Patient Education Management™

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

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IN THIS ISSUE

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Special Report: Annual 2008 Salary Survey

Going beyond clear language when writing patient education materials

Consider such factors as scientific, civic and cultural literacy

Delivering health information in simple, clear language is important for comprehension. However, the use of plain language and employing a low reading level are not the only factors that determine comprehension.

"There are all kinds of issues involved in what causes people to really understand and engage with the information," states **Christina Zarcadoolas**, PhD, an associate clinical professor at Mount Sinai School of Medicine, Department of Community and Preventive Medicine in New York.

EXECUTIVE SUMMARY

In the December 2008 issue of *Patient Education Management*, we looked at the qualities of a well written handout that make it easy to read and understand. For example, handouts that are considered easy to read would have text written at a sixth-to-eighth-grade reading level, medical terms defined, and a user-friendly layout consisting of generous use of white space and bullet points.

This month we go beyond plain language to examine other factors that affect a person's ability to understand and use health information. These factors include scientific literacy, civic literacy and cultural literacy.

Simplifying information does not always make it understandable and usable, she adds. While fundamental literacy, or the ability to read, write, speak, and work with numbers, is key to understanding health messages, it is not the only factor in comprehension. Therefore, readability, good layout, and clear language are only part of the focus when writing materials. **(To learn more about honing the readability portion of manuscripts, see article on pp. 3.)**

What other factors should be considered when creating educational handouts? According to Zarcadoolas, when writing materials it is important to consider how literate a person is scientifically, civically, and culturally.

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She discusses these issues in detail in a book she has co-authored with Andrew F. Pleasant and David S. Greer titled *Advancing Health Literacy: A Framework for Understanding and Action*.

"Less than 20% of adults in the United States know anything about the scientific method or how science works — and that science evidence is always changing and is dynamic," says Zarcadoolas. Yet an understanding of basic science often improves their ability to comprehend a health message.

Scientific evidence is addressed all the time in health information, she adds. Handouts include the percentage of people with diabetes in a certain state or warnings of a possible flu epidemic and how to avoid getting sick. Zarcadoolas says she uses an example in her book about readers confused by a message that was designed to teach people not to ask for antibiotics to cure the common cold, which is a virus. The confusion was caused by the fact that most did not understand the difference between a virus and bacteria.

Zarcadoolas describes scientific literacy as "the skills and abilities to understand and use science and technology, including some awareness of the process of science."

In her book she suggests that authors of health education handouts ask two questions about the scientific literacy of readers when writing health education materials.

1. What science must a person know to comprehend and decide to act on a specific health message?

2. What assumptions about the listeners' scientific literacy are made by developers of health messages?

Another factor that affects a person's ability to understand health information is civic literacy. Zarcadoolas describes it as "skills and abilities that enable citizens to become aware of public issues, participate in critical dialogue about them, and become involved in decision-making processes."

This component has to do with how a person judges the source of information and determines whether it is reliable, she explains. People's civic literacy provides a good indicator of how they will receive health messages and engage with them by changing their behavior.

In *Advancing Health Literacy*, Zarcadoolas states that civic literacy covers a range of understanding that includes: "judging the sources of information; judging the quality of information; knowing where and how to access information; knowing how to advocate for oneself and others;

and understanding the relationship between one's actions and the larger social group."

An example of a person acting for the greater good of a social group would be parents keeping a sick child home from day care so as not to expose other children to a cold or flu.

"When we look at people's civic literacy, we get a very good indicator of how they are going to receive health messages and trust them enough to engage with them and change their behavior," says Zarcadoolas.

Many factors affect point-of-view

The fourth component that must be considered when writing understandable patient education materials is cultural literacy, according to Zarcadoolas. Culture is "the shared and dynamic characteristics of a group of people, which may include language, patterns of behavior, beliefs, customs, traditions, and other modes of expression."

People who are culturally literate not only recognize their cultural beliefs but recognize that the authors of health information have a professional culture as well. According to the authors of *Advancing Health Literacy*"the communicator should understand aspects of the culture of the recipient, and the recipient should understand aspects of the professional culture of the sender."

In their book, the authors discuss information on medication coverage provided by a health care insurance provider that assumes the reader has a basic understanding of industry practices. Yet the insured party needs to know that the company does not necessarily cover all drugs that might be prescribed by a physician in order to understand the message.

To create messages people will act upon requires an awareness of the cultural beliefs people have, says Zarcadoolas. It includes values, perceptions, and actions.

For example, the fact teenagers are at a stage in life where they are building an identity and have confidence in their immortality makes lessons on HIV medication adherence difficult. Teens are notoriously noncompliant because they do not want to be identified as sick people, says Zarcadoolas. Thus, the health care providers must find a way to deliver the message that works.

In this particular situation, options to consider might be the use of trusted sources to deliver the message, or people who have gone on to accomplish and build strong identities in spite of being HIV positive, she says.

Writing patient education materials in simple language is the first step in clear communication; however, authors must also take into account the reader's cultural literacy, science literacy, and civic literacy as well, according to Zarcadoolas.

Therefore, when creating written materials for a patient population, Zarcadoolas advises authors to give thought to four areas: fundamental literacy (a person's ability to read, write, speak and work with numbers), scientific literacy, civic literacy, and cultural literacy. ■

SOURCE & RESOURCE

For more information about consideration of the four areas of literacy when writing heath education materials, contact:

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Tips for getting an accurate reading level score

Make simple changes to copy while calculating

While many factors determine whether patients will understand written material, their ability to read the piece is fundamental. Therefore, copy must be written at an appropriate reading level.

Readability formulas offer a way to evaluate the reading grade level of a document. These formulas look at the number of syllables in a word, the number of words in a sentence, and the number of sentences in a paragraph, says **Doug Seubert**, guideline editor in Quality Improvement and Care Management at Marshfield (WI) Clinic.

Readability formulas are included in some word processing software, and some web sites offer free readability calculators that allow you to cut and paste your text and have the reading

EXECUTIVE SUMMARY

The evaluation of reading level is a basic step in keeping manuscripts understandable when writing for the general public. The process also helps the author learn to write in clear language. Learn how to achieve an accurate grade level in writing.

grade level automatically calculated, he adds.

Diane C. Moyer, MS, RN, program director of patient education at The Ohio State University Medical Center in Columbus, prefers to use the Fry readability scale.

Using this method you select three 100-word sections in the document at the beginning, middle and end. You count the number of sentences in each section of 100 words and the number of syllables in each 100 words. You then find the average number of sentences and the average number of syllables. With this information and the use of a Fry graph, one can determine the reading level.

Moyer says a good resource for an overview of the readability tools is the book *Teaching Patients with Low Literacy Skills* by Doak, Doak, and Root, which is available as a free download at www.hsph.harvard.edu/healthliteracy/doak.html.

To determine the reading level of materials used at Phoenix Children's Hospital, **Fran London**, MS, RN, health education specialist at The Emily Center, prefers the Suitability Assessment of Materials (SAM score). This too can be obtained from the book authored by Doak, Doak and Root in chapter four, "Assessing Suitability of Materials."

"I find readability formulas helpful in the initial writing of a document to help gauge the initial material. If you run your draft through a readability calculator and the results show a reading level of 11th grade or above, you know you have some rewriting to do," states Seubert.

The best way to use readability formulas is in training yourself to write in plain language, he adds.

While working on the manuscript, take a paragraph from the draft and calculate the reading level. If it is higher than desired, use plain language recommendations to rewrite the paragraph. **(For more information on these recommendations, see cover article of *Patient Education Management* December 2008.)**

Tips on reducing reading level

To reduce the reading level of a written piece, look for complex sentences that can be broken into two sentences, replace words with multiple syllables with simpler alternatives, and change sentences in passive voice to active voice.

"Run the revised text through the readability calculator and notice the effect your changes have on the reading grade level. The more you do this as you write your documents, the more familiar you become with the plain language recommendations," says Seubert.

While writing, keep in mind the text should flow easily without sounding too choppy. There comes a point when cutting up sentences and paragraphs to get a lower reading grade level score does more harm than good. "Read your text out loud and notice how it flows," advises Seubert. "If it starts to sound too choppy, you've probably broken it down too far. The key is finding the balance so that your writing is clear, concise, and direct yet maintains a natural flow that is easy to read."

When doing a readability assessment of a printed handout, read through it and note any medical terms, as these terms can raise the score. Remove the term before running a reading grade level assessment, but do not remove a medical term unless it is clearly defined in the document, says Seubert.

Also, check lists of bullets. Typically, if bulleted or numbered text are complete sentences, they have a period at the end; if not, there is no period. To get a more accurate reading level, Seubert puts a period after each bulleted item whether it is a complete sentence or not, then simply removes the period after the assessment.

"If you don't have periods at the end of your bulleted text, the next period is most likely at the end of the first sentence that starts the paragraph following your list. That can result in one very long sentence with a lot of syllables and will make your readability assessment less accurate," explains Seubert.

He also advises adding periods after the title, headings and subheadings throughout the document. Putting the periods after headings and subheadings will separate them from the following sentence. Without them, the readability software will consider them as one sentence and that will affect the reading grade level score. ■

SOURCES

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Public outreach on thyroid disease advised

AACE & ATA designate January as awareness month

According to the American Association of Clinical Endocrinologists based in Jacksonville, FL, when people's thyroids do not work properly their bodies don't either.

The small, butterfly-shaped gland below the larynx produces hormones that impact the function of many of the body's organs, including the heart, brain, liver, kidneys, bones and skin.

That's why the theme for Thyroid Awareness Month designated for January 2009 is "Your Thyroid: A Key to Good Health." AACE and The American Thyroid Association based in Falls Church, VA, are co-sponsors of this national campaign to target 27 million Americans living with a thyroid condition. According to these organizations, thyroid disease is more common than diabetes or heart disease. More than half of those people with an underactive or overactive thyroid remain undiagnosed.

The association wants health care institutions "to help people understand the effects of the thyroid throughout all aspects of life: conception, birth, adolescence and adulthood."

"Many people with thyroid disease are often undiagnosed for years," says **Jeffrey Garber**, MD, FACP, FACE, chief of endocrinology at Harvard Vanguard Medical Associates in Boston, MA, and president-elect of the AACE.

That's because people with symptoms of hypothyroidism, or an underactive thyroid, or overactive thyroid called hyperthyroidism can often attribute their cause to something else that is happening in their life. For example, fatigue might be due to job stress.

Through public awareness, ATA and AACE are hoping to prompt people to ask their physician to test for thyroid disease when certain symptoms and risk factors are present.

The AACE reports that women are more likely to have a thyroid disease than men. Age is a factor, as well. People are also at greater risk if they are Caucasian, have a family history of autoimmune thyroid diseases, eat an iodine-deficient diet, smoke, or take medications with high levels of iodine.

Hypothyroidism is more common in people over age 60 and steadily increases with age, especially among women. Symptoms that signal hypothyroidism include: fatigue, forgetfulness, depression, heavy menses, dry, coarse hair, mood swings, weight gain, hoarse voice, dry, coarse skin and constipation.

Common symptoms for hyperthyroidism according to the AACE include: heat intolerance, sweating, weight loss, alterations in appetite, frequent bowel movements, fatigue and muscle weakness, menstrual disturbance, impaired fertility, mental disturbances, sleep disturbances, tremors, and thyroid enlargement.

"Being aware of the risk and the symptoms, that combination gives you a fairly good shot at what the odds are that the test will prove something or show something," says Garber.

Awareness key during pregnancy

The AACE also recommends that women who want to become pregnant understand the impact the thyroid has on the health of the baby. Because thyroid hormone is necessary for the normal brain development of the child, all pregnant women should take a prenatal vitamin with iodine. In this way the mother can be sure there is enough iodine to produce fetal and maternal thyroid hormone.

Due to the fact that thyroid hormone is critical

EXECUTIVE SUMMARY

January is Thyroid Awareness Month, and the AACE and ATA suggest consumer outreach efforts focus on awareness of the signs and symptoms of thyroid disease.

for brain development in the baby and a fetus depends on the mother's hormone until he or she can produce it, women with hypothyroidism need to be under treatment. Also, pregnant women should be aware they could develop hypothyroidism during pregnancy. During the first trimester, women with untreated hypothyroidism are at the greatest risk for miscarriage.

Women with hyperthyroidism must undergo a closely monitored treatment during pregnancy for it can cause stillbirth, premature birth, or low birth weight for the baby.

To help get the word out about thyroid disease, the AACE has created an interactive web site for Thyroid Awareness Month. It has information about hypothyroidism, hyperthyroidism, thyroid nodules and thyroid cancer. The web site has a "Neck Check," the "Top 10 Things You Should Know about Your Thyroid," and a list of the "Things Every Mother Should Know," which is an educational sheet for pregnant women. This information can be accessed at www.thyroidawareness.com.

[Editor's note: Jeffrey R. Garber, MD, wrote a book with Sandra Sardella White titled "The Harvard Medical School Guide to Overcoming Thyroid Problems" published by McGraw-Hill.] ■

SOURCE

For more information about Thyroid Awareness Month, contact:

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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.] ■

Coordination of care helps patients manage disease

Chronic care model links providers, community

The only way to help people with chronic illnesses manage their disease is to develop a care management protocol that extends through the entire disease process from the acute care episode to the community and back to the acute care facility, says **Donna Zazworsky**, RN, MS, CCM, FAAN, manager of network diabetes care, faith community nursing and telemedicine for Carondelet Health Network in Tucson, AZ.

"So often we work in an organization where patients come in because they're already sick and we are reacting to what is presented. We need to develop ways to be proactive and screen people ahead of time to identify those who are at risk for a disease to help them avoid it and to help those with the disease keep it under control," Zazworsky says.

Case management across the continuum is the key to helping people manage their chronic diseases and keeping them out of the hospital, she adds.

"Evidence suggests that providing high-quality chronic care involves more than just adding additional interventions; linkage between the health care delivery system and the community plays a big role," she says.

For a treatment plan to succeed, health care providers must link the patient to outside resources such as exercise, weight management, and diabetes programs and collaborate with staff at community organizations and agencies to coordinate care, she adds.

"Everyone needs to work as a team to coordinate patient care. We need to all know our roles and tasks," she says.

Zazworsky is a proponent of the chronic care model, which extends health care beyond the provider or health plan and incorporates community-wide efforts to improve clinical outcomes.

For instance, in Tucson, St. Elizabeth Health Center, a faith-based community health center serving the uninsured and underserved, has collaborated with other community agencies and developed a comprehensive program for diabetics that provides recommended care at a reduced cost and co-pay.

The chronic care model is an evidence-based

model that takes an organized approach to treating people with chronic diseases and emphasizes the patient's role in managing his or her disease, Zazworsky adds.

The model extends care beyond the health care system and into the community to provide better functional and clinical outcomes, she says.

"The issues related to the cost of chronic care are profound," Zazworsky points out.

For instance, total diabetes spending tops $98 million in a year, she says. A person without diabetes incurs an average of $2,669 in health care costs each year. Health care for diabetics on average cost $10,071 a year.

Each year, diabetics have a mean hospital stay of 5.4 days, for a total of 13.9 million days and a cost of $72.5 billion. Patients make 30.3 diabetes-related visits to the doctor each year and generate $10.9 billion in outpatient costs.

Americans with diabetes account for 15% of national health care costs, although they make up only 5% of the population, Zazworsky adds.

An additional 15% to 20% have undiagnosed impaired fasting glucose, impaired glucose tolerance, and gestational diabetes, she says.

The problem is compounded by the fact that the prevalence of the disease is increasing at a rapid pace, she adds.

In 1994, there were 99 million people worldwide with diabetes. That figure is expected to rise to an estimated 215 million by 2010.

However, there is a solution to the problem, she adds.

A three-year study of a comprehensive care program showed that diabetics who were closely monitored achieved a 26% decrease in inpatient days along with a 10% decrease in length of stay. Specialty visits decreased by 25% while pharmacy costs increased by 16% due to increase use of medications. Overall, the program achieved an 11% decrease in costs, Zazworsky says.[1]

An effective chronic care program takes a proactive, rather than a reactive approach to care, Zazworsky points out.

To develop a chronic care model in your organization, start by looking at the population you serve to determine how to design the program, Zazworsky advises.

Look at the diagnoses of your patients, how you treat the disease, and how you manage complications. Follow the disease process to the acute care episode and back, and look at ways to minimize the progression of the disease, she says.

"We need to develop ways to assess patients to identify those with no disease who are at risk and if they do have a disease to look at what kind of interventions they need," she says.

Examine how the organization of health care is established within your hospital, health system, or health plan. Look at the goals, incentives for providers, process improvements, and strong senior leadership support.

Look at effective programs in the community as well as within your organization, she suggests.

Research the resources available within your community including non-profit organizations, health plans, and governmental agencies such as local health departments.

Develop agreements that facilitate care coordination within and across organizations in your community, she adds.

Create formal partnerships among organizations in the community so you clearly understand what your relationship will be. Come up with a contact person at the agency.

Compile a list of community resources that can be used to help patients find resources that can help them manage their diseases, she says.

For instance, the St. Elizabeth Health Center created a list of agencies that offer walking and exercise programs as well as places where patients could go for low-cost diabetes supplies.

Within the delivery system, look at the roles of the team. Do you have planned visits to deal with chronic illness? How do you continue the care, handing off the patients from the hospital system to other providers in the community?

Look at each cost component of the program and determine what costs may be a barrier to patients. Look at the barriers to people in your community receiving care, she says.

"You need as an organization to determine how you can influence the cost of care for the uninsured," she says.

An effective chronic care program needs a clinical information system that maintains comprehensive information about patients, their conditions, and their adherence, she says.

For instance, you should be able to pull up a subgroup of patients with diabetes and a co-morbidity of congestive heart failure who are female and age 40 and older.

You should track how often the patients are hospitalized or visit the emergency department and whether they are filling their prescriptions or having the recommended tests and procedures.

[For more information, contact Donna Zazworsky,

RN, MS, CCM, FAAN, manager of network diabetes care, faith community nursing and telemedicine for Carondelet Health Network in Tucson, AZ. E-mail: donnazaz@aol.com.]

Reference

1. The New Economics of Diabetes Management, presented at the 60th Scientific Session of the American Diabetes Association, June 20, 2000. ■

Field of patient education growing strong

Trends in health care bolster the need for a position

Patient education managers have an important position within health care institutions. Several trends have put this field in the spotlight, according to **Kathy Ordelt**, RN-CPN, CRRN, patient and family education coordinator at Children's Healthcare of Atlanta.

National campaigns by such organizations as the Chicago-based American Medical Association with "Ask Me 3" for better health communication have helped bring family- and patient-centered care to the forefront. In addition, organizations such as the Joint Commission in Oakbrook Terrace, IL are pushing patient involvement and clear health communication to the forefront. Achieving national patient safety goals also requires strong educational intervention. All these issues involve the field of patient education, says Ordelt.

As awareness of health literacy issues increases, health care systems are looking to patient education experts to make documents easier for patients and their family members to read and understand, says **Diane Moyer**, MS, RN, program director for patient education at The Ohio State University Medical Center in Columbus.

"Having a person or department responsible for the quality and scope of resources available for patient education within the organization results in a more cost-effective, consistent and easy-to-understand set of resources for clinicians to use in educating patients and families," says Moyer.

Someone in the position of patient education manager or coordinator advocates for the consistency of patient and family education throughout the organization and continuum of care, says **Fran London**, MS, RN, a health education specialist at The Emily Center at Phoenix (AZ) Children's Hospital.

Patient education managers help develop the infrastructure for programs, says **Louise Villejo**, MPH, CHES, executive director of the University of Texas M.D. Anderson Cancer Center Patient Education Office. They help staff develop programs, creating the educational structure and resources needed to implement them.

Are patient education managers being paid what they are worth? Many in the field believe health care institutions are staying competitive with the local job market. For example, at M.D. Anderson Cancer Center, the human resources department surveys the jobs in the area to make sure its salaries for similar positions are in the same range as those of competing institutions.

However, many other factors could influence the salary a patient education manager or coordinator receives. The title of his or her position is important, whether a person is a coordinator, manager or director, states Ordelt. In addition, organizational structure could play a role, with salary influenced by the position of the person providing oversight. For example, a patient education coordinator could report to a company vice president or a manager.

In our 2008 *Patient Education Management* Confidential Salary Survey, the annual gross income of readers who participated ranged from about $40,000 to over $100,000.

The extent of responsibility for supervising others is most likely related to this wide range in pay," states London.

Moyer adds, "Salary is largely impacted by whether the position is a salaried position or an hourly rate position, and whether or not the position is able to collect premium, overtime, or certification pay. Some positions also have dual responsibilities in patient and staff education, and that impacts hours and schedules."

The degree required for the role also would impact salary. *PEM* readers answering the survey ranged from LPNs to PhDs. London states the preparation of the person in the job will determine how the job is implemented, because each degree provides a different skill set.

"I would think organizations determine what role they want the patient education coordinator to have and define the job with the appropriate qualifications to accomplish that. I have an MS in nursing, so I approach the role as a clinical nurse specialist," explains London.

Moyer says that often people with advanced degrees have more project development experience, and they are seen as more valuable contributors to the organization as they apply for grants or do collaborative projects with other organizations.

Another factor affecting salary could be whether or not an RN is preferred, adds Moyer. Salary ranges will improve when organizations need to attract qualified people.

While many readers who answered the survey were RNs, whether this is the best certification for the position of patient education manager is debated by experts in the field.

The fact that many patient education coordinators are RNs shows a poor understanding of the unique skill set of health educators that make them better suited for the role, states **Cezanne Garcia**, MPH, a senior program and resource specialist at the Institute for Family Centered Care in Bethesda, MD.

Health educators have knowledge of adult learning, as well as knowledge of program development, implementation and evaluation, she says.

Ordelt says an RN is better suited for the position of patient education coordinator than someone with some other clinical background training such as physical therapy. By training, an RN is more holistic and can take care of patient education issues whether clinical nutrition, physical therapy or nursing.

"I think an RN has a much broader overview of the health care system and the whole patient," she adds.

Ordelt sees three key skills required for the job of patient education coordinator. These include the ability to communicate, manage a multitude of projects at one time, and collaborate with oth-

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 patient experts to shape programs
- Using technology to improve patient teaching
- Making good staff selections when hiring
- Best practice for selecting vendors
- Education's role in demand management

CNE Questions

1. When creating patient education material, in addition to considering the fundamental literacy of a patient population, writers should consider literacy in which of the following areas?

A. Science
B. Civics
C. Culture
D. All of the above

2. Readability formulas can be used as a training tool for writing in plain language.

A. True
B. False

3. To reduce the reading level of a written piece an author can do which of the following?

A. Divide complex sentences.
B. Replace words with multiple syllables.
C. Use active voice.
D. All of the above.

4. Written communication is improved when health care professionals understand the culture of their target patient population and patients understand aspects of the professional culture of the provider.

A. True
B. False

Answers: 1. D; 2. A; 3. D; 4. A.

ers on the importance of patient education.

Whatever the skill set required for the job of patient education manager at a health care institution, it seems hospitals of all different sizes and locations are hiring people for this job position. PEMs answering the survey worked at urban, suburban and rural health care institutions.

"I think most facilities have someone in a role to oversee patient education, since there needs to be consistency within the organization, and there is often a need to have someone coordinating the resources available in the organization," says Moyer.

It is becoming more common to have someone overseeing patient education no matter the size or location of the facility because of accrediting requirements, says Garcia. Such accrediting organizations have a strong expectation that institutions will have in place individuals with knowledge of health literacy, program planning and other skills commonly attributed to patient education managers.

Over the past year several readers reported no change in their salary, while others had a 1% to 3% increase, and other salaries increased by 4% to 6%.

"The economic situation is and has impacted salary increases for a number of years, in some areas more than others. The salary increase for the patient education role is not much different than many roles," says Moyer.

Villejo says at M.D. Anderson, higher salary increases depend on whether the employee receives a merit for doing an outstanding job, such as meeting the institution's financial goals. In tough economic times, these pay raises may not be given, she adds. ■