Patient Education Management™

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

AHC Media LLC

IN THIS ISSUE

Financial Disclosure:
Editor Susan Cort Johnson, Associate Publisher Coles McKagen, and Managing Editor Jill Robbins report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study. Consulting Editor Magdalyn Patyk reports a consultant relationship with Pritchett and Hull Association.

DECEMBER 2007
VOL. 14, NO. 12 • (pages 133-144)

Bringing the big job of materials distribution and managment down to size

Select system, train staff, create guidelines for writing and review

The process of managing patient education materials and databases is a big job.

"I had no idea this could be a full-time job for maybe even two people to manage a system of patient education material. It takes so much more time than I have on a daily basis to devote to it," says Ashley Ave, a health education specialist at Children's Hospital Central California in Madera.

What makes it such a big job? Centralizing patient education materials means uncovering all the different handouts used by staff across the continuum of care. And when there are redundant teaching sheets, there must be agreement among clinicians on what information to include in the revised single copy. One document took a year to consolidate and revise, says **Leslie Catron**, RN, BSN, who co-chairs the patient and family education committee with Ave and works as a clinical educator and student coordinator at Children's Hospital Central California.

EXECUTIVE SUMMARY

Is "more" better when it comes to patient education materials? It all depends. Sometimes specific pieces are required by a department, yet often one handout can be used throughout the system. Making sure materials are managed in such a way that they meet the educational needs of each patient, yet are easy to find when putting together a lesson plan is a big job. In this issue, those in charge of education materials oversight discuss the distribution and management process.

There's also the issue of getting material into the hands of clinicians in an uncomplicated manner and making them aware of the inventory so it will enhance their teaching and benefit patients with up-to-date information.

To get control of the process, patient education managers must determine how to identify the handouts that will be used across the continuum of care, train staff on the nuances of the system, and provide guidelines for the creation and review of materials.

The first step is creating a system or method for the distribution of materials.

At Children's Hospital Central California two databases are used. One is a commercial database with about 4,000 titles that was purchased by the health care system a couple of years ago and the second is a smaller database with documents that were created in-house.

The educational materials created in-house are instructional, while the items on the commercially produced Health Encyclopedia provide general information. For example, there is an in-house sheet on cast care but a description of orthopedic care would come from the commercial database.

At The Ohio State University Medical Center in Columbus, patient education materials are available through the institution's Intranet and Internet sites and the expectation is that clinicians will print copies as needed for patients, says **Diane C. Moyer**, BSN, MS, RN, program manager, consumer health education.

A number of disease-specific books that are a collection of various handouts can be ordered online for delivery to the units for distribution to patients and family members. The books include information on diabetes survival skills, heart failure, cardiovascular surgery, and bariatric surgery. Additional resources are available in person, by e-mail, or by phone through the Library of Health Information, says Moyer.

Vendors can meet needs

Although the vast majority of items are created in-house, certain titles are created by outside sources. Clinicians have access to several products from MicroMedex for medication instructions and alternative therapies.

"The medication instruction sheets were just too hard to keep up with as part of internal inventory and the alternative therapy component adds information on various herbs and other treatments that we did not have in our internal inventory," says Moyer.

In addition, the health care facility has a link to foreign language materials created as a joint effort by several health systems in central Ohio.

"The link to the translated materials was done rather than having to spend the time and manpower to load them into our system and update them," says Moyer.

While there are many good commercial products available that provide easy-to-access written materials for patient education, The Ohio State Medical Center had such a large inventory of in-house handouts, which had been worked on for readability, it would be difficult to find a product to meet its needs.

Patient Education Management™ (ISSN 1087-0296) is published monthly by AHC Media LLC, 3525 Piedmont Road N.E., Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals postage paid at Atlanta, GA 30304. POSTMASTER: Send address changes to **Patient Education Management**™, P.O. Box 740059, Atlanta, GA 30374.

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291. Hours of operation: 8:30 a.m.-6:00 p.m. Monday-Thursday; 8:30 a.m.-4:30 p.m. Friday EST. E-mail: customerservice@ahcmedia.com. World Wide Web: www.ahcmedia.com.

Subscription rates: U.S.A., one year (12 issues), $489. Add $12.95 for shipping & handling. Outside U.S., add $30 per year, total prepaid in U.S. funds. Discounts are available for group subscriptions. For pricing information, call Tria Kreutzer at (404) 262-5482. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue date. **Back issues**, when available, are $82 each. (GST registration number R128870672.)

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

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

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

This activity is intended for nurse managers, education directors, case managers, discharge planners, hospital clinicians, management, and other health care professionals involved in designing and/or using patient education/staff education programs. It is in effect for 24 months from the date of publication.

Opinions expressed are not necessarily those of this publication. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought for specific situations.

Editorial Questions

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

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

AHC Media LLC

"Because our system has so many specialty areas and new treatments and technologies, we would still need to supplement most products to keep our clinicians happy," says Moyer.

In addition, staff have been developing more materials for the outpatient services and often those are not part of the packages commercial vendors offer.

A wide selection of materials is available to clinicians at Children's Hospital & Regional Medical Center in Seattle through a web-based database with search functions as well as many commercial databases such as Pediatric Advisor and Health and Wellness.

In addition, about 500 handouts developed at Children's are available to print on demand for educational purposes, says **Melissa Tumas**, MPH, a health educator.

While a wide selection of handouts seems like a good way to enhance patient education, clinicians are not always sure what vendor might be the best choice or which piece to choose. Therefore, the patient and family education department created what is called "toolkits" for various departments.

"We have been hearing for years from nurses and doctors that they wanted information accessible on the web and they didn't just want to go to Google and search for something. They wanted to have reliable sites and they wanted to have everything, even the Children's-produced pieces, to be print on demand," said Tumas.

The education toolkits are housed on the Intranet and are a collection of materials and resources pertinent to a department. Staff can go to their own clinical page to find the most pertinent educational pieces produced in-house. And there are links to five additional information sites where clinicians can search for items. There also is the option of sending patients to the Family Resource Center.

Distribution more than a system

While a good system is important, it will not be used if staff are not aware of the options they have for educating patients. Patient education managers must get the word out.

There are a number of ways to promote the use of databases for accessing patient education, says Tumas. She has used a resource fair held either in the cafeteria, front entrance to the medical center, or at the Family Resource Center. In-house communication channels also work, such as a weekly central e-mail that broadcasts information throughout the medical center, and system-wide newsletters.

"We have a group of patient education liaisons who are generally nurses and clinical educators in both ambulatory and inpatient clinical areas that we access quite a bit as well. They are the one patient education champion in their area," says Tumas.

It is difficult to make staff aware of the wealth of resources available, says Moyer. Information is given during nursing staff orientation and some details are given during department orientations.

"We try to spread the word during accreditation fairs, in-services, and newsletters but often staff are not aware of what is available except for maybe a few books they use on the unit all the time," says Moyer.

Colorful, laminated cards that explain how to access the health encyclopedia were made and distributed to the computer stations in each department at Children's Hospital Central California by members of the patient and family education committee. It is the responsibility of committee members to communicate with staff about both the commercial database and access to in-house materials, says Ave.

As part of the health care organization's quarterly clinical updates, staff took a screen shot of the directions for accessing the Health Encyclopedia and Intranet site and explained how to retrieve materials.

Some staff are having difficulty changing from a paper filing system to a print-on-demand database, says Catron. However, all staff understand that with a database the copy can be up-to-date, evidenced-based information, Ave says.

Commercial vendors automatically update the material they offer on a regular basis. When copy is written in-house, a review process must be enacted.

"We send out about 1,000 titles each year for clinician review and ask them to let us know if changes are needed or if the title should be deleted. In addition, as clinicians see the need for changes on titles, they may send us revisions at any time and we make those revisions," says Moyer.

When Ave gets an e-mail from an author of one of the documents on the Intranet telling her the process has changed, she pulls the sheet until the revisions are complete and then uploads it again. When the date comes for a document to be reviewed, she pulls it and has the author or a

content expert revise it as needed. Copies of each revision are kept for tracking and historical purposes, says Ave.

Just as policies must be in place for review of materials in a database, there must also be guidelines for creating the pieces.

Moyer says there is a "request to develop" form that must be filled out at her institution. In this way people can be notified if someone is already working on a topic or if there are other areas that may be interested in working on the title. The requests come to the review committee and the response is given to the author. If a handout already exists, it might be sent back to the author as well to see if the title meets the intended need or if alterations might be made.

Requests to create a handout are sent directly to Ave at Children's Hospital Central California and because she is familiar with the databases, she is able to let them know if a similar piece exists. The staff member who made the request is sent a copy of the handout to see if it meets his or her needs.

If the staff member writes a new piece, it is with the aid of Ave or another member of the patient and family education committee so they can make sure health literacy principles are followed and the handout is easy to read.

Tumas says when requests for writing handouts are made at Children's Hospital, the author is asked to research existing sources. "Developing materials is time-intensive and there is so much material available, we don't want to write something if something really good already exists," she explains.

One danger of having so many choices for written handouts is that patients might be inundated with information. Moyer says it is difficult for some clinicians to understand that more is not always better and they don't need to give patients all the information at once.

"With some of our books we started with everything the patient could possibly need to know for the life of the illness, and over time and revisions we keep narrowing the content because of patient and family input," she says. ■

SOURCES

For information about distributing and managing patient education materials, contact:

- **Ashley Ave**, health education specialist, Children's Hospital Central California, 9300 Valley Children's Place, Madera, CA 93636. Phone: (559) 353-5908. E-mail: aave@childrenscentralcal.org.
- **Leslie Catron**, RN, BSN, clinical educator & student coordinator, Children's Hospital Central California, 9300 Valley Children's Place, Madera, CA 93636. Phone: (559) 353-5592. E-mail: lcatron@childrenscentralcal.org.
- **Diane Moyer**, BSN, MS, RN, program manager, consumer health education, The Ohio State University Medical Center, 1375 Perry Street, Room 524, Columbus, OH 43201. Phone: 614-293-3191. E-mail: Diane.Moyer@osumc.edu.
- **Melissa Tumas**, MPH, health educator, family resource center, patient and family education, Children's Hospital & Regional Medical Center, 4800 Sand Point Way NE, T-5112, Seattle, WA 98105. Phone: (206) 987-2893. E-mail: melissa.tumas@seattlechildrens.org.

Ideas for avoiding those budget cut blues

Job satisfaction impacted when funds are cut

In the 2007 Reader Survey conducted by *Patient Education Management*, readers said the "topic" that most affected their job satisfaction is a reduced budget and the impact of cost-cutting on quality of care. Why does the budget impact job satisfaction?

According to seasoned workers in this field there are many reasons. A reduced budget means patient education managers will need to devote time to creatively working around limited funding to accomplish goals, says **Nancy Goldstein**, MPH, patient education program manager at the University of Minnesota Medical Center, Fairview in Minneapolis.

Also it is difficult seeing the impact of cost-saving measures on patient experiences, she adds.

Patient education managers are generally very passionate about what they do, says **Annette Mercurio**, MPH, CHES, manager of patient, family, and community education at City of Hope Medical Center in Duarte, CA. That's why many work more than 50 hours a week to make the greatest possible difference.

"Clearly seeing the education needs that exist

and not having adequate resources, whether staff and/or funding for materials and programs to close those gaps for patients and families is a continual stressor," she explains.

When patient education departments conduct assessments and determine needs for the overall institutional program or specific patient populations and then have no money in the budget to develop resources for teaching, it is frustrating, agrees **Louise Villejo**, MPH, CHES, executive director of the patient education office at the University of Texas M. D. Anderson Cancer Center in Houston.

Often medical centers will consolidate staff and patient education to save money and when that happens the staff education component begins to dominate, says **Yvonne Brookes**, RN, manager of clinical instructors-onboarding, Versant RN Residency, and a patient education liaison at Baptist Health South Florida in Coral Gables. The majority of time is spent on orientation and training of staff, not on patient education processes, she says.

If staff within the patient education department are eliminated then the scope of the manager's job usually increases, says **Mary Szczepanik**, MS, BSN, RN, manager of cancer education, and support and outreach at OhioHealth Cancer Services in Columbus. Job satisfaction is always affected if employee cuts are part of the budget projection or reality, she says.

Strategies to avoid cuts

While it is not always possible to avoid budget cuts, there are some things patient education managers can do to make a reduction in funding less likely.

Szczepanik has a long list of suggestions. Those include:

- talk about patient education all the time;
- know what your insurance payers require in regards to patient teaching;
- be willing to take on other responsibilities;
- be as efficient as you can;
- set standards and policies and procedures for patient education;
- know what your accrediting bodies require for patient education.

Brookes advises patient education managers put processes in place to determine outcomes so the value of patient education can be shown; it is evident that educating a patient and family members reduces readmission and increases satisfaction.

According to Brookes, this can be done by focusing on a certain disease that is costly and determining readmission rates before and after an education program has been implemented. To gain information on patient satisfaction surveys, ask questions such as, "Did you receive the information you needed before discharge?"

Prove value of education

Goldstein agrees that statistics supporting patient education are important. "Collect data regarding the scope and range of services you provide and conduct ongoing outcome-based evaluations and research to demonstrate the impact your program makes," she says.

Help your institution achieve specific strategic objectives through patient education and make sure administrators recognize your efforts, advises Mercurio. For example, if patient safety is a top

SOURCES

For more information about reducing the impact of budget cuts, contact:

- **Yvonne Brookes**, RN, manager clinical instructors-onboarding, Versant RN Residency, patient education liaison, organizational learning, Baptist Health South Florida, 1500 Monza Ave., Suite 200, Coral Gables, FL 33146. Phone: (786) 596-1333. E-mail: yvonneb@baptisthealth.net.
- **Nancy Goldstein**, MPH, patient education program manager, University of Minnesota Medical Center, Fairview, 420 Delaware St. SE, Minneapolis, MN 55455. Phone: (612) 273-6356. E-mail: ngoldst1@fairview.org.
- **Annette Mercurio**, MPH, CHES, manager, patient, family, and community education, City of Hope National Medical Center, 1500 East Duarte Rd., Duarte, CA 91010-0269. Phone: (626) 301-8926. E-mail: amercurio@coh.org.
- **Mary Szczepanik**, MS, BSN, RN, manager, cancer education, support, and outreach, OhioHealth Cancer Services, 3535 Olentangy River Rd., Columbus, OH 43214. Phone: (614) 566-3280. E-mail: szczepm@ohiohealth.com.
- **Louise Villejo**, MPH, CHES, executive director, UT M. D. Anderson Cancer Center, Patient Education Office, 1515 Holcombe – 21, Houston, TX 77030. Phone: (713) 792-7128. E-mail: lvillejo@mdanderson.org.

priority for your organization, collaborate with organizational leaders in various departments such as nursing to plan and implement partnerships in safety initiatives. If increasing patient satisfaction is an organizational priority, highlight ways that patient education can help accomplish that goal.

"As clinical programs are targeted as priorities for development, such as prostate cancer programs, make sure you're working closely with the leadership of that program to develop patient education as an integral component of that service," Mercurio adds.

Villejo says it is important to use your entire budget and keep a list of projects that have been identified as important as well. Often if funds are not used, the budget for patient education will be cut so know the mechanics of how the budget is created at your institution, she says.

If you experience budget cuts despite all you do, persevere, says Mercurio. ■

Increased awareness needed for thyroid disease

AACE highlights the condition during January

More people need to be aware of the impact an underactive or overactive thyroid has on their health, says **Richard Hellman**, MD, FACP, FACE, president of the American Association of Clinical Endocrinologists (AACE).

That is why this organization has designated January National Thyroid Awareness Month. Thyroid disease is common though people frequently do not connect the symptoms they have with this gland located at the front of the neck. The gland makes a hormone that increases cellular activity and its purpose is to regulate the body's metabolism.

According to Hellman, millions of people have hypothyroidism, which means too little thyroid hormone is being produced. However, about half don't know they have an underactive thyroid and the different conditions that may result from this disease, such as depression or a miscarriage for women during the first trimester of their pregnancy.

People can be treated for an ailment, such as depression, and not get well because their thyroid problem has not been addressed, says Hellman. For example, if a person is being treated for depression by medication, their condition will not improve if they have an underactive thyroid that is not corrected as well.

There are many thyroid conditions that are not well understood and are not dealt with appropriately, says Hellman.

To increase awareness about thyroid disease it is good to help people recognize the symptoms of an overactive or underactive gland. It is common for people with hypothyroidism to complain of fatigue or tiredness; constipation; depression; dry skin; and coarse, dry hair.

A person with an overactive thyroid or hyperthyroidism might become nervous, have trouble sleeping, have loose stools, increased sweating, a fast heartbeat at times, and for women irregular menstrual periods.

People who are experiencing symptoms for either hypothyroidism or hyperthyroidism can have a simple blood test completed in their physician's office that will determine if further evaluation is necessary, says Hellman.

In addition to knowing the signs and symptoms of thyroid problems, it is important to know who is most likely to have them. Hellman says that thyroid disorders are more common in women and they tend to run in families. After age 60, people are more likely to have hypothyroidism. Hellman says in community surveys about 15% of older women will have an underactive thyroid.

Thyroid cancer is another disease that people need to be aware of, says Hellman. This cancer is the fastest growing cancer in the United States but can be completely cured if diagnosed early enough, he says. There is a simple neck check people can do to determine if they have nodules that might need to be assessed for malignancy.

While goiters, or enlarged thyroid glands, have not been common in the United States in many years, now that more and more people are turning to fast food for the majority of their meals, iodine deficiencies are increasing. For this reason, there is growing interest in making sure young women who are likely to become pregnant or are pregnant have adequate amounts of iodine, which is very small, says Hellman.

An important message is that too much iodine can cause the thyroid to malfunction just as too little can cause problems as well. "It is like the thyroid hormone, too much is bad and too little is bad. The right amount is just right," says Hellman.

RESOURCE

For more information about National Thyroid Awareness Month, contact:

• **American Association of Clinical Endocrinologists**, 1000 Riverside Ave., Suite 205, Jacksonville, FL 32204. Phone: (904) 353-7878 Fax: (904) 353-8185. E-mail: info@aace.com. Web site: www.aace.com.

Since January 1995, AACE has selected a different aspect of thyroid disease to highlight during Thyroid Awareness Month. The theme each year has provided the public with different information about the thyroid and its function. This year the focus is on quality of care when addressing thyroid disease.

There are many ways to get the word out about thyroid conditions and any kind of community outreach is helpful, says Hellman. ■

Program serves young Medicaid beneficiaries

Program targets ill members ages 6 months to 21

A multidisciplinary care management program for young Medicaid beneficiaries with complex conditions has resulted in significant increases in members' use of effective treatments and services.

In the first year of the program, administered by CareSource, the percentage of children using appropriate asthma medications rose from 50% to 57% and well child visits increased among all age groups, earning the health plan a rating of excellent from the Ohio Department of Job and Family Services.

The program started in 2001 in response to a new state requirement to promote case management for chronically ill children in the Medicaid population.

"As part of our mission to help the underserved population, CareSource has always offered case management services to its members but expanded the program to meet the state requirements. When the state specified providing case management for members ages 6 months to 21 years with special health care needs, we expanded the program in-house and hired case managers who specialize in conditions such as prenatal care and asthma management," says **Daniel Paquin**, COO of the Dayton, OH-based Medicaid managed health care plan.

The department includes asthma educators, diabetic educators, prenatal care specialists, and behavioral health specialists.

"We have included case managers who are experienced in a variety of areas so we can provide the best possible care coordination for our members," Paquin adds.

Members in the program have chronic diseases that range from asthma and sickle cell disease to depression. A sizable percentage of members in the program are pregnant teenagers. "Unlike members in a commercial plan, the individuals in our programs have a complex array of psycho-social needs, along with multiple chronic conditions with multiple comorbidities," Paquin adds.

Population is a tricky one

Medicaid members provide a challenge for case managers because the population is transient, often changing addresses, and they may not have telephones, says **Mia Lowe**, RN, CCM, CCP, director of case management.

"We utilize a lot of different forms to reach members, including calling providers and contacting pharmacies to get current addresses and phone numbers, as well as reaching out to members with postcards asking them to get in touch," she adds.

Many of the members have social issues along with their medical needs, she adds.

Attending to social needs first

"They may have trouble affording food and clothing or may be about to be evicted because they can't pay their rent. We have to take care of these needs first, before we can start helping them manage their health," Lowe says.

A team of social workers, one of whom is bilingual, team with case managers to help manage the needs of the members.

"We help them first with their social needs. If they are worrying about finding food or staying in their home, they're not going to take care of their health care problems," Lowe adds.

The social workers are familiar with community resources throughout Ohio and can help

members get connected to programs and agencies in their communities that can meet their needs. If needed, the case manager can bring in a social worker or a behavioral health case manager to help meet the member's needs. If the member has trouble with medication compliance, the case manager can refer him or her to the pharmacy department for help.

About 6% of the members in the Covered Families and Children Program need case management, says **Candice M. Freil**, RN, EMBA, MHA, senior vice president of care management.

When new members enroll in the program, a CareSource nurse calls the parent or guardian and administers a health questionnaire to identify the presence of health conditions that require ongoing care. If the child has any of the conditions, the case is referred to a case manager who calls the parent or guardian and conducts an assessment to determine if the child is appropriate for case management.

Other members are identified through claims data analysis, referrals from local physicians and emergency departments, medical management staff, the health plan's 24-hours nurse advice line, and the on-site nurse liaison who is located at one of the hospitals with the largest volume of patients served by CareSource.

When a child is enrolled in the case management program, a nurse case manager calls the parent or child if he or she is old enough, providing education about the condition. The case manager works with the parent or child to set health care goals and to develop an individualized care plan and shares the plan with the patient's primary care physician for input and follow up.

"In addition to the initial assessment when they enroll, if the members need case management, we conduct a more thorough disease-specific assessment and get the provider involved in developing a care plan," Freil says.

The case manager assesses the members' educational needs and makes sure they have information about their condition. They refer pregnant teenagers to agencies within their community that can provide them with help throughout the pregnancy.

Once the assessment is completed, the case manager stratifies the members according to their needs. The case managers get back in touch with the members according to their stratification and other needs.

The program is telephonic but case managers have the option to call on a home health agency for a face-to-face visit if it is necessary.

"The medical home concept is one of the biggest drivers for us," Freil says.

Breaking the habit

Members in the Medicaid population tend to use the emergency department for primary care, a habit that CareSource wants to break.

"Once members come into our plan, we encourage them to pick a primary care physician and go for a visit as soon as possible. Our focus is to help these members find a medical home and get preventive health care. We want to educate them, that they don't have to sit in the emergency room for six or seven hours for a non-emergent condition," she says.

The case managers promote well child visits and talk to parents about getting regular checkups and tests such as mammograms.

"We have a holistic care management program. Instead of separating case management, behavioral health, and social services, we offer family-oriented care management by a team that works closely together to coordinate care," she says.

The health plan contacts the members within 90 days of their enrollment to assess for case management needs. Based on their needs, some members are placed in case management for a short period of time. The majority of members receive case management for a year or longer.

"Some of the members have ongoing medical, behavioral health, and social needs and require interventions over the long run," Lowe says.

The health plan regularly reviews claims data to identify members, Freil says. "If claims data indicate that a member who no longer is in case management may need assistance, we contact them again and get them back into the program," she adds. For instance, if a member makes a visit to the emergency department or is hospitalized, the case manager gets back in touch with the member.

"We want to identify those members who are likely to have the highest utilization and provide appropriate case management," she says.

The health plan launched a new, similar product line in January for aged, blind, and disabled members who have comorbid conditions and complex needs. "Many of these members are aged. The majority have three or four comorbid conditions and take five to seven medications a day. About 60% have complex behavioral

conditions as well as medical conditions and social and economic needs," says **Kimberly Byrwa**, RN, BA, CPHQ, director of case and disease management.

The case managers help the members locate resources within the community that can help with their housing, transportation, and other needs, Byrwa says.

"The case managers help the members identify opportunities to improve their health. They help them understand their pharmacy benefits and become compliant with medication. At the same time, they communicate with the treating physicians, forwarding the information we have gathered and the care plan we have developed for the member in terms of education and resources," she says. ■

Plan complements disease management program

Targets ill at risk for health care expenditures

Members with chronic conditions that put them at risk for high health care costs but don't fall into traditional disease management programs are learning how to manage their conditions through the ComplexCare program from Health Management Corp.

"We've recognized for a long time that dealing with the core disease management conditions can have a positive outcome for people who are at risk, but there also are people with multiple chronic conditions who do not fall into traditional disease management categories but who account for a lot of expense and poor outcomes," says **Sam Cramer**, MD, chief medical officer for Health Management Corp.

Health Management Corp., a wholly owned subsidiary of WellPoint, with headquarters in Richmond, VA, supplies disease management and case management for WellPoint and other clients.

ComplexCare helps members avoid preventable episodes of care by seeing a physician regularly and following their care plan, complying with their medication regimen, setting lifestyle goals, and following healthful practices, such as dieting and exercising.

The program provides outreach to at-risk members who may have conditions such as cancer, multiple sclerosis, muscular skeleton problems such as fibromyalgia and behavioral health conditions such as schizophrenia and bi-polar disorder. Members with the core disease management conditions — asthma, diabetes, chronic obstructive pulmonary disease, heart failure, and coronary artery disease — are referred to the health plan's traditional disease management program.

Predictive model used to identify members

The health plan identifies members through a predictive model that is based on utilization and laboratory claims and targets those who appear to be at risk for future utilization. For example, the model identifies members who regularly see three or more doctors, have three or more emergency room visits within six months, or have more than two hospital admissions in a three-month period. Additional members who might benefit from the program come from the results of a health risk assessment, referrals from physicians, and the health plan's utilization management department.

When members are identified, a health outreach specialist calls them on the telephone, explains the program to them, and enrolls them if they are willing to participate. The outreach specialists collect initial demographic information, and then transfer members to an RN care manager. The care manager verifies the member's medical history and diagnosis, then conducts an assessment of the member's functional status, social and economic status, support system, and any needs they may have beyond their medical condition.

"So many things besides a patient's medical condition have an effect on their health. We do a very complete assessment in terms of medication, transportation issues, the type of support they have at home and use the information to develop a care plan that looks at all of their needs and what we can do to help," Cramer says.

The care managers provide information that helps the enrollees understand their conditions and their medication instructions. They work with the members to develop a care plan that includes lifestyle goals and health-related priorities.

"The goals are based on the most important steps that the member should take to stay healthy, and at the same time, the care manager takes into account what goals the individual is most ready or most willing to work on. They

have to balance the two," Cramer says.

For instance, if the member needs to stop smoking or lose weight but isn't ready to address that issue, the care manager and member may decide to start to work on medication compliance and tackle smoking or weight loss later.

"It's not just the nurse and clinicians who drive the care plan. We want the individuals to buy into it," Cramer says.

The care manager may contact the member's primary treating physician to determine or clarify a plan of care for the member. The care manager notifies the physician that the member has enrolled in the program, and shares the member's care plan and the goals, and provides status updates. The care managers work with the members to help them follow their physicians' plans of care.

"One of the roles of the nurse care manager is to make sure the members have providers and see them on a regular basis. Some have lost contact or don't have a primary care provider. The care managers facilitate getting the members in to see their physician," Cramer says.

The plan has medical director oversight at every call center who reviews the new enrollees and is available for consultation if the care manager needs information or if the treating physicians have a question.

Members are stratified by acuity level, which drives the frequency of the telephone calls from the care managers. The nurse care managers call participants at least once every six weeks. Members also can contact the nurses with any health-related questions using a toll-free number.

The program is designed to provide support for six months to a year to help members meet their health care goals. If a member is still not meeting his or her goals after a year, the nurse care manager consults the medical director to determine if the member is still appropriate for the ComplexCare program or if he or she might benefit more from a different type of program.

The care managers help members obtain referrals for specialty care, home health services, durable medical equipment, and other needs. They also work with members to help them obtain community services such as free transportation for health care visits, Meals on Wheels, or other services.

"We are not CPAs or lawyers, but our members may need these services. Beyond dealing with the clinical issues, we help the members find the resources they need to solve their problems," Cramer says.

Care managers located at call centers around the country coordinate the care of members nationwide. The care managers have resource guides for individual areas and rely on other colleagues at other locations for help in identifying the community organizations that can help the members.

"The nurse care manager is the expert in terms of resources. They don't know every resource in every location but they know how to find them," Cramer adds.

The care managers also conduct assessment screenings to identify members who might benefit from a mental health program. "People with chronic conditions frequently become depressed and depression can have an impact on their medical condition. They may not be as compliant as they should be because of mental health issues," he says.

If the care manager identifies that the member has severe behavioral health or mental health issues, she connects him or her with a mental health program and follows up to make sure that the member has kept his or her appointments.

The care managers assigned to the member work with the pharmacy staff on medication compliance. They can consult with exercise physiologists, dieticians, and other ancillary providers if needed. ■

CMS keeps emphasizing patients' right to choose

Discharge guidance refers to BBA

Federal regulators continue to make it clear that they are serious about patients' right to freedom of choice of providers, says **Elizabeth E. Hogue,** Esq., a Burtonsville, MD-based attorney specializing in health care issues.

Draft supplemental compliance guidance published recently by the Office of the Inspector General (OIG) of the U.S. Department of Health and Human Services, Hogue notes, refers to requirements of the Balanced Budget Act (BBA) of 1997. The excerpt below, she adds, specifically relates to patients' freedom of choice:

"When referring to home health agencies, hospitals must comply with section 1861(ee)(2)(D) and (H) of the Act, requiring that Medicare participating hospitals, as part of the discharge plan-

ning process, (i) share with each beneficiary a list of Medicare-certified home health agencies that serve the beneficiary's geographic area and that request to be listed and (ii) identify any home health agency in which the hospital has a disclosable financial interest or that has a financial interest in the hospital."

Based upon that excerpt, Hogue says, the OIG has shown a clear willingness to treat violations of the requirements of the BBA as a form of fraud and/or abuse of federal health care programs.

The OIG also indicated that it has authority to exclude individuals or entities from participation in the federal programs if they provide unnecessary items or services, she adds, such as those in excess of the needs of the patient, or substandard items, including those of a quality that fail to meet professionally recognized standards of health care.

The OIG further states that knowledge and/or intent are not required for exclusion under this provision, Hogue continues. The exclusion can be based upon unnecessary or substandard items or services provided to patients, she says, even if the care provided is not paid for by the Medicare or Medicaid programs.

Violations of hospital conditions of participation, including those that govern discharge planning, or any other applicable standards of care may result in either over- or under-utilization of services and sanctions by the OIG. "It is logical to conclude that applicable standards of care also include the requirements of the BBA."

Consequently, she adds, hospitals that violate applicable standards of care related to patients' right to freedom of choice of providers and discharge planning may be subject to sanctions by the OIG.

"It is also important for discharge planners and case managers who work for hospitals to know that there is a broad array of tools available to providers and regulators to enforce patients' rights," Hogue says, including the following:

• Helping patients pursue violations of their common-law rights to freedom of choice of providers regardless of payer source or type of care rendered primarily through the use of signed statements that describe violations.

• Helping patients pursue violations of two federal statutes that guarantee Medicare and Medicaid patients the right to freedom of choice of providers primarily through the use of signed statements that describe violations.

• Reports to the Centers for Medicare & Medicaid Services (CMS) regional and central offices of violations of patients' rights to freedom of choice of providers by providers who participate in the Medicare/Medicaid programs.

• Reports about violations of patients' rights to

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

■ Using technology to improve patient teaching

■ Self-care still a major focus for patient education

■ Educating unique patient populations

■ Most common areas for improvement identified by The Joint Commission

■ Empowering patients for improved education outcomes

CNE Questions

21. Which of the following are helpful techniques for managing patient education materials?
    A. Provide computer-based distribution.
    B. Consolidate similar teaching sheets.
    C. Create guidelines for writing and reviewing.
    D. All of the above.

22. One way to help prevent budget cuts to patient education is to help the institution achieve specific strategic objectives with your programs and teaching efforts.
    A. True
    B. False

23. According to **Mia Lowe,** RN, CCM, CCP, why are Medicaid members a challenging population?
    A. They are transient.
    B. They may not have telephones.
    C. A & B
    D. None of the above

24. The ComplexCare program from Health Management Corp. does not consider utilization as a factor in identifying members.
    A. True
    B. False

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

state surveyors who treat such information as complaints and conduct surveys of hospitals and other providers that participate in the Medicare and Medicaid programs.

• Reports to the OIG of violations of patients' rights to freedom of choice of providers and/or violations of applicable standards of care that may result in sanctions against providers.

"There are more and more avenues for both patients and providers to pursue violations of patients' right to freedom of choice of providers," Hogue says. "Discharge planners and case managers should be proactive when they encounter such violations."

(Editor's note: Elizabeth Hogue may be reached at ehogue5@comcast.net.) ■

Patient Education Management™
For Nurse Managers, Education Directors, Case Managers, Discharge Planners

PEM120107TM

CNE Evaluation

Please take a moment to answer the following questions to let us know your thoughts on the CNE program. Fill in the appropriate space and return this page in the envelope provided. **You must return this evaluation to receive your certificate.** Thank you.

CORRECT ● **INCORRECT** ⊘ ✓ ✗ ⌇

1. If you are claiming nursing contact hours, please indicate your highest credential: ○ RN ○ NP ○ Other _____

	Strongly Disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree
After participating in this program, I am able to:						
2. Identify clinical, legal, or educational issues relating to patient education.	○	○	○	○	○	○
3. Explain how those issues impact health educators and patients.	○	○	○	○	○	○
4. Cite practical ways to solve problems that care providers commonly encounter in their daily activities.	○	○	○	○	○	○
5. Develop or adapt patient education programs based on existing programs from other facilities.	○	○	○	○	○	○
6. The test questions were clear and appropriate.	○	○	○	○	○	○
7. I am satisfied with customer service for the CNE program.	○	○	○	○	○	○
8. I detected no commercial bias in this activity.	○	○	○	○	○	○
9. This activity reaffirmed my clinical practice.	○	○	○	○	○	○
10. This activity has changed my clinical practice.	○	○	○	○	○	○

If so, how? _____

11. How many minutes do you estimate it took you to complete this entire semester (6 issues) activity? Please include time for reading, reviewing, answering the questions, and comparing your answers to the correct ones listed. _____ minutes.

12. Do you have any general comments about the effectiveness of this CNE program?

_____

I have completed the requirements for this activity.

Name (printed) _____ **Signature** _____

Nursing license number ***(required for nurses licensed by the state of California)*** _____

Please make label address corrections here or PRINT address information to receive a certificate.

PLEASE NOTE: If your correct name and address do not appear below, please complete the section at left.

Account # _____

Name: _____

Company: _____

Address: _____

City: _____ State: _____ Zip _____

Fax: _____ Phone: _____

E-mail: _____

Patient Education Management™

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

2007 Index

When looking for information on a specific topic, back issues of Patient Education Management *newsletter, published by AHC Media LLC, may be useful. For additional information, contact our customer service department at P.O. Box 740060, Atlanta, GA 30374. Telephone: (800) 688-2421 or (404) 262-7436. Fax: (800) 284-3291 or (404) 262-7837. E-mail: customerservice@ahcmedia.com.*