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Covering Case Management Across The Entire Care Continuum

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IN THIS ISSUE

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Three-pronged approach saves money, helps members avoid asthma attack

Health plan contracts with nonprofit agency for home-based services

An asthma management program that includes telephonic case management, home visits, and physician incentives has saved money and earned accolades for Priority Health, a health plan company based in Grand Rapids, MI.

In six years, participants in the HealthyEncounters asthma program reduced the number of emergency department visits for asthma by 26% and increased the use of proper medication from 69% to 98%, according to **Mary Cooley**, RN, BSN, MS, CCM, senior manager of case and disease management at Priority Health. During the same time, hospital admissions for asthma dropped dramatically for both the health plan's commercially insured and Medicaid members.

In 2005, the health plan saved an estimated $1.5 million when actual costs were compared with expected costs, Cooley says.

The health plan's model received the National Leadership Award from the U.S. Environmental Protection Agency (EPA) as well as the Region 5 National Exemplary EPA award and the Michigan Association of Health Plans' Pinnacle Award for chronic illness.

About 8,000 people insured by Priority Health have persistent asthma. The health plan's goal is to help them understand their disease and learn to manage it by using medication properly and avoiding situations that can trigger an asthma attack, Cooley says.

Understanding asthma

"Asthma is quite misunderstood. Persistent asthma is a chronic disease but many people treat it acutely. They go to the emergency department and receive nebulizer treatment, which makes them feel better so they don't follow up. They don't understand that they need to take daily controller medication," she says.

The program takes a three-pronged approach to asthma management

combining case management and disease management, community partnerships, and provider initiatives.

Case managers and disease managers work telephonically with members who are at risk for an exacerbation and refer those who are at highest risk for face-to-face case management provided by the Asthma Network of West Michigan, a grassroots, nonprofit agency.

Priority Health was the first health plan in the country to provide reimbursement for home-based services to members with asthma, Cooley points out.

"This partnership underscores Priority Health's commitment to its members as well as to the community," Cooley says.

The Asthma Network sends certified asthma educators, who are nurses or respiratory therapists and act as case managers, into homes to assess the home for environmental issues that could trigger an asthma attack, provide education and support, says **Karen Meyerson**, MSN, RN, FNP-C, AE-C, manager of the organization.

After the referral, the Asthma Network case managers take over care coordination for Priority Health members who agree to participate in the voluntary program.

"We contact them if necessary and provide a discharge summary when the member completes the process. It's a seamless process," Meyerson says.

The community case managers work with the members' physicians to create an asthma action plan, visit schools and daycare centers that members attend and provide asthma education to the staff, and work with the members to ensure that they are following their treatment plan.

'Eyes and ears in the home'

"We realized that our case management program is excellent but we did not have the ability to assess the members' environment. We needed eyes and ears in the home," Cooley says.

The health plan pays for up to 18 home visits a year for members with high-risk or difficult-to-control asthma, Myerson says. "Some members don't require 18 visits to learn how to manage their asthma. Others need long-term support," she adds.

Initially, the asthma educators visit the families every two weeks for three months, presenting a series of six asthma education sessions. After that, they visit the family once a month if they feel the family needs more support, or more often if appropriate.

"We follow the members for a year and help them learn how to manage their disease through the seasonal changes and to deal with environmental and psycho-social concerns," Myerson says.

They educate the members about their disease; make sure they are using the right tools, such as peak flow meters and inhalers, and teach them to use them correctly; work with the family on trigger management; and help them understand what factors in their home could be contributing to asthma exacerbations.

"The most important part of the visit is to

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Editorial Questions

Questions or comments? Call **Mary Booth Thomas** at (770) 934-1440.

Editor: **Mary Booth Thomas**, (770) 934-1440, (marybootht@aol.com).
Senior Vice President/Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@ahcmedia.com).
Associate Publisher: **Coles McKagen**, (404) 262-5420, (coles.mckagen@ahcmedia.com).
Managing Editor: **Jill Robbins**, (404) 262-5557, (jill.robbins@ahcmedia.com).
Production Editor: **Ami Sutaria**.

assess the home environment for triggers. The personal assessment helps them identify problems that we may not find out about over the phone. If we ask a member if anyone in the family smokes, they may or may not say yes but the case manager visiting the home can smell it if someone is smoking," Cooley says.

The on-site case managers look for pets or evidence of cockroaches, dust mold, and water stains on the ceiling that indicate proliferating mold. They zero in on the bedroom and may recommend removing the carpeting or encasing pillows and mattresses in a plastic cover.

Making home modifications

The organization has a social worker who can help the family get assistance for home modification issues, such as removing carpeting or getting an exterminator to deal with a cockroach problem.

The case managers who visit the homes can also identify physical and psycho-social problems the members may be facing and call in a social worker for assistance, Myerson says.

"Many of the families we visit are living from crisis to crisis. Life gets in the way of complying with their asthma treatment plan. They're worried about not having enough food or being evicted and have to deal with whatever bubbles to the top of their list. They have so many issues, that a chronic disease is at the bottom of the list until they have an attack," Myerson says.

The social worker can help the family find assistance with issues such as housing and transportation so the asthma case managers can help patients learn to treat the disease as a chronic condition, rather than wait until they have an asthma attack.

Having someone go into the home and assess a member's living condition and home life helps the health plan's case managers understand the obstacles to following their treatment plan that the member may be facing, Cooley says.

"We know that we need to deal with the psycho-social issues that people confront in their everyday lives before we can tackle the asthma issue. Our community-based model helps us see what the barriers are and help the members overcome them," Cooley says.

Once the Asthma Network case managers have completed their work, the Priority Health case managers pick up the cases.

"We pick up the case to make sure they understand their asthma action plan and that they comply with their treatment plan so that the outcomes are sustainable over time," Cooley says.

Priority Health began its asthma disease management initiative in 1995 with a population-based health management initiative. The health plan created an asthma registry that contained the names of all members with asthma, stratified by risk level.

The members in the HealthyEncounters program receive targeted interventions based on their risk level.

High-risk members include those who have been hospitalized for asthma, who have multiple emergency department visits for asthma, and those who are overusing their rescue medicine or under-using their control medication.

"Our case managers reach out to every member who is at high risk. One of our current innovations is to move upstream and touch members with moderate risk as well. We always have taken a reactive approach and worked with the members who are having difficulties but we also want to take a proactive approach and target people upstream who haven't yet had a crisis. We want to keep them from reaching that point," she says.

Referring members in real-time

As part of its vision to provide assistance to people "just in time" the health plan has implemented an on-line stratification tool that refers members who are newly categorized as moderate or high risk to the case management department on an ongoing basis.

"My nurses are apprised of new cases on a weekly or bi-weekly basis," Cooley says.

In addition, the case managers receive e-mail alerts as soon as a member they are managing hits a risk factor, such as refilling his or her rescue medication too frequently or having an emergency department visit for asthma.

"Our interactive tools not only notify the case managers when new members are at risk but it gives them real-time information that helps them manage the care of their patients," she says.

The health plan is in the process of implementing between 15 to 20 different alerts into its software system to automatically notify case managers when members are newly diagnosed or hit certain thresholds.

"Our case managers will be able to click onto a dashboard when they receive an alert that a member has hit a risk level. Then they can pick

up the phone and call the member to find out how they are doing. This gives the case manager an opportunity to help the member avert a potential crisis and avoid an emergency room visit or a hospitalization," she says.

The health plan offers provider tools that include a patient profile that identifies all patients with asthma who are covered by Priority Health. The physicians can use the tool to identify patients who are not refilling controller medication or refilling rescue medication too frequently.

In addition, physicians who meet quality benchmarks for asthma care receive additional reimbursement from the health plan.

"We give the physicians the tools to make them successful in treating their patients with asthma and we incentivize them to meet quality benchmarks," she says. ■

CM helps high-risk members avoid hospitalizations

Initiative reduces cost, improves members' health

Face-to-face case management for members at high risk for health care exacerbations has paid off for Great-West Healthcare, a Greenwood Village, CO, health plan that serves as a third-party administrator for about 6,000 self-insured employer groups.

In about 50% of Great West's markets, eligible patients in the health plan's end-stage renal disease program and the neonatal intensive care program meet face to face with case managers who go on-site to the hospital or to members' homes.

Case managers in the health plan's end-stage renal disease program work with members at home or in the dialysis center, helping them stick to their diet and plan of care. The neonatal ICU program places case managers in the NICU where they collaborate with the physicians and nurses on the plan of care and ensure that the parents have the skills they need to care for their newborn after discharge.

Since the case management program began, hospitalization rates for end-stage renal disease patients have decreased by 10% to 14%.

The neonatal ICU program has shown a 32% reduction in readmissions for premature infants and generated a three to 5.5 return on investment for the program.

Great-West contracts for the NICU case management program through an outside vendor. The high-risk pregnancy program is provided by another vendor but they are linked together through the data feeds and through the health plan's care management system.

"The programs provided by our vendor partners are completely branded for Great-West Healthcare. The vendors all feed information into our system or use our software system so we can ensure that our members receive continuity of care and no one falls through the cracks," Norris says.

When the health plan is notified that a member has delivered a baby prematurely, it triggers a referral to the on-site case manager who goes to the hospital's neonatal intensive care unit and goes over the chart with the physician who is managing the infant's care.

The health plan has arrangements with the hospitals to have the nurse case managers come to the unit and review the cases.

"They work very closely with the NICU nurses and physicians. Having another pair of eyes looking at the chart and the child's condition is very beneficial to the baby," Norris says.

If the mother is still in the hospital, the case manager meets with her at the same time.

"The case managers make it a point to meet with the family to discuss what is taking place and go to the family's house if necessary. We want to help the family understand the child's condition, and the discharge plan," Norris says.

The neonatal case manager visits the NICU and reviews the chart weekly, working with the doctors and nurses to make sure that the infant gets the appropriate level of care that meets their needs.

"Some of these infants have very intensive needs and requirements for care and others are in the NICU only a few days before discharge and could receive a lower level of care. We work with the doctors and nurses to make sure that the level of care the baby receives is based on the severity of his or her condition," Norris says.

They stay in touch with the family, keeping them apprised of what is going on and when they can expect the infant to be discharged to home.

"The biggest piece of our on-site neonatal case management program is to make sure that the parents receive the education they need to be able to take care of the baby at home," he says.

When a premature infant is scheduled for dis-

charge, the case manager verifies that the baby meets the required outcomes for going home.

They educate the family on the plan of care, teach them how to use the equipment and monitors that will accompany the baby home, and reassure them that they will receive the support they need when the baby is home.

"We want to make sure the family knows how to take care of the baby. If the infant is on a nebulizer or a ventilator, we make sure that they understand how it works and what they need to do," he says.

Once the baby is discharged, the case manager follows up with the family to make sure they are following the plan of care and educates them about when they should call the doctor or take the baby to the emergency room.

For instance, infants often get a stomach ache or vomit when they are being transitioned to oral feedings. If the family takes a baby who has been in the NICU to the emergency department, the baby almost always will be readmitted to the NICU as a cautionary measure.

"We want to educate the family about what is normal and what is not so they can avoid unnecessary trips to the emergency room and hospitalizations," he says.

The family also has around-the-clock access to the health plan's nurse line in case they have questions or concerns.

Many of the members in the NICU program are identified through Great-West's high-risk maternity program, a telephonic program in which case managers follow members at risk for complications of pregnancy or premature births through the pregnancy and work with the members' physicians to ensure that they receive the care they need.

When claims data or referrals identify a member as being pregnant, she receives an outreach call from a case manager who conducts multiple assessments to determine the risk.

The high-risk maternity case managers follow up with women who are at risk for complications of pregnancy on a regular basis and work with the members' physicians to make sure their needs are being met.

Members are referred to the end-stage renal disease program when they are in active dialysis.

When a case manager receives a referral, she contacts the members' physician for information about the patient's condition, meets with the patient in their home, at the dialysis center or the nephrologist office and conducts an extensive assessment to find out where the case management focus should be.

The assessment includes questions about the members' home life, living conditions, and personal life.

"We make sure that the patient's home environment and family support would facilitate them being able to complete the dialysis process. We make sure the family can handle getting the patient to the dialysis center and assist the family in communicating with the physician," he says.

The case managers help the members stick with their physician's dietary recommendations and teach them how to keep their dialysis access point clean.

"The majority of hospitalizations for these patients are due to infection of the access point for dialysis. By educating the members and working with them on the correct type of access, we have been able to reduce hospitalizations quite dramatically," he says.

The case managers reinforce the physician's recommendations for a diet and exercise regimen.

"We fill the space in between the doctor visits, following up to make sure they are following the treatment plan," he says.

The case manager contacts the member every other week on average, depending on the member's needs and availability.

If the members have comorbidities, such as diabetes or congestive heart failure, the renal disease case manager coordinates the care for those conditions.

"All our programs follow a primary nurse model. One case manager works with the member as much as is possible," Norris says. ■

CM program leverages resources in the community

Pharmacists are crucial part of case management

A community-based program that provides face-to-face care management for people with chronic disease has resulted in decreased health care costs, fewer missed days at work, and improved quality of life for program participants.

"The purpose of the program is to leverage resources that are already available in their community to help people learn to manage their chronic diseases," says **Barry Bunting**, PharmD,

who was clinical manager of pharmacy services at Mission Hospitals in Asheville, NC, at the time of a pilot project and now is vice president of clinical services for American Health Care, a pharmacy benefit management and disease management company.

The Asheville project started as a pilot project conducted by the North Carolina Association of Pharmacists to determine if pharmacists could use their specialized skills and knowledge to help people with diabetes adhere to their treatment plan.

"Originally, we wanted to see if it would be of benefit for the pharmacists to spend this type of time developing a relationship and use their knowledge and skills to help people stick to their treatment plan. What actually happened was that people got the best medication for them and took it. It made a huge difference," he says.

Participants in the first phase of the pilot project were employees of the city of Asheville, covered by the city's self-funded employer health plan.

At the end of the pilot project, Mission St. Joseph Hospital, the largest employer in the area, decided to offer the disease management services to its employers.

As a result of the community-based interventions, two self-funded employer health plans saved more than $6 million in eight years, Bunting says.

The net decrease in total health care costs averaged $2,000 per patient per year for people with diabetes and $725 per patient per year for people with asthma, he adds.

Diabetics participating in the program decreased their missed work hours by 50%. For people with asthma, missed work hours decreased by 400%.

The employer's return on investment for diabetics was four to one, Bunting says.

The program has been so successful that it now includes 10 employers in Asheville for a total of 14,000 covered lives, Bunting says. Based on the success of the Asheville project, pharmacy associations in other states have created similar programs.

"The strength of our model is that it is community based and provides face-to-face contact. The personal contact allows the health care professionals who are serving as disease managers to establish a personal relationship with the participants and accomplish things that it would be much more difficult to do over the telephone," Bunting says.

Here's how the program works:

Employers offer the program to employees with chronic health conditions such as diabetes, asthma, hypertension, and high cholesterol.

The program is voluntary. The health plans agree to pay for medication and supplies and any copay the employees are responsible for as long as they are in the program.

"We have found that the program saves the health plan far more than the cost of the incentives. People in the program have far fewer hospitalizations and trips to the emergency department. The program makes a difference in their lives and lowers health care costs at the same time. It's a win-win situation for everyone," Bunting says.

People who enroll in the program agree to attend self-education classes covered by their company's health plan and meet face to face on a regular basis with a specially trained health care professional, either a pharmacist, a certified diabetes educator, or a nutritionist who becomes their case manager.

Participants initially meet with a pharmacist for medication assessment.

"Lack of medication adherence is a huge problem among people with chronic diseases. Patients often don't understand their medication regimen or they experience side effects and stop taking the medication. Pharmacists have the knowledge to help them understand their medications and to work with physicians to find alternatives that don't have side effects," he says.

Depending on his or her needs, the participant may be referred to a nutritionist, a diabetes educator, or in some cases a medical social worker.

"The program routes people to the resources they need to help them live healthier lives," he says.

Once the person is matched with a case manager, the case manager is responsible for setting a schedule with the participant. If the person doesn't show up for appointments, the case manager notifies the health plan administrator.

The case managers notify the participants' physicians about the program and their patients' participation and work with them to ensure that the treatment plan is being followed.

They monitor adherence and side effects, helping patients understand their treatment plan and helping them set goals, which may include exercise, diet, or smoking cessation.

They follow up on each monthly visit to find out if the participant met his or her goals for the

month.

"Accountability is one of the reasons the program works so well. The pharmacist, nutritionist, or diabetes educator is someone the participant is accountable to. They set goals and report on them face to face. Being accountable to someone that they are going to see in person helps them be adherent," Bunting says.

To recruit pharmacists, the pharmacy organization sent a letter to all pharmacists in the Asheville area, offering a free training program in diabetes that qualified for continuing education credits.

Of the 24 pharmacists who came to the seminar, 18 signed up to participate in the pilot project and be compensated for their time.

"People who have knowledge about medications aren't spending the time they need to with people who need it. By compensating them for their time, we made it possible for them to do so," Bunting says.

The program benefits all participants, Bunting points out. The pharmacists are paid for their work with the patients. The health plan saves money. The patients receive their medication and supplies free, with no copay, and enjoy improved quality of life.

"We have found that when pharmacists, nurses, nutritionists, social workers, and diabetes educators work together, we can help people get their diabetes under control," he says. ■

Create communication despite health literacy

Health outcomes for low literacy patients improve

Health literacy, according to the Institute of Medicine, is "the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions" and research has shown that patients are not all created equal.

According to the National Assessment of Adult Literacy issued by the U.S. Department of Education, people with below basic health literacy skills do not recognize a medical appointment on a form or when to have a specific medical test from clearly written, basic information.

So how does a health care institution make sure all patients, no matter their level of health literacy, have the ability to make appropriate decisions? By teaching staff how to educate these patients and providing the tools they need to do a good job.

The starting point is to make sure staff are aware of the problem and the importance of addressing it.

"Staff need to be given an 'awareness' session on health literacy during orientation, or as a mandatory continuing education module," says **Sandra Cornett**, RN, PhD, director of the AHEC Clear Health Communication Program at The Ohio State University College of Medicine in Columbus.

They need to learn how to assess literacy skills and the strategies to use when communicating with these patients, adds Cornett.

People need to know what health literacy is, that the problem exists, and how it impacts their patient population, says **Helen Osborne**, MEd, OTR/L, president of Health Literacy Consulting in Natick, MA.

Staff need more than facts, the topic must become personally relevant to them, she adds. They need to know that people in health care are not only part of the problem but can also be part of the solution.

"Not only do people need the facts but they need to have that internal sense of why it is important and how they can make a difference," says Osborne.

She gets the point across at workshops by having conversations with the professional staff, sharing stories, and encouraging them to talk amongst themselves and reflect on the issues.

The key is effective communication no matter the level of health literacy. One of the best teaching strategies for people at basic or below basic health literacy is found in "Ask Me 3" (www.askme3.org), a program of the Partnership for Clear Health Communication, says **Kathy Ordelt**, RN-CPN, CRRN, patient and family education coordinator at Children's Healthcare of Atlanta.

The first question is, "What is my main problem?" The health care professional should first tell the patient what is wrong with him or her. The second question is, "What do I need to do?" Then the patient would be given specific information such as how to take medication or follow a diet plan. The third question is, "Why is it important for me to do this?" The patient would learn how taking the medication or following the diet plan would benefit him or her.

Ordelt says this method of teaching fits the five

basic goals of patient education, which are:

- Make sure patients understand the needed treatment so they can give informed consent.
- Teach patients what they need to know to provide self-care at home.
- Provide the information needed to recognize problems, such as signs of infection.
- Make sure patients know who to contact when problems occur.
- Give patients time to speak and have their questions answered.

Focus on teaching strategies

Providing education that answers the Ask Me 3 questions is a good basic teaching strategy. But for patients who have a difficult time understanding verbal instruction or reading information, teachers should keep instruction short and simple, advises Ordelt; discuss the health problem in conversational language and chunk information into small sound bites, she says.

There are a multitude of teaching strategies that will improve the education of low literacy patients. One is the use of plain language in conversation and in print — which is using words people know or explaining clearly terms they need to learn, says Osborne. Ideas can be conveyed by drawing simple pictures or using models that people can see, touch, and manipulate.

Osborne says one of her favorite teaching methods is the use of metaphors or comparing new, unfamiliar medical information to something familiar in a person's life.

"The fall-back plan of education has been talking at people and giving them something to read; yet learning about health and really comprehending what needs to be done is so much more than that," says Osborne.

The assessment is important, which includes asking people how they learn and offering examples of learning styles such as reading, watching television or conversation.

Another important technique for good teaching is to confirm understanding by stopping after key points and asking the patient to explain what was said. Using the teach-back approach, practitioners need to listen for what is not said and correct any misunderstandings, says Osborne.

Cornett says an important element of good teaching is to individualize the information by using examples to which the patient can relate. Also, information given should be relevant to a patient's lifestyle and current situation such as his or her age, gender, occupation, marital status, and culture.

There are even techniques to improve understanding when answering a patient's question. In a paper Cornett wrote, titled *Effective use of Teaching Methods*, she provides a list of such strategies. For example, practitioners should rephrase the question to make sure they are addressing what the patient wants to know and limit the information to what was asked without adding additional detail.

Addressing the issue of low health literacy with good education techniques is vital as studies have linked low literacy skills to poor health outcomes and a greater use of health care resources, says Cornett. For example, patients with low health literacy skills are more likely to misinterpret prescriptions or to be non-adherent with HIV/AIDS therapy. They have more emergency department visits and are at greater risk of being admitted to the hospital.

The good news is that teaching staff good strategies for education will benefit all patients. Good teaching strategies apply to all patient education, regardless of whether a patient has limited literacy skills, says Cornett. ■

Improving care for low health literacy patients

Resources to use when creating a plan

There are many resources that help health care institutions develop strategies for teaching people how to appropriately access health care and use it to their best interest. Following is a description of two sites:

- www.healthliteracy.com — The official web site of Health Literacy Consulting based in Natick, MA. In addition to a description of services offered by this company such as writing, editing, and workshops, the site has several resources.

These resources include an archive of articles with titles such as: *Actively listening for what patients do not say*, *Confirming understanding with the teach-back technique,* and *Using graphics and humor to convey healthcare essentials.* Monthly tips are also posted such as how to use stories to explain health concepts and teaching in ways

people learn.

• medicine.osu.edu/ahec/4977.cfm — The Ohio State University Medical Center College of Medicine Area Health Education Center has details addressing health literacy in a section titled "Clear Health Communication Content."

Information includes: *Guidelines for selecting and writing easy-to-read materials*, *Getting your message across*, *Who's reading your writing: How difficult is your text?* and *Creating a shame-free and patient-centered environment for those with limited literacy skills.*

There are also details on consultative services such as training workshops, audience research, and developing and field testing new materials. ■

Improve system navigation for low literacy patients

Assessment of environment reveals barriers

To determine what barriers prevent patients with low health literacy from navigating a health care system, it's important for organizations to do an inventory. Once an inventory is complete, the information should be used to come up with strategies on ways to improve the environment, says **Sandra Cornett**, RN, PhD, director of the AHEC Clear Health Communication program at The Ohio State University College of Medicine in Columbus.

To help one Ohio hospital complete an organizational inventory, the AHEC Clear Health Communication program created a staff survey to assess the environment. It was adapted from a tool called the Literacy Audit Kit produced by Literacy Alberta in Canada (www.literacyalberta.ca).

The purpose of the staff survey is to determine how well the hospital communicates with patients. The areas assessed include promotion/publicity, telephone communication, printed materials, verbal communication, and staff awareness of literacy issues. To complete the survey staff read a statement and check one of four option: We are NOT doing this; We ARE doing this but could improve; We are doing this WELL; or Does not apply to our hospital.

Statements on the survey include:

• If there is an automated phone system, it offers the option of repeating parts of the message.

• We regularly review our printed materials, including forms, to check how easy they are to read.

• We avoid hospital jargon when we talk with patients.

• Staff, volunteers, audio or video tapes are available to help patients fill out our forms.

• Once the staff survey is completed and the data analyzed a patient/family/community survey will be conducted.

Cornett said this tool has not yet been finalized but some of the possible questions are:

• Was it hard to find the hospital (office) the first time you came here? If it was hard to find, please explain why.

• In the lobby or reception area, is it easy to find information that you want or need (brochures, posters, signs, how to register, etc.)? If it is hard to find the information, please explain why.

• If you were asked to fill out a form, did the staff member offer to help you? How helpful was the staff member in assisting you fill in the form?

• If staff used medical or technical terms, did they explain them? How helpful were the explanations staff gave you? What are some of the words or terms that were hard to understand? ■

Make time for skin cancer education in May

Observance month, community outreach a natural

Education about skin cancer is still needed, says **Linda K. Franks**, MD, FAAD, director of Gramercy Park Dermatology in New York City, though it is common to see adults on vacation making little effort to avoid the known risks for skin cancer, which is exposure to ultraviolet radiation.

"The behavioral aspect of melanoma can be changed. It is like asking people not to smoke and decreasing the incidence of lung cancer; it is the same thing with the sun and melanoma," says Franks.

To raise awareness of prevention of skin cancer and importance of the early detection of melanoma the American Academy of Dermatology has designated May Melanoma/Skin Cancer Detection and Prevention Month.

Its purpose is to help people learn the warning signs of skin cancer and catch melanoma early as well as to teach about skin cancer prevention.

"It's important to remember that sun damage is cumulative," says **Ronald S. Davis**, MD, MS, FAAD, a dermatologist practicing in Tyler, TX, and a professor of dermatology at Tulane University Medical Center in New Orleans.

Davis says studies have shown that damage begins after only a few minutes of sun exposure and accumulates over the course of the day with five minutes here and there. It's not just extensive time in the sun while at the beach, pool or playing tennis or golf.

"Most skin cancers are directly related to lifetime sun exposure, so education needs to begin in childhood, both with parents and children," states Davis.

To help prevent skin cancer, people need to know how to protect themselves from ultraviolet rays. According to Davis, sunscreens are the primary means of protection and most dermatologists recommend a waterproof, broad-spectrum sunscreen that protects against both types of ultraviolet radiation: UVA and UVB.

The UVB rays cause sunburn and the UVA rays penetrate the skin more deeply, causing wrinkling. According to the Skin Cancer Foundation, "UVA rays also exacerbate the carcinogenic effects of UVB rays, and increasingly are being seen as a cause of skin cancer on their own."

Davis says the greatest stumbling block to the prevention of skin cancer is the persistent idea of a "healthy tan."

"There is nothing healthy about a tan. It is simply an indication of the skin's response to sun damage. This has been difficult to change in the public mind, especially among teenagers. The proliferation and use of tanning beds has made matters worse. I think early and continued education is the key," says Davis.

According to the Skin Cancer Foundation, determining which sun protection factor (SPF) to choose when selecting a sunscreen can be calculated by knowing how much protection the ratings offer.

For example, if it takes 20 minutes for unprotected skin to start turning red, a sunscreen with an SPF of 15 would protect the skin 15 times longer, or about five hours.

Davis recommends an SPF of at least 20 to 30; however the degree of protection also depends on a person's skin color. The more fair-skinned a person is the greater their need for protection; people with darker skin, including African-Americans, can get skin cancer from sun exposure, too, he says.

Putting on sunscreen should be something that is done routinely such as brushing teeth, says Davis. Year-round use is especially important for people in sunny climates such as the southern states and California.

Other measures recommended

In addition to the proper use of sunscreen, people should know that clothing can protect their skin from the sun as well. However, the value of each piece of apparel depends on the weave and the fabric — some are too thin to block sunrays. There also are products that can be added to the wash that increase the protection factor and several companies make clothing with a high SPF rating, explains Davis.

Hats are also important because they help protect the ears, which are very sensitive. Davis says a hat should have a four-inch brim. Sunglasses with UVA and UVB protection listed on the label should be worn as they help decrease sun damage to the eyelids where it is often difficult to apply sunscreen, adds Davis.

Spotting the warning signs

While people need to know what steps to take to prevent skin cancer, equally important is knowledge of the warning signs. Most important is to learn the warning signs of melanoma because if caught early it can be cured with simple surgery, but when diagnosed late it has a high mortality rate, says Franks.

Melanoma in situ is on the surface of the skin and is completely curable with surgery. The critical factor of a melanoma is its thickness measured in the skin at the time of diagnosis, says Franks. A very early, thin melanoma has a prognosis higher than 95%. The worse prognosis is a four-millimeter-thick melanoma, which means there is a high chance it has spread, says Franks.

To catch skin cancer, especially melanoma early, she tells her patients to stand in front of a full-length mirror naked and do a skin check every two months.

The ABCs of melanoma

The first five letters of the alphabet provide a guide:

• The A stands for asymmetry and during a body check people would look for moles where one half is different from the other. It may be higher, a different texture or different color.

• The B is for border irregularity. "Your mole should not look like the coast of Maine. It should have a smooth, round border. A tiny bit of notching is allowable but when there starts to be jagged edges or tails jutting out that is an irregular feature of a mole and could be a warning sign that it is evolving into melanoma," explains Franks.

• C is for color. If a mole has two or three colors or a variation that includes blue, black, or red, that is a warning sign.

• D is for diameter and moles larger than six millimeters, which is about the size of a pencil eraser, should be checked by a physician.

• E stands for evolving or changing and moles should be watched to determine if they have changed in any way.

While routine personal skin checks are important, people should also have their skin examined by a dermatologist. Franks says every adult should have a baseline skin exam completed. People who have any of the risk factors for skin cancer should have a yearly skin exam by a dermatologist.

These risk factors include having fair skin, which is typified by blond or red hair and blue or green eyes. Also a family history of melanoma puts people at greater risk, as well as having three or more blistering sunburns as a child. People who have spent a lot of time in the sun as a child or teenager working as a lifeguard or golf caddy or simply laying on a beach are more likely to develop melanoma as are those who have had other types of skin cancer or precancerous skin lesions.

People who have a lot of risk factors or a lot of moles should be checked by a dermatologist every six months, says Franks. Others should see a dermatologist if they notice a change in a mole or other warning signs when doing a skin check.

Melanoma/Skin Cancer Detection and Prevention Month is a good time to distribute information on skin cancer, hold seminars, and do free skin screenings, says Franks.

Conduct a seminar at a community pool, a country club or the local middle and high schools, advises Franks. Offer a list of places where people can receive a free skin cancer screening. ■

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COMING IN FUTURE MONTHS

- How technology can improve care for your clients
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- Empowering patients to take charge of their own health

CE questions

13. Priority Health saved about how much in 2005 when actual costs and expected costs were compared?
    A. $1 million
    B. $1.5 million
    C. $2 million
    D. $2.5 million

14. Since the case management program began at Great-West Healthcare, the NICU has seen a 42% reduction in readmissions for premature infants.
    A. True
    B. False

15. According to **Barry Bunting**, PharmD, which of the following is a huge problem among chronically ill patients?
    A. lack of medication adherence
    B. after experiencing side affects, patients take more medication
    C. B only
    D. none of the above

16. According to **Ronald S. Davis**, MD, MS, FAAD, most skin cancers result from lifetime exposure to sun.
    A. True
    B. False

Answers: 13. B; 14. B; 15. A; 16. A.

CE 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.
2. Explain how those issues affect case managers and clients.
3. Describe practical ways to solve problems that case managers encounter in their daily case management activities. ■

CE instructions

Nurses 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 semester's activity with the **December** issue, you must complete the evaluation form provided in that issue and return it in the reply envelope provided to receive a credit letter. ■