Patient Education Management™

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

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IN THIS ISSUE

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For best results, create systemwide plan for overcoming literacy barriers

Organized committee tackles specific projects along the lines of members' expertise

Barriers to health literacy are best addressed if a systemwide plan is initiated, says **Kimberly Wicklund**, MPH, manager of health information & promotion at Group Health Cooperative in Seattle.

"If you don't address health literacy needs in a formal way, you will get pockets of change — but not systematic change," she explains.

What has worked at this health care institution is a network of diverse disciplines, representing such departments as health information, communications and community relations, continuing medical education, patient safety, pharmacy, web services, and health studies and interpretative services. They are called the Group Health Plain Language Network.

Wicklund says when she arrived at Group Health three years ago, she found that the people in her department were interested in a more proactive approach to health literacy but worked only within their sphere of

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Recently, The Joint Commission, based in Oakbrook Terrace, IL, announced it is investigating how diversity, culture, language, and health literacy issues can be better incorporated into current or new standards.

While many patient education managers have been involved in work on these issues to improve education and overall patient care, a change in Joint Commission standards could pressure institutions to formalize the process.

In this issue of *Patient Education Management*, we look at the efforts of a couple of institutions that already have formed committees focused on addressing barriers to health literacy.

influence, which was patient education.

To advance the process, Wicklund set up a workshop for her staff on health literacy, taught by an expert, and opened it to other departments, as well. As a result, about 20 additional people interested in health literacy attended. At the workshop, they realized that by working on health literacy within departments, they were duplicating efforts.

"It made sense for us to come together and do some information sharing and collaboration, for we were all working in our silos and reinventing the wheel. We had our first meeting in late 2006," says Wicklund.

Collaboration is the key to addressing health literacy issues systemwide, agrees **Nadia Ali**, MD, MB;BS, an academic internist with the University of Pennsylvania Health System in Philadelphia.

The Health Literacy Task Force at Pennsylvania Hospital was formed after Ali presented the results of a survey she conducted assessing barriers to health literacy focusing on printed health information given to patients. She gave the findings to the interns, residents, and nurses surveyed, as well as department heads and committees linked to the issues identified, such as the patient and family education committee. *(To learn more about her survey process, see article on p. 124.)*

The presentation of the findings helped Ali identify those who were interested in analyzing and addressing the issues, and a group of individuals from different clinical departments were invited to formally come together as a task force.

"The members of the task force also act as liaisons between the different departments and committees," says Ali.

Although both health care institutions are addressing health literacy, their methods differ, shaped by their unique circumstances. At Group Health, there were no extra resources to do the work, and staff members needed to justify the time spent on projects and meetings, according to Wicklund. Therefore, it was determined that the group would meet only quarterly. However, a listserv keeps them connected and allows others who are interested — but do not want to be involved in active work — to be included in the information sharing. The network has diverse representation across the organization.

Working groups are organized when a collaborative project is identified. People from the network are pulled into work groups that meet more regularly if the work is relative to their expertise. Those on the listserv who are not active often identify beneficial connections and advocate for health literacy.

Pinpoint projects

In the beginning, the Group Health Plain Language Network decided its reason for coming together to collaborate on health literacy was to create a plain language communication culture at Group Health.

Wicklund said the network determined it was important not only to identify the problem, but also the solution, so people could see what their

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role is when addressing the problem.

"Saying 'we will all use plain language in our communication with patients' is very solution-oriented. People understand it, because they see the kind of information patients get, and they see they can improve it. We planned it that way very strategically and set our goal as trying to promote a plain language communication culture," says Wicklund.

Projects completed at Group Health

Projects completed or in progress at Group Health include a toolkit posted on the Intranet that helps people understand how to use plain language. It has a comprehensive alternative word list, and suggestions for communicating orally in plain language and communicating in writing with plain language. It also has before and after examples of plain language.

A lot of information distributed by Group Health has been edited, such as a letter sent to patients from the lab that resulted in calls for clarification, because the language was confusing. All diabetes resources were revamped, as well. The material was in the form of a book but is now in a modular format, so patients are only given information that is relevant to them at the moment, and it is written in plain language.

Information on the Web site is now written in plain language, and a few nurses were trained to do presentations on health literacy throughout the organization. Currently, the group is in the process of editing the general surgery consent forms. The new forms, written at a fifth grade level, are being reviewed by surgeons and legal experts. Patients will be shown the completed form, as well. *(For details on the framework the network uses to approach the work, see p. 124.)*

"A lot of our accomplishments have been around communication and editing," says Wicklund.

Pennsylvania Hospital initiatives

The Health Literacy Task Force at Pennsylvania Hospital identifies barriers to health literacy and comes up with recommendations to address them, says Ali. For example, a new medication form was created, because available patient information is usually extensive, with readability levels above the fifth-grade, says Ali. Frequently, the authors use medical jargon.

"The form is very simple and brief, yet it assures that all-important aspects pertinent to a new medication are covered. Teach-back technique can be used once the form is filled out by the provider with the patient," says Ali. *(The form can be viewed at www.healthliteracynow.org/new-medication-form.htm.)*

People on the task force who have an intense interest and expertise on a topic are usually selected to do the work on a project. For example, a standardized needs assessment form is being written by two nurses with help from Ali. Once completed, all work goes to the task force for review.

Other projects in progress include the redesign of a patient admission brochure and organizing a group of lay people to evaluate the forms being used in the hospital. A web site with written health information designed for patients with low health literacy was created, and health providers are being encouraged to use it (www.healthliteracynow.org).

There are many organizations and resources that help committees address health literacy, says Wicklund — for example, the Minnesota Alliance for Patient Safety, which developed a statewide consent form. She used information from such resources when writing a charter for the official initiative. The Plain Language Initiative was formalized in October 2007 to coincide with health literacy month. ■

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Assessment can identify need for addressing literacy

For best results, narrow the survey focus

To assess the barriers to health literacy at the University of Pennsylvania Health System, **Nadia Ali**, MD, MB; BS, an academic internist, decided to conduct a survey of the interns and residents in the residency program and the nurses on the medical floors. The purpose of the survey was to help identify a need for addressing health literacy systemwide.

Because the topic of health literacy is so broad, she narrowed the focus to printed health information and broke it into three categories: patient factors, system factors, and physician-related factors.

The first question assessed the practice of the health care professionals with the question "How often do you provide health information to patients or their families?"

The next question looked at the factors that could affect their practice and was patient-related: "How often do patients or their families ask for printed or written health information?"

The third question was directed at the system: "Do you find there are resources available for providing written health information for patients on the floor?"

The last two questions addressed physician factors and were designed to determine their understanding of health literacy.

One read: "Do you agree or disagree that most written health information or most written health material or health pamphlets are difficult for patients to understand?"

Ali says the answer is true. "The question was to determine if they understood the concept of health literacy and how written health information can be a barrier itself," she explains.

The second question in this category read: "Do you agree or disagree that verbal health information is more effective than written health information?"

Ali says when verbal information is given, about 80% is lost by the time the patient leaves the clinic, and what they retain is often incorrect. "This question was basically geared towards knowing if the provider has understood the limitation of providing verbal information," says Ali.

The survey provided information on whether the institution had issues with written health information.

"The survey helped me establish a need for addressing the health literacy barriers and also helped shed light on the types of barriers that existed in my setting," says Ali. ■

To improve health literacy, follow QI model

Goal is to create a culture change

The way the Group Health Plain Language Network approaches work is based on quality improvement models, according to **Kimberly Wicklund**, MPH, manager of health information & promotion at Group Health Cooperative in Seattle.

That's because the network is trying to create culture change within the organization, which is similar to how a lot of improvement work is done in health care, she explains.

Therefore, the members of the network determined to get senior leader buy-in for its health literacy efforts, identify champions throughout the organization, train staff and raise awareness, create tools for people to use in order to implement the network's recommendations, and do some reporting and evaluation.

That's the framework used to approach the work, explains Wicklund.

To get senior leader buy-in, the network wrote a charter for an official initiative. Champions for health literacy weren't hard to come by, for the diverse makeup of the network meant there was at least one in most departments. They not only reinforce the message but also serve as gatekeepers for the information coming out of the department, says Wicklund.

The continuing medical education department approved a web-based training program, and the network developed a PowerPoint presentation about plain language and how to use it in order to address staff training and awareness. They also developed a toolkit for the Intranet with information on how to communicate in plain language. Articles about plain language are frequently placed in the staff newsletters published by the various departments.

Wicklund said a lack of resources has made reporting and evaluation more difficult to complete. Therefore, the network seeks opportunities

for evaluation where the results can be easily tracked. For example, the health promotion department wrote a letter to group health members in plain language and did not receive any calls from members confused about the content. Before writing letters in plain language, the department usually received about 20 calls about content. ■

Children learn asthma care while playing a game

Action cards based on actual patient comments

A board game to teach children how to manage asthma symptoms is being developed at Phoenix (AZ) Children's Hospital by health care professionals who staff the Breathmobile.

This mobile, self-contained asthma clinic provides free care to students at about 20 schools in the Phoenix metropolitan area. According to **Audrey Schoonmaker**, RN, BSN, a clinical nurse with the Breathmobile, children who are uninsured or underinsured find this service useful.

When the Breathmobile is parked at a school, children from the surrounding area are welcome to come for diagnosis, treatment, and follow-up, as well. When children reach the age of 18, every effort is made to transition them to adult services.

"Our goal when we started in 1999 was to decrease the amount of deaths of children due to asthma, as well as to decrease the number of missed work days and missed school days, because asthma is a financial burden on families and communities. Yet asthma is one of the most easily treated chronic illnesses for children," says Schoonmaker.

Education for these students and their parents, who are required to come to the appointment, is an important element of the treatment. Currently, families are given a book chosen by the parent advisory committee that is written at about a fifth-grade reading level and has lots of illustrations. In addition to the book, families are given one-on-one, individualized education, so if they are unable to read additional educational materials, strategies are incorporated such as pasting photos of a child's medications on a print-out of a clock. That way, parents know what time to administer the medicine.

The board game is a new tool that came about following a survey of the parent advisory committee that asked their opinion of the best way to learn. Methods for learning included games, video, verbal instruction, and reading, and 95% of those surveyed chose games.

Schoonmaker says the parent advisory committee is always consulted when changes to the program are considered. Often, what staff think will work for children and their families is quite different from what the group actually advises, she adds.

To design the game, Schoonmaker talked with children about the types of games they liked to play, and all were very familiar with Monopoly. Therefore, the first game format was similar to Monopoly. However, a quick telephone call to the company that produces the game determined that the question-and-answer format they had created for the Monopoly-style game board was a problem because it did not follow the traditional game rules.

Education as play

A new game board was created in the shape of a pair of lungs, and children progress across the board by answering questions about asthma correctly. As they do, they collect cards with pictures of the equipment they need to manage their asthma.

"The goal of the game is for the player to collect all the necessary equipment to take care of his or her asthma," says Schoonmaker.

Questions asked include why it is important to take asthma medication daily and what might trigger asthma.

While some of the spaces result in questions that earn equipment cards if answered correctly, other spaces result in the receipt of an action card. These cards contain statements such as "You went to your grandmother's house for the weekend and you didn't take your medicine. Now, you are sick." Players are penalized for their actions. For example, they may lose a turn because they have to be hospitalized.

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In an effort to teach children how to manage their asthma, staff at Phoenix (AZ) Children's Hospital created a board game, which was overwhelmingly endorsed by the parent advisory committee.

SOURCE

For more information about the asthma education board game, contact:

• **Audrey Schoonmaker**, RN, BSN, Clinical Nurse, Phoenix Children's Hospital, Arizona. Telephone: (602) 546-0345. E-mail: aschoon@phoenixchildrens.com.

The action cards were based on stories staff members actually hear from patients and families who come to the mobile clinic.

During the preliminary research just completed, the questions were evaluated for overall difficulty according to age group. Also, children were asked if they liked playing the game; what they thought was the best part of the game; if anything about the game was confusing; and if they had any ideas to improve the game.

The data that were collected will be evaluated. However a few observations were made during play that will determine how the game is used. Schoonmaker says children need an adult facilitator, because often all the correct answers to a question won't fit on a card. For example, a child may name a trigger that is not on the card.

Data were not only collected by playing the game with patients who come to the mobile clinic, but also at two summer asthma camps, as well. The data should help determine which age group is appropriate and how to use the game.

Staff envision using the game at the schools they serve, working with the students who have asthma in order to teach them how to proactively manage the disease. It also might be used at physician offices, says Schoonmaker.

A pharmaceutical company provided the funding to develop the game, and additional funds will be sought to produce and distribute it once the research is complete. ■

New heart institute gives education opportunities

Teaching spills out into community, as well

The new Ronald O. Perelman Heart Institute of New York-Presbyterian Hospital/Weill Cornell Medical Center in New York City, which opened Sept. 14, 2009, not only focuses on the diagnosis and treatment of heart disease, but also prevention.

According to **Holly Andersen**, MD, assistant professor of medicine at Weill Cornell Medical College and assistant attending physician who serves as director of education and outreach, the cardiac community is good at treating patients — but not at preventing heart disease.

"The new center does patient education, but also outreach education. The way to impact the disease is to put more money into prevention instead of the next best drug or medical device," says Andersen.

There are several ways the institute provides an opportunity for those who are not patients to learn about heart disease. A five-story public atrium, which is the gateway to the Perelman Heart Institute, has an interactive education resource center. While patients use the center to view videos at computer kiosks on procedures they are scheduled for and obtain other information, it is designed to attract and educate members of the public as well.

The waiting area for most family members is near the resource center. Andersen says that families are a captive audience at this time and are interested in heart health, because a loved one is having a procedure or being treated for a heart attack.

The public is drawn to the education resource center when they attend scheduled screenings for blood pressure, glucose, and lipids.

As people exit the resource center, they pass a healthy food kiosk with literature on the topic that includes how to read food labels and how to shop.

A comfort zone in the patient lounge is a place for patients and family members to come listen to presentations on nutrition, stress reduction, meditation, and massage therapy.

Opportunities for education are not limited to the institute. Andersen plans to take education on

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To prevent heart disease, education at the Perelman Heart Institute in New York City is spilling into the community via outreach efforts and events that draw people to the center.

prevention beyond the walls with community outreach. In preparation, she testified before the New York City Council in February and came away with ideas on how to help community members practice prevention. For example, she learned that in some communities, it is common to have fried chicken dinners with church members on Sunday. Therefore, she will come up with ways to get into these local churches and teach women how to make healthier meals by changing their recipes, so they use less salt and saturated fats.

Also, Andersen is working on a program with the American Heart Association aimed at school children. It will bring exercise into the classroom, especially in schools where there is no gym, and work for better nutrition in the school cafeteria.

In addition to educating the public, Andersen says there is a need to educate the medical community. Although heart disease is the number-one cause of death among women, they are not educated on the topic, because many see gynecologists during their childbearing years. These physicians must be taught to screen for risk factors, says Andersen.

It is never too early to begin education and screening; therefore, pediatricians must be educated as well, she says.

Prevention of heart disease is as much about physical activity, diet, sleep, and stress reduction as it is about blood pressure and the size of a person's waistline, says Andersen. Education and outreach can save lives by helping people adopt healthier lifestyles, she adds. ■

SOURCE

For more information about the education program at the Perelman Heart Institute, contact:

• **Kathleen Robinson**, New York-Presbyterian Hospital. Telephone: (212) 821-0560. E-mail: krobinso@med.cornell.edu.

Health plan, physicians collaborate on care

Pilot project focus: Care for people with diabetes

A unique partnership between a health plan and a physician practice is helping patients with diabetes get the care and resources they need to manage their disease.

The patient-centered medical home pilot project focuses on people with diabetes who are members of BlueCross BlueShield of South Carolina, BlueChoice Health Plan of South Carolina, the State Health Plan, or BlueCross Blue Shield Federal and who are patients of Palmetto Primary Care Physicians in the Charleston, SC, area.

The pilot project began in April using a model that integrates quality improvement, coordinated care management, and patient educational services into primary care practices.

Case managers located in the physician practice corporate business office act as liaisons between individual physicians and their patients between visits. They collaborate with the health plan's disease management nurses and certified diabetes educators to help patients comply with their treatment plan, receive the recommended tests and procedures, and reduce gaps in care. The physician office-based case managers contact the patients by telephone to help them schedule appointments with specialists and access community resources when necessary.

"We believe that if patients become more educated and better able to self-manage their disease and physicians are enabled to deliver evidence-based care, patients will experience fewer hospitalizations and emergency room visits and enjoy a better quality of life," says **Laura Long**, MD, MPH, vice president of clinical quality and health management for BlueCross BlueShield of South Carolina.

The program should reult in overall lower costs for employers and less absenteeism as well, she adds.

"Our employers are interested in patients being healthier and at work. They're looking beyond lowering their costs for health care. They want their employees to feel good on the job so they can be more productive in the workplace," she says.

Palmetto Primary Care Physicians receives the

traditional fee-for-service reimbursement for the care they provide patients, as well as an additional fee per participant, per month that allows them to fund the case management program.

In addition, through BlueCross BlueShield of South Carolina's pay-for-performance program, the physician practice receives quality-based bonuses, which reward the practice for improving quality and outcomes.

"Before we began this project, case management wasn't a reimbursable service, so it wasn't practical for the physician practices to have case managers. By realigning reimbursement, it allows them to provide a different type of service to support their patients and to take a more proactive approach to care. It helps the physicians focus on delivering evidence-based care and quality outcomes," Long says.

The program takes a proactive approach to care and reaches out to all patients who have been identified with Type 1 or Type 2 diabetes, Long says.

"In the past, programs focused on the most complex patients. All patients are eligible for this program. Rather than just treating the patients who walk in the door, the program also reaches out to the patients who are not coming in for services and helps them overcome the obstacles to seeking care," Long says.

Once patients are identified for the program, they receive a welcome letter from the physician practice and the health plan. The introductory packet includes information on the physician practice's extended care hours, an offer for a free glucometer from the insurer, and a blood sugar tracking booklet.

The case manager follows up with a telephone call to ascertain the patient's willingness to participate. Interested patients receive another packet with information on diabetes and tips for better nutrition, diet, and exercise.

The program is an opt-out program to which most have responded favorably when the case managers call to explain the project, says **Amber Winkler**, MHA, case manager with Palmetto Primary Care Physicians.

After the initial call, case management outreach is customized based on the needs and requests of the patients.

The physician-based case managers are non-clinical staff who provide support and resources for the patients and work with the BlueCross BlueShield clinical disease managers to ensure that patients get the clinical information they need.

Each physician-based case manager works with about 500 patients.

"We strictly avoid giving patients clinical advice. We concentrate on giving the patient the resources they need to follow their treatment plan," Winkler says.

For instance, the physician-based case managers make sure that the patients keep their appointments to see their doctor, facilitate referrals when needed, make sure that the patients' test results get back in the chart, and help patients overcome obstacles to adherence.

They provide additional resources to the patients, including free week passes and discounts to local gyms; cookbooks; American Diabetes Association-approved nutrition materials such as meal plans; diabetic education classes; free glucometers; discounts on prescriptions or free samples of medication; and patient assistance programs.

Patients have access to the case managers at the corporate office and their physician offices through a secure web-based portal.

"We look at information like their last appointment date, gaps in care, and their most recent laboratory values. We assess what they are willing to learn about and do to manage their condition. When patients need clinical advice, we help them interface with the BlueCross clinical diabetes educator and their physician's office," Winkler says.

The improved communication, coordination, and interaction between the physician offices and the health plan are unprecedented and are a key component of the program, Long says.

In the past, the two organizations tended to work in silos. Now they work together to make sure that the gaps in care are covered, she adds.

"Before we started this program, case managers and disease managers at the health plan level communicated with members and occasionally talked to someone in the physician offices. Under this model, we're tightly interfaced with the case manager in the physician office through an electronic link into the electronic medical record in the doctor's office," Long says.

"It's been a great arrangement for both of us. It's opened up a lot of communication between the physician practice and the insurer. Having direct contact with the insurer is a big help," Winkler adds.

For instance, the arrangement allows the health plan's diabetes educators to access patients' medical record and care plan as they work with them.

"The ability to follow through and the level of communication are significantly enhanced. The

diabetes educators can add an electronic sticky note for the case manager or physician based on the conversation they've had with the member and vice versa," Long says.

By having access to the health plan's data, the physician office case manager can tell if the patient actually filled his or her prescription and can discuss it with the patient on the telephone and get the patient medication assistance or a coupon for a prescription if needed.

"We work so closely with the health plan and know our patients so well that we can advise them on the best way to get prescriptions or supplies. We have access to each patient's individual coverage so we can advise the patients what is best for them," Winkler says.

For instance, the case managers have suggested that patients consider generic drugs or a different glucometer because they would be covered under their plans.

One patient was paying out of pocket for his glucometer strips. Winkler advised him that his health plan would pay for the strips if he got a prescription for them and paid the copay.

"Benefits can be so complex and so difficult for patients to understand. We try to work out the best way for the patient to get what they need and pay for it so they will keep following their treatment plan," Winkler says.

The case managers take an individualized approach to each patient's unique situation, identifying why gaps in care occur and working to overcome the barriers.

"We look at whatever we can rearrange to make the situation workable. If the patient is on a high-deductible health plan and can't afford the deductible, we see if they qualify for a patient assistance program," she says.

They assist patients who are eligible for Medicaid supplemental insurance but need help filling out the paperwork.

In some cases, the case managers work with the health plan to get an out-of-contract social worker visit authorized as an alternative treatment plan.

"Within this pilot, we have the ability to be flexible on a case-by-case basis," Long says.

In one instance, a patient who had lost his job was afraid to come into the office with a broken toe and an infection because of financial problems. The case manager at the physician practice called the health plan to get approval for an office visit and get him help with his medication needs.

"The health plan bridged a gap until the physician office case managers could get other resources in place," Winkler says.

The physician office case managers have compiled a tremendous amount of information on community resources and other programs that can help patients overcome their obstacles to getting care or complying with the treatment plan.

"Since the case managers are in the Charleston area where the patients live, they are able to identify an amazing amount of community resources that help patients overcome the barriers to care. The case managers at Palmetto Primary Care Physicians have wonderful social and organization skills, which help them connect with the patient and identify their needs. Anytime they need us, they can call us in and we'll get involved," Long says.

The physician office case managers work closely with the patients to make their health care dollars stretch.

"Many times when we get to know the patients, we find they are spending money unnecessarily on things that are covered by insurance and are skimping on things that they really need. We utilize every resource we can find to help the patients get what they need to keep their disease under control," Winkler says.

For instance, when the case managers can help patients find transportation assistance or get help with an electric bill, it frees up money to pay for medications, or if patients can get low-cost generic drugs, they can use the money they would have spent on drugs for their copay.

"It's kind of like a shell game, a matter of arranging and maximizing the patient's available dollars. The case managers have been very adept at identifying community and health plan resources to fill the gaps in care," Long says. ■

CMS through the continuum help keep patients healthy

Organization provides seamless continuity of care

A comprehensive case management program at Desert Oasis Healthcare that provides care coordination for patients throughout the continuum keeps patients healthier and out of the hospital. And it's cost-effective.

"Our belief is that excellent patient care is also the most cost-effective care. We try to fill all the gaps in the health care system and give patients the

support they need to stay healthy and out of the hospital," says **LaDonna Headley**, RN, director of case management for the IPA and medical group.

The case management program at Desert Oasis Healthcare has multiple components that work hand in hand to provide continuity of care for patients along the continuum, Headley says.

"We have different programs to take care of a patient's needs throughout the continuum of care. They can go from one program to another or be in multiple programs simultaneously, if needed," Headley adds.

Desert Oasis Healthcare is a team of primary care physicians and ancillary providers. The organization has headquarters in Palm Springs, CA, with offices located throughout the Coachella Valley area. The medical group is a full-risk provider with most of the health plans.

The Desert Oasis physician group provides care for about 22,000 seniors enrolled in Medicare Advantage and a total of 78,000 patients. The 30-day readmission rate for Medicare Advantage patients enrolled in Desert Oasis is between 11% and 12%, Headley says. This compares to an average of 19.6% readmitted within 30 days for traditional Medicare beneficiaries, according to a study in the April 2, 2009, issue of the *New England Journal of Medicine*.

Case managers who are employed by Desert Oasis work in local hospitals and nursing homes to ensure that patients get the care they need in a timely manner. Intensive case managers coordinate follow-up care for patients with complex needs and multiple comorbidities. Case managers follow up with patients who have been discharged from the hospital or the emergency department.

Desert Oasis' Living and Aging Well program provides an array of services for seniors, including in-home physician visits for homebound patients, disease management for chronic diseases, and health education programs.

In addition, Desert Oasis provides case managers on call around the clock so that if a patient or a physician calls, he or she always speaks to a live person.

"We're always looking at better ways to serve our patients. We want to be the GPS for our patients to help them navigate the health care system and to provide care that is coordinated and timely," Headley says.

The case managers call any patients who made an emergency department visit and those who are discharged from the hospital within 24 hours to ensure that they get follow up.

In addition, when patients make an emergency department visit or are admitted to the hospital, the case management team analyzes each case to determine what, if anything, could have been done to give them the service and medical care they needed to prevent the admission, Headley adds.

"We are always looking for gaps in care and ways that we can eliminate them," she adds.

Desert Oasis has its own staff of case managers in four local hospitals and a regional tertiary medical center who work with the hospital case managers to coordinate care.

"Hospital case managers have numerous responsibilities, and our case managers help supplement their care coordination efforts. When a consult is ordered with a specialist, they make sure the consult is done in a timely manner that day and doesn't fall through the cracks in the system because the cardiologist office wasn't notified," Headley says.

The Desert Oasis case managers make sure that when the physician orders a test or procedure, it gets done in a timely manner and the information is in the chart.

"We make sure there aren't discharge delays because of lack of transportation or because the information the physician needed wasn't in the chart," she says.

The Desert Oasis case managers spend time with patients and family members and assess the patient's support system and the situation at home to determine if the patient may need additional care after discharge.

For instance, there may be an elderly patient whose wife doesn't drive after dark. The case manager makes sure the discharge happens early in the day so he will have transportation available.

Often, the hospital-based care managers identify high-risk patients who could benefit from other case management programs.

When they leave the hospital, patients receive a Desert Oasis discharge card with a dedicated number to call 24 hours a day, seven days a week with questions about follow-up care.

"We want to know about it if the patient has problems understanding his medication regimen or home health doesn't come when expected. Those are things that can lead a patient back to the emergency department," Headley says.

Desert Oasis's outreach clerical staff call patients after discharge to make sure they have a follow-up appointment with their primary care physician.

A nurse case manager follows up the day after discharge to make sure the patients have gotten

their prescriptions filled, are not experiencing any problems, and that their support system is in place.

"We work closely with the emergency departments at our four local hospitals. If they identify patients in the emergency department who are not necessarily being admitted but need follow up, they call our case manager," she says. Desert Oasis has case managers on call around the clock.

It has developed an intensive case management program, staffed by RNs with emergency department and intensive care unit experience to coordinate care for at-risk patients with complex needs that aren't being met.

Patients eligible for the program have multiple comorbidities, are frequently hospitalized, make frequent visits to the emergency department, or have been diagnosed with cancer.

Referrals come from primary care physicians, emergency department staff, skilled nursing facilities, home health providers, and the physician group's customer service line.

When a patient is referred to the program, the intensive case manager reviews the patient's chart and immediately calls the patient to determine what is going on.

When the situation indicates it, the intensive case manager and a physician see the patient in the home, often within an hour of getting the call.

"Whether we see the patient in person or handle it by telephone depends on the patient and the patient's needs," Headley says. ■

CE Answers: 1. A; 2. E; 3. D; 4. B

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

- ■ Role of education in demand management
- ■ Online classes for better outreach
- ■ Using technology to teach children and their families
- ■ Improving retention with photos
- ■ Education to curb the obesity epidemic

CNE Questions

1. According to Kimberly Wicklund, MPH, manager of health information & promotion at Group Health Cooperative in Seattle, barriers to health literacy are best addressed if a systemwide plan is initiated.
   A. True
   B. False
2. One way to approach work on helth literacy is by using a quality improvement model that includes which of the following?
   A. Obtaining senior leader buy in.
   B. Identifying champions of the cause.
   C. Staff Training.
   D. Reporting and evaluation.
   E. All of the above
3. Improving health literacy can be accomplished in many ways at a health care institution including which of the following?
   A. Creating a task force.
   B. Editing for plain language.
   C. Asking staff not to use “medical jargon.”
   D. A&B.
4. According to Holly Andersen, MD, director of education and outreach at Ronald O. Perelman Heart Institute of New York-Presbyterian Hospital/Weill Cornell Medical Center in New York City, prevention of heart disease is best taught at a health care facility.
   A. True
   B. False

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I certify that all information furnished on this form is true and complete. I understand that anyone who furnishes false or misleading information on this form or who omits material or information requested on the form may be subject to criminal sanctions (including fines and imprisonment) and/or civil sanctions (including multiple damages and civil penalties).

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