

Patient Education Team Recommendations

Team Leader: Coral S. May, RN, BSN
Regional Director
Health Education–Western Region
Humana, Inc.
San Antonio, Texas

The Patient Education Team was tasked with the following case scenario and critical assumptions:

Your department is responsible for creating patient education materials about menopause. As a part of this process, your managed care organization (MCO) has recommended the creation of a patient advocacy committee to act as a quality check when designing these materials and to review the menopause counseling plan.

The team was asked to consider

questions concerning lessons learned from experience with counseling in other medical areas; challenges expected to be encountered when creating patient education materials for menopause counseling; characteristics of effective patient education materials; barriers to implementation and possible strategies to overcome them; measurements of success; and the pros and cons of forming a patient advocacy committee to assist in the development of such materials and review a counseling plan.

Developing Objectives

The Patient Education Team developed 2 major objectives:

- Implement an awareness campaign to motivate members to take action and go to their providers, where they would have opportunities for counseling.
- Provide accurate information/tools to the provider for that counseling.

Lessons Learned

Implementation challenges. The

team began by examining patient education materials in use and outlining some of the challenges faced in their implementation. Some were high quality but expensive; others were too broad in scope; and some were of inferior quality, such as multigeneration copies of faxes. Plans can survey physicians' offices for what is currently being used as patient education materials to get a sense of the spectrum of quality. Material that is not visually appealing or is of inferior quality will detract from its content. If a piece

from a pharmaceutical company is branded (ie, bears the company logo or a specific product name), the plan often cannot use it, no matter what its quality or relevance. The final challenge the team noted was distribution: How can the plan ensure that the information is seen by the right audience?

Attributes of effective materials. The team next identified effective patient education materials and agreed that each had to have at least 1 of the following attributes:

- Be targeted and focused with a particular audience in mind and on a single topic, so that it delivers 1 powerful message to the recipient.
- Provides a call to action with bulleted points of information but gives the member/patient the opportunity to say: "What do I do next?" In such a case, it would be to guide the member back to her provider's office for a conversation about menopause.
- Deliver a consistent message by ensuring the plan, provider, and member all receive the same message at the same time. For example, if members are mailed information and providers are not informed, the latter will call the plan and ask to see what was sent out.
- Coordinate efforts with the Prochaska "readiness to change" model, which ensures that a message is delivered at exactly the right time for a member to hear, accept, and act on it.

Design and creative challenges. The team also addressed the challenges plans face in creating patient education materials. These include adequate financial resources, plan type (health maintenance organization [HMO], preferred provider organization [PPO]), and types of members. For example, does the

plan have Medicare or Medicaid members? Commercial members?

Cultural diversity, literacy level, and the actual design of the materials also are important considerations. When Humana conducted a focus group among its commercial members, it found that they did not want to come home after a long day at work and pick up something with small print; it was too overwhelming. Instead, they recommended pieces that are short and concise, with bulleted points that convey information in an easy-to-understand manner. Internal or external review processes are another challenge to the development of materials.

Finally, what is the priority of menopause counseling education to the plan? For example, each plan prioritizes its initiatives differently, based on a specific focus for any 1 year.

Characteristics of Effective Materials

Formats. Printed material was identified as the most effective patient education format because of the ability to distribute information through multiple venues (mail, provider office, availability through a toll-free telephone number, or business reply card mechanisms); they also provide credibility for the plan. Such material should be tailored to the literacy and language needs of members and offer permanency, so that it can be put aside and read later. As discussed by the Pharmacy Team, printed materials that are available at the pharmacy distribution point are another way to reach members who are coming in to have their prescriptions filled.

The second most effective route identified by the team was distribution of patient education materials through the public media or consumer press, including radio, television, newspapers, and billboards. These provide a great avenue for reaching not only plan members but the community at large and con-

tribute to positive public relations for the plan.

The Internet is fast becoming a frequent route of dissemination of electronic media and is likely to be widely used by plan members. Plans would do well to develop opportunities for their members to enroll at their Web site and establish links to other credible sites. Enrollees could then be e-mailed preventive reminders such as, "Have you scheduled your annual examination?" during their birthday month or a reminder about breast self-examination in October (Breast Health month). This would be a relatively inexpensive way to communicate with members.

Also discussed was development of an Intranet site for member access. Those who registered would be able to ask specific health-related questions, eg, about nutrition or hormone replacement therapy (HRT), and receive a response by return e-mail.

The CD-ROM format can also be used to provide information on a particular topic to members. A list of topics would be available in a member publication; for example, if a member is interested in menopause, she could call a toll-free telephone number or send in a business reply card to receive the CD-ROM. Twenty-four hour lines staffed by nurses are also ideal educational venues that members can call to receive printed materials or audiotapes. A member can use her fax machine to request information on any one of a number of topics from a central menu. This fax-on-demand service is a relatively easy-to-access opportunity to educate members.

Videotapes were believed to be the least effective patient education format, primarily because of logistics and lack of time. Although some plans have set up videotape lending libraries for members to check out resource materials, the return of materials remains an issue. Also,

whereas many providers' offices have a television set with a video loop or a separate video room where members can watch educational pieces, they often do not have the time to do so.

Barriers to implementing patient education materials included funding, distribution, customization, the approval process, and member confidentiality.

Cultural diversity. The next topic the Patient Education Team addressed was cultural diversity. To create successful patient education materials, a plan must know the demographics of its population, including an intimate understanding of the written and spoken languages and literacy levels as well as customs, religions, and traditions. Once a plan has this understanding, specific pieces could be tailored so that members receive information in a format that is relevant and meaningful.

Barriers and Strategies

Barriers to implementing patient education materials included funding, distribution, customization, the approval process, and member confidentiality.

Funding. To overcome the funding barrier, strategies suggested included writing grants, forming partnerships—including with pharmaceutical companies and nonprofit organizations—and selling the concept as a marketing retention tool to senior management so that funds are allocated within the plan. This also increases the importance of patient education to the plan.

Distribution. Strategies to overcoming distribution barriers for patient

education materials were viewed as being plan specific and can include targeted mailings to specific age groups of women or including a targeted article in a member publication that offers an opportunity to get more information on a particular topic.

Customization. Customizing patient education materials for a specific population (ie, addressing cultural diversity) is necessary to overcome resistance from members.

Approval process. Regardless of whether approvals are needed internally or externally or both, it is important that the appropriate people review the material.

Member confidentiality. A pregnant member was sent prenatal information; however, her husband happened to gather the mail that day. Unfortunately, he did not know she was pregnant, and it became an issue because it was not his child. In order to prevent such breaches of member confidentiality, a broad campaign targeting all members within a certain group would be more well received.

The team also identified the following barriers to counseling programs: clinician buy-in, time, cultural issues, and patient readiness to change.

Clinician buy-in. It is important to identify what will motivate physicians to buy into or participate in a menopausal counseling program and to embrace the idea as important. One way would be to compensate physicians for this service with an *International Classification of Diseases, Ninth Revision (ICD-9)* code for counseling; this may not be possible in a capitated environment. Communication from the plan also is important to help clinicians identify it as a central initiative.

Time. The team believed a key solution to lack of time by physicians is to open up the menopausal counseling opportunity to other healthcare providers, including nurse practitioners, registered nurses, physician assistants, or health educators. Use of the

Perimenopausal Health Evaluation Form from the American College of Obstetricians and Gynecologists (ACOG) can also help assist obstetricians and gynecologists in incorporating counseling into annual office visits.

Cultural issues. Research has shown that providers need education on cultural diversity as it pertains to menopause.

Patient readiness. If a woman is not ready to change her behavior and is bombarded with information, it will mean absolutely nothing to her. One solution would be to put together a “tool box” for provider offices that would include an algorithm with targeted questions to determine where a member is on the “readiness scale.” Particular educational pieces can then be suggested that would be appropriate for the level of readiness.

Measures of Success

To determine whether goals are being accomplished with patient educational materials, which were viewed as the “transportation system” to get plan members into the physician’s office, the Patient Education Team would examine survey results from Health Plan Employer Data and Information Set (HEDIS); review pharmacy data (new starts or refills); conduct quality improvement and satisfaction surveys; and gather patient success stories to feature in member publications.

Patient Advocacy Committee: Advantages and Disadvantages

The Patient Education Team decided that the advantages of forming a patient advocacy committee outweighed the disadvantages. The committee would include the following members: plan medical director and representatives from the quality improvement, health education, and utilization management departments; contracted providers, pharmacy director, sales, large employer groups

(commercial clients), and plan members who are culturally diverse and truly represent the plan. In addition, a subset of plan members would form focus groups with whom the plan could test market its materials and counseling opportunities. To have good cross-sectional representation on the committee, some of the members would be recruited by invitation and others by mandate. The key is that the members of the committee are the organization and should take their responsibilities seriously.

Broad dissemination of information from the committee would depend on the existing plan infrastructure and on current routes of communication from such committees to departments and ultimately to plan members.

One solution may not necessary fit each member. It is important to have consistency in the information being provided and to view the educational process as a continuum, with multiple modes for each individual. One-on-one counseling has clearly been shown to have the greatest effect thus far on initiation and continuance of any medication or treatment. However, such counseling is not a singular event and it needs to be backed up by measures that provide the potential for questions and answers. For example, a first step is getting the patient into the office to be counseled, perhaps during an annual well-woman visit, but approximately 15% of women will not make an appointment. This is where patient education materials can play a much larger role.