Higher Quality and Profitability in Home Health Care with SelfCareKits™

Three major challenges home health faces:

1. **How to compete** for referrals when all agencies have caring professionals
2. **How to be profitable** under the prospective payment system and other regs
3. **How to fulfill the mission** of helping people become independent with selfcare

The Communication Science SelfCareKits™ meet all three challenges.

<table>
<thead>
<tr>
<th>VALUE PROPOSITION FOR THE ENTIRE PROGRAM</th>
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<tr>
<td><strong>BETTER OUTCOMES</strong> Ten years of studies and demonstrations showing <strong>dramatic reductions in readmissions</strong> in 30, 60 and 90 days</td>
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<tr>
<th>INCREASED REVENUE</th>
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<tr>
<td>• <strong>Increased referrals</strong> when doctors and clinics see the quality of the education program—how well patients are prepared for self care—especially if the doctor is at risk under pay for performance.</td>
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<td>• Dramatic reductions in readmissions enable an agency to <strong>earn pay-for-performance payments</strong> and win quality achievement awards.</td>
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<td>• Increased success at self care means <strong>more patients can be enrolled</strong> who might otherwise be judged as not ready for discharge in 60 days.</td>
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<tr>
<th>INCREASED SATISFACTION SCORES</th>
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<td>Ten years of surveys showing <strong>dramatic improvement in patient satisfaction scores</strong>—in one case, tripling the previous score.</td>
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<th>INCREASED PROFITABILITY</th>
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<tr>
<td>• Shorter visits with each patient to accomplish more—fewer calls back for repeat instructions, less time spent demonstrating: <strong>increased nurse productivity</strong></td>
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<td>• Increased nurse productivity means <strong>more patients can be enrolled</strong> without increasing the number of nurses</td>
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<td>• Reduced readmissions and ER visits make <strong>full payment</strong> more likely.</td>
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<th>VALUE FROM SPECIAL KITS</th>
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<td><strong>INCREASED REVENUE</strong></td>
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<tr>
<td>Shoulder, Hip and Knee Surgery Rehab Kits justify additional visits for PT and OT to teach how to use the tools.</td>
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**NEW!** Available soon—a **Falls Prevention Kit** to meet the new requirements
About the Company
Our Story - President's Letter

The company was officially incorporated in 1997, but the story of Communication Science began in 1989, when I learned about the "three-sided problem" that sends patients back to the hospital:

- Doctors and nurses, no matter how sincere, don't spend as much time teaching as they think they do.
- Patients, otherwise honest, often say they understand when they don't.
- Even when they have time, on the phone or in writing, patients and providers just don't speak the same language.

Now there's a problem I can fix. I have a PhD in linguistic pragmatics, how to change the way a person speaks and writes so the message gets across to people who don't have the same background.

For example:

Doctors and nurses say healthcare is the most important thing in your life because it's the most important thing in their life!

People who succeed at staying out of the hospital all say their healthcare is "No big deal." They do just what they have to and get on with life!

Every SelfCareKit™ Kit begins with national guidelines expert opinion from top medical centers. Then my team of linguists "translates" the instructions so they make sense to people who are not professionals in health care.

Best of all are the studies that show how a SelfCareKit™ makes a difference. People who get a SelfCareKit are up to 74% more likely to stay out of the hospital in the future than people who don't.

That's our mission at Communication Science: to help you stay out of the hospital. Let us know how you and your SelfCareKit™ succeed!

Best regards for health and life,
Board of Directors

Roger Ritley
Mr. Ritley is the president/CEO of Property Economists, Inc. a real estate development firm specializing in shopping malls and other large public spaces in the Cleveland, OH area. He often serves as an expert witness regarding real estate valuations and other real property issues.

Norman R. Weldon, Ph.D.
Dr. Weldon is Managing Director of Partisan Management Group, Inc., an early stage venture capital company that assists with the funding and management of medical device startups. He is also on the Board of two medical device companies he co-founded. Dr. Weldon received his BS in Biochemistry in 1956, MS in Industrial Management in 1962, and PhD in Economics in 1964, all from Purdue University. He has been the CEO of three public companies: CTS Corporation, Cordis Corporation (which was purchased by Johnson and Johnson as the basis for its cardiovascular division) and Corvita Corporation. He was a co-founder of CTS Microelectronics, Inc., Corvita Corporation, Novoste Puerto Rico, Inc., Novoste Corporation and Enable Medical Corporation and he is a director of two mutual funds: New Economy Fund and SmallCap World Fund.

Advisory Board

Fredric I. Orkin, PE
Fredric I. Orkin, PE, is currently President of Czarnek-Orkin Laboratories., a medical products design firm. Mr. Orkin is an author of the Juran Quality Handbook and consults both domestically and internationally in FDA compliance for manufacturing and medical device approvals. From 1978 to 1985, he was Corporate Director, Reliability and Quality Engineering for Baxter International and from 1985 to 1993 he was General Manager of Baxter's intravenous fluid delivery division. Mr. Orkin currently serves on the Boards of four medical device venture companies. He received his B.S. in Industrial Engineering from Ohio State University, and completed the Executive Development Program at San Diego State in 1974 while launch operations manager for General Electric Aerospace division.

Edward E. Gustavson, MD, FAAP
After graduating Harvard Medical School, Dr. Gustavson dedicated his career to high-risk pregnancy and neonatology, targeting areas of the country where rates of infant mortality and child abuse are high. He is currently Head of the Pediatrics Committee of the Children’s Medical Center of Tulsa and Chairman of the medical Advisory Board of the Parent-Child Center of Tulsa.

Robert Rose, MD
Dr. Rose is the Executive Director, Mind Brain Body and Health Initiative, where, under a grant from the Rockefeller Foundation, Dr. Rose was the first to demonstrate a biological change as part of the placebo response. He was the Director of Psychiatric Clinical Research Center, University of Texas, and served as a Fellow of the MacArthur Foundation in Chicago.
Nancy M. Valentine, RN PhD MPH FAAN FNAP

Dr. Valentine is Senior Vice President and Chief Nursing Officer of Main Line Health, an integrated healthcare system in suburban Philadelphia, Pennsylvania. She formerly served as CIGNA Healthcare’s first Vice President, National Nursing Executive, Medical Strategy and Health Policy, located at CIGNA headquarters in Bloomfield, CT. where she was responsible for developing the nursing talent pool, a group of professionals located across the country who comprise approximately 10% of the company’s total employees for CIGNA Healthcare and CIGNA Behavioral Health (2001-2004). Prior to CIGNA, Dr. Valentine served in the Department of Veterans’ Affairs headquarters; first as national Chief Nursing Officer (1993-1998) and then as Special Assistant to the Secretary and Advisor to the Under Secretary for Health (1998-2001). While in DC, she concurrently held adjunct faculty positions at Catholic and Georgetown Universities School of Nursing, and the Uniformed Services University of the Health Sciences. She holds degrees in nursing (BSN, Rutgers University and MSN, University of Pennsylvania) public health (MPH, Harvard University) and economics and health policy (Ph.D. Brandeis University).

Sharon M Weinstein, MS, CRNI, RN, FAAN

Sharon is President, Core Consulting Group, LLC specializing in workforce-related issues impacting healthcare delivery, globalization, nurse-physician collaboration safety and wellness. Prior to founding Core, she was Executive Director, The Premier Foundation, and directed Premier’s international efforts for 9 years in over 24 countries. Prior experience includes administrative roles at the American Hospital Association, Hospital Corporation of America, Kimberly Quality Care, Chicago Medical School and the VNA of Dallas. A past president of the Infusion Nurses Society, and past Chair of the Infusion Nurses Certification Corporation board, she is a director member. A recipient of the Dr. Thomas Frist Humanitarian Award, she is the author of four nursing textbooks, including Plumer’s Principles and Practice of Intravenous Therapy and Restructuring the Workload: Methods and Models to Address the Nursing Shortage, Sharon has also published over 75 manuscripts in peer-review journals. She is a well-known national and international speaker. She is currently health writer for Remarkable Woman Magazine and a contributor to Healthy Aging.

Sharon has facilitated strategic partnerships, bringing the expertise of organizations such as the International Council of Nurses (ICN), Sigma Theta Tau International (STTI), the World Health Organization (WHO), and the American Organization of Nurse Executives (AONE) to foreign nurse leaders. She previously served on the U.S. Secretary of Labor’s Immigration Relief Advisory Council (INRAC) representing the Federation of Nursing Specialty Organizations. She is an elected member of STTI’s Leadership Succession Committee. Sharon earned a Master’s Degree in health management and gerontology from North Texas State University, a certificate in health administration from Trinity University, a bachelor’s degree from Wilmington College, and a diploma from Pennsylvania Hospital School of Nursing. She is a graduate of the Kellogg Executive Management Program and a Fellow of the American Academy of Nursing.
Managers

Sylvia Aruffo, PhD
Dr. Aruffo spent twelve years at Fortune 100 corporations developing products and services based on ethnographic research, preparing her to be an advocate for "evidence-based" innovation in health care. She has served on the Advisory Task Force for URAC accreditation, the International Disease Management Association and the Case Management Leadership Council. Her publications on patient compliance appear regularly in health care journals. Her health care innovations have received national awards, most recently from the Consumer-Directed Health Congress. She was named Elite Circle Speaker by the Medical Device Industry Congress. Her doctorate is in ethnolinguistics from Northwestern University. She speaks five foreign languages. Dr. Aruffo also has an MBA from Northwestern and was a Director of Technology Sourcing for Baxter Healthcare. A passionate advocate of the Juran Quality Cycle, she served as a quality award examiner.

Shirley Grey, RN MSN
Ms. Grey is Executive Vice President and principal of Communication Science, Inc. She has been in that position for 11 years. She has a rare combination of experiences: 13 years' home health executive preceded by 10 years' hospital nursing ending as Director of Nursing. For 8 years, she was administrator of a $4 million home health agency. She handled national sales for one of the country's largest home health care firms. She is a past president of the Illinois Chapter of the Case Management Society of America. Ms. Grey is on the boards of several charitable organizations and is founder of the Don Johnson Chapter of Us TOO! International Prostate Cancer Organization. In 2008, UsTOO presented Ms. Grey with its Edward C. Kaps Hope Award for her work spanning 12 years with patients and their families surviving Prostate Cancer. Her undergraduate degree is from Arizona State University and master's degree in Perinatal Nursing is from University of Illinois. She is co-author of “Think You Have a Compliance Problem? Think Again,” The Case Manager, March/April 2005.

Judith Franks-Farah, RN
Ms. Farah managed the emergency room at Mt. Sinai Medical Center on the south side of Chicago for 22 years. Concurrently, she was the manager of a physician practice clinic. She knows the case managers' perspective from experience as a precertification nurse in an independent physicians' association from 1996-98.

Carol Outland, RN MSN
Ms. Outland was professor of nursing and the director of an innovative birthing center at the University of Colorado. She has also been administrator of a home healthcare agency and hospice.
Why do SelfCareKits Work?

Because they are developed with communication science: ethnographic research and sociolinguistic design.

Ethnography is the research techniques of anthropology: a professional system to discover the patient’s perspective, gaps in abilities and understanding and even define how certain common health care tools and instructions may not in fact be appropriate for the home.

Before a SelfCareKit is produced, Communication Science researchers go to patients’ homes spending hours and days observing the patients’ lives.

The Consumer Products industry has used these techniques for decades to enhance their ability to change behavior. Nissan used ethnography to double its sales in one year. Pepsi used ethnography to increase the sales of Gatorade 23%. Communication Science is the first to turn these proven techniques toward helping patients succeed at self care.

Sociolinguistic Design is the understanding of how get a message across in ways that engage and inspire for the long term. There are six principles of sociolinguistics:

- Present the unexpected in the first four seconds
- Overcome resistance with humor
- Dispel skepticism with concrete answers
- Use adult memory links
- Inspire with powerful images
- Prioritize goals as section headings, not topics

At the end of this document is a deeper explanation of each six principles to use in evaluating patient content. The following article, from the Remington Report, September 2009 shows how communication science makes a difference in home care practice and outcomes.

The article includes financial data on the savings to an agency from using the SelfCareKits.
2009 Care Transitions
Collaborative Care Transition Strategies: Patients, Physicians And Hospitals

By: Sheila Smith, RN, BSN, CDE, And Sylvia Aruffo, PhD

The Patient As Collaborator
The only element of the healthcare delivery system that touches each of its components is the patient. Yet the patient is the most underestimated and overlooked resource in the entire system.

How do we collaborate with the patient?

Providers have a tendency to do things for the patient, a labor-intensive model. Alternatively, we lean toward doing things to the patient in a technology-intensive model. The first tendency fosters "learned helplessness," where the patient comes to rely on the provider rather than becoming independent. The second tendency fosters genuine helplessness - that is, when the technology is removed, most patients have not learned how to manage and monitor independently. Both tendencies miss the opportunity to make the patient a partner in care.

We need to stop thinking about the patient as the reason we do our work - its end - and start thinking of the patient as a collaborator, a means to get the job done. Redesigning healthcare for patient collaboration puts the patient at the center, rather than at the end. How do we collaborate with the patient?

Start by investigating the patients' perspective on the healthcare delivery system. What elements of the system does the patient most want to improve? With many years of collecting patient satisfaction data Press-Ganey1, the California patient satisfaction survey2, and others 3 indicate patients' top concern is being prepared for self care, the transition from hospital to home. This gives home care the opportunity for a major impact on collaborating across the system.

What Does The Patient Need To Become A Collaborator?

To collaborate, patients need to absorb knowledge and skills as rapidly as possible. And it is possible - after all, every provider at one point had no knowledge or skill. The three most important elements of preparation are: (1) Explain the disease and medications, (2) define the steps of self care and (3) provide user-friendly tools.

1. Explain the disease and medications. Too often we providers
give oversimplified explanations; that is, what passes for "simplification" is in fact vagueness in the name of "health literacy." For example, a father and son with CAD were puzzled by an American Heart Association handout about triglycerides: "What does this mean," they asked each other, 'Another kind of fat?'" The phrase may be at a low reading level, but it doesn't mean anything. We owe it to our patients to dig into our textbooks for explanations that have continuity with other elements of the teaching. A search of medical literature uncovers that triglycerides are also called VLDL, Very Low Density Lipoprotein. If we have taught our patients that High is good and Low is bad, then "another kind of fat" that is "very low" makes sense: of course it's another bad fat if it's low. There's continuity and coherence in our explanation: HDL, LDL and VLDL: High, low and very low.

If we do not clarify their diseases and treatments, patients invent their own "meaning." One woman was told she needed a Beta Blocker. "Will it heal my heart?" she asked. When told it wouldn't, she concluded that "blocker" must mean the pill merely "blocks" or "masks" what is going on. She decided not to take it. To prevent this line of reasoning, we might even need to read FDA package inserts to find the mechanism of action. Then we can explain: Your heart has a tendency to race. The Beta Blocker blocks adrenalin, which can make the heart race. The heart stays beating steadily even when stressed. So there is value in taking the pill, even if it doesn't "heal." When she understands, the patient can collaborate.

Patients resent being shut out of collaboration. One woman related the story of asking her doctor, "Why do I have to take metformin, glyburide and Actos, when all three are for the same thing, diabetes? The doctor just said, 'You need them.' She just left it like that. That was when I decided to change doctors."

2. **Define the steps in self care.** Teaching how to do self care procedures should be straightforward. But patients can be confused when each nurse has a different method. *We serve providers, not patients,* by tolerating such variation. One home care administrator lamented, "I have 15 different sets of instructions on self-catheterization. The nurses can't agree, so I have the inventory headache and patients have the headache of starting over again with a different set of instructions every time they talk to a new nurse.

Patient education committees too often approve handouts that say to do a procedure "as you were instructed." If the patient doesn't remember how they were instructed, what good is the handout? Such a decision is not patient-centered but provider-
centered, appeasing providers who refuse to come to agreement.
Vagueness in instructions discourages patients from engaging in self care.

3. **Provide user-friendly tools.** Most devices and supplies are designed for hospital use by professionals, not self care at home by patients. This is in sharp contrast to the consumer products industry, where hundreds of millions are spent researching, designing, testing and redesigning products to make them maximally user friendly - even "idiot-proof." One DME sales rep expressed concern that increasingly complex equipment goes home for nonprofessional use. She spends more time training, but on leaving, she is not sure they can do it. We in home care need to be aware that most tools patients must use are not user-friendly. We can be on the lookout for new tools to facilitate patients' being collaborators.

Monitoring in the home is a hot topic. If our goal is to make patients independent, we should be sensitive to how a monitor might foster passivity, instead of preparing them for independence. On the one hand, patients are not always accurate in self-reporting results (whether deliberate or simply mistaken). On the other hand, automated monitoring may be an overreaction, creating as many problems as it solves.

For example, the Medical Director of the AARP related a story of a HF patient whose son brought her a take-out Chinese dinner, complete with soy sauce. Afterward, the woman had difficulty breathing. The Medical Director reported with satisfaction that a telemonitoring device caught the decline and connected the woman to her PCP, preventing a trip to the hospital.5
But this is not a **success** of telehealth. This is a **failure** of patient education. Why had no one taught this woman about sodium? Probably because they were transferring the responsibility to the device.

Another criterion for choosing a tool is how well it fits the patients' environment. Some patients enjoy tapping diet behaviors into a smart phone - but the majority of patients do not have .smart phones. Patients with computers may do well entering glucose scores on a website, but the majority of older people are not comfortable on line - even if they own a computer. At a medical device conference, Boston Scientific reported they had a "very successful" e-newsletter for patients. An attendee asked how many patients ask for the paper version vs. the electronic. "Eighty-five percent ask for a paper edition to be mailed."6
A Case Study In Collaboration

The home care agency of Great Plains Regional Medical Center addressed the three elements by adopting a self care kit for the patients. The kit facilitated collaboration, using the patient as the element of continuity through transitions.

Collaboration with the hospital. Communication with the hospital nurses was facilitated because the messaging to the patient was the same in both environments. Patients could build on the messaging from one provider to the next.

For example, one patient, after completing diabetic education classes at the hospital, reported he still felt confused, uncertain where to begin. When home care delivered his self care kit, he reported that seeing all the elements of diabetic self care in one organized package clarified the process for him. Many of the principles already taught in the classes "clicked" for the first time. "This is my 'go-to' box," he reported. "It all seems much more do-able now." The patient saw continuity across the transition from hospital to home care, appreciating that the home care staff knew how the kit linked back to what he had learned in the hospital classes. "We're all on the same page now," he said.

Collaboration with the doctors. The home care nurses showed the kits to the doctors. The sharing over the kit made the doctor more aware of the service, process and value of home care. All the doctors became more enthusiastic about home care, increasing the sense of collaboration. The hospital also collected the data on readmissions, using software that sorted the patients by doctor, comparing patients who received kits and home care to those who did not.

During the study period, none of the patients who received kits through home health were readmitted. Of patients discharged without home health, 13% of HF patients and 3% of CAD patients were readmitted.

The hospital reported to the doctors the superior outcomes of the patients who had received kits through the home care agency, promoting even greater appreciation of - and referrals to - home health.

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<tr>
<th>Condition</th>
<th>Without Kit or Home Health</th>
<th>With Kit and Home Health</th>
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<tr>
<td>HF</td>
<td>13%</td>
<td>0</td>
</tr>
<tr>
<td>HTN</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>DIABETES</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>CAD</td>
<td>3%</td>
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NOTE to Sales Reps: See Home Care Folder, “Our Product is a Smarter Patient” for more graphs and charts of outcomes and productivity.
Collaboration with the patient directly. Too often, a home care nurse tells a homebound patient they need a scale or a pillow encasing, but weeks later they still haven’t found a friend or family member to get it for them. Bringing a complete kit with all the tools needed to the patient’s home means the patient starts their self care immediately. "For us as professionals," reported several nurses, "Instead of just 'telling and leaving,' hoping for the best, we see the patient actually begin successful self care. We use those immediate, positive results to reinforce the behavior."

The improved outcomes were achieved at the same time fewer visits were necessary in three out of four conditions, allowing the home health agency greater profitability.

Conclusion
Collaborating across the healthcare continuum in a way that is patient-centered means creating continuity the patient can perceive. Expand our definition of the elements in the care continuum that need "continuity" if patients are to be successful at taking responsibility for self care: Continuity and clarity in the explanations of their diseases and medications, standardization in their instructions for self care and user-friendliness in their tools for self care. If we do not scrutinize the delivery system for means of collaborating with the patient, we actually - if inadvertently - discourage self care. On the other hand, if we dig deep for explanations, reach consensus on procedures and find tools best adapted for home use, we inspire patients to collaborate with providers across the health care delivery system.

References
4. All patient quotations are from the Ethnographic Research Library, Communication Science, Inc. unless otherwise noted.
5. Conference Washington DC.
6. Conference Chicago IL.
Sheila Smith, RN, BSN, CDE, Director of Home Care and Behavioral Medicine, Great Plains Regional Medical Center, Elk City OK; Sylvia Aruffo, PhD, President, Communication Science, Inc. Buffalo Grove, IL
How to overcome objections

“Education material is available in the public domain, or we can make our own. We wouldn’t pay for it.”

Have you ever used your handouts to get more referrals? Can you show your handouts to doctors who are so impressed that they say, “I want my patients to have that. I’ll send them to you.” Isn’t a new referral stream worth more than $50 to you? *If the person doesn’t find that interesting, then you’re not talking to someone responsible for the profit and loss of the agency.*

“Why are they so expensive? I could see maybe $15 to $20.”

**Actually, the kits are worth far more than we can charge for them. Our customers get up to 14 times their money back on their purchases.** Don’t forget the kits have tools in them, like blood pressure monitors and mattress encasings, that are worth more than $15 to start.

Too often, a home care nurse tells a homebound patient they need a scale or a pillow encasing, but weeks later they still haven’t found a friend or family member to get it for them. Bringing a complete kit with all the tools needed to the patient’s home means the patient starts their self care immediately. ”For us as professionals,” nurses report, ”Instead of just ‘telling and leaving,’ hoping for the best, we see the patient actually begin successful self care. We use those immediate, positive results to reinforce the behavior.”

“Is anyone else using this? Would we be the first?”

**More than 120 agencies are already using the SelfCareKits.** Many have been using them for more than five years.

“Our educational material works OK.”

**Works ‘OK?’ OK for what?** There is a 70% national patient non-compliance rate across therapeutic areas. No matter what the disease, patients do not do what they need to do. *If it is acceptable that over 2/3 of the people are not successful at selfcare, then, yes, the free materials available today are OK.*

But let’s take a look at those free materials. Some free materials are flat-out clinically wrong: One Sanofi-Aventis piece claimed that a slice of bread, a cup of milk and a cup of blueberries each have ONE carbohydrate. As you know, each of those is a one SERVING, which is 15 carbohydrates. Because of this error, the recommended day’s meal plan of 195 carbs, when the ADA upper limit is 150.

But even when freebies are *clinically correct,* they do not inspire *behavior change.* Let’s use the standards of communication science to judge whether handouts currently available change behavior:
Six Standards of Healthcare Communication

How to Evaluate Patient Handout Materials

Cedars-Sinai Medical Center, despite massive education and motivation campaigns, could not move the rate of doctors’ handwashing above 80%. Finally, they had each doctor press a palm into a Petri dish. Photographs of the results were posted as screensavers on all computers. Handwashing compliance shot up to 100%.

The purpose of a handout is not education by itself.
Of course it must be clinically correct.
Of course health literacy standards enhance comprehension.
But the purpose of a handout is behavior change.

Handouts change behavior if they meet the Six Standards of communication science:

1 Engage: “The Four-Second Rule”

Advertisers know if a brochure doesn’t capture attention in the first four seconds, the viewer will move on.
A handout should also capture attention instantly with:
• An unexpected image or
• Words that arouse curiosity or
• The beginning of a story or
• All of the above

Names like “Healthy Eating” “Your Guide to Hypertension” are not unexpected. Photos of generic, smiling people do not arouse curiosity. A list of definitions is not a story.

2 Overcome Resistance with Humor

When an authority says, “Do this,” most people do the opposite. Just the word ‘should’ can spark resistance. A laugh can break the ice.

But The Joint Commission missed the mark on humor. To inspire shy patients to ask doctors questions, The JC concocted a “superhero” character, “SpeakUp!” The patients felt ridiculed rather than inspired.

Humor that humiliates or belittles the patient will create resentment. Humor that allows a patient to laugh at the disease, the situation, anything outside themselves will overcome resistance.
3 Win Compliance with Concrete Answers


Barbara went home and thought it out. “It doesn’t heal my heart. It blocks something. It must just mask effects. I don’t need that. I won’t take it.”

Too often, trying to be simple, a handout will be vague. If a handout does not give concrete answers, patients will invent their own answers—generally to support a decision to be non-compliant.

How to tell VAGUE information from CONCRETE information:
Answer applies to many items Answer applies to only one item

VAGUE = A Beta Blocker is for your heart.

CONCRETE = When you’re stressed, your body makes adrenalin. Adrenalin makes your heart beat faster. Faster does not mean stronger.

A Beta Blocker blocks adrenalin. Your heart stays beating strong and steady, even when you’re stressed.

4 Use Adult Memory Links

Children can learn by rote repetition. Adult brain cells have changed—they remember if new information connects to familiar concepts. So look for handouts that use metaphors: “What you’re facing now is like a ball game, a receive, driving a car, playing bridge, etc.” Don’t accept handouts that use exotic metaphors like climbing a mountain or entering a space station airlock unless your patients are rapellers and astronauts.

Check if the handout offers help in remembering: Rhyme, rhythm, alliteration, pattern.
Look for these in the names of a list of tasks.
Watch how long those lists of “To Do” items are!
Prioritize Goals

Professionals are told to set **measurable** goals for work. Many handouts seem unaware of this rule. They describe **topics** instead of setting measurable **goals**. They fail to relate self-care to any goal—\-or offer only a vague, unquantified goal: “You’ll feel better.”

**Handouts that don’t change behavior** present self-care actions **first**, then explain why—\-or neglect to explain why.

**Handouts that change behavior**
- First state the goal and then
- Explain what self-care actions accomplish it.
- Tell how to measure progress.

“Our goal is to open up your arteries. You do that by eating good oils and taking an ACE inhibitor. You’ll see progress in lower blood pressure readings.”

*Bonus: By breaking up the topic of medication, relating each pill to a different goal, a handout automatically clarifies why a patient must take multiple pills.*

How to tell a TOPICAL handout from a GOAL-ORIENTED handout:

**Topics start with nouns**

**Goals start with verbs**

**Diabetes: Your Skin and Feet**

Like many other complications of diabetes, having high blood sugar (glucose) levels for a long period of time may damage your feet and skin.

**Foot Problems**

The two most common conditions associated with diabetes are:

1. Nerve damage. Diabetes can damage your nerves—a condition called diabetic neuropathy. When nerves are damaged, you may have difficulty feeling pain, heat or cold. A sore or cut on your foot may get worse because you’re not aware it’s there.
2. Poor circulation. Diabetes can lead to poor circulation or blood flow to your legs and feet—a condition called peripheral vascular disease. This condition makes it difficult for a sore or an infection to heal. It’s also made worse by smoking.

**A Doctor’s Help**

To make sure your doctor checks your feet, take off your shoes before your doctor comes into the room. The doctor may recommend lotions or creams. If you cannot cut your toenails, ask the doctor to refer you to a podiatrist.
Inspire with Powerful Images

The story of Cedars-Sinai and handwashing is a testimony to the power of images. The doctors did not need more education. They knew the facts. They did not need greater comprehension. They understood the facts. They did not need to do a return demonstration. They needed to be inspired. Images inspire.

VISUAL IMAGES
Cutaway diagrams of body parts are a staple of patient handouts. By themselves, however, diagrams rarely inspire. At a glance, which image is more likely to inspire you to exercise and avoid trans fat?

“The inside of your artery looks like this:”

VERBAL IMAGES
Telling a story well can conjure up mental images as powerful as photos. Stories can be concrete, moving and memorable. Look for handouts that tell stories: about the disease process, about people with the disease, about how treatments work.

The inside of your artery looks like this:

Summary: The Six Standards

Some say, “You can’t change behavior with brochures.” But in fact you can if you choose materials that follow the Six Standards of Healthcare Communication.

1. Engage: A surprise in 4 seconds or less
2. Overcome Resistance: Laugh at disease
3. Win Compliance: Give concrete answers
4. Link to Adults: Use rhythm & familiar metaphor
5. Prioritize Goals: First ends, then means.
6. Inspire: Use powerful images in stories

For a demonstration of materials that change behavior, call Communication Science, Toll Free 1-877-CAREKIT
www.communicationscience.com
How Does this Fit in Your Business?

**SALES CALL**
Sales Representative for Home Health Agency shows doctors and discharge planners the kit and Log Book. Walk them through the Marketing Folder

**VISIT ONE**
OASIS evaluation visit:
Deliver the kit. Tell the patient and caregivers to read it over and you’ll look at it together on the next visit

**VISIT TWO**
Go over each piece, answer questions, get stories on how the patient has used the kit on own initiative. Get started on the Log Book if they haven’t already.

**NEXT VISITS**
See how patient is using the tools in the kit already, making progress and enjoying success at self care. Encourage patient to take Log Book on each MD visit.

**Wrap up with OASIS exit.**

**Make a follow up phone call to see how the patient is doing. Ask for a report on the entries in the Log Book. Ask what patterns or cause-and-effect the patient has seen so far.**

**SALES CALLS**
Sales Representative for Home Health Agency gets patient testimonials to share with Nurses and Doctors

**REPORTS**
Agency receives higher referral volume. On next visits to Dr., sales rep. reports patient s progress and good outcomes. Show different kit for additional referrals

**NEXT VISITS**
See how patient is using the tools in the kit already, making progress and enjoying success at self care. Encourage patient to take Log Book on each MD visit.

**Wrap up with OASIS exit.**

**Report progress and good outcomes to MD.**

**Encourage MD to ask patient to bring Log Book to each visit and review.**

**ADMINISTRATORS**
Collect data on increased referrals, increased enrollment, increased revenue and savings, decreased readmissions and higher patient satisfaction

**Agency receives recognition for “Best Outcomes” and participates in “Pay for Performance” activities as available**