Patient Education Management™

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

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IN THIS ISSUE

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Create an education culture to ensure all take the time to teach

Training and resources make every minute count and work for best outcomes

Creating a patient education culture within an institution will help ensure that teaching is part of the care that is provided, not an afterthought or something that is completed if there is time.

"We are not providing quality care if we do not provide patient and family education," says **Fran London**, MS, RN, a health education specialist at The Emily Center at Phoenix (AZ) Children's Hospital.

"Great drugs and skilled surgeries are not enough to optimize health outcomes. Behavior changes with improved self-care skills must accompany our interventions to make them work as they were meant to work. There can be no quality health care without patient and family education."

Education is an important element for achieving good health outcomes, agrees **David Wiljer**, PhD, director of knowledge management and inno-

EXECUTIVE SUMMARY

Making patient education a part of everyday practice is often difficult because many health care practitioners feel there is no time to teach. Yet, education as well as good patient care are required if good health outcomes are to be achieved. In this month's *Patient Education Management,* several health care professionals offer insight into building a patient education culture within an institution.

In the upcoming months, we will build on this topic, offering details on making patient education a part of annual competencies and job evaluations, creating educational opportunities for staff to learn teaching techniques, and empowering the patient to take an active part in his or her education.

vation for the oncology education/radiation medicine program at Princess Margaret Hospital in Toronto.

"We know from a lot of research that patient education is a huge piece of behavioral change for patients," he says.

Yet acknowledging its importance does not automatically mean it will become a part of everyday care. Steps must be put into place to make patient education part of the pattern of patient care, rather than something that is done if time allows.

Many experts in the field of patient education say that those in jobs where teaching is appropriate, such as nursing, physical therapy, or nutrition, must understand they are expected to teach.

Write patient education into job descriptions; make it part of annual competencies and annual job evaluations, advises **Kathy Ordelt**, RN-CPN, CRRN, patient and family education coordinator at Children's Healthcare of Atlanta. "This helps make the idea 'stick' that patient education is not to be pushed aside, it's to be taken seriously," she explains.

It should be integrated into nursing policies and procedures as well, states **Magdalyn Patyk**, MS, RN, BC, patient education program manager at Northwestern Memorial Hospital in Chicago.

Staff must understand there are standards that must be maintained, adds Wiljer. "Determining best practice for patient education is really an essential part of the care so there has to be a process around educating patients in the same way there is a process around delivering chemotherapy. It has to happen according to standards and guidelines," he says.

However, policy is not enough; staff members must be trained to teach effectively. At Princess Margaret Hospital, staff can enroll in a one-and-a-half-day course titled "Maximizing Your Patient Education Skills." Curriculum includes information on learning principles including assessment of educational needs and tailoring teaching to individual learning styles; students learn through various clinical scenarios.

Ordelt says she discusses patient education during staff orientation, offers in-services and training opportunities, and speaks at meetings.

At Northwestern Memorial Hospital, all employees receive information on patient education in the general orientation packet and it is included in the professional clinical orientation. In addition, information is available in an on-line orientation packet that includes an electronic quiz. Patyk says nursing has made this on-line orientation and quiz mandatory for all RNs.

More than techniques

To prevent health care providers from teaching "only if time allows," helps them recognize that most care is self-care, as patients are eventually discharged from the hospital; education to promote optimal self-care is essential, explains London.

A good exercise for teaching this concept is to ask staff to imagine providing care without teaching, says London. Ask them: How would it look? What would you do? Could you hand over a prescription and not say what it was for or how to take it? Could you discharge a patient from a hos-

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pital without any information beyond goodbye?

"Once they recognize their job is to optimize self-care, we need to show them how education is integrated into care. We need to depend on informal education, done in conversation within the context of care for most of our assessments and teaching," says London. Staff should learn to recognize opportunities for teaching while they are providing care such as describing a medication before giving it or talking through a dressing change while doing it.

If health care providers are skilled at providing care, they have all the knowledge they need to teach self-care skills to patients and their families. The provision of care includes assessments, medical interventions, the recognition of problems, and knowing how to respond.

When caring for patients, nurses assess their condition all the time, looking for opportunities to intervene with treatments or calling in other health care team members. A nurse caring for a patient with a fever knows what signs and symptoms to look for such as whether the temperature responds to medicine or if the patient is also having chills or seizures.

"These assessment skills are some of the things patients need to learn to care for themselves at home. They must recognize problems and how to respond to them as well as learning concrete skills such as a bandage change," says London.

The content of what is taught should come out of the assessment of the learner, which determines what he or she needs to learn to provide safe self-care at home.

Ordelt agrees that educational content for one-on-one teaching should be patient- and family-specific as learning needs are assessed but she adds that teaching sheets and other patient education resources are important.

"They provide consistency throughout the health care system, help make learning better and quicker for families, help make teaching easier and quicker for staff, and can also be used as a resource at home," explains Ordelt. Of course, teaching patients is never simply checking items off an education plan but involves evaluation so staff know the patient is actually learning, absorbing, and changing as a result of the teaching.

While it is reasonable to expect staff to teach patient populations they care for routinely, educational resources are helpful for new staff or those who do not routinely care for a certain population. At Northwestern Memorial, one-page teaching guides are available on the Intranet that list key survival skill topics on the left and the supporting resources on the right.

A solid infrastructure to support patient education, including programs, procedures, and services, is important, says Wiljer. "For us, the essential question is how to bridge the gap between education and clinical care and make sure education, in general, is central to the clinical practice. We spend a lot of time on those issues," he says.

A patient and family library on the main floor of Princess Margaret Hospital serves as the hub of activity for patient education. Workshops on all types of topics are held in the library including chemotherapy, radiation, diet, and nutrition. In addition, in each clinical waiting area, there is a patient education center with a computer, printer, and in some cases, a collection of library books. Some centers are staffed by volunteers.

To make education an integral part of patient care, the institution has specially trained patient education volunteers who work in the library and resource center. They disseminate education to patients, do searches for them, and direct them to resources.

"Health care professionals are very busy, so we try to support them with volunteers as much as possible. That is part of the infrastructure," says Wiljer.

Also, initiatives are set in place to make education as easy as possible. "We try to take innovative approaches," says Wiljer. For example, an on-line support platform that consists of chat groups for patients with breast cancer has been created to educate patients. Patients access the chat line from home, and nurses, physicians, dietitians, and others can schedule special sessions to directly communicate with patients.

"We are exploring methods of making it easier for health care professionals to deliver the education and make it part of the overall process," explains Wiljer.

Yet putting the tools in place and creating innovative methods of education won't guarantee that education is completed. Getting the word out to both patients and staff that resources are available is vital. **(To learn ways of making sure patients know about resources available to them, see article, p. 112.)**

"We do try to put infrastructural support around each of the education points to make it easier for health care professionals and to make sure if they need something they know where to get it," says Wiljer. ■

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More than one way to get the word out

A variety of methods alert patients to opportunities

To enhance patient learning and increase patients' access to books and resources available at M.D. Anderson Cancer Center in Houston, a patient education office communication plan has been established. This plan consists of a number of steps to promote health education programs and other resources so patients are fully aware of the opportunities for learning available.

The education office maintains a number of handbooks and information packets that are automatically provided to patients at certain points of their care.

The first packet is mailed to patients once they register for an appointment and includes a welcome brochure, a general instruction sheet, and an instruction sheet specific to the center where they will be treated. It also has information about what to bring and about clinical trials available.

"That packet is to help them get to M.D. Anderson and to start introducing them to the institution," says **Louise Villejo**, MPH, CHES, executive director of the patient education office at M.D. Anderson Cancer Center.

Once patients arrive at the health care facility, they receive a handbook that has more information about the clinical services available as well as resources such as the learning center and place of wellness. Also, it has information on patient rights and responsibilities, advance directives, and HIPPA.

A patient education guide is also given to patients and lists all the resources that can be accessed via the video-on-demand system and other educational resources.

In conjunction with the communications department, the patient education office prints a weekly newsletter with information on the programs available that week. There is a list of the classes held in the M.D. Anderson classrooms and place of wellness as well as short articles on research written from a patient perspective. These newsletters are placed next to elevators and in patient service areas.

Literature racks that hold flyers promoting classes and programs are also used to get the word out as well as in-house television channels. Bulletin boards with lighting are located in several areas of the hospital. This space is used to communicate various messages such as patient safety, learning center resources, or questions patients might ask their physician.

A variety of ways to get information to patients helps make sure everyone will learn what educational resources are available to them. ■

SOURCE

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Education on postpartum mood disorders needed

Information vital for society as a whole

Expectant mothers receive a lot of information over the course of their pregnancy and are sometimes inundated with things to remember. Yet one important message that needs to be stressed is that some may experience postpartum mood disorders that can adversely affect their mental health.

"It is helpful to keep the basic message pretty concise and then if a woman is having difficulty elaborate more at that point," says **Laurel R. Spence**, MS, PA-C, maternal and child health director for Baylor College of Medicine School of Allied Health Sciences physician assistant program in Houston.

What is the basic message? According to Spence, there are a couple of key points. First, postpartum disorders can happen to anyone, although there are some patients that are considered higher risk. Also, it is important to know that these disorders are medical illnesses, which respond well to treatment.

"There is such a stigma surrounding postpartum depression, we need to demystify it," explains Spence.

In addition, women should be prepared for some baby blues after they deliver. According to Mental Health America, based in Alexandria, VA, 80% of women experience them.

Baby blues are mood swings that are a result of high hormonal fluctuations and cause women to cry easily and experience a wide range of emotions, from sadness and frustration to happiness. The mood swings last about two weeks, but if a woman has more dramatic symptoms or they linger beyond two weeks, she may be dealing with a postpartum mood disorder, says Spence.

Postpartum disorders include depression, and in rare cases, psychosis. Postpartum depression has symptoms similar to clinical depression that may include fears, such as excessive preoccupation with the health of the baby, or intrusive thoughts of harming the baby. One main symptom of postpartum depression is an inability to sleep when the baby sleeps, whether day or night. Also the new mother may experience irritability and feel easily overwhelmed.

A woman who develops postpartum psychosis loses touch with reality, experiencing delusions and hallucinations.

While baby blues are common, less than 30% of women experience postpartum depression and about 1% of women are diagnosed with psychosis.

"The reason it is very important for women to recognize the symptoms of postpartum disorders is because the symptoms don't just affect them — they affect the baby and the bonding with the baby, they affect the immediate family and extended family. When members of our society are not functioning well, which is the case with postpartum mood disorders, then that affects everyone in our society in some way," says Spence, who experienced postpartum depression with the birth of her three children.

Good education dispels myths

Education about postpartum mood disorders should be included in classes for expectant parents, says Spence. Also, health care practitioners should discuss them with their patients and make sure resources are given that can be referred to later to help people identify symptoms and seek treatment. Women who experience a postpartum mood disorder, such as depression, need medical intervention, therapeutic intervention, and social support, says Spence.

Identifying and treating disorders is important because women who have had one occurrence of postpartum depression that is not treated are 50-70% more likely to have a second occurrence says Spence. With two or more occurrences of postpartum depression, chances of a reoccurrence are elevated to as high as 90%. "It is pretty much guaranteed it will happen again," says Spence.

The Texas legislature passed a bill in 2003 mandating that resources and references be given to women who deliver in a hospital or birthing center of a certain size. The legislation was a result of the Andrea Yates case. Yates, a Houston resident, drowned her five children following the birth of her daughter. She battled with depression and had episodes of psychosis.

Spence says women such as Yates who are at high risk for postpartum disorders can be identified. A family history of mood or psychiatric disorders or prior personal history are indicators of risk.

"If a woman has had depression in the past or if there is a history of bipolar disorder or something more pervasive and chronic, then hormonal

changes may induce a more severe state in that woman," says Spence.

In addition, stressful situations such as relationship problems, marital discourse, death in the family, or a job loss can all act as triggers.

Spence says that having a baby is stressful physically and emotionally, even under the best circumstances. If a woman is at high risk for disorders, it is wise to have a postpartum plan in place with support people identified in advance, along with their duties, all of which have been agreed upon. With a plan, a woman in the middle of a crisis doesn't have to find family and friends who are willing to help.

According to Mental Health America, screening women to determine their risk for postpartum disorders and setting into place a social support system to include physicians, partners, friends, and coworkers can help prevent a crisis.

Spence says providing written materials, such as books, to women who have had problems with previous pregnancies or have a history of disorders helps them know they are not alone. Also, it gives them confidence that they can get through an episode with proper help and treatment.

A major barrier to education about postpartum disorders is the belief that new mothers should be in good spirits in all circumstances. The media reinforces the image of the happy mom and baby with smiling women giving their newborn a bottle or changing a diaper.

"In some ways, having a baby can be the best time of a woman's life, but also it can be the hardest time. Imagine a woman with a mood disorder who wants to enjoy her baby. That special time can be stolen away, especially if she does not get treatment," says Spence.

Several factors contribute to postpartum depression, according to Mental Health America. Intense hormone fluctuation after giving birth is one factor. Also, a major event that coincides with childbirth can make a woman more susceptible, as well as life stresses such as increased demands at work.

Screening should be part of a woman's postpartum visit to her physician. Answers to simple questions, such as, "Do you sleep when the baby sleeps?" provide cues.

A society that is well educated is important as well so there is compassion and understanding. And it isn't always family members who notice a problem as they often are too close to be objective. It may be friends who notice when a new mom doesn't want them to come over to see the baby because she is too overwhelmed. That is not characteristic behavior of a new mom, explains Spence.

"One of the initiatives of the Mental Health Association in Houston is to educate both the public and health care professionals regarding postpartum mood disorders," says Spence.

(Editor's Note: Mental Health America also recommends that couples having a baby be given information on the Postpartum Support International web site. This site provides details on disorders and has an on-line list of support groups as well as chat and discussion boards. Web site: www.postpartum.net). ■

SOURCE

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Delivering the Medicare Important Message

Education, documentation will help

If your hospital is having difficulty complying with the new Medicare rule for notifying patients of their right to appeal their discharge, you're not alone.

"It's difficult to deliver the message and everybody is struggling with the new components," says **Cassandra Barnes**, RN, MS, CCM, senior consultant for case management at Pershing Yoakley and Associates' Atlanta office.

The new rule, which went into effect July 2, updates a previous regulation establishing how hospitals must notify Medicare beneficiaries of their right to appeal their discharge, their financial responsibility, and how to appeal a hospital discharge.

The rule applies to traditional Medicare beneficiaries, beneficiaries enrolled in Medicare

Advantage programs, and other Medicare health plans that are subject to Medicare regulations.

The Important Message (IM) from Medicare must be delivered within two calendar days of inpatient admission and must be signed by the beneficiary or his or her representative and dated and a copy must be given to that person. If a patient stays more than two days in the hospital, he or she must receive a copy of the original signed form within two calendar days of discharge.

The Centers for Medicare & Medicaid Services (CMS) allows hospitals to issue the IM at preadmission but not more than seven calendar days before the admission.

Medicare beneficiaries who are admitted to outpatient observation can be given the IM when they are admitted if they are advised of the difference between observation and inpatient admission.

If the patient's status is converted to an inpatient level of care, the IM should be delivered within two days of when the level of care changes.

If a patient disagrees with the discharge and requests a review by the Quality Improvement Organization (QIO) following the hospital's or Medicare's determination that inpatient care is no longer necessary, the hospital must give the patient a more detailed notice that further explains the appeals process. This notice should be delivered as soon as the QIO notifies the hospital that a Medicare beneficiary has requested a QIO review.

Historically, patient registration staff have delivered the initial Important Message from Medicare, but just handing patients a notice and getting their signature doesn't meet the intent of the law, Barnes points out.

"The whole intent of the Important Message is to let Medicare beneficiaries know that they have the right to appeal their discharge date if they disagree with the physician. This means that all hospital staff involved in the delivery of the Important Message must make sure that patients understand what they are signing," she says.

She recommends that hospitals create a script for the admissions staff, making sure they explain what the notice of appeal means in order to meet the intention of the requirement and maintain continuity in the delivery process.

"We tell the admissions staff to make sure the patients understand that if they are in the hospital more than two days, they'll get another copy. Otherwise, they may be confused when they get the second notice," Barnes says.

When is the best time?

At Weatherford Regional Medical Center in Weatherford, TX, patients are given the Important Message from Medicare when they go through registration. Then the case managers discuss the document with the patients and family members and make sure they understand it when they make their initial assessment, says **Lyn Clark,** RN, BSN, MHA, director of case management for the 99-bed hospital.

"Sometimes patients coming into the hospital are disoriented and put it with their other papers. Admission may not be the right time to make sure they understand it. That's why we cover it when we complete our initial assessment," Clark adds.

The case management secretary at Southern Ocean County Hospital in Manahawkin, NJ, is responsible for making sure that Medicare patients receive the Important Message in a timely manner. She goes on every unit each morning and gives the document to the new patients.

If the patient doesn't seem to understand the document, she notifies the case manager, who talks to the patient about the document and contacts the next of kin or person with power of attorney for the patient, says **Marilyn Butler**, RN, MSN, CCM, director of case management.

Hospitals should take an interdisciplinary approach to ensuring that the patients get the Important Message as specified by the regulation, Barnes says.

"In most organizations, case managers don't work 24 hours a day, seven days a week. Hospitals must make sure that someone delivers the Important Message when case management is not available," she says.

Make sure that all hospital staff who may be involved in delivering the Important Message can accurately inform beneficiaries of their appeal rights and answer questions.

"Ultimately, the entire organization is responsible for becoming compliant with this process," adds **Lorraine Larrance,** BSN, MHSA, CPHQ, CCM, manager with Pershing Yoakley & Associates**.**

Schedule follow up

She suggests setting up a mechanism to ensure

that the follow-up copy of the Important Message is delivered on weekends and holidays or other times when the case manager is not available and assign responsibility to the charge nurse, house supervisor, discharging nurse or other staff member.

Any staff who may be responsible for delivering the Important Message should receive formal education on the process and what is required. The same formal education should be part of orientation for new employees, Larrance adds.

"Clinical conditions may change drastically during the day. If the doctor says a patient can be discharged at 5 p.m. on Sunday, Medicare recognizes that the patient recovered sooner than anticipated but that doesn't eliminate the necessity to deliver the Important Message. It's OK to give patients the Important Message on the day of discharge. However, there should be a four-hour window between the time the Important Message is delivered and discharge to give the patient a chance to appeal," Barnes says.

At Weatherford Regional Medical Center, nurses and house supervisors are trained to deliver the notice if the discharge, takes place sooner than anticipated and the case manager is not on duty.

In the event that a patient wants to request a review by the QIO, someone on the staff should know what steps the hospital should take, Larrance says. This could be charge nurses, house supervisors, case managers, social workers, or utilization review nurses, she says.

Someone on the evening, night, and weekend shifts should be educated on the process, she says.

Help staff facilitate review

Larrance suggests preparing a packet of information with specific instructions on copying/faxing the medical records, QIO contact numbers, designated contact persons for the QIO, required turnaround times, and other information that will help staff facilitate the QIO review process.

Making sure that patients with longer lengths of stay receive the Important Notice two days before discharge has proved to be a challenge, Barnes says.

"Some organizations have chosen just to deliver the notice every couple of days so they won't be noncompliant. This is really confusing to patients and should not be the normal practice," she adds.

Hospitals can ensure that they are compliant and not issuing notices unnecessarily by proactively identifying potential discharges, she adds. Interdisciplinary team meetings, bed control meetings, and hospital rounds are all ways to capture potential discharges.

"If you watch patients' clinical progress, there is a point at which you can recognize that the patient is almost ready for discharge. Taking this proactive step can help hospitals comply," Barnes says.

At Weatherford, the case manager puts a sticker on the front of the chart noting the date that the Important Message has been delivered and alerting staff that the patient needs to receive another copy if the length of stay exceeds two days.

"We look at the charts every day to see what the anticipated discharge will be and make sure the Important Message is delivered within the specified time frame," Clark says.

At Southern Ocean County Hospital, the case management secretary keeps a spreadsheet showing who has received the document and communicates with the case managers on each unit every morning to find out which patients may be discharged within the next few days — then makes sure that they receive a copy of the form.

Documenting that the Important Message was delivered is important, Larrance points out. She suggests creating an admissions checklist so that patient registration staff can document that Medicare beneficiaries admitted to inpatient or outpatient observation status receive the initial Important Message.

Discharge planning worksheets should provide documentation of the discharge planning activities, including anticipated discharge dates. They should be updated every two to four days, she adds.

Larrance suggests monitoring compliance with all aspects of the rule at least every three months until trends are stable and the compliance officer has determined that compliance with the rule has been achieved. Include the results of the compliance audits in your process improvement initiatives, she adds.

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Project targets patients in Latino community

'Secondary gains' affected willingness to accept help

The "yes means no" phenomenon was one of several challenges encountered by the team conducting a community case management pilot project for diabetes patients in Nogales, AZ, says **Donna Zazworsky,** RN, MS, CCM, FAAN, diabetes care center manager for the Tucson-based Carondelet Health Network.

The project which targeted emergency department (ED) "frequent flyers" with diabetes focused on establishing the care team and developing a case management toolkit for home diabetes education visits, Zazworsky adds.

"Nogales is primarily a Latino community, with a very high incidence of diabetes," she notes. "Carondelet Holy Cross Hospital had started an inpatient case management program, where anyone hospitalized with diabetes would be seen by a nurse case manager/diabetes educator and referred to diabetes self-management classes held in the community."

This helped people who were hospitalized, but the process missed those ED frequent flyers with diabetes, Zazworsky says. "These individuals were not making their way to the classes.

"Many of these patients said that it was just too hard to get to the classes," she explains, "or there was a secondary gain they had. In one case, a gentleman wanted to get on disability and needed to get documentation, so he didn't want to get any better.

"Others wanted to [use their disease to] get attention from family," Zazworsky says. "They had the wherewithal to get to classes, but just didn't go."

Another barrier identified by the team was "the concept of 'yes means no,'" she points out. The phrase, used as the title of a book written in regard to Native Americans, also applies to Latinos, Zazworsky says. "It's not polite to tell you, 'No, I don't want to do that,' so they say yes."

Carondelet Holy Cross Hospital in Nogales received a grant from the Arizona Department of Health Services to conduct the pilot project in March 2007, she says, and had to complete it by June 30. "We had to use [the funds] by the end of the fiscal year.

"We already knew the community nurse case management program would be funded beginning July 1, but we got the grant to fund the nurse to identify the tools, test them, and put them in place," Zazworsky adds.

"We had a tracking system in place for inpatients and were building a database for why we needed a program to extend beyond the walls of the hospital," she explains. "When the grant came along, it gave us the opportunity to put the structure in place for that program."

The program was promoted to the hospital's ED nursing supervisor, case manager, and social worker, each of whom was involved in shaping the pilot, Zazworsky says. "The program targeted only patients who came through the ED for a diabetes-related episode."

One of the objectives of the project was to reconvene the Nogales Diabetes Partnership Team, which already had been instrumental in establishing a number of programs and services related to diabetes for the Nogales community. The team met every other Thursday from noon to 1 p.m. over a period of seven weeks.

In addition to Zazworsky, that team includes a diabetes nurse practitioner with the Carondelet Diabetes Care Centers; the diabetes nurse case manager and several other clinicians and administrative staff with Holy Cross Hospital; and three representatives from the Mariposa Community Health Center in Nogales.

The behavioral health specialist from the Mariposa center was an active member of the partnership team, Zazworsky notes, attending the biweekly meetings and available to coordinate visits to his counseling program.

As part of the pilot project, the team used assessment tools from the Case Management Adherence Guidelines (www.CMSA.org), as well as a risk assessment tool that was already in place for Carondelet diabetes inpatients, she adds. "We were targeting everybody and trying to get a baseline on readiness, knowledge, and motivation."

The tools were translated into Spanish by a licensed translator from the area who works with the Carondelet system, Zazworsky says. "This is important to guarantee that we are using the appropriate terminology specific to our Latino region.

"The bottom line was that we were able to get patients into the program and agree to have a nurse case manager make a home visit," she says. "The key was the ED nurse, who provided patient referrals to the community nurse case

manager and explained the program to patients. There had to be some kind of handoff so that the patient was aware of the program."

To facilitate that process, Zazworsky notes, the ED nurse made 3 x 5 note cards explaining that the nurse case manager would call to set up a time for a home visit in order to see how she could help the patient.

The nurse case manager would call within 24 hours to set up the visit, and would then make the visit within 48 hours, Zazworsky says. During the visit, she adds, the nurse case manager would use the tools to gauge the patient's knowledge, readiness, motivation, and literacy level in regard to the diabetes.

Of 36 patients contacted about participating in the pilot, 20 ranging in age from the 40s to older than 70 became part of the project, she explains. Fifteen patients actually completed the project.

Short-term outcomes, she adds, showed that "the tools worked, and helped guide the case manager on how to do her work, and there was immediate improvement in patients' levels of confidence."

The project evaluation process showed that even with short-term nurse case management interventions in the home, the target goal of four and a half out of five in confidence levels was met in these areas:

- make health food choices (4.5);
- identify foods with carbohydrates (4.5);
- find diabetes information and support (4.5);
- detect and take action for low blood sugar (4.8);
- examine feet for problems and know how to care for them (4.6);
- work with a health care provider (5).

However, project results showed that patient confidence levels went down in one area how diabetes medications work and their possible side effects. That drop may be related, team members suggested, to an increase in medication awareness that happened as a result of patients' ED visits and their work with the case manager.

"Patients were either put on new meds or they realized they didn't understand the action of their medications," Zazworsky notes.

As a result of the pilot, she adds, the partnership team will continue to monitor numbers to determine appropriate cutoffs for risk level, adherence level, and intervention strategies.

"We still have those outliers that refused services from the nurse case manager and continued to use the ED," she says. "We know as case managers that we are not able to convince everybody that they could benefit from our help."

One of the team's observations in regard to the outliers, Zazworsky says, was that high knowledge/high motivation does not equal better self-care, and that in fact, modifiers such as the desire for more attention from the family have a greater effect on patient behavior.

"When we realized that, we really wanted those patients to have some behavorial health [intervention], but they weren't willing to get the appointment, and it wasn't the kind of scenario in which we could have [therapists] come into the home."

One possibility for addressing that issue, she adds, is to look at "telebehavioral health" a video phone setup that allows the therapist to work with the patient remotely.

"That can open the door to other modalities," Zazworsky says. "What it's about is building the trusting relationship."

(Editor's note: Donna Zazworsky can be reached at donnazaz@aol.com.) ■

Health care stakeholders collaborate on the elderly

Coalition addresses transition of care issues

As the baby boomers age, creating a huge influx of Medicare recipients, health care providers are going to be challenged to provide coordinated care for the elderly as they move through the fragmented health care system.

The National Transitions of Care Coalition, an organization representing 23 groups from throughout the health care spectrum, was formed in 2006 to address gaps that occur when patients leave one care setting and move to another.

"Our health system often fails to meet the needs of the elderly patient population during these transitions of care because there is little communication across care settings or multiple providers. We firmly believe that case managers are essential in establishing effective communication for coordination of care between health care participants," says **Connie Commander**, RN, BS, CCM, ABDA, CPUR, president of Commander's Premier Consulting Corp. and immediate past president of the Case Management Society of

America (CMSA).

CMSA initiated the coalition and solicited support from the other health care stakeholders. Commander and **Nancy Skinner**, RN, CCM, president of Riverside Healthcare Consulting, represent CMSA on the coalition.

In addition to case managers, the coalition includes physicians, social workers, health care executives, representatives from The Joint Commission, URAC, The National Business Coalition on Health, organizations that advocate for the aging, and representatives from the pharmaceutical industry.

"As patients transition from one part of the health care system to another, barriers can impede communication or result in redundant or conflicting information that can create serious issues for patients, their caregivers, and their families. We are trying to put together an orchestrated plan to reach across all venues of care so patients can make a seamless transition," Commander says.

The coalition has developed workgroups to address numerous serious health care issues that occur when patients move from primary care to specialty physicians; from the emergency department to intensive care or surgery; or when patients are discharged from the hospital to home, assisted living arrangements, or skilled nursing facilities, Commander says.

The overriding goal of the collaboration is to facilitate a seamless transition from one treatment environment to another for informed patients, whether it's acute care, rehabilitation, long-term care, skilled nursing care, or home, Skinner adds.

"To me, transition of care is a big, big problem that we face in America. Health care truly operates in silos. Patients see a hospitalist in acute care, then go back to their primary care provider or a specialist and they don't do a good job of communicating with each other. Care is fragmented and that's why transitions of care are so important," Skinner says.

One workgroup is focusing on awareness and education to increase the general knowledge of problems associated with transitions of care and to provide information to critical stakeholders, including patients, caregivers, health care professionals, and government officials.

Another group is focusing on health policy issues and ways to improve care including the possibility of enhanced reimbursement for transitional care support and medical information sharing between care settings.

The third workgroup is developing tools and resources that can be used by health care professionals to improve communication between care settings and reduce the risks associated with care transitions. ■

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

- ■ Making patient education a part of job performance
- ■ Best practice for teaching staff to teach
- ■ Empowering patients in the learning process
- ■ Educating unique patient populations
- ■ Most common areas for improvement identified by The Joint Commission

CNE Questions

13. Steps to create a patient education culture at a health care institution might include which of the following?
    A. Include teaching in job descriptions.
    B. Make teaching part of job performance.
    C. Provide training on teaching techniques.
    D. All of the above.

14. A common symptom of postpartum depression is that a new mom is able to sleep when the baby sleeps day or night.
    A. True
    B. False

15. CMS allows hospitals to issue the Important Message from Medicare, which informs patients of their right to appeal their discharge, at preadmission but not more than seven calendar days before admission.
    A. True
    B. False

16. Fragmented care is one main reason transitions of care are important, says **Nancy Skinner**, RN, CCM.
    A. True
    B. False

Answer Key: 13. D; 14. B; 15. A; 16. A.

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