Patient Education Management™

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

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IN THIS ISSUE

- Make sure all voices heard 16
- Unit-based classes a time-saving teaching strategy . . . 17
- Follow-up care helps avoid readmissions 18
- Initiative helps keep uninsured out of ED 20
- What do you do if you don't have data? 21
- Phone coaching saves $311,755 in health costs . . 22
- Yes, worksite weight loss programs do work 23

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Patient and family advisory councils help usher in a culture of family-centered care

To make council effective, create a partnership between patients/families, staff

Family-centered care is becoming a familiar concept. It is defined by the Institute of Family Centered Care in Bethesda, MD, as: "an innovative approach to the planning, delivery, and evaluation of health care that is grounded in mutually beneficial partnerships among health care patients, families, and providers."

Many health care institutions working to create a partnership find that the establishment of a family and patient advisory council is a good start.

These councils help bring patient voices into the discussion of ways to improve the care experience, says **Cezanne Garcia**, MPH, senior program

EXECUTIVE SUMMARY

Family-centered care often is initiated at a health care facility by the implementation of a patient and family advisory council. These councils are viewed as such a valuable way to improve the patient care experience that Massachusetts passed legislation that requires every medical center within the state to establish one in 2009.

Yet to make them valuable, they must be designed properly. In the February issue of *Patient Education Management,* we explore the steps to establishing an effective patient and family advisory council.

Next month, we will explore ways patient education managers can make use of such councils and other family members and patients to improve patient education resources and delivery. Also, we will discuss how patient education managers can work with patients and family members to ensure patient education follows the family-centered care concept.

and resource specialist for the Institute of Family Centered Care.

"Hospitals have found that advisory councils bring tremendous insights and can be a responsive sounding board," she adds.

What is valuable about councils is that not only can department heads, special committees, and others bring issues, topics, tools, or programs to them for review, but also these entities can return if they continue to have questions, says Garcia. This differs from the use of focus groups, which are disbanded once they have given their input.

While creating a patient and family advisory council is one of the traditional steps to implementing family-centered care, the philosophy of partnership must exist within the organization for it to be effective.

"If that philosophy is not present and acted upon, a family advisory board is not sufficient. You will not have family-centered care because you have a family advisory board," says **Michele Lloyd**, senior vice president for patient care and family services at The Children's Hospital of Philadelphia.

However, one way this health care facility uses families as partners to guide its decision-making process is via a family advisory council.

What does an effective patient and family advisory council look like? First, the majority of its membership must be patients and family. The Institute of Family Centered Care advises two to three family members for every staff member.

With staff members seated alongside families on the advisory boards, many points of view are heard, and the education process takes place, says Lloyd. If only families were on the council, there would be no partnership.

It also is important to put in place a good selection process for patient and family members as well as staff.

Membership selection is critical, says **Lora Harding Dundek**, MPH, manager of birth and family education and perinatal support services and co-chair of the University of Minnesota Children's Hospital, Fairview, parent advisory board in Minneapolis.

"We are looking for patients and families that have a variety of experiences both positive and negative, but more importantly, those that can broaden their view to support all patients and families. They really have to be able to take a broad view," says Harding Dundek.

It is a big mistake to seat parents with lots of complaints on the board simply because staff is stymied on how to resolve their issues, she adds.

Criterion for selection is an active relationship with the hospital or clinic system, says Harding Dundek. Parents must have had a child hospitalized for at least five days or made three visits to the University of Minnesota Physicians clinic system.

Interested parties fill out an information sheet and then are contacted by Harding Dundek and a parent member of the advisory council.

The interview includes probing questions about the candidates' experience to determine if they can broaden their view to speak for all parents and children.

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According to Garcia, it is good to have application forms with open-ended questions on all kinds of issues, such as ways the applicant would like to see care improved and the types of issues on which they would like to work. In this way, the selection committee can determine if the applicant is a one-issue person or can see the broader picture, says Garcia.

Sometimes, patients and family members are not emotionally ready to sit on an advisory council. These councils are not support groups, she adds.

Choose staff carefully

Although staff members are a smaller percentage of a patient and family advisory council, it is important to determine their selection process as well.

At Cincinnati (OH) Children's Hospital Medical Center, staff members apply for seats on the Family Advisory Council when terms expire in the same way family members do. Not only do they fill out application forms, but they also are interviewed by parents who sit on the advisory board. Yet these positions are in great demand, and more staff members apply than there are seats available, according to **Joy Bennett**, and **Kay Fricke**, parent coordinators and co-chairs of the Family Advisory Council.

In the past, the council looked for staff members who were simply knowledgeable about family-centered care. Now that family-centered care is more embedded in the organization, the council seeks staff members who are well-positioned and passionate about spreading family-centered care in areas where it is lacking.

The Children's Hospital of Philadelphia selects leaders from various areas such as nursing, the residency program, and the department of pediatrics to fill the eight staff positions on the advisory council.

"We select representatives from very large segments of our organization who can both take information back but also bring leadership decision making to the table," says Lloyd.

It's important to dialogue, engage, and exchange in educating one another, so in time the people from the hospital leadership team and the families have changed. It is always a rich and rewarding conversation when there is representation from both groups, says Lloyd.

Simply sitting at the table together engaging in conversation builds relationships and the partnership, says Garcia.

It's all about working together, adds Garcia, and collaboration means patients and family members learn about some of the opportunities as well as the realistic constraints within health care organizations. **(To learn more about creating a method in which all voices are heard, see article on pp.16.)**

Councils can be very effective. Input from the council is sought at The Children's Hospital of Philadelphia for all new building projects, whether a new radiology department or operating room. Also, it is involved in the designing of enhanced care coordination systems and with patient safety issues. Recently they helped with the design of the family-centered care pages on the web site to make them accessible and helpful.

At the University of Minnesota Children's Hospital, the council has assisted with the design of a new pediatric sedation service, the establishment of a new family lounge, and the design of a new children's hospital. It also provides input on processes and procedures. For example, members helped the children's units design an enhanced security system. Feedback is frequently provided to units on such issues as patient transfers and family presence at invasive procedures and resuscitation.

In 2009, the council's goal is to work more on parent-to-parent support. One idea to accomplish this goal is to hold a pizza night every few weeks where parents can connect with other parents who have children with similar diagnoses.

The council aligns its yearly goals with the medical system's strategic initiatives. One of the strategic initiatives for 2009 is patient satisfaction, explains Harding Dundek.

The purpose of the family advisory council at The Children's Hospital of Philadelphia is to provide advice, input, and recommendations to the senior leadership of the hospital. Family council members participate in the strategic planning sessions of the hospital as well.

"When councils are engaged in support of the work of the organization they have a much greater degree of success, satisfaction, and accomplishment," says Lloyd.

For this to happen, a senior-level staff member must sponsor the work of the council, taking part in meetings and providing information on any new work that is being initiated within the health care organization. ■

SOURCES/RESOURCES

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Making sure all voices are heard

Preparation for committee work a must

Some health care facilities provide medical treatment to people throughout the United States, while others serve those who live in the surrounding neighborhood. Whatever the demographics, it is important for a family advisory council to represent the diversity of patients and families served, states **Cezanne Garcia**, MPH, senior program and resource specialist for the Institute of Family Centered Care in Bethesda, MD.

EXECUTIVE SUMMARY

When selecting patients and family members to form a partnership with staff in creating a culture of patient-centered care, it is important to represent all people served by the medical center. In addition, it is important to make sure all the representatives know how to make their voices heard.

When Garcia worked at the University of Washington Medical Center in Seattle, getting all voices to the table was a constant effort because the institution served a five-state area. It is difficult for a family from Alaska to sit on a council that meets monthly in the state of Washington, she explains.

Some methods used to remedy the situation included bringing patient satisfaction data or comment cards from patients who lived some distance away to meetings. This information would help the council work on better ways to serve these families, says Garcia.

One committee that included family advisory members decided to trial a partnership system where a family advisory member in Washington would call a family advisory member in Alaska to discuss an issue and then convey his or her perspective at the meeting.

In addition to hearing from a good representation of the patients and families served, each council member must have an opportunity to provide input on the projects, issues, policies, and proposals discussed at each meeting. Time constraints make this difficult; therefore, meetings must be conducted efficiently. At Cincinnati (OH) Children's Hospital Medical Center, the co-chairs sit on opposite sides of the room and monitor the discussion to ensure everyone has a turn to speak.

With 39 people on the council, this can be difficult, but the rule is that no one provides input a second time on a topic until everyone has spoken. This year, a system of follow-up discussion via e-mail was initiated, so council members could make points they did not get a chance to make during the meeting or contribute something that occurred to them after the meeting, says **Joy Bennett**, a parent coordinator and co-chair of the Family Advisory Council.

Another important element of a successful council is preparing patient and family members. Without an orientation, it takes a long time to understand how the council works, says Bennett. Bennett and her co-chair, **Kay Fricke**, who is also a parent coordinator, started with a brief

one-hour session immediately prior to the first council meeting.

At the request of patient and family council members, they created a two-hour orientation on a separate day. This covers such topics as confidentiality, because many of the topics discussed at meetings cannot be made public.

All family leaders at The Children's Hospital of Philadelphia attend an orientation whether they sit on the family advisory council or fill some other role. The purpose is to help them understand some of the language and principles of family-centered care, so everyone within the organization has the same frame of reference, says **Michele Lloyd**, senior vice president for Patient Care and Family Services at The Children's Hospital of Philadelphia.

"The orientation is intended to help families take on a new role. While they are experts in being a family with chronic or complex illness, they have not served in a health care organization in a leadership role, and the orientation helps them take on that role," explains Lloyd. ■

Unit-based classes a time-saving teaching strategy

Create curriculum, train teachers, write action plans

Do you work with a unit on education resources for a homogeneous patient population? Do you find that the bedside nurses on this unit struggle with time management because they are repeating the same patient instructions to almost every patient they care for? Is it possible for patients on this unit to leave their room and go to a centralized location for about 30 minutes or so?

If the answer is "yes," then you might want to consider conducting unit-based patient education classes.

Early in 2008, Chicago-based Northwestern Memorial Hospital's patient education department approached the post-partum leadership team to determine if the staff would like to collaborate on such a project. The response was overwhelmingly positive.

The collaboration drew upon the expertise from both areas: The post-partum staff and advance practice nurse provided the clinical knowledge, and the patient education department provided the program structure employing sound educational principles.

EXECUTIVE SUMMARY

To save time at the bedside teaching patients individually, a class for new moms was designed for the post-partum units at Northwestern Memorial Hospital in Chicago. Learn more about its design and implementation.

During a four-month period, the patient education department worked with clinical staff to develop the learning objectives, supporting course content, and to identify teaching resources. The work was accomplished through a series of meetings, with a patient education specialist handling most of the discussions with unit staff.

The curriculum focused on the basics of care for both mom and baby during the first six weeks after birth.

"It took a while to whittle down the topics and really focus on what was important and what the moms needed to know during that first six-week period," says **Magdalyn Covitz Patyk**, MS, RN, BC, program manager for the patient education department at Northwestern Memorial Hospital.

The teaching plan drew upon the key topics reflected in the discharge instruction check-off sheet that the post-partum staff was currently using. There was one sheet for baby care and one for new moms, and each had 10-12 topics nurses would check-off as taught.

It was decided that unit-based nurses would teach the class. To assist, the patient education department devised a detailed instructor guide. It includes goals and objectives for class time and information on how to deliver the content. Some information in the guide is not covered in class but is included to make sure instructors have the correct answer should one of the patients ask. For example, it is not the policy of Northwestern Memorial to have staff use alcohol on a baby's umbilical cord, but if moms ask about the use of alcohol, they are told to follow their pediatrician's instructions.

To help train instructors, mentoring sessions were offered by a patient education specialist. The specialist would present the class to the staff instructor and teach them how to handle

questions in class. Then the staff instructor would present to the specialist. In this way teachers gained a greater comfort level before instructing patients and their family members.

Classes were to be held in the Patient Education room found on each unit. When a new women's pavilion was built, these rooms were designed to foster access to patient education resources and to provide a venue for conducting classes. The rooms seat about 12 people and have teaching tools available such as white boards, televisions, and computers with printers.

Participant sign-in sheets and a simple four-question evaluation form also were developed by the patient education department.

Before the class was launched, system issues were discussed and action plans devised. For example, management had to determine who would teach, what time of day to hold the class, and how to document the class on the patient's record.

Clarify roles

Each unit handled the scheduling of classes and patient care coverage for the instructors. Manager support was invaluable in assuring that the instructors had the out-of-staffing time while teaching the class.

The units are responsible for stocking handouts, sign-in sheets etc. Each new mom receives a post-partum book when admitted, but units supplement this book with internally produced patient education brochures.

The patient education department manages the data. That includes tracking the number of participants, information from the evaluations, and producing program summaries.

Staff nurses are responsible for following up with each patient to see if there are any additional questions, evaluating the response to teaching, and documenting the education in the medical record.

The class was first offered on one unit and then rolled out to the other two post-partum units at one-week intervals. This allowed the initial pool of staff instructors from all three units to team-teach the class and become more comfortable with their instructor role. It also provided the opportunity for other nurses to observe a class to see if they would like to teach the class.

During the initial pilot, the class was about 45 to 50 minutes long. Based on participant and instructor feedback, the content was "tightened up" and now the total class time is 30 minutes.

In most instances, the bedside RN sets the expectation that attending the class is an important part of discharge preparation. As needed, moms are escorted to the patient education room for class. Fathers/partners and grandparents are welcome to attend the class, but only the new mom participation is tracked. It has been seven months since the post-partum discharge class was initiated. During that time, 376 class have been conducted, with a total of 1,378 moms in attendance.

Participant evaluations have been very positive. All three post-partum units offer the class—most on a daily basis.

Currently, Northwestern Memorial patient education department is in the midst of exploring new teaching strategies to add more interest to the classes. Covitz Patyk says she hopes to increase the number of instructors. This would help share the work-load and prevent instructor "burn-out." ■

SOURCE

For more information on the design of unit-based classes, contact:

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Follow-up care helps avoid readmissions

Team helps patients navigate health care system

With the number of uninsured patients increasing rapidly, the case management and social work staff at North Broward Medical Center are faced with the challenge of making sure patients receive the follow-up they need to stay healthy and out of the hospital.

"In North Broward County, our hospital case managers and social workers work with the district

clinics and other providers to make sure our patients have continuity of care after discharge. We try to focus as much as possible on preventive care, so these patients manage their health care and reduce readmissions," says **Gavin Malcolm**, LCSW, coordinator of social services and trauma social worker at the Deerfield Beach, FL, medical center.

The hospital has seven full-time social workers, an emergency department social worker, and a trauma social worker, in addition to 20 case managers.

"We work as a team. The case managers and social workers are unit-based and work together to determine the patients' needs and how to meet them," he says.

Non-compliance with follow-up care is a huge issue with uninsured patients for many reasons. One issue is that people don't want to go to a clinic and wait for hours, Malcolm says.

South Florida has a large population that doesn't speak English. The hospital has some bi-lingual staff and uses a telephonic certified service to talk to people who do not speak English.

After the hospital implemented a process improvement project to increase compliance with follow-up visits, the percentage of uninsured patients who follow up with their scheduled initial appointment with the clinic rose from 7% to 15%.

"It's still miserably low, but it has doubled," he says.

The social workers and case managers use a central scheduling line to set up a primary care appointment before people leave the hospital.

"Because of sheer numbers, there is a long wait for appointments, so we try to set an appointment as early in the process as possible. Once they get established in the clinic, they can go there for medication refills without having to have an appointment," he says.

The social workers obtain contact information at assessment and confirm it at discharge so the clinic can call to confirm the appointment, but often, the patients can't be contacted for follow-up.

"Contact information can change on an almost daily basis," he says.

If preventive care is not possible, Malcolm encourages patients to go to an urgent care center, where care may be covered by tax funds, instead of coming to the emergency department. The urgent care centers and primary care clinics result in lower financial burdens on the patients and focus more on the patient's history while the emergency department has to stabilize the patients as efficiently as possible, he says.

"When we make the follow-up appointments, we give the phone number of the patient to the clinic so they can call to confirm the appointment," he says.

Malcolm talks to patients about the benefits of seeing a primary care physician, rather than visiting the emergency department for treatment.

"I point out that they will rarely get the same doctor or the same treatment at the emergency department, and that a physician who is familiar with them will give more consistent care. I also point out that the cost of follow-up at the emergency department is more than at a clinic," he says.

Once patients get established in a clinic, they tend to follow up at the clinic, rather than going to the emergency department, Malcolm says.

"The health care system is confusing for people who work in it every day. It's totally bewildering to other people, especially if there is a language barrier. Giving them education and connecting them with community resources keeps them out of the emergency department and keeps them from being readmitted," he says.

Any patient who indicates he or she is self-pay is screened to determine if he or she is eligible for Broward County Tax Fund assistance, a program that provides medical care for patients who do not have any type of health insurance, including Medicaid.

"It can take up to six months to get a patient approved for Medicaid. This makes it difficult to discharge patients in a timely manner. The county programs can issue approval the next day, so we can ensure that patients have follow-up visits, whether it's with the cancer center, a primary care physician, or a specialist," Malcolm says.

In addition to the financial and medical requirements, to qualify for Medicaid, a patient has to prove residency for five years. The Broward County Tax Fund requires the same financial information but proof of only 30 days residency in Broward County for people to qualify for the Star Card assistance program, he says.

"For people who have immigrated and lived here less than five years or who are undocumented, the Star Card would be the primary option," he says.

The program covers people whose income is up to 300% of the poverty level. Patients pay copays based on their income level.

The benefits include assistance with medications and outpatient, inpatient, and acute rehabilitation services and provides home health through a partnership with a home infusion and

home health care agency.

"It's essentially set up like an HMO once they qualify," he says.

People are ineligible for Medicaid if they have savings or other assets, he adds.

"In addition, people have to have medical issues before they can apply for Medicaid. The Star Card fills that gap. When I'm meeting with families, I encourage them to apply for the Star Card and get care at the clinics before they get so sick they have to be hospitalized," he says.

If people are undocumented, they can apply for tax fund assistance but not Medicaid.

"When a patient is in the hospital, I try to talk to the whole family. I tell them that I'm not interested in their immigration status, I just want to get them resources," he says.

Malcolm reports varying degrees of success in trying to help undocumented workers. Many times people say they don't remember their address or how long they've lived in the area for fear that they will be turned into the Immigration and Naturalization Service.

With the exception of people who have both criminal and medical issues and patients with tuberculosis or other public health risks, hospital staff do not notify the authorities of a patient's immigration status.

In the past year, there's been a huge increase in self-pay patients who previously had insurance, Malcolm says.

"People who were doing OK a year ago have lost their jobs, and they are scrambling to find health care for their families. And, there are a lot more people who are just one paycheck away from being homeless," he says. ■

Initiative helps keep uninsured out of ED

CMs help patients connect with PCPs

Case managers at the University of Michigan Faculty Group Practice help low-income individuals enrolled in a county-supported health plan learn to navigate the health care system and access primary care services so they can stay out of the hospital and the emergency department.

"Many of these patients have never received health care except by going to the emergency department. Many of them don't know how to make an appointment with the doctor for well care or when they are sick. We work on getting continuity of care for these patients. A big portion of our efforts is to educate them to access care appropriately," says **Donna Fox,** RN, health services manager and case manager for University Health System.

The practice, part of the University of Michigan medical school, includes all 1,500 faculty physicians who care for patients at three hospitals and 40 health centers operated by the University of Michigan.

The case managers manage individuals who are enrolled in the Washtenaw Health Plan, a partnership between Washtenaw County, the University of Michigan Health System, and St. Joseph's Medical Center, to provide medical coverage for low-income individuals who do not qualify for other public assistance health care programs.

More than 7,800 county residents are enrolled in the Washtenaw Health Plan, and about half of them receive their health care through the University of Michigan Health System. The two hospital systems absorb most of the cost for the care provided.

The program allows the uninsured to access health care appropriately, to make an appointment with the primary care provider, and to get referrals to specialists for medically required treatment, Fox says.

The case managers receive daily reports of patients covered by the plan who are admitted to the hospital or who have had an emergency department visit.

"We contact the patient to make sure they have gotten their medication, that they have a follow-up appointment with a primary care provider, and that they understand how to use the health system appropriately," she says.

The case managers explain the treatment plan and help the patients follow up so they won't have to go back to the hospital or have an emergency visit.

"Many of our patients simply do not understand how to manage their health care. They are confused by the system and don't know what to do," she says.

A lot of people sign up for the health plan while they are healthy, but they don't see a doctor to establish a relationship before they get sick, Fox points out.

Then, when they are sick and can't get in to see a doctor for several weeks, they end up back in the emergency department.

"We help them understand that if they are a new patient, it will take awhile for them to get in, so they should have a physical and get established with a primary care provider before they are sick. We help teach them that they should see a physician, not go to the emergency room, when they are sick and help them recognize the symptoms that indicate they should call for an appointment," she says.

The case managers are notified when a patient in the program is hospitalized or makes a visit to the emergency department, or if they call the health plan with questions, if they can't get an appointment with a doctor, or if they feel their doctor isn't listening to them.

Physicians also call the case managers to help when patients don't appear to understand the treatment plan.

"Sometimes it's a matter of low literacy, or they are just so overwhelmed by their illness and their psycho-social issues that they don't understand what the doctor says. They get home and they don't understand what to do, so they can call me for help," she says.

The case manager may attend appointments with patients to help them understand what the doctors are saying. They talk to the patient between visits to answer any questions and to make sure the patient is following the treatment plans.

If patients are referred to a specialist, the case managers follow up to ensure that the patients keep the appointments.

If the patients have problems paying for their medication or if it's not in the formulary, the case managers ask the physicians if there is a medication in the formulary that could be substituted. If that's not possible, the case managers help patients apply for a patient assistance program to cover the medication.

"We do whatever it takes to see that patients have continuity in care and that they get the assistance they need," she says.

For instance, they work with the state Medicaid agency to identify community resources, such as housing assistance programs, that can help the patients.

The case managers at both hospitals, representatives of the health plan, and county agencies meet regularly to talk about the program and how it might be improved.

"We brainstorm on some cases and help each other identify resources that might help our patients. We try to keep in tune with what is going on in the community, so we can assist the patients in receiving the help they need," she says.

Most of the patients are enrolled in the health plan at the county health department offices. They choose their provider based on proximity.

The health plan covers the working poor who have some income and may have children. Indigent people who otherwise qualify for Medicaid but don't have a health condition also also enroll.

The program has a limited formulary for medications that includes basic types of antibiotics, statins, and blood pressure medications.

"They picked those that are most prescribed and most cost-effective. These aren't the newest and most expensive medications, but ones that are reliable and frequently used," Fox says.

The co-pay is minimal — $3 for most medications. ■

What do you do if you don't have data?

You may not have "knock-your-socks-off" data to show that you saved your company thousands of dollars in health care costs because of a wellness program or other initiative. But there are still ways you can demonstrate success and, possibly, save the program or your job in the process.

"Look for things to measure that can bridge the gap if you don't have hardcore data showing ROI [return on investment]. You can still show that there are positive things being provided," says **Don R. Powell**, PhD, president and CEO of the American Institute for Preventive Medicine, a wellness program provider based in Farmington Hills, MI. Some examples:

- **Give participation numbers.**

"Clearly, the more participation you get for the activities that you provide, the more value is perceived," says Powell. Record the number of people who attended a lunch and learn or how many employees took a brochure at an occupational health "stop by" table.

- **Prove that employees are happy with what you are doing.**

Give employees a questionnaire that asks them to rate a service provided by occupational health as excellent, very good, good, fair, or poor. "You are then able to show the percentage of employees that say the service was excellent," says Powell.

- **Come up with small but eye-catching**

statistics.

Tell your bosses how many extra steps employees walked this week as a result of an occupational health program, suggests Powell.

- **List the "no cost" things you did.**

Report on initiatives that the company spent absolutely nothing on, says Powell. "For instance, people will lose weight by putting a scale in a key company location with the diet-plan-of-the-week above it.

"It gets people thinking about weight loss, so they can weigh themselves privately," he says. "Or, set up a stress reduction room, so employees have a place to go to listen to restful music, instead of drinking coffee, which is a stimulant." ■

Phone coaching saves $311,755 in health costs

Use this method to compute your own ROI

Demonstrating a program's return on investment (ROI) is more important than ever.

"To sell a program, you need to talk about more than just health outcomes. Business people are also looking for an economic calculation for how it might impact their bottom line," says **Ron Goetzel**, PhD, research professor of health policy and management at Emory University's Rollins School of Public Health and vice president for consulting and applied research at Thomson Reuters.

Researchers followed 890 employees enrolled for 12 months in a telephone-coaching program for obesity management, and measured 11 key health risk variables including nutrition, fitness, current smoking, former smoking, stress, cholesterol, blood pressure, alcohol abuse, depression, glucose, and body weight.[1] At the end of one year, the study found statistically significant reductions in seven health risk factors, including a 21.3% decrease in poor eating habits and 15.1% reduction in poor physical activity. The program saved $311,755, mostly from reduced health care spending costs and improved productivity.

Claims-based ROI studies typically require time and financial resources or skills that are not available or not justified, based on the scale of the intervention, says **Kristin M. Baker**, MPH, the study's lead author. "Thus, an evidence-based ROI model, such as the one presented in this paper, is an ideal tool for occupational health professionals to use to determine prospective or retrospective ROI in an efficient manner," she says.

Come up with a good estimate

You can use a similar method to establish a potential ROI for a risk reduction program in your workplace. "If you are able to determine what the actual parameters are, then you can plug in that data along with demographic population to come up with an estimate of cost savings. You can then subtract the investment cost to predict the ROI," says Goetzel, one of the study's authors.

If you don't have that information, though, Goetzel says you can make a guess and come up with a good estimate. "Let's say 30% of the population is obese, and you think the program will be able to reduce obesity rates by one percentage point a year. So, you would go from 30% obese to 25% obese in five years. You can plug that into the model, along with demographic information, age, gender, and medical costs. It will then predict how much savings you can expect over that five-year period."

The model used by the researchers can do this for 11 risk factors. "This is not easy to do. The foundation for our model is research we did over the last 10 or so years, using a large database that connects risk factors, demographics, and expenditures." Goetzel says.

Even if you don't have access to this type of detailed data, you can begin with studies that link certain risk factors to higher costs. Show how much more it costs to have a stressed or obese employee, for example.[2] "You need that basic information to do this kind of calculation," Goetzel says. "But you can do that kind of estimate on your own. Then, refer to research that shows you are able to change risk profile in the workplace.[3] And if you change risk, then you save money."

References

1. Baker KM, Goetzel RZ, Pei X, et al. Using a return-on-investment estimation model to evaluate outcomes from an obesity management worksite health promotion program. *J Occup Environ Med* 2008, 50:991-997.
2. Goetzel RZ, Anderson DR, Whitmer RM, et al. The relationship between modifiable health risks and health care expenditures: An analysis of the multi-employer HERO health risk and cost database. *J Occup Environ Med* 1998; 4:843-857.
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Yes, worksite weight loss programs do work

But results might be a 'best case scenario'

If anyone questions whether your company's workplace weight loss programs are really getting workers to lose pounds, you have a ready answer in light of a new review of studies.[1]

Researchers looked at 11 studies published since 1994 on programs to improve diet and physical activity, most involving education and counseling. They found that participants lost an average of 2.2 pounds to almost 14 pounds, while non-participants ranged from a loss of 1.5 pounds to a gain of 1.1 pounds. Programs involving face-to-face contact more than once a month were more effective.

The findings show that these programs work modestly in the short term for those who choose to participate, says **Michael Benedict**, MD, one of the study's authors, and an assistant professor in the Department of Internal Medicine at University of Cincinnati (OH). However, Benedict acknowledges that the programs that were looked at might be a "best case scenario," because subjects were mainly volunteers and highly motivated. "I would anticipate less success if trying to recruit a broader group of obese employees," he says.

The research doesn't give any information on weight maintenance or return on investment for employers. "There is also not much to guide us on how to optimally set up the program, although we believe frequent contact with employees — more than once a month — may be important," says Benedict.

CNE instructions/objectives

Nurses and other patient education professionals participate in this continuing education program by reading the issue, using the provided references for further research, and studying the questions at the end of the issue.

Participants should select what they believe to be the correct answers, then refer to the list of correct answers to test their knowledge. To clarify confusion surrounding any questions answered incorrectly, please consult the source material. After completing this activity each semester, you must complete the evaluation form provided and return it in the reply envelope provided in order to receive a credit letter. When your evaluation is received, a credit letter will be mailed to you.

After reading *Patient Education Management*, health professionals will be able to:

- **identify** management, clinical, educational, and financial issues relevant to patient education;
- **explain** how those issues impact health care educators and patients;
- **describe** practical ways to solve problems that care providers commonly encounter in their daily activities;
- **develop** patient education programs based on existing programs from other facilities. ■

COMING IN FUTURE MONTHS

- Using technology to improve patient teaching
- Making good staff selections when hiring
- Best practice for selecting vendors
- Education's role in demand management
- Improving education via a partnership with patients

CNE Questions

4. Patient and family advisory councils help bring patient voice into the discussion of ways to improve the care experience.
   A. True
   B. False

5. The right patient or family member for an advisory council implemented to create a culture of patient and family centered care might include which of the following traits?
   A. Ability to have a broad viewpoint.
   B. Positive and negative experiences.
   C. Having an unresolved issue.
   D. Answers A and B.

6. Ways to get input from a variety of patients to provide council guidance for the improvement of patient care might include which of the following?
   A. Patient satisfaction data.
   B. Comment cards.
   C. Telephone calls.
   D. All of the above.

7. A unit-based class is a timesaving method of education for all types of patient groups on all types of units.
   A. True
   B. False

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

Reference

1. Arterburn D, Benedict MA. Worksite-based weight loss programs: A systematic review of recent literature. *Amer J Health Promot* 2008; 22:408-416. ■

Use this formula for productivity savings

Researchers calculated the productivity benefits for 890 employees enrolled in a telephone coaching obesity management program, using these assumptions based on previous research:[1]

- If a person loses significant weight and also reduces another risk factor, 40 hours of productivity are gained annually due to reduced presenteeism.
- An additional 20 hours are gained for those who lose significant weight and reduce a third risk factor.
- An additional 20 hours are gained for those who lose significant weight and reduce a fourth risk factor.
- An additional 10 hours are gained for those who lose significant weight and reduce a fifth risk factor.
- Thus, the maximum productivity gain from losing weight and modifying another health risk factor is 90 hours. Annual productivity gain was monetized by multiplying total hours of productivity gained in the year by the participant's average hourly wage.

Reference

1. Burton WN, Chen CY, Conti DJ, et al. The association between health risk change and presenteeism change. *J Ocx Environ Med* 2006; 48:252-263. ■