Patient Education Management™

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

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Appropriate connections help expedite work on patient education databases

Look for colleagues with the right expertise

To provide easy access to patient education resources that support teaching, many patient education managers are considering creating a database (an organized collection of information records) to be used via the Intranet or Internet.

While a database seems like a good tool for supporting patient education, managers should not rush into a project too quickly. It is important to consider what a database can and cannot do.

"Creating a database can give users access to available materials and organize them in a way that is more accessible to more users," says **Diane C. Moyer**, MS, RN, program manager for consumer health education at The Ohio State University Medical Center in Columbus.

A database can make it easy to access information quickly and provide relevant and authoritative resources, adds **Emily S. Lawson**, MSLIS, medical librarian/information specialist at Children's Healthcare of Atlanta.

One benefit of a commonly used database is that patients will be receiv-

EXECUTIVE SUMMARY

In recent months there have been many messages on the patednet listserv pertaining to patient education databases. Many managers want to create an electronic database of resources and/or educational materials, but are not quite sure how to go about it; one said, "I need all the help I can get."

In this issue of *Patient Education Management*, we have approached a variety of people with experience in this area to help clarify the steps for creating a database.

ing standardized information if there is a process in place to guarantee that all patients are receiving the information or accessing the database, says **Tanya Smith**, MPH, CHES, manager of the Cancer Learning Center at the Huntsman Cancer Institute at the University of Utah in Salt Lake City.

It also can help staff provide information in a consistent manner and cover specific topics identified as important to the hospital or department, she adds.

A database of educational resources also would aid staff in teaching patients with diagnoses that aren't common on their unit or who have preexisting conditions that impact care, says **Peg Allen**, MLS, AHIP, a library consultant located in Stratford, WI, and coordinator of the Hmong Health Education Network.

While there are many benefits to implementing a patient education database, it is not a magic wand that will guarantee good teaching. Moyer says having a database will not insure that the right materials are being used to educate patients and family members. It also does not stop clinicians from bringing in other materials that are not on the database.

"A database of information cannot replace the individualized assistance provided by staff giving education to patients and their families," says Smith.

Staff need to be available to provide the in-depth, individualized assistance to patients, she adds.

In addition there is a lot of good, current, medically reviewed information available via the Internet from free services, such as MedlinePlus, and from for-profit organizations, says Smith. Therefore, it's important to spend a lot of time up front determining your organizational information needs. Determine what exists for free, what exists for a fee, what funding is available to purchase ready-made programs, and what staff expertise is available on site to develop content in-house prior to taking on the project, advises Smith.

Do a needs assessment

It's important to determine your institution's needs. In the case of St. Joseph's Hospital Health Center in Syracuse, NY, it was becoming increasingly difficult to keep educational materials stocked on the units. When an Intranet site was implemented, it seemed the logical solution to this problem.

"I knew I wanted accurate patient education material, a variety of it, available to our clinicians in the fastest manner possible. I wanted clinicians to get materials fairly easily, and, once we had an Intranet site, that is where I wanted it," explains **Kathy Fitzgerald**, MS, RN, CDE, patient educator at St. Joseph's.

The patient education site on the Intranet has internally designed materials, medication sheets from a commercial vendor, and a bank of general consumer information also from a purchased reference.

Also on the site are instructions for using the on demand TV system, a list of the videos that can be accessed on that system, and a list of outpatient programs and support groups. An index

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provides details on purchased booklets in stock that can be ordered as well.

It is important to decide what the database will do, as that will determine the type of software required to create and implement it. **(For details on what questions to ask before getting started, see article on p. 65.)**

When working up the list of software requirements it is best to work with your information technology department, says **David Starr**, MBA, director of systems development information technology services at City of Hope National Medical Center in Duarte, CA.

Remember you may not know a lot about technology and those in IT aren't familiar with patient education, he says. The two groups need to sit down in a room with a white board and start mapping out what is really important.

For example, IT will need to know what sort of educational materials will be included in the database. Will there be videos or interactive tests? A good systems analyst can help a patient education manager articulate their needs for the database, says Starr.

Once this is completed, a five-or-six page document of software requirements can be written and distributed to vendors in order to find the appropriate product, he says.

Working with IT from the start is a good idea, says **Farrah Schwartz**, MA, patient education specialist at St. Michael's Hospital in Toronto.

Schwartz began work on an inventory of in-house patient education materials about a year ago.

"I am trying to develop an inventory or repository of materials that have been developed internally by the organization that, in the first phases, would be able to be accessed by staff internally when they were looking for something in up-to-date, approved health education information. Over time I would like to expand that to include patient access via the Internet," explains Schwartz.

She launched into work on a database using Access software, and after spending time on it, she found it was not compatible with the hospital's IT requirements. Although she is a technology-savvy consumer, she has discovered it is different when designing a system and her expertise does not transfer over.

Someone from IT needs to be in the loop from the beginning unless the patient education manager has the technological expertise or knows a person who can help them build a database, she says.

Tailor to end user

To select appropriate software, the users of the database need to be identified, whether they are nurses, a multitude of disciplines, or patients.

Knowing the end user will not only help patient education managers determine what should be included in the database, but also how sophisticated a search engine is needed to find material, says **Abigail Jones**, MLIS, MA, consumer health librarian at the John A. Prior Health Sciences Library at The Ohio State University Medical Center.

For example, Google, a common Internet search engine, appears to order information based on the key word or phrase entered, but it is not necessarily true the key piece of information needed is at the top. Jones says it is extremely important that a search engine be intuitive and try to second guess what the consumer of health information is trying to find. A good search engine will pull important information to the top quickly and index it so busy clinicians can get resources quickly, explains Jones.

Poll the intended users to find out what key words or search terms would work in their professions. Jones says she sometimes notices library volunteers who are retired from the medical field using outdated terms in their search, and, therefore, they do not find the information. This sometimes occurs as well when people use trade names.

The best databases are set up so people can browse as well, says Jones. It may have a section in the left-hand column with major categories — such as exercise, nutrition, etc. — that people can click and see subject headings which might lead them to the information without putting in a key word. They find the information through a series of clicks.

"If someone does not have the correct word, they will eventually find the information through a series of clicks. It is like leaving bread crumbs through the forest. Looking for cancer? Click here. A particular part of the body? Click here. And eventually they find it," says Jones.

Cross referencing and search functions make a database more useful when it is designed for use by all clinical personnel, says Moyer. When there are topic headings, there is a risk that titles placed in another category might be missed, she says. For example, a physical therapist may only look under the headings "exercise" or "rehab" when looking for educational material, and there could be titles elsewhere on the database.

A search engine for a database can be sophisti-

cated enough to pull up unique fields such as patient education materials with pictures, says Allen.

Whenever possible, it is always best to get software off the shelf, says Starr. In that way it will be the vendor's job to remain on top of the market and know where the industry is headed and what new regulations are passed that might impact the database.

Also there is instant collaboration when there is a problem because there is a pool of several hundred customers using the same product that may have had similar issues and the vendor can draw on those experiences to help solve the problem, explains Starr.

Lawson recommends that patient education managers make sure extensive research is done on software products before one is purchased. "Research the company and interview other customers so that you can be confident their product is reliable and reputable," she says.

Know your limitations

While a patient education manager takes the lead on a project to implement a patient education database, he or she does not necessarily have to learn all there is about such technology or be the person to actually do the work.

Determine what you do not know, advises Fitzgerald. For example, she did not know how to maintain the site or store information so she looked for people to work with who had the skills she lacked. A person who oversees a databank of forms is the one that posts the information on the patient education database at St. Joseph's. Edited materials are put into a template and posted in the forms catalogue that automatically updates the patient education site.

Allen suggests patient education managers work with a librarian when trying to create a database. "It may be the hospitals' on-line catalogue could be adapted to include all your patient education materials. Most of them are very sophisticated databases," she explains.

It's also a good idea to learn from other's mistakes. Moyer says the current database for patient education inventory at The Ohio State University Medical Center was developed long ago and there have been difficulties making it accessible to other systems.

To avoid this problem, Allen recommends a standard record format. "Software changes over time and you want to be able to take the records and move them from one system to another, and when people design databases not based on that standard record format, it is a lot harder to move things," she says.

Moyer says the Ohio State system is not able to track the use of documents either and that would be beneficial when trying to determine whether a title should be deleted or maintained on the inventory. Maintaining a database can be labor intensive, says Smith, for you must create documents, iden-

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tify resources, enter data, and update data. At this point, her institution is considering purchasing a product, such as "Cancer Knowledgebase," to provide the cancer-related content and focusing on keeping the local support group and program information up to date.

Most importantly, understand that a database is an evolution that will need to be tweaked from time to time; it is a work in progress, says Fitzgerald. There is an e-mail address on the site at St. Joseph's Hospital Health Center database so staff can provide information about topics they can't find and materials they can't use. ■

Developing a patient ED culture is one PEM's goal

Consistency of information across continuum

To maximize the value of educational opportunities at Northwestern Memorial Hospital in Chicago, **Magdalyn Patyk**, MS, RN, BC, patient education program manager, works closely with inpatient and outpatient services and the Health Learning Center.

"I develop and implement strategic plans for patient education to accomplish this," explains Patyk.

In her job as program manager, she is responsible for the development, implementation, and maintenance of all patient education resources, programs, and support for the organization. She reports to the director of health information and education.

Currently, the hospital has 800 beds, but is building a new women's pavilion that will open in the fall of 2007. In addition, a new women's hospital will open in the fall of 2007.

The patient education department is staffed by the program manager and a part-time patient education specialist. This person works with Patyk to coordinate the review of materials and classes to assure all are in compliance with hospital standards. Together, this two-person department also addresses staff development needs related to patient education.

In 1993, Patyk was hired at Northwestern as a patient education coordinator. It was a part-time position. In 1994, the position was expanded to full-time but Patyk had to split her time between patient education and nursing staff development.

Before work begins on database, ask the right questions

Uncover issues and address them during design

In order to design a good database for patient education resources and materials, managers must ask the right questions. Following is a list of questions from those who have been through the process or are currently working on a database:

- Who will use the database and how will it be accessed — internal web site, external web site?
- Will it be restricted by department or by staff who provide that specific education?
- Do I need to consult with the information technology department, and, if so, who manages it?
- In what format are the materials — electronic, print, web sites?
- Are there paper collections that need to be scanned and turned into searchable PDF files?
- Who will be responsible for checking the web sites indexed to make sure all URLs are updated and current?
- Who will maintain the database, entering information, reviewing the content, and keeping it current?
- How easy will it be to make changes to the database over time?
- Can the use of one database serve several needs, such as searching for documents, tracking use of documents, knowing when a document needs to be reviewed/revised, while only certain functions are available to the general users?
- Are there search capabilities and what limitations are there to the search functions?
- Are there tracking capabilities to know which items have been accessed or which are most often used?
- Will there be someone in my department who will have administrative rights to make changes to the database, or do those changes need to be finalized by someone in the information technology department or elsewhere?
- Will there be any support provided to maintain the database?
- How often will the content of the database be reviewed to be sure it is current?
- If the database works for the current inventory, what are the limitations if the inventory would continue to expand?
- What is the potential for expanding the uses over time?

In 2000, she was able to focus strictly on patient education, and in 2004, patient education became a department and she was named program manager.

She is a BSN-prepared nurse and has a master's degree in nursing with a focus on education. Also, she is certified through the American Nurses Credentialing Center for nursing professional development.

Prior to her job at Northwestern, Patyk worked for three years in cardiac rehabilitation at a hospital in a Chicago suburb. Before moving to the Chicago area, she worked as a staff nurse at a hospital in Dearborn, MI.

In a recent interview, Patyk, who is the consulting editor on the editorial board of *PEM*, discussed her job, her philosophy on patient education, the challenges she has met, and the skills she has developed that help her to do her job well.

Following are the answers to the questions posed:

Q: What is your best success story?

A: "Northwestern has offered so many opportunities for professional growth and involvement in new projects. One of the most exciting occurred in 1998 when I was involved in the planning and implementation of Northwestern's Health Learning Center, which is one of the largest centers in the country. At that time, I developed an educational program model linking the Health Learning Center with physician offices and outpatient sites. It included a referral process for return documentation of education sessions conducted with outpatients in the Health Learning Center.

"Another major initiative included the development of a cardiovascular microsite on the Northwestern Memorial Hospital Internet site. Working with clinical experts and internet strategists, I provided patient education content dealing with all aspects of the cardiovascular health diagnostics and treatment.

"These projects are excellent examples of coordination of patient education among the multidisciplinary team. It is my belief that this type of coordination is the key to effectively meeting the educational needs of our patients."

Q: What is your area of strength?

A: "Personally, I am able to multi-task and reprioritize on a daily basis. This is essential because I am usually involved in several projects at a given time.

"Organizationally, I like to feel the department is a resource for directors, managers, and staff, not only to drive patient education projects, but also to assist with other information needs across the continuum of care.

Making the right connections

"Consistency of information across the care continuum is something we strive for on a daily basis. A good example is diabetes. Working with the Health Learning Center, we focused on selecting/developing patient education resources for use both in the inpatient and outpatient settings that complement and support a clear, consistent message to our patients," Patyk contunes.

"This involves coordination with inpatient and outpatient dietitians from two separate departments and reporting structures. In addition, we collaborated with the inpatient advance practice nurse and outpatient nurse clinician to achieve our goal."

"The patient education department and the Health Learning Center team also recently initiated a caregiver program to help support family members who are taking their loved ones home. We are targeting those families who do not have access to outside support, such as a home health aide. We provide instructions that will assist family members in caring for the patient in the home setting. Specific topics include bed making, lifting, moving a patient, and infection control."

"Rehabilitation services approved the program to ensure that the content taught was aligned with the information they provided. Given their unique insights into family situations, the case management staff played an important role in referring family members to the program."

Q: What lesson did you learn the hard way?

A: "I have a tendency to over-commit and I have learned that when taking on a new project, I need to look at timelines and communicate realistic expectations."

Q: What is your weakest link or greatest challenge?

A: "I no longer report up through patient care so I had to develop a small network of information providers to stay attuned to changes in nursing.

"One goal that I am constantly striving to attain is the creation of a patient education culture at our organization. Working with the Patient Family Education Committee [PFEC], we recently distributed a survey tool to all health professionals who consistently work on a select medical unit. The survey gauges staff perception about their role in the provision of patient education. Using the resulting date, an action plan will be developed and implemented by PFEC and the

patient education department. We will then measure the impact of our action plans by conducting a follow-up staff survey."

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

A: "Patient education will be provided to our patients prior to all tests and procedures and before prescheduled admissions. In addition, patients will be equipped with the information they need to safely move from one level of care to another. This information will be provided in a timely manner and tailored to the patients' specific needs and in a format and manner that best optimizes their learning."

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

A: "Recently we successfully passed our first unscheduled Joint Commission visit. In the interval between our last scheduled visit and this visit, we have focused on direct communication to staff at the unit and departmental level through in-services and paper communication.

"Also we developed teaching guides to assist staff with patient education. Working with clinical experts we have developed about 10 to 15 teaching guides on such topics as diabetes, heart failure, and breast feeding. We have found this to be valuable for new staff or at times when patients are admitted to units that do not routinely care for these specific patient populations."

"To foster a patient education culture, we want to incorporate it into each activity that the health care professional performs. One example of this was a project where we partnered with the Nursing Education Committee. Together we were able to add a patient education component into common nursing competencies."

"The Patient Family Education Committee developed an orientation packet for all health care professionals. The accompanying quiz was electronic. This allows managers and preceptors to track the progress of staff completion of the patient education orientation packet."

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 have completed a campus-wide, patient education needs assessment twice since 1998 with the last one completed in 2005, so I have a pretty good sense about the staff needs and where there are gaps. Patient satisfaction also provides important insights. It is monitored on a routine basis and includes Press Ganey data along with results from focus groups and con-concurrent surveys conducted on the inpatient units."

"Working with clinicians we look at high-volume, high-risk procedures. We also focus on outpatient tests and procedures along with discharge instructions." ■

SOURCE

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Integrated program takes proactive approach to care

Care coordinators link members with local resources

When members of Blue Cross Blue Shield of Florida are seriously ill, injured, facing surgery, or need help negotiating the health care system, their care is managed by a care coordinator located in their region.

The Jacksonville-based insurer consolidated its utilization management and case management functions and added member outreach, discharge planning, and cross-training registered nurses to handle all of the functions.

Members now have a single point of contact — locally based care coordinators who are registered nurses and who can support them in making decisions about their health care, help them understand the alternatives available under their benefit, assist them in managing their health care dollars effectively, and promote compliance with their treatment plan.

Members happy with single-point contact

Since the company rolled out its Regional Care Coordination on Feb. 14, 2006, member satisfaction has soared, according to **Claudia Castro**, RN, CHCQM, FAIHQ, senior manager of regional

care coordination for the northern region.

Recently, the care coordination program received a score of 4.82 out of a possible 5 points on the health plan's member satisfaction survey.

"With the complexity of today's health care system, members are very appreciative that someone is there to help them," she says.

The enhanced model provides a single point of contact for members, eliminating handoffs and the need for members to talk to multiple individuals as they move through the continuum of care.

"Now a single care coordinator handles member outreach, concurrent review, discharge planning, member education, case management, and member satisfaction. Our members have a single point of contact and one person they can call when they have questions or issues. There is also the single point of contact for facilities and physician providers for that member as well," she says.

Before the health plan went live with its integrative care coordination program, the utilization review nurses and the case managers went through an intensive skills assessment process and were cross-trained to perform all components of the job.

The insurer has three regional care coordination offices with field offices located throughout the state that help the company provide care and options that are tailored to the regional differences and different cultures located in various areas of Florida.

The care coordinators in the local markets are knowledgeable about the local health care delivery system as well as community resources that the members might need, Castro says.

"Care coordinators who are familiar with the local market can provide enhanced assistance for members as they navigate through the entire health care spectrum. They are informed about our participating providers and any type of service the member may need, whether it's acute inpatient care, home health, or durable medical equipment," she says.

The fact that the care coordinators have established a relationship with local providers makes it easier to facilitate care for the member, she adds.

Members are referred for care coordination by all internal departments at Blue Cross and Blue Shield of Florida — facility providers, physicians, ancillary network providers, and self-referral.

Any member with complex needs is referred for care coordination. For instance if a member is having difficulty getting an appointment with a specialist or is having problems getting precertified for a certain test or procedure, the care coordinator can review the provider network and options for the member and, if necessary, ask the medical director to assist in bridging any access to care issues.

"We take a personalized approach based on the member's need. There is no cookie-cutter plan for care coordination. Someone may be in care coordination for one or two months or through the entire continuum of care over a long period of time," she says.

For instance, a member might have a complex infection or serious injury that requires intensive wound care and may result in care from providers from the acute inpatient setting to a skilled nursing facility, then home care, and then outpatient care.

"We continue to actively participate in the member's care throughout the episode so we can ensure that the member is getting the right services in the right setting at the appropriate time and is moving to the next level of care when appropriate. At the same time, we make sure that the member is aware of his or her responsibilities and options based on their benefit structure," she says.

The arrangement results in increased efficiency because the care coordinators are already familiar with the members when they call and they don't have to spend a lot of time reading someone else's notes, allowing them more time to address the needs of the members, she adds.

The company takes a proactive approach to reach out to members who may be facing surgery or another health care event by initiating calls to the member as soon as the provider requests precertification for treatment.

As soon as a care coordinator is notified that members are scheduled for orthopedic surgery, he or she calls the member, conducts an assessment, and starts to develop the discharge plan before the surgery takes place.

Proactive approach to discharge planning

The proactive approach to discharge planning is a benefit for members who have to assume responsibility for part of the cost of their health care, Castro points out.

"Our care coordinators prepare the members for what to expect depending on their benefit structure, such as what their covered benefits are and what they will have to pay out of pocket. They discuss discharge planning options, such as rehabilitation, discharge to a skilled facility, or

discharge to home," she says.

In the case of members who are having orthopedic surgery, such as total knee replacement, the care coordinators educate them about a home exercise program they can do in advance of the surgery to facilitate the recovery process.

The care coordinators call members after discharge to make sure everything is going well and that their discharge needs have been met and that they have made an appointment for a follow-up visit with their physician. They answer any questions or concerns the members have and refer them to a physician if the situation warrants it.

"This is a proactive step to help the members avoid rehospitalization. If things are not going well, the case manager can assist the member getting the care they need," she says.

If the member is discharged to a post-acute rehabilitation center, the care coordinators follow them while they are in the facility and after they are discharged to home to make sure their needs are being met. When a member is home from the hospital and stable, the care coordinator closes out the active part of care coordination and follows up with a member satisfaction survey.

The health plan is rolling out the next wave of member outreach to members who have been precertified for other surgical procedures.

When hospitals notify the health plan that a member has been admitted, within a day after admission, the care coordinator assigned to that facility is aware the member has been hospitalized. The care coordinators then make outreach calls while the member is still in the hospital, if he or she meets the outreach criteria.

"We triage our members who are hospitalized to ensure that we reach the people who can most benefit from an intervention," she says.

For instance, a healthy 19-year-old member with appendicitis who is moving through the continuum of care on schedule is not likely to receive an outreach call.

On the other hand, a 19-year-old with appendicitis who stays in the hospital beyond the normal two-day stay will receive an outreach call.

"The care coordinator will call to determine what is keeping the member in the hospital. It may be that there is a comorbidity, such as diabetes, or a ruptured appendix with a level of infection that may require antibiotic therapy after discharge," she says.

When a hospitalized member has a chronic disease, the care coordinator takes the opportunity to link the members with the BluePrint for Health disease management program if the member is not already enrolled.

The care coordinators work with the discharge planners at the hospital to complete the discharge plan in advance of the discharge day. The members are active participants in creating the discharge plan and are aware up front of what their financial obligations will be, depending on the post-acute options they choose.

"In the previous model, concurrent review and case management were handled by separate nurses. The discharge planning was largely relied on as a facility obligation. We've taken a lot of the burden off the facility. They're not spinning their wheels creating a discharge plan and finding on discharge that the patient does not have that benefit," she says.

The care coordinators work with other community resource local providers to ensure that all of the members' health care needs are met.

"It's a collaborative process. We work with all providers, whether it's a surgical coordinator, a physician, a hospital, a skilled nursing facility, rehabilitation facility, home health agency, durable medical equipment provider, or infusion care company," she says. ■

Patient-centered care management saves money

Provides contact for people with late-stage illness

Patients with life-limiting conditions who received patient-centered management had dramatically reduced utilization and cost of care compared to patients with similar conditions who received regular case management, a study by Blue Shield of California has concluded.

The study was so successful that the health plan opened the program to its entire commercial population who meet the criteria and has begun providing patient-centered management to its seriously ill Medicare HMO population with late-stage illness, according to **Andrew Halpert**, MD, senior medical director for the San Francisco-based health plan.

During the 18-month study, half of the patients received typical telephonic case management and half received patient-centered management, which included an initial home visit followed by an average of 10 hours a month of telephonic contact.

All of the participants in the study had access to the same benefits, network of providers, and HMO approval process.

The average utilization cost for the patients receiving patient-centered management was $49,742 during the 18 months of the study compared to $68,341 for the control group.

The patient-center management reduced hospital admissions by 39%, hospital days by 36%, and ED visits by 30%, while increasing home care by 22% and hospice care by 62%.

In addition, patients in the program gave it high scores in patient satisfaction studies, Halpert adds.

"We knew that patient-centered management was beneficial for our members who had complex medical needs. This study showed that it has value to the company as well," Halpert says.

The study included 756 patients in California with a life-limiting diagnosis and multiple comorbid conditions. About 75% of the participants in the original study were oncology patients. All were members of Blue Shield of California. The patient-centered management was provided through a contract with Paradigm Health Inc., a medical management company based in Upper Saddle River, NJ.

Blue Shield has continued its contract with Paradigm Health to provide management for patients in the expanded program.

"They have the infrastructure, expertise, and experience to run the program. We felt it would be more effective to continue to work with them, rather than doing it ourselves," Halpert says.

Currently, about 900 members are enrolled in the patient-centered management program at any one time. The RN case managers who coordinate their care handle a total of about 1,500 to 2,000 cases a year, Halpert says.

The expanded program includes Medicare patients who have neurological conditions, such as stroke and late-stage cardiac disease, as well as terminal cancer.

"We don't have the results of the interventions on the managed Medicare population but I anticipate it will work as well as in the commercial population. This program works very well for people who have very complicated diagnoses," Halpert says.

The health plan is conducting another study involving patients who have multiple complex conditions that do not qualify as late-stage illness. The program has the same design and structure with fewer interventions and no home visit, Halpert adds.

The patient-centered management team includes a care manager, a team manager who acts as a liaison with the health plan, and a physician advisor.

When members are enrolled in the program, the care manager makes a home visit and works with the patient and family members to create goals in six "care domains" — disease knowledge; treatment plan; terminal care planning; benefit plan management; family and living environment; pain and symptom management; and provider support.

A goal for the pain control domain might be to work with the physician to obtain better pain medications for the member, Halpert says.

"The nurse might encourage the patient to alert the physician to issues of poorly controlled pain. Often patients are hesitant to broach this issue, " he says.

A goal for the care plan domain might be to come up with a plan to deal with the side effects of medication and keep the patient from the emergency department.

Terminal-care goals might be to deal with financial issues or family support, such as having a caregiver in the home, he adds.

For instance, in one situation, a nurse worked with an employer so the wife of a terminally ill man could telecommute instead of leaving her husband to go to work.

"What these nurses do goes off the typical playbook for case management. They do whatever their patients need," he says.

The care managers in the patient-centered management program have a caseload of about 22 patients at a time, compared to typical health plan case managers who oversee the care of 75 to 100 or more people at a time, usually working intensely with the members for only a week or two then calling them occasionally, Halpert says.

After the home assessment, the patient-centered management care managers make frequent telephone calls, an average of 14 a month, to the patients.

The outbound calls from the RNs to patients helped identify potential lapses in care, such as the case of a brain cancer patient who was about to run out of his anticonvulsant medication.

During a home visit, the nurse discovered that a patient with metatastic lung cancer, who was repeatedly being admitted for diarrhea, had confused his Lomotil with milk of magnesia. She removed the milk of magnesia from the medicine

cabinet and the hospital admissions ended.

Members of Blue Shield who have chronic illnesses but don't qualify for the patient-centered program are enrolled in the health plan's disease management programs.

If their illness intensifies, Blue Shield of California's disease managers can refer them to the patient-centered program.

"Our disease management programs are very robust but they aren't geared to the late-stage illness paradigm. When patients' conditions become life-threatening, they can benefit from more intensive care management," he says. ■

JCAHO report addresses language, cultural issues

Hospitals should provide ongoing training to staff on how and when to access language services, The Joint Commission recommends in a recent report.

Other strategies suggested include establishment of a centralized program to coordinate services relating to language and culture and implementation of a uniform framework for systematic collection of data on race, ethnicity, and language.

The recommendations are based on a study of how 60 hospitals are providing health care to culturally and linguistically diverse patient populations.

The most frequently cited challenges related to language and staffing. Hospitals often reported finding it difficult to find staff with cultural or linguistic competency, and some indicated there are challenges created by having a diverse staff.

All but six hospitals reported financial stresses in relation to serving diverse populations. ■

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

- Creating communication plans
- Educational needs of families coping with autism
- Addressing JCAHO recommendations on low health literacy
- Making patient education part of your culture
- Improving patient medication records

CNE Questions

21. To create a database for patient education materials and resources, it is a good idea to partner with which of the following?
    A. Information technology department.
    B. Colleague that understands process.
    C. The hospital librarian.
    D. All of the above.

22. A good search engine will pull important information to the top quickly and index it so busy clinicians can get resources quickly.
    A. True
    B. False

23. Blue Cross Blue Shield of Flordia consolidated utilization management and case management functions, and added which of the following?
    A. member outreach
    B. discharge planning
    C. cross-training RNs
    D. all of the above

24. Which of the following is true about Blue Shield of California's patient-centered management program?
    A. The average utilization cost for patients increased compared to the control group.
    B. Hospital admissions were reduced 39%.
    C. ED visits decreased 30%.
    D. B & C

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

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