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Zendejas – ACHIEVING RECOVERY FOR PATIENTS IN HOSPITAL REHABILITATION

Achieving Recovery for Patients in Hospital Rehabilitation Units through Education

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Abstract

Millions of people are admitted to hospitals every day with the hope of alleviating, if not eliminating, their health conditions. Rehabilitation units within hospitals also admit patients every day for various medical conditions that result in decreased functioning. Unfortunately, many patients are not leaving hospital rooms healthier nor are they leaving with the confidence that they can follow through with their treatment instructions. Most importantly, patients lack health literacy skills that can help them navigate the healthcare system and understand their care, causing a limited recovery. As an intern at the Sam Karas Acute Rehabilitation Unit (ARU), I developed an educational intervention aimed at increasing Medicare patients' knowledge about their insurance and available community resources in order to improve their rehabilitation. Materials presented included videos, pamphlets, and fact sheets all containing brief and useful information about Medicare coverage. Pre- and post-tests were used to measure patient knowledge and results showed a significant increase in health literacy.

Keywords: hospitals, rehabilitation, health literacy, Medicare, Sam Karas Rehabilitation Unit

Achieving Recovery for Patients in Hospital Rehabilitation Units through Education

I. Problem Description

Problem Definition

Millions of people are admitted to hospitals every day with the hope of alleviating, if not eliminating, their health conditions. Rehabilitation units within hospitals admit patients every day for reasons such as strokes, spinal cord and brain injuries, and surgeries of different types that cause general debility. Specifically, rehabilitation patients enter hospital units with the goal of receiving specialized therapies such as occupational, outpatient, and speech therapies in order to improve their functioning.

Unfortunately, many patients are not leaving hospital rooms healthier nor are they leaving with the confidence that they can follow through with their treatment instructions (Engel, K.G., et al. (2009). Patients are not fully recovering and are being readmitted into hospitals because of inadequate discharge planning and poor communication between patient and health professionals (Goodman, D.C., Fisher, E.S., & Chang, C., 2011). The following will discuss why patients are not fully recovering after discharging from hospital units, what the consequences would be if left unaddressed, and what inputs are causing the problem. See Figure 1 in the Appendix section for a visual description of the problem model I used in developing my capstone project.

Problem Consequences

The problem of patients not fully recovering after discharge is an issue that affects many

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for varied reasons. It is not good for the patient, for caregivers, for the hospital, nor for the financial entities paying for the medical services (Family Caregiver Alliance National Center on Caregiving, n.d.). Refer to Figure 1 in the Appendix section for a visual representation of the consequences.

Patients, caregivers, and insurances are all affected by patients' recovery. If patients continue to be ill, they can burden public assistance and become part of the high unemployment rates. Caregivers are also affected because they must learn new and more complicated ways to help and assist their loved ones once the patient is readmitted (United Hospital Fund, n.d.). Hospital stays are very expensive and most insurance have restrictions on what they are willing to pay for. If patients have Medicare, readmissions are costing taxpayers millions of dollars a year (Social Security Administration, 2011).

The issue is that hospital patients are being readmitted at an increasing rate (Goodman, D.C., Fisher, E.S., & Chang, C., 2011). Specifically, more than 18% of Medicare patients discharged from a hospital are readmitted within 30 days of initial discharge (Engel, K.G. et al, 2009). A report states that in Salinas alone, 13.8% of patients are being readmitted to hospitals within 30 days, as compared to the national average of 12.7% (Goodman, D.C., Fisher, E.S., & Chang, C., 2011).

The increasing rate of readmitted patients implies not only that patients are getting sicker after their initial discharge but that something within the process of transitioning care, is going terribly wrong (Goodman, D.C., Fisher, E.S., & Chang, C., 2011).

If patients are not recovering, they are losing their ability to be independent and productive members of society. They may begin to utilize public assistance. This means patients

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may become part of the growing unemployment rate in the nation. The unemployment rate in Salinas alone rose to 11% as compared to 9.1% nationally (U.S. Bureau of Labor Statistics, n.d.). In addition, once patients are discharged, they may apply for disability and social security assistance. These services are funded by taxpayers, who then become affected by the rehabilitation population. It is estimated that nearly 55 million Americans have already received \$727 billion in Social Security benefits this year (Social Security Administration, 2011). As one can see, it becomes critical to insure patient recovery.

Contributing Factors to the Problem

Consequences of not addressing patients' care and recovery are unsettling. But why is this occurring? Several reports concur that readmission rates are often a sign of inadequate discharge planning, poor care coordination between hospitals, community clinicians and caregivers, and lack of effective community-based care (Goodman, D.C., Fisher, E.S., & Chang, C., 2011 & Engel, K.G. et al, 2009 & Lattimer, 2011). A few contributing factors affecting patient recovery are included in Figure 1 found in the Appendix section.

Patients lack health literacy skills that can help them navigate the healthcare system and understand their care (Lattimer, 2011). Health literacy refers to the patient's understanding of their medication indications, therapy or treatment plans, and the discharge planning process (Lattimer, 2011). Affecting a change in one of these causes can potentially reduce the consequences and improve patients' health.

Medicare explains that discharge planning is, "a process used to decide what a patient needs for a smooth move from one level of care to another" (Family Caregiver Alliance National Center on Caregiving, n.d.). When social workers or other health professionals arrange for

patient discharges, a lot of information is discussed yet little is actually retained (Goodman, D.C., Fisher, E.S., & Chang, C., 2011).

Specific steps in discharge planning include: evaluation of the patient by qualified personnel; discussion with the patient or his representative; planning for homecoming or transfer to another care facility; determining if caregiver training or other support is needed; referrals to home care agency and/or appropriate support organizations in the community; and arranging for follow-up appointments or tests (Family Caregiver Alliance National Center on Caregiving, n.d.).

According to the U.S. Department of Health and Human Services' Health Care Research and Quality (AHRQ) division, patient and family education is very important (n.d.). They assure that having patients and family understand follow-up needs and whom to contact with questions or problems after discharge is essential in preventing adverse events after discharge (AHRQ Patient Safety Network, n.d.). Adverse events could include: not understanding medication or follow-up instructions. The absence of clear information during discharge planning leads to preventable hospital readmissions (Goodman, D.C., Fisher, E.S., & Chang, C., 2011).

II. Field Agency, Alternatives, and Justification

Field Agency

I had the opportunity to intern at Sam Karas Acute Rehabilitation Unit (ARU) in Salinas, California. It is housed within the Natividad Medical Center (NMC) hospital. The following will describe NMC's mission and vision, explain the goals of the ARU, and relate each to the issue of

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patient recovery.

The Natividad Medical Center (NMC) is a public, safety-net hospital that has served the people of Monterey County for over a century (Natividad Medical Center, n.d.). The National Association of Public Hospitals and Health Systems define safety-net hospitals as those that provide, “a significant level of care to low-income, uninsured, and vulnerable populations” (n.d.). Many of NMC’s patients are covered by Medicare and Medi-Cal (T. Stickler, personal communication, September 6, 2011), which are safety-net programs.

The ARU does not have its own vision and mission statement but observes that of NMC’s. Natividad Medical Center’s mission is to, “continually improve the health status of the people of Monterey County through access to affordable, high-quality healthcare services” (Mission, Vision & Values, n.d.). Its vision is to, “set the standards for a model safety net hospital; be an accessible and desired resource of care; and be responsible for best practices, great outcomes and high patient and caregiver satisfaction levels” (Mission, Vision & Values, n.d.). NMC values patients and their unique situations. According to their website, NMC is committed to providing compassionate, respectful care and they strive to understand each patient’s needs in order to develop tailored care plans (Mission, Vision & Values, n.d.).

The ARU is a relatively new unit within NMC. The ARU opened its doors five years ago and was named after a local community leader, Sam Karas. Karas was a Monterey County Supervisor and Coastal Commissioner who spent more than 30 years working on such issues as affordable housing and farmworkers rights (News Briefs, n.d.).

The Acute Rehab Unit is a comprehensive, interdisciplinary inpatient unit offering medical care, physical therapy, and occupational therapy as well as social work services (T.

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Stickler, personal communication, September 6, 2011). The ARU is a 22 bed facility that offers patients a temporary stay of usually 12 days (Sam Karas Acute Rehabilitation Center, n.d.). Patients admitted to the ARU include those who have had a stroke, surgery of various types, heart disease, or complications of previous illnesses (Natividad Medical Center, personal communication, September 6, 2011). Ages range from 18 and older, yet a typical census may list patients that are older than 45 and up to 85 (T. Stickler, personal communication, September 6, 2011).

Goals and objectives for the patients of the ARU include, “medical stability, pain control, education of the patient and caregivers to promote functional independence, and reintegration of the patient back into the community” (Natividad Medical Center [Brochure], n.d.). The ultimate goal is to have 85% of patients discharged to their homes (Natividad Medical Center [Brochure], n.d.). For many patients though, this is not feasible because of physical and cognitive impairments that require 24 hour care. In these cases, social workers and the health care team work together to arrange placement at Skilled Nursing Facilities or arrange for home health services (T. Stickler, personal communication, September 6, 2011).

Discharge planning is the primary tool used to insure safe placement of patients after discharge, which is one of the goals of the ARU. Thorough and informative discharge planning is important in preventing adverse events after discharge (AHRQ Patient Safety Network, n.d.) yet this does not always occur. The proceeding will discuss a few interventions designed to impact patient knowledge at discharge, which can improve their health and help prevent hospital readmissions.

Alternative one: Quick discharge

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Choosing to maintain discharge and care planning as is will produce the same results: inadequate communication, education, transition of care, and ultimately raise readmission rates. Discharge planning will be done in the same way; that is, social workers or other health professionals will evaluate the patient, plan for homecoming or transfer to another care facility and determine if caregiver training or other support is necessary (Family Caregiver Alliance National Center on Caregiving, n.d.).

This alternative would allow the health care team to continue to do their work and ensure a safe transfer from hospital care but it would not push them to change their procedures for the patients' benefit. Patients and care givers will miss opportunities to be informed about care, community resources, and understand Medicare coverage. Most importantly, patients' health may not improve and many will form part of the growing readmission rates.

Alternative two: Patient education

In order to improve communication skills between health professionals and patients, an intervention can be done to educate patients about Medicare coverage. As mentioned before, the majority of patients at Sam Karas Acute Rehabilitation Unit are insured through Medicare (Natividad Medical Center, n.d.). Offering clear information about their coverage can improve discharge planning and affect a positive change in readmissions (Family Caregiver Alliance, n.d.).

Pre- and Post-tests can be given to patients to test them on their knowledge of Medicare insurance. A few basic questions would gauge what information they know about their insurance. Answers from the pre-test would help us create relevant educational material to present to patients during their stay. The post-test would then show if we had any success in

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improving patients' knowledge about Medicare.

Throughout the intervention, patients would be presented with resource pamphlets that would list Medicare approved community resources such as: skilled nursing facilities, medical equipment providers, outpatient clinics, and home health agencies.

Alternative three: Caregiver education

Discussions among experts on improving transitional care and discharge planning have centered on improvements that emphasize education and training (Family Caregiver Alliance, n.d.). Because caregivers are usually involved in discharge planning (AHRQ Patient Safety Network, n.d) and the patients' care after discharge (United Hospital Fund, n.d.), an intervention can be done to educate and support their role.

The education can center on Medicare coverage and community resources. Caregivers often have questions about what type of care is covered after discharge. Providing educational material would help them understand and better care for their loved one (United Hospital Fund, n.d.). A brochure of community resources can be developed and tailored to their needs. Resources could include support groups located in the area that focus on caring for loved ones with illnesses such as stroke and Alzheimer's. Respite care or adult day care opportunities would also be listed as well as mental health resources.

Pre- and Post-tests can be given to caregivers to test them on their knowledge of Medicare insurance and community resources. Questions such as: Do you know what insurance the patient you will be caring for has? Do you know what services it covers? Do you know where to go for support as a caregiver? Would seek to understand what the caregiver knows as well as serve as a tool to create the educational material and pamphlet of needed services. The Post-test

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would serve as an evaluation tool to analyze what knowledge was gained, if any, and provide recommendations for improvements.

Selected Alternative and Justification

My capstone project will focus on Alternative Two: Patient Education. It is a relevant solution to the issue of hospital patients' recovery because many ARU patients have Medicare and require education about insurance and community resources. Figure 2 includes the problem model with the chosen alternative.

According to a Dartmouth report about Medicare beneficiaries, poor communication was cited as one of the critical reasons patients were being readmitted to hospitals after discharging (Goodman, D.C., Fisher, E.S., & Chang, C., 2011). It is through discharge planning that social workers can improve communication about medication, follow-up indications, and education in order to minimize readmission rates (Family Caregiver Alliance, n.d.). The above report also concluded that for Salinas, the percent of patients being readmitted within 30 days of discharge was 13.8% in 2009 as compared to the national average of 12.7% (Goodman, D.C., Fisher, E.S., & Chang, C., 2011).

In addition, health care professionals and social workers each have ethical codes to abide by. In working to develop safe and relevant discharge plans, social workers must remember their duty to respect patient's self-determination. The National Association of Social Workers (NASAW) Code of Ethics specifically states that, "social workers must seek to enhance clients' capacity and opportunity to change and to address their own needs by promoting clients' self-determination" (Code of Ethics, n.d.). Without thorough education and discharge planning, the ability for patient and/or caregiver's to make informed decisions about their health is threatened.

Most importantly, patients' health may not improve causing readmissions to hospital units.

If the issue of patient recovery is not addressed properly, patients may apply for disability and social security assistance. These services are funded by taxpayers, who then become affected by the rehabilitation population. It is estimated that nearly 55 million Americans have accessed more than \$727 billion in Social Security benefits this year (Social Security Administration, 2011). Not to mention, many will become part of the already high unemployment rates both locally and at a national level. As one can see, it becomes crucial to affect change within hospital setting in order to prevent many of these outcomes.

III. Implementation tense

Communication and health literacy issues are causing hospital patients to be inadequately prepared for discharge. As a result, hospital patients are being readmitted at a high rate within a short period of time. Specifically, more than 18% of Medicare patients discharged from a hospital are readmitted within 30 days of initial discharge (Engel, K.G. et al, 2009). In Salinas alone, 13.8% of patients are being readmitted to hospitals within 30 days, as compared to the national average of 12.7% (Goodman, D.C., Fisher, E.S., & Chang, C., 2011).

This Capstone project aims to increase Medicare patients' knowledge about their insurance and available community resources. In other words, this capstone aims to impact one of the many causes to the problem that hospital patients are not fully recovering their health and independence after discharging from hospital units. See Figure 1 in the Appendix for a visual description of the problem model used in developing my capstone project. The ultimate goal of the educational intervention is for patients of hospital units to become productive members of

society once discharged.

Objectives are important in guiding the intervention process. Two overarching objectives used to guide my project included:

1. Increasing Medicare patients' knowledge about their insurance by 50% by April 27, 2012.
2. Increasing Medicare patients' knowledge about Medicare-approved resources in the community by 30% by April 27, 2012.

The patient education intervention consisted of surveys and a presentation of printed materials, a video, and pamphlets of community resources. Our sample consisted of 20 patients who have Medicare insurance. This is a significant number because the Sam Karas Acute Rehabilitation Unit (ARU) admits approximately 30 patients in any given month (T. Stickler, personal communication, September 6, 2011). Since not all patients have Medicare insurance, it was feasible to obtain 20 Medicare patients within the two months of the intervention stage. See Table 1 in the Appendix for a timeline of activities.

I chose to survey two groups: a control group and an experimental group, each consisted of 10 patients. The control group was given a pre-test (see Appendices for a sample English and Spanish survey), but will not receive the educational intervention. Results of these tests were used to show what patients knew and the data was compared to the experimental group in the evaluation stage of the intervention.

The experimental group was also given a pre-test to gather baseline information. The educational material was then presented throughout the course of their stay. On one day, I gave

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the patient a pre-test and on the next day, I explained a fact sheet, pamphlets, and answer any questions they had. I also presented a short, seven minute video that provided an overview of Medicare; and finally I administered the post-test. The post-test or survey contained the same questions as the pre-test survey.

I visited each patient in their rooms, explained my project and the informed consent, and then administered the pre- and/or post- tests. When patients were unable to read or mark the answers, I assisted them.

I developed the curriculum that was presented to the Medicare patients. The information for the curriculum was derived from the government Medicare website which contains fact sheets, publications, and other resources about the different parts of Medicare and the services and equipment they help cover. I put together the most important concepts from each of these sources in an appealing and simple format. Because Spanish is one of the most prevalent languages spoken in the ARU, all materials including the informed consent form, survey, and pamphlets were translated and given to Spanish speaking patients.

My mentor served as primary resource in including information about appropriate agencies and services within the community, which is Monterey County. As a social worker, she must find and secure medical equipment, home health services, or facility placement before any patient is discharged. She is knowledgeable about this and has provided me with brochures from these agencies.

As far as budgeting for the project, the ARU provided all materials in-kind. The ARU provided its facilities, equipment such as printers and computers, as well as its employee time. I gathered additional information about patients from employees such as nurses and office staff.

We didn't anticipate having any out-of-pocket expenses; and indeed, we had none.

One issue we expected to encounter while providing the patient education was that of patients' cognitive and physical impairments. Another will be time. Many ARU patients have suffered damage that may not allow them to understand, process, or remember information. Others may not have the ability to read or write. In these cases, additional measures were taken to improve the possibilities of learning. For example, using bigger fonts, reading them the questionnaires, helping them mark the answers, speaking in an appropriate tone and volume. In more severe situations, patients were not chosen to partake in the intervention.

Time was another obstacle for both patients and me. I had to be able to identify and survey several patients each week. Since some patients were discharged sooner than the typical twelve days, I had to be careful who I chose for the control and experimental groups. Since I was scheduled to work only two days per week, it was tough making time to find 20 participants and teach ten of them. I was able to complete the intervention stage in late April, which gave me time to evaluate in May.

IV. Evaluation

Evaluation Design

Two important objectives were used in evaluating the success of my project: Increasing Medicare patients' knowledge about their insurance by 50% by April 27, 2012; and, Increasing Medicare patients' knowledge about Medicare-approved resources in the community by 30% by April 27, 2012. This section will discuss my findings and whether I met these two objectives.

Evaluation is an important component in this project. Two forms that were relevant

for this project are summative and quantitative evaluations. Summative is used at the end of a project to judge its success or impact; and used internally and externally in an organization (Zenk, 2011). My evaluation will be quantitative because I converted answers to the surveys into numerical values, which I then analyzed mathematically. This project was also left at my agency, the ARU for any future use. See the Appendix section for the evaluation tools such as the consent forms and surveys used in this project.

The process of evaluation includes: implementing the data collection, analyzing the data, preparing & disseminating reports, and finally making programmatic changes as indicated (Zenk, 2011). The evaluation instruments used were the pre- and post-tests. I collected and analyzed the data from these and provided recommendations for improvements in the end.

Ultimately, I was looking to show that this project was a success. In order to do this, I compared the objectives and goals I set for this project against the data gathered. Both the control group and the experimental group data provided insights into patients' knowledge and what improvements can be made in the project design. Finally, the project was measured against the organization's mission: "education of the patient and caregivers and reintegration of the patient back into the community" (Natividad Medical Center [Brochure], n.d.)

Evaluation Results

After gathering all the survey data, I can conclude that my objectives were met. I set out to improve Medicare patients' knowledge of their insurance by 50% and to improve patients' knowledge about Medicare-approved resources by 30% and I was able to achieve both.

I found that my Control group and my Experimental Pre-test group were at very similar knowledge levels. Three out of 10 patients in my control group received "C" grades and three

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out of 10 patients scored “F’s.” There was only one “A” grade. Similarly, my experimental pre-test group had four “C” grades; three “F’s”, and no “A’s.” Because these groups were so similar, I will be able to make more accurate comparisons across the groups. Table 2 in the Appendix gives a detail break-down of these two groups’ grades.

My data also show an improvement in the Experimental group. The Experimental Pre-test surveys showed that one patient actually improved from a “C” to an “A.” There were also no F’s in the post-test. A detailed list of each patient’s scores can be found in Table 3 in the Appendix.

Most importantly, I found that the Experimental group patients showed significant improvement in knowledge levels. As listed in Table 4 in the Appendix, the most improved patient increased their score by 37 percentage points! Other patients improved by significant amounts: two increased their knowledge by 18 percentage points and another by 28. Results were generally favorable except for two patients, whose scores actually decreased between the Pre- and Post-tests. Possible reasons for these lower scores will be discussed in the next section.

According to Dr. Navarro, an Assistant Professor who teaches the Applied Statistics and Research Methods course, our evaluation of my data using hypothesis testing showed the mean score for the Experimental Pre-test was 7, while the mean for the Post-test was 8.5. This represents the scores of patients who took the 11 question survey. The difference in means, which is 1.5, is significant because I can use it to verify that there was an actual increase in knowledge.

It is important to note that the increase in knowledge was not 50 or 30 percent as my objective aspired. The Experimental Pre-test patients started off at a somewhat high level, with a

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mean score of 7 (63% or answered seven of eleven questions correctly). Increasing this by 30 or 50% did not make sense.

The hypothesis test done with the help of Dr. Navarro yielded a p value of .022 or 2.2%. The Social Sciences gives between 1 and 5% chance that we incorrectly reject the hypothesis (Navarro, I., 2012) meaning that the two test scores were the same. In other words, my hypothesis test proved that there was a significant, positive change between the Experimental Pre- and Post-test surveys.

The surveys contained four critical questions that I want to discuss. The first was question number 1, which asked for a definition of Medicare. See Appendix for the complete survey and Table 6 for the scores on each question. This question encompassed an understanding of what Medicare is about; correctly answering this would reflect a somewhat educated patient. Question two probed whether patients understood that Medicare offered different plans of care. The last two questions, number 7 and 11, tested whether patients knew about medical equipment and where to find more information about Medicare. Answering these critical questions would reflect a more health literate patient.

The results proved interesting. As listed in Table 6 in the Appendix, I found that 80% of patients in both the control and the Experimental Pre-test group correctly defined Medicare. An increase was also found between the Pre- and the Post- test surveys of 10 percentage points.

For question two, there was a significant decline between the Experimental Pre-test surveys and Experimental Post-test surveys of 30 percentage points. In other words, there was a significant decline in knowledge for question two where 50% of patients knew the different parts of Medicare in the Experimental Pre-test but then only 30% knew in the Post-Test. Possible

reasons for this decline will be discussed in the next section.

Question seven asked what Durable Medical Equipment (DME) was and which part of Medicare covered it. The control group scored the highest; 90% of patients answered correctly compared to 70 and 80% for the Experimental Pre- and Post-test surveys, respectively.

The last question, number eleven, tested how resourceful patients were in finding additional information about Medicare. Both groups scored high on this question although a perfect score was observed for the Experimental Post-test surveys!

Discussion of Results

The design of my educational intervention caused many positive and negative results. In the previous section, I highlighted the greatest improvements and discussed how statistically significant these changes were but I did not discuss the limitations in my project that lead to outlier data.

As mentioned before, patients are admitted to the ARU for various medical reasons. Once admitted they are faced with meeting goals set by their occupational, outpatient, and speech therapists. They must complete their therapies and take many medications in addition to adjusting to their new situation. Teaching them about their insurance and then testing them is the last thing patients want to do. The negative results in Table 4 and 6 reflect patients' circumstances.

Most patients were courteous and eager to help even though they would rather rest. Others, grudgingly participated even when their rights were explained. Some patients were on

medications that made them sleepy and/or caused unpleasant side effect, others were hard of hearing or could not write, and still others were tired from therapies or preparing for breakfast or lunch. Each of these circumstances could have caused patients to forget material or guess on the surveys. These limitations are important to note because recommendations can be made so future attempts to educate patients can be more successful.

Favorable results can also be ascribed to circumstances. I found that some patients were very educated people, others were resourceful and independent, and all came from very different backgrounds. The significant increases in knowledge noted in my data may have come from these types of patients who were more medically stable, educated, and had a positive disposition.

V. Conclusion and Recommendations

Conclusion

In conclusion, my project specifically helped the patients that I worked with. Patients did learn about their insurance and community resources yet there is no way of accessing whether this knowledge will be retained or actively be used by patients. What I feel was most successful was spending time with patients, conversing with them, and answering their pressing questions about their discharge. So many of these patients are alone, vulnerable, and scared and I was glad, as they might have been also, to spend time with them. Caregivers were not part of the intervention and I feel they should be because they play a critical role in patients' recovery.

In addition, I feel that while hospitals may have state-of-the-art equipment and excellent health care professionals this does not assure that patients are fully recovering or that they are

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ready to become independent. It is their duty to make sure that patients are receiving quality care and that their needs are met. It is not enough for health care professionals to do the minimum for their patients in arranging for treatment, therapies, and discharge. My project compelled professionals to be patient-driven and provide more comprehensive, compassionate help through education.

Recommendations for the Agency

I would like the agency to keep my project as a resource for future students to use and modify. My mentor can show it to future students to help them get ideas about a capstone project they might want to pursue.

Recommendations for Future Students

A few recommendations for future students who wish to continue this project include: continue to educate patients, include caregivers in education, expand to other insurances, modify surveys as needed, allow for more time during the presentation of educational materials, and present on more than one session.

As my research showed, education is a relevant endeavor but caregivers should also be involved. Future students should find a way to incorporate caregivers in the education. Also, since patients come in to the ARU with different insurances, the education can be focused on insurances other than Medicare.

In order for patients to truly be health literate, they need to be given less information for a longer period of time. Educational sessions should be done on more than one session and patients should be tested after completing sessions to measure knowledge.

CHHS Major Learning Outcomes

Many Major Learning Outcomes (MLO's) are applicable to my Capstone project including: Knowledge of Health and Human Services, Leadership, Public Policy Analysis, and Statistics and Research Methods.

I learned the social work aspect of my mentor's job, which covered the Knowledge of Health and Human Services MLO. I had to conduct psychosocial assessments of patients and participate in discharge planning as well as provide proper documentation of all activities.

I also had to demonstrate leadership skills while negotiating what my Capstone project would be as well as by facilitating patients' learning throughout the intervention. It was not easy to identify a problem that the agency could impact and my mentor had different ideas than mine. My negotiation and leadership skills had to be used in order to find the most satisfying project for both of us.

In order to teach patients about the basics of Medicare, I had to teach myself about all aspects of this insurance. Using this knowledge, I created a survey and chose relevant teaching materials. This process allowed me to practice the Public Policy Analysis MLO competencies.

In addition, I incorporated what I learned through my statistics class by analyzing the data I collected through the Pre- and Post-test surveys, thus fulfilling the Statistics and Research Methods MLO.

University Vision

California State University, Monterey Bay has adopted a comprehensive vision statement which seeks to meet the needs of all stakeholders including faculty, students, and the surrounding community. Here is a shortened version of the vision statement found in the university website:

California State University, Monterey Bay (CSUMB) is envisioned as a comprehensive state university...serving the diverse people of California, especially the working class and historically undereducated and low-income populations...The curriculum of CSUMB will be student and society centered and of sufficient breadth and depth to meet statewide and regional needs, specifically those involving both inner-city and isolated rural populations, and needs relevant to communities in the immediate Tri-County region (Monterey, Santa Cruz, and San Benito) (n.d).

My project has produced important results that have been attained because of the commitment of its faculty to teach us about community issues and tools used to empower them. The campus has set up critical partnerships with community agencies where we as students are able to practice the skills learned in lectures and research projects.

Specifically, I was able to grow as a professional in the health and human services because of the campuses' vision. I am ready to serve my community!

Final Thoughts

I have learned many things through this one-year process. First, I can better appreciate

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how difficult social work is. My mentor had a very busy schedule and many professionals looked to her for answers. What I think helps her stay afloat is her communication and organizational skills as well as having a healthy personal life. She has helped me reflect on my strengths and weaknesses and whether I would be a good helping professional. I can see myself being burnt out quickly because I want to help everyone as much as I can. The biggest lesson my mentor has taught me is that help and support are two very different things; helping burns you out because you end up doing things they can do themselves while supporting empowers them and replenishes you.

Second, I understood that work cultures exist everywhere and it is important to know how to navigate them especially when it comes to conflict resolution. For me, conflict resolution will always be a skill I have to actively work to attain.

I also saw how critical paperwork is. In my last placement in a behavioral health agency, I saw how inundated case managers were. In this placement, I actually did a lot of paperwork and found that the more I did it, the less tedious it became. I already understood the importance of professional communication and the skills needed to write case/patient notes and assessments. It is just an aspect of working in the social services that I have to accept.

I learned the most from patients though. They were inspirational and so wise. Many gave me advice about life and career. Their strength gives me strength and hope in life. I will surely miss them.

I would like to dedicate this project to my son who has been my driving force to continue in school and who has suffered with me the madness of balancing our time with school. His love and his patience truly inspired me to continue even when I felt I could give no more.

I have to thank God as well for giving me strength and competence to complete this project. My Capstone instructor and Mentor have been critical in guiding and supporting the completion of my project. My parents and my family have been incredible in allowing me to vent and supporting me in every which way.

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Appendices

Figure 1

Problem model with listing causes and consequences of identified problem

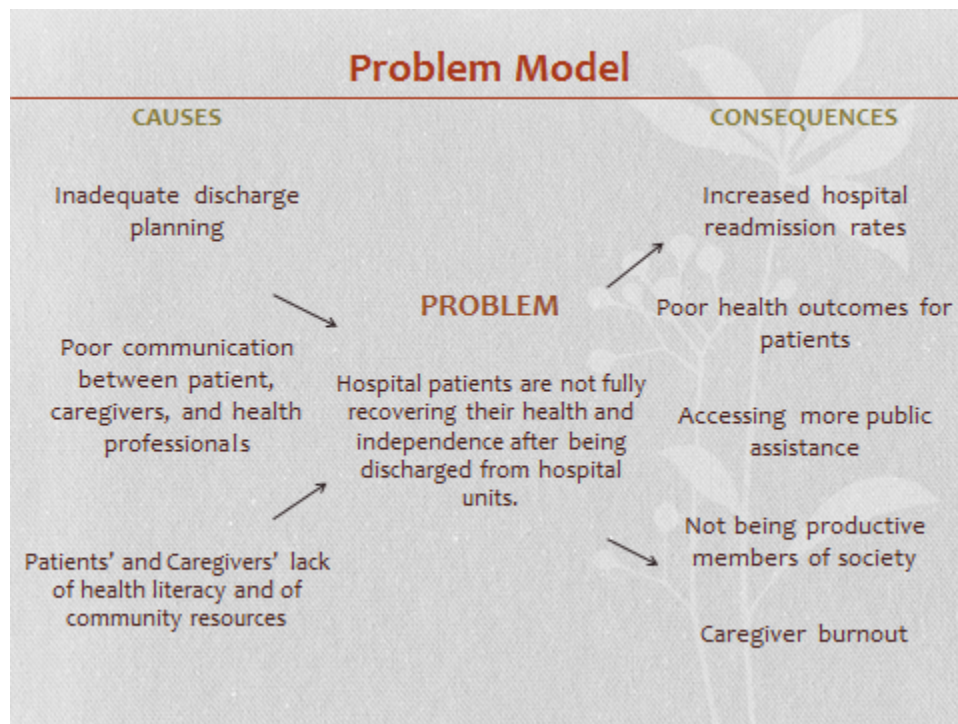
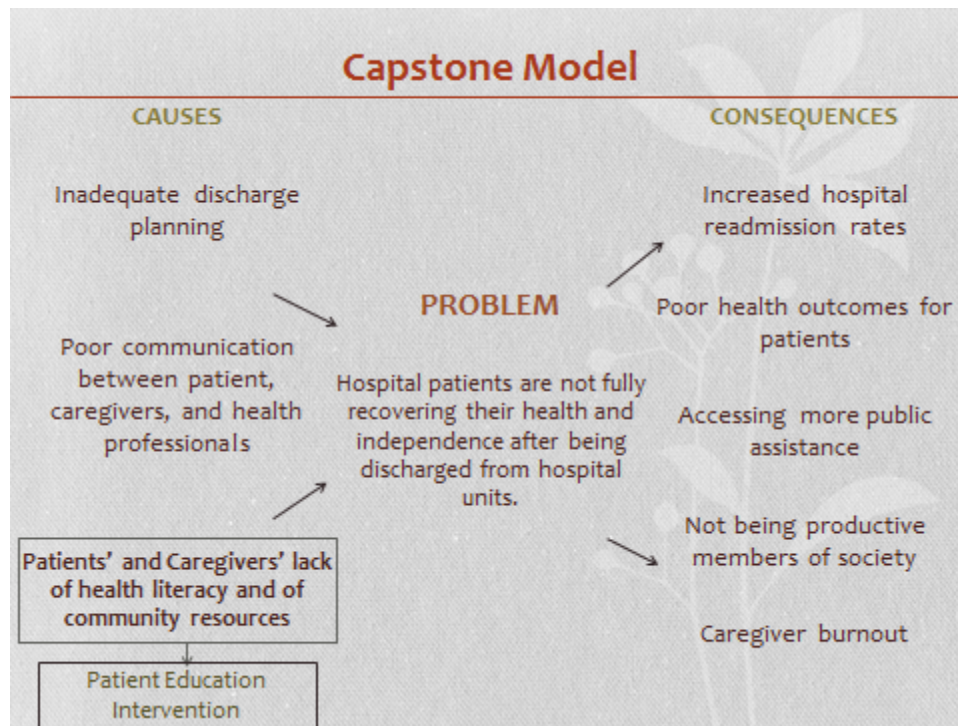


Figure 2

Problem model with chosen intervention



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Table 1

Timeline

Sam Karas Acute Rehabilitation Unit																	
Action Steps																	
Objectives	Strategies																
Research MediCare Insurance	Read scholarly articles, websites, reports; use supervision to ask meaningful questions																
Research Community Resources	Find skilled nursing facilities, medical equipment providers, health agencies that accept Medicare patients.																
Create Questions for Test	Use supervision to ask professionals in agency what questions would be measurable and simple patients to understand. Test questions on a few patients and revise.																
Present Curriculum																	
	Pre-Test																
	Presentation																
	Post-Test																
Evaluation	Determine Project Success																
		week 1	week 2	week 3	week 4	week 5	week 6	week 7	week 8	week 9	week 10	week 11	week 12	week 13	week 14	week 15	
		January 24	January 31	February 7	February 14	February 21	February 28	March 7	March 14	March 21	March 28	April 4	April 11	April 18	April 25	May 2	May 9

Table 2:

Survey Grades for Control and Experimental Pre-test Groups

Control Group Surveys				Experimental Pre-Test Surveys			
	Number of Patients	Survey Grade	%		Number of Patients	Survey Grade	%
	1	A	10%		0	A	0%
	2	B	20%		2	B	20%
	3	C	30%		4	C	40%
	1	D	10%		1	D	10%
	3	F	30%		3	F	30%
Total	10		100%		10		100%

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Table 3:

Control and Experimental Pre-test Patient Grades

Control Group		Experimental Group		
Patient	Grade and %	Patient	Pre-Test Grade and %	Post-Test Grade and %
1	F 55%	11	B 82%	D 64%
2	B 82%	12	C 73%	A 91%
3	B 82%	13	C 73%	C 73%
4	D 64%	14	F 36%	D 64%
5	C 73%	15	D 64%	C 73%
6	A 91%	16	C 70%	B 82%
7	C 73%	17	C 70%	B 80%
8	F 55%	18	F 45%	B 82%
9	C 73%	19	F 55%	C 73%
10	F 45%	20	B 82%	C 73%

Table 4:

Experimental Group Percent of Change

Experimental Group			
Patient	Pre-Test Score	Post-Test Score	Change
11	82%	64%	-18%
12	73%	91%	18%
13	73%	73%	0%
14	36%	64%	28%
15	64%	73%	9%
16	70%	82%	12%
17	70%	80%	10%
18	45%	82%	37%
19	55%	73%	18%
20	82%	73%	-9%

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Table 5

Mean Scores and p value for Experimental Group

Experimental Group	Mean Total Score
Pre-Test	7
Post-Test	8.5
Difference	1.5
ttest p value	0.02

Table 6

Critical Questions Scores across Groups

Survey Question	Control Group	Experiment Group Pre	Experiment Group Post
Q1	80%	80%	90%
Q2	40%	50%	20%
Q7	90%	70%	80%
Q11	90%	90%	100%

CSUMB
Consent Narrative

Title of Project: Medicare Basics

Consent to participate in survey

By completing this brief questionnaire you are consenting to participate in this survey.

You were selected as a participant in this study. If you decide to participate in this research, you will be asked to confidentially fill out a brief survey regarding Medicare and Medicare-approved resources within your community. The expected time burden is 15 minutes. The benefits of participating in this project include helping us gather information about your knowledge about your health insurance and available resources as well as giving you a sense of satisfaction in helping us complete our studies.

Taking part in this project is entirely up to you. You can choose whether or not to be in the study. If you volunteer to be in this study, you may withdraw at any time without consequences of any kind. You may also refuse to answer any questions you do not want to answer and still remain in the study. If your participation involves or provokes any discomfort, please seek assistance from qualified professionals such as the Sam Karas social worker.

Your responses to this survey are completely confidential. Information obtained in the course of this study will be presented to selected members of the Collaborative Health and Human Services department and possibly others from the campus community.

If you want to know more about this capstone project or have questions or concerns, please call Adrienne Saxton at 831-582-3565 or email her at asaxton@csumb.edu.

You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this survey.

You will get a copy of this consent form. Thank you for considering participation.

Sincerely,

Sylvia Zendejas

Signature

Date

Patient Signature

Date

CSUMB

NARRATIVA DE CONSENTIMIENTO

Título del Proyecto: Básicos de Medicare

El propósito de esta investigación es para investigar su conocimiento del seguro medico llamado Medicare además de su conocimiento de recursos que puede utilizar en su comunidad.

Ud. ha sido seleccionado como participante en este estudio porque necesitamos su opinión sobre esta cuestión.

El beneficio de participar en este proyecto será que va a tener un sentimiento de satisfacción por ser parte de esta evaluación de la comunidad.

Si usted decide participar en esta investigación, se le pedirá que complete una breve encuesta acerca de su seguro medico y recursos en la comunidad que son aprobados por Medicare.

Cualquier información que se obtenga en relación con este estudio y que se puede identificar con usted se mantendrá confidencial y sólo será revelada con su autorización escrita o verbal.

La participación en este proyecto es totalmente opcional. Usted puede elegir si desea o no participar en el estudio. Si voluntariamente decide participar en este estudio, puede retirarse en cualquier momento sin consecuencias de ningún tipo. También puede negarse a contestar cualquier pregunta que usted no quiere responder y aún permanecer en el estudio. También el investigador puede retirarlo a usted de esta investigación si surgen circunstancias que justifiquen hacerlo.

Si desea saber más sobre este proyecto de investigación o si tiene preguntas o preocupaciones, por favor llame a Adrienne Saxton al (831) 582-3565 o por correo electrónico asaxton@csumb.edu

El proyecto ha sido revisado y aceptado por Adrienne Saxton. Usted puede retirar su consentimiento en cualquier momento e interrumpir su participación sin penalización. Usted no se renuncia a cualquier reclamación legal, derechos o recursos a causa de su participación en este estudio de investigación.

Sinceramente,

Sylvia Zendejas

Firma

Fecha

Firma de Paciente

Fecha

Medicare Basics Survey

1. Medicare is:
 - a. A federal system of health insurance for people over 65 years of age
 - b. Health insurance for people under 65 who have certain disabilities
 - c. Health insurance that covers hospitalizations, medical equipment, and medications
 - d. All of the above.

2. Medicare has two parts. True/False (Please Circle one).

3. Medicare Part A helps cover:
 - a. Inpatient care in hospitals
 - b. Home health care services
 - c. Inpatient care in a skilled nursing facility
 - d. All of the above

4. Medicare Part B helps cover all of the following EXCEPT:
 - a. Home health care
 - b. Medication
 - c. Preventive services to help maintain your health
 - d. Durable medical equipment (DME)

5. What is Medicare Part C?
 - a. Optional plans run by Medicare-approved private insurance companies
 - b. A health plan that helps cover medications
 - c. Helps cover hospitalizations
 - d. Both a) and b)
 - e. None of the above

6. Medicare Part D helps cover the cost of prescription drugs. True/False (Please circle one).

7. Durable Medical Equipment (DME) is:
 - a. Covered through Medicare Part B
 - b. Medical equipment that's ordered by your doctor for use in the home
 - c. Includes medication
 - d. Both a) and b)

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- e. None of the above.
8. Medicare Part B covers these DME supplies EXCEPT:
- a. Wheelchairs
 - b. Medications
 - c. Walkers, Canes, & Crutches
 - d. Hospital beds.
9. Windsor Gardens is an agency that:
- a. Offers skilled nursing services
 - b. Accepts Medicare patients
 - c. Has locations in Salinas and Monterey
 - d. All of the above
10. Visiting Nurses Association and Hospice (VNA) is an agency that offers home health care services. True/False (Please circle one)
11. Where can you find more information about Medicare?
- a. Contacting the hospital social worker
 - b. Reading brochures about Medicare
 - c. Accessing the <http://www.medicare.gov> website
 - d. All of the above

Thank you for taking the time to participate in this survey!

Básicos de Medicare

1. ¿Que es Medicare?
 - a. Un sistema federal de seguro medico para personas mayores de 65 anos
 - b. Un seguro medico para personas menores de 65 anos que tienen ciertas discapacidades
 - c. Un seguro medico que ayuda a pagar visitas al hospital, equipo medico, y medicamentos
 - d. Todas las respuestas anteriores son correctas.

2. Medicare consiste de dos partes. Cierto/Falso (Favor de circular su respuesta).

3. La Parte A de Medicare ayuda a cubrir estos:
 - a. Asistencia medica mientras esta internado en un hospital
 - b. Asistencia medica dentro de su casa
 - c. Asistencia medica en un centro de enfermería especializada
 - d. Todas las respuestas anteriores son correctas.

4. La Parte B de Medicare ayuda a cubrir todos estos servicios MENOS:
 - a. Asistencia medica dentro de su casa
 - b. Medicamentos
 - c. Servicios preventivos para mantener su salud
 - d. Equipo medico duradero (DME)

5. ¿Que es la Parte C de Medicare?
 - a. Planes opcionales dirigidos por compañías privadas aprobadas por Medicare
 - b. Un plan medico que ayuda a pagar medicamentos
 - c. Ayuda a cubrir estancias en hospitales
 - d. Tanto a) como b) son correctas
 - e. Ninguna respuesta anterior es correcta

6. La Parte D de Medicare ayuda a cubrir costos de medicinas. Cierto/Falso (Favor de circular su respuesta).

7. Equipo Medico Duradero (DME):

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- a. Esta cubierto atreves de la Parte B de Medicare
 - b. Es equipo medico que ordena su doctor para usar en casa
 - c. Incluye medicamentos recetados
 - d. Tanto a) como b) son correctas
 - e. Ninguna respuesta anterior es correcta

8. La Parte B de Medicare cubre estas provisiones de Equipo Medico Duradero (DME) EXCEPTO:
 - a. Silla de ruedas
 - b. Medicinas recetadas
 - c. Andadores, bastones, y muletas
 - d. Camas de hospital

9. Windsor Gardens es una agencia que:
 - a. Ofrece servicios de enfermería especializada
 - b. Acepta pacientes con Medicare
 - c. Tiene localidades en salinas y monterey
 - d. Todas las respuestas anteriores son correctas

10. La Asociación de Enfermeras Visitantes (VNA) es una agencia que ofrece servicios médicos en el hogar. Cierto/Falso (Por favor marque una respuesta)

11. ¿Donde puede encontrar mas información acerca de Medicare?
 - a. Hablando con la trabajadora social del hospital
 - b. Leyendo folletos
 - c. Revisando la pagina <http://www.medicare.gov>
 - d. Todas las respuestas anteriores son correctas

¡Gracias por su tiempo y por participar en esta investigación!