replying to the survey, 83% of parents of asthma patients and 75% of adult patients with asthma reported unscheduled visits to the physician over the past year due to asthma attacks.

Most patients and parents of patients who responded to the survey believed that asthma should be treated when symptoms appear and do not recognize the difference between controller and reliever medications.

The lack of understanding of the treatment and management of asthma is present even among those with persistent asthma, the survey showed.

When asked to name a controller medication, 73% of adult patients and 79% of parents of asthmatics named a reliever medication.

"One of the reasons people are not compliant with their medication regime is that they don't see immediate results from inhaled steroids. Patients have to use them every day for a while before they notice a change in symptoms. When they use the rescue medication, they notice a difference as quickly as 30 seconds later," Sabol says.

When she talks to members about asthma management, **Amy Vissing**, RN, BSN AE/C, asthma disease manager for Passport Health Plan, compares using the controller medication to using sunscreen when you go out into the sun.

"People with asthma have sensitive airways, and they are very sensitive to things they breathe in. The controller medication helps them avoid attacks, just like sunscreen helps them avoid a sunburn," she says.

Among the misconceptions that people with asthma have is thinking that they outgrow asthma. Although the symptoms can abate as people age, once someone has asthma, they always have sensitive airways and can experience an asthma attack at any age, adds **Terry Watson**, RN, manager of Passport's health management department.

"We need to circle the wagons to get around this disease process. We have to work together because there are so many people being diagnosed," says **Pamela Persichilli**, RNC, director of clinical operations for Horizon NJ Health. ■

Comprehensive approach includes educating docs

Decreases asthma-related admits, ED visits

Blue Cross of California State Sponsored Business takes a comprehensive approach to asthma management, partnering with the Fresno Valley Air Quality Board on ways to improve air quality in Fresno County, piloting a project to help physician practices improve their asthma treatment methods, and developing a three-tiered approach to managing members' asthma.

The health plan experienced a 60% decrease in asthma-related hospital admissions and a 46% decrease among members enrolled in its comprehensive asthma interventional program, according to an evaluation of claims for services performed between 2004 and 2006.

In an effort to reduce asthma attacks among its members, Blue Cross of California State Sponsored Business went beyond the standard asthma management programs and created a unique private-public partnership to deal with air quality issues that precipitate asthma attacks.

The health plan received the 2006 National Environmental Leadership Award in Asthma Management from the U.S. Environmental Protection Agency for its asthma intervention program.

The health plan compiled information on hospitalizations, emergency department visits, and physician's office visits related to asthma among its members residing in Fresno County. It shared the information with the local air quality board, Fresno Public Health Department, and researchers at California State University, Fresno, to see if there was a correlation between asthma attacks and air quality issues in the community, according to **Dawn Wood**, MD, vice president, medical director of the health plan, an operating subsidiary of WellPoint Inc. with headquarters in Thousand Oaks, CA.

The data showed that asthma attacks increased during the time that landfill fires were burning out of control in Fresno County.

"At the time we did the study, there were periodic fires in county landfills that burned out of control. Our data helped the county and other community partners take steps to get the fires under better control," Wood reports.

The health plan is continuing to work with the air quality board on ongoing air quality management, Wood adds.

"The landfill fires are not as much of an issue now, so the project is working to identify other air quality factors that contribute to asthma attacks," she says.

Practice improvement project

As part of its initiatives to find better ways to control asthma, the health plan is piloting a practice improvement project with five physician practices in San Francisco, says **Margot Lisa Miglins**, PhD, clinical research manager.

"We are helping physicians and their staff learn what they can do to educate the patient and family about environmental toxins, pollutants, and asthma triggers in the home, the school, and the work environment," she says.

The insurer provides the physician practices with asthma education materials to share with the members, along with pillow covers and mattress covers that the physicians can give to the patients whose asthma is triggered by allergies.

The health plan's health promotion consultant in San Francisco makes periodic visits to the physician offices, bringing them materials and working with them on practice modifications.

The project has resulted in four practice modifications that have made a big difference in improving services to asthma patients, Miglins says.

The clinics have begun to use registries for asthma patients. These are computerized databases that allow physicians to immediately identify who has asthma, how severe it is, and when the patient was last seen.

Instead of taking patient encounter notes on a blank piece of paper, the physicians in the pilot project have begun using guided, structured progress notes that prompt them with questions to ask and procedures to implement.

At least one person in each physician practice has taken a comprehensive training program and become certified to be an asthma educator. The asthma educators work with the members with asthma and those involved in their care, including schools and day care centers.

All of the practices have revitalized their procedures for involving families in the management of the member's asthma.

The health plan's asthma intervention program takes a three-pronged approach to asthma management, intensifying the interventions based on the severity of the member's asthma.

When members are identified as having made an asthma-related ED visit, they are enrolled in the asthma program and screened for case management.

"Some of our members go to the emergency room two or three times during the high season when their allergies are the worse. These members most likely end up being case-managed by a nurse who helps them learn to manage their environmental triggers," says **Thi Montalvo**, MHA, senior health services analyst.

Members who have been to the emergency department receive additional interventions, including more educational material and an easy-to-read handbook covering 200 conditions and how to manage them.

Members are encouraged to call the insurer's 24-hour nurse information line if they have questions about their condition and are unable to reach their physician.

"If members are repeatedly going to the emergency room and not to the primary care physician, this tells us the member has not established a medical home. These are the kinds of members that we know interventions will help," Montalvo says.

Using claims and pharmacy data, the health plan stratifies members with asthma by risk level. There are about 47,000 members with asthma.

All members who are identified with asthma are enrolled in the asthma disease management program and receive an educational package. The

materials include an offer to send members an inhaler case, a pillowcase cover, or other asthma-related items if the members send in a form indicating that they have seen their doctor.

The plan's proactive case management and/or clinical operations specialists call patients who are at moderate risk if they have not been to the primary care physician for an office visit and encourage them to work with their doctors to develop an asthma action plan.

High-risk members go through an intensive screening process to see if they are appropriate for the asthma case management program.

"After our annual sweep of claims data, all moderate and high-risk members with asthma are mailed educational materials that focus on how to manage asthma, how to reduce exposure to environmental triggers, and the importance of going to the doctor and working with him to develop an asthma action plan," Montalvo says.

Low-risk members are eligible to receive the asthma education packet upon request. All identified members are put into the asthma registry, which tracks and trends each member's asthma condition over the years, she adds.

The case management nurse works with the physician and patient to manage the disease, prompts the patient to go for office visits, and works with him or her on taking controller medication regularly and relying less on the rescue medicines.

The plan provides physicians with triplicate copies of the asthma action plan — one for its medical files, one for the patients, and one to forward to the specialist if the patient is referred to an allergist or pulmonologist.

The health plan provides primary care physicians with a member-specific asthma fact sheet to insert into the medical record.

The fact sheet includes information on emergency department visits, inpatient hospital stays, specialist visits, primary care visits, the number of times the controller medicine and rescue medicine were refilled, and any comorbidities the patient may have.

The pharmacy information helps the physicians understand how much medication their patients are using and if they are following the prescribed medication regimen.

"We encourage the physicians to utilize the information. For instance, if they see that the patient has had no primary care visits, we hope that they will take the next step and try to get the patient to come in for a visit," she says. ■

Disease managers visit asthma patients in the ICU

Members are more agreeable when in crisis

When members of Passport Health Plan are hospitalized in the intensive care unit for asthma, the plan's asthma disease managers visit them on-site and work with the hospital's asthma educator to help them learn to manage their disease.

"In the beginning, we attempted to reach the high-risk members telephonically, but the high volume of members was difficult to manage on a one-on-one basis. We decided to concentrate on members who are in the intensive care unit because they are at most risk and tend to be more willing to allow the disease manager to work with them when they receive a personal visit while they are still in the crisis mode," says **Amy Vissing**, RN, BSN AE-C, asthma disease manager for the Louisville, KY-based HMO.

Last quarter, the disease managers provided one-on-one care management to 88 members in the intensive care unit. The majority of members who receive individual disease management visits in the hospital are children.

"We have a large population of children with pure persistent asthma. The adult population tends to have emphysema or chronic obstructive pulmonary disease, as well," says **Terry Watson**, manager of Passport's health management department.

The disease managers have worked with the hospital's case managers, utilization review nurses, and asthma educators, asking to be notified when a member is hospitalized in the intensive care unit with asthma.

"When we find out about a member who is in the hospital, we attempt to make a visit to the hospital and talk with the parent or guardian and the patient about the asthma. If they are in agreement, we follow them one-on-one and may accompany them on their first follow-up visit to their physician and get them connected to a specialist, when needed," Vissing says.

At one time, the disease managers provided individual care management following reports culled from the claims data.

"That data was old, since it was based on claims. It had been two to six months since the member was in the intensive care unit. By then, their acute episode was over and we had trouble getting them to agree to continue our interven-

tions," Vissing says.

Many of the health plan's members are transient and often are difficult to locate.

"When we meet them in the hospital, often they will give us their new phone number or their new address. That's been one of the biggest pluses for the one-on-one piece," Vissing says.

The disease managers follow the patients for as long as they need interventions, sometimes for a year or more.

"Some of the children are very severe and require a lot of interventions," Vissing says.

Passport Health established its asthma disease management program in 2000 with a goal of improving the quality of life for members with asthma and reducing unnecessary asthma-related hospitalization and emergency department use.

HEDIS data from the National Committee for Quality Insurance rank Passport Health Plan in the top 10% of plans nationally for use of appropriate medications by people with asthma.

Using claims data, the health plan divides members with asthma into five groups, based on the severity of illness and the services they have used.

All members with asthma receive a welcome package, a peak flow meter, and monthly educational mailings.

The health plan sends members with asthma periodic educational materials, such as an asthma pocket guide that explains what patients should do every day and what steps they should take in case of an emergency.

"What members don't recognize are the persistent symptoms of asthma. They can be very inconspicuous, such as frequent nighttime coughs," Vissing says.

High-risk members are those who have been hospitalized with asthma, who have utilized the emergency department, or have been admitted to the intensive care unit.

Quarterly, out of about 6,000 members with persistent asthma, about 200 are considered high risk.

Passport Health mails extra information to high-risk members, urging them to talk with their physicians about controller medications. Additionally, Passport sends letters to providers, alerting them that members have been designated at high risk, based on their utilization of services for asthma.

"We attempt to make telephone contact with adult high-risk members and tell them about the program. We have access to information about their medication. If we can't talk with them, we send them a letter saying we noticed they have not refilled their controller medication and ask them to contact the pharmacy for a refill as soon as possible," Vissing says.

The plan pays for an environmental assessment and a follow-up visit by a home health agency.

The health plan mails asthma assessments to newly identified members with persistent asthma. Last month, the health plan received 354 completed assessments.

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 credit letter. When your evaluation is received, a credit letter 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

- Strategies for improving pre-surgery teaching
- Education's role in creating a safer health care experience
- Improving the newborn survival rate with education
- Education committees: not for review only
- Using consumers for material evaluation

CE Questions

9. When creating a survey tool to measure staff competency in patient teaching, which factor/s did PEMs find important to measure?

A. Personal skill level
B. Importance of the skill
C. How often skill is used
D. A and B

10. The Situational Education Theory helps the nurse adapt his or her teaching style to the learner's readiness by doing which of the following based on the patient's readiness to learn?

A. Adjusting amount of instruction.
B. Adjusting amount of supervision.
C. Adjusting amount of support in teaching.
D. All of the above.

11. Blue Cross of California has experienced a decrease of ____ in hospital admissions for members enrolled in its comprehensive asthma interventional program.

A. 20%
B. 40%
C. 60%
D. 80%

12. Out of about 6,000 members with persistent asthma at Passport Health Plan in Louisville, KY, ___ are considered high risk.

A. 200
B. 500
C. 1,000
D. 1,400

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

"We're filtering through the assessments and contacting members who need more interventions," Watson says.

The asthma disease managers work closely with providers who see a high volume of members, visiting them in person, providing them with educational materials, and encouraging them to follow guidelines from the National Institute of Health's Heart, Blood and Lung Institute.

"When we go into the physician offices, we teach the staff providing asthma education to our members how to use the various types of inhalers. There are a lot of different types of devices, and the amount of medication that patient receives is directly related to how well they are able to use the device," Vissing says. ■

NEWS BRIEF

HCEA annual conference scheduled for September

The 9th annual Health Care Education Association conference is scheduled for Sept. 20-22 at the Georgia Tech Hotel and Conference Center in Atlanta. The theme is "The Cutting Edge of Health Care Education."

A free post-conference session will be held Friday, Sept. 22 from 4-9 p.m. and Saturday, Sept 23 from 9 a.m. to noon covering family libraries and family resource centers.

For more information visit www.hcea-info.org. ■