Improving Approaches to Patient Education and Improving Tracking of Patient Outcomes

Amanda Smithers, PA-S/MMS-S

RRCC PA Program/ St. Francis University

Site: Central Mississippi Health Services

July 9th- Aug 31st, 2012

INTRODUCTION

BACKGROUND

Patient education is elemental to improving patient outcomes[1,2]. What a patient retains and understands after a visit with his/her provider depends greatly on the patient's health literacy level. According to the Department of Health and Human Services, health literacy is defined as the patient's " *...capacity to obtain, process and understand basic health information and services needed to make appropriate health decisions*"[1].

> *"Nearly 9 out of 10 adults have difficulty using the everyday health information that is routinely available in health care facilities, retail outlets, media, and communities. Limited health literacy is associated with poorer health outcomes and higher health care costs.[1]"* (Health and Human Services, 2011)

According to the most recent NAAL study conducted in 2003 (White 2008), only 13% of patients are fall into the "Proficient" level concerning Health Literacy. The remaining numbers reflect that 33% have intermediate health literacy proficiency, 33% basic and 22% are below basic. It was noted that Basic is not the desired level of health literacy.

There are many factors that affect a patient's health literacy level[3]. The most important determining factor, and probably the most obvious, is a patient's basic education level. If a patient is has impaired reading, writing and comprehension skills, many of the approaches that we use today would not only be frustratingly unhelpful, but may even further impair that particular patient's willingness to endure an education session from a provider. Other factors that put patients most at risk for falling into the Below Basic and Basic health literacy levels are 1) poor oral reading proficiency, 2) failure to finish high school, 3) not speaking English before starting school, 4) living below the poverty level, 5) age 65 years or older, 6) being a non-internet users 7) having no insurance and 8) having a disability (White, 2008).

Particular attention must be given to how information is presented to patients with Below Basic and Basic Health Literacy Levels. There are many guidelines available for reference, but they all follow the same general principles.

1. Present important information first and by itself
2. Only address 2-3 major concepts at one time
3. Present information in non-medical terms and in short, clear sentences. Repeat as often as necessary.
4. When presenting health care statistics, equate higher numbers with good outcomes and lower numbers with poor outcomes
5. Use visual aids where appropriate
6. Ask questions that let you know the patient understands the information (open ended, not yes or no questions)
7. Encourage the patient to ask questions
8. Ensure that patient education materials are given to the patient. Make sure that they are easily readable, or that important information and key concepts are marked on the papers (highlight, underline, circle, etc).
9. Enlist the help of caregivers in understanding information conveyed

The other essential piece health literacy puzzle is proper documentation by providers in the EMR. Research shows an undeniable positive correlation between patient health literacy levels and patient outcomes. AHRQ evidence-based studies show that the impact of low health literacy for patients with Below Basic and Basic Health Literacy levels has led to higher incidence and severity of chronic illness, lack of patient initiative to seek out preventative services and the failure of the patient to follow through with follow-up or referral services[2].

Characteristics of the Health Services Delivery System

Central Mississippi Health Services, Inc (CMHS) is a Community Health Center (CHC), whose mission is to provide quality health care to medically underserved and uninsured patients in the Jackson, Mississippi area. Central Mississippi Health Services consists of 3 clinics and serves over 12,500 patients a year. Patients at this clinic have a long and ongoing history with its founding practitioner, Dr. Robert Smith.

Definition of the problem or issue, site, clientele

According to the 2010 UDS Report, of the patients at Central Mississippi Health Services 75.2% live below the poverty line, 56.3% are 65 or older, and 55.5% are either uninsured or on some form of Medicare or Medicaid[4]. Mississippi has one of the highest high school dropout rates in the nation (38%), second only to Nevada (43.7%)[5]. Given these statistics it is apparent that the majority of the Central Mississippi Health Services patient population is at risk of falling into the Below Basic and Basic levels of health literacy. This would indicate that modified approaches should be considered when educating patients.

The current EMR used at Central Mississippi Health Services is over 15 years old and is cumbersome to use. Many of the providers have resorted to just filling in essential information and moving on. The issue is that this has resulted in an inadequate data required for reporting accurate patient outcomes because they are not traceable in the EMR. Without being able to demonstrate improvement in patient outcomes, the clinic is putting itself at risk for losing federal funding in the future.

INTERVENTION

Description of the project

My project was two fold: Assist in improving approaches to patient education and help to improve tracking of patient outcomes. The overall scope of the project entailed revisiting and modifying current approaches to patient education, making educational materials more readily accessible and user friendly and reiterating to providers the importance of proper CPT coding in order to meet UDS reporting requirements.

Relevance to health service delivery at the site

This project, and its two basic elements, is relevant to this site for several reasons:

1) The demographic make up the Central Mississippi Health Services's patient base includes an inordinate amount of risk factors that would place the majority of their patients at the Below Basic and Basic Health Literacy Level. These factors include the majority of their patients meeting at least one of the following criteria:

Living below the poverty level, age 65 or older, uninsured or on Medicare/Medicaid.

2) All of the providers at this site have been trained on their EMR, but not all of the providers use it. Some still dictate their notes and have them transcribed. Of those that do use the EMR system, most are only using it to its minimal extent. This is in part due to the cumbersome nature of their particular EMR. Another factor that plays into the EMR being under-utilized is a lack on ongoing/follow-up training on the system.

3) Specific to the EMR, educational materials that are in the database are not always titled how a Provider would expect them to be titled, so it makes retrieving the materials frustrating and often fruitless. According to the EMR reports reviewed, the majority of Providers have essentially stopped using the educational materials attached to the EMR. Interviews revealed that this was due mostly to not being able to find the information they wanted, or that searching for the information took too long. Many of the providers do actively educate their patients, but not all of them provide educational materials for the patient to take home and review or use for reference. This has led to patient education not being appropriately documented in the EMR. Furthermore, as part of the clinics AHRQ requirement, any educational materials that are handed out to patients must either be in the EMR database or the provider who gave them out must be able to provide a copy of them to any investigating official. Essentially, this translates to Providers having to keep a copy on hand. Most Providers at this site have very limited office space and are hard pressed to find enough room to keep educational materials readily available.

4) Providers that do provide education try and fit as much information into the session as possible. Modifications to delivery of information were reiterated to Providers.

5) UDS codes are used to track patient outcomes and directly correlate to federal funding. Under reporting of patient outcomes at this site is an issue and essentially leaves very little data to track that reflects patient improvement. If this trend continues, the site risks losing federal dollars and will have to find funding

elsewhere. It should be noted, that diabetic numbers have been consistently and more accurately tracked here with the addition of the diabetic educator and the patient outcomes are extremely favorable.

Methods

The CFO generated reports on all providers concerning their EMR charting. Specifically, information on education statistics (how often the "provider" used the education tab and what material was given out) and on UDS codes for tracking patient outcomes was reviewed. Reports generated from the EMR indicated that there were several areas in particular that "providers" needed to focus on when charting CPT codes for tracking patient outcomes. These were ranges for BMI, BP, HbA1C, Asthma and Smoking Cessation efforts.

There was an issue with accurate reporting concerning educational materials due to a recent system update glitch that prevented accessing of the educational section of the EMR being recorded. The company is aware of the glitch and is working to fix it. As a result, reports with the required information had to be pulled from the previous six months. The date reviewed came from the January to June 2012. Further investigation suggests that this issue has been going on intermittently for some time, but the last update completely restricted all information from the educational materials from being recorded.

Implementation of better patient education practices included briefly reiterating to providers the best approaches to education of patients with Below Basic and Basic health literacy levels. In addition to this, the following actions were also taken to make materials more available to providers and to better facilitate Provider access to the EMR and it's Education Materials:

1. Educational materials located on the EMR were printed out, organized according to body system and indexed. Every provider was given a copy of the index and shown how to pull up educational materials on the EMR and how to ensure that education was documented. The printed educational materials were also assembled into a set of binders and put in a common area for Providers and their nurses to access and copy in the event that a) a Provider is currently not using

EMR, b) the EMR system goes down.

2. UDS tracking codes (specific CPT codes) were assembled and printed out into pocket references.   Every provider was then re-trained, one-on-one, on how to access and apply these codes for proper CPT coding in order to appropriately track patient outcomes. Equating traceable patient outcomes to the amount of federal funding that they represent emphasized the necessity for proper coding.

3. The QI/QA committee was given a copy of all the materials created for future training/retraining of personnel. They are currently working on integrating better educational materials and "designer templates", the latter of which would link appropriate educational materials with specific ICD-9 and 10 codes, force the providers to fill out the appropriate UDS codes in order to close out the chart and then automatically print patient education materials.

Results

With the recent HRSA site visit that took place and all the preparation that was needed for it, implementation of interventions was postponed until my final week at the clinic. This made it difficult to track any real short-term results. The upside is that the atmosphere was still very positively charged from the site visit and the QI/QA committee, whose coordinator is very motivated, readily embraced my plans and was already building on improving and expanding the materials that I had put together. The QI/QA committees has already set up further training with the rest of the staff in order to build in redundancies and help ensure all individuals are assisting in making sure proper coding is occurring. In general, Providers were very receptive of the information and very happy to have it in such an accessible format and to have the one-on-one training.

CONCLUSION

Discussion

Reiteration of patient education focused on approaches based on assumed average health literacy levels of the patient population. The patient base at Central Mississippi

Health Services faces more risk factors than most patient populations so education requires a different approach. Issues with proper CPT coding for UDS tracking purposes are already being addressed further by the QI/QA Committee through future repeated training sessions. These will be to remind Providers and staff of the importance of proper coding and to keep the issue in the front of their minds.

Best practices and lessons learned

Further discussion with one of my preceptor's concerning the issue of health literacy provided a different approach to addressing the issue. With a large portion of the clinic's population at or below the Basic health literacy level, approaches other than education in the office need to be explored. Simple education and educational materials are not always the best answer to the problem and the challenge is to develop new, effective and innovative ways of improving patient literacy levels

During my time at this site, I had amazing opportunities to participate in several different mediums that could be capitalized on further as possible approaches to patient education. For example, the clinic currently holds what started out as Wednesday night nutrition class. The name has not changed, but the class itself evolved into an open forum for discussion of topics that drive the philosophy of patients being in control of their own health. While the class remains small, the patients that attend have become regulars and have had very candid discussions about their specific conditions. This is a potential medium for reaching patients who thrive on social interaction but who's health literacy is limited by their own education level, who don't use the internet much or who have traditionally been raised in more social conditions. The challenge comes with growing the group to reach more patients.

Another medium to explore is public radio. One of the physicians here hosts a regular Wednesday night radio show, during which they address issues surrounding healthcare. The show has quite a following, demonstrating the potential for reaching patients that might have a more difficult time with traditional patient education materials.

My original project was to develop patient driven support groups for those with chronic disease, specifically Hypertension, Diabetes and Obesity, but a request from the site to assist with staff educational pieces required a change in project. I believe that this

idea could be further developed and utilized as a tool to further patient education and improve health literacy levels.

Final recommendations and acknowledgements

The QI/QA Committee has already started improving on the products and approaches I was working on. I have no doubt that they will incorporate what I had to offer into a much bigger and better product with measureable outcomes.

One of the amazing things about Central Mississippi Health Services is that the bond formed between patient and Provider is powerful. There is a lot of trust put in the Provider, beyond just medical treatment. Some patient-provider relationships have been intact for over 40 years, and Dr. Smith in particular is spectacular at being able to recall a personal story with every patient. When I think about the kind of provider that I want to be, he ranks in the top three of individuals I hope to be able to emulate.

I would like to take the time to acknowledge the time and effort that my preceptors at Central Mississippi Health Services dedicated to furthering and enriching my educational experience. Truly these amazing individuals manage an unprecedented number of medically disadvantaged and underserved patients with an incredible amount of compassion. It is obvious that they love what they do and know that they are positively impacting the community they serve. The trust and respect that their patients have for them, only reflects the incredible sense of dignity that they instill in those around them. I am humbled and honored that they have allowed me to walk along side them and learn. I would also like to thank GE and the National Medical Fellowship Primary Care Leadership Program for sponsoring, organizing and generating such an amazing opportunity. You have all played a part in developing and inspiring one more leader in the future of healthcare. Thank you for the opportunity to work with these everyday heroes and national legends. It's an experience I am convinced that I will draw on for the rest of my life.

References

1. Health and Human Services. (2011, November 28). *Health literacy*. Retrieved from http://www.health.gov/communication/literacy/

2. Berkman ND, Sheridan SL, Donahue KE, et al. *Health Literacy Interventions and Outcomes: An Updated Systematic Review*, Executive Summary, Evidence Report/Technology Assessment: Number 199. AHRQ Publication Number 11-E006-1, March 2011. Agency for Healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/clinic/epcsums/litupsum.htm

3. White, S. (2008). Assessing the nation's health literacy: Key concepts and findings of the national assessment of adult literacy (naal). *American Medical Association Foundation*, Retrieved from http://www.ama-assn.org/ama1/pub/upload/mm/367/hl_report_2008.pdf

4. Chapman, C., Laird, J., Ifill, N., and KewalRamani, A. (2011). Trends in High School Dropout and Completion Rates in the United States: 1972–2009 (NCES 2012-006). U.S. Department of Education. Washington, DC: National Center for Education Statistics. Retrieved [date] from http://nces.ed.gov/pubsearch.