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IN THIS ISSUE

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Increased scrutiny, more complex patients top list of 2009 challenges

Look at trends in other states to prepare for changes

Home health managers don't normally keep a crystal ball in their supply closet, but the ability to predict, or at least guess, at the future of home health as our country faces economic and political changes could be helpful.

Because no one has a reliable way to predict the future, **Marcia P. Reissig,** RN, MS, CHCE, chief executive officer of Sutter VNA and Hospice in San Francisco, suggests that all home health managers, "Stay on top of what is happening so nothing takes you by surprise." Reading, staying in touch with state and national home health associations, and networking with colleagues in the industry can keep you up to date.

Although the economy has received the headlines during recent months, a slowing economy is not completely negative for home care, points out Reissig. "It will probably be easier to retain experienced staff members, because people are less likely to job-hop during tough economic times," she says. When employees stay in place to retain seniority and

EXECUTIVE SUMMARY

Tough financial times are not new to home health managers, but the economy and its effect on different aspects of the home health industry may result in even closer monitoring by regulatory agencies. Fraud audits to recoup money will be more frequent, and claims will be monitored closely to identify patterns of care.

- Private duty agencies may see a reduction in clients as families tighten their household budgets.
- Retention may become less of a problem as staff members stay in their current positions rather than risk changing jobs and losing seniority.
- Technology, such as telemonitoring, will become an important tool for HHA managers as they look for more efficient ways to provide quality care.

reduce the likelihood of being laid off, the managers spend less time hiring and training new employees, she points out. "We may also see nurses return to home health after leaving to work in other businesses," she adds.

One area of home health that will probably feel the negative effect of the economy is private duty care, says Reissig. "I anticipate that some families who are now using private duty nurses will have changes in their financial situations, so that they can't afford private duty care," she says. Families that have used private duty home health to offer respite care, supplement family care, or provide care in addition to Medicare home health may choose to have family members take on more of the caregiver responsibilities, she says.

Florida may indicate regulatory trends

"From a legal and regulatory point of view, I don't see the economy or the new administration changing the issues faced by home health managers in 2009," says **Elizabeth E. Hogue, Esq**., a Washington DC-based attorney. "I do think that home health managers should pay attention to what happened in Florida in July 2008," she says. State regulations now prevent home health agencies from providing anything of value to discharge planners to promote the use of their agency, she explains. Notepads, lunches, pens, and educational sessions that offer free continuing education credits are all banned, she adds. "This is a trend that is showing up in all areas of health care," she says.

Florida also can be used as an example of increased scrutiny of claims, says **Beth Carpenter**, president of Beth Carpenter and Associates, a Chicago-based healthcare consulting firm. "There is increased monitoring of claims to see what types of services are provided," she says. This use of claims data to look at drugs, treatments, and patterns of care is a change, she says. "State surveyors used to be the main face of compliance, but now Florida, and other states, want home health agencies to use accreditation organizations to handle licensure and compliance surveys," she explains. "The state is focusing on monitoring home health services through claims made," she adds.

Audits to detect fraud also will continue to increase, says Hogue. Even if you cross your "t's" and dot your "i's" — be prepared for auditors to find something, she warns. "An auditor's job is to find stuff, so they will scrutinize the little details in every document," she points out. Budget control has been a high priority issue for the Centers for Medicare & Medicaid Services over the past four years, and one way to recoup money is to find evidence of fraud, she explains. "Home health agencies will face more retrospective audits in the coming year," she adds.

While regulatory and economic issues will continue to challenge home health, Carpenter believes that the overall aging of the United States' population has more effect on the home care industry. "As the population ages, we see more patients with one or more chronic disease states in addition to the reason for their admission to home

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care," she says. Not only do the multiple conditions mean an increased need for nursing resources, but they also mean that agencies must change how they provide care, she adds. "Although patients need more care, we are facing increased scrutiny from regulatory organizations that monitor claims, so we must find ways to provide care needed in the most efficient way possible," she says.

Technology, such as telemonitoring, can be used to enhance patient care without increasing visits, and motion sensors or fall monitors can improve patient safety, says Carpenter. "Some home care agencies have been slow to adopt technology," she admits. Although the initial and ongoing costs of implementing a telemonitoring program cannot be reimbursed, the improved outcomes and increased efficiency of staff time offset the costs, she says. **(See technology story, right.)**

The acuity and complexity of home care patient conditions also will give home care a great opportunity as chronic disease management programs become more important, says Reissig. **(See disease management on pg. 4.)** As more states evaluate and pass legislation supporting the concept of the "medical home," home health agencies can use their expertise in coordinating patient care in a home to take a lead, she says.

Perhaps the biggest challenge that home health managers face is the fact that things in the industry will continue to change, says Reissig. "This is the time that leadership and execution are critical," she says. "Don't just have a plan to handle change; be prepared to implement the plan, hold people accountable for their responsibilities, and be ready to adapt." ■

SOURCES

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Telemonitoring, electronic orders improve efficiency

Check state regs for use of electronic signatures

A shrinking workforce, expanding patient base, and sicker patients are challenges that many home health agencies are meeting with technology.

Most home health patients have chronic conditions not related to their referral to home care, but agencies must often address them in order to provide needed care, points out **Beth Carpenter**, president of Beth Carpenter and Associates, a Chicago-based healthcare consulting firm. Diabetes, congestive heart failure, and chronic obstructive pulmonary disease cannot be ignored by home health nurses caring for a patient who is recovering from surgery, she points out. "These patients often require more frequent monitoring, but home health agencies may not have the staff to increase visits — and reimbursement may not cover the cost," she says. "Fortunately, technology that helps home health agencies become more efficient exists," she adds.

Telemonitoring is one way to increase contact with the patient and to monitor the patient on a daily basis without making a visit, Carpenter points out. "Small agencies find it most difficult to implement telemonitoring because of the financial commitment," she adds. "Although telemonitoring can keep nurses from making too many visits, it can also help a nurse identify the need to amend a visit schedule," she adds.

Frequent monitoring of a patient's vital signs helps a home health nurse identify potential problems or the need to adjust a patient care plan quickly, Carpenter points out. "This flexibility is important to good patient care, but CMS [Centers for Medicare & Medicaid Services] regulations don't help us be flexible, because we are still required to get orders and physician signatures for every change," she says. Electronic orders and electronic physician signatures are one way to speed up changes in care plans, but the ability to use them varies from state to state, she points out. ■

HHAs have opportunity to lead in management care

Use of programs for chronic disease improves

Between 12% and 13% of the people living in the United States are aged 65 or older, and of these people, 80% live with at least one chronic disease.[1] Even when the chronic disease is not the reason for home health referral, care plans must take into account all of the chronic conditions that might affect the patient's outcome.

"Home health disease management programs for chronic obstructive pulmonary disease and congestive heart failure have been around a long time, because we were reporting outcomes and had to respond with a way to manage underlying conditions as well," says **Beth Carpenter**, president of Beth Carpenter and Associates, a Chicago-based health care consulting firm. The challenge for chronic disease management programs in home care is that the Medicare payment system is based on acute events or episodes, she says. "Even when a home health agency has a program that can manage the patient's condition and improve his or her life, we have to wait for the hospital to treat the patient and discharge to home care," she says.

Pallative care growing

Palliative care also is a growing area, but reimbursement issues face home health managers, adds **Marcia P. Reissig,** RN, MS, CHCE, chief executive officer of Sutter VNA and Hospice in San Francisco, CA. "There are people who qualify for palliative care as home care patients, and people who qualify as hospice patients whose care can be reimbursed — but there are people that get caught between the two services with no care," she says. "I'd like to see more effort to blend the two payment systems of home health and hospice so that the 'in-between' group of patients can be served."

Reference

1. Centers for Disease Control and Prevention and the Merck Company Foundation. The State of Aging and Health in America 2007. Atlanta, GA; 2007. ■

Study shows PCA results in more medication errors

Wrong dose, wrong drug cited most often

Intravenous patient-controlled analgesia (PCA) improves pain control for most patients, but a recent study[1] shows that errors related to this practice are four times more likely to result in patient harm than errors that occur with other medications.

The study of more than 9,500 PCA errors over a five-year period in the United States showed that patient harm occurred in 6.5% of incidents, compared to 1.5% for general medication errors. The PCA errors examined also were more severe—harming patients and requiring clinical interventions in response to the error—than other types of medication errors. Most errors involved either the wrong dosage or the wrong drug caused by human factors, equipment, or communication breakdowns. For example, one case involved a patient who received several 10 mg doses instead of 1 mg medication doses after surgery because of an incorrectly programmed dispensing pump. The PCA errors examined also were more severe—harming patients and requiring clinical interventions in response to the error—than other types of medication errors.

"The entire PCA process is highly complex," says the study's lead author, **Rodney W. Hicks**, PhD., MSN, MPA, UMC Health System Endowed Chair for Patient Safety and Professor, Anita Thigpen Perry School of Nursing, Texas Tech University Health Sciences Center, Lubbock, Texas. "PCA orders must be written, reviewed and then accurately programmed into sophisticated delivery devices for patients to be pain-free. Such complexity makes PCA an error-prone process."

The authors recommend three strategies to reduce PCA errors:

• Simplify the technical equipment used in PCA.

The study shows that the PCA process is heavily dependent on the ability of caregivers to execute sequential tasks successfully, so easy-to-follow setup instructions for equipment could reduce errors. The study urges PCA vendors to look for ways to make it less likely that programming errors will lead to a wrong dose.

• **Use bar codes and an electronic medication administration record to reduce errors that involve the wrong medication**.

Independent double-checks of the PCA orders, the product, and the PCA device settings should be standard practice, the study advises.

• **Ask pharmacists to design easily understood and standardized forms for PCA, and ensure that prescribers use only these standardized forms.**

These actions would address communication problems that lead to errors and bring regional standardization to the PCA process.

Reference

1. Hicks RW, Heath WM, Sikirica V, et. al. Medication Errors Involving Patient-Controlled Analgesia. *Joint Commission Journal on Quality and Patient Safety* 2008; 34:734-742(9). ■

Staph germs harder than ever to treat, studies say

At least 10% of infections involving staph bacteria were able to survive antibiotics commonly used to treat them, according to a Centers for Disease Control and Prevention (CDC) report presented at a joint meeting in October of the American Society for Microbiology and the Infectious Diseases Society of America.

A number of different CDC studies show that drug-resistant staph bacteria is growing more common even among healthy members of the community, according to **Rachel Gorwitz**, MD, director of the health care quality promotion division of the CDC. Approximately 95,000 serious infections and 20,000 deaths occur in the United States every year due to drug-resistant staph bacteria.

Bacteria found in ordinary community settings are increasingly acquiring "superbug" powers and causing far more serious illnesses than they have in the past.

"Until recently we rarely thought of it as a problem among healthy people in the community," says Gorwitz. Now, the germs causing outbreaks in schools, on sports teams, and in other social situations are posing a growing threat. A CDC study found that at least 10% of cases involving the most common community strain were able to evade the antibiotics typically used to treat them.

The germ is methicillin-resistant *Staphylococcus aureus*, or MRSA. People can carry it on their skin or in their noses with no symptoms and still infect others — the reason many hospitals isolate and test new patients to see if they harbor the bug.

MRSA mostly causes skin infections.

To treat them, "we've had to dust off antibiotics so old that they've lost their patent," said **Robert Daum**, MD, a pediatrician at the University of Chicago.

The CDC used a network of hospitals in nine cities and states to test samples of the most common community MRSA strain, USA300, over the last few years.

MRSA usually is resistant only to penicillin-type drugs. But 10% of the 824 samples checked also could evade clindamycin, tetracycline, Bactrim or other antibiotics.

"The drugs that doctors have typically used to treat staph infections are not effective against MRSA," and family doctors increasingly are seeing a problem only hospital infection specialists once did, Gorwitz said.

Even more worrisome: many of these community strains had features allowing them to easily swap genes and become even hardier. ■

OCR addresses HIPAA privacy in emergencies

The Office of Civil Rights (OCR) recently posted an FAQ regarding the status of the privacy rule during a national or public health emergency on the OCR web site.

The new FAQ addresses the question, "Is the HIPAA Privacy Rule suspended during a national or public health emergency?"

The OCR confirms in the FAQ that the HIPAA privacy rule is not suspended. However, the Secretary of Health and Human Services may waive certain aspects of the rule pursuant to the Project Bioshield Act of 2004. Provisions that may be waived include:

• The requirement for authorization to discuss care with a patients' family members or friends;

• The requirement that covered entities dis-

tribute the notice of privacy practices;

• The right of a patient to request privacy restrictions or confidential communications.

To see the FAQ, go to http://www.hhs.gov/hipaafaq/providers/hipaa-1068.html. ■

Assistants free up case managers for clinical tasks

Teamwork is the key to program's success

At Hudson Health Plan in Tarrytown, NY, case management assistants who handle non-clinical tasks that don't have to be done by a licensed professional are freeing up the nurse case managers for jobs that require their special clinical skills.

Hudson Health Plan is a not-for-profit managed care plan servicing more than 80,000 members in the Hudson Valley of New York.

"Case managers didn't go to school to do data entry and they like having help with the front-line things so they can spend time on other duties. Having case management assistants allows our nurses to carry a larger caseload and still have time to give the members the attention they need," says **Margaret Leonard,** MS, RN-B, C, FNP, senior vice president for clinical services.

Each program at Hudson Health Plan has a case management assistant assigned to work with the case managers in that program.

The case management assistants work closely with the nurses in the individual programs to which they are assigned. They are cross-trained so they can work in any program and with all populations.

"At this point, we are operating in silos. Nobody can learn one system and plug into any population. The case management assistants are knowledgeable about all the programs so they can fill in whenever they are needed," Leonard adds.

Most of the case management assistants have some college education and experience in health care or customer service. Many have worked for private physician practices or at health centers. All are bilingual.

"These are people with myriad talents. Some are experts in technology. Others have terrific people skills and are able to engage members on the telephone. All of them are eager to learn and have been cross-trained, so they can perform any of the jobs in any areas of the case management department," Leonard says.

The case management assistants are enthusiastic about learning more about the programs that Hudson Health Plan offers and are always willing to take on more responsibility, she says.

"When they take on a new task, we make sure we create scripts and standards so that everyone is giving out the same correct information," she says.

Here's an example of how the program works:

The asthma management program is staffed by one nurse case manager and one case management assistant who work together to coordinate care for members with asthma who meet the criteria for case management.

The health plan uses data from its claims system to perform the first layer of stratification for members with asthma who may be eligible for case management. The department receives a report listing everyone who has had an emergency department visit or been hospitalized for asthma as well as people who are taking medication for asthma.

The nurse case manager and case management assistant divide up the list according to the language spoken by the member.

The bilingual case management assistant calls the Spanish-speaking members and conducts the initial information-gathering assessment.

If a Spanish-speaking member meets the criteria for the program, the case management assistant transfers the member to the case manager for a clinical assessment and acts as a translator or sets a time when both can call the member.

When providers call for approval for a treatment or hospitalization, the case management assistant takes down the information and enters it into the system. If the case falls under the health plan's set criteria, the case management assistant has a script to use for issuing the approval. If the procedure is not on the list of approved procedures or more clinical information is needed, he or she will transfer the call to a nurse.

"The case management assistants are skilled at recognizing when they have reached the limits of what they can do to help the member and knowing when to triage the member to the appropriate personnel," she says.

The case management assistants work on the outreach portions of the program as well as handling some of the front-line intake and data entry.

They make outreach calls to members in the program to which they are assigned after discharge from the hospital. They ask members if they understand their discharge plan, if they have had their prescriptions filled, and if they have made a follow-up appointment with a primary care physician.

"When people are in the hospital, they are under stress and may miss some aspects of the discharge plan. This gives them another opportunity to ask the questions they didn't ask in the hospital," Leonard says.

If the member has clinical questions, the case management assistant refers them to a nurse.

"This makes the case management assistant's job more interesting. They do far more than data entry. They are trained to conduct outreach calls and to engage with members. This gives them that feeling of satisfaction that comes from helping someone," she says.

The department also has project coordinators, case management assistants on another level, who work with the nurses to collect and retrieve data from the health plan's information system for various projects.

Every morning, everyone in the department participates in a "stand up meeting" during which the staff discuss what they are working on, if they need help on a particular project, or if they are available to help.

"Our case management assistants are the best. Everyone in the department has a good working relationship with each other and we help each other out when needed," Leonard says.

(For more information, contact Margaret Leonard, MS, RN-B, C, FNP, senior vice president for clinical services, Hudson Health Plan, e-mail: mleonard@HudsonHealthplan.org.) ■

Program gets ill, injured patients back to work

Proactive approach helps health plan exceed

The award-winning medical and disability case management program developed by Blue Cross and Blue Shield of Texas has shown a significant impact in getting employees back to work in a timely manner.

In the first year of the program, more than half of the participants returned to work earlier than expected, based on national averages for their type of injury.

"Statistics show that the longer an employee remains off the job, the less likely he or she is to ever return. The key to our success is that we begin coordinating the care of members early on in their illness and injury and ensure that they get all the services they need to recover and go back to work, says **Patricia Sumner**, RN, BA, CCM, COHN-S, disability nurse case manager with Blue CareLink Disability Case Management.

For example, after six months of disability, the worker's chance of not returning to work is about 50% and after nine months, the figure climbs to 90%, she adds.

The program has received a BlueWorks Award from the Blue Cross Blue Shield Association for its success in decreasing the time that injured or ill patients need to return to their job, reducing costs and increasing employee productivity.

The Richardson, TX-based health plan started the disability case management program in 2005 to help members who are ill or injured get well and back to work as soon as possible.

The program emphasizes early intervention and coordination between the medical benefit and the disability carrier as well as proactive patient management across the spectrum of care, Sumner says.

Before the program, injured and ill members were eligible for case management but there was limited coordination with the disability carriers, Sumner points out.

Most members enroll in the volunteer program after they file claims for short-term disability. However, in the first year, 24% of participants entered the program before they filed a claim.

Those members were identified through the health plan's predictive modeling, which mines claims data to identify members who have the benefit through their employer and who have an illness or injury that is likely to result in a short-term disability.

Other members are referred by their disability carrier or by referrals from other Blue Cross and Blue Shield of Texas programs.

"The beauty of this program is that through our internal processes and predictive modeling, we identify members as early as possible and can start them on the road to recovery earlier," she says.

For instance, real-time referrals identify members who have had a recent hospitalization for catastrophic injuries, such as those who have

suffered a stroke or have been involved in a motor vehicle or other type of accident.

The predictive model identifies those who are at risk for joint replacement surgery, such as members who are older, are taking anti-inflammatory medications, or are receiving frequent physical therapy.

"By identifying them in the early stages of their illness or injury, we can see that they receive appropriate care by the right providers, help them understand and adhere to their treatment plan, and make sure they know how to file for disability benefits if they need them," she says.

If the member needs to file for short-term disability, the case managers can help them do so.

"If they need help with community resources, we help them find what they need. We work in any way possible to help them get moving and back to work," Sumner says.

If they have complications or comorbidities, the case managers also refer them to other Blue Cross Blue Shield of Texas programs.

If patients aren't appropriate for the disability management program, the case managers refer them to programs where they can get assistance.

For instance, if the disability carrier refers a member with a spinal cord injury to the program, the disability case manager would refer him or her to the catastrophic case management programs so the patient can get the help he or she needs, she says.

The program's focus is on early intervention with members who are likely to file to have a temporary disabling condition and are likely to be able to return to some type of employment within six months after their injury or illness.

The majority of members are in the disability case management program for a maximum of six months.

The care for catastrophically injured or more seriously ill patients who will need more long-term management is coordinated by the company's catastrophic case managers.

When members are identified as eligible for the program, they are contacted by a disability case manager who offers them the option to enroll.

When members enroll, they work with the disability case manager to define their goals.

"We want to ensure that realistic and appropriate treatment, financial, and psychosocial needs are identified and met. Our goal is for the patient to achieve maximum health benefits and be able to return to work," she says.

The disability case manager works with the physicians and other medical providers to coordinate the plan of care and treatment plan and ensure that the ill or injured worker receives timely assessments and referrals for necessary medical, surgical, and/or rehabilitation services.

At the same time, the disability case managers work with the patient, helping him or her comply with the treatment plan and ensuring that he or she is progressing according to expectations.

The interventions are based on standard guidelines for treatment of the patient's condition, the severity of the injury or illness, and the patient's progress.

The case managers use national standardized measurements, such as the Workloss Data Institute's Official Disability Guidelines, to develop their plan of care. The guidelines include evidence-based medical treatment guidelines and an estimated time of duration of each condition, allowing the case managers to track the patient's progress.

The program integrates the health plan's medical management and disability management program. The disability case managers are able to access the claims system for the disability carrier to determine patient demographics, physician contact information, and claims status.

Case managers add current case management notes to the system, allowing the claims handler to expedite the processing of the patient's return-to-work status.

"The disability case management program addresses any medical and psychosocial needs of the patients with interventions that assist them in moving efficiently and facilitating early return to work" Sumner says.

For instance, when appropriate, the case managers refer the members to a mental health provider or their employee assistance program for help with mental health issues.

"Statistics reveal that depression and other mental health disorders may be brought on by a potentially disabling physical illness, and progress toward recovery depends on early treatment of mental health issues," she says.

When the case managers talk with the members, they identify what other comorbidities they may have and refer them to other programs that are part of the medical plan.

For instance, if a member has had a stroke and has hypertension, the case manager would link the patient with the health plan's wellness

initiative, which would help the patient get his or her blood pressure under control, come up with an exercise and weight loss plan, if needed.

"We want to create a continuum of care, so once we have gotten them through the process of getting back to work, they can continue with the other wellness programs and stay healthy," she says.

The case managers help members connect with community support programs, such as those provided by the American Cancer Society. They also provide the member with access to resources available through their company's employee assistance plan.

The disability management team coordinates with all other programs offered by the health plan, including the wellness initiative, catastrophic case management, and specialty programs such as disease management or behavioral health management.

When appropriate, the member is co-managed by the disability case manager and a case manager from a disease management and behavioral health management program.

"An integrated medical and disability management program promotes early identification of patients with conditions that may place them at risk for prolonged disability. Our wellness initiative programs, predictive model tool, and trigger diagnosis reports allow us to identify and reach out to members and provide them with tools that may help them maximize their health benefits and minimize or prevent a permanent disability," Sumner says.

(For more information, contact Patricia Sumner, RN, BA, CCM, COHN-S, disability nurse case manager , Blue Cross and Blue Shield of Texas, e-mail:Patricia_Sumner@BCBSTX.COM.) ■

Make written material easy to read, understandable

Plain language documents suitable for 80%

What makes educational material a must-read? The key is to make documents easy to read and understand, says **Doug Seubert**, guideline editor in Quality Improvement and Care Management at Marshfield (WI) Clinic.

"You can have a document that is easy to understand, all the medical terms are defined, and there are even good diagrams that 'show' what the text is 'telling.' However, if the font is too small, there is little white space, and the information is not broken into sections, it may be too hard to read and the majority of patients won't even try reading it," explains Seubert.

The reverse is also true. A document that has a larger font, uses white space and bullet points to break up the text, and is in a two-column layout may have medical terms that are not explained and long, wordy sentences that make it difficult for most people to understand, he adds.

"If a pamphlet looks hard to read, people will not read it. If they try to read material and find long words and medical jargon, it is difficult for them to get through, or they don't see how the information will help them, they will throw it away," says **Sandra Cornett**, PhD, RN, director of the OSU/AHEC Health Literacy Program at The Ohio State University in Columbus.

Effective educational materials must be easy to read and easy to understand—the two cannot be separated, says **Linda Benn**, RN, BScN, patient education coordinator at QEII Capital Health in Halifax, Nova Scotia, Canada.

Easy-to-read material is written in plain, everyday language and flows well from one topic to the next. The content is of interest to the reader. Easy to understand applies to comprehension and whether the reader can explain what he or she just read—for example, if he or she can list the steps in correct order for drawing up insulin, explains Benn.

Written materials that are easy to read share several characteristics, and the same is true of articles that are easy to understand.

What do easy-to-read materials have in common?

Reading grade level is part of the process of making a document easy to read. Readability formulas are used to help assess the reading difficulty, which has to do with such factors as the number of syllables in a word and the number of sentences in a paragraph, says Cornett.

Grade level only a beginning

"Reading grade level is a good start, but readability is more than that. You can put together gobbledygook made up of short words and sentences, and have a very low reading grade level but a useless document," says **Janet Sorensen**, a writer for the Arkansas Foundation for Medical

Care in Little Rock.

Design elements contribute to readability, she adds. Use a 12-point font or larger if readers may be visually impaired. Serif fonts, such as Times New Roman, work well for the body of the text, because these fonts are easier to read. San serif fonts, such as Arial, can be used for headings and subheads.

White space, or areas without text, add to the readability of written material. "It's recommended that 30% to 50% of a document should be white space. This includes margins, spaces between paragraphs and lines of text, and space around graphics and photos," says Seubert.

The length of the lines of text on a page impacts the readability of a document. Lines of text that span across the page make a person's eyes work harder as he or she reads. On a standard 8.5"x11" page, a two-column layout is recommended, or the margins on a single-column layout should be increased so the lines of text are between 50 and 70 characters, says Seubert.

Breaking the information into sections or "chunks" makes a document easier to read, because the eyes can scan the document and focus on each section. Using lists helps break up text and makes key points stand out. "Lists can be bulleted or numbered. Numbered lists should be used for directions or instructions that require a series of actions that must be done in order," says Seubert.

Design should not be an afterthought but part of the entire writing process, says Cornett. How the information is to be structured with subheads and sections makes the information more readable.

Layout and design also can make a document easier to understand. Subtitles help guide the reader to the important information. Organizing the material under subtitles also will help the writer limit the information to three to five important points. "Too much information is overwhelming, and the reader will not remember any of it," explains Cornett.

In order for headings and subheadings to be useful, they must be written clearly, so readers can find the information they want. "Labeling a section 'symptoms' or 'what to do' may not be clear to the reader. Headings should serve as a summary of what is covered in that section," explains Seubert.

One of the most effective ways to write clear headings is to use the question and answer format, he says. For example:

- What is high blood pressure?
- What causes high blood pressure?
- How is high blood pressure treated?

This technique helps the writer focus on one key piece of information at a time and provides natural breaks in the document to separate the sections. Also, it helps readers scan through the document and find the information they need.

Creating understandable content

To make sure documents can be understood by the reader, they must be written in plain language. This is clear, simple, direct writing using only as many words as necessary to state a point.

"Plain language also avoids jargon and instead uses common words that are easier to understand," says Seubert.

For example, "chest pain" is used instead of "angina." Yet authors need to make sure medical jargon does not creep into the text. "Often I see words like 'chronic' and 'acute' used in a document without being defined. Or a phrase like, 'Call your doctor if your child exhibits any of the following symptoms.' Since the majority of health information for patients is written by health care professionals, it's easy to slip into medical jargon without even knowing it," says Seubert.

Words like 'consistent,' 'observation,' 'modify,' and 'intake' are common in health care documents and writers need to watch for them, determine if they are necessary and if there are easier alternatives, he adds.

"The words, even the one-syllable words, need to be familiar to your audience. If they're not, and you must use them, define them as clearly and simply as possible," states Sorensen.

Medical terms do not need to be included

in the text if there is a common term that means more or less the same thing, continues Sorensen. For example, "heart attack" can be used rather than "acute myocardial infarction." If a medical term is used, it needs to be defined as clearly as possible. "The definition might need to be a separate sentence to keep the sentence from getting cumbersome," she adds.

Benn states that she often uses a definition with a medical word or difficult word she cannot eliminate or change, because doing so would change the intent of the brochure.

Cornett says she likes to put the lay term first in the sentence with the medical term afterward; however, she does not place it in parentheses because people with limited literacy do not always understand that grammatical practice. Instead she would write: "a heart attack, or what some doctors call an acute myocardial infarction." In this way, the reader would not stop at a medical term he or she is not familiar with, and when the word does come up in the sentence, the reader can skip the word without altering the meaning of the text.

When writing content, keep the tone friendly and involve the reader using pronouns such as 'you', 'we,' or 'us,' advises Benn.

A personal approach draws in the reader, agrees Seubert. Instead of writing, "People with diabetes should examine their feet every day," write, "Because you have diabetes, it is important to check your feet every day," he explains.

It's also important to write in active voice rather than passive voice, he adds. Active voice is more direct: "Your doctor may prescribe some medicine to help control your blood pressure." Written in passive voice it might read: "In order to help control your blood pressure, some medicine may be prescribed by your doctor."

Photos, diagrams, and drawings help to explain the text as well, says Seubert. However, any photos or drawings that are used should be labeled and placed close to the appropriate text in the document.

Surveys show that people of all education levels prefer information that is clear and easy to understand. Therefore, documents written in this manner will be suitable for about 80% of a patient population. This is the concept of universal design, explains Seubert.

"Universal design is fairly prevalent in our society, and we often take it for granted. Handicapped-accessible doors at grocery stores

CNE *questions*

1. What is one area of home health that may be greatly affected by a slowing economy, according to Marcia P. Reissig RN, MS, CHCE, chief executive officer of Sutter VNA and Hospice in San Francisco, CA?
   A. Palliative care programs
   B. Disease management programs
   C. Durable medical equipment
   D. Private duty care

2. Why is it more important than ever for home health agencies to adopt technology such as telemonitoring or electronic orders, according to Beth Carpenter, president of Beth Carpenter and Associates, a Chicago, IL-based healthcare consulting firm?
   A. To increase reimbursement levels
   B. To improve documentation
   C. To increase efficient use of staff time
   D.To meet regulatory requirements

3. What percentage of people aged 65 and older in the United States lives with at least one chronic disease?
   A. 60%
   B. 70%
   C. 80%
   D. 90%

4. What types of medication errors occur more frequently with patient controlled analgesia?
   A. Wrong dose
   B. Wrong medication
   C. Wrong frequency
   D. A and B

Answer Key: 1. D; 2. C; 3. C; 4. D.

and other public buildings are a good example. They provide access to everyone equally, and we all benefit from the convenience," states Seubert.

Therefore elements that make documents easy to read and easy to understand can be universally applied to health care information, and as a result handouts will fit the majority of patients. ■

BINDERS AVAILABLE

HOSPITAL HOME HEALTH has sturdy plastic binders available if you would like to store back issues of the newsletters. To request a binder, please e-mail **binders@ahcmedia.com**. Please be sure to include the name of the newsletter, the subscriber number and your full address.

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CNE objectives

After reading each issue of *Hospital Home Health*, the reader will be able to do the following:

1. Identify particular clinical, ethical, legal, or social issues pertinent to home health care.
2. Describe how those issues affect nurses, patients, and the home care industry in general.
3. Describe practical solutions to the problems that the profession encounters in home care and integrate them into daily practices. ■

CNE instructions

Nurses 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 semester's activity with the **March** issue, you must complete the evaluation form provided in that issue and return it in the reply envelope provided to receive a credit letter. ■