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

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Nutrition education an important element of disease prevention

American public often confused about healthy eating habits

Healthy eating is a good target area for education, because people are confused about what healthy eating means, contends **Andrea Giancoli**, MPH, RD, an American Dietetic Association spokesperson who lives in Southern California.

The American public lacks good, basic nutrition knowledge. As a result, people are unable to sort out the misinformation passed along by any entity ranging from the media to their next door neighbor.

Misconceptions about healthy eating are always changing, depending on what is being marketed, she says. For a long time, people stopped eating carbohydrates, thinking they were unhealthy. Yet it is the quality of a carbohydrate that determines the nutritional value of the food, for some are nutrient-dense, says Giancoli.

For example, often people take a lot of food supplements thinking they are practicing healthy behavior, yet people should obtain the right nutrients from the food eaten, she says. "Multivitamins and supplements have taken on the quality of being necessary as part of the diet, and food has taken a back seat. People think in order to be healthy, they need to take

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A proper diet is an important component of overall good health and is a factor in the prevention of many diseases, such as certain cancers. Often, unhealthy diets lead to weight gain and chronic ailments, such as heart disease. According to the Centers for Disease Control and Prevention, in 2009, only Colorado and the District of Columbia had a prevalence of obesity less than 20% of the population.
In this issue of *Patient Education Management*, we look at nutrition education and how medical institutions may improve the health of the patient population served by teaching healthy diet practices.

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supplements, and that is not the case at all," says Giancoli.

Manuel Villacorta, MS, RD, CSSD, an American Dietetic Association spokesperson in San Francisco and author of a weight loss program called Eating Free, says that generally people know that sugary and high-fat foods are not good for them. However, often they think a healthy food can be eaten in unlimited quantities. Many of his clients, for example, will think nothing of using a quarter cup of olive oil to cook food, because they know it is a heart-healthy fat. People are often told what foods are good to eat and which are bad, yet they are not told how much they should eat. Portion size is an important part of education.

"Our portion sizes are on steroids," says Villacorta.

Both Villacorta and Giancoli agree that people not only need much more than information, they also need to understand how to put it into practice. For example, people need to see a realistic meal to understand portions.

"You really have to show people what food looks like on a plate," says Giancoli.

Another area for education is the definition of a plant-based diet and how to implement it, she says. There should be more emphasis on eating fruits, vegetables, nuts, beans, and whole grains — with meat a smaller component on the plate. Meat also should no longer be the main entrée, Giancoli explains.

Learning to interpret food labels and the terms on packaging should also be a focus in education. Multi-grain bread is not always the healthiest choice if enriched wheat flour is the first ingredient on the label, rather than whole wheat flour. Enriched means the flour has been refined, and some of the nutrients have been added back, says Giancoli.

"People need to understand the terms on labels. They need to look at the label and understand the ingredient list and what the nutrition back panel means to them," she explains.

Food preparation needs to be a part of nutrition education, says Villacorta. In his private practice, he finds many of his clients are not preparing their meals from fresh product, but instead eating a lot of processed food, which frequently leads to weight gain. People need to allow time to shop and cook and get back into the kitchen. He adds that people once ate out to celebrate a special occasion, and eating in was the norm. Now, it is the opposite, and often people eat several meals from restaurants during the day.

Make lessons personal

Ideally, education about healthy eating should be individualized, according to Giancoli. The problem with a generic diet approach is that people are complex and have various reasons for their dietary and lifestyle behaviors; therefore, it is good to conduct an individual assessment, she adds.

The assessment should include viewing lab work to see such health risks as high cholesterol, determining a person's body mass index (BMI), and his

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or her regular, daily diet. Another important element of the assessment is determining the person's relationship to food. It's important to know when people eat, why they eat, what time of day they eat, and what is going on in their life, explains Giancoli. For example, is the person juggling two jobs; is he or she home all day and bored; does the person have access to healthy food and the money to purchase it?

"We must assess each person individually and base the plan on their individual needs, so assessment is critical. If you give people a piece of paper without knowing anything about them, you miss an opportunity for a teachable moment," says Giancoli.

People have different cultural points of view, likes and dislikes, routines, and schedules that affect how they eat, says Villacorta. Also, it is important to look at the obstacles to a healthy diet, he adds.

He had a client who was 50 pounds overweight, but was having trouble eating healthy meals, because he was on the road most of the day working as a salesman. Together, they looked at the obstacles and worked out a plan that included packing an ice chest with yogurt, fruit, and sandwiches.

Also, Villacorta asked for a menu from each of the restaurants the man frequented and picked the best options, so he would know what to order. "We had to come up with a plan he was willing to do," says Villacorta.

It is important to assess what the patient is willing to do, he adds.

Registered dietitians are trying to use the motivational interviewing technique, i.e., where a patient comes up with a plan vs. being told what to do, says Giancoli.

"We educate them, give them skills-based learning, and then have the patients come up with the changes they will make; and we come to a mutual agreement," she says.

While health care facilities cannot always work closely with patients when providing nutrition education, they can tell them how to get an individual consult with a registered dietitian, says Giancoli. The Chicago-based American Dietetic Association has a section on its website (eatright.org) that provides a list of registered dietitians that people can find in their region by entering a zip code.

There are many reasons to consult with a registered dietitian for help with an eating plan, she adds. These might include: health problems such as diabetes, cardiovascular disease, or high blood pressure; digestive problems; weight gain or loss; sports performance improvement; and food allergies. Sometimes people are just interested in healthy eating and want to learn more about navigating all the food options.

"Overall, a dietitian's job is to figure out a person's current situation, where he or she wants to be, and the steps to an improved diet," explains Giancoli.

With obesity on the rise in the United States — along with the health problems associated with it — nutrition literacy is one of the factors that must be addressed to help reverse the trend. Yet it is only one piece of the pie, says Giancoli. Another piece is the amount of food marketing that goes on in the United States, pushing people to eat foods that are not the healthiest choices. A third piece is sedentary behavior. It is very easy for many people to do almost everything, including their jobs during the workday; therefore, the activities of daily living don't require much energy.

Another piece of a healthy diet is the affordability and accessibility of healthy foods.

"There are many factors at play contributing to the obesity epidemic," says Giancoli.

She adds that reaching the public with nutrition education is a goal that can be addressed with a multitude of teaching methods.

Hospitals can offer healthy living classes, healthy cooking classes, and nutrition 101 classes. A sign might be placed on the elevator reminding people to take the stairs and telling them how many calories they would burn climbing one flight. Hospitals might book their dietitian on talk radio, create a TV ad, place messages in grocery stores and other public places, or post daily nutrition tips or healthy recipes on Facebook.

Also, every hospital could have a nutrition Twitter feed or create a mobile phone app. Giancoli suggests an app that would allow a person in a restaurant to assess the meal he or she is about to eat by taking a photo of it. There are similar applications already created, she says, so if a hospital doesn't have the funding to create an app, staff could connect patients with apps that are already available.

One thing people must always be told is that nutrition and physical exercise are a marriage, says Giancoli. Optimum health is achieved by both healthy eating and engaging in physical activity, she explains.

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DVDs meet needs of visual learners

Evaluate a DVD first

A resource library for patient education should contain DVDs to help visual learners understand information, according to **Taryn J. Bailey**, MSN, RN-BC, executive director of Professional Practice and Patient Education Services at North Shore Medical Center in Salem, MA.

Patient education managers should have DVDs available as a teaching option. If funds are limited and managers must prioritize, select the DVDs that help patients learn skills, such as administering an injection, tracheotomy care, or the use of an inhaler, Bailey advises.

Yet not just any DVD will do. Each must be assessed to determine if it is an appropriate educational tool for patients. Clinicians in the particular specialty area should provide feedback, says Bailey. Also, if an institution has a patient educator, he or she should review the content.

To provide guidelines for review, develop a media evaluation form. Bailey says there are several areas that should be covered when assessing a DVD.

Content needs to be accurate and reflect current practice. It must be comprehensive, covering the basic information on the topic, as well as essential components. Make sure the content is patient-oriented, as well. Bailey says groups within a health care system may want to create a DVD by filming a lecture, and often this content is clinician-oriented rather than patient-centered.

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DVDs are an important part of a patient education resource library. Before making them part of an educational resource collection, a proper assessment of content and other features is required.

Plain language must be used, with minimal medical jargon. Clear explanation of concepts should be included. Storytelling is also important. DVDs in which people tell how they made a medication work, or dealt with congestive heart failure, help viewers grasp the points made in the DVD, says Bailey.

Content and concepts must be culturally appropriate, matching the experiences of the targeted culture. For example, a DVD on nutrition that targets Hispanic patients should use actors from that culture and culturally appropriate foods so it makes sense, explains Bailey.

If a manager thinks a DVD needs to be assessed for cultural appropriateness, he or she should contact interpreter services within the health care system, or the company the hospital contracts with for services. However, the evaluation needs to be done by a medical interpreter, says Bailey. That is because words in English sometimes have no corresponding word in the foreign language.

"You want to make sure the appropriate word for that concept is used," says Bailey.

She adds that in her opinion, foreign language DVDs produced by reputable, professional vendors do not need to be reviewed for appropriate language.

Health literacy considered

While there is no tool to assess speaking level in a DVD such as there is in grade reading level in written material, in order to make sure people with low health literacy can understand the content, reviewers can determine if complex words are being used, says Bailey. Also, they can make sure there are graphics that help explain terms. One of the benefits of film is that concepts can easily be graphically illustrated.

The visual and sound quality are also important. If permission is given to copy DVDs for an in-house television system, make sure the quality is not diminished, warns Bailey. Also, DVDs should have closed captioning as an option for people who are hearing impaired.

Before a DVD is purchased, always make sure the organization producing it is reputable. Bailey advises patient education managers to go to the vendor's website to get information on its editorial board or make a phone call. Make sure the content is evidence-based and the vendor updates the material when necessary.

"DVDs have to keep pace with changes in prac-

tice, research, clinical innovations, and recommendations," says Bailey.

Before purchasing a DVD in a foreign language, make sure it is on one of the top medical issues for which this patient group is hospitalized, advises Bailey.

There are many options for the distribution of DVDs within a health care organization. The best is to have them available on an in-house television system, where they can be shown on demand or as part of regularly scheduled programming, says Bailey. The worst option is to have copies on units, because a process for pulling outdated DVDs has to be in place when new versions come out, she adds.

Many hospitals have video streaming on their website and make their library available to the public. Also, health care organizations post patient education videos on YouTube. Copies of DVDs can be sent home with patients to view, which is helpful should patients need to review the teaching one more time.

While vendors often market DVDs as a tool to aid busy clinicians, like print material, it never is a substitute for one-on-one education, says Bailey. The nurse or clinician must always review the information with the patient.

SOURCE

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Community partnership addresses health needs

Task force keeps group focused

To improve access to health care in Logan County, IL, the Healthy Communities Partnership was formed 13 years ago. The mission statement of the partners is "to improve the health and quality of life for people in the communities we serve." This is accomplished in many ways, but almost always, education is a key component.

Yet education is not always delivered at traditional sites, such as hospitals and clinics, or by common methods. For example, to address the problem of alcohol abuse and demonstrate a healthy lifestyle, the task force on substance abuse, which operates within the partnership, rents the bowling alley in Lincoln on a Sunday afternoon and invites families to bowl free of charge. The task force provides the food, but there are no alcoholic beverages available.

"We are showing people family activities can be fun without alcohol," explains **Kristin Lessen**, MS, director of Healthy Communities Partnership, at Abraham Lincoln Memorial Hospital in Lincoln, IL. To reduce substance abuse, a change in mindset must take place, says Lessen.

The original partnership included Lincoln Memorial Hospital, Logan County Department of Public Health, Mental Health Centers of Central Illinois, the Chamber of Commerce, and a physician group called Family Medical Center. However, the group quickly realized that in order to reach a diverse population with a multitude of needs, it would need many agencies partnering to provide services within the communities. There are now 56 agencies and organizations, 15 community volunteers, and 14 churches working within the partnership.

In order to stay organized, representatives from the five original agencies form the oversight committee and meet regularly. Members from other agencies and the community sit on task forces that have been approved by the steering committee. A proposal must be submitted to determine if a particular task force is a good fit for the partnership, says Lessen.

Currently, six task forces have been formed. They include: Alcohol, Tobacco & Other Drugs; Healthy Families; Domestic Abuse & Violence; Senior Issues; Parish Nurse; and Education.

Priority health issues are identified by an assessment of needs conducted every five years by the county health department. Issues identified have included access to care, substance abuse, teen pregnancy, sexually transmitted diseases, and most recently, obesity. Health needs are not always addressed through a task force. For exam-

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To improve health within Logan County, IL, several agencies have formed a partnership to address high-priority needs, such as improved access to health care and many areas of education. The partnership is targeting such issues as the spread of sexually transmitted diseases and the use of smokeless tobacco.

ple, to help people access care, the Rural Health/HOPE mobile care unit was implemented. The acronym stands for healthcare/oral health/prevention/education.

To create the mobile care unit, the group obtained a federal grant to purchase a recreational vehicle with two exam rooms. It goes out into the county on a regularly scheduled basis to serve the community. It is staffed by a public health nurse and nurse practitioner, who see patients. Patient education is part of the care process, and health screenings are also routinely held, including blood pressure screenings and glucose screenings.

Recently, a second RV was purchased with a dental exam room, in addition to medical exam rooms. Children are the focus of oral health care.

It's important to go out into the community, because people will not always come to the health care provider, says Lessen. "They don't like to get out of their comfort zone," she explains.

Health as all-encompassing

Healthy Communities Partnership sees health as all-encompassing; therefore, a new task force is working to increase the graduation rates and decrease truancy of high school students within Logan County. "Education does contribute to the health of our community," says Lessen.

Young people are targeted in many ways. An evidence-based substance abuse program that focuses on life skills is taught in the seventh grade, with follow-up sessions taught in eighth grade. A pregnancy prevention program is available to middle schools, high schools, and colleges. Preventing the use of smokeless tobacco is a new emphasis. Statistics tracked in Logan County indicate girls in junior high are using it, says Lessen.

To reach the public, each task force identifies programs offered by the agencies within the partnership that fit its goals and objectives. Urban areas within driving distance of Lincoln often provide services that are not available locally. "What we try to do is eliminate, or at least decrease, duplication of services," says Lessen.

Also, people are directed to services that best fit their needs. For example, the Senior Issues Task Force released a resource manual to help meet one of their objectives, which is to "increase senior's awareness of available resources through education."

Funding of programs can be an issue. Many have grant funding, and if funding is lost or budgets are cut, programs can be dropped, Lessen explains. The Logan County Health Department offered a family planning/pregnancy prevention program to schools, but lost the grant funding. In order to keep from losing this educational resource, the Healthy Families Task Force developed a flash drive for teachers, so the education would continue to be available to students. The partnership provides technical assistance to support the schools providing this education.

While the partnership has to go after funding to support programs, it does have a main financial supporter in the Abraham Lincoln Health Care Foundation. About 10 years ago, this foundation provided $1 million, and the interest and dividends from that original grant are used to fund programs, along with grant money.

The primary health care and preventive care offered by the HOPE Mobile is not free, but private insurance, Medicare, and Medicaid are accepted. The health department provides the public health nurse, and the physician group provides the nurse practitioner. Abraham Lincoln Memorial Hospital is the fiscal administrator.

Is there evidence Healthy Communities Partnership is improving the health and quality of life for the people it serves? Lessen says each task force establishes measurable objectives. For example, the ATOD Task Force wants to increase Logan County DUIs (driving under the influence) by 10%, decrease usage of smokeless tobacco by 5% by 2012, and educate about over-the-counter and prescription drug misuse.

In 2010, DUI arrests decreased almost 11%. The Safe Ride Program has helped. This program provides free cab rides home on nights when people are most likely to consume alcohol. These nights include traditional holidays, such as New Year's Eve and July 4th, but also on Super Bowl Sunday — and on Friday and Saturday nights during the Logan County Fair.

The task force is hoping to track the effectiveness of education to reduce the use of smokeless tobacco through the Illinois use survey completed every two years.

The most recent assessment of community needs has identified obesity as a health issue to target. The partnership has obtained grant funding to help obese patients that access the HOPE Mobile develop healthier lifestyles with a focus on diabetes and heart disease.

SOURCE

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Post-acute transition program cuts LOS

Case managers visit facilities

UnitedHealthcare's post-acute transition program has reduced the average length of stay in skilled nursing facilities by three to five days, depending on the market, for members in the program.

"Inpatient stays are some of the most stressful and unsettling health care events members experience," says **Rhonda I. Randall**, MD, chief medical officer for UnitedHealthcare Medicare & Retirement.

"Our care managers work collaboratively with facilities, families, and caregivers to ensure members receive the right care, in the right place, and at the right time," she adds.

The program, which began in 2005, provides face-to-face case management for Medicare Advantage members who are discharged from the acute care hospital to a skilled nursing facility.

"Our program focuses on the member and making sure the members get appropriate services at the appropriate level of care. What has resulted has been a reduction in the length of stay. We want to be good stewards of a member's medical dollars and remove the barriers, so they don't experience unnecessary delays in services," says **Michelle McPhillips**, RN, CCM, BA, program director for the post-acute transition program.

Planning for the program started in late 2004 as a way to ensure that transitions to post-acute facilities go smoothly — and that the members get the services they need in a timely manner, so they don't stay longer than necessary, McPhillips says.

The program began with a pilot project in Ohio in mid-2005. During the pilot, two nurse case managers, hired in separate markets, visited participating skilled nursing facilities. They evaluated the members early in their post-acute stay, met with them every week, talked with family members, and monitored the members' progress.

"Often, the people in our program are the frail and elderly patients with comorbidities who are at risk for frequent hospitalizations and require a lot of care. Many of these members are admitted to the hospital with pneumonia, heart failure, or respiratory conditions that put them at risk for frequent hospitalizations. We wanted to make sure that the transitions were smooth," McPhillips says.

Following the success of the pilot project, the health plan has instituted the program in geographic areas where there is a large population of members who could benefit from the program.

Many of the patients have multiple comorbidities such as heart failure, diabetes, a respiratory condition such as chronic obstructive pulmonary disease, or pneumonia. Many members have dementia and cognitive issues. Some have had joint replacement surgery or suffered a stroke.

The members no longer meet inpatient criteria but have had a decline in function during their hospital stay that makes a discharge to home impossible.

"They have to learn how to get back to walking or transferring, or they may need continued medical treatment such as wound care or IV antibiotics. A lot of their needs are therapy-related," McPhillips says.

The nurses work in facilities where significant numbers of members are admitted. The nurses are assigned to facilities within a geographic area. They make rounds in facilities at least once a week. When there are a lot of members in the facility, the nurse may round twice a week.

"It's a hands-on program. The nurses visit with the member every week, talk with the family and caregivers and involve them in the plan of care, and work with the interdisciplinary team at the facility," she says.

By being in the facility regularly, the case managers are viewed as part of the interdisciplinary team, McPhillips says.

"It helps us move the member along, because everybody is on the same page," she says.

When a member is newly admitted, the case manager completes a comprehensive assessment and begins to develop goals for discharge.

"We invite them from day one to participate in setting their goals. Most people want to go home, but, unfortunately, that may not be realistic," she says.

Most of the members in the program are cov-

ered by United's Medicare Advantage plan. Some have a chronic illness plan.

The case manager determines the member's baseline functionality before hospitalization, what caregiver support will be available after discharge, and other services the member already has.

"When we meet with the member, we get permission to make a follow-up phone call to the family and caregiver. We review the medical record and speak with the therapist and nurse on the unit to find out how well the patient is doing medically and from a therapy standpoint," she says.

The case managers see the members a minimum of once a week.

They spend a lot of time building a rapport with members and their family and including them in developing the discharge plan.

"We want to make sure that people are medically and functionally stable to go home and that the discharge plan is as safe as possible. We give the member and family the information they need to make decisions about the discharge destination," she says.

For example, a member may want to go home, but that may not be a safe discharge option.

"This is always a difficult situation. That's why the onsite program is so beneficial to the member and to us. It's better to have difficult discussions face-to-face than over the phone. The case managers get to know the members and their families by being there consistently throughout the entire stay, and this makes it easier to talk about discharge options," she says.

They collaborate with the treatment team at the facility to develop the member's plan of care.

"We want to make sure that the services the member needs are provided in the skilled level of care, that they are receiving the appropriate modalities, and that they have the equipment they need. That's why it's so important to partner with the facility. If the case manager has questions about member needs or wants to talk to the physician, they are comfortable in asking, because they have a relationship with the staff," McPhillips says.

As the day of discharge approaches, the United case managers focus on preparing members for discharge, making sure they know to get their prescriptions filled, when the follow-up with their physician is, and who to call if they don't hear from home health services.

They make sure their post-discharge needs are being met, so the patients don't stay longer than necessary in the facility, until home care visits are set up, or durable medical equipment is delivered.

If the case manager has concerns about the member's living situation after discharge, he or she asks the skilled facility to send someone to conduct a home assessment.

The duties of the case managers focus more on making sure that the members get what they need in the skilled nursing facility and that they have what they need after discharge, rather than spending a lot of time educating them about managing their conditions after discharge.

"These patients have so many issues going on while they are in the skilled nursing facility that they aren't in the state of mind to benefit from a lot of education. We do a lot of coaching with the caregivers, and the therapists work with them to make sure they understand the capabilities of the member after they return home," she says.

The nurses often identify members who would be eligible for United's disease management or telephonic case management programs.

"Our program focuses on members while they are in the skilled facilities. When the members are discharged, the case managers collaborate on handing them off to nurses in other programs that may benefit them," she says.

The case managers give business cards to the members, so they and their families can call with questions or concerns. It's not unusual for a case manager to receive a phone call six months after the case is closed from a member saying, "You really helped me when I needed it," McPhillips says.

The case managers typically have a caseload of 20 to 24 members at a time.

"The team is all remote, which brings challenges," she says. The nurses have home offices and start the day answering e-mails, then round in the field between 10 a.m. and 3 p.m.

At the end of the day, the nurses go back to their home office, catch up on paperwork, and communicate with family members.

The nurses are in the field four days a week and spend one day catching up on their phone calls and documentation.

The program employs nurses with a case management background who are experienced in more than one level of care, so they understand the whole continuum of care. "Many on the team are certified case managers or are pursuing certification," she says.

Some of the nurses have hospital backgrounds. Others have experience in a skilled nursing or rehabilitation setting or a hospice background.

"The skill set for case managers is very important for an onsite position. The biggest part of the job is relationship-building. The nurses are on site at multiple facilities and must be able to communicate. They must collaborate with members and families in care planning and partner with the facility staff and physicians. Collaboration and communication doesn't come naturally to everyone," McPhillips says.

The program has a low turnover rate, McPhillips says.

"Most of our staff have been with the program from the day we opened up in their state. They're here because of the members. They get so much from seeing the members being able to improve and go home and from seeing the dedication and development of the caregivers. My mantra is, 'It's all about the members.' Everyone has the member's goals in mind," she says. ■

Physicians, health plan, hospital team up

At least a 30% drop in rehospitalizations

When a health plan, a physician network, and a hospital teamed up to reverse the trend of Medicare hospital readmissions within 30 days of discharge, readmissions dropped by 30% or more over an eight-month period when compared to the readmission rate in the same hospital the previous year.

According to data compiled through September 2010, patients in the program had a 9.25% readmission rate compared to 16.5% for a similar group in 2009.

"Hospital readmissions are a costly problem for everyone. The triple goals of this program are to improve quality of care and the patient experience while reducing readmissions Each prevented readmission will keep patients healthier and could save almost $10,000 per patient," says **Barry Baines**, MD, associate medical director of U-Care, an independent, nonprofit health plan.

The project is a joint effort of U-Care, based in Minneapolis; Fairview Physicians Associates (FPA), a large network of primary care and specialty providers; and Fairview Southdale Hospital, both located in Edina, MN.

The initiative involves collaboration between the hospitalist, the discharge planner, and the pharmacist at the hospital — and the case manager and the primary care provider, Baines says.

"All of these professionals work together to ensure that the patient is safely discharged back home. We ensure a safe transition by making sure the patient knows what medication to take and when to take it, that they have the equipment and post-acute care they need, and that they have a timely follow-up visit."

U-Care provides an incentive to the primary care physicians to see patients within five days after discharge and provides funds to the hospital for a pharmacist to evaluate patients in the program.

The pilot project, which began Feb. 1, 2010, targets patients covered by U-Care for Seniors Medicare Advantage plan who are hospitalized and who have diabetes, chronic obstructive pulmonary disease, or heart disease, or a combination of the three, Baines says.

"Because they are seniors, many of our members admitted to the hospital have one or more of these conditions," Baines says.

When a patient is admitted to Fairview Southdale Hospital, the case manager at Fairview Physicians Associates is notified within 24 hours, according to **Becky Schmidt**, RN-BC, manager of care delivery and clinical operations for the physician organization.

The hospital and FPA case managers use software that allows direct communication between the case manager and the staff at the hospital.

"We get a notification every morning listing all of our patients who have been hospitalized. When a U-Care for Seniors patient is identified through the admission report, we activate our tool so that the social workers, nursing staff, hospitalists, health information management system, and pharmacy staff are aware that the patient is in the pilot," Schmidt says.

Because the physician network provides case management for all of its patients, the FPA case managers have information about the patients' conditions and the care they have been receiving, as well as any services that are in place or they have had in the past, Schmidt says. For instance, some congestive heart failure patients are on a self-management program. Others may be receiving telemanagement. The case managers also have

a record of any post-acute services, such as home health, that the patient has used in the past.

"The case manager informs the hospital social worker about what has been going on with the patient before hospitalization. That way, they don't have to re-create the wheel," Schmidt says.

The FPA case managers visit the patient in the hospital to check on his or her condition and to help coordinate any care the patient may need after discharge.

They follow up with the hospital social worker by phone or by electronic communication.

"This communication puts everyone on the same page, so there are no surprises at discharge," Baines says.

Before discharge, the patient is visited by a pharmacist, who completes medication therapy management and discusses the medication regimen with the patient.

"Pharmaceutical reconciliation or issues with medication are the reason for between a third and a half of readmissions. In some cases, the patient is taking medication he shouldn't take. In other instances, he or she is taking a generic prescribed before admission and an identical drug prescribed in the hospital or simply hasn't gotten the prescriptions filled," Baines says.

The pharmacist's role goes beyond typical medication reconciliation, Schmidt says.

"The pharmacist is not simply handing the patient a list of what new medications he's taking and what he came in with. He's looking at the big picture. A congestive heart patient may be managing multiple medications very well, but if one is changed, it could be confusing. We take a proactive approach to eliminating any medication problems that could occur after discharge," she says.

The Fairview Physician Associates case manager works with the hospital discharge planner to make sure the patient has everything set up, such as durable medical equipment and oxygen, and making sure home health is in place if that's appropriate, Baines says.

"One of the more important aspects of the program is to ensure that the patient has a follow-up visit with a primary care provider within five days," he says.

The hospitalists also are alerted when a patient is in the pilot project. Their responsibility is to emphasize that the patient needs a follow-up appointment within five days after discharge and to provide a discharge summary to the primary care physician within 24 hours of discharge, Schmidt says.

"We know that the primary care physician is at the heart of the care plan. Our communications tool alerts the hospitalists when a patient in the pilot is in the hospital. They know to facilitate a follow-up appointment," Schmidt says.

The primary care clinics have accepted the responsibility of seeing patients within five business days by being flexible and getting patients in, she adds. When a patient has a primary care visit, the case manager receives a visit summary from the clinic.

The case managers at FPA call the patients within 24 to 48 hours of discharge, then again at 14 days and 28 days after discharge.

"These phone calls are instrumental in identifying what problems are occurring before the patient winds up back in the hospital," Baines says.

The case managers reinforce the education the patients received in the hospital and find out if they need anything else. "If they haven't made a follow-up appointment, we offer to help them call the clinic," Schmidt says.

"The case managers work to engage the patients in their own care. They don't just tell patients to do something. They provide an explanation and education. We are looking at the big picture and partnering with the patients to make the discharge safe and successful," she says.

Fairview Physician Associates has always had case management as part of its contract with U-Care for Seniors, Baines says.

"All our care systems offer complex medical case management. For this project, FPA reallocated some of their case managers to the program and are taking more of a broad focus using predictive modeling to assess the most at risk patients," he says. ■

Want workers to listen to you? Gain their trust

Get your message out

If employees don't trust you, they probably won't listen to your advice, agree to take a health risk assessment, or participate in your wellness programs.

Talei Akahoshi, director of occupational health at Piedmont Healthcare, says you must be proactive in reaching out to employees. She gives these

recommendations to establish trust:

• **Make yourself visible.**

"Our employees like seeing faces they know. One-on-one events on site, with individual attention, increases participation rates," says Akahoshi.

• **Engage middle management.**

"If they are not supportive, those below will be less likely to participate," says Akahoshi. "They are my biggest supporters in reaching my employees. How do you do it? That is the million dollar question."

Akahoshi says you need to have several approaches to gain middle management support, as follows:

— First, they have to know that there is senior leadership support. "Get them to participate or endorse your programs," says Akahoshi.

— Be open and honest with your middle managers.

— Show managers the results of their actions. For example, report participation rates weekly, and show which entity or department are top performers.

— Make sure they have the right resources and tools. "They may not have all the information to assist you, or may feel uncomfortable," says Akahoshi. "Address any of their concerns."

— Support them by making yourself available.

"Ask if you can attend one of their staff meetings," says Akahoshi.

— Perhaps most importantly, make sure they know why you need their support.

"Have a manager tell a story of how they made a difference," Akahoshi suggests.

• **Be sure that everyone on your team is able to**

COMING IN FUTURE MONTHS

■ Motivating patients to change bad health behaviors

■ Educating to reduce obesity

■ Be ready to educate the deaf

■ Expanding resources for preferred learning methods

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

9. According to the American Dietetic Association, the American public needs to be educated on nutrition in which of the following areas?
A. Proper use of supplements.
B. Portion size.
C. Reading food labels.
D. All of the above

10. Individual assessments help people put nutrition education into practice in which of the following ways?
A. Addressing obstacles.
B. Creating a strict list of dos and don'ts.
C. Dealing with food likes and dislikes.
D. A & C

11. It is important to investigate the credentials of the editorial board of the organization that produced a DVD before adding it to a resource collection.
A. True
B. False

12. It is not necessary to assess the health needs of a community before implementing educational programs for they are obvious.
A. True
B. False

Answers: 9. D. 10. D; 11. A; 12. B

answer questions.

There must be a clear, consistent message communicated to employees. "If your occ health team is not on board or isn't selling it, who will?" asks Akahoshi.

Leave door open

For **Michelle L. McCarthy**, RN, COHN, on-site medical case manager for Genex Services in Norcross, GA, saying "my door is always open," is more than just an expression. "You actually need to leave the door open! Acknowledge associates as they walk by. This lets them know they aren't bothering you."

The only time McCarthy shuts her door is when an employee is already in her office with a concern. "Do not multi-task when talking to associates. Make eye contact, and repeat questions to ensure they know you are listening," she advises.

Follow up with that employee later in the week to see how he or she is doing, or to provide answers to questions. "If they have a question or problem and you don't know the answer, admit it," says McCarthy. "But let them know you will find it!"

Any time you're out in the building, make eye contact, speak to associates, and encourage them to drop by any time, advises McCarthy.

When walking through the buildings to speak with workers, McCarthy makes a point of asking questions about how they do their job. "I find that they are much more forthcoming with information," she adds.

[For more information on establishing trust with employees, contact:

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