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Covering Case Management Across The Entire Care Continuum

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IN THIS ISSUE

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Non-adherent patients? Check your communication skills

It may be that they just don't understand

If your patients aren't following their treatment plan and end up in the hospital or emergency department or fail to keep their chronic disease under control, resulting in complications, don't automatically blame the patient. Instead, look to yourself to see what you could do to help them understand, says **BK Kizziar**, RN, CCM, owner of BK and Associates, a case management consulting firm based in Southlake, TX.

"Patients do not freely decide to cause harm to themselves, to deliberately cause deterioration in the quality or quantity of their lives, or as care providers, in the lives of their loved ones. In my opinion, the issue of non-adherence is more a matter of health literacy than anything else," adds **Catherine M. Mullahy**, RN, BS, CRRN, CCM, president and founder of Mullahy and Associates, a case management consulting firm based in Huntington, NY.

The healthcare system can be frustrating and anxiety-producing for everyone, even if a person has a lot of knowledge and skills, adds **Sandy Roland**, senior communications coordinator for Passport Health Plan, a

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Medicaid HMO with headquarters in Louisville, KY. "When someone is struggling with literacy, the healthcare environment can be very overwhelming, and that's why we work so hard to make a difference," she says.

Healthcare professionals often take for granted that people know more about their illness than they really do, Kizziar says. "We are expecting our patients to be adherent and change their behavior when they don't always understand what they are supposed to do or the reason to follow the treatment plan," she says.

"Low-income patients and people for whom English is a second language tend to have greater healthcare literacy challenges than the general population. However, people may be extremely well educated in other areas, but when it comes to health information, they have trouble understanding," says **Lucy Ricketts**, director of marketing for Passport Health Plan with headquarters in Louisville, KY.

The National Patient Safety Foundation estimates that the health of 90 million people in the United States may be at risk because of difficulties in understanding and acting on health information and that 66% of adults over age 60 have inadequate or marginal literary skills.

"Case managers as an individual, as a member of a team, and organization can make a difference in developing ways to help people understand and navigate the healthcare system. This is regardless of the setting in which they work," says **Helen Osborne**, MEd, OTR/L, president of Health Literacy Consulting, a Natick, MA-based firm.

In addition to being aware of health literacy yourself and applying what you have learned when you communicate with patients, use your knowledge to raise awareness about health literacy among others in your organization, Osborne says. She recommends that case managers review the white paper "Ten Attributes of Health Literate Healthcare Organizations by members of the Institute of Medicine Roundtable on Health Literacy" and apply the attributes to their everyday activities.[1]

Keep in mind that not everybody has the same level of knowledge, so don't assume anything when you work with patients, Roland says.

Remember that the ability to comprehend instructions depends on many things, Kizziar adds. Older adults may have problems understanding because of cognitive issues or the decline of physical

EXECUTIVE SUMMARY

Patients who don't follow their treatment plan often are confused about what they should be doing. That's why case managers should take the time to make sure patients understand their medication regimen and treatment plan.

- Slow down and spend time with patients to find out their literacy level as well as cultural practices and beliefs that could interfere with adherence, then help them come up with ways to adapt healthy behaviors.
- Watch for cues that indicate that patients don't understand, such as body language or silence after a question, then repeat the information in a simpler form.
- Use the teach-back method, but make sure to use language that isn't insulting or doesn't make the patients feel inadequate if they don't understand.

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functions, such as vision and hearing.

Stress can play a role in a patient's ability to process information and understand his or her treatment plan, Mullahy adds. "Even those of us who are healthcare professionals respond quite differently when we or a member of our family becomes the patient," she adds.

"All of us in the healthcare field want patients to take more responsibility for their own health, and as case managers we can provide information and make sure they understand it so they can do so," Kizziar says.

Case managers often feel they don't have time to spend with patients and make sure they understand their medication regimen and treatment plan, Kizziar points out.

"The case management job has gotten so complex and multi-faceted that there is a tendency to get in a hurry. But it's crucial to make sure patients understand, and find out why patients are not adherent," she says.

She advises case managers to slow down and spend time with patients. "Typically, in the hospital, the case manager is the most consistent face the patient sees," she says. The same is true of case managers who work for payer organizations and have a telephonic relationship with members.

Make sure patients are given information in a way they can understand and incorporate it into their lives, she says. Keep in mind that behavior often is influenced by culture and financial status, she points out. For instance, you can't expect someone with a low income level who has eaten unhealthily all his or her life to switch to more expensive fresh vegetables and fruit.

When they give patients instructions, case managers should look for cues to determine if the person they are working with can understand. Body language can be a tip-off that people don't understand when you're talking face to face, Roland says. If you are talking on the telephone, silence after a question is an indicator that the person is confused about what you are telling them, Roland says. She suggests repeating the information, maybe using simpler language, or offering to read the material to them.

In addition to clearly explaining to patients what they should be doing, include information on why it's important to do so, Kizziar adds. "Too often, case managers give patients instructions, but the patients don't understand the rationale behind what we are telling them to do. We can't expect patients to be adherent if they don't understand the reason for their treatment plan or changing their behavior," she says.

For instance, if you are going over a patient's medication regimen, explain what will happen if they take it at the wrong time or take certain medications at the same time, she says. Say something like: "Remember if you take the red pill and the blue pill at the same time, it will make your heart flutter," or "Since you're usually at home in the morning, take your water pill when you get up so the pill will be used up in the afternoon and you can go shopping without worrying about where there is a bathroom."

At the same time, if patients make an informed decision not to be adherent, leave that behavior alone and concentrate on something else, Kizziar says. For instance, if someone tells you they aren't willing to stop smoking, don't harp on that. "If you keep after people to do something they aren't willing to do, you'll alienate them," she says.

REFERENCE

1. Institute of Medicine Roundtable on Health Literacy. *Ten Attributes of Health Literate Healthcare Organizations*. http://iom.edu/~/media/Files/Perspectives-Files/2012/Discussion-Papers/BPH_Ten_HLit_Attributes.pdf ■

Slow down and keep it simple

Make sure patients understand instructions

As a case manager, your job isn't done just because you told a patient something. Your job is done when the other person understands it, says **Helen Osborne**, MEd, OTR/L, president of Health Literacy Consulting, a Natick, MA-based firm.

Use the teach-back method to find out if people understand what you are telling them, whether you're working with them in person or over the phone, Osborne recommends. Remember that teach-back is not a test of the other person. It's about whether you have explained the information in ways others can understand it, she says.

The teach-back method is much more effective than asking questions that can be answered with yes or no, adds **BK Kizziar**, RN, CCM, owner of BK and Associates, a case management consulting firm based in Southlake, TX. When you ask your patients to repeat their instructions, phrase the question in language that isn't judgmental or insulting so they don't feel inadequate if they don't understand, she suggests. Say something like "I want to find out if I have done a good job of teaching you."

Improve communication by speaking slowly and distinctly and spending a little more time with each patient, suggests **Catherine M. Mullahy**, RN, BS,

CRRN, CCM, president and founder of Mullahy and Associates, a case management consulting firm based in Huntington, NY. Sit rather than stand when you see patients in person, listen more than speak, and encourage patients to ask questions.

Whether you are talking to patients or writing out materials, include only key information that people need to know rather than including information that would be nice to know, Roland says. For instance, if you are educating people with diabetes on how and when to monitor blood sugar, there's no need to overwhelm them with the causes of diabetes. Instead, teach them how to insert the needle, how many times a day they should monitor the blood sugar level and when they should do it, and what to do if the level is elevated.

"It's better not to overwhelm people with too much information. Give them small chunks at a time and build on that," she says.

Work on a few key points during each visit or telephone conversation and reinforce them with patient-friendly handouts, Mullahy says. If you're seeing patients in person, follow up with telephone calls to clarify the information and correct any misunderstandings.

Whether you're speaking or writing, use active voice, suggests **Sandy Roland**, senior communications coordinator for Passport Health Plan, a Medicaid HMO with headquarters in Louisville, KY. "It's much more straightforward than passive voice and tends to take fewer words to explain things," she says. Use short sentences and words with only one or two syllables. "It's all about organization and putting information in the right format and the right order so people understand it," she says.

Roland recommends that clinicians use bullet points and graphics to make health promotion materials more readable. Use "living room language" — words anyone can understand — rather than clinical terms. Keep the information short and to the point. Remember that every word you add is a layer that has the potential to complicate the process, Roland says. For instance, if the medication label instructs patients to take the medication three times a day, make sure they realize it means morning, noon, and night. Take a few additional seconds to explain that they should take it with breakfast, lunch, and dinner, she says.

Remember that for some patients, a picture is like a thousand words and use pictures or diagrams to illustrate your point.

When patients have trouble understanding and don't have a caregiver to help, Kizziar suggests using illustrations to demonstrate what patients should do. For instance, create a daily schedule on a small piece of posterboard with the times of day they are supposed to take their medication and glue an actual pill next to the time they should take it.

As you work with patients and uncover written information they have trouble understanding, share it with the rest of your team and organization and work together to make it more understandable, Osborne says. Ask people who represent the intended audience if they understand your materials and use focus groups to get their input, she suggests.

"In any organization, case managers are the ones who are working directly with people, and they are in a great position to bring information to everyone else on the team about how to better communicate with patients," she says.

For more information on health literacy in general, including links to articles, see www.healthliteracy.com, the Institute for Healthcare Advancement at www.iha4health.org, and the National Patient Safety Foundation at http://www.npsf.org

To download free podcasts about health literacy, see www.healthliteracyoutloud.com. ■

Health plan focuses on healthcare literacy

Staff make sure members understand

Passport Health Plan, a Medicaid HMO with headquarters in Louisville, KY, provides health literacy training for employees so everybody who comes in contact with the members knows the

EXECUTIVE SUMMARY

Passport Health Plan has committed resources and staff to provide health literacy training for employees so they can help members understand their treatment plan.

- All materials are written at a sixth grade or lower level and the health plan uses interactive software to confirm the readability of materials and choose easier-to-understand terminology.
- Before introducing new materials, the health plan invites members in the targeted population to participate in focus groups to evaluate the materials.
- When the health plan sends out written materials, it encourages members to contact care coordinators for help in understanding them.

importance of making sure people understand their benefits, when to seek care, and how to follow their treatment plan.

"Health literacy is a science, and providing the training people need to understand it is a good investment. We made a commitment of resources and staff to make sure every employee knows the best practices in health literacy and that our members can understand the materials we give them," says **Lucy Ricketts**, director of marketing for the health plan.

It's not enough to give members materials and make sure they go to the doctor's office, she adds. "If people can't understand their benefits, their treatment plan or how to take their medication, we haven't closed the circle of care. We serve a diverse, multicultural population, and an emphasis on health literacy has been a part of the health plan from the beginning," she adds.

All of the materials Passport provides to members are on a sixth grade or lower reading level, says **Sandy Roland**, senior communications coordinator. Roland, who writes all of Passport's materials and provides training for the staff, has received extensive training in health literacy and communication using plain language at New England's Summer Health Literacy Institute in Freeport, ME, and the Institute for Healthcare Advancement in LaHabra, CA.

The health plan uses plain language and works with internal graphic designers to ensure that the fonts and layout have maximum readability. "We want people to pick up our literature and, with a moment's glance, they should be able to read and understand it. A first impression is very important because people will decide very quickly if they want to take the time to read the piece," she says.

Passport serves a culturally diverse population, and Roland makes sure all of the health plan's materials and communication with members take into consideration the needs of the non-English speaking members.

When Passport creates written materials, the health plan invites members in the segment of their population that is targeted to participate in focus groups to evaluate the materials. "Focus groups are a critical and powerful tool for making sure we are reaching the intended audience. Health literacy is impacted by a person's culture as well as education," Roland says.

For instance, recognizing that diabetes is a significant problem for Passport's Spanish-speaking and African-American members, the plan held focus groups for each population to make sure they could understand the information from a healthcare literacy and a cultural standpoint. Roland used the input received to change the materials to make them more meaningful to each group. "We learned more than we anticipated. They told us that some of the photos and terminology we used didn't relate to the Spanish-speaking culture. Our focus group of African-American members gave us similar feedback regarding their preferences," she says.

When the health plan sends out written materials, it encourages the members to reach out to the care coordinators for help in understanding the message. "The nurses can talk them through their instructions. They have been trained to assess the member's level of understanding and go over the materials if needed," she says.

When Roland collaborates with the clinical staff, she encourages them to be basic health educators and minimize the words they use. "We encourage staff to take continuing education classes and attend health literacy conferences," she says. She uses software that confirms the reading level of materials and offers suggestions of words that are easier to understand and considered more health literacy. "We are constantly searching for the best words to use in order to provide people with the information they need," she says. ■

Embedded CMs work with physicians, hospital

Goal is to improve care, reduce readmissions

As part of its efforts to reduce admissions and emergency department visits, Capital District Physician Health Plan (CDPHP) has embedded case managers in 15 primary care practices and is conducting a pilot project that embeds a case manager in a local hospital.

"Communication between the health plan and providers is the key to improving patient care and preventing readmissions. We are working to exchange information with the hospital and the physician practices. Most of the time, none of us has the whole patient story because we don't know what the patient isn't telling us," says **Charlene Schlude**, RN, CCM, director of case management for the Albany, NY-based not-for-profit health plan. The health plan started its initiative in 2010 with a pilot project in which case managers were embedded in three

EXECUTIVE SUMMARY

Capital District Physician Health Plan, based in Albany, NY, has embedded case managers in 15 primary care practices and one hospital to improve patient care and prevent admissions.

- Case managers are embedded in large practices that provide care for a large number of patients with significant healthcare needs and work with physicians to educate the patients on their treatment plan and identify barriers to adherence.
- In a pilot project, a case manager is embedded at a large medical center that provides care for a large number of CDPHP members. She visits CDPHP members with chronic illnesses before they are discharged, explains the care management process and sets up a primary care visit within seven days of discharge.
- A readmission avoidance case manager follows up by telephone with at-risk patients on Days 7, 14, 21, and 28 after discharge from the hospital.

practices. The program has been expanded into other practices with a high number of CDPHP members who are chronically ill, Schlude says. "We decided to expand based on the initial evaluation of the costs of the case managers compared to the reduction in admissions and emergency department utilization," she says.

The embedded case management program is part of CDPHP's Enhanced Primary Care initiative, a patient-centered medical home model that works directly with physicians and staff to provide care coordination. Large practices that care for a large number of patients with significant healthcare needs are offered the embedded case managers. The health plan also provides telephonic case management for high-risk patients in the smaller practices.

The embedded case managers partner with the physicians to determine which patients would benefit from case management and address their needs. "The patients targeted for this program are the most chronically ill ones who consume a good portion of healthcare dollars," she says.

Typically the embedded CDPHP case manager gets a list of patients coming into the practice that week and determines which ones need to be seen. They meet with patients who come into the office and follow up by telephone. "The goal of the program is to assist physicians to educate patients on the importance of their treatment plan and to identify any barriers to adherence. That's where the embedded case managers can help, by taking time to look at each individual patient and his or her needs," Schlude adds.

The embedded case managers have private office space where they meet with patients. They follow up by telephone or during the patient's next visit. They always offer patients the option to come in and talk to them when they don't have a primary care provider visit.

"The case managers take a lot of time with the patients and often uncover problems such as financial and social issues that can interfere with patients following their treatment plans," she says.

The health plan has refined its model over the years as the nurses have developed a better understanding of what patients they need to see and how to collaborate with the medical office staff. "We recognized what really works and what patients and physicians feel is valuable," she says.

Case managers are in the large practices every day and the smaller practices a few days a week. They can call on support from health plan social workers who visit patients at the primary care offices on a case-by-case basis. For instance, they work face-to-face with Medicaid managed care beneficiaries who have a lot of social needs. Some are in shelters and the social workers try to find them lodging. Many have lost their medication.

Some patients have been followed by the embedded case manager for a year or longer. Others just need help for a short period of time to get their disease under control.

The health plan also has embedded a nurse case manager at a large medical center that provides care for a large number of CDPHP members. The case manager visits CDPHP members with chronic illnesses before they are discharged, explains the care management process and how it can benefit the patient, and sets up a primary care visit within seven days of discharge.

"Readmissions are on everybody's mind these days. Hospitals are being challenged with readmission penalties, and it's beneficial for them to partner with health plans instead of doing their thing while we do ours," she says.

The case manager on site has access to the hospital's electronic medical record and reviews the records of members who have been

admitted to determine if they are appropriate for follow up. "Often patients will be in the hospital for a procedure such as a joint replacement but the case manager will determine from the medical record that he has heart failure, diabetes, or another chronic condition," she says.

If the case manager at the hospital identifies a patient with a chronic condition, she will refer the patient to the readmission avoidance case manager, who follows up on Days 7, 14, 21, and 28 after discharge.

The case manager in the hospital visits patients who are appropriate for case management at the bedside and identifies social concerns and other information that might not show up in the chart and shares the information with the embedded case manager or the telephonic case manager. "Patients go home much quicker today, and this way we can identify situations and issues that might send them back to the hospital," she says. For instance, a patient might live alone or have had frequent falls, and a discharge to home might not be the best option.

"This is another level of how we support our enhanced primary care practices. We let the physician know that their patients have been in the hospital and that we are going to follow them for 30 days to make sure the transition goes smoothly," she says.

Visiting patients in person helps engage them in the case management process after discharge, Schlude says. "We have learned from the embedded case management model that patients are more receptive when they see the case manager face to face rather than getting a phone call," she says. The embedded case manager typically sees the patients a couple of times before discharge and prepares them for the follow-up phone call, she says. The case manager determines if the patient has financial concerns or needs community services. She discusses the medication regimen and tries to get a feel for whether they can afford to purchase them or pay their co-pay and contacts the physician when appropriate to see if a less expensive medication would be as effective.

"We take a lot of time trying to determine what might interfere with a safe and effective discharge. We know that if patients can't afford their medication, they choose not to fill the prescription or to omit one. The goal of our embedded case management programs is to help patients maximize their health and improve their quality of life," she says. ■

Physician follow-up makes patients happy

Email provides efficient outreach

It is entirely understandable for emergency providers to question any new task or responsibility handed down by regulators or administrators. Busy providers are already stressed with burgeoning patient volumes and all the pressures associated with handling acute care crises. Consequently, it is no surprise that when Kaiser Permanente's Northern California region rolled out an initiative aimed at getting emergency providers to initiate post-ED visit contact with patients, it was a tough sell, at least initially.

However, three years into the initiative, ED directors report that not only is the practice improving patient satisfaction, which was a primary goal of the effort, it is also giving physicians the opportunity to reinforce instructions that may have been missed or misunderstood in the midst of a medical emergency, and to answer critical patient follow-up questions that can have an impact on outcomes. In addition, emergency providers are receiving feedback on their performance, which they never had access to before.

Phone follow-up presents challenges

Kaiser's decision to implement the post-ED visit callbacks followed a pilot of the practice, led by **Pankaj Patel**, MD, former chief of the EDs at Kaiser Sacramento and Roseville Medical Center. A few of the physicians at these facilities were already contacting patients by phone following their ED visits. Patel and some of his colleagues wanted to see if they could leverage a tool that was already in use among Kaiser's primary care practitioners, which enables secure messaging between providers and patients via e-mail. "We thought it would be a great opportunity for ED physicians to use this tool also, even though these were not our own private patients," says Patel. "These were potentially patients we had never seen before, but we thought the impact might be equally valuable in the ED setting."

Kaiser's secure messaging capability is a HIPAA-(Health Insurance Portability and Accountability Act) compliant process that patients can sign up for, explains Patel. Patients who elect to take advantage

of secure messaging understand that the process will be used to exchange medical information, and they determine what the confidentiality will be in the e-mail address that they provide, he says.

The pilot, which was conducted between May 1 and June 30 of 2010, involved 42 emergency physicians who volunteered to participate by either e-mailing or telephoning patients within 72 hours of their ED visit. In an alternate month, the physicians provided no follow-up contact.[1]

Among all patients who received follow-up contact, 348 patients returned patient satisfaction surveys, with 87.7% reporting their experience as "very good" or "excellent." Among all the patients who did not receive follow-up contact, there were 1,002 patients who returned patient satisfaction surveys, with 79.4% who rated their experience as "very good" or "excellent."

There was little difference between patients who received follow-up via phone and those who received e-mail contact, but Patel notes the e-mail contact was more efficient. The study showed that it takes about two minutes to send a follow-up e-mail to a patient, but reaching a patient by phone may take much longer, requiring multiple attempts.

"If you do not get a hold of the patient and leave a message, then you have to leave a phone number. And if you leave a phone number, then when the patient calls back, it may be in the middle of your shift, so it presents real challenges," says Patel. "In the ED environment, the study shows that there is no better way to communicate at this point than via e-mail because you can do it on your time and the patients are able to reply on their time."

Positive feedback is the norm

While patients reacted positively toward the physician contacts, investigators found that they were also contacting the physicians back, and that nine times out of 10, this feedback was positive, says Patel. "It was nice. In our day-to-day affairs, we would go days and days without getting any comments or feedback at all, or just get feedback that was bad," he says. "This was the first time when we were getting feedback that was consistently positive from the patients that were taken care of by the physicians."

Another finding was that in instances in which an ED visit or patient interaction didn't go as well as the physician would have liked, the follow-up provided a second opportunity to "make a good first impression," says Patel. "Also, it allowed us to reinforce things that we may have not had enough time to reinforce during the ED visit."

For example, if a key instruction was for a patient to stop one medication and start on a new one, the physician could state this in the follow-up e-mail message. "It gave us that opportunity to reinforce important things," adds Patel.

When the study was completed, the two participating EDs institutionalized the practice, and it is now a standard of care in the departments. "Out of our 85 physicians in the group, almost all of them are using the e-mail function," says Patel. "About half of the physicians are contacting every patient who is on secure messaging, and the others are contacting various percentages."

The physicians often want to send the follow-up messages to patients with whom they have had a good interaction, explains Patel. But they also use the opportunity to reach out to patients who may not have had a good experience in the ED. "Roughly half of the patients who are on secure messaging are being contacted through our department standards," he says. "Even patients with lacerations or simple ankle sprains will contact us back and say that they have never, in all their visits to the ED over the years, had a doctor contact them."

The patient feedback is often infused with praise and gratitude, says Patel. "It is a nice pat on the back for physicians, and it makes them feel better about their jobs," he says.

One very big fear of the investigators initially was that the post-ED follow-up contacts might generate all kinds of time-consuming questions and concerns from the patients. Fortunately, this has not proven to be a problem, says Patel. "It is interesting that out of 100 patients that we e-mail, literally there is only one who makes those kinds of requests," he explains. "Our policy is that we want to respond back at least one time again if the patient asks a question, but if it is a question that is outside the realm of the ED physician, our recommendation would be that this is something that the patient really needs to follow-up with through his or her PCP. That would end the e-mail communication."

However, there are times when physicians will carry on the e-mail communications with patients for a week or two following an ED visit — perhaps because they have a strong interest in the case — although this does not happen very often, says Patel.

Establish goals, incentives

Since the pilot was completed in 2010, the post-ED visit contacts have been adopted in all of the other 20 EDs in Kaiser's northern California region,

but physician leaders in these settings acknowledge that it took some time to get attending physicians on board.

"On the surface, it seemed like a superfluous responsibility added to an already long list of duties. It was an abstract concept that sending an e-mail to a patient after you had seen him or her in the ED added any value for the provider or the patient," explains **David Roth**, MD, chief of the ED at Kaiser's Walnut Creek Medical Center in Walnut Creek, CA, a facility that treats 54,000 patients a year. "It was difficult to explain or prove the value in secure messaging initially, and we used alternative measures to increase adoption of this practice."

For example, ED administrators established an attainable goal that each physician would follow-up with 30% of his or her patients via secure messaging, and then the leadership began to publish each physician's messaging rate. "It evoked a heightened awareness that this was important to the group and the organization," says Roth. "I am sure it also fostered some healthy competition [among the physicians] to avoid being the laggard."

Once the physicians started adopting the practice at higher rates, the benefits of the practice became more tangible and personal. "I and the others in the department now consider secure messaging as one of the more gratifying parts of our practice," says Roth. "Unlike our MPS [member patient satisfaction] scores, which give aggregate data, we now get personal messages from patients and parents which are overwhelmingly complimentary and thankful for the care they received during their visit."

Roth says he uses the opportunity to answer questions the patients have or to remind them of follow-up appointments. "It is a fantastic way of communicating and reinforcing our integrated model of care within Kaiser," he observes. "The patients seem to enjoy having this level of access with their treating physicians, and this has driven even more consistent use of secure messaging by our physicians."

While patient satisfaction has been gradually increasing in the ED at Walnut Creek, Roth acknowledges that this is probably a result of many factors. "I am convinced that secure messaging has played a large part in our record MPS scores," he says.

To continually reinforce the importance of the practice, Roth regularly asks his physicians to send him accumulated patient secure message responses without any identifying information so he can share them with the entire department. "This reminds our physicians and staff how important their work is in the lives of our patients and their families," adds Roth.

The ED at Kaiser Hospital in Santa Rosa, CA, a facility that treats about 49,000 patients per year, was among the first in northern California to adopt the secure messaging practice three years ago, explains **Hilary Bartels**, MD, the chief of emergency medicine. However, she experienced many of the same challenges with physician buy-in that Roth confronted at Walnut Creek.

To facilitate physician adoption of the practice, administrators began including the percentage of patients who received a secure message as one of the metrics that is tied to bonuses and salary. "It is transparent, and it is shared with all the other physicians," explains Bartels. "It needs to become part of the culture for physician behavior."

As with the other EDs that have adopted the practice, Bartels notes that physicians have come to realize that the practice is a nice way to keep in touch with patients. "Also, physicians have the incentive to send the secure message because it allows them to catch any overlooked follow-up items, and because it is on our publicly shared physician dashboard," says Bartels.

Consider legal aspects

Adoption of the post-ED contacts was a very low-cost intervention for the Kaiser EDs because they already had access to Kaiser's secure messaging system, explains Patel. "If I didn't have a system to e-mail patients in my ED, I would probably have to go through med-legal and make sure that I have some type of HIPAA-compliant feature that allows me to do e-mail," he says.

Another task that is critical to the successful adoption of the practice is having mechanisms in place to verify patient phone numbers and e-mail addresses. "We make it a point with our reception staff that if we don't have accurate phone numbers, then following up with patients is going to be very difficult. For EDs that want to do this type of post-visit contact, this practice would need to apply to checking e-mail addresses also," says Patel. He advises ED managers who are interested in adopting this practice to make sure that the reception desk gets an accurate e-mail address on record for every patient who comes in.

One nice thing about written communications is that they can be easily uploaded onto a patient's electronic medical record. Kaiser now does this automatically with all secure messages that are both sent and received. "If you call a patient by phone, you then also have to enter notes in the chart

to make the communication part of the medical documentation," says Patel. With e-mail messages, such documentation is a much simpler matter, he says.

The time commitment involved for carrying out post-ED visit e-mail messages has turned out to be relatively small, says Patel. "If a physician is seeing 15 patients in a shift, roughly half of whom [have elected to take advantage of Kaiser's secure messaging feature], the time commitment is 15 to 20 minutes per day," he says.

Roth advises ED leaders to set attainable milestones of performance and to publish transparent data on the rates of compliance by each physician. "Physicians are, by nature, competitive and want to validate themselves to their colleagues," he says.

Roth also recommends that administrators take the time to share patient comments with the physicians and staff, particularly in the initial stages of the intervention. This should help to increase buy-in among physicians and a willingness to give the approach a try. "After the initial adoption of this practice, I think the benefit and importance of this quick and easy communication tool will become self-evident," he says.

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SOURCES

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Text message tool cuts time for stroke patients

Door-to-needle time cut from 80 to 60 minutes

Sometimes just making people aware of their performance is all that is necessary to significantly improve care. Investigators at the University of California at San Francisco (UCSF) found this to be precisely the case when they attempted to use this approach to improve door-to-needle times for stroke patients who presented to the ED for care at UCSF Medical Center.

As a teaching hospital, it can be challenging to reinforce care guidelines with residents who continually rotate through the stroke care team, explains **Molly Burnett**, MD, who is a resident in the Department of Neurology at UCSF. "We rotate so frequently that a lot of times we are not [with the stroke team] long enough to get feedback about how long we are taking, or even to realize that the goal for [time-to-treatment] is 60 minutes," she says.

Administrators observed that when stroke patients presented to the ED, it was taking the hospital longer than some of the other hospitals in the area to deliver brain-saving tissue plasminogen activator (tPA). "Our average door-to-needle times were over 80 minutes, and definitely not in compliance with the guidelines," explains Burnett.

To address the issue, Burnett and colleagues decided to test whether immediate notification about the door-to-needle time for each patient, delivered to all members of the stroke team in real time via text message, would be enough to boost awareness of the guidelines and expedite care to patients.

Monitor performance

The intervention was designed to follow the traditional "code stroke" page that is always triggered by an ED provider whenever a patient presents with symptoms of stroke. That page goes to the entire treatment team, including representatives from radiology, bed control, the lab, and several others, explains Burnett. Investigators added a "reply" page to this sequence that would go to the same group of people as the initial "code stroke" page. It would indicate via text message whether tPA was given and, if so, what the door-to-needle time was.

Initial results from the test of this intervention, which was completed in 2011, were clear cut. The average door-to-needle time for 95 patients treated before the intervention was implemented was 82 minutes. The 45 patients who received tPA after the intervention was employed were treated within 61 minutes. Further, investigators report that a significantly higher percentage of intervention-group patients were treated within the recommended 60-minute

time frame (50%) than was the case in the pre-intervention group (16%). Burnett notes that since 2011, results have continued to improve at UCSF Medical Center, as the text-messaging intervention is now a standard of care at the facility. "On average, our door-to-needle times are in the 50- to 60-minute range now," she says.

Burnett emphasizes that one key to the intervention's success is the constant monitoring of the text messages by **Andy Kim**, MD, MAS, an assistant professor in neurology and medical director of the Stroke Center at UCSF. "If a door-to-needle time is more than 60 minutes, he will contact the treating team and ask what the impediment was to making the 60-minute time frame," says Burnett. "He also sends out stroke performance results to the entire multidisciplinary team about every two weeks. These data show us how well we are doing."

Deliver real-time feedback

While it would seem that the Stroke Center director serves as the task master in this intervention, Kim explains that the approach was actually very easy to implement. "I spent the first month or two sending reminder pages at all hours of the day and night, but quickly it became self-sustaining even without the additional reminder pages," explains Kim.

Kim also emphasizes that ED staff are crucial to making the intervention work. "Providing objective feedback to the entire team, including the ED, in real-time rather than a week, a month, or a quarter later, only serves to enhance our existing relationship because it allows us to celebrate our successes together rather than just interacting when things do not go as smoothly," he says.

Other hospitals interested in experimenting with a similar strategy need to design their approach around the specific challenges that they face, advises Kim. "Here, we knew that our existing system was capable of delivering tPA quickly because in individual cases we were able to achieve our goal," he says. "We focused on the problems of short institutional memory due to rotating residents in our training programs and the diffusion of responsibility, given the large team of people involved."

Having the technology already in place to implement the intervention was certainly helpful, says Kim. But he suggests that success of the approach had more to do with what the technology enabled the UCSF team to accomplish. "It is the real-time nature of the feedback, clear and immediate accountability, and frequent and sustained effort to improve care that are the key components of any successful quality improvement initiative," he says.

SOURCES

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COMING IN FUTURE MONTHS

- Incorporating behavioral health into medical CM
- Helping seniors live independently
- How cultural beliefs affect healthcare
- New opportunities for case managers

CNE QUESTIONS

1. According to the National Patient Safety Foundation, the health of 90 million people in the United States may be at risk because of difficulties in understanding and acting on health information and 66% of adults over age 60 have inadequate or marginal literary skills.
   A. True
   B. False

2. According to Catherine M. Mullahy, RN, BS, CRRN, CCM, president and founder of Mullahy and Associates, how can case managers improve communication?
   A. Speak slowly and distinctly
   B. Sit rather than stand when you see patients in person
   C. Encourage patients to ask questions
   D. All of the above

3. How does Sandy Roland, senior communications coordinator for Passport Health Plan, suggest that case managers make what they are saying easier to understand?
   A. Use active voice rather than passive voice.
   B. Use short sentences and words with one or two syllables.
   C. Avoid medical jargon and use "living room language."
   D. All of the above.

4. When does Capital District Physicians Health Plan's readmission avoidance case manager follow up by telephone with at-risk patients after discharge from the hospital?
   A. Days 7, 14, 21, and 28 after discharge
   B. Seven days after discharge
   C. The day after their primary care appointment
   D. The day they are discharged and weekly after that for four weeks

CNE OBJECTIVES

After reading this issue, continuing education participants will be able to:
1. Identify clinical, legal, legislative, regulatory, financial, and social issues relevant to case management.
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3. Describe practical ways to solve problems that case managers encounter in their daily case management activities.

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