SOCIAL DETERMINANTS OF HEALTH

Health Confidence & Simulation: A Novel Approach to Patient Education to Improve Patient Engagement & Reduce Readmissions

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patients who had been recently discharged from the hospital. One particular

patient was a focus for me due to this being his fourth time back at the hospital. In speaking with him, he stated he felt overwhelmed by the information that was sent home with him. He couldn't figure out his follow-up appointment schedule, stated that no prescriptions had been included and that he did not understand the majority of what he was sent home with. Upon further exploration, I realized that we had changed the format from standard prescriptions (1/4 sheet forms that most physicians have been using for decades) to prescriptions printed on 8 ½ × 11″ paper from the electronic medical record. His follow-up appointments were not centralized in one place, on one sheet, making it very difficult for him to understand when he was supposed to be where. Reviewing the information he had been sent home with demonstrated that the well-meaning nurse who was discharging him followed protocols to the letter, printing the Micromedix printouts on every medication the patient was discharged home with (12) and "patient education handouts" on every one of his eight comorbidities. The discharge packet was 4 ½" thick and was not written in a patient-friendly format. Most importantly, the patient stated that he had reading difficulties and that this was not the best way for him to learn. Readmission after readmission followed. Failure of discharge plan.

Value-based purchasing, readmissions, patient-centered care…case managers are central players in every initiative and, with our "whole picture" view, are keenly positioned to make a significant impact. For example, case managers have long made the connection between social determinants of health (SDoH) and increased risk for readmission through anecdotal observation. Failure to create overarching strategies to address the gaps caused by SDoH continues to impact the care continuum's ability to adequately equip the patient for success post-discharge. With health literacy being identified as not only a social determinant of health but as the "newest vital sign," "addressing patient health literacy and health confidence is as much a necessity as identifying patients' extra-medical needs and linking with needed services and resources to provide the patient with excellent patient-centered care, promote client self-advocacy and independence in alignment with the *CMSA Standards of Practice"* (Morley & Walker, 2019).

Health literacy is defined as the degree to which an individual has the capacity to

literacy as "a shared responsibility between patient (or other recipient of the health

communication) and providers (or other "giver" of the health communication)." Bidirectional communication is a MUST.

Current statistics demonstrate that 36% of the population of the U.S. is rated as basic/below basic literacy (reading) level. The health literacy rate is significantly lower than this at 12%. Health literacy is considered a social determinant of health, a key in patient safety and should be assessed and addressed for every patient, every time in every healthcare encounter. The need to focus on health literacy goes to the core of healthcare. Although the evidence supports that some populations are at higher risk for lower literacy/health literacy rates, it is important to note that anyone can be affected by low health literacy and that people who may have been previously able to self manage may no longer be able to do so. Research on health literacy has shown that those patients with poor health literacy are less likely to access preventative care consistently. They are less able to successfully manage when diagnosed with chronic disorders and incur higher healthcare costs, use the emergency department for healthcare more often and are more frequently readmitted after acute care discharge.

Wagner's Chronic Care Model seeks to "optimize each healthcare team member's abilities, expertise and willingness to achieve high-quality health outcomes…that are safe, necessary, cost-effective, timely, desired and patient-centered" (Potter and Wilson, 2017, p. 311). Patients engaged in this model study reported higher satisfaction with the healthcare team, their healthcare experience and increased confidence in managing their chronic conditions. In this era of patient-centered care, the patients and their caregivers are identified as part of the healthcare team. As such, it is vital that the information transfer between patient and provider(s) is clear, understood and actionable by the patient/caregiver. This means that assessing the patient/caregiver's preferred learning styles and how to leverage the roles of the healthcare team to meet those needs is key to patient engagement and success.

Case management applies this theory by educating and providing coordination of care, services and resources in alignment with the patient's needs, provider's recommendations and benefits available under the patient's payer plan and network. The *Standards of Practice for Case Management* direct case managers to assume the

providing cohesion to other professionals in the healthcare delivery team, enabling their

clients to achieve goals more effectively and efficiently" (Case Management Society of America, 2016, p. 3).

PROJECT INFORMATION

The vision for this project was to create an inpatient education intervention to better prepare patients with chronic medical conditions for more effective self-management after DC using a Skills Simulation Experience and focused one-on-one structured education format in a circuit-based intervention. The Health Confidence Lab allowed for patients admitted with COPD or CHF to receive focused chronic condition management education. As an interdisciplinary intervention, the healthcare team presents standardized education in a circuit training presentation to allow for one-on-one interaction with healthcare professionals, using multiple teaching/learning strategies, to assist the participant in acquiring or reinforcing skills needed to successfully self-manage their conditions post-discharge.

Data analysis for this project included the review and evaluation of the thirty-day readmission rate monthly over the project period. Patients were recruited daily and reviewed after 30 days post-discharge to evaluate for any readmission occurrence. During the timeframe of the project, 323 patients were identified as eligible for participation in the project. Of those identified as eligible, 130 patients completed the intervention.

Data collected included:

- Participation in SIM LAB experience
- Readmission events within 30 days from index admission
- Patient Self- Evaluation of Ability to Care (Pre/Post Intervention Test)
- Patient Self Evaluation of Health Confidence Score (Pre/Post Intervention)

The initial evaluation is reported as a straightforward percentage of population

readmissions for the participation group versus the non-participation group. The intervention period (Jan-Dec 2019) noted a readmission rate for the target population of

COPD/CHF patients of 10.12% compared to the non-participation group readmission rate of 21.05%. This demonstrates a 10.93%-age point decrease in readmissions in the participation group. Notably, SIM LAB participants accounted for 4.3% of all COPD/CHF readmissions for the 2019 data period.

Upon entry to the SIM LAB, each participant completes a 10-item inventory of self-management tasks, covering topics such as exacerbation recognition, activation with primary care physician, medication self-management and durable medical equipment maintenance. This inventory (pretest) is scored on 1-5 scale (1 not confident to 5 very confident) with a maximum score of 50 points. The same inventory is completed at the end of the SIM LAB experience (post-test). We noted that many participants were giving themselves a "5+." In order to account for this "upgrade," the team elected to award an additional 1 point for each "5+" noted; giving a maximum point value on the post-test of 60 points. The average pre-test score of the participants was 39.6/50, while the average post-test score increased to 50.2 — a 21% increase in perceived knowledge base.

SIMPLE STEPS TO HEALTH LITERACY PROMOTION

*Tips for Case Managers to Address Health Literacy; adapted from **AHRQ.gov***

1. Assess every patient, every time you meet with them
    a. Don’t assume there have been no changes, even day to day
2. Use plain language
    a. Keep away from medical/healthcare jargon
3. Limit information
    a. 3-5 key points per encounter, revisit/reinforce
4. Be specific, avoid generalizations
5. Demonstrate, draw pictures, use models
    a. Don’t rely on verbal/written communication
6. Repeat/summarize/restate a different way
7. Teach back!
    a. Confirm that the patient/caregiver understood the information you just taught them
8. Be positive, hopeful & empowering!
    a. You are their lifeline and cheerleader

At the same time the self-management inventory is administered, patients are asked to complete the one-question health confidence survey. Created and validated by Dr J Wasson, MD, & Dr E Coleman, MD, MPH, the tool considers that "health confidence is an effective proxy for engagement, and practices can easily measure it using a single question: 'How confident are you that you can control and manage most of your health problems?'" (Wasson & Coleman, 2014). Patients can rate their confidence on a scale from 0 (not very confident) to 10 (very confident). A score of 7 or higher is the desired response. SIM LAB participants' average health confidence score prior to intervention was 6.71 (under the baseline desired 7.0 or .95/1.00 desired outcome) and post-intervention was 8.74 (significantly higher than the 7.0 baseline or 1.25/1.00 desired outcome). The net gain is noted as 2.03 points on the 10-point scale.

CONCLUSION

Unless health literacy is better understood and addressed, the likelihood of creating an environment where patients are engaged and empowered, able to achieve self-care with greater confidence and success is not achievable. The question we need to ask is, "How do we, as healthcare practitioners, engage and empower our patients and their caregivers to be successful in managing complex medical issues combined with the day to day business of living?" Once asked, we need to act to create sustainable education strategies and opportunities for the 88% of the population who do not have adequate health literacy.

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