Patient Education Management™

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

AHC Media LLC

IN THIS ISSUE

Financial Disclosure:
Editor Susan Cort Johnson, Associate Publisher 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.

MARCH 2007
VOL. 14, NO. 3 • (pages 25-36)

Strategies for improving safety through patient and family involvement in care

Institutions create ways to achieve latest National Patient Safety Goals

In order to successfully meet the requirements of many of the National Patient Safety Goals for hospitals, educational initiatives must be created and applied.

This is especially true of a goal added in 2007:

Goal 13 states: "Encourage patients' active involvement in their own care as a patient safety strategy."

Goal 13A states: "Define and communicate the means for patients and their families to report concerns about safety and encourage them to do so."

"In order for patients and families to do this, they have to know that involvement is wanted and they have to understand how to go about it so that is where education comes in," says **Richard J. Croteau**, MD, executive director for patient safety initiatives at The Joint Commission in Oak Brook, IL.

Croteau explains that organizations are required to provide ways for patients and families to express their concerns about safety. In addition, they must go beyond giving patients permission to discuss concerns and

EXECUTIVE SUMMARY

There often is a link between National Patient Safety Goals and education. It is education that helps family members and patients understand that their safety is improved if they ask questions. In 2007, The Joint Commission acknowledged this, as well, by making a patient's active involvement in his or her own care a safety goal. In the March issue of *Patient Education Management,* we explore ways to meet the requirement of this goal.

actively encourage them to do so.

"The general message is there are a lot of ways to do this, and it is probably a good idea to have more than one way in an organization," adds Croteau.

Part of the education process is to help patients and families become more observant and know when to speak up. **(To learn more about the types of things in which to teach patients to be more actively involved see information on "Speak Up" campaign on p. 28.)**

In addition to educating patients and families, it is important to educate health care professionals as well as they must not only accept patient involvement but encourage it, says Croteau.

Patient Education Management™ (ISSN 1087-0296) is published monthly by AHC Media LLC, 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: customerservice@ahcmedia.com. World Wide Web: www.ahcmedia.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.)

AHC Media LLC is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

This activity has been approved for 15 nursing contact hours using a 60-minute contact hour.

Provider approved by the California Board of Registered Nursing, Provider # 14749, for 15 Contact Hours.

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.

Editorial Questions

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

Editor: **Susan Cort Johnson**, (530) 256-2749.
Senior Vice President/Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@ahcmedia.com).
Associate Publisher: **Coles McKagen**, (404) 262-5420, (coles.mckagen@ahcmedia.com).
Managing Editor: **Jill Robbins,** (404) 262-5557, (jill.robbins@ ahcmedia.com).

In anticipation of Goal 13 being implemented in 2007, **Annette Mercurio,** MPH, CHES, manager of patient, family, and community education at City of Hope National Medical Center in Duarte, CA, was asked by the vice president of patient care services and vice president for quality and safety to take the lead on addressing the goal.

So she established a "Patient and Family Partnership in Safety" performance improvement team. The team consists of several patients, along with a cross-section of staff, such as a patient advocate, nurse, and social worker.

To identify strategies for partnering with patients the team is in the process of conducting 300 surveys. The survey results also will serve as a baseline for measuring the institution's progress on Goal 13A, determining whether patients know how to report their concerns about safety.

Also the team revised a booklet titled "Be a Partner in Safe Patient Care." This booklet, written in English and Spanish, addresses multiple National Patient Safety Goals, such as improving the accuracy of patient identification by encouraging patients to show their armband to care providers and reducing the risk of health care-associated infections by encouraging patients to ask their care providers if they've washed their hands.

The new improved booklet includes explicit statements about how patients can communicate concerns about their safety.

Another project with the communications department involves identifying tools to remind patients and family members of their key role in preventing falls, reducing risk of infection, having staff use two identifiers, and using medications safely. "We're considering tent cards for patient rooms," says Mercurio.

While many tools have been devised to educate patients, Mercurio says handing a booklet to patients or having videos available is never enough.

"We've worked to encourage care providers to talk with patients about their role in safe patient care. To prompt that discussion we included a pre-printed section on our patient and family education flow sheet that requires documentation that the patient's role as a partner in safe patient care was discussed and that the patient's understanding was assessed," she explains.

Prompting participation

Staff members at the University of Minnesota Medical Center, Fairview in Minneapolis always involve patients in the site marking for invasive procedures; thus the safety precaution becomes routine.

Also staff wear buttons that state: "Ask me if I have washed my hands" and posters with a similar message can be found throughout the medical center.

"What we are doing is getting patients used to being involved and we are getting our staff used to being asked if they are doing the things they need to do to keep patients safe," says **Susan Noaker**, PhD, LP, senior director of quality and patient safety.

Currently, a brochure provides information on how to report concerns, and patients and family members can contact patient relations, a nurse manager, a physician or enter their concerns on The Joint Commission web site. Also, an employee position at the hospital is dedicated to soliciting patient concerns. This employee visits patients and asks if they have worries about their safety.

In the near future, patients will have access to kiosks that will allow them to enter safety concerns into a web-based tool.

Noaker says the University of Minnesota Medical Center provides information on its safety performance to patients and families so they are more aware of the issues. "We are being very transparent, not only with our staff, but patient and families, about our hospital performance — whether that has to do with national patient safety goals or a patient safety initiative we have initiated," says Noaker.

To educate staff, a series of three eight-hour classes have been implemented called "A Leader's Role in Patient Safety." Lessons from other industries are viewed in light of how they apply to health care. Also, research is reviewed that shows the frequency of human errors, even though providers are well-intended caregivers.

A campaign to encourage patients and family members to partner with health care professionals at Vanderbilt University Hospital and Clinics in Nashville, TN, is called "Asking is the Answer." To prompt people to ask the right questions, posters focusing on safety goals are tacked up all over the medical center with a fresh message every three months, says **Terrell Smith**, MSN, RN, director of patient/family-centered care.

The posters have been designed for a quick read based on research about how much information can be read on a poster while someone is walking past it.

Along with these posters, Vanderbilt developed a video that plays on a continuous loop on a TV system that also is safety related. It reinforces the safety messages introduced on the posters, such as asking providers to wash their hands.

At Ohio State University Medical Center in Columbus patients' rights and responsibilities, as well as information on how to partner in their health care, are posted on the web site and printed in the visitor guide. There also are many handouts available to patients on how to partner in patient safety.

In addition, nurse managers encourage patients to call them if they have concerns. They provide patients and families with a card that has the contact information, says **Diane Moyer**, MS, RN, program manager of consumer health educa-

SOURCES

For more information, contact:

- **Cynthia Barnard**, MBA, MSJS, CPHQ, director, quality strategies, Northwestern Memorial Hospital, 676 St. Clair #700, Chicago, IL 60611. Phone: (312) 926-4822. E-mail: cbarnard@nmh.org.
- **Annette Mercurio**, MPH, CHES, manager, patient, family, and community education, City of Hope National Medical Center, 1500 East Duarte Rd, Duarte, CA 91010-0269. Phone: (626) 301-8926. E-mail: amercurio@coh.org.
- **Diane C. Moyer**, MS, RN, program manager, consumer health education, Ohio State University Medical Center, 660 Ackerman Road, Room 667, P.O. Box 183110, Columbus, OH 43218-3110. Phone: (614) 293-3191. E-mail: Diane.moyer@osumc.edu.
- **Susan Noaker**, PhD, LP, senior director of quality and patient safety, University of Minnesota Medical Center, Fairview, 2450 Riverside Ave., Minneapolis, MN 55454. Phone: (612) 273-6992. E-mail: snoaker1@fairview.org.
- **Terrell Smith**, MSN, RN, director, patient/family-centered care, Vanderbilt University Hospital and Clinics, Hospital Administration, AA-1204 Medical center North, Nashville, TN 37232-2102. Phone: (615) 322-3454. E-mail: Terrell.smith@vanderbilt.edu.

tion at Ohio State University Medical Center.

The accreditation committee or safety committee usually makes recommendations on how to meet patient safety goals based upon suggestions from a task force. The task force reviews where the medical center currently is pertaining to a goal and comes up with ways to move forward, says Moyer.

Pinpointing the best strategy

The process for meeting patient safety goals is similar at Northwestern Memorial Hospital in Chicago, where a team was created to figure out the right strategy for the organization, says **Cynthia Barnard**, MBA, MSJS, CPHQ, director of quality strategies.

Barnard says a team is formed as soon as a new goal is clarified by The Joint Commission and there usually is at least six months lead time.

To help meet the goal to encourage patients' active involvement, a team created a pamphlet that explains how the organization wants to work with patients on patient safety goals. The information is given according to the acronym PARTNER.

The P is for "provide information," and there are details on what health care providers at Northwestern Memorial would like to know, such as what medications a patient is taking. The A is for "ask questions," and the R for "review information," such as the treatment plan.

The T is for "tests and treatment," encouraging patients to make sure they ask questions so they understand what their tests and treatment are for and that they participate in marking the surgery site. The N stands for "notify," something they are asked to do if they have safety concerns. The E is for "engaging a friend or family member" to help make decisions and provide oversight of safety issues. The R prompts patients to "recognize their risk for falls."

Barnard says there are a few things listed at the end of the document patients need to be sure they have when they leave the hospital. This includes discharge instructions with diet guidelines and instruction sheets such as details on wound care. There also is a medication record that can be carried in a person's wallet.

Mercurio says when National Patient Safety Goals are discussed amongst members of the patient safety team at City of Hope Medical Center she makes sure patient education/partnership strategies are considered whenever possible. Also, she includes partnership with patients and families in safety on the agenda of the patient and family education committee.

"Patient education is all about partnering with patients and their families to improve the outcomes of care. We know that patients who are

Joint Commission tells patients to "Speak Up"

Materials give instruction on patient involvement

"Speak Up" is a program offered by The Joint Commission in Oak Brook Terrace, IL, which features brochures, posters, and buttons on a variety of patient safety topics.

The acronym stands for the following:

- Speak up if you have questions or concerns, and if you don't understand, ask again.
- Pay attention to the care you are receiving. Make sure you're getting the right treatments and medications by the right health care professionals.
- Educate yourself about your diagnosis, the medical tests you are undergoing, and your treatment plan.
- Ask a trusted family member or friend to be your advocate.
- Know what medications you take and why you take them. Medication errors are the most common health care errors.
- Use a hospital, clinic, surgery center or other type of health care organization that has undergone a rigorous onsite evaluation against established state-of-the-art quality and safety standards, such as that provided by The Joint Commission.
- Participate in all decisions about your treatment.

"The whole campaign is about patient involvement and it provides materials for health care organizations to use if they wish; it is not required. They can develop their own or there are other products they can purchase," says **Richard J. Croteau**, MD, executive director for patient safety initiatives at The Joint Commission. For more information: www.jointcommission.org. ■

informed and actively involved in their own care are likely to experience optimal outcomes — including safe care," explains Mercurio. ■

Education targets Native American population

Lessons on prevention leads to lifestyle change

About five years ago, **Carol Maller**, MS, RN, CHES, left her job as patient education coordinator for the Veterans Administration Medical Center in Albuquerque, NM, a position she had held for 15 years. She now works in community health education as a grant coordinator for Southwestern Indian Polytechnic Institute (SIPI), where she oversees four awareness and prevention education grants for diabetes, AIDS, substance abuse, and hepatitis C.

"I work primarily in tribal communities, both with the college students on campus as well as outlying tribal communities in the state of New Mexico. The thrust of everything I do is with Native American people," says Maller.

In addition to overseeing four health care grants, Maller writes grants as she sees new opportunities for additional funding or to expand health education among her target population. She reports directly to the chair of the special programs department at the Southwestern Indian Polytechnic Institute.

"I use my medical background to run these projects, but I am not situated in a clinical environment so my past connections and networks are invaluable," she says.

Maller has a nursing license, a master's of science degree in community health education, and she is a certified health education specialist. In addition to these degrees, Maller has 30 years' experience in a clinical setting. During her time with the VA system, she worked on the AIDS project, which was a patient education initiative for the prevention of this disease. Also, she gained a lot of insight on chronic illness such as diabetes as chronic lifestyle diseases are prominent among veteran patients, she says.

The diabetes grant she oversees focuses on creating diabetes curriculum for grades K-12 and is funded by the National Institutes of Health. She works with seven other tribal colleges across the United States, with her portion of the project focusing on middle school children.

"I have several middle school pilot projects in Native American communities throughout New Mexico. Our goal is to get the message out about the prevention of type 2 diabetes and to work with students on making healthier choices in the areas of activities and eating. We want them to bring the message home," says Maller.

The AIDS, substance abuse and hepatitis C grants all work with the SIPI student population. The message on healthy and appropriate lifestyle choices is delivered by peer educators who have undergone training. Peer educator training is a successful model used across the United States, says Maller.

"We train our peer educators, who are students, and then they train other students because students listen to students," she explains.

The amount of staff Maller oversees depends on the resources within the grant. The diabetes grant provides funding for a full-time program assistant. The AIDS grant funds a full-time health educator, and this individual is able to help with education for the substance abuse and hepatitis C prevention programs as well.

In a recent interview, Maller, who also sits on the editorial board of *Patient Education Management*, discussed her job, her philosophy on patient education, the challenges she has met, and the skills she has developed that are helpful in her

profession. Following are the answers to the questions posed:

Prevention makes a difference

Q: What is your best success story?

A: I really enjoy working with the students, and in terms of success, you can see you are making a difference.

For the diabetes grant, our curriculum is a social studies unit for the fifth- and sixth-graders, and the emphasis is lifestyle and environment. It is put together as a mystery, with the students getting a letter from an individual looking for his or her roots. In order to answer the letter, the students have to look back at what lifestyle and environment was like in the 1920s. It gives them a chance to compare how things used to be vs. how they are today and how that impacts health.

It is done in terms of the way we eat today, fast food vs. growing your own food, and activity. The students start to see how the changes have made a difference in our lives today.

The students get to be investigators and interview people in their family. The solution comes from them and they start to see it rather than it being a one-way, didactic presentation.

Native Americans like to learn through storytelling and this builds on that, as the children go back and get the stories from their ancestors. It is wonderful to see the difference it is making in terms of their understanding.

Q: What is your area of strength?

A: Prevention is the drive I am using now. In a clinical and hospital setting it is usually too late for prevention because the event has already happened. While working in a hospital I always felt, "If only we could get out there and somehow divert people and prevent some of these things from happening through education and awareness." We always tell the students they can make a difference and we do know type 2 diabetes can be prevented or delayed. AIDS, substance abuse, and hepatitis C can be prevented by looking at behavior and making the right choices.

Q: What lesson did you learn the hard way?

A: Prevention is such a positive approach to health care; it is just so uplifting. When you are in a medical environment, a medical health care facility, it is more of a doom and gloom aspect of managing one's health and when doing prevention you are with healthy people and it is very positive.

When people have an acute event that brings them to the hospital, they want to make changes, but then they go back home to all the habits and the environment that put them at risk. When you are working in prevention education, people are not at the crisis point yet and they are going through stages of change, making decisions about altering their lifestyle, and it is easier to work with them. There is not the complexity of a new diagnosis and people feel a little more in charge of their life.

Q: What is your weakest link or greatest challenge?

A: In my situation, it is funding limitations. We are always looking for funding to support the initiatives we feel we can carry out. It is having the vision; then being able to put it on paper to get the funding. There are monies earmarked now for minority initiatives, but grants are very competitive.

Native American communities are lumped with all the other minority groups and we all compete for the same dollars. A number of institutions hire grant writers, and that is all those people do, whereas I write grants in addition to running the grants.

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

A: Consumer-directed, consumer-led, consumer-driven education. The more you can put the power with the individual the more success you will have. It has to come from within each person; it can't come from providers wagging their fingers.

People start to see the solution and how to change behavior. It comes from within; they want to make the change, instead of someone on the outside telling them they have to change the way they eat. The more it comes from within, the more successful they will be, because it is their choice and not the choice of a health care professional.

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

SOURCES

For more information about prevention education or funding programs via grants, contact:

• **Carol Maller**, MS, RN, CHES, grant coordinator, Southwestern Indian Polytechnic Institute, Albuquerque, NM. Address: 11909 Rocksberg St. NE, Albuquerque, NM 87111. E-mail: Ckisco@cs.com.

which to work?

A: I find the Internet invaluable for everything, whether the most current patient information or on-line sources for health information for lay people. I am always so impressed on how everything is getting better and better, more user friendly, easier to understand. I use the Internet a lot both in grant writing and grant administering when looking for health information. ■

Flu campaign goes beyond the mandate

Virginia Mason uses incentives, options

Almost everyone gets the flu shot at Virginia Mason Medical Center in Seattle. It isn't an option. It's a condition of employment.

But the hospital still works hard to spice up its annual flu vaccine campaign with other options, incentives, education, and innovative approaches. There's more to the mandatory vaccine than the mandate.

"You have to continuously educate and promote [the vaccine] and work with staff," says **Beverly Hagar,** BSN, COHN-S, employee health manager. "It's definitely a year-long campaign."

The Virginia Mason flu team includes representatives from employee health, human resources, inpatient nursing, pharmacy, asthma and allergy, infectious disease, and communications, as well as legal and other management staff.

The campaign slogan, "Save Lives, Immunize," was chosen from employee suggestions as part of a promotional campaign in 2005. This year, employees received a lanyard with the slogan when they got their flu shot.

The flu vaccine "kick-off" began with a tailgate party featuring football players and cheerleaders from the Seattle Seahawks. In a room adorned with Seahawk posters and paraphernalia, the football players were among the first to get their vaccine — followed by about 750 employees.

Nurses wore Seahawks jerseys as they vaccinated employees at six stations, and the party atmosphere included music, hotdogs and chips, and prizes.

The hospital then launched its "Double Shot" promotion. Hospitals (and patients) could get their flu shots from drive-through stations. As a bonus, they also received a shot of espresso.

Within a month, the hospital had already vaccinated 78% of its employees.

The mandatory flu vaccine policy has brought both acclaim and controversy to Virginia Mason.

The Washington State Nurses Association argued that the policy violated nurses' rights to bargain over their working conditions. A U.S. district court judge agreed, and the vaccine is optional for those inpatient unionized nurses. However, last fall, an administrative law judge ruled that the hospital could require nurses to wear masks in patient care areas for infection control during the influenza season.

"We take an oath: 'First, do no harm,'" says **Gregory Poland**, MD, a flu vaccine expert and director of the Mayo Vaccine Research Group at the Mayo Medical School of the Mayo Clinic and Foundation, who has been outspoken in favor of mandatory vaccination of health care workers. "This is a patient safety issue."

In this flu vaccine campaign, Virginia Mason employees were required to receive their flu vaccine by Dec. 13 or begin wearing masks and face possible termination. Those with documented medical contraindications such as allergies or religious objections must wear masks during the flu season and may be asked to take antiviral medications during a flu outbreak. Nurses who choose not to receive the vaccine also must wear masks.

Virginia Mason vaccinated 98% of its employees in the 2005-2006 flu season — 4,504 of 4,588 employees. Most nurses received the vaccine despite the dispute: 515 of 599, or 86%, were immunized. Thirty-one employees received an accommodation and seven were terminated.

In the 2006-2007 flu season, more than 98% have been vaccinated. "The organization has reached a 100% fitness for duty, combining influenza immunization and masking," says spokeswoman **Kim Davis**. Before establishing the mandatory policy, the hospital's highest rate of vaccination was 55%.

"As an organization, we're proud that we were the first to implement this," says Hagar. "It wasn't easy to implement. We had to face a lot of hurdles. We definitely had administrative support, and they were forward-thinking in moving on this initiative."

Coping with logistic challenges

The logistics of vaccinating some 5,000 employees within six weeks is daunting for the employee health staff of two full-time nurses and an admin-

istrative assistant. They received support from light-duty nurses and flu "champions" on units. In a "peer vaccination" program, nurses who received training from employee health provided vaccinations to their co-workers in their units.

Every shot administered at the hospital generated two copies of documentation — one for the employee to keep and one to be entered into the Oracle database.

Physicians were required to receive vaccines as a condition of their credentialing, and vendors had to demonstrate proof of vaccination to receive a badge allowing them on campus. Volunteers, students, and contracted service workers, such as the housekeeping staff, were also required to receive the vaccine.

In 2005, the hospital conducted educational forums and answered staff questions. Poland spoke to physicians at grand rounds.

Education has been a key part of the program to combat common myths about the vaccine. In the first year of implementation, as part of an education blitz, employees could answer flu quiz questions to enter a drawing for prizes. Meanwhile, those who delayed getting their flu shot were required to view a computer training module.

This year, educational materials remain on the hospital's web site, and new employees are informed of the policy and its purpose. "It's becoming part of the hospital culture," says Hagar. "It flows right into our culture of safety." ■

Difficult cases make staffing models obsolete

Time studies no longer accurate, CMs contend

With increasingly complex cases and more and more uninsured patients, traditional case management staffing models have become obsolete, suggests **Kate Tenney,** RN, manager for case management at Sutter General Hospital in Sacramento, CA.

"In the old days, with the original case management staffing models," she adds, "you took the overall census and determined which patients would need utilization review [UR], which would need discharge planning and some coding documentation, and then calculate staffing based on, for example, UR takes 20 minutes and discharge planning maybe 45 minutes."

With current patient acuity levels, however, those time studies are no longer accurate, Tenney contends. "I have case managers who have large caseloads of homeless, uninsured, young patients with multiple diagnoses.

"It used to be that if a patient was 45 years old, he didn't require anything but UR," she says. "Now that 45 year old has hypertension, diabetes, is a smoker, and has peripheral vascular disease."

In addition, that patient might be a drug user with wounds that are infected because he lives on the street, Tenney adds. "Since he has no insurance and is homeless, there is no place in the community he can go. Skilled nursing facilities are not geared to the young."

The picture doesn't even have to be that bad for the case to be a challenge, notes **Barbara Leach,** RN, director of case management for Sacramento Yolo Sutter Health.

"Say the person is a skilled worker, works for a mom-and-pop operation [and so doesn't have insurance] and barely pays the rent," she says. "We have a 57 year old who has lived here [in the hospital] more often than not because [he needs post-acute care] and there isn't anywhere else for him to go."

Adding to the pressure is the faster turnarounds that have been expected since the advent of the hospitalist program, Leach points out. "If there is a test in the morning, [hospitalists] are expecting to do something by that afternoon."

In the past, case managers would open a case in the morning, spend 30 minutes on it, and not touch that case again for 24 hours, adds Tenney. Now, the hospitalist handling the case might come back to it during the day — multiple times — necessitating more involvement by the case manager.

Despite these increasing demands on the case manager's time and expertise, she says, most hospital budgets are dependent on that initial staffing model.

A reevaluation of staffing ratios is obviously in order, Leach says, but the fact that models vary a great deal among hospitals complicates the issue.

"Some hospitals do not have what we call an integrated model," she adds. "At Sutter, our case managers do UR, discharge planning, and a fair amount of care coordination. In other hospitals those are all distinct roles, which makes it hard to compare models and staffing."

At some hospitals, notes Tenney, social workers do a great deal of discharge planning, and at

others they don't do any part of it.

Leach says she has done some "work sampling," whereby one identifies categories of work that are expected to occur and then observes staff to see what category they are performing at particular intervals.

"You can say you spend 30% of your time doing this and 60% doing this," she explains, but work sampling can reveal that those percentages are way off. In an "80-20 world," where the most intense work takes up 20% of one's time, Leach adds, "20% feels like more. You always write down the things that drive you insane."

Meanwhile, Sutter Health has added "nurse extenders" to help relieve the staffing crunch, she says.

The drawback there, however, is that most of the increased demands on case managers require nursing expertise, Leach notes. "The nurse extender can't assess the results of a critical test or resolve a complicated family dynamic or determine what level of care the patient needs."

At Sutter Health, explains Tenney, these nurse extenders are known as case management specialists. They act as assistants to the case managers, she says, and do provide invaluable help.

"The job description requires some college education and some background in medical care," Tenney says. "[Case management specialists] are responsible for the entire placement process once the case manager has identified what is needed."

A certain percentage of time in the staffing model is calculated for placement, she notes. "The nurse extender can pull that [function] out of the nursing model, and the case manager can handle twice as many patients that will need placements because of the nurse extender positions."

At Sutter General, four specialists do 800 placements a year, Tenney says. "The other piece [they perform] is that once the case manager has determined that a patient will go to a skilled nursing facility [SNF], the specialist will meet with the family, coordinate the actual transfer including transportation, communicate with the SNF, and copy charts.

"So basically, the specialist will make all the arrangements and follow through and then back it up with documentation," she adds. "So a case manager can hand off the rest of the case to that person. It's one thing to have a clerical person who can make copies, but to have a person you can hand a case to is a huge help for case managers."

While the nurse extender helps with a piece of the case manager's work, what Leach refers to as "how long it took to Xerox something" has been eliminated from the case manager's schedule, she points out. "It took away that down time, that time to think."

"Because we've moved hospitals into a 24-7 operation," Tenney adds, "case managers are constantly trying to maneuver patients and keep up with documentation."

Under normal circumstances, managers would go to the hospital's administrative team and say more case managers are needed because of the acuity of the patients, she says, "but in the current environment, that's not an option anymore."

Instead, the focus at Sutter General is to bring down the number of full-time equivalents (FTEs) per discharge, Tenney continues, because it's higher than at other facilities.

To make the most of the staffing that is available, she says, "We concentrate on making the case managers as efficient as possible. We try to train them not to take on other people's jobs."

The tendency, Tenney explains, is for case managers to do a lot of things that are not part of the case management role, such as helping nurses and physical therapists with their tasks, because it facilitates discharge.

"For instance, the physician writes that the patient can go home as soon as his labs are normal," she says. "The case manager will go to the nurse and say, 'The labs are normal. Is the physician going to discharge?'"

The nurse, Tenney adds, will respond, "I don't know. I didn't know the labs were normal." Under normal circumstances, she says, the case manager will then call the physician herself and then go back to the nurse and say, "Here are your orders for discharge."

Other staff members may not be as aware of time and length of stay, as well as other patient issues, as are case managers, Tenney notes, which can lead to another potential drain on case management resources.

"Traditionally on any hospital unit, the case manager was the center of information if someone didn't know what was going on," she says. Being that resource for a unit is very time consuming, Tenney adds, and not realistic in today's environment.

"Ask yourself," she advises case managers, 'Can you afford to take every phone call of every nurse and physician that comes by to talk to you?' Time is such an issue. That [pattern] may have to change."

(Editor's note: Kate Tenney may be reached at TenneyK@sutterhealth.org. Barbara Leach may be reached at LeachB@sutterhealth.org.) ■

Complacency could be deadly in pandemic

Hospitals are ill-prepared, reports say

Hospitals are ill-prepared to cope with even a mild pandemic and are likely to face shortages of staff, protective equipment, bedspace, and other supplies.[1]

The pressures that face hospitals daily would be magnified and health care systems would quickly become overwhelmed if there were a sudden influx of patients suffering from a novel influenza virus, according to a panel of preparedness and public health experts and hospital leaders convened by the Center for Biosecurity of the University of Pittsburgh Medical Center.

That conclusion echoes other warnings. Complacency could be deadly, says **William Charney,** DOH, a national occupational health consultant based in Seattle who compiled the recent book, *Emerging Infectious Diseases and the Threat to Occupational Health in the U.S. and Canada* (CRC Press, 2006).

"We are taking for granted that our health care systems are going to be able to deal with thousands of sick and dying people, when in fact at the current level of preparedness they will be overwhelmed and chaos is quite predictable," Charney writes.

About half of the nation's emergency departments (48%) function at or above capacity, according to the Center for Biosecurity report. About 30% of hospitals lose money, and the total number of hospital beds, hospitals, and emergency rooms has been declining.

"We have a lot less surge capacity in our health care system now than we did even 20 or 30 years ago," says **Eric Toner,** MD, senior associate with the Center for Biosecurity and lead author of the report.

The pandemic of 1968 was one of the mildest on record. But Toner says, "I doubt we could handle a 1968 pandemic now. Our hospitals have trouble dealing with a bad flu season as it is."

One of the greatest areas of weakness involves the protection of the health care workforce. Hospitals already struggle with staff shortages, particularly with respect to nurses or other licensed practitioners. Yet more than a third of hospital employees may fail to show up if there is a pandemic; in one survey, 42% of health care workers said they would not report to work during a flu pandemic.[2]

"The already existing shortage of health care workers will certainly be worse in a pandemic," says Toner. "How bad it will be is anybody's guess, but certainly it will be significant."

Preparing for a pandemic will be costly; the Center for Biosecurity estimates that to be ready for a severe pandemic, similar to the historic influenza pandemic of 1918, an average-sized hospital of 164 beds would need to spend $1 million, including $200,000 to develop a pandemic-specific plan, $160,000 for staff education and training, $400,000 to stockpile "minimal" personal protective equipment, and $240,000 to stockpile basic supplies.

Hospitals also will need to spend about $200,000 a year to maintain preparedness, the center estimates.

Meanwhile, a pandemic would financially cripple hospitals, as they would lose money on delayed or canceled elective procedures while paying more for staff and supplies and treating more uninsured patients.

The solution: more government spending for preparedness, tied to specific goals, and funds to reimburse hospitals for uncompensated care and extraordinary costs in a pandemic, the center said.

But don't rely on the federal government to save the day when a pandemic hits. Although there is a national stockpile of antiviral medications, N95 respirators, and vaccine, the supply is small compared to the immediate demand that would occur. Preparation must be local and regional, says Toner.

Yet for most hospitals, pandemic planning has been sketchy. "Hospitals are not taking this nearly as seriously as they should," says Toner. "Few hospitals have started stockpiling [PPE, antivirals, and other supplies] to the extent that they should. Almost every hospital has some sort of pandemic plan, but they've not been committing the resources necessary to get prepared."

Occupational health is one of the most critical areas of preparedness. "The No. 1 priority is protecting the health care workers. If we don't have health care workers, then everything else is moot," says Toner.

Yet Charney worries that hospitals are not planning to provide adequate respiratory protection. Charney and contributors to his book, Mark Nicas,

John H. Lange, and Giuseppe Mastrangelo, contend that health care workers caring for patients with emerging infectious diseases need respirators that are more protective than the N95 — either the elastomeric half-mask respirator or powered air-purifying respirator (PAPR).

Both of those respirator types are reusable; the PAPR does not require fit-testing. Currently, the Centers for Disease Control and Prevention says that the use of an N95 during an influenza pandemic would be "prudent" and that an N95 or greater respiratory protection should be used during aerosolizing procedures, such as a bronchoscopy.

"We don't know how many viruses will be emitted and how far they'll travel and what the dose response will be [with an emerging infectious disease]," Charney asserts. "While the experts are arguing about [how influenza is transmitted], they're recommending lower-quality safety measures."

In their planning, hospitals must think through issues of supply for disposable products and disinfection of reusable ones. Toner recommends tiered levels of protection based on the health care worker's patient contact and degree of risk.

"Hospitals can't just stockpile one [item]," he says. "They need to really think this through and stockpile a number of different measures."

Cohorting patients can reduce the potential employee exposure and allow the hospital to concentrate its protective measures on those employees at greatest risk, he notes.

If your health care workers don't feel safe, they won't show up for work. That is a maxim that many occupational health experts emphasize in pandemic planning.

HCWs also may stay home to care for ill family members or as the only caregiver for children whose schools have been closed as an infection control measure. Meanwhile, you'll need more health care workers than ever to care for a surge of patients.

Where will you find them?

As part of pandemic planning, hospitals need to identify volunteers, including retired health care workers and those who have left clinical care, who can help during a crisis period, according to the Center for Biosecurity. Their credentials would need to be verified, and the registration of volunteers would need to be kept up to date.

"What are the essential things they need to be taught in order to do what we ask them to do?" says Toner. You should also consider "what functions in a hospital can be done by relatively untrained people."

References

1. Toner E, Waldhorn R, Maldin B, et al. Meeting report: Hospital preparedness for pandemic influenza. *Biosecurity and bioterrorism: Biodefense strategy, practice, and science.* 2006; 4:1-11. Available at www.biosecurityjournal.com/.

CNE 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

- Educating about herbal supplement/medication interaction
- Improving education with the use of technology
- Effective pain control education
- Reaching the population at risk for hepatitis
- Teaching consumers how to keep a medication record

CNE Questions

9. To encourage patients to be actively involved in their own care as a safety strategy, institutions might set in place which of the following practices?
A. The distribution of instructional booklets.
B. Messages on posters and buttons.
C. Discussing patient's role as partner.
D. All of the above.

10. Health care institutions must actively encourage patients and family members to discuss their concerns about safety.
A. True
B. False

11. The Virginia Mason flu team includes representatives from:
A. employee health;
B. human resources;
C. inpatient nursing;
D. all of the above.

12. According to the Center for Biosecurity, hospitals would need to spend about $200,000 a year to maintain preparedness.
A. True
B. False

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

On-line bonus book for *PEM* subscribers

Readers of *Patient Education Management* who recently have subscribed or renewed their previous subscriptions have a free gift waiting — *The 2007 Healthcare Salary Survey & Career Guide*.

The report examines salary trends and other compensation in the hospital, outpatient, and home health industries.

For access to your free 2007 on-line bonus report, visit **www.ahcmedia.com**. ■

TONER.pdf.