Patient Education Management™

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

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AMERICAN HEALTH CONSULTANTS

IN THIS ISSUE

MARCH 2005
VOL. 12, NO. 3 • (pages 25-36)

Use proven strategies to meet the health literacy challenge

Assess the situation and implement policies that include training staff

Clear communication is in the best interest of everyone — health care institution and consumers — for many reasons. It improves patient satisfaction. Patients leave an institution dissatisfied when they fail to get information, or it is delivered so quickly they can't understand it, or the vocabulary or concepts are too complex, says **Sue Stableford**, MPH, MSB, director of AHEC Health Literacy Center at the University of New England in Biddeford, ME.

Clear communication improves patient safety and quality of care. The Oakbrook Terrace, IL-based Joint Commission on Accreditation of Healthcare Organizations recommends patients partner with health care systems. This means patients are able to check medications they are given to make sure they are right, and to understand the procedures and treatments. Yet, for such partnerships to take place, there must be clear communication and

EXECUTIVE SUMMARY

Research indicates that people with low literacy make more medication or treatment errors, are less able to comply with treatments, lack the skills needed to successfully negotiate the health care system, and are at higher risk for hospitalization than people with adequate literacy skills, according to the Pfizer Clear Health Communication Initiative.

Health care information often is difficult for many patients to understand, regardless of their reading skills, when they are unfamiliar with the medical terms and issues of their diagnosis.

In this issue, *Patient Education Management* discusses ways to meet this health literacy challenge so communication between health care providers and patients can be improved for better health outcomes systemwide.

patients must feel comfortable asking questions.

Legal challenges often result from poor communication. According to case law, even if a consent form is signed, it is not legal and valid if the patient did not understand what he/she was agreeing to, says Stableford.

Poor communication can be costly. When forms are difficult to understand, they are often filled out incorrectly and must be mailed again. Unclear verbal or written instructions often means more work for staff who might spend much time answering questions about disease management over the telephone.

"I have been told repeatedly by clinical care providers that they have to counsel and reschedule tests for patients because they haven't understood the preparation instructions. When that happens, it is very costly for the institution and inconvenient for the patient, and they are not happy," says Stableford.

Although there are many benefits to implementing policies and procedures that lead to better communication between patients and staff members, often facilities do not have them in place because administrators do not realize there is a problem.

However, patient education managers are usually fully aware of the impact of low health literacy because they have seen how difficult it can be to educate a patient who can't read or write well, or is simply unfamiliar with the medical terminology for a health problem. Because of their knowledge, they might want to take the lead in trying to get an initiative addressing low health literacy off the ground at their health care institution.

Regardless of who leads the way, the first step to improving health literacy problems is to raise awareness, says **Sandra Cornett**, PhD, RN, director of OSU/AHEC Health Literacy Program at The Ohio State University in Columbus.

The best way to raise awareness is to use national and local statistics on literacy skills, she adds. The National Adult Literacy Survey, completed in 1992-93, shows there are many vulnerable populations. These populations include the elderly, people with chronic conditions, and those who speak English as a second language.

A new study, the National Assessment of Adult Literacy, will be released this summer and, unlike the old survey, it includes a health literacy component, according to Cornett.

Decision makers should be shown the research that links low health literacy to poor health outcomes. "Health literacy in and of itself is an indicator that you will have some problems with health outcomes," she explains.

It is important to note, Cornett adds, that the institution will save money when communication is improved.

To determine how to improve communication, a task force or committee should be assembled, and it should encompass all areas that might

Patient Education Management™ (ISSN 1087-0296) is published monthly by Thomson American Health Consultants, 3525 Piedmont Road N.E., Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals postage paid at Atlanta, GA 30304. POSTMASTER: Send address changes to **Patient Education Management**™, P.O. Box 740059, Atlanta, GA 30374.

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291. Hours of operation: 8:30 a.m.-6:00 p.m. Monday-Thursday; 8:30 a.m.-4:30 p.m. Friday EST. E-mail: ahc.customerservice@thomson.com. World Wide Web: www.ahcpub.com.

Subscription rates: U.S.A., one year (12 issues), $489. Outside U.S., add $30 per year, total prepaid in U.S. funds. Discounts are available for multiple subscriptions. For pricing information, call Steve Vance at (404) 262-5511. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue date. **Back issues**, when available, are $75 each. (GST registration number R128870672.)

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Statement of Financial Disclosure

In order to reveal any potential bias in this publication, and in accordance with the American Nurses Credentialing Center's Commission on Accreditation guidelines, we disclose that Editor Susan Cort Johnson, Consulting Editor Patyk, and board members Maller, Ruzicki, Szczepanik,and Villejo report no relationships with companies related to the field of study covered by this CE program. Board member Ball is a consultant and stockholder for Steris and Encision; she also serves on the speaker's bureau of AORN. Board member Cornett is a consultant for Pritchett and Hull Associates. Board member Garcia serves on the editorial board of Thomson Micromedex. Board member London serves on the advisory board of Pritchett & Hull Associates. Dr. Lorig (board member) acknowledges that she receives royalties for publications used in courses at and developed by the Stanford Patient Education Research Center, Stanford University School of Medicine. Dr. Lorig also has had research funded by the National Institutes of Health, The Robert Wood Johnson Foundation, the Centers for Disease Control and Prevention, and the Arthritis and Rheumatism Foundation. Board members Mercurio serves on the steering committee for the NCI Cancer Patient Evaluation Network.

have health literacy problems including the business office. The committee should do a facility-wide literacy audit or assessment to uncover barriers that make it difficult for people with low literacy to successfully use services. **(To learn how to assess a physician's practice for barriers, see article, p. 30.)**

Cornett says that the barriers might be grouped in four areas: promotion/publicity; print/electronic materials; verbal communication; and staff sensitivity to literacy.

Often patients with low literacy even have trouble accessing health care, says **Janet Ohene-Frempong,** MS, president of JO Frempong & Associates, a plain-language and cross-cultural communications consulting firm based in Elkins Park, PA.

People use to go to one site for treatment, but now they have to navigate entire systems. Often they get lost trying to follow directions, so it is important to anticipate these problems and provide clear directions. For example, signs using common terms, such as kidney rather than renal, also are helpful.

Another barrier to health care is the denial of benefits because application forms are incorrect or incomplete. People can't get the benefits they are qualified to have because of poor reading skills, says Ohene-Frempong.[1]

Once problem areas are identified, the committee can write policies and procedures to address them. There are a multitude of policies that might be appropriate.

For example, a policy could call for patient education materials to be at the appropriate level of literacy and language to meet the skills of the populations the institution serves. A policy also could require staff to use health materials written in plain language for teaching patients.

A process could be implemented to review all documents, such as consent forms, advance directives, and the patient Bill of Rights, to make sure they are in plain language. Policies also might require the institution to develop nontraditional approaches to communication such as audiotapes, videotapes, pictographs, and dialogue and storytelling.

The type of policies and procedures implemented depend on what is found in the organizational assessment and what efforts the committee sees as necessary to meet the challenges. "I would strongly suggest the committee not try to tackle all the problems at once," says Cornett.

She advises institutions to pick a starting point. And she emphasizes the changes will make health care better for everyone, not just patients with limited literacy.

"There are a lot of proficient readers who still have low health literacy because, whenever you are trying to impart information that is outside the context of that person's frame of reference, it is difficult information," explains Cornett.

Staff training a must

One policy that must be implemented at all health care facilities is staff training. This will enable them to more effectively teach patients with low literacy skills.

A session on health literacy awareness should be a part of all new employee orientation. Also, staff need to learn how to assess patients for health literacy and use appropriate teaching strategies when problems are identified.

For example, people who have low health literacy skills cannot take factual information from one lesson and apply it to another situation, says Cornett. The educator must do that for them. If the health care provider is teaching the patient how to pace him- or herself during an activity because of fatigue problems, every situation will have to be addressed, such as walking up a flight of stairs, doing chores around the house, etc.

"The higher-literate person can take those principles and apply them to another situation in their life, but the person who has low literacy can't. You have to find out enough about [which] situations they may find themselves in after they go home and talk to them about how they [should] pace their activity," says Cornett. **(To learn more about teaching methods for working with low-literacy patients, see article, p. 28.)**

Staff members responsible for written communications need to learn how to create plain-language materials. While this includes those who create forms and directions, patient education materials can be effective tools for people of all reading abilities if designed correctly.

Patient-friendly materials have four elements, says Ohene-Frempong:

1. They are not limited to text but have illustrations as well.

2. The text in a patient-friendly pamphlet is well organized and broken up so there is not a wall of words on the paper that intimidates people. Also, it is made readable by the sentence format.

3. Questions and answers or a checklist engages the reader.

SOURCES

For additional information about strategies to meet the health literacy challenge, contact:

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4. The material must address the patient's issues providing information that is relevant to him or her.

To provide incentive for following the policies and procedures set in place, staff need to be evaluated on their ability to communicate appropriately with people with low health literacy. "One of the ways that you make using those skills a priority is to tie them to staff performance appraisals," says Cornett.

In addition to training, staff need a variety of health communication resources to help them do their job effectively.

"You are building a communication structure that is going to basically enhance the individual interaction between a staff person and a patient. That might be everything from making sure that all the patient education materials are easily located and developed in plain language to interpretation and translation services," Cornett explains.

Institutions also should consider establishing a learning center or library for patients and consumers. These libraries should contain collections of plain language materials in English and in various languages that target the patient groups they serve.

To address the problem of health literacy, an institution needs to be committed to developing a strategic plan that will take place over time.

Reference

1. Williams MV, Parker RM, Baker DW, et al. Inadequate functional health literacy among patients at two public hospitals. *JAMA* 1995; 274:1,677-1,682. ■

Give staff skills to teach low-literacy patients

Methods will increase learning for all patient types

During training sessions on how to more effectively teach patients with low literacy skills, staff members at health care facilities mention several barriers, says **Sue Stableford**, MPH, MSB, director of AHEC Health Literacy Center at the University of New England in Biddeford, ME.

The staff are constantly pressured to do more in less time and have tremendous charting requirements. Patients are generally very sick when admitted to the hospital, and then discharged quickly. Therefore, it is difficult for the patients to learn the many skills they need for a safe discharge. Also, culture and language issues can complicate the patient-provider interaction.

"People bring different perspectives to the amount of information they want and what they think they need. A clinical care provider may well have ideas about what the patient is going to need to know to manage his/her care, but the patient may be more worried about other things at that moment so there is a discontinuity in priorities," says Stableford.

To help overcome these barriers to teaching, Stableford recommends organizations use the teaching strategies suggested by the Chicago-based American Medical Association as part of their health literacy campaign:

1. Slow down and take time.

Health care professionals familiar with the topic often talk too fast to patients who may know nothing about their condition, says **Sandra Cornett**, PhD, RN, director of OSU/AHEC Health Literacy Program at The Ohio State University in Columbus.

2. Use plain nonmedical, everyday language.

It is important to use lay terms when discussing health problems and treatment, says Cornett.

3. Show or draw pictures and use other teaching tools whenever possible.

Having tools available for teaching, such as models or drawings, will help people visualize situations, says **Janet Ohene-Frempong**, MS, president of JO Frempong & Associates, a plain-language and cross-cultural communications consulting firm based in Elkins Park, PA.

4. Limit the amount of information provided and repeat it.

"I tell staff to come up with two or three messages so they have the time to repeat them, and make sure that patients understand rather than cover five to eight points only once. Therefore the staff need to prioritize the most important things for the patient to know," says Cornett.

It's also a good idea to frame the message, she says. The educator needs to tell the person what is going to be taught. For example, he or she would explain that the lesson would cover three points about diabetes, and then briefly state what they are. Once the patient understands the lesson, the educator can go into more detail on each point.

"We find ourselves giving too much information and not organizing it in a way that helps people learn. Also, we overteach to some degree and give too much information too rapidly for most to grasp," says Cornett.

5. Use the teach-back or show-me technique.

Don't say, "Do you understand?" or the patients will just nod their heads. Say "Show me how you'll be giving yourself your insulin every day," explains Stableford.

6. Create a shame-free environment.

In a shame-free environment, patients feel comfortable asking questions. They know their questions are welcome, and it is OK to take time to learn, says Stableford.

"Make it safe for people to express confusion, give people permission to not understand," adds Ohene-Frempong.

(For additional teaching strategies for low health literacy learners, see teaching strategies, right.)

Teaching Strategies for Low Health Literacy Learners

- **Establish** a trusting relationship.
- **Invite** a second person to attend the teaching session, if appropriate.
- **Discuss** with the person what he or she can and want to do.
- **Limit information** to essentials for achieving desired behaviors. Be realistic.
- **Plan what to say** and organize information with the three most important points. (Frame the message first.)
- **Slow** down!
- **Use common words** consistently — no medical jargon.
- **Define** terms.
- **Make instructions** concrete/specific and vivid rather than general.
- **Teach** one step at a time.
- **Break down** complex instructions.
- **Make time** for the patient to tell his/her story and express feelings.
- **Use a variety** of teaching methods and tools.
- **Use techniques** of tailoring and cuing.
- **Verify** patient understanding by using teach-back technique and problem solving situations.
- **Use praise** and rewards.

Source: The Ohio State University AHEC Health Literacy Program, Columbus.

Model helps patient-provider interaction

A good way of organizing the patient-provider interaction is to use the AskMe3 model, she says. **(For contact information on AskMe3 and other resources, see "Web sites" on p. 30.)** This model encourages patients to ask and health care providers to answer three questions: What is my main problem? What do I need to do? Why is it important for me to do this?

The model increases the likelihood that patients will actually get something out of the patient-provider interaction and physicians will give as much information as possible in the limited amount of time they have, Ohene-Frempong points out.

At the end of a teaching session, it is a good idea to give patients written information summarizing or supplementing the teaching session, says Stableford. That way, patients leave with a better understanding of what they need to do.

Of course, the first step in teaching patients is to assess for learning barriers and, at this time, health literacy could be evaluated, says Cornett.

The best way to assess for low health literacy is to look for clues. Often, patients will give excuses for not reading the pamphlets they were given. Also, if they fall into the patient populations more likely to have literacy problems, such as the elderly or those who speak English as a second language, the educator might apply the skills for teaching low literacy patients.

However, the methods for teaching patients with low health literacy are excellent for all types of patient teaching, says Cornett.

"There is no magic bullet [to] use with people with low literacy. A lot of the strategies would enhance teaching anybody. For example, using common words consistently or making sure your terms are defined," she explains. ■

Web Sites and Materials to Support Teaching

A number of excellent web sites are available to provide information to help health care organizations create systemwide initiatives for clear communication. The following are four examples:

• **www.amafoundation.org**

On this web site's menu, under health literacy, you will find information on the Chicago-based American Medical Association's health literacy toolkits, health literacy videos, health literacy grants, and health literacy partnerships. The tool kits can be purchased for $35, and are free to qualifying organizations.

• **www.askme3.org**

Sections on this site include information for providers, patients, and large-scale implementers such as health plans and health departments. The site has information on low health literacy, including research studies. It also has lists of literacy resources, explanations of interaction techniques, and simple interventions.

A handout for patients has tips for clear health communication as well as the three most important questions to ask their health care provider to increase understanding: What is my main problem? What do I need to do? Why is it important for me to do this?

The sheet also has a section where patients can write down what they need to do to make healthy lifestyle changes.

• **www.pfizerhealthliteracy.com**

This web site has information on health literacy and how to improve it. Tools for improving patient understanding include signs of low health literacy.

• **www.chcs.org** (*Type "Health Literacy" in key word search at left.)*

This web site offers materials on the impact of low literacy skills on annual health care expenditures, resources for locating health literacy publications, and health literacy fact sheets.

Source: Janet Ohene-Frempong, MS, President, JO Frempong & Associates, Elkins Park, PA.

How to create a patient-friendly atmosphere

Better communication creates better health care

There are many changes staff at physician practices can make to ensure their office is patient friendly, says **Janet Ohene-Frempong**, MS, president of JO Frempong & Associates, a plain-language and cross-cultural communications consulting firm based in Elkins Park, PA.

She recommends health care providers in a clinical setting examine their practice in four areas suggested by the Chicago-based American Medical Association.

1. General attitude

Are the office staff friendly, helpful, and respectful of patients? Do they make patients feel comfortable? Ohene-Frempong says it is not enough to be helpful — staff must enjoy helping people. Health care providers should set the tone by example and make sure staff members are well trained.

2. Scheduling appointments

When people telephone the office, it's important to have a person answer rather than a machine, says Ohene-Frempong. If they are making an appointment, only the essential information should be gathered on the phone.

Also, directions to the office location need to be clear. Instead of telling people to drive south on a certain roadway, she suggests staff use landmarks when giving patients directions.

Tell the person what he/she should bring to the appointment, always keeping in mind that some patients may have low health literacy skills. For example, if a list of medications is required, tell patients they can bring a written list or, if they don't feel like writing the information down, to put their medications in a bag and bring them.

3. Office check-in procedures

Provide forms in an easy-to-read format, suggests Ohene-Frempong. It's a good idea to provide assistance with completing forms for patients who might have difficulty.

4. Referrals and ancillary tests

"Look at the instructions you are giving people and look for opportunities to make them more clear, because the potential for misunderstanding pre-procedural instructions is significant," says Ohene-Frempong.

It's important to be specific when writing instructions. For example, if people should not eat or drink after midnight, make it clear. Write: "Do not eat or drink after midnight."

While physician's offices may not be able to implement all the improvements Ohene-Frempong suggests, it is good to discuss all elements of a patient-friendly practice to determine what would work and what wouldn't work in each office. ■

Poor communication root of many patient safety ills

Change culture, improve patient satisfaction

A 54-year-old man presented to the emergency department (ED) with chest pain, and the emergency physician performed an initial evaluation, including an electrocardiogram and cardiac markers, but they didn't reveal a diagnosis.

As the doctor continued to work on his differential diagnosis, the patient was having problems maintaining his blood pressure, so the physician considered the possibility of a thoracic aortic dissection.

As a result, he took the chart and, according to him, notated in the order section that he wanted a computed tomography (CT) scan of the chest with infusion, and gave it to the clerk.

The order was not put in. The clerk said she never saw the order and didn't believe it was communicated to her. Two hours later, the patient still was in the ED and had not gone for a CT scan. The physician, upon realizing this, ran to the nurse and clerk to get the scan performed. The patient went down for a CT scan, and he died in the room.

In court, the ED physician pointed a finger at the clerk and vice versa. The jury believed the clerk.

The verdict was more than $2 million, according to **Daniel J. Sullivan**, MD, JD, FACEP, president of the Sullivan Group, a consulting company in Oak Brook, IL.

As this example illustrates, poor communication in the ED can have dire consequences. In fact, poor communication between health care professionals is the root cause of nearly seven of 10 sentinel events, according to the Joint Commission on Accreditation of Healthcare Organizations, and nowhere is communication more critical than in the ED.

According to the Joint Commission, there were a total of nearly 500 sentinel events in 2003 and more than 400 in 2002.

"The ED is a high-stress, high-risk environment where there is not a lot of room for mistakes," says **Marc Taub**, MD, FACEP, chairman and medical director of the ED at South Coast Medical Center in Laguna Beach, CA, and director of team training for California Emergency Physicians, an emergency physician partnership that includes more than 600 emergency physician partners in California.

Taub points to the pilot, co-pilot, crew model. "No one can possibly know everything that's going on, so if there's not good communication between staff and nurse and physician, there will be things [the physician] will not know about," he says. The physician's decision-making ability and patient safety will be diminished, he adds.

Attitude important part of communicating

Attitude is an important component of communication, adds **Diana S. Contino**, RN, MBA, CEN, CCRN, a consultant with MedAmerica, an Oakland, CA-based medical practice support company for emergency services, and owner of Emergency Management Systems, a Laguna Niguel, CA-based consulting firm that specializes in staffing issues.

"A nurse will be reluctant to approach a physician who is unapproachable, and vice versa," she explains. "It makes them less likely to solicit information from one another."

Whether you communicate openly should not be an option in the ED, Taub says.

"You must open lines of communication and constantly work to improve," he advises. "Even when people have information they may not think is that important, it should be brought to the decision makers."

For example, a registration clerk might hear a patient mentioning a suicidal plan. "That information should be brought immediately to the physician or nurse caring for the patient," Taub says. "Don't assume they already know."

On the flip side, he says, decision makers should share what they're thinking and planning and ask for input from others. "By communicating to others, it allows them be more proactive and helps you achieve your goals," he says.

Taub recommends that after seeing a patient, physicians share their impression and treatment plan directly with the patient's nurse.

For example, a physician could say, "I saw Mr. Jones in Bed 8, and I don't think he's having cardiac chest pain, but given his age and risk factors, I'm going to order a cardiac work-up. Any other thoughts or concerns?"

In addition, he says, it must be recognized that although physicians and charge nurses are the designated leaders, at any time, anyone may become a situational leader.

"For example, if multiple critical patients are in the ED simultaneously, a nurse or technician may

need to step up to the plate and assume temporary leadership for a patient while waiting for the physician," Taub notes.

Better communication is built upon what Contino calls key tenets:

- Create systems that foster double-checks for verbal orders and clarification of written orders.
- Track and trend errors.
- Promote optimal communication through a multitude of channels.
- Hold people responsible for their interpersonal actions.
- To promote patient safety, remove blame and look for solutions.
- Give staff the tools to improve.

Principles such as insisting on open communication sound fine in theory, but how do you translate that theory into reality?

Taub's hospital and five others affiliated with California Emergency Physicians implemented a program called MedTeams, a teamwork-training course from Dynamics Research Corp. in Andover, MA.

The course teaches teamwork principles, including communication, based on a model used in high-risk industries. The program is based on error reduction, teamwork, specific behaviors, and cultural change.

The course begins by recognizing human fallibility, Taub says. In this new paradigm, everyone is encouraged to feel confident and empowered to bring information forward. In this culture, "It is no longer good to have a hierarchy if patient safety is involved," he explains.

Two behaviors are key

Taub points to two specific behaviors he says have been instrumental in improving performance:

1. Interdisciplinary rounds or briefings.

Scheduled after each shift, these include physicians, nurses, registration, and anyone else who worked on the shift. "The physician leads a quick briefing on all available information on each patient, as well as logistics, such as are we on diversion, bed issues, and so on," Taub explains. "It's like a preflight briefing." And, he notes, no pilot would ever take off without a preflight briefing.

2. Conflict management.

"You want to get away from notes like 'Doctor so-and-so was aware . . .'" Taub explains. "If you have a concern, go to the physician and voice the concern. "We give staff a specific script to voice concerns; and as in aviation, if the concern is not answered, we have a double-challenge rule; you can go back a second time." he adds. ■

Learning collaboratives help improve primary care

Patient-friendly environment needed

A Commonwealth Fund study reports that while community health centers deliver primary health care to much of New York City's low-income population, the design and delivery of health care services at the centers can be made more patient-friendly. There often are delays in access to care, according to researchers **Pamela Gordon** and **Matthew Chin**, making it difficult to get an appointment. Inefficiencies in patient flow also are common, they wrote, resulting in office visits that are needlessly long.

To help the community health centers improve, the nonprofit Primary Care Development Corp. (PCDC) implemented a learning collaborative model at four New York City community health centers.

"Using PCDC's methods, each center made dramatic improvements in key operations: getting patients in and out of the center quickly; offering appointments with the patient's primary care provider on demand; enhancing revenue collections; and attracting and retaining patients," the researchers wrote.

The researchers said a successful implementation model is based on clear, simple, and effective principles, with five strategic principles applying to all collaboratives:

1. Build a high-functioning team.
2. Cultivate leadership support and involvement.
3. Track data and map the process from the patient's perspective.
4. Open lines of communication.
5. Use the expertise of PCDC coaches and program leaders.

The four models stress providers to:

- **Redesign the patient visit program.**

The redesign reduced the cycle time 40% from 68 minutes to 41 minutes, with a 58% increase in productivity from 2.85 patients per hour to 4.5 patients per hour. The researchers said the Jerome Belson Health Center serves a developmentally disabled population, which made the task of reducing patient cycle times even more challenging than

usual. "Even so," they said, "the principles of redesign successfully transformed an overcrowded waiting room that was far from user-friendly into an environment where the patient comes first, and providers and staff are highly productive."

Redesign principles include: Don't move the patient; eliminate needless work; increase clinician support; communicate directly; exploit technology; monitor capacity in real time; get all the tools and supplies you need; create broad work roles; organize patient care teams; start all visits on time; prepare for the expected; and do today's work today.

• **Redesign the patient visit process.**

At Union Health Center, PCDC said the key to reducing backlog and meeting demand was to measure the third next-available appointment time. Union patients commonly had to wait as long as 15 days before they could schedule an appointment. After the seven-month redesign, patients received appointments in one day or less, a 93% decrease in appointment scheduling time. And the patient no-show rate dropped as staff and patient satisfaction levels increased. Redesign principles include: Do today's work today; work down the backlog; reduce appointment types and times; develop contingency plans; reduce demand for visits; and balance supply (provider time) and demand (patient visits) daily.

• **Improve efficient revenue collection.**

The Brownsville Multi-Service Family Health Center undertook an effort to collect revenues efficiently through the entire collection process. The center serves a low-income community living predominantly in public housing. Its challenge was how to sustain revenue while meeting its clients' overwhelming needs. As a result of changes made through the learning collaborative process, average weekly cash receipts increased by 46%. Reimbursement per visit rose 55%, from $78 to $121. The researchers reported that the case study also documents how the work of the learning collaborative improved employee morale and encouraged high performance throughout the organization.

Another significant result of the effort was the adult medical care unit increased patient visit volume by 5% after several years of decline. Ten revenue-maximization principles identified in the redesign are: Do it right the first time; collect money due at the point of service; eliminate lag times between service and billing; manage claim rejections; redesign bad processes; encourage teamwork; leverage technology; share data; establish good internal control systems; and maintain appropriate staffing.

• **Improve marketing and customer service.**

This case study provided insight into how the South Bronx United Health Plan (UHP) health center adapted highly targeted marketing practices and increased and sustained patient volume in a very competitive environment. UHP had conducted an extensive media campaign for a new facility, which had generated much interest. But it realized it needed help in understanding the process of marketing without relying on expensive consultants. UHP enrolled in PCDC's Marketing and Customer Service Learning Collaborative. PCDC helped UHP understand the importance of a two-pronged approach to community outreach — creating an in-house marketing division able to customize outreach efforts to narrowly defined populations, and creating and maintaining employee and customer satisfaction.

Marketing principles applied included situational analysis, marketing objectives, marketing strategies, marketing tactics, and evaluation. Eight customer service principles are leadership commitments, service defined from a patient perspective, service standards, continuous improvement, internal communication, ongoing communication, reward and recognition, and patient satisfaction measures.

Re-engineering patient throughput, provider paneling, and patient scheduling is at the heart of the PCDC collaborative approach, according to the researchers. "Overhauling these processes is the key to enhanced health care success, provider and customer satisfaction, and operating efficiency," they said.

"The end result is the delivery of patient-centered care. Patients are very satisfied with these changes. They are able to access their primary care provider on the same day instead of next week or next month and are able to complete the visit in less than one hour instead of the typical two to four. For staff, the days run more smoothly. Employees are able to work at their highest level. People are able to go to lunch and the clinic closes on time. Ultimately, clinicians have better support for their work and can focus on building relationships with patients," the researchers explained.

All PCDC collaborative participants use the same collaborative model, which has three different stages. At each stage, elements of the collaborative are introduced and implemented.

PCDC cautioned, however, that the path through the stages is not linear but rather is

more like a spiral, with each collaborative stage overlapping the stage that comes before it and also the one to follow. The work of one stage spills into and informs the work of the other stages.

"Rather than following directions that take them from Point A to Point Z," the researchers said, "participants also move forward in an elliptical path that is marked by their growing awareness of what works and what does not what at their particular health center. With this awareness comes an ability to use tools to make and sustain permanent changes in productivity, efficiency, and attitude."

The first step of the pre-work stage is to form a team from multiple disciplines within the center and start to gather the baseline patient tracking data that will be the basis upon which all improvements are measured. Teams participate in three learning sessions facilitated by PCDC staff and nationally recognized leaders in the collaborative field being worked on.

Two action periods take place between the three learning sessions. During the action periods, teams run through rapid tests of change in highly controlled situations. These sessions use the plan, do, study, act cycle method that leads to a final redesign model that is completed over a period of three full days. Once the process is finalized, the methods are passed on to nonteam personnel.

Transform how people work

According to the evaluation, collaboratives do more than simply fix particular operations problems. They transform the way people work, expand the boundaries of responsibility, and instill a sense of accountability to patients.

PCDC contended it is very important to engage health center leadership in the process. Organizational leaders are inspired when they experience the change process through the perspective of their newly motivated staff, officials said. Senior leadership must be involved if the collaborative team is to be successful over the long run.

Teams with weak organizational leadership frequently reach their goals. But without consistent, engaged leadership, few teams can sustain success.

PCDC said it is difficult to tell if gains delivered by learning collaboratives can be maintained. Data collection often stops shortly after a collaborative ends, and there is no strong evidence that supports sustainability of the gains long term.

"PCDC has often observed that when a collaborative ends, there is little focus on sustaining the initiative," the report said. "Inevitably, the improvements do not last. Teams are consistently able to make breakthrough changes and completely overhaul existing processes, but if they do not build in accountability for ongoing measurements, the improvements are lost. . . . Health center leaders must recognize that they should take steps to preserve these gains, even after the collaborative concludes."

Designing a model

Gordon and Chin said a model familiar to many people that is able to extend involvement without creating dependency is Weight Watchers. The program is based on three simple principles — eat less, move more, and drink eight glasses of water every day. The principles are easy to understand, but often quite difficult to follow.

Likewise, principles for redesigning the patient visit and advanced access are simple and easy to understand, but hard to follow. For redesigning patients' visits, the principles are: Don't move the patient; eliminate needless work; increase clinician support; communicate directly; exploit technology; monitor capacity in real time; get all the tools and supplies you need; create broad work roles; organize patient care teams; start all visits on time; prepare for the unexpected; and do today's work today.

For advanced access, the principles are: Do today's work today; work down the backlog; reduce appointment types and times; develop contingency plans; reduce demand for visits; and balance supply (provider time) and demand (patient visits) daily.

The researchers suggested that those who participate in a learning collaborative need ongoing support after the process every bit as much as Weight Watchers participants do. "Perhaps, the problem lies in the way a collaborative is described as a framework for learning a new method," they wrote.

"Instead, it should be recast as a process used by a community of participants to make lifelong behavioral changes. Transforming the dismal patient experience into one that is satisfying for both patients and health care workers takes effort. Health centers must permanently change their individual and collective work behaviors: the way they treat patients, the engineering of work processes, the ability to work together in teams, and the use of technology.

"Problems arise because an organization's leadership often views the collaborative journey as a consulting engagement. Leaders demand solutions that require little effort or time on the part of management. Despite their health center's participation in the collaborative, many leaders never learn how to initiate and sustain change," the researchers said.

PCDC said it understands that gains achieved through the collaborative process are fragile and are almost certain to unravel if left unattended because the organization's transformation is incomplete.

The solution, it noted, is to make a health center's leadership responsible for anchoring the new culture in the organization.

First, management should communicate to employees frequently and clearly that the new methods and new ways of measuring results are not part of the organization's culture. And second, management should implement clear, consistent systems for defining, measuring, and sharing key results. "These two actions by management form the foundation of a strong organizational culture," the report said.

(Editor's note: More information is available from The Commonwealth Fund on-line at www.cmwf.org.) ■

CE 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 certificate of completion. When your evaluation is received, a certificate will be mailed to you.

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

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

Prepare your hospital for a strange flu season

It's not over yet!

This year is a wild card, and anything could still happen. First, we had a dangerous shortage of influenza vaccine, followed by many high-risk people who couldn't get or decided to forgo immunization. Fortunately, this has been a mild flu season — so far.

But February and March are the historical peak months for influenza activity, and the large numbers of high-risk unprotected people make this a potential recipe for disaster. Influenza vaccine shortages and delays are a recurring problem, and at some point, we will inevitably face another influenza pandemic.

Are you and your hospital prepared if we run out of luck? Do you know where to turn for guidance and help? Do you know how to prevent the spread of this infectious disease? Or how to handle major staff shortages due to record absenteeism?

Thomson American Health Consultants has developed an influenza sourcebook to ensure you and your hospital are prepared for what could happen this flu season — or the next flu season.

Hospital Influenza Crisis Management provides the information you need to deal with ED

COMING IN FUTURE MONTHS

- Adapting teaching to learning styles in large groups
- Innovative ways to use the intranet/ Internet in teaching
- Creating good policy for interpreter services
- Strategies for evaluating education programs
- Community outreach ideas for disease prevention

CE Questions

9. To address health literacy problems systemwide an institution should do which of the following?
   A Conduct an assessment.
   B. Create policies and procedures.
   C. Put in place staff training.
   D. All of the above
10. To overcome the learning barrier of low health literacy, educators should use which of the following teaching strategies?
   A. Deliver information in short sentences.
   B. Ask, "Do you have any questions?"
   C. Cover two or three points and repeat information.
   D. Simply show the person a video on the topic.
11. According to Diana S. Contino, RN, MBA, CEN, CCRN, which of the following is a key tenant for building better communication in an ED?
   A. Create systems that foster double-checks for verbal orders and clarification of written orders.
   B. Hold supervisors responsible for staff interpersonal relationships.
   C. Find out who is to blame for each mistake.
   D. Channel all communication through supervisors.
12. According to Pamela Gordon and Matthew Chin, which of the following strategic principles apply to all learning collaboratives?
   A. Build a high-functioning team and cultivate leadership support and involvement.
   B. Track data and map the process from the patient's perspective.
   C. Open lines of communication.
   D. All of the above

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

overcrowding, potential liability risks, staff shortages, and infection control implications for staff and patients. This sourcebook addresses the real threat of a potential pandemic and the proposed response and preparedness efforts that should be taken in case of such an event. Major guidelines and recommendations for influenza immunization and treatment are included, along with recommendations for health care worker vaccination and the efficacy of and criteria for using the live attenuated influenza vaccine.

Hospital Influenza Crisis Management will offer readers continuing education credits. For information or to reserve your copy at the price of $199, call (800) 688-2421. Please reference code **64462**. ■