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

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Literacy coalitions: Fruitful partners in literacy efforts

Improve training of health care providers and consumer education

To improve health literacy, a key factor in effective patient education, medical facilities may want to consider forming partnerships with literacy coalitions in their area.

The Literacy Coalition of Central Texas, headquartered in Austin, began collaborating with health care institutions when it needed help in creating educational materials to improve health literacy among its clientele.

Adult literacy instructors teach students who are at high risk for low health literacy; therefore, it makes sense to create health literacy-related lessons or to incorporate health information into existing lesson plans, says **Peter Morrison**, health literacy coordinator for the Literacy Coalition of Central Texas, which is a network of literacy programs in a five-county region.

Presently, these partnerships also give the coalition an opportunity to

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Improving the health literacy of the population served, as well as the skill of providers in communicating with patients with low health literacy, is a goal of most medical institutions.

Realizing that goal is much easier when partnerships are formed with agencies that work with a segment of the population that is most likely to struggle in the area of health literacy.

In this issue of *Patient Education Management*, we look at the work the Literacy Coalition of Central Texas, headquartered in Austin, is doing in the area of health literacy. The coalition's activities are designed to improve communication between patients and providers in order to achieve better health outcomes.

This effort involves a collaboration between those in the field of literacy and those in health care, which patient education managers may find a perfect fit.

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work with health care providers to improve their understanding of health literacy and their ability to communicate with all types of patients.

Morrison says it is important to work with both consumers of health services and health care providers. Health literacy is described as a person's ability to obtain, understand, and process health information and services in order to make appropriate decisions. Good communication is always a shared responsibility between the provider and the patient, says Morrison.

"It is not only our goal to teach effective communication to health care providers, but we are training the adult literacy instructors, all of whom teach students who are at the high-risk levels for low health literacy," says Morrison.

How might patient education managers/coordinators benefit from such partnerships? Morrison says literacy programs can help form focus groups to test the effectiveness of written materials and educational programs in reaching the patient with low health literacy patient.

He adds that literacy organizations often have expertise in the area of health literacy and can save health care organizations time and money by providing information and suggestions about the needs of the local community.

They often have the demographics of the people in the area with low health literacy, who might access the local hospitals and clinics as patients. For example, in Central Texas, the population consists of those who speak English as a second language and native English speakers, says Morrison. He adds that in Central Texas, one in five English speakers can't read or write well enough to fill out a job application.

"Most of our clients fit into the high-risk populations that the American Medical Association identifies, which are elderly, low income, unemployed, minority ethnic groups, and people who speak English as a second language," says Morrison.

However, he warns that at the same time, it is important to understand that it is hard to put a face on low health literacy, because it is so widespread. He says more than one-third of the population, or 90 million Americans, struggle with low health literacy.

In addition, someone who is an expert in a professional field may have no clue about navigating the health care system or communicating with a physician. It is important not to assume that someone has high health literacy, because he or she does not fit the high-risk groups, says Morrison.

Targeting low health literacy

To target low health literacy in all segments of the population, the Literacy Coalition of Central Texas created Healthcare Provider Workshops that are customized for each group. These workshops on health literacy are for anyone in health care, from nurses and physicians to receptionists.

Health care institutions may want to look into training programs offered by local literacy orga-

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nizations before duplicating efforts and creating workshops on their own.

What they would find in workshops offered by the coalition in Central Texas are sessions ranging from simple to detailed. For example, there are 20-minute presentations that introduce the importance of health literacy. Also, there are half-day, interactive workshops in which audience members participate in activities to help them empathize with patients with low health-literacy, practice the Chicago-based American Medical Association's (AMA) six steps to improved communication, and create patient-friendly materials.

"Once we have identified who is at risk for low health literacy — and how you can identify patients with low health literacy — we do some activities and role plays to help address low health literacy using the AMA's six steps to improve interpersonal communication with patients," explains Morrison.

The six steps advise health care providers to slow down; use plain, nonmedical language; show or draw pictures; limit the amount of information provided and repeat it; use the teach-back or show-me technique; and create a shame-free environment.

Morrison says that coalition trainings frequently offer continuing education credits for medical professionals who attend workshops on addressing low health literacy.

Experts from the Literacy Coalition of Central Texas also help health care institutions improve patient access to medical care by conducting a walk-through of a hospital or clinic to determine how easy the facilities are to navigate. Also, they pinpoint where improvements might be made. Signs can be particularly confusing, says Morrison. Families are looking for children's health and may not know the meaning of pediatrics.

"Medical language is a completely different language. People may speak English fluently but not speak medical English fluently," explains Morrison.

Paralleling the health care provider workshops, the Literacy Coalition of Central Texas offers health literacy workshops for adult education instructors.

The workshops cover the importance of teaching health literacy to adult students, which topics are important to teach in the classroom, strategies to incorporate health-related material into existing curricula, and methods for creating one's own health-related lessons.

Instructors are encouraged to cover three major areas, says Morrison. The first is health care access and navigation, to include finding a physician and understanding when it is appropriate to use the emergency department or urgent care — and when and how to make an appointment at a clinic.

To aid teachers, nurses, social workers, and other professionals in helping Central Texas residents access and navigate the health care system, The Central Texas Healthcare Resource Directory was developed. The directory is designed to help community advocates make referrals for low health literacy, uninsured, or underinsured community members to appropriate health care services.

The second area of education is disease prevention by focusing on good nutrition, stress management, and regular screenings. For example, the instructor may introduce the food pyramid, and then use a grocery flyer to help students plan inexpensive meals, based on the guidelines of the food pyramid.

A third area of coverage is disease management. This curriculum helps students learn to read prescriptions labels, follow a medication regimen correctly, and know what questions to ask physicians during an office visit.

The goal of this education is to empower the patients, so they can be advocates for themselves and their families in the health care setting, says Morrison.

A joint effort

Creating a community that is 100% health-literate takes a joint effort, says Morrison. Therefore, the Health Literacy Action Group was established by the coalition. The group currently consists of 12 members with expertise and an interest in health literacy. To form the group, the coalition invited certain people from the community, such as the health educator from a clinic, a professor from the University of Texas, Austin, and the owner of a company that develops plain-language materials for health care providers. These people were told to bring others interested in health literacy to group meetings.

At the last meeting of the action group, members discussed the seven goals to improve health literacy issued by the U.S. Department of Health

and Human Services as part of its National Action Plan to Improve Health Literacy.

"We shared the ways in which members of the group are currently addressing each goal. In recognizing the areas of the seven goals, which we are already addressing, we were able to see the gaps that are left and develop plans to address those issues. Overall, we have decided to use the goals as a framework for our group's development and action plans moving forward," says Morrison. (*To learn the seven goals, see the story below.*)

SOURCE

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Seven goals of health literacy

Ways to improve

The seven goals to improve health literacy issued by the U.S. Department of Health and Human Services as part of its National Action Plan to Improve Health Literacy are:

1. Develop and disseminate health and safety information that is accurate, accessible, and actionable.
2. Promote changes in the health care system that improve health information, communication, informed decision-making, and access to health services.
3. Incorporate accurate, standards-based, and developmentally appropriate health and science information and curricula in child care and education through the university level.
4. Support and expand local efforts to provide adult education, English language instructions, and culturally and linguistically appropriate health information services in the community.
5. Build partnerships, develop guidance, and change policies.
6. Increase basic research and the development, implementation, and evaluation of practices and interventions to improve health literacy.
7. Increase the dissemination and use of evidence-based health literacy practices and interventions. ■

Improve health literacy with presentations

Keep in mind terms of engagement

To address the issue of low health literacy, The Humana Foundation is seeking ways to engage consumers at presentations on the subject. Presenters have been particularly successful with seniors, by dumping the PowerPoint and capturing the attention of this group of consumers through interaction.

"Interaction is a powerful tool for engagement," says **Charles Jackson**, project manager for The Humana Foundation, based in Louisville, KY.

To engage an audience of seniors gathered for lunch at a Senior Center, Jackson and presenter **Ken Schulz**, a consultant for Human MarketPoint, used a skit to introduce the topic.

"We performed misdirection on our audience, and that was a good thing. They thought they were going to get a lecture, and we delivered a play. I believe it caught them by surprise and allowed them to let their guard down a little. It was fun to be at a play and not a study hall," explains Schultz.

Seniors often worry about their health problems, yet they don't ask the physician questions, says Jackson. He explains that seniors are often overwhelmed by doctors as authority figures and by a complex health system. Many seniors also face chronic multiple health problems, with a lot of time to worry about possible consequences. Many factors encourage silence, including fear, embarrassment, confusion, poor vision or hearing, and low health literacy.

The presentation that included the skit was designed to help seniors improve health literacy by obtaining basic health information they can understand and using the information to make good decisions.

Part of that process is making sure they understand what their physician tells them and then sug-

EXECUTIVE SUMMARY

Health care organizations are exploring ways to improve health literacy among consumers. The Humana Foundation, based in Louisville, KY, has added the topic to the menu at its speaker's bureau. Yet education is not based on content alone, but also on the method in which it is delivered. A presentation must engage the audience to make the most impact.

gesting they ask questions to clarify health issues and recommended treatment methods.

To highlight the importance of asking questions during a doctor's visit, Schulz took on the role of Dr. Ken. He asked a member of the audience to volunteer as the patient. Dr. Ken presented the patient with a large bottle of pills the size of ping-pong balls with a long name in fake Latin. The pills would hopefully take care of the mysterious pain in the patient's side.

The patient had one line, which was printed on a card: "But Dr. Ken, I am worried."

Dr. Ken would reassure the patient. He told the patient to come back in a month.

The skit was used to engage the audience. Schulz and Jackson, who were presenting the topic of health literacy, asked the audience if the patient felt better or worse after leaving the physician's office. According to Jackson, the answers varied. However, when they asked the audience what the patient should have asked the doctor, they got several good questions. For example: "How will these pills interact with my other medication?"; "Is this a generic medication?"; "What is my prognosis?"; "What is causing my pain?"; "Is this an experimental drug?"

The skit demonstrated the importance of asking questions, instead of silently and needlessly worrying, says Jackson.

Following the skit, the presenters covered additional ways audience members could get the information they needed on a health topic to make good decisions about health care, says Jackson. For example, the group leaders recommended talking to the pharmacist about medications and going to the reference desk at the public library to find information. Also, The Humana Foundation sponsors a website (www.wellzone.org) that has health information, which was shared with the seniors.

Discussion part of interaction

The skit was used to introduce the topic and prompt discussion on ways to become more health literate. Seniors were encouraged to tell their stories and share their ideas.

Jackson explains that interaction mirrored the active role the audience was being encouraged to take in their health care. Rather than remain passive listeners, they were to ask questions of the physician and be aggressive in looking for information.

However, there is a downside to encouraging audience participation, warns Schulz. Audience members may want to share long monologues about personal medical histories. To avoid losing members of the audience who do not relate to the particular problem of the storyteller, determine what the person is saying and give a summary. To re-engage the audience, spin the information into a question, says Schulz.

To help involve the audience, use a simple, matter-of-fact approach and make points with the use of stories. For example, Jackson says he tells a story from his childhood to describe the futility of needless worry. He shares the story that as a child, after swallowing a blue string, he worried for days that he would die or have to go to the hospital. He tells his audience that adults can carry around blue strings.

The presenters also share a Swedish proverb that says people can cut their worries in half by sharing them with someone.

Also used is the simple analogy of buying a pair of shoes, says Jackson. The person wearing the shoes is the only one who knows if they are really comfortable. Likewise, patients are the experts about what is going on with their body and must provide the information for the physician.

"Don't mix right-brain, emotional issues and left-brain, instructional issues at the same time," advises Jackson.

Information is relayed through anecdotes and stories rather than statistics, says Jackson. Then at the end of the presentation, a simple handout is provided with a few points the presenters want the audience to remember.

SOURCE

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Creating an app to educate on melanoma

Technology works for younger audiences

For a decade, the Mollie Biggane Melanoma Foundation in Garden City, NY, has been educating people about the prevention and early detection of skin cancer and melanoma.

Many educational methods have been used to deliver the message, but most recently the foundation produced an app for certain branded forms

of handheld technology, because it is embraced by younger consumers. Information at your fingertips is what young people want, says **John Biggane**, president of the Mollie Biggane Melanoma Foundation.

It is a good way to reach the foundation's target audience, which is youth in middle school, high school, and college, he adds. According to the New York City-based Skin Cancer Foundation, melanoma is the most common form of cancer for young adults 25-29 years old and the second most common form of cancer for adolescents and young adults 15-29 years old.

Mollie, the daughter of John and Maggie Biggane, the foundation co-founders, discovered a mole on her thigh while a sophomore in college and died of melanoma at age 20 following surgery, chemotherapy, and radiation.

While the software for the app had to be developed, the basic design did not. It was patterned after a bi-fold, wallet-size brochure that was distributed to about 400,000 people via physicians, health fairs, and various organizations. Information includes a five-step skin check; a tracking calendar; the ABCDE's of moles; and details on how to guard against skin cancer. As part of the mole identification, pictures showing the progression of a mole that could be cancerous are included.

"We were so successful with this brochure, we thought if we could present something that was free through technology we would have an even greater audience," explains Maggie.

Getting the word out

In order for the target audience to use the new app, information about it must get out. To get the word out, the foundation distributed a news release to alert the media about the new app in mid-November 2010, when it became available. Also an infomercial was produced for the small viewing devices New York City taxi companies have in the back of their cabs. It ran over the holiday season in December when thousands of tourists come to the city.

The devices in the back of the cabs have proven to be a good educational method as well as ad method, according to John. The Mollie Biggane Melanoma Foundation created a 30-second PSA to run during May, which is Melanoma Prevention Month. It featured Cara Biggane, who told the story of her sister Mollie's death from melanoma and advised people to become familiar with their skin in order to identify moles that change color.

According to the Bigganes, the foundation received a tremendous response from the PSA, and their daughter was invited to speak about melanoma prevention on several national television shows.

Every picture, as well as the information, must be copyrighted. Also if a photo is used from a second source, permission for its use needs to be documented, the Bigganes explain.

"From a technology standpoint, the process is probably one month or less, but legally it is a three-month process," says John. He advises anyone creating an app to use an attorney in the field of copyright law. Finding someone qualified to develop an app is not difficult, he adds.

Because the app has several photos to assist with mole identification, the developers of the program did have to spend time making sure the resolution in this section of the app was good.

Yet the work should be worth the effort, according to the Bigganes.

"We spent a lot of time and resources trying to educate young people about seeing a dermatologist if they have an elevated freckle or freckle that changes colors. What we do is that overall education," says John.

SOURCE

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ACOs emphasize prevention, coordination

Partnerships aim to improve care, eliminate waste

As talk of reimbursement reform, pay for performance escalates, and health care stakeholders look at ways to improve patient access and outcomes while reducing waste and costs, payers and providers are joining together to create accountable care organizations (ACOs).

ACOs are partnerships that agree to be accountable for the quality, costs, and overall care of a

patient population.

Accountable care organizations are patient-centered partnerships between payers and providers and have an emphasis on prevention and care management across the continuum.

In an accountable care organization, the payer, the providers, and, in some cases, the purchaser agree on a payment model and share the savings as waste is eliminated.

According to **Richard Bankowitz**, MD, MBA, SACP, enterprise-wide chief medical officer for Premier, an alliance of health care providers with a mission to improve the health of the communities, the ACO initiative has a triple mission:

- to improve population health;
- to improve the care experience;
- to reduce the total cost of care.

"To be part of an accountable care organization is any case manager's dream. Accountable care brings to the forefront what case managers have been talking about for decades: the need to have solidly constructed and effective multidisciplinary teams. As case managers, we know how important it is for the patient experience across the continuum of care to be seamless; but it remains a bumpy ride. ACOs are designed to eliminate the bumps and gaps in care," says **Victoria Choate**, RN, CCM, RN-BC, CCP, PAHM, vice president of performance excellence and chief quality officer at Cheyenne Regional Medical Center in Cheyenne, WY.

Cheyenne Regional Medical Center is partnering with a local health plan and a physician organization to develop and implement an ACO.

The accountable care model places the focus in health care back where it belongs — on improving the health of individuals, says **David Epstein**, MD, CIGNA senior medical director for Georgia. The Philadelphia-based health service company and Piedmont Physicians Group, part of Atlanta-based Piedmont Health, have launched an ACO pilot program.

"Health care in the United States has shifted away from prevention and primary care, which has resulted in a 'disease care' system that relies more on specialist intervention and rescue procedures rather than improving health and providing greater value to patients. The patient-centered model places the emphasis on improving the health of individuals through comprehensive primary care services and delivering better outcomes through enhanced care coordination," Epstein says.

The goal of the accountable care organization initiative is to improve quality and moderate costs, Choate says.

"We don't want to eliminate necessary costs, but by anticipating what the patients' care needs are and by shepherding them across the care continuum, we want to eliminate the costs associated with unnecessary care," she says.

Studies have shown that up to 30% of health care funds are spent on unnecessary and duplicative tests, treating complications that could have been avoided, and providing care in an expensive setting when it could have been provided at a lower level of care, Bankowitz says.

"The current system simply is not sustainable. The accountable care model is an exciting concept and one that is badly needed," he says.

The primary problem with the current health care system is that care is fragmented and not coordinated from the patient's point of view, Choate says.

"Patients often see several providers in multiple settings. Sometimes their records are available, and sometimes not. There is a lot of duplication of services and waste. Accountable care organizations provide a mechanism to coordinate care and eliminate duplication across the continuum," she says.

Fragmented care can lead to medical errors and waste, Bankowitz says.

Accountable care organizations are designed to eliminate waste and unnecessary spending and to ensure that patients get preventive care that will keep them well by proactively managing chronic disease and coordinating care provided in multiple settings, Bankowitz says.

"Everybody tries to eliminate waste, but one of the realities of the current model is that if you eliminate waste and reduce unnecessary emergency department and hospital visits, the savings go to the payer, and hopefully back to the purchaser and the consumer. There is no incentive on the part of the provider to eliminate waste," he says.

Accountable care organizations require an infrastructure that includes a person-centered health home provider, a mechanism for coordinating care, and a way to share information.

"We need health care professionals who are trained to think about the whole continuum of care, how to coordinate care, and how to be proactive to help patients get the level of care they need but not receive wasteful or unnecessary care," Bankowitz says.

The model may differ depending on the needs

of the communities and the structure of the collaborating organizations, but all include payer/provider partnerships and reimbursement models that reward providers for providing value rather than on the basis of patient volume, Bankowitz says.

Payers always have been especially interested in cost and quality, he says.

"Their role is to provide for efficient care of the patient, and that hasn't changed. What is changing is that we are looking at the whole delivery model and not just the payment model. The delivery model is changing with better coordination of care and emphasis on the patient's health home," he says.

Premier is partnering with nearly 80 health care systems nationwide to help them develop and implement the accountable care model in their areas.

The ACO Implementation Collaborative is designed to assist health systems in partnering with payers and physician practices to implement the model in their area. Twenty-four health systems with more than 80 hospitals are participating in the collaborative.

More than 50 health care systems are part of Premier's ACO readiness collaborative and are developing the organization, skills, team, and operational capacities needed to develop the model in their areas.

"We brought hospitals to the table because the organization's owners are hospitals, but it can't be solely a hospital activity. Patients receive care along the continuum within multiple levels. If care isn't coordinated, it results in excess services and waste and has the potential for errors," he says.

Regardless of the structure of the model, accountable care organizations all include people-centered health homes that deliver primary care and coordinate with other providers as patients move through the health care continuum, Bankowitz says.

"Historically, continuity of care has been a series of hand-offs. Now, people are sitting at the table and discussing what the patient needs in their environment — and what is needed when the patient goes to another level of care," Choate says.

The initiative refers to "person-focused care" rather than "patient-focused" care, and "health homes" rather than "medical homes," because an accountable care organization looks at the health of a population and keeping a population healthy.

"Many individuals in that population may be healthy, and they're not patients. We want to keep them as healthy as possible. That is why this model has greater emphasis on primary care and preventive care," he says.

Under the accountable care model, the case managers' role will continue to be to promote better coordination of care, elimination of waste, and duplicated efforts, Bankowitz says.

"The scope of work for case managers may change, because now case managers tend to focus on a patient or a case, whereas in the new accountable care organization, their job may be more of health management. We are not interested only in taking care of sick people; we want to keep people healthy and out of the system if they don't need to be there," he says.

The principles and goals of accountable care organizations are similar to those envisioned in the capitated payment programs in the 1990s, Epstein says.

"The premise of the capitation program was to empower the primary care physicians to improve their patients' overall health and to guide them effectively through the health care system when necessary, as opposed to simply referring them to various hospitals and specialists when they need specialty care. Some primary care groups were prepared to take on population health management tasks and did quite well under the capitated system. But the program did not succeed in moving the quality dial, due to lack of infrastructure and constructive dialogue between the provider community and the payers. Accountable care organizations have the potential to deliver more efficient care and better health outcomes through enhanced care coordination," he says. ■

Insurer, physicians team up for patient care

Goal of ACO pilot to increase quality, cut costs

When CIGNA members being treated by Piedmont Physicians Group in Atlanta are high-risk or noncompliant, **Jennifer Farlow**, RN, BSN, clinical care coordinator, contacts them and helps them get back on track for regular visits and recommended tests and procedures.

The health plan and the physician group split

the cost of Farlow's salary as part of the two organization's accountable care organization pilot project.

The program, which began July 1, 2010, focuses on 10,000 individuals covered by CIGNA who receive care from one of more than 100 primary care physicians who are members of the Piedmont Physicians Group.

"Our goals are to increase quality and decrease the cost of care at the same time. We believe that we can achieve better clinical outcomes by collaborating to ensure that patients are receiving recommended care in a timely manner," says **David Epstein**, MD, CIGNA senior medical director for Georgia.

Epstein and other CIGNA officials meet every other week with the physician practice operational group and every other week with the clinical team to discuss how the project is going and to brainstorm on any changes that need to be made.

CIGNA is providing data from its own case management and disease management program to the Piedmont organization.

"We are sitting at the table with providers, and for the first time in my career, I feel that instead of duplicating resources, we are sharing information and optimizing resources," Epstein says.

Farlow enhances patient care by coordinating CIGNA data and clinical programs of the Piedmont Physicians Group, Epstein says.

Each month, the health plan sends two reports to Farlow. A gap report shows patients who are missing recommended care, such as a diabetic who hasn't had a hemoglobin A1c test recently or a patient with heart failure who hasn't filled his prescription for a beta-blocker.

The other report, called the previse risk report, shows who is at highest risk in the patient population, such as patients who use the emergency department for certain diagnosis codes.

When CIGNA's claims information indicates that a patient has a gap in care, Farlow reviews the chart in the electronic medical record to make sure that the patient hasn't already seen the doctor.

"Sometimes there is a lag in the claims data, and when I look at our records, I find that the patient saw the doctor last week," she says.

When she identifies patients who have gaps in care, Farlow makes an outreach call and works to get them back in to see the doctor.

"When a doctor tells a patient to follow up in six months, he or she has to trust the patient to follow up. This program gives us a chance to make sure that they do follow through," she says.

Farlow contacts all patients who show up on the gap report, regardless of their disease state or medical conditions.

"Many patients have multiple comorbidities. When I call the patients, I find out how educated they are about their conditions and identify their goals. I reinforce the education they have gotten and work with them to follow their treatment plan," she says. For instance, she says she finds that many diabetics check their blood sugar only once a week.

"I try to establish a rapport with every person I contact. If I know they have a lot going on or are having trouble being compliant, I make follow-up phone calls and support their adherence with the treatment plan," she says.

After she talks to the patients, Farlow sends a follow-up letter to them and sends the information to the physician by entering it into the computerized charting system.

She helps patients who have issues getting their prescriptions refilled or have a question about medication.

The program also targets patients who are making multiple visits to the emergency department for simple things that should be treated in another venue. When Farlow talks with them, she identifies the barriers to care.

For instance, some patients have told Farlow that they use the emergency department frequently because they can't afford the copay for a primary care visit.

In those cases, she works with the physician practice manager to set up a payment plan, so the patient can get treatment at the appropriate level of care.

"Access to care is a big issue. Some patients try to see the doctor, and they can't get an appointment, so they end up going to the emergency department for treatment. One of our major focuses in improving access to care is making sure there are same-day appointments available for patients who need to be seen," she says.

The physician group is working on ways to increase the number of same-day appointments available by expanding office hours, providing weekend care, and, in some cases, triaging after-hours callers rather than having a recording that tells them to hang up and go to the emergency department, Epstein says.

The primary goal of the care coordinator is to get patients with gaps in care or who are using the

emergency department inappropriately back into the physician office, Epstein says.

"In a way, she's playing family therapist trying to get the two parties back together. That is the epicenter of how this process works. The patient needs to see his or her physician on a regular basis and receive recommended care. At the same time, the physicians need to make sure patients have access to care. If someone has a sore throat, they can't wait three weeks for an appointment," he says.

The outreach calls are particularly effective, because they are coming from the patient's doctor and not from CIGNA, Epstein points out.

"It's not the message as much as it is the messenger. The subject of the call and the information passed on could be exactly the same, but because it's coming from within the physician practice, and not from the insurer, the patient is more likely to pay attention. The physician practice has a lot more credibility than the insurer," he says.

The initiative also is addressing hospital readmissions in real-time, Epstein points out.

"When patients leave the hospital, there's often not enough good communication with the primary care physician. This program bridges that gap and makes sure patients receive a follow-up visit, that they get their medication, and understand their treatment plan," Epstein says.

Farlow collaborated with the case managers at Piedmont Hospital and is able to access their documentation system for information on the patients she is following.

"I can see who is in the hospital, who is in the emergency department, when they are discharged, and follow up to make sure they receive appropriate outpatient care. Our hope is to get them back to see their primary care physician or a relevant specialist and avoid any rehospitalization," she says.

She typically coordinates care for patients over the telephone. The physician group has 40 offices throughout the metropolitan Atlanta area, which makes it impossible for her to see everyone in person.

Farlow has a weekly conference call with the lead CIGNA case manager assigned to the Piedmont account, the health plan's health service specialists, and Epstein.

The health service specialist is the individual who understands the benefit plan eligibility and what each employee has purchased.

That way if the care coordinator is working with a patient with diabetes who doesn't know his or her benefits, the health service specialist can let that coordinator know what the health plan can offer the patient.

"We cover the administrative bases as well as the clinical bases," Epstein says.

The project is a collaboration between CIGNA and Atlanta-based Piedmont Physicians Group and is the first accountable care organization in Georgia. The project is one of several accountable care organizations the Philadelphia-based health service company is developing nationwide.

"We have a relationship with the Piedmont system on two levels. They are a key provider system in our network, and we administer their health benefits plan," Epstein says.

CIGNA is paying the primary care physicians as usual for the medical services they provide in addition to a fee for care coordination and other medical home services. The physicians also will be rewarded through a pay-for-performance structure if they meet targets for improving quality and lowering medical costs.

"We are going to analyze data from the project using evidence-based measures and compare it to baseline quality performance. We're also looking at the effects on costs year over year and trends in cost reduction. We believe this project will result in better clinical outcomes and save money at the same time," Epstein says. ■

Use hand cleansers to decrease absenteeism

Get workers thinking about it

Use of alcohol-based hand cleansers significantly reduced several common infections and reduced absenteeism in a study of 129 white-collar workers in 2005 to 2006, according to research from the Institute of Hygiene and Environmental Medicine in Greifswald, Germany.[1]

Participants were told to wet their hands fully with the rubs at least five times a day, especially after visiting the restroom, blowing their noses, before eating, and after touching other people or papers. No hand-hygiene behaviors were suggested to the control group.

Putting disinfectants on employees' desks helped reduce absenteeism as well, with workdays lost

because of diarrhea cut dramatically.

"Hand cleansers are an important component of an overall approach to creating a culture of health at a business location," says **Brent Pawlecki**, MD, corporate medical director at Stamford, CT-based Pitney Bowes. "Hand hygiene is something that we want our employees thinking about at all times."

Because the hand sanitizing stations are so noticeable, their strategic placement can set a tone for the workplace. "This has symbolic value, by encouraging hand hygiene even when the employees are not passing by the station itself," says Pawlecki.

COMING IN FUTURE MONTHS

- Expanding resources for preferred learning methods
- Motivating patients to change bad health behaviors
- Educating to reduce obesity
- Be ready to educate the deaf

At Pitney Bowes' headquarters, the first sanitizing station that visitors and employees who use the main entrance see is right in the lobby. In addition, sanitizers were installed in high-traffic locations: The entrances to the main cafeteria, fitness center, and the on-site clinic.

Every single restroom in the company's facilities has signage with tips on how to wash hands effectively, and instructions on how to leave the restroom in a hand-healthy manner. That means drying your hands with a clean paper towel, and using that same towel to turn off the water at the sink and open the door when leaving.

"We provide a wastebasket next to the outer door of every restroom for convenient disposal of used paper towels," says Pawlecki.

Pawlecki says that he believes that accessibility of hand cleansers does have an impact on absenteeism.

"It certainly helps, although we have not undertaken a comprehensive study to prove the degree to which it helps," he says. "There are many factors that influence absenteeism, but having a

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.

Upon completion of this educational activity, participants should be able to:

- identify the management, clinical, educational and financial issues relevant to patient education
- explain the impact of the management, clinical, educational and financial issues relevant to patient education on health care educators and patients
- describe practical solutions to problems health care educators commonly encounter in their daily activities
- develop patient education programs based on existing programs.

CNE QUESTIONS

5. Partnerships with literacy coalitions might benefit patient education managers in which of the following ways?
A. Help form focus groups.
B. Provide demographic information.
C. Educate providers on health literacy.
D. All of the above

6. Adult literacy classes can improve health literacy among high-risk consumers by teaching on such topics as disease prevention while teaching reading and writing.
A. True
B. False

7. Engaging presentations get the audience involved. To engage the audience, the presenter might do which of the following?
A. Deliver message via stories and anecdotes.
B. Present a skit using audience volunteers.
C. Give lots of statistical information.
D. A and B

8. When delivering prevention education via an app for a handheld electronic device, word-of-mouth is enough to promote use.
A. True
B. False

Answers: 5. D; 6. A; 7. D; 8. B

comprehensive and aggressive healthy-hands program can be a meaningful contributor to overall employee health, well-being, and productivity."

REFERENCE

1. Hubner, NO, Hubner C, Wodny M, et al. Effectiveness of alcohol-based hand disinfectants in a public administration: Impact on health and work performance related to acute respiratory symptoms and diarrhea. *BMC Infect Dis* 2010; 10:250; doi:10.1186/1471-2334-10-250. ■