

Patient Education Management™

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



'We can work it out' should be motto in addressing conflicting cultural beliefs

Set systems in place to address differences and demolish barriers

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Cultural traditions that conflict with Western medicine can be a barrier to safe and effective patient care so it is important to identify them and work out a plan with patients and family members that will result in good outcomes.

It is possible to address cultural preferences without compromising patient safety, says **Yvonne Brookes**, RN, manager of clinical instructors and patient education liaison for Baptist Health South Florida in Coral Gables.

"We need to be able to sanction other methods of prevention or healing and not necessarily make moral judgments on the behavior of patients. We can't always adhere to the Western system of health care delivery completely. For safer care, we need to merge systems. There are lots of ways we can maintain safety while recognizing other methods patients may have of healing, thus bringing Western medicine and alternative methods together," she explains.

In order to have culturally appropriate health care, staff members must

EXECUTIVE SUMMARY

Both language and cultural issues pose challenges to hospitals seeking to deliver safe, effective care. With this in mind, The Joint Commission has begun to focus on ways to overcome barriers in these two areas. Last month, in our two-part series on communication, we addressed the use of interpreters. This month we look at ways to bridge cultural differences for better patient outcomes.

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work with patients and families to accommodate their customs and beliefs without compromising safety, says **Leslie Catron**, RN, a clinical educator at Children's Hospital Central California in Madera.

For example, when a Hmong child is being prepped for surgery and there is a piece of yarn tied to his or her wrist, it is taped off rather than removed because it is understood the yarn was blessed by the family's priest for healing; if it is cut off, the family would feel the child would not heal.

Catron says the palliative care program at the hospital is strong and ensures that each family's religious requirements are met when a child dies. For example, the hospital has worked with a family's Shaman following the death of a child, per-

mitting burnt offerings on the grass outside the window instead of the traditional way, which is under the bed.

To provide culturally appropriate care it is important to know the population base that the medical center serves. The second largest group of Hmong immigrants in the United States settled in the Madera area.

Also, Catron says about 46% of the patient population at Children's Hospital is Spanish-speaking. The central valley of California is an agricultural area that attracts farm workers from the rural parts of Mexico. From March through October, there are as many as 400,000 Mexicans in the area who do not speak English or understand the health care system.

Because the hospital's policy is to treat patients regardless of their ability to pay, the Mexican farm workers with sick children seek medical care at Children's Hospital. The health care institution has set in place an interpreter services department that is strong in Spanish. There are about 20 Spanish interpreters available Monday through Friday from 7:30 a.m. to 5:30 p.m., with interpreters on-call after hours. In addition, there is a Spanish interpreter in the emergency department 24 hours a day, seven days a week. **(For additional information on the use of interpreters, see *Patient Education Management*, July 2007.)**

Understanding that many of the farm workers are from poor rural areas of Mexico, handouts in Spanish are written at a low grade level. The goal is to write at a fifth-grade level in a question-and-answer format. In addition, more and more pamphlets are being created with a lot of pictures, says Catron. **(For additional culturally appropriate patient education tips, see article p. 88.)**

Learn to fill in the blanks

While knowing your patient population base is helpful, it is important to remember patients and their families are not cut from an identical cultural mold.

"It is not always true a person from a certain culture will act a certain way," says **Silvia Goldstein**, senior medical translator and language assistance for the University of Texas M.D. Anderson Cancer Center in Houston.

It is important to see each situation as unique and not depend on stereotypes, she explains. However, for culturally appropriate health care, a general knowledge of the culture is helpful. At

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Editorial Questions

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M.D. Anderson, the interpreter services department has created a manual with bulleted lists of basic beliefs, customs, and traditions to aid communication between staff and patients from other countries. **(For details about an on-line cultural manual that is available, see article p. 89.)**

In addition, the interpreters act as cultural bridges. To enhance their skills in this area, the interpreters are continuously studying the various countries the cancer center serves to understand what is happening politically and socially. For example, Brookes says that in some cultures, people are mistrustful of those in authority because their leaders were not good to them. In the medical environment, everyone who is taking care of a patient is considered a person in authority, she explains. In such cases, patients must be made to feel comfortable with health care workers so they will learn to trust them.

Connecting with patients by learning their life stories is an important element of bridging the cultural gap as well, says Brookes. Today, medicine is fast-paced and people are in and out of the hospital quickly; therefore, patients often are treated as medical objects and detached from their life story.

To connect with patients, staff members at Baptist Health South Florida are trained to explore ways of meeting the patient's needs within the limits of the hospital setting. This means they must learn to recognize patients' needs, determine what is important to them, and come to know the patients, says Brookes.

To learn about the cultural beliefs of patients, Children's Hospital Central California has seven questions that address cultural and religious needs on the admissions database. These include:

- What do we need to get for you?
- Who do we need to call for you?
- Is there something that needs to be done for you?

The answers to the questions are written on the patient's chart and included in the interdisciplinary care plan. There is a section on the care plan for the nurse to determine what needs to be done with the information, such as contacting a social worker, explains Catron.

Set systems in place

Finding ways to address the needs of a culturally diverse patient base often involves setting systems in place to target specific requirements. For example, it is common for Baptist Health South Florida to receive patients from the Miccosukee

Indian Reservation, who have many special requests — for example, wanting to be turned a certain way.

When a patient from this group is admitted there is an automatic referral to pastoral care or social work so a staff member from one of these departments can help recognize and address the patient's needs.

While it is important to accommodate the patient in as many ways as possible, each health care facility has a method for delivering care and teaching patients what to expect is one way to help them feel more comfortable. That is why M.D. Anderson Cancer Center uses its interpreters to explain how the health care team works and what is expected of them, says Goldstein. For example, many times, patients from another country will expect the physician to make a treatment decision but at the cancer center patients often must make an educated choice between two options.

Harborview Medical Center in Seattle is in the process of creating an educational tool for patients that explains what the facility has to offer, what a person's stay will be like, what health care team members will interact with them, and what they might expect from each. The way to deliver the information has not been determined yet but the web or a CD-ROM is being considered, says **Ella Mae Kurashige**, RN, BSN, MSN, manager of patient education at Harborview Patient and Family Resource Center.

Also in the works is a class to help people be better patients. Kurashige envisions the class as a partnership, with the instructor interacting with participants, listening to their concerns, and providing answers. For example, in some cultures, people never ask questions of people in authority and the class could help them learn to ask questions and give them permission to ask.

With so many people on a medical team, it is important for health care professionals to educate patients about their job. Often Brookes will tell people who do not share her cultural beliefs that she is trained to make sure patients follow a certain medical regimen. She also tells the patient she wants to learn what he or she thinks is possible.

"You educate them as to what we have to do in our job, but at the same time you want to have a two-way conversation and agreement with them as well," explains Brookes.

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Addressing cultural issues is part of good education

Questions during one-on-one teaching

Except for the use of an interpreter, teaching techniques need not be altered when the patient is from another country.

"Just as we approach education in general teaching, patients from other cultures should be done the same way. Ask the patient questions and involve family members," says **Yvonne Brookes**, RN, manager of clinical instructors and patient education liaison for Baptist Health South Florida in Coral Gables.

Find out a little bit about patients and what is important to them. Tell them what they need to do and find out how they might follow through at home - what might work best for them. To determine if it is aligned (rather than merges) with their belief system, get to know the patient's story. A lot can be learned upon admission by

asking a few questions.

Making observations is helpful too, says Brookes. Watch to see who is coming to see the patient, how he or she interacts with family members, what he or she eats, and what is left on the tray.

"One of the biggest barriers to education is communication. We must learn how to have meaningful communication with patients, verbal as well as nonverbal," says Brookes.

At Children's Hospital Central California all educational handouts and videos are translated into Spanish because a large percentage of the patient base is Hispanic. There also are Spanish on-demand TV channels, says **Leslie Catron**, RN, a clinical educator at the health care facility in Madera.

While interpreters can always be present in classes to interpret for patients and family members, it is best to tailor the curriculum to the target culture as well.

For example, Harborview Medical Center in Seattle began several years ago to have multicultural diabetes outpatient classes. Each year they host four classes focusing on people from different countries at each one — such as Cambodia or Vietnam — explains **Ella Mae Kurashige**, RN, BSN, MSN, manager of patient education at Harborview Patient and Family Resource Center.

Before each class, a meeting of all the presenters is held with the cultural mediator from interpreter services. At that time, the mediator explains the traditions, beliefs, and concerns of the people who might attend the class and discusses any contradictions their view may pose with Western medicine.

"We need to know the participants' background before the class so we can address it or explain the information differently so there is not confusion," says Kurashige.

While currently the multicultural classes focus only on diabetes, staff members are looking at using this model to teach patients how to manage other chronic diseases. To help staff become more competent teachers when working with multicultural patients, Kurashige plans to add a patient education return demonstration to the annual staff competencies. Nurses would be asked to show how they would teach a patient from another country to give insulin. They would need to know what tools to use, what resources to call upon, how to teach the skill, and how to assess whether or not the patient understood. ■

Cultural profiles available on-line for various groups

Harborview Medical Center has developed a web site that describes the cultural beliefs, medical issues, and other related issues pertinent to the health care of several ethnic groups that recently immigrated to the United States. The information can be found at www.ethnomed.org.

Culturally specific pages include a profile on each group. Currently groups covered are Amharic, Cambodian, Chinese, Eritrean, Ethiopian, Hispanic, Oromo, Somali, Tigrean, and Vietnamese.

Printable patient education handouts on various topics are also available on the web site.

Knowledge of normal development key in diagnosis

Deviations signal need for exam and intervention

Early intervention is important for children with autism. To make sure this early diagnosis occurs, every pregnant woman should be given a chart on childhood development so she knows what is considered typical behavior.

"It is important for all families to know what the typical developmental patterns of a child is, so if things are starting to go wrong, they can start asking questions early," says **Sheila Wagner**, MEd, assistant director of the Emory Autism Center, Emory University School of Medicine in Atlanta.

It is impossible for parents to learn the warning signs of all the various disabilities including autism, but if they know what is normal they can seek medical attention when there are deviations, she explains.

If children are diagnosed at an early age, they can be taught normal patterns for play, communication, and language, which brings them more in line with typical development patterns.

"It doesn't mean you are getting rid of autism, but you are starting to shape those behaviors. If that child was not identified and traveled along this atypical pathway for years and years, those learned behaviors become cemented and it

becomes much more difficult to retrain learned behaviors," says Wagner.

According to the Autism Society of America based in Bethesda, MD, this developmental disability is a neurological disorder that interferes with the normal functioning of the brain and typically appears during the first three years of life. People with autism usually have difficulty with verbal and non-verbal communication, social interaction and leisure or play activities.

Some of the traits often exhibited include the use of gestures or pointing to express needs, not responding to verbal cues, a preference for being alone, little or no eye contact, odd play, tantrums, and resistance to change.

While people with autism may exhibit certain traits, each is unique. According to the ASA, autism is a "spectrum disorder" and, therefore, affects each child differently and in varying degrees.

With early diagnosis and intervention, the cost of lifelong care for adults with autism can be reduced by two-thirds, according to ASA.

For a successful intervention what do parents need to know? Education should start even if a toddler has not had a firm diagnosis but is only considered at risk, says Wagner. At the Emory Autism Center, children can be placed in the early childhood program at the age of one. The majority of children who graduate from this program are placed in a regular kindergarten classroom.

Include parents in intervention

It is a good idea to include parents in the intervention, training them to do what the therapist does with the child. Children with autism have difficulty generalizing information, so parents can transfer what has been learned from setting to setting and person to person, says Wagner.

Without parental involvement, the child will only be learning in a school setting. Education needs to be on a 24-hour basis so he or she can learn to use the skills in different environments.

There is a broad spectrum in the disability range for people with autism. While some may need support and supervision all their lives, others, with mild characteristics and behavior, are fully independent. Many are professionals and have full-time jobs, some earn a PhD degree, and others get married and have children.

While the cause of autism is not yet known, researchers believe there is often a genetic link

but something in the environment triggers it. “It is a mystery in many areas and all that we know about autism at this point is nothing compared to what we don’t know about the disability,” says Wagner.

A child may be developing language and starting to babble, saying a few words and then for some reason stop all progress.

“Developmentally, it is like they are going along a pattern of development and for some reason they hit a pothole and they can’t jump over it to progress. What makes that pothole nobody knows; research has not been able to discover the reasons why some children with this disability seem to appear to be doing fine in language and in social skills and then for some reason that stops,” says Wagner.

Some children never go through a regression in language or social skills but show delays and deviance in language and social development all along.

What is known is that families need a lot of support when they have a child with autism. Physicians need to provide families with a resource packet when a child is diagnosed that has the names of agencies that can help as well as web sites and books that provide good information.

The divorce rate is high in families who have a child with autism so couples must build a support system. Children with autism are extremely vulnerable — families must find people they trust fully to care for their child.

“It is important for families to have outside interests beyond autism. I often tell couples they need a date night once a week to have dinner and go to a movie,” says Wagner.

On date nights she gives parents two rules to follow. One is not to talk about autism and the second is to avoid conversations about their children.

It is also a good idea to spend time alone with other siblings who do not have the disability. “Many times siblings feel left out because all the focus is on the child with autism so they need some care and attention and loving and nurturing as well,” explains Wagner. There are support groups in which siblings of autistic children can participate as well.

“Autism is a very complicated thing and our families get pulled in a lot of directions. These kids tend to be very challenging for families and finding that balance is very difficult,” says Wagner. ■

SOURCES

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WHO unveils patient strategies to redesign care

Joint Commission bodies coordinate effort

The World Health Organization (WHO) has published nine strategies aimed at assisting member states in the redesign care process to prevent human errors in patient care. The strategies, developed by WHO’s Collaborating Centre for Patient Safety Solutions, include:

- **Look-alike, sound-alike medication names:** The recommendations focus on using protocols to reduce risks and ensuring prescription legibility or the use of preprinted orders or electronic prescribing.
- **Patient identification:** The recommendations emphasize methods for verifying patient identity, including patient involvement; standardization of identification methods across hospitals in a system; patient participation; and use of protocols for distinguishing the identity of patients with the same name.
- **Communication during patient hand-overs:** The recommendations include using protocols for communicating critical information; providing opportunities for practitioners to ask and resolve questions during the hand-over; and involving patients and families in the process.
- **Performance of correct procedure at correct body site:** The recommendations include a pre-

operative verification process; marking of the operative site by the practitioner who will do the procedure; and having the team involved in the procedure take a “time out” immediately before starting the procedure to confirm patient identity, procedure, and operative site.

- **Control of concentrated electrolyte solutions:** The recommendations address standardization of the dosing, units of measure, and terminology; and prevention of mix-ups of specific concentrated electrolyte solutions.

- **Assuring medication accuracy at transitions in care:** The recommendations address creating the most complete and accurate list of all medications the patient is currently taking; comparison of the list against the admission, transfer and/or discharge orders; and communication of the list to the next provider of care whenever the patient is transferred or discharged.

- **Avoiding catheter and tubing misconnections:** The recommendations address the need for meticulous attention to detail when administering medications and feedings (i.e., the right route of administration), and when connecting devices to patients (i.e., using the right connection/tubing).

- **Single use of injection devices:** The recommendations address the need for prohibitions on the reuse of needles at health care facilities, periodic training of practitioners and other health care workers regarding infection control principles, education of patients and families regarding transmission of blood borne pathogens, and safe needle disposal practices.

While many of the topics and strategies are familiar to quality managers and patient safety officers in the United States, several of the strategies were influenced by international experts participating in the process, says **Peter Angood**, MD, vice president and chief patient safety officer for The Joint Commission. It is The Joint Commission and The Joint Commission International that were named as the Collaborating Centre, or, as Angood puts it, a “Center of Excellence.”

“We have developed these ‘solutions’ with the help of a couple of different groups we use as external advisors for vetting — including an international steering committee,” he explains. In addition, Angood says, there are three regional advisory groups — Europe, Asia Pacific, the Middle East — and there will eventually be five. “In addition, there are three other expert panels — for communication, medication safety, and patient/family involvement,” he notes.

WHO’s Alliance for Patient Safety, he adds, has been active for more than two years, and includes a number of different topic areas. “Since the start-up, our recommendations have been based on review data from our own sentinel event database and National Patient Safety Goals program, and other international safety organizations,” Angood explains. “We presented a variety of topics to our steering committee and eventually focused on those nine topics.”

The draft solutions were vetted through the advisory groups and expert panels, followed by an extensive Internet-based survey (field review). “The recommendations were revised based on all that input, and re-presented to the steering committee for approval, and then released,” says Angood.

All of the recommendations are designed with a similar template — that is, the same topic areas are found within each solution — and “are basically meant to highlight and profile issues and general strategies that could be used to address the problems,” says Angood. “We have stopped short of specific implementation protocols because it would have been really complex to simultaneously disseminate information and try to evaluate if there had been any impact.”

(The complete patient safety solutions can be found at: www.jointcommissioninternational.org/solutions.)

Angood says that while The Joint Commission saw many of its standards validated through the process, there was also new and valuable knowledge gained. “Patient safety problems are fairly uniform around the globe, and we found that our National Patient Safety Goals program and standards are pretty solid overall, but there are differences and other areas within these topics that other countries have addressed differently,” he says.

For example, notes Angood, the UK has done a good deal of work focusing on avoiding catheter and medical tubing missed connections. “African countries have taught us a lot about injection safety and the use of single injection devices.”

As a result of these new insights, “we’ve learned from these and they will be incorporated into our solutions,” says Angood. “Our attitude, after all, was to learn as much as we could and be as all-encompassing in the development of solutions as we could. We did *not* promote America-based strategies.”

Quality managers, he says, will find The Joint Commission web site on these findings a valuable resource, “not only the preamble but the

nine strategies and 'Access to Patient Safety Goals.' It could help improve their own patient safety strategies," Angood offers.

As for the future, Angood says the center is in the process of getting an implementation test pilot project off the ground. "We will take five of these solution topics, with the goal of organizing far more specific protocolized approaches to solutions, and implement those into at least seven different countries through technical lead agencies," he reports. "We will then implement them into at least 10 health care facilities in these countries, and we will evaluate sentinel event activity, do root cause analyses, collect patient safety indicator data, culture of safety information, and economic data. We will learn from all of this what works and what doesn't."

[For more information, contact Peter Angood, MD, Vice President and Chief Patient Safety Officer, The Joint Commission. Phone: (630) 792-5000.] ■

A partnership between patient and case manager

Treat pain like any other chronic condition

An estimated 50 million Americans — some of them your patients — live with chronic pain caused by disease, disorder, or accident, according to the American Academy of Pain Management.

Chronic pain represents a major health care problem and affects every aspect of the lives of people with pain. Consider these statistics from a patient survey recently released by the American Pain Foundation:

- Six out of 10 patients reported experiencing breakthrough pain at least once daily, severely impacting their quality of life.
- More than half of those surveyed felt they had little or no control over their pain.
- Nearly 70% said their pain has a great deal of impact on their work and more than half said pain has put a strain on their relationships with family and friends. Half have lost a job due to chronic pain.
- More than three-quarters of chronic pain patients reported being depressed while 70% said they have trouble concentrating and 86% reported an inability to sleep well.

"Chronic pain, like any other chronic disease, has an impact on all aspects of a person's life. When people have a set of symptoms that can't be cured, it affects them physically, emotionally, and socially," says **Dennis C. Turk**, PhD, John and Emma Bonica professor of anesthesiology and pain research at the University of Washington in Seattle. Turk is past president of the American Pain Society.

Chronic pain management should be a partnership between the patient and the case manager, Turk says. "Since there is not a cure for chronic pain, self-management becomes very important. People have to work with their health care providers to find a way to manage their pain," he adds.

The person with pain has to become part of the treatment team. Unless they have an active role, it doesn't matter what else health care providers do, adds **Penney Cowan**, executive director of the American Chronic Pain Association, based in Rocklin, CA.

Case managers should help their clients understand the solution to their pain involves much more than just a medical one, Cowan says.

"There's not just a medical solution to diabetes. People with diabetes have to be responsible for their diet, medication, monitoring their blood sugar levels. We empower them to control their disease and give them the tools for doing so," she says.

The first step in helping people learn to manage their pain is to believe that their pain is real, Cowan suggests.

"Pain is invisible and there's no way to physically document the pain someone is having. The only way case managers can help people live with it is to validate them and believe that they have the pain," she says.

Many patients are concerned that people don't believe their pain is real, since there are no objective signs that characterize pain, Turk asserts. He points out that 86% of people with back pain and 98% of people with chronic headaches exhibit no physical pathology to indicate pain.

People with pain feel so strongly about convincing health care providers that their pain is real that the pain is all they can talk about, Cowan adds. "This represents their desperation to get people to believe what they are saying about their pain," she says.

Concentrate on the entire person and not just the pain, Cowan suggests.

"Pain is not a person's whole identity. It's a

small piece of who they are. That's why we prefer to call them people with pain, rather than chronic pain patients," Cowan says.

Take time to listen to your clients with chronic pain, Turk advises. "One of the things that people with chronic pain tell us most often is that clinicians and case managers don't really listen to them. They just start focusing on what to do and the body parts and not the person," he says.

Listen to your patient's worries and concerns, Turk advises. Find out what patients are worried about, what areas of their lives are impacted by pain, and work with the patients to come up with solutions. Many people with chronic pain are concerned that it's going to get worse and they'll become disabled, bedridden, and totally dependent.

Find out what their symptoms are, what their greatest problems are, and what will represent an acceptable improvement to them. For instance, if a patient indicates on a scale of one to 10 that his pain is an eight, find out what level he is willing to tolerate.

Managing, not curing, pain

For many people, additional medical treatment won't eliminate the pain, Cowan points out. That's why people with pain need to understand that a chronic pain program is not about a complete cure. It's about learning to manage the pain and learning to live with it, she adds.

"People with pain often look to medication to give them that quick fix. They have unrealistic expectations. Those issues have to be addressed first. They have to understand that their pain is not an acute condition," she says.

Cowan likens treating chronic pain to fixing a car with four flat tires. "If you give a person with pain appropriate medication, it's like putting air in one of their tires. Health care providers and the person with pain need to work as a team to identify how to fill those other three tires," she says.

Many of the treatments for chronic pain have side effects, particularly the more invasive treatments, such as surgery, Turk points out. "Any surgery can lead to a different set of problems. Many medications have side effects as well," he says.

Encourage your patients to start with exercise and put off the more aggressive types of treatment unless there is a good medical reason, such as a tumor or a fracture.

"People have to accept the fact that they have a

chronic condition that won't be cured. There are a lot of options for improving the symptoms but they need to understand that one more surgery or one more nerve block will not eliminate all pain," he says.

People with pain need to understand the responsibility of the medical community and their own responsibility in controlling their pain, Cowan says.

Non-drug solutions

"It takes a team, not just a pill," she says. Solutions may include physical therapy, counseling, occupational counseling, stress management, or a variety of techniques, she says.

Help people with chronic pain break down their goals into manageable steps so people don't set themselves up to fail, Cowan says. For instance, stretching is helpful for people with chronic pain but if someone gets a workbook with 18 sketches and tries to do 10 repetitions of each exercise, they're going to hurt the next day.

"We recommend that the first day, they do one leg lift and work up gradually. The whole point is to take it gradually," she says.

People with chronic pain tend to focus on what they can't do any more. Case managers can help them focus on what they can do, Cowan says. Encourage people with pain to understand that they can do things but they have to do it within their own limits.

"Pain is never consistent. On good days, people with pain may overdo it and wear themselves out completely, which increases their level of pain. Then they may stay sedentary on their good days," she adds.

Recognize the emotional aspect of people with chronic pain but be cautious about immediately referring them for counseling, Cowan suggests.

"Many people with pain hear that they have to live with the pain and they become depressed but they're not clinically depressed.

"Case managers shouldn't start by referring them for counseling because they will become defensive and feel like they have to defend their pain," she adds.

"I get calls all the time from people with pain who say that their health care providers think it's all in their head. If they have to defend their pain, it will reduce the effectiveness of any treatment," she adds.

Case managers should direct their patients to resources that can help them manage pain day by

day. "Health care providers can't do that. People with pain need information on support groups, workbooks, and other resources to help them," Cowan says.

Help patients communicate with doctors

Help your patients prepare for doctor visits. "Most people don't know how to communicate with their doctors. Case management coaching on the types of questions to ask and how to ask them will be a big help," she says.

She suggests the pain log tool on her organization's web site, a two-page instrument that patients can use to measure pain, stress, activity level, exercise, mood, sleep, and appetite:

<http://www.theacpa.org/documents/8%20x11%20Pain%20Log%202-8-06.pdf>.

The doctor can immediately get a total picture of the patient and can compare the patient's results on previous tools.

Be aware that family members and significant others can be helpful but can also undermine the patient's progress, Turk says. Find out about the patient's support system. Know what support is available and how family and friends are helping or hindering the patient's progress.

Turk tells of a patient whose wife was so afraid he was going to overdo it, that she interfered with his exercise regimen. "She literally prevented the patient from engaging in the activities we had worked to develop. People can be non-supportive, even when they intend to be helpful. Patients with chronic pain do have limits and may need assistance but they also need independence," he says.

Health care providers can work with families to help them be supportive but at the same time, help them understand that giving patients too much help can prevent them from making progress, he adds. ■

Pain program includes cognitive, physical therapy

Multidisciplinary approach includes classroom

A multidisciplinary pain management program with a strong case management focus helps members of Kaiser Permanente with moderate to severe levels of pain receive effective care

and avoid using treatments that don't work.

"The goal of the program is to help our members to live as full and productive a life as they can in spite of their chronic pain condition. We want to make sure they don't end up using just one technique, such as medication, but use a variety of strategies to manage their pain," says **Andrew Bertagnolli**, PhD, care management consultant with Kaiser Permanente's Care Management Institute in Oakland, CA.

The program includes an intensive 10-week program of cognitive behavioral therapy and physical therapy followed by individual contacts by care case managers who work with members for about a year, acting as health coaches and helping members follow care plans.

"We treat chronic pain as a chronic condition, like diabetes or congestive heart failure, and work with the member to develop strategies that can help them learn to self-manage their pain," Bertagnolli says.

The program is a win-win situation for Kaiser Permanente and its members, Bertagnolli points out.

"The literature shows that members with chronic unmanaged pain are high utilizers of health care services. These people's lives are topsy-turvy because of the pain. That often drives them to come in to the medical centers for service. By learning to manage their pain effectively, members feel better, improve their functional status, and cut down on their use of the health care system," he says.

Kaiser developed the program in 2000 in response to employers who expressed concern about increases in absenteeism due to chronic pain and the health plan's goal of ensuring that members with chronic pain receive treatment based on scientific evidence.

A work group of physicians, physical therapists, psychologists, pharmacists, nurses, and osteopaths with expertise in chronic pain developed clinical practice guidelines that emphasize a multidisciplinary approach to treatment.

The program was distributed to medical directors in all Kaiser regions. The regions have tailored the program to meet the needs of their members.

"The program is being used in many of the Kaiser regions but not uniformly. The program is being used most frequently in Northern California, Southern California, the Northwest region, and the Mid-Atlantic states region," Bertagnolli says.

The majority of members eligible for the program are identified through referrals from their

primary care physicians. In addition, when claims data identify members who are heavy users of health care services that may indicate chronic pain, they contact the member's physician to determine if the member could benefit from the chronic pain program. The majority of the members in the program have back pain diagnoses. Other conditions include fibromyalgia, nerve disorders such as diabetic neuropathy, chronic headaches, neck pain, shoulder pain, and other painful bone and muscle conditions, he says.

"In addition to chronic pain, these members are also experiencing moderate to severe levels of impacted functional status. Not only do they have severe pain but their lives are a wreck. They're not working, they have problems with activities of daily living, and their social lives are in chaos," Bertagnolli says.

When members are identified for the program, they are contacted by a nurse case manager who tells them about the program and lets them know that their physician believes the program would benefit them.

Program participants are evaluated by the chronic pain team that includes a physician, a psychologist, and a physical therapist, all trained in chronic pain management. The team develops an individual care plan for reducing pain, which is shared with the member's primary care physician. During the initial evaluation, members are assigned to either the moderate or the high intensive program, based on their pain and dysfunction.

The more complicated, dysfunctional patients are in the more intensive program and may be managed by a psychologist following the 10-week classroom session. Those at lower risk may have mild mood symptoms or problems with relationships and are managed by a care case manager.

The team may suggest strategies that include physical therapy, diet, medications, walking and stretching, stress management techniques, and psychotherapy for depression and anxiety, depending on the needs of the individual member.

The intensive treatment phase of the program

is a group intervention led by a psychologist and a physical therapist at Kaiser medical centers throughout the regions.

The program includes cognitive behavior therapy led by the psychologist and sessions with physical therapists who help the members learn exercises and body mechanics that can help alleviate their pain. The team works with members to help them accept their pain as a chronic condition.

"Most people who experience chronic pain believe that it is an acute pain problem that will go away with the right medication and right treatment. There is no magic bullet for chronic pain. It's a condition you manage not only by

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

■ Ideas for Patient Education Week

■ Preventing type 2 diabetes in Hispanic children

■ Making patient education part of your culture

■ Revitalizing the patient education committee

■ Effective pain control education

CNE Questions

5. Which of the following teaching methods can be used when cultural differences might prevent a patient from following a medical regimen?
- A. Find out what is important to them.
 - B. Make observations.
 - C. Ask how they will follow the regimen at home.
 - D. All of the above.
6. To make sure children with autism are diagnosed early, every pregnant woman should be given a developmental milestone chart.
- A. True
 - B. False
7. Which of the following does the American Pain Foundation report:
- A. Six out of 10 patients reported experiencing breakthrough pain at least once daily, severely impacting their quality of life.
 - B. More than half of those surveyed felt they had little or no control over their pain.
 - C. Nearly 70% said their pain has a great deal of impact on their work and more than half say pain has put a strain on their relationships with family and friends.
 - D. All of the above
8. How many weeks is Kaiser Permanente's multidisciplinary pain management program?
- A. Four weeks
 - B. Six weeks
 - C. 10 weeks
 - D. 14 weeks

Answer Key: 5.D; 6.A; 7. B; 8. C.

medication, but a variety of strategies," he says.

During the 10-week program, the case managers help participants overcome barriers to attending the sessions, such as child care or lack of transportation, and may help them adjust their pain medication using protocols under the direction of the chronic pain physician.

"Chronic pain is not an easy problem to solve because it affects so many aspects of life, including recreation, occupations, and relationships. When people have severe chronic pain, they become depressed and need help in managing their moods as well as their pain," he says. ■

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