Patient Education Management™

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

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IN THIS ISSUE

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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.

OCTOBER 2006
VOL. 13, NO. 10 • (pages 109-120)

U.S. newborn death rate high but early education could reduce infant mortality

CDC: Changes in knowledge and attitude are necessary

Health education aimed at healthy babies should begin long before conception, before even the thought of conception. According to a report issued by the Centers for Disease Control and Prevention, the majority of U.S. adults do not know how unhealthy lifestyle choices, such as smoking, obesity, or misuse of alcohol, influence reproductive health and childbearing. To improve preconception health, the report says, "Changes in the knowledge and attitudes and behaviors related to reproductive health among both men and women need to be made."

"Education needs to happen before a woman gets pregnant to prevent any kind of adverse outcome for the woman and for the infant," says **Samuel F. Posner,** PhD, assistant director for science at the CDC's division of reproductive health.

To achieve better outcomes for both mother and baby, the CDC issued recommendations in April on both preconception health and preconception health care. There are 10 categories of health action steps

EXECUTIVE SUMMARY

Education is an important part of prenatal health care. However, in a report issued recently by the Centers for Disease Control and Prevention much of the routine education progams and interventions should be part of an ongoing educational strategy that takes place throughout a woman's reproductive years. Early screenings could identify potential risk factors to head off before conception. In this issue of *Patient Education Management*, we discuss educational strategies for improving preconception health.

and many focus on education. **(See a list of educational action steps on p. 111.)**

"There are endless opportunities for health education in the context of preconception care and preconception health," says Posner.

One important message is that women should not wait until they are pregnant to make sure they are eating a healthy diet, taking vitamins, and getting enough sleep. Healthy behaviors should be developed before a woman becomes pregnant so that she doesn't have to adopt multiple behavioral changes afterwards, says Posner.

"This area is a great opportunity for patient education. What are some of the key areas they might want to think about? If there were some behavior changes they might want to initiate for improving their health, what would be the top priorities?" Posner says.

Education can start in schools with information on how decisions regarding health impact a person in the short and long term. While it is difficult to get young people to consider the consequences of poor health choices over a lifetime, it is important to begin to think about such things at a young age, Posner says.

Education should include learning how to prevent pregnancy, whether through abstinence from sex or use of effective contraceptive methods, so that pregnancy occurs at a time when couples are ready — psychologically, physically, and mentally. "All those things have an impact on a mother's health and well-being throughout the lifespan, as well as the infant's health," says Posner.

Creating a reproductive life plan

Women and men should consider developing a reproductive life plan that is part of a broader life plan. This plan considers what a person wants to achieve and what they want to do, whether traveling or obtaining a certain career, as well as becoming a parent, and how it all fits together.

Health care institutions can provide tools and education about reproductive life plans. Such tools can help people plan when they might want to become pregnant and what they need to do to prepare themselves spiritually, mentally, and socially, says Posner.

If preconception health screenings were part of routine care for women of reproductive age, such issues as poor nutrition and medical conditions and use of certain medications could be addressed to prepare for pregnancy whenever it might occur.

According to the CDC report, "a reproductive health plan might increase the number of

SOURCES

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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.)

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Thomson American Health Consultants also is approved by the California Board of Registered Nursing, provider number CEP10864. This activity is approved for 18 contact hours per year.

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.

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.

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planned pregnancies and encourage persons to address risk behaviors before conception, reducing the risk for adverse outcomes for both the mother and the infant."

"About 50% of the pregnancies in the U.S. are unintended. We need to recognize that is the case and work toward lowering that number and also realize that will not happen overnight," Posner says. "Anything we can do to improve how people plan how they will move through their lives, including their reproductive decisions, will benefit the women and the men, as well as any children they will have."

There are health care facilities that have developed tools for creating a reproductive health plan and other educational materials to support preconception health strategies. Posner says it would be beneficial for each institution to evaluate its tools for effectiveness and then share the materials along with the evaluation results.

"We are looking to people like patient educators who are doing these things to evaluate and disseminate their findings. If we can take advantage of what people have already done, it will help move this forward rather then having each clinic develop their own materials. What we need to do is share what we have already learned so everyone can benefit from it," says Posner. ■

Health action steps to smarter conception

In April, the Centers for Disease Control and Prevention recommended several preconception health action steps to improve the health of women and men in their reproductive years for healthier families.

- Develop, evaluate, and disseminate reproductive life planning tools for women and men in their childbearing years, respecting variations in age, literacy (including health literacy), and cultural/linguistic contexts.
- Conduct research leading to development, dissemination, and evaluation of individual health education materials for women and men regarding preconception risk factors, including materials related to biomedical, behavioral, and social risks known to affect pregnancy outcomes.
- Develop, evaluate, and disseminate age-appropriate educational curricula and modules for use in school health education programs.
- Integrate reproductive health messages into existing health promotion campaigns (e.g., campaigns to reduce obesity and smoking).
- Conduct consumer-focused research to identify terms that the public understands and to develop messages for promoting preconception health and reproductive awareness.
- Design and conduct social marketing campaigns necessary to develop messages for promoting preconception health knowledge and attitudes and behaviors among men and women of childbearing age.
- Educate women and couples regarding the value and availability of pre-pregnancy planning visits.

The complete list can be found at www.cdc.gov/reproductivehealth. Look for the report titled, "Recommendations to Improve Preconception Health and Health Care — United States." ■

Reaching at-risk women to save mothers, babies

Programs arm potential mothers with knowledge

Recently, Save the Children, an international relief organization, reported that the U.S. infant mortality rate is nearly five per 1,000 babies. Of 33 industrialized nations, the U.S. ranked near the bottom, tied with Hungary, Malta, Poland, and Slovakia.

According to data gathered by the organization, the leading cause of newborn death in industrialized nations is premature birth and low birth weight.

The best way to address both these problems is to provide good prenatal care for women and that includes education, says **Lora Harding Dundek**, MPH, manager of birth and family education and support services at the University of Minnesota Medical Center and UM Children's Hospital, Fairview in Minneapolis.

"It is a process of good prenatal care and good pre-pregnancy care and education for good nutrition, exercise, and stress management," says

Dundek. While most people know that such habits as cigarette smoking are not good for the health of a baby, additional education and support can help them change their behavior, she says.

The earlier the better

Entering into prenatal care early is important, says **Renee Padmore-Baccus**, MEd, coordinator of the New York state-funded Prenatal Care Assistance Program at New York-Presbyterian Hospital in New York City.

"When women enter our program early, we are able to give them a lot more education and a lot more background in terms of caring for themselves appropriately so the baby is cared for and has a healthy outcome," explains Padmore-Baccus.

Many institutions throughout the United States have created programs that target women who are at risk of receiving inadequate prenatal care. They have been designed to reach specific populations.

Yet, one challenge for any program targeting the underserved is making contact and getting women enrolled. That's why staff involved in the Community Health Worker Program for Urban Health Plan Inc., a New York state-funded clinic in the Bronx, go out into the community on foot to find clientele.

According to coordinator **Colette Sturgis**, staff members canvas the streets looking for pregnant women that would benefit from the educational program, which includes home visits. They talk to women about the importance of prenatal care at laundry mats and beauty salons. And they get referrals from clinics, social services, and daycare programs.

The program targets women at high risk, such as those who are receiving little or no prenatal care, might be drinking or using drugs, are HIV-positive, or are teen-agers.

To get the word out to its target population, staff for the OhioHealth Wellness on Wheels Mobile Unit network with prenatal health care teams throughout Columbus so everyone is aware of the services they provide, says **Sonia Booker**, RN, clinical coordinator for the program.

A lot of marketing is done, including participating in community events sponsored by organizations that reach out to pregnant women. A phone base called Pregnancy Care Connection at OhioHealth makes appointments for the mobile unit, as well as other providers, to get women into prenatal care. Three appointment slots for the mobile unit are kept open each week so the program can get women connected.

"Our goal is to at least have first trimester entry to care; however, we will take women up to 35 weeks. If women are late entry to care we try to see them at least three times before their baby is born," says Booker.

Removing obstacles to care

Enrolling women in a program is only beneficial if they show up for the appointment. To make sure this occurs the mobile unit, which contains exam rooms, a lab, a small pharmacy, and two counseling rooms, goes out six times a week to eight locations. All the sites are on the bus line, and cab passes are provided when needed. A 12-passenger van also picks up patients. Booker says there are 13 high schools in the Columbus area and the mobile unit goes to five of them and the van driver picks up pregnant teens from other schools. The mobile unit serves women age 12 to 40. Although once it was used for a variety of programs — hence its name, Wellness on Wheels — it is now used for prenatal care and also goes to high schools to give students free sports physicals.

The Community Health Worker Program makes access simple because staff members go to the women's homes. However, Sturgis says some of the women come to the office for their meetings.

Once women have made it to their appointment, there are opportunities for education. However, it's important to have a system to follow to make sure quality education is delivered. Padmore-Baccus says at one time education for the Prenatal Care Assistance Program was delivered randomly but now there is a plan that is followed. Women in the waiting room watch videos and when they see their provider they are given information appropriate to the visit. Before they leave the nurse reinforces the education that took place in the exam room and adds to it.

Staff for Wellness on Wheels follow a critical path for education that adheres to the guidelines set in place by the American College of Obstetricians and Gynecologists.

In addition, women receive a pregnancy guide

about 30 pages long and nurses review parts of it with them. "We do a lot of education. Much of our population is the young women having a child and we know they may not have a lot of support, people who can take the time to educate. So we do an enormous amount of education," says Booker.

The outreach workers in the Community Health Worker Program cover many topics in their visits. Sturgis says staff members, who often are residents of the community in which they are working, have educational goals.

Women in the program are taught the importance of prenatal and postpartum care and are connected to support programs that help provide the means to obtain nutritious food for mothers and babies, as well as medical coverage.

Breastfeeding is taught and women are encouraged to breastfeed their babies six months or longer. Also the peer counselors try to make sure the children have a family physician they see regularly for preventive care.

Women are taught about such safety issues as domestic violence and the importance of having a baby sleep on his or her back to prevent sudden infant death syndrome. Women are encouraged to know their status for HIV and AIDS and if addicted to drugs or alcohol they are asked to get help. A social worker provides assistance when clients are willing to enroll in a substance abuse program.

Community health workers act as a bridge between the women and support programs and point them in the right direction, says Sturgis. "We want to make sure they are able to make healthy decisions," she says.

SOURCES

For additional information about preventing infant mortality, contact:

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- **Renee Padmore-Baccus**, MEd, Coordinator, Prenatal Care Assistance Program, New York-Presbyterian Hospital, Cornell and Columbia campuses, New York, NY. E-mail: rbaccus@nyp.org.
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Crossing barriers

The language barrier can be a big problem. That's why a telephone interpreting service is accessed when a non-English-speaking patient calls for an appointment to the mobile care unit. "The interpreter tells us what we need for the first visit and also tells the patient how to get to the site of the mobile unit," says Booker. An interpreter from OhioHealth then comes for the patient's appointment and continues to work with the patient for the full nine months of pregnancy.

Sometimes people from other cultures are noncompliant because they do not agree with what is taught. When cultural or religious beliefs clash with the teaching or practice it is important for both parties to work to understand one another, says Dundek.

For example, Somali women who were in labor at the University of Minnesota Medical Center refused to get into a tub of water to make the labor progress faster. It was a foreign concept to them and their modesty prevented them from willingly participating in the practice.

Therefore, hospital staff met with women from that ethnic population and learned they felt abandoned in birth. People who did not speak their language and did not understand their culture surrounded them.

Speak in terms patients can understand

To remedy the problem a Doula program was introduced. ("Doula" is a Greek word that means servant of women.) When a Somali woman comes in to give birth she has the option of using a Doula, also a Somali woman, who provides support during the labor process.

"It has been a useful program for us and the rate of Caesarean births in Somali women is about half. It impacts clinical outcomes and it helps them be more satisfied," says Dundek.

It is easier to educate the patient if she has an active role in her care, says Padmore-Baccus. To

overcome compliance challenges, patients must understand why they are being asked to do something. For example, a Hispanic woman eats a lot of beans and rice, which might make her feet swell. If she understands this she is more likely to agree to eat fewer servings.

(Editor's note: Data and reports compiled by Save the Children can be accessed at www.savethechildren.org.) ■

Partner with patients and families for education

How one educator involves families in care

As associate director of patient and family centered care and education services at the University of Washington Medical Center in Seattle, **Cezanne Garcia**, MPH, CHES, directs and facilitates a broad range of patient- and family-centered care, quality improvements, and patient education programs.

"My work focuses on how we can actively engage patients, families, and staff in collaborative partnerships to improve the care experience," says Garcia.

The goal is to bring the best patient education resources and processes to the fingertips of clinicians who are primary educators and to put in place processes that elicit patient and family involvement on quality improvement initiatives and operating committees so there is a complete interdisciplinary team present to make the best decisions.

Currently there are 18 committees on which patient and family members sit. These include the ethics committee, grievance committee, patient safety committee, and patient and family education committee.

The medical center is part of the University of Washington campus. Each year 18,000 to 20,000 patients are hospitalized and about 350,000 people are seen as outpatients.

Patient education is part of patient care services that includes nursing, therapies, social work, and interpreter services. Garcia reports to the nurse executive officer and the director of professional practice and quality improvement.

Her team includes three health educators who work part-time, a part-time production coordinator, an hourly graphic artist, a program support supervisor, and a part-time program coordinator.

Two of the health educators act as project managers for material production, from videos to written items. They also train staff on health literacy and communication. A third health educator was recently hired to oversee a health resource center that is opening in the main lobby. It is linked to six small libraries located throughout the clinical care areas.

The production coordinator helps manage the database of written materials distributed via the Intranet and does simple design and layout of posters and other signs. The graphic artist illustrates patient education materials.

The program support supervisor helps with office management, budget reconciliation, and departmental marketing and communications initiatives (e.g., newsletter, patient and family education toolkit, etc.).

The program coordinator helps manage projects, oversees councils, and recruits people for the patient and family advisor program.

Garcia states that it is the capabilities of her strong team, interdisciplinary committees, and patient and family advisors that keep activities in pulse with "point-of-care needs" and able to adapt to the constantly changing health care and patient and family care system needs and demands.

Garcia has been in her current position for 11 years. With a master's in public health and health education and a minor in health policy, she has held a variety of jobs including work as a senior health planner for the Navaho Nation. The patient/family-centered care work that is now part of her position is a new branch the medical center added in the past four years.

In an interview, Garcia, who also sits on the editorial board for *Patient Education Management*, discussed her job, her philosophy on patient education, the challenges she has met, and the skills she has developed that help her do her job well.

Family-centered care best success

Q: What is your best success story?

A: We now have 12 patient and family advisors who review our patient education materials and family-completed forms. They make sure the forms are easy to understand and have adequate space for people to write in their comments and the education materials are clear

and understandable and that we address the key issues important to patients and families.

Additionally, we are engaging patients and families in the authorship of our larger publications, which are booklets or manuals of 15 pages or more. We work to have advisors on the writing/planning teams and when that is not possible we use surveys and send draft versions and core objectives to patients and their families to ask for feedback. Also, we send the tool out to patients after clinicians have done the final review. There are some tools in which the patients and families have been the main authors.

We have engaged our patients and families as faculty to help clinicians understand what is most important in the care experience.

Q: What is your area of strength?

A: To design, implement, and then continually refine organizational processes that address clearly defined objectives and goals, but are refined so they are as efficient as possible and bring forward the best quality product.

The skill that augments that is the ability to see the organization from point of care to the big system pieces. I am able to migrate up and down from those differing perspectives and try hard to bring forward the best work.

Q: What lesson did you learn the hard way?

A: Patient and family involvement in designing educational programs and materials requires a thoughtful and steadfast focus on culture change. Many of our clinicians are so oriented to what is needed for a technically competent care experience, but this also needs to be abridged with information that highlights the functional and emotional support needs of our patients and families.

The integrity of our efforts must include securing clinician and administrator commitment to not only listen, but hear and guide their actions to reflect patient and family-defined needs — not our translation of what "we" think they need or serves our system-centered or clinician-centered lens alone.

Q: What is your weakest link or greatest challenge?

A: Our greatest challenge is limited resources to support the growing programs and patient and family education needs of our clinical teams. The bottom line is having resources invested in the frontline clinical piece, where we give the time staff need to provide patient education and all the support functions such as documentation. We continue to groom systems so that with a click of a button on the computer they have material to reinforce verbal education or streamline the documentation as much as possible.

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

A: To change it to patient and family education rather than just patient education; I think family involvement is often assumed but not directly engaged. In some areas with decreased length of stay we are increasingly sending patients home with family members or trusted friends who are providing clinical care.

Part of my vision is for us to robustly address and engage our patient and family members in our education and directives. We also need to more actively demonstrate our positive contribution to our organization's outcomes, whether clinical care, patient satisfaction, financial goals, patient safety (reduction of medical errors), or marketing strategies. There is a lot of opportunity to show how we demonstrate our integration with the financial goals and safety mission of our organization.

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

A: Our last visit with the Joint Commission on Accreditation of Healthcare Organizations was about 18 months ago. We did very well in the patient education area and have not made any profound changes. We are continuing to direct our organization toward demonstrating the education provided by the use of documentation practices. We also are continuing to grow ways our patient and families are active partners in the care experience.

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

A: We talk directly with our patients and fami-

SOURCES

For more information on patient-centered care and other topics discussed, contact:

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lies and with the staff and try to engage as many of the interdisciplinary team members as we can. Also we go to the literature and do searches to see what is the best evidence-based practice. My strategy is to tear copies of articles and features from publications and file them according to specific diseases, processes, or skills, so that when I am working on diabetes, for example, I pull my folder out and see what I already have or what was culled from an earlier literature search. I have one general articles drawer and another that is more skills-based. ■

Initiatives aim to enhance patient communications

AMA, NIH announce programs

A report offering guidelines to help health care organizations ensure effective, patient-centered communications with patients of diverse backgrounds has been released by the American Medical Association (AMA) Ethical Force Program.

Hospitals can use the report to identify areas of strength or weakness and focus resources where needed, according to a statement from the program, which is field-testing an organizational self-assessment toolkit based on the report.

The report separates organizational performance into six main areas and three "subareas." Quality improvement efforts to promote patient-centered communication could focus on any or all of these interrelated areas, which include:

- understand your organization's commitment;
- collect information;
- engage communities;
- develop workforce;
- engage individuals;
- sociocultural context;
- language;
- health literacy;
- evaluate performance.

It lists a number of specific, measurable expectations for performance in each of these areas — more than 50 in all.

The AMA's Institute for Ethics and Health Research and Educational Trust, an affiliate of the American Hospital Association, is conducting the program's initiative on patient-centered communication. More information is available at EthicalForce@ama-assn.org.

In another effort aimed at enhancing patient-provider communication, the National Institute on Aging, part of the National Institutes of Health, has published a guide to help older Hispanics communicate effectively with their physicians and other health care providers.

The Spanish-language publication also helps consumers choose a physician, prepare for an appointment, work with an interpreter, discuss sensitive health issues, and find additional information in Spanish.

A national program recently announced by the Robert Wood Johnson Foundation (RWJF) is designed to support hospitals in improving the quality and availability of health care language services for patients with limited English proficiency (LEP).

"Speaking Together: National Language Services Network" (NLSN) has four goals:

- To improve communication between patients with LEP and their health care providers.
- To work in partnership with hospitals to develop models of high-quality language services.
- To develop useful measures in the area of language services to enable hospitals to conduct ongoing measurement of effectiveness and create performance benchmarks.
- To encourage the spread of successful strategies to increase language services within and across hospitals and health systems.

The core component of the program is a 16-month hospital learning collaborative aimed at fostering shared learning and innovation among participants. Sites selected to participate in the

collaborative will receive grants of up to $60,000, as well as technical assistance and training using measures developed by the national program office (NPO). George Washington University Medical Center will serve as the NPO for this program.

Eligible sites are non-federal, general acute-care hospitals that have a minimum of 10,000 discharges per year and serve substantial numbers of patients with LEP. Hospitals must be operating a language services program that involves on-site professional interpreters. ■

Speaking their language: Crossing cultural barriers

Be familiar with practices of populations you serve

Navigating the health care system often is bewildering for people who were born in the United States and speak English; it may be incomprehensible for some of this country's growing immigrant population, who bring their own cultural beliefs and practices with them.

Addressing the needs of this increasingly diverse population has become a major challenge for health plans, clinicians, and health systems, and the job only is going to get more challenging as the immigrant population increases, according to the Agency on Healthcare Research and Quality (AHRQ).

Minority Americans are expected to make up more than 40% of the U.S. population by 2035, according to AHRQ.

"Culturally and linguistically diverse groups and individuals of limited English proficiency typically experience less adequate access to care, lower quality of care, and poorer health status and outcomes," the AHRQ reports.

Managed care plans must become sensitive to the multicultural populations that they serve, says **Catherine Mullahy**, RN, BS, CRRN, CCM, president of Huntington, NY-based Options Unlimited, a Matria Healthcare company.

This means that case managers should take an active role in improving their own cultural competency and gain an understanding of the beliefs and practices of the populations they serve, she adds.

"We live in such a melting-pot kind of society that it is a challenge for health care to keep up with the changes in the populations they serve. I believe in the value of culturally competent care, and I think managed care organizations have done some good things, depending on where they are located," she says.

Blue Cross and Blue Shield of Minnesota has provided health literacy and motivational interviewing training for its case management staff and provides additional education through its continuing education program, says **Jane Cavanaugh**, RN, CCM, CPHQ, nurse case manager for the St. Paul-based health plan.

"Our health care demographic has changed as a non-English-speaking population has moved into the area. When the first influx of immigrants arrived in our area in the 1970s, we were not prepared to deal with the health issue and communications issues that arise when people of other cultures need the services of Western medicine," she recalls.

At the time, health plans and hospitals didn't have interpreters on the staff, Cavanaugh says. "They didn't speak English, and we couldn't understand them. It was a difficult time for us and for the members."

When she began managing the care of the first member who didn't speak English, Cavanaugh began doing research for information on that member's cultural beliefs.

"Case managing someone from another culture means being flexible. You have to respect their ideas and look for ways to meet their needs that still respect their traditional medicine. Some of the traditional techniques we use with American-born members won't work with people from other cultures," Cavanaugh explains.

For instance, when she managed the care of a Vietnamese woman with lung cancer, she learned that the woman would ride in a car only with her husband.

Instead of arranging transportation so the woman could see her physician, she had to arrange the appointments around the husband's work schedule. **(For more details, see related article, p. 118.)**

"More and more managed care organizations are becoming increasingly sensitive to the multicultural population that they serve," Mullahy says.

For instance, when care coordinators with UCare Minnesota's Minnesota Senior Health Options (MSHO) visit the homes of their clients from other cultures, they often are accompanied

by another staff member who is from the same cultural background as the client they are visiting.

MSHO is a health coverage plan created by the Minnesota Department of Human Services and offered through UCare Minnesota.

Case manager **Cindy Radke**, LSW, and **Maiyer Vang**, BS, associate case manager, work as a team to coordinate the care of MSHO members from the Hmong community.

"Maiyer is an asset to me. She helps me understand the traditional beliefs of our Hmong members and assists in setting up services. We work as a team to help members get everything they need to remain healthy at home," Radke says.

The UCare population includes Hmong, Somali, Russian, Cambodian, Vietnamese, and Spanish members. Hmong and Somali are among the biggest populations.

If you are serving people from a multitude of backgrounds and cultures, it's a good idea to familiarize yourself with the beliefs and practices of the people whose care you manage, Mullahy suggests.

"Understand the culture you're working with and look for resources to expand your knowledge base so you can meet the needs of your clients," Cavanaugh adds.

There are a multitude of web sites and materials that can help provide insight into diverse populations, she suggests.

Case managers should look to resources in the ethnic communities they serve to learn about what programs are available for members and for information on how to develop materials that are geared to that population, Mullahy suggests.

RESOURCES

For more information, contact:

- **The Cross Cultural Healthcare Program:** www.xculture.org/
- **DiversityRX:** www.diversityrx.org/
- **The Center for Cross-Cultural Health:** www.crosshealth.com
- **The Minority Health Network:** www.pitt.edu/~ejb4/min/
- **National Multicultural Institute:** www.nmci.org/

Source: Blue Cross and Blue Shield of Minnesota, St. Paul.

"It's worth the time and energy to develop materials that are user-friendly for large ethnic populations," she adds.

Most health plans have information available in Spanish, but consider developing educational materials for other ethnic groups if your membership includes a large population, Mullahy says.

Some managed care organizations list physicians who speak a variety of languages on their web site so that speakers of that language can select a physician with whom they can communicate, she says.

Look to the community itself for help in writing the materials and making them user-friendly for your membership, or turn to people on your staff for help.

Recruit nurses from the multicultural communities you serve, Mullahy recommends.

"There is more than one class of people immigrating to this country. A lot of professional people are immigrating here and can be an asset to managed care organizations because they speak the language and they are aware of the cultural beliefs and needs of the community you serve," Mullahy says.

If you have a large number of members from an ethnic group, find a nurse who speaks that language and can be an interpreter.

"One of our biggest assets is having staff members we can call on to find out about the traditional beliefs of each of the cultures we serve," Radke says.

Become comfortable with using a language line and an interpreter service, Cavanaugh suggests.

If you find an interpreter the member is comfortable with, request that interpreter for follow-up calls, she adds.

Make sure an interpreter is available to talk with hospitalized members about their discharge plan; and if you call in a home health agency, make sure it uses an interpreter as well, Cavanaugh says. ■

Learn cultural practices of the population you serve

Language barriers, beliefs can be barriers to care

When **Jane Cavanaugh**, RN, CCM, CPHQ, nurse case manager for Blue Cross and Blue Shield of Minnesota, began managing the care of a

Vietnamese woman with lung cancer, she researched beliefs of the Vietnamese culture and tailored her care management plan around them.

The St. Paul-based health plan has internal triggers for referrals to case managers. In the case of the Vietnamese woman, the referral to case management was triggered by a 12-day length of stay.

The patient was discharged to a nursing home that did not have easy access to a medical interpreter. The husband, who also spoke no English, could visit his wife only after work.

"There was a language barrier and problems with communication during the discharge process and during the nursing home stay," Cavanaugh recalls.

Before the patient was discharged, Cavanaugh called the hospital social worker to arrange a meeting with the patient, the family, the doctor, and a medical interpreter who went over the post-discharge plan of care.

"There was a tremendous communication deficit when it came to medications and which one she should take when. We discovered that it doesn't work to discuss colors of pills with the Vietnamese because the blue and green both translate to the same word," she says.

Cavanaugh arranged for home health with an interpreter present. She called the family with the help of an interpreter to remind them of meetings.

The woman was afraid to go through chemotherapy treatment because she was afraid she'd use up her health insurance benefits and there would be nothing left for her husband.

Cavanaugh spent a lot of time explaining Western medical treatment to the family and eventually persuaded the woman to undergo chemotherapy treatment.

For instance, she resisted having blood drawn because of concerns that if a fluid was removed from her body, she would suffer a loss in this life as well as the next.

Using an interpreter, Cavanaugh explained that blood is naturally replenished.

Because the woman's cultural beliefs would allow her to ride in a car only with her husband, Cavanaugh was able to get a specific Friday appointment with an oncologist so she could be evaluated for chemotherapy when the husband was there. She arranged visits for treatment around the husband's work schedule.

Cavanaugh found her motivational interviewing training helpful when dealing with the Vietnamese population.

"To them, saying 'no' means life is in disharmony. I had to ask them open-ended questions," she says.

Many Southeast Asians believe that good health is achieved by harmony between two

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

- Targeting family members for education
- Strategies for helping patients manage pain
- Making good use of patient education committees
- A look at what constitutes documentation of education
- Ways to improve pre-surgery teaching

CE Questions

13. Preconception health education might include which of the following?
A. information on birth control;
B. creating a reproductive life plan;
C. developing healthy eating habits;
D. all of the above.

14. Good prenatal care could help decrease the infant mortality rate. Which of the following strategies help to get women into a program?
A. taking the clinic to them;
B. making home visits;
C. waiting for the women to walk through the doors;
D. A and B.

15. According to the Agency on Healthcare Research and Quality, minority Americans are expected to exceed what percentage of the population by 2035?
A. 20%
B. 30%
C. 40%
D. 50%

16. When possible, U-Care of Minnesota uses family members as interpreters for members who do not speak English.
A. True
B. False

Answers: 13. D; 14. D; 15. C; 16. B.

opposing forces. Their traditional remedies are used when they feel things are out of harmony, she says.

Although the Vietnamese woman's condition was terminal, Cavanaugh was able to help her through the health care maze, taking her cultural beliefs into account.

When the woman's condition deteriorated, Cavanaugh worked collaboratively with the hospital social worker to find a facility that had a Vietnamese-speaking staff member.

Cavanaugh works with an employee group that includes Spanish, Cambodian, Vietnamese, and other immigrant populations and tailors her case management techniques to each member's cultural beliefs.

Members get better care and better health outcomes if you understand their health care practices and their cultural structure, she adds. "It is incumbent on us to be respectful of people's traditional cultures and medical beliefs as we reach out to them." ■