

NC IOM Health Literacy Task Force

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NC Hospital Association
Cary, NC

Meeting Summary

WELCOME AND INTRODUCTIONS

Thomas J. Bacon, DrPH

Co-Chair
Executive Associate Dean & Director
NC Area Health Education Centers Program

L. Allen Dobson, MD

Co-Chair
Assistant Secretary for Health
NC Department of Health and Human Services

Dr. Bacon welcomed everyone to the meeting. The day's agenda focused on private efforts to serve low health literate populations. The speakers discussed different places we can educate providers on better ways to serve people with low health literacy, steps Iowa has taken to integrate health literacy strategies into their health system, and ways practitioners can incorporate health literacy strategies into their practices.

WHAT ARE EFFECTIVE INTERVENTIONS FOR PEOPLE WITH LOW HEALTH LITERACY?

Darren DeWalt, MD, MPH

Assistant Professor of Medicine
Division of General Internal Medicine

We examined the medical literature for interventions to improve health outcomes for persons with low health literacy. Only 20 studies examined the effect of interventions designed to mitigate the adverse impact of literacy on health outcomes. Health literacy interventions showed improvement in the following areas: quitting smoking during pregnancy; arthritis knowledge, behavior, and function; blood pressure; self-care ability; mammography rates; dietary behavior; and comprehension of health information. Health literacy interventions in these studies did not show improvement in the following areas: cholesterol and blood pressure levels; colorectal cancer screening rates; sleep apnea knowledge; comprehension of educational materials; and dietary outcomes. Overall, interventions to make healthcare materials easier to understand have had mostly positive effects on knowledge in populations with low literacy. However, interventions have not consistently improved actual health outcomes or narrowed disparities between high and low literacy groups.

Although writing documents at lower reading levels is valuable, empirical studies demonstrate that more modifications need to be made. Other studies have examined the effectiveness of pictures, the teach-back method, literacy training programs, and planned care interventions. Pictures may be particularly beneficial for people with low health literacy. Pictures improve comprehension, recall, and adherence. Pictures should preferably be concrete, rather than abstract, and photographs, rather than drawings.

Educational materials alone will not solve the problem of health literacy. Materials should be designed to promote communication between patients and physicians. Although there is not much empirical data to guide providers, common sense tells us providers should avoid jargon, use visuals, limit the number of recommendations they make, and use the teach-back method. In the teach-back method, the provider explains the treatment and then asks the patient if he/she can explain what they have talked about or what he/she will do at home. If there is any miscommunication, the provider should clarify until understanding is reached. The teach-back method does not have to increase the length of visits.

Some studies have tried to incorporate these strategies. DeWalt et al. (2006) found that teaching self-management for heart failure improved heart failure knowledge, self efficacy, and self-care behavior. More impressively, the intervention resulted in a 44% reduction in hospital admission or death incidence, and individuals with low literacy benefited as much as, perhaps more than, people with high literacy. Rothman et al. (2005) did a study on diabetes planned care. The health of individuals who received the pharmacist-led intervention aimed at care coordination improved more than those in the control group, and individuals with low literacy experienced greater improvement.

To improve health literacy and health outcomes, we need to use more than educational strategies and more than improved written and verbal communications. It is important to engage the patient and use frequent reinforcement, especially for chronic conditions. We need to: compose all materials using health literate strategies, ask the audience whether materials are understandable, analyze tasks involved in self-management and clearly organize them, integrate better health communication strategies into all interactions, use the teach-back method, and integrate best communication practices into planned care systems.

Comments/Questions

The discussion that followed began with the roles people play in health literacy initiatives. Social support can play an important role in health literacy. Dr. DeWalt's team is putting into practice the concept of family literacy, especially for Hispanics. They also found, in their diabetes study, that focus groups often turn into support groups. The next set of discussions centered on financing health literacy interventions. Initially, research grants funded Dr. DeWalt's studies, but now that the diabetes intervention has been rolled out to 1,500 patients, the intervention is funded by reimbursement for the midlevel providers and money the healthcare system is able to save as a result of the intervention. The discussion then turned to the manner in which information is collected.

Dr. DeWalt's studies used the REALM and TOFLA to measure literacy, and information about a patient's literacy was stored on the registry.

INCORPORATING HEALTH LITERACY INTO PROFESSIONAL PRACTICE: LEVERAGE POINTS IN THE EDUCATIONAL AND CREDENTIALING PROCESS

Thomas J. Bacon, DrPH

Executive Associate Dean & Director
NC Area Health Education Centers Program (AHEC)

We have used a pipeline in our discussion of education for health professionals. At the beginning of the pipeline, there are opportunities to incorporate life skills into public school education. As we move through the pipeline, community colleges, non-health professional schools, health professional schools, residency programs, and community practice offer a lot of opportunities for education regarding health literacy.

In health professional schools, there are opportunities to incorporate health literacy into curricular content, assessment tools, clinical experiences, and community health experiences. In residency programs, there are opportunities to incorporate health literacy into curricular content and core competencies. All physicians must have six core competencies, and communication is one of those competencies. Health literacy skills fall into several of the competencies. Continuing education is important for providers that have no experience with the area of health literacy. In continuing education, there are opportunities to incorporate health literacy through multiple formats, such as didactic or experiential formats and discipline-specific or interdisciplinary formats. We also have the capacity to deliver massive amounts of information electronically through the AHEC digital library and health sciences libraries. For health professionals, there are opportunities to incorporate health literacy into licensure or other credentialing processes. The importance of health literacy could be reinforced through quality improvement initiatives and by payors.

However, there are several challenges to taking advantage of these opportunities. First, medical curricula are already full. There is great pressure not to lengthen training but rather to do it more efficiently. A rudimentary survey of four state medical programs found that the schools assume health literacy is covered in health education, they briefly cover (i.e., 1-2 hours) health literacy in their required curricula, and health literacy is covered more extensively in community health electives or in volunteer community-based opportunities. There is more health literacy content in nursing and public health curricula; it is incorporated into health education and patient education courses along with public health practice and other experiential courses. Second, faculty are not conversant in the area of health literacy. Some faculty are not even familiar with the term "health literacy," and there are not a lot of experts to teach health literacy. Third, resources are not widely available nationally.

AHEC could play a key role in improving health literacy awareness because AHEC touches students and professionals at all points of the pipeline. Focusing on health

literacy meets AHEC's mission of improved access to care for the underserved. Health literacy is best taught at the experiential level, and it is an ideal focus for interdisciplinary experiences for students and residents. Health literacy education also fits well with the current focus on competencies required for 21st Century healthcare and the new focus on quality and patient safety.

Comments/Questions

The discussion that followed began with possible standards of health literacy knowledge that providers would need to meet in order to practice. However, the professions cannot measure patient communication skills like they measure scientific knowledge. The discussion then turned to whether providers would participate in training designed to increase their understanding of health literacy. There are physicians that are very interested, but they do not want to take time out of their practice for training. Physicians may be driven by electronic medical records. Instead of offering continuing medical education (CME) on health literacy, health literacy should be built into existing CMEs (e.g., diabetes CMEs). If the market share is in a low literate population, the industry will be driven to learn how to serve low literate populations. Finally, the discussion ended with the points that providers often do not know how their patients are living and that behavioral change, whether it be patient or provider, is difficult to achieve.

THE IOWA HEALTH SYSTEM HEALTH LITERACY COLLABORATIVE

Mary Ann Abrams, MD, MPH

Clinical Performance Improvement

Iowa Health System

The Iowa Health System (IHS) is the largest health provider system in the state. The objective of the IHS health literacy collaborative is to: describe the overarching strategy the IHS uses to address health literacy, including an overview of interventions tested; highlight key interventions that emerged as strategies and tools resulting in action and improvement; summarize outcomes to-date; and share learning.

For our initiative, we have used the model of a learning collaborative, which is healthcare organizational teams sharing a commitment to make major, rapid changes and working together to identify improvement strategies and test changes. The model focuses on improvement and the idea of all teach, all learn. Two reports by the Institute of Medicine of the National Academies (IOM) (i.e., Health Literacy and Priority Areas for National Action) and the National Adult Literacy Survey (NALS) report resonate with senior IHS leaders. The finding that health literacy is fundamental to quality of care was particularly important. We have found that some points of care are useful for engaging patients and providers—admissions, home care, discharge, and medications. We have used a universal approach as opposed to screening and have emphasized the multidimensional nature of health literacy. We also use personal stories from patients and healthcare staff to get buy-in. Health literacy initiatives have to be longitudinal and cross-cutting.

Our collaborative was created in 2003 with the goal of creating a patient- and family-centered environment fostering effective communication that enables individuals to read, understand, and act on healthcare information. We have had six learning sessions and continue to have monthly learning calls. We have 10 teams across 7 cities in hospitals, outpatient clinics, home health, and wellness support and call centers. We recently launched a similar collaborative with our rural affiliates. One of the most important operating principles is the partnership. We have asked teams to be as multidisciplinary as possible. Most teams come from nursing and education, but we have pulled in other disciplines. We believe patients and families are vital to the work. Several of the teams have adult learners and adult literacy educators on them. These groups provide valuable insight into what does not make sense and teach us how to make appropriate referrals to adult learning programs.

We have tested the following interventions in inpatient and general hospital settings: shame-free care environment, assessment of learning style and reading comfort at admission, written materials, consent process, Ask Me 3, Warfarin education, wayfinding/navigation pilots, support services (i.e., transportation and dietary), and teach back. We have tested some of these interventions in clinics, home health, and staff development.

For written materials, we provided a training workshop on creating reader-friendly print materials for all Health Literacy Teams. We found the training to be very energizing and immediately beneficial. Now, the quality of the patient education materials the Education Committee receives is much higher. We also use an on-line education module and readability software.

For informed consent, we tried not only to create health literate forms but also to improve the informed consent process. It took 13 drafts to get the consent form where we wanted it. We used the original form and small tests to guide our revisions. Adult learners and the law department have been involved in improving the informed consent form. Four of the seven affiliates have adopted the surgery/procedure consent form organization wide. We have changed the informed consent process by using the teach-back method and asking each patient or legal surrogate to recount what he/she has been told during the informed consent discussion.

We have used Ask Me 3 in both internal and external settings and have sought out both provider and patient perspectives. We asked each group how they would like to work with Ask Me 3 and how well Ask Me 3 worked. One of the more formal evaluations involved posters and pamphlets and expanded the providers involved. Ask Me 3 improved patients' awareness and perception of communication, and it also held the staff more accountable. Ask Me 3 plays a role in creating a shame-free environment and makes patients more comfortable with taking notes and asking questions.

Although it would be ideal to measure health outcomes to make a business case, we have been measuring Press-Ganey patient satisfaction with communication. We have not seen huge improvements, but it is difficult to move these ratings at all. We have seen

improvement in each measure except caring for self at home and physician keeping patient informed. We can motivate physicians with the Healthy Community Access Programs (HCAP) quality initiative. Translating Research into Practice (TRIPP) involves three elements for action: senior leadership, local literacy and testing/evaluation data, and passion through personal stories.

Comments/Questions

The discussion started off asking how the collaborative began. The American Medical Association offered state medical societies the opportunity to send teams to be trained. The IHS sent a team, which also received support from the Iowa medical society, a hospital CEO, and other public health committees. We have focused on chronic diseases. We have worked primarily with the state department of health and education, and health literacy is one of the state Blue Cross Blue Shield Foundation funding priorities. Then the discussion turned to health literacy screening methods. The questions of reading comfort are safer for patients. Other formats involve explaining that all patients are asked these questions or that providers want to make sure patients understand.

REACTORS PANEL: PRACTITIONERS

Timothy W. "Tim" Lane, MD

Moses Cone Health System

The vast majority of care in this country is done in small practices; 80% of interactions are in practices with five physicians or less. The way we look at our profession and the way the public sees our profession are very different. When the local Greensboro paper ran a story about an intern who cried upon learning of her patient's fatal condition, my medical colleagues thought her reaction was disgraceful but my neighbors wanted her as their doctor because she was empathetic. Our payment system is designed to pay for procedures but not for listening. There are some methods that can be incorporated into practice now, such as Ask Me 3 and teach-back. These methods do not require a huge investment in time, money, or education. Residency programs could focus on patient-provider communication because interns and residents are funded to learn and interact. If we focus on methods that are time efficient and have some impact, I think they can be promoted today to practitioners across the state.

Barbara Knopp

Education Consultant

North Carolina Board of Nursing

The mission of the Board of Nursing is to protect the public. We protect the public through our licensing and educational requirements. We have established a written competency, and we have discussed the requirement of a spoken competency. Because we get a lot of foreign-educated people, we have looked at the minimum English proficiency of the practitioners. The difficulty is implementing these requirements without developing barriers. In nursing, we have already incorporated health literacy into education so we need to work more on translating that knowledge into outcomes. The

concept of health literacy fits well with evidence-based practice, patient-centered care, quality improvement initiatives, continuing competency, and patient safety initiatives. We could measure health literacy skills during transition to practice, post education, and before licensure.

Michael D. Murray, PharmD, MPH

Professor and Chair
Pharmaceutical Outcomes & Policy
School of Pharmacy

We have looked at the relationship between health literacy and adherence/compliance. Materials are helpful in assisting patients in their comprehension of basic elements of their disorder. We like to think of these materials as part of a broader kit that improves adherence and health outcomes. The information must be accurate and the amount of information must be decreased. We have to focus on the elements critical to becoming an effective self-manager. These materials have to be complemented by communicating practitioners. Good communication is the way to prevent adverse events and medication errors.

Comments/Questions

The discussion began with the question of what other individuals (e.g., lay health advisors, interpreters, and case workers) can be a part of this dialogue/transaction and how open practitioners will be to outside help. About 85% of traditional small practices do not know anything about those systems because they do not have the ability to hire those types of positions, but collaboration in private practice could work. The only way practices can transform care is through collaboration. At Moses Cone, we have social workers, translators, and residents who speak several different languages to communicate with patients. Health literacy requires community collaboration. We can tap into existing resources (e.g., CCNC) and existing models (e.g., HIV/AIDS support groups improve compliance). The discussion then focused on the role of pharmacists in health literacy initiatives. Pharmacists struggle with time constraints, patients' home conditions, and risks of contradicting what healthcare teams have instructed patients to do. We need to develop strong collaborative links between pharmacists and physicians and nurses. Compliance has improved when the pharmacist works with the patient to negotiate when the patient will take the medication. The discussion ended with the concern that health literacy needs to appear in the big five journals so that practitioners are more aware of and concerned with the problem. We can learn from the 100,000 Lives Campaign how to spread an idea and get providers on board. Another way to get provider buy-in would be to incorporate health literacy into the concept of medical home, which is an approach for providing quality healthcare.

DISCUSSION ON OPTIONS TO DISSEMINATE HEALTH LITERACY STRATEGIES TO CLINICAL SETTINGS

Mark Holmes, PhD

Vice President

Dr. Holmes presented an overview of the ideas discussed in the meeting to improve health communication for people with low health literacy. They are outlined below:

Increasing Awareness and Understanding of Health Literacy

- Integrate health literacy into condition-specific courses (e.g., diabetes course) rather than having a “health literacy” course / symposium
- Teach health literacy in a systematic way in provider education settings:
 - AHEC
 - Residency (because residents are salaried so provider cost is lower)
 - Post-education assessment of health literacy (at licensure renewal)
- Make providers aware of the term “health literacy”
- Educate senior leadership on the extent of the problem
- Use the North Carolina Medical Journal and other websites to increase awareness
- Publish local area synthetic estimates based on the National Adult Literacy Survey

Best Practices

- Intervention
 - Include health literacy as part of a broad intervention (e.g., disease management)
 - Multi-dimensional/multi-modal interventions are more effective
 - Some conditions (e.g. diabetes) have reimbursement designs more conducive to health literacy interventions
 - Electronic health records and registries are key because they allow practices to “triage” patients with chronic disease (e.g., red, yellow, green)
 - Translate research into practice, allowing others to learn from one affiliate’s experience (Iowa Health System)
 - Get physicians as local champions
 - Pfizer visiting experts can help train local experts on Clear Health Communication principles
 - Offer skills-building and sensitivity-training workshops delivered by local literacy council professionals for local healthcare providers (e.g., techniques for making materials consumer-friendly); alternatively offer periodic statewide workshops (Maine AHEC’s Health Literacy Institute)
- Collaboration
 - Build support organizations (lay health people, health educators, etc.)
 - Collaborate with adult literacy organizations
 - Involve literacy professionals as expert reviewers of consumer materials either before or after consumer input (Scotland County literacy council)
 - Co-sponsor a ‘New Reader’s Conference’ where literacy consumers, adult educators, and healthcare providers can share ideas for better communication (Iowa Health System).
- Healthcare teams
 - Develop a care plan

- Community Care North Carolina is piloting the “group visit,” facilitated by a nutritionist
- Pharmacists and patients negotiate a timeline of when to take medication to increase compliance
- Assign a pharmacist to specific conditions / floors to increase communication between providers and pharmacists (Moses Cone)
- **Materials**
 - Materials have to be vetted by experts in health literacy
 - Involving the patient in designing communication materials improves effectiveness
 - Review consumer-focused websites in addition to print materials
 - Check out California’s health literacy initiative (cahealthliteracy.org)
 - Produce a ‘health literacy toolkit’ for use in adult education settings to build health literacy skills and self-advocacy skills (strategic plan on health literacy for NC Women and Children)
 - Online toolkit for public health literacy tools
 - Create a clearinghouse of health literacy-aware materials
 - Perhaps in AHEC digital library?
 - A telephone-based care assistant provides the patient a level of virtual anonymity
 - Review intake paperwork and process because it may be intimidating to individuals with low literacy skills
 - Assess reading comfort using more conversational, less judgmental approaches (e.g., “Some people read magazines to relax. Is that something you like to do?”; Iowa Health System)

Generating Provider Buy-In

- IOM reports of competencies for healthcare providers have three domains relevant to health literacy:
 - patient-centeredness
 - evidence-based practice
 - quality improvement oriented
- “Accountability” / pay for performance / quality initiatives (with or without public reporting) will motivate providers to engage if they believe that addressing health literacy can improve outcomes
 - IOM reports say that health literacy helps determine quality of care
 - Patients are more satisfied after health literacy interventions, and satisfaction is sometimes reported as a quality measure
 - Good communication reduces risk of adverse events / medication errors
- As information volume increases, providers have to be more efficient in transmitting information to patients
- Some health literacy measures (e.g., teach back) do not add time to visits
- Provide incentives to clinic management to implement a health literacy program (Iowa Health System)
- Medical home is the best place to address health literacy