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Covering Case Management Across The Entire Care Continuum

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IN THIS ISSUE

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Unique model provides disease management to home care patients

New approach to delivering care includes face-to-face interventions

When the home health nurses at Little Rock, AR-based Baptist Health Home Health Network began observing that many of their patients had poorly managed chronic diseases and were not receiving evidence-based care, the network designed a new approach to delivering care for patients with chronic diseases.

The home-based chronic care model, implemented in 2007, provides disease self-management support to home health patients with diabetes, heart failure, coronary artery disease, chronic pulmonary obstructive disease, and asthma.

The National Association of Home Care & Hospice has given its Excellence in Innovation Award to Baptist Health Home Health Network in recognition of its work in creating a better way to deliver heath care to patients with chronic diseases.

The goal is to reduce health care utilization and the rehospitalization rate by engaging patients in disease management.

The initiative was so successful that the department created 2020 Health Solutions to provide similar services for employees of Baptist Health under an arrangement in which the home health network will share in any health system cost savings, says **Paula Suter**, RN, MA, CNS, CCP, director of chronic care management for Baptist Home Health and 2020 Health Solutions.

"When we started telemonitoring services for our patients, we began noticing that many of our patients with chronic diseases were not receiving evidence-based medicine. What was more concerning to us was that many of these patients also had poor disease self-management ability and knowledge. They were not very engaged in disease management for a variety of reasons," Suter says.

The home health nurses were frustrated because they couldn't engage the patients in efforts to get their conditions under control and sometimes labeled them as noncompliant.

"At that time, our nurses didn't have the competencies they needed to engage the patient, especially those who are non-adherent to the plan of care or the competencies needed to help change behavior," she says.

Recognizing that the Centers for Medicare & Medicaid Services (CMS) and private insurers are moving toward value-based purchasing and that poor disease management affects patients' quality of life and often results in rehospitalization, the home health network made it a strategic objective to provide evidence-based chronic disease management, Suter adds.

The team researched the literature to identify the best practices in medical care as well as the best ways to educate adults and to effect behavioral change.

They looked at CMS demonstration projects that revolved around disease management and researched what the experts in the field were recommending.

"We took all of that and came up with a cohesive model for home health patients," she says.

Four areas of focus

The program has four key focus areas: a high-touch delivery system, theory-based self management, specialist oversight by advanced practice nurses, and technology.

"We found that when we provide all components of the program, rehospitalization drops significantly with the sickest of the patients," Suter says.

Before beginning the program, Baptist Health developed a chronic care course to teach clinicians how to effectively work with patients and change their behavior. The curriculum includes principles of motivational interviewing, methods to improve patient confidence with disease management, and principles of adult learning.

The course also provides information on expert guidelines and best practices for heart failure, diabetes, and chronic obstructive coronary disease care. When clinicians pass the course, they are considered a home-based chronic care specialist (HBCCS), Suter says.

"Most health care professionals don't receive this kind of training as part of their education. We work with the clinicians to help them hone their skills for patient engagement and behavioral change," Suter says.

The purpose of the program is to help people learn to keep their chronic diseases under control by modifying their behavior and adapting healthy habits, says **Paula Evans**, MSN, RN, CCM, CS, clinical practice specialist with Baptist Health 2020 Health Solutions. **(For details on 2020 Health Solutions, see the related article on pg. 16.)**

"Our goal is to get our clients to make a commitment to take the smallest positive step. So many of them have lost confidence in their ability to stay healthy. If they can experience a small success, we can build on that. We use motivational interviewing to determine what they are willing to work on and to get to the crux of what might prevent them from being successful," she says.

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Editorial Questions

Questions or comments? Call **Mary Booth Thomas** at (770) 934-1440.

In the home health program, the nurses work with patients who have been hospitalized because of exacerbation of their chronic disease as well as those who need home health services for other reasons.

"Patients are so overwhelmed when they are in the hospital that they often don't understand their discharge instructions or what they should do. They don't know what symptoms indicate that they should call a physician. They are a very sick population and require a good bit of support," Evans says.

Some patients are not referred for chronic disease management but when the nurses go into the home, they realize that the patient also has a chronic disease that he or she is having trouble managing.

For instance, the nurse or physical therapist may be visiting the patient after a hip replacement and learns that the patient has diabetes and a blood sugar level that is out of control.

"We are seeing more and more patients with two or more chronic diseases. Due to overcrowded emergency rooms, a shortage of beds, and reimbursement constraints, hospitals are under pressure to discharge patients as soon as they possibly can. Since patients are in the hospital only a short period of time, they don't have enough time to absorb all the education on self-management that they receive," Suter says.

Patients in the 2020 Health Solutions program are referred by the self-insured health care system, which identifies patients who are not managing their chronic diseases well.

The nurses in the home health program make several home visits in the early weeks of the program to comprehensively assess the patient for their needs, to learn about the barriers in the home, and to develop rapport with the patient. In the 2020 employee program, the nurses may meet with their clients in the workplace instead.

"Studies have shown that it takes face-to-face encounters to develop a trusting relationship with an individual. Provider services over the telephone don't work as well," Suter says.

After the relationship is established, the patient is supported by telephone calls from the home-based chronic care specialist nurse and the telehealth nurse.

The nurses use laptops with air cards to access current patient information, enter new assessment information, and to document the patient encounters while they are in the patients' homes or at the worksite.

"We have a lot of point-of-care assessment tools built into the software," Suter says.

For instance, if the nurse administers an assessment for depression, the computer system scores it instantly and the nurse can talk to the patient's physician about the need for medication or referral to a counselor, right on the spot if appropriate.

Because the nurses document during the patient encounter and don't have to rely on notes or memory, the documentation is much more complete than it would be if they didn't have the laptops, Suter points out.

About 160 patients use telehealth monitors, which measure typical vital signs such as blood pressure, pulse rate, weight, and pulse oximetry, along with disease-specific information. The devices can be programmed to ask patients questions about symptoms every day. The patients transmit the data over the telephone on a daily basis to a computer database at the home health network, which is monitored and acted upon by telehealth nurses.

"The telehealth nurses are very experienced. They review the data seven days a week and if they don't look right, they intervene before the patient ends up in the emergency department. Depending on the situation, they may call the patient, send out the home health nurse if needed, or call the physician for orders," she says.

The telehealth nurse also helps provide positive reinforcement for the patients. For instance, if a patient's blood pressure drops to the recommended level, the nurse will call and praise him or her for a job well done.

"This helps the patients understand what variables are important, and it reinforces self-management," she says.

Based on results from the CMS demonstration project, the agency hired advanced practice nurses in key fields, including pulmonary medicine, heart failure, and diabetes.

They oversee the care being provided by the nurse generalist, make sure evidence-based guidelines are being delivered, and intervene with physicians on the nurses' behalf when they report that patients are not receiving recommended care.

*(For more information, contact says **Paula Suter**, RN, MA, CNS, CCP, director of chronic care management for Baptist Home Health and 2020 Health Solutions, e-mail: Paula.suter@baptist-health.org.)* ■

Program helps employees learn to stay healthy

Face-to-face encounters, telehealth keys to success

An overweight nurse with diabetes who works for Little Rock, AR-based Baptist Health System summed up the key to the success of the 2020 Health Solutions disease management program: "Knowing that you are going to be looking at my blood sugar levels helps me be consistent in taking my medication and checking my blood sugar," she told her disease management nurse, **Paula Evans**, MSN, RN, CCM, CS.

"She knew what to do, but having me check on her made her accountable to someone. She's lost weight and her blood sugar is under control," says Evans, clinical practice specialist with Baptist Health 2020 Health Solutions.

When the nurse joined the program, she already was going to a fitness facility and was a member of Weight Watchers, but she kept forgetting to take her medication, was not monitoring her blood sugar, and hadn't been to her primary care physician in more than a year. That's all changed now.

"Not everybody has such fabulous success but the people who participate in the program are more aware of what they have to do to stay healthy," Evans says.

Baptist Health Home Health Network created 2020 Health Solutions after the successful implementation of a disease management program for home health patients.

The home health agency shared the results of their home health patients' outcomes with the health care system administration and suggested using the same process with employees since the model can be applied to anyone with a chronic disease, says **Paula Suter**, RN, MA, CNS, CCP, director of chronic care management for Baptist Home Health and 2020 Health Solutions.

Many of the first employees in the program were diabetics who didn't understand the importance of testing their blood sugar or who were not taking insulin, either because they couldn't afford it or they didn't understand the importance of keeping their blood sugar under control.

"Our clinicians work with our clients in a way that they feel comfortable, divulging any ambivalence they may have with treatment as a first step toward facilitating behavior change. As a result of our work using motivational interviewing principles, we rectified a lot of those problems within the first months and, based on that, anticipate very good future results," Suter says.

The agency plans to enroll 100 to 150 individuals in the first phase of the program and use the cost savings to expand the program to include people with chronic diseases who have not been hospitalized or those at risk for developing a chronic disease.

"We know that early intervention can prevent hospitalizations and save money in the long run," Suter says.

Employees of Baptist Health, their family members who are covered by the health plan, and retirees have the option of joining the program if they have been hospitalized for chronic diseases.

The program is completely voluntary. To encourage participation, employees may choose from four benefit options if they participate in the program. Those include paying the generic-level copay for any medication related to a chronic disease; free membership in a fitness club; waiver of the two-year employment requirement to participate in the health system's weight management program; and an additional paid day off from work every quarter, Evans says.

When employees agree to participate in the program, a 2020 Health Solutions nurse visits them at work for a minimum of an hour and a half to complete a comprehensive three-part health and behavioral assessment and gather other information that will help in developing a plan of care.

"Whenever possible, we go to the worksite to make it convenient for the employees. If they are retired and home bound, we will make a home visit," Evans says.

Evans sees the employees in person at least twice, and follows up with them by telephone or e-mail, depending on the employee's preference.

"By meeting with them face to face, we begin to establish a rapport with the employees so they will feel comfortable working with us," Evans says.

The nurses ask the employees to bring in a list of all the medications they are taking and request their lab values and other information from the physicians.

Through an arrangement with a cell phone

service provider, the agency has purchased Blackberry phones with Blue Tooth technology that are programmed to collect data from blood glucose meters and scales and send the data to the database monitored by the 2020 telehealth nurses.

Evans sets up the employees with the Blackberry device and teaches them how to use it on her second face-to-face visit. The device reminds the clients to check their blood glucose consistently and is a communication tool between the nurse and client for coaching.

Employees with heart failure or those who are at home use a different device that interfaces with a telephone landline.

The heart failure patients enter their weight and answer questions every day.

"Having the device helps make people aware of what they need to do to stay healthy. For instance, a heart failure patient may not remember what her weight was last week but the computer will make her aware," she says.

The 2020 nurses work with the employees to develop goals and a plan for meeting the goals.

"We talk to them about their disease and how it impacts their lives and what they would like to change. We ask them to rate the things they want to work with on a scale of one to 10, depending on the importance," she says.

Sometimes the employee's initial goal may be as small as to walk for 10 minutes a day or cut out one soft drink a day.

"What's important is for them to experience success. We're there to be their cheerleader as they work on getting healthier. We follow up with them to help them continue working on their goals and progressing to new goals. As a clinician, it is so rewarding to engage the client in a meaningful way. It reminds me of why I went into nursing in the first place," Evans says. ■

Program cuts medication costs for hep C patients

CMs focus on appropriate management of the diseases

In the first year of a disease management program to promote effective treatment for hepatitis C, BlueCross BlueShield of Tennessee was able to cut medication costs for the treatment of the disease by $1.63 million.

The savings were generated by ensuring that physicians conduct genotype blood tests that indicate the recommended length of treatment and by working with members with hepatitis C to ensure that they complete their full medication regimen, says **Beverly Franklin-Thompson**, PharmD, regional pharmacy director for the Chattanooga-based health plan.

The purpose of the disease management program is to make sure patients are getting appropriate treatment regimens for the appropriate amount of time, says **Jocelyn Bryant,** RN, MSN, CCM, supervising clinical project manager.

Case managers in the health plan work with the members and their physicians to implement strategies to make sure that the members receive appropriate management of the disease, Bryant says.

"Treatment for hepatitis C is not well tolerated and can result in flu-like symptoms, depression, and diabetes. People who are taking medication for the disease can feel pretty miserable," she adds.

The health plan developed the program several years ago when data analysis indicated an uptick in the number of people receiving treatment for hepatitis C, Franklin-Thompson says.

"It wasn't so much that the acute cases were increasing, but there was an increase in the people who had been infected in the past and were becoming symptomatic and were realizing they have the diagnosis," Franklin-Thompson says.

Patients with hepatitis C often are asymptomatic for many years after the initial infection, she adds.

"The symptoms begin to appear 10 to 15 years later and include fatigue, joint pain, sore muscles, and jaundice," she says.

The health plan analyzes pharmacy claims each month to identify members who are receiving prescriptions for hepatitis C treatment.

Case managers call the members' prescribing physicians to verify the diagnoses and the dates they began treatment and to obtain clinical information about the patients.

When the program began, the case managers determined that physicians were not ordering genotype blood tests because they didn't understand the importance of the test in developing a treatment plan.

The genotype blood test determines the strain of hepatitis C that infects the patient, which will determine the length of treatment.

Different genotypes require different lengths of

therapy. For instance, genotype 1 is the most difficult to treat and requires 48 weeks of therapy; genotype 2 requires 24 weeks of treatment.

"The nurse case managers began educating the physicians about the importance of the genotype blood type test early in the treatment and notifying them that the health plan covers the cost of the tests," Franklin-Thompson says.

After the patients have been receiving treatment for a few weeks, the case managers call them and conduct an assessment and provide information about the disease and the treatment regimen, Bryant says.

They work with the member and the physician to develop a plan of care.

The case managers educate the members about possible medication side effects and the need to take the medications as directed.

They contact the members every 30 days for up to six months, and longer if necessary, working with them to help them comply with their treatment plan. In the 12th week of treatment, the case managers contact the members' physicians to determine the result of the viral load tests, which indicate whether the medications are working.

"The unique aspect of this program is that we are conducting outreach to the patient and the physician instead of waiting for them to contact us," Bryant says.

The case managers offer suggestions on how to manage side effects, which can include fatigue, nausea, and depression.

They help the members access other resources within the health plan or in the community and link them to community support groups that can help them cope with the condition.

"The main issue with members is the side effects. The case managers emphasize that they should not stop taking the drug until they complete the treatment regimen. Some patients stop the therapy because of side effects. Others stop because of the cost of the drug. We try to intervene and prevent that from happening," Franklin-Thompson says.

If patients stop the therapy because of side effects, they have to start the treatment course over and take the medication for the full 24 or 48 weeks, she says.

"We want to ensure that they take the full course of treatment so they have the best opportunity for success," Franklin-Thompson says. ■

Faith-based programs help Medicaid members

Initiative aims to reduce health care disparities

African-American women with diabetes showed significant health improvements after participating in Keystone Mercy Health Plan's "40-Day Journey," a faith-based educational program at local churches that emphasizes nutrition, exercise, medication compliance, and water intake.

Keystone Mercy, the largest Medicaid managed care plan in Pennsylvania, was awarded the "Recognizing Innovation in Multicultural Health Care" award from the National Committee for Quality Assurance for reducing health disparities and helping African-American women and their families receive appropriate services.

The "40-Day Journey," an educational program for diabetics, is a component of the company's Health Ministry Program, a faith-based wellness program that partners with community churches to help people learn to manage their chronic diseases. More than 2,500 people participated in the program at 12 local churches.

Participants in the six-week program achieved a 20% drop in triglycerides; a 22% drop in LDL cholesterol; a 17% decline in fasting blood glucose; and a 4.5% weight reduction as well as drops in resting heart rate and blood pressure, says **Tonya Moody**, associate vice president, health promotions and program development for the health plan.

Keystone Mercy collaborated with local hospitals, the American Diabetes Association, the American Heart Association, nursing organizations, the Philadelphia Department of Health, and the Philadelphia Mayor's Office of Health and Fitness to create the program.

The health plan and other coalition partners fund the program, which is supported by community faith-based organizations.

Recognizing that churches often are the most trusted point of contact for people in underserved populations, Keystone Mercy started its Heath Ministry Program nine years ago to address health care disparities among its Medicaid members.

"The local churches have a ministry to help their members stay healthy, and many of them have nurses who volunteer to help members with

their health care. We have developed a coalition of community churches and volunteer nurses who work with the community on health care issues," says **Maria Pajil-Battle**, senior vice president, public affairs and marketing for Keystone Mercy.

The purpose of the Health Ministry program is to educate women and their families about the importance of preventive care and regular screenings, to teach them the risks and warning signs of chronic diseases, and to increase their knowledge of stress triggers and stress management techniques, Moody says.

The health plan targets areas where residents have the highest instances of chronic diseases and comorbidities and work with local churches to present the programs.

"These are community programs, but we personally target our members and send them invitations to participate. We notify our providers in the community and ask them to inform their patients as well. The churches in the area let their members know about the program," Pajil-Battle says.

Other participants are referred by case managers and identified through gaps-in-care analysis.

The program's 40-Day Journey targets women with diabetes and educates them about the importance of healthy eating, losing weight, and increasing their daily cardiovascular activities. It emphasizes and reinforces the importance of seeing their primary care physician and complying with their medication regimen.

Participants meet once a week for six weeks in two-hour sessions that include lessons on topics such as medication compliance, exercise, healthy lifestyle changes, water intake, and nutrition as well as a cooking demonstration and a healthy meal.

To eliminate the numerous barriers for care that Medicaid members encounter, the health plan provides transportation and childcare for participants in the program.

"We want these women to understand what they need to do to stay healthy, so we have worked to remove all the barriers that might prevent them from participating in the program," she says.

"People on Medicaid have extremely stressful lives, and we know that stress can trigger an exacerbation of their chronic disease. We include stress management in our program to help them learn what triggers stress and how to keep it under control," Moody says.

In a related program that is part of the health plan's Health Ministry Program, "The Empowerment Tour for a Healthier Life," Keystone Mercy presented five conferences on different health care topics at five churches in communities throughout Philadelphia. More than 6,000 people participated.

Participants in all the sessions were screened for blood pressure, body mass index, cholesterol, vision, blood sugar, and breast cancer.

Sessions included breast health, diabetes and weight management, high blood pressure and stroke, heart health, and prostate health. The series ended with a program on depression and other behavioral health conditions. ■

Capture patients' attention with a photonovela

Creativity, collaboration key to success

People in health education are beginning to use a literature genre called a photonovela. This genre tells a picture story and is designed like a comic book with text in bubbles to indicate who is speaking.

William Smith, EdD, executive vice president for the Academy for Educational Development in Washington, DC, says photonovelas work best as an educational tool when viewed as an act of entertainment that coincidentally educates, not as a picture book curriculum.

"I think it is an entertainment medium which is terribly powerful as an education[al] one, as well," says Smith.

A visual medium with simple text, this written format works well with patients who have low literacy skills, says **Susan Auger**, MSW, owner of Auger Communications, a consulting and educational services firm in Durham, NC.

At the core of every photonovela is a story, and storytelling is a universal way of educating and sharing information, adds Auger. This makes it a relevant educational tool for many cultures.

A photonovela needs to have humor when appropriate, drama, and familiar language. Health care professionals tend to want to edit the drama out of the text, leaving only facts, yet a photonovela is not created by changing a brochure into dialogue bubbles, says Auger.

Photonovelas have been created to provide education on gestational diabetes, prenatal care, how to re-hydrate a baby, the prevention of HIV-AIDS, depression, post-traumatic stress, and substance abuse.

However, to make sure a photonovela adds up to time and money well-spent, it is important to pinpoint the learning objective up-front.

The Center for Addiction and Mental Health in Ontario, Canada, produced photonovelas targeting its immigrant communities on five topics that included depression, post-traumatic stress, drugs, alcohol, and gambling. This project began with the goal of improving mental health, addiction literacy, and service access, says **Antoine Derose**, BSW, the program consultant for policy, education and health promotion at the center.

The five topics to cover — and the decision to deliver the information in the form of photonovelas — came from the community members. It was gathered by holding a number of focus groups. Derose says the community members clearly stated they did not want to receive information in pamphlets with lots of scientific facts. Instead, they wanted something that was easy to read and would not draw attention to the reader.

There is strong stigma around mental health issues in many communities. People wanted to make sure that if they were reading something about depression or other mental health issues, those observing the material would not make assumptions about their reasons for getting information, says Derose.

Two creative styles

Once the topic and learning objective is selected, the creative process must be determined. Auger says there are two ways to create a photonovela. One is the community-controlled process where various members take the lead on script writing, the photo shoot, design, printing, and distribution.

"It is empowerment based in terms of community members taking control of the process. You've got health professionals that are seen as the outsiders who provide technical assistance," explains Auger.

The second process is to balance input between community members and health professionals, acknowledging that both have an important perspective. This team approach was used in the creation of a photonovela on gestational diabetes for Latino women.

To determine the meaning of diabetes and gestational diabetes for Latino women, Auger and her colleagues began to research diabetes programs that served the Hispanic community in the United States and also diabetes programs in the Latin American countries and Mexico, from which these women emigrated.

In addition, focus groups made up of Latino women who had experienced gestational diabetes were held. From these groups, a woman was identified to write her story in Spanish explaining her experience with gestational diabetes.

"That was the starting point of the photonovela," says Auger.

The woman's personal story was then given different dimensions to make it more universal. It was tailored to fit various teaching issues, different themes that emerged during research, and difficult teaching points or misconceptions. Two groups were formed to oversee the development process for the photonovela. They included a community advisory board and an expert advisory board made up of a multidisciplinary team that included diabetes educators, physicians, and midwives who served pregnant Hispanic women.

To determine whether to use the community oversight method for creating a photonovela or team effort, know your learning objectives, says Auger. If the goal is to create behavioral change within a particular group of people or a geographical location, then have them create the story and take ownership, she advises. If the goal is to create a more universal story that is relevant to a lot of people, then the team approach might be more appropriate.

An example of a community project is a photonovela created in the Dominican Republic, on which Smith worked. This piece was created to promote the use of condoms to prevent the spread of AIDS and was aimed at female sex workers, who were a key element in the creation process. The photonovela was about a man who would pay the sex worker more if she did not insist they use a condom. The tricks female sex workers actually used to talk the man into using a condom were woven into the story.

An imaginative artist worked with the female sex workers to develop the materials. "The storyline lent itself more to drawings. The photonovela was like a really hot comic book," says Smith.

The team approach was used by the Center for Addiction and Mental Health to create photonov-

elas that could reach a wide array of people. The idea was that these materials, which were written in French, could be translated into English, Spanish, and other languages to serve a wide array of people.

The teamwork was a time-intensive process, but it helped make the piece balanced. The community group and health care professionals worked closely to develop the storyline, according to **Saroj Bains**, creative consultant and production manager on the project. Also, a professional script writer was hired.

"We went into a writer's workshop where everyone had the scripts in front of them, and we went through it line by line, word by word to determine if one character would say something or if a better word might be used. That was the attention to detail that was foremost in the development of these photonovelas," says Bains.

The photonovelas were shot with a professional photographer and production team in public schools, because it is one location where diverse populations gather. Each topic was covered through snapshots of situations pertaining to a particular mental health issue. For example, in the photonovela on post-traumatic stress, a young boy is playing in the schoolyard with other children when a loud noise from a nearby construction site prompts him to run to the restroom to hide. He emigrated from a country at war and experienced a flashback. Through this story, the concept of post-traumatic disorder is explained.

Before the photo shoots, storyboards were sketched that determined the position of each person in the photograph. Each shot had been approved by the advisory boards.

When creating a photonovela, the production team must not only design the product, but also determine the distribution process. How the piece is distributed depends on its purpose.

The photonovelas pertaining to mental health issues were distributed to school boards, public libraries, community health care centers, and other sites where the target audience would have access to them.

Auger says the photonovelas she helps to create often are used in educational settings, read like a play, and discussed.

One of the strengths of a photonovela is it allows many different dimensions to be part of the story. For example, with the gestational diabetes photonovela, it was clear that when women were first diagnosed, they just heard the word "diabetes" and were gripped with fear because of bad outcomes experienced by close relatives. Therefore, the photonovela focused on the emotional impact of learning about diabetes.

To capture these dimensions and thus take full advantage of the photonovela as an educational tool, it is important to ask the right questions of the target audience, really listen, and then let go of the notion of being the expert, says Auger. ■

Photonovela to educate on nutrition

ESL speakers create copy that is easy to understand

A photonovela became a master's project for **Laura Nimmon**, MA, a doctoral fellow with the Social Sciences and Humanities Research Council of Canada and the Michael Smith Foundation for Health Research in Victoria, British Columbia.

Her MA research involved work with immigrant women who spoke English as a second language (ESL). Together, they created a photonovela — literature that looks like a comic book with photographs and captions — about eating well after immigrating to Canada.

She knew from the start of her project that she wanted to target the topic of language as a barrier to good health for women who immigrate to Canada. During her project research, she found that educational health literature was more effective when health seekers help create their own materials, because it is written in a way they can understand.

Nimmon says photonovelas were, therefore, the perfect choice for her project, because they are participatory. To create a photonovela, she went to the local immigrant center where a woman's group consisting of South American, South East Asian, and East Asian immigrants met once a week. Five women ranging in age from 35 to 72 participated in the project.

"Because a photonovela is participatory, the women chose the topic that was most important to them. They found that nutrition was the biggest hindrance to having good health in Canada and felt they ate better food in their native country," says Nimmon.

To create the photonovela on nutrition,

Nimmon hired a public health nurse to provide lessons on how to eat well on a low-income diet including exercise. This information was used in the photonovela to teach good nutrition. The group created a story about their experience of moving to Canada and not eating well. As a result of poor eating habits, they felt upset and depressed, and they gained weight.

In the photonovela, the main character goes to talk to her teacher about the problem, and the teacher brings in a nurse to teach the ESL women's group about diet and exercise.

The purpose of the photonovela was to create written information immigrant women could use to learn about eating well and exercising. Also, it helped to create community among the women in the group and other ESL-speaking women in Canada, says Nimmon.

"The idea was to create health literacy material that would be disseminated to all ESL-speaking immigrant women. They wrote the photonovela at a language level that was appropriate for them, so it is a fairly low language level. Therefore, immigrants of all language backgrounds can understand the English," says Nimmon.

A $3,000 grant covered the project expenses. The biggest portion, $1,000, was used to hire a person to put the manuscript together. Nimmon said at the time there was no software program available, but now "Comic Life" can be downloaded from the Internet for $30.

Another large expense was printing. She printed 50 copies for $500.

The rest of the money was used to hire the nurse to teach the class, provide food during work sessions, and other incidental expenses.

Each member of the women's group was assigned a task. For example, one was in charge of photography, another directed, and others were actors. A digital camera was used to take the photos.

The women felt a sense of empowerment by being given a chance to tell their story, says Nimmon.

The photonovela was distributed throughout immigrant centers in Vancouver, British Columbia. Staff members were so interested in the project, Nimmon did workshops on creating a photonovela and also wrote articles on the topic for their newsletters.

"I think it is a wonderful way to involve participants and users in the creation of health literacy materials. The only advice I have is do it," says Nimmon. ■

Photonovela to be introduced to Appalachia

Part of toolkit, new teaching opportunity provided

A photonovela is part of the diabetes tool kit **Sharon A. Denham**, RN, DSN, professor of nursing at Ohio University School of Nursing in Athens and director of the Appalachian Rural Health Institute, is creating for use in the Appalachian region. It will address family support for patients with diabetes.

Although it has not been used in the Appalachian region, the storyline of a photonovela creates drama and interest that has been shown to be appealing to other groups. Therefore, Denham decided to try it.

The toolkit will have two photonovelas. One will have a positive storyline and one a negative, but both will be used to generate discussion about family support for patients with diabetes. On the positive side will be a discussion on managing diabetes with family support, and on the negative will be a discussion about problems that occur when there is no family support.

Denham envisions educators using the photonovela in groups, with people playing characters and reading different parts or reading them silently before discussing the storyline. There will most likely be a guidebook on their use with a few discussion questions.

The whole idea of the toolkit is to provide ways for people to look at how diabetes is managed in their home and what the entire family can do to cooperate.

"Diabetes should be considered a family disease — not an individual disease — so the materials I am creating will be used with that in mind," says Denham.

The process for creating the photonovelas for the toolkit included the following steps:

- **Step One** — Determine the storyline and write the script.

Denham says developing the story took time as she worked through her ideas and simplified the language. She also had to get the storyline in the proper order.

- **Step Two** — Create a storyboard for the photo shoot.

Once the storyline was completed, Denham created a storyboard, sketching each page with stick figures to determine how to take each photo.

• **Step Three** — Create a shot book to determine the order to take the photos.

The photographer is involved in the creation of a shot book, says Denham. The story in the photonovelas happens over five days. Therefore, clothing changes had to be brought to the photo shoots.

Denham says she noticed that the photos in Hispanic photonovelas were taken at close range, showing facial expressions, but she wanted to show background, because place is important in Appalachia.

She solicited the help of a graduate student from Appalachia and her family members for the photo shoot. It was important to use a family so people in the photonovela looked like relatives.

The one mistake made with the photos is that all were taken horizontally, says Denham. She said it would be wise to create more of a map of how the photos will appear in the book in that one horizontal photo could cover one entire page.

• **Step Four** — Work with a printer to format the photonovela with the script in bubbles on each appropriate page.

There was lots of discussion during the formatting process, says Denham. During this time, she simplified language further. "The script has a different visual quality that you don't necessarily notice in a document, so it is a continual simplification process. You don't want the picture to be overwhelmed, and then it is a conversation taking place in the picture, so you must make sure the right person and the right dialogue are connected," explains Denham.

The design work and printing was the most expensive part of the process, costing several thousands of dollars. Denham had 300 copies of each version of the photonovelas printed for the initial pilot project. They are in full color, because that is more appealing than black and white, she says.

It's important that they are attractive, so people will pick them up and read them, says Denham. ■

BINDERS AVAILABLE

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COMING IN FUTURE MONTHS

- Case management starts with primary care
- Legal issues for case managers
- Helping seniors stay healthy at home
- Disease management for the underserved

CE questions

4. According to **Paula Suter**, RN, MA, CNS, CCP, director of chronic care management for Baptist Home Health and 2020 Health Solutions, when they began offering telemonitoring services for patients, they noticed that patients were not receiving evidence-based medicine.
   A. True
   B. False

5. Employees participating in Little Rock, AR-based Baptist Health System's 2020 Health Solutions program are equipped with Blackberries to:
   A. remind them to check their blood glucose levels
   B. serve as a communication tool between the nurse and client for coaching
   C. A &B
   D. none of the above

6. In its first year of a disease management program for hepatitis C patients, BlueCross BlueShield of Tennessee cut medication costs for the treatment of the disease by how much?
   A. $1.52 million
   B. $1.63 million
   C. $2.52 million
   D. $2.63 million

7. The process of creating a photonovela often includes the following steps.
   A. Identifying a personal story.
   B. Writing a script.
   C. Creating a storyboard.
   D. All of the above.

Answers: 4. A; 5. C; 6. B; 7. D.

CE objectives

After reading this issue, continuing education participants will be able to:

1. Identify clinical, legal, legislative, regulatory, financial, and social issues relevant to case management.
2. Explain how those issues affect case managers and clients.
3. Describe practical ways to solve problems that case managers encounter in their daily case management activities. ■

CE 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 **June** issue, you must complete the evaluation form provided in that issue and return it in the reply envelope provided to receive a credit letter. ■