

**NC IOM TASK FORCE ON HEALTH LITERACY
OCTOBER 17, 2006
NC HOSPITAL ASSOCIATION**

MEETING SUMMARY

WELCOME

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 the role payers play in improving health literacy. The speakers discussed the State Health Plan's strides toward delivering quality healthcare, the need for health literacy in quality improvement initiatives, and examples of best practices in the state.

NORTH CAROLINA STATE HEALTH PLAN: SUPPORTING MEMBERS, FAMILIES AND PROVIDERS

Nancy Henley, MD, MPH, FACP

Medical Director of the North Carolina State Health Plan

The topic of helping our patients understand their illnesses is very important to the North Carolina State Health Plan (SHP). The SHP covers almost 600,000 employees, dependents, and retirees. There is great variability in the job type, education level, and literacy level of these individuals. The SHP is covering a growing population of non-English speakers. Health literacy is focused on helping individuals become literate; our role as the payer is to facilitate this literacy. We have a wealth of information for people. About a third of people are eager to engage, a third will engage if we reach out to them, and a third are not interested regardless of our efforts.

The SHP is focused on building partnerships between the plan, members, families, providers, and vendors. Our goal is to provide excellent care along with excellent customer service and support. Within customer service, plan members can access both English and Spanish customer service lines; an AT&T translation line is also available. Our training for customer service representatives includes components on adult learning and active listening. Our members' frequently asked questions are available on the SHP website.

Although we are legally bound to have certain information in our documents, we try to make our materials understandable. Materials are available in English and Spanish. They are targeted to the sixth-grade reading level. Brochures are printed in large type, if needed. Materials are reviewed by a panel of experts with experience in customer service interactions, are based on research with members, and are based on the Flesch-Kincaid grade level scale. For the switch to PPOs, we put a slideshow with audio commentary on our website so people could listen rather than read this information. We had 30,000 hits on this program.

For pharmacy services, we have customer service pharmacists who answer benefit and medication questions. Counselors are available to discuss safe and effective use of special medication. We also offer drug information sheets written in non-medical terms. On the web, Medco's Savings Advisor Tool provides members with a list of cost-saving pharmaceutical alternatives (i.e., generics). For the hearing impaired, we offer telecommunication devices; for the visually impaired we offer prescription labels printed in Braille. For specialty pharmacy (i.e., medications that often require injection, monitoring, and special handling), we offer review of medication regimes, training on medication compliance, side-effect management, over-the-counter usage counseling, and consultation and coordination with care managers. The patients who take specialty pharmacy tend to be ill and high risk patients with particular medical needs. We have a team of pharmacists dealing with these patients on an individual basis. A nursing team also can be brought into the home to do training on how to take the medication.

NC Health*Smart* is a healthy living initiative that aims to: empower healthy members to stay healthy; help those with chronic disease or disease risk factors better manage their health; and offer integrated, cutting-edge resources and programs to members at work, at home, and through their healthcare provider. Two of the guiding principles behind NC Health*Smart* are empowering individuals to play an active role in the management of their health and strengthening the patient-provider relationship. NC Health*Smart* has several components: health promotion and education, health risk assessment, worksite wellness, disease management, and high risk case management.

To support members and their families, we offer health coaches. Any member can contact a health coach, but coaches call our high risk groups. Health coaches motivate individuals to participate in their healthcare. They listen to patients and help patients collect information, engage with their own values, and prepare for provider visits. Health coaches are trained to "meet the members where they are" culturally and educationally. Coaches provide services over the phone and follow-up materials are sent to patients. Literacy experts and focus groups are involved in making those materials. Non-Healthwise materials are written at the fifth-grade level; Healthwise materials are written at the eighth-grade level.

For patients that need disease or high risk case management, conference calling is available. The call can include a variety of providers and/or family members. Case managers for disease and high risk case management are trained to ask members how

they prefer to learn, to assess understanding, and to identify resources. Translation services are available.

The leaders behind the member/provider approach are the Center for Evaluative Clinical Services and the Foundation for Informed Medical Decision Making. They believe individuals need to understand their options thoroughly, participate fully in decision-making for their health, and work in partnership with physicians to make shared medical decisions. NC HealthSmart recognizes that the doctor-patient dialogue is at the heart of clinical care. The program engages physicians to: support the program, encourage patient participation, provide timely referrals for health coaching, close care gaps, and improve outcomes at the point of care. The program is designed to: integrate with the physician office workflow, add value to the physician practice, and work in multiple settings.

There are three SMART Registry Tools. The Group Report helps physicians identify gaps in their care. The Network Comparison Report helps physicians compare themselves to their peers in the network. The Patient-Specific Report helps physicians improve their care of individual patients. As a result of NC HealthSmart, patients are better prepared for their office visits, patients are more satisfied with their care, and physicians feel like they are providing better care.

Comments/Questions

The discussion that followed began with successful strategies for training staff in physicians' offices. The SHP has hired people who are familiar to the providers and conducts training during staff meetings. The discussion then turned to the possibility of collaborations between Community Care of North Carolina (CCNC) and the SHP. The SHP took the materials that CCNC developed and told people not to reinvent the wheel. However, the way the system is built does not encourage collaboration. More payers need to be around the table to attack the problem together. Finally, it was suggested that providers could play information videos in hospitals and doctors' waiting rooms.

HEALTH LITERACY AND HEALTHCARE IMPROVEMENT

Meera Kelley, MD

WakeMed Health and Hospitals

We have revolutionized our healthcare system without changing how we deliver it. The medical system is inundated so we do not have time to rearrange the infrastructure; also, there is no financial incentive to restructure. We are asking physicians to do what is not humanly possible. There is no way doctors can recall all types of drugs and their side effects or recall each step of all the best practices. We currently operate under the beliefs that we will not have a problem if each of us independently does our best within our area of expertise and that problems arise when individuals are either inadequately trained or not conscientious. Communication across individuals, either between provider and patient or among staff, is the number one cause of sentinel events in healthcare. Because our healthcare system is so complex, even people with high literacy levels struggle with health literacy.

There has been a recent focus on quality and safety efforts, and most of these efforts involve improving communication. The Joint Commission on Accreditation of Healthcare Organizations' patient safety goals include: improving the accuracy of patient identification; improving communication among caregivers "read-back," abbreviations, critical test results, and standardize hand-offs; improving safety of medication use; reconciling medications; and encouraging patients' active involvement in their own care.

The goal of the WakeMed Center for Patient Safety is to ensure the best, safest care for all of the patients we serve. The Center for Patient Safety will serve as the "heart" for communication of quality and safety initiatives: inviting input from hospital staff, physicians, patients and families, and outside quality and safety organizations; transforming the input into key lessons or take home points; and conveying messages to WakeMed staff, physicians, and patients and families. The initiative involves enlisting the participation of patients in their care and encouraging crucial conversations between providers and patients and among staff members.

Comments/Questions

The discussion began with an inquiry into how WakeMed is trying to change written materials as part of their patient safety culture change. Dr. Kelley responded that WakeMed is going to review all of its educational pamphlets. Then, the discussion turned to standardization of information. The whole process of medical mistakes is very expensive. The information people get at the hospital might conflict with information they get elsewhere and if the cost of confusion was calculated, there could be a greater incentive to put money in quality improvement restructuring programs. Finally, it was suggested that hospitals should identify a point person who is taking care of the patient and can make sure the patient or a family member understands the patient's needs.

QUALITY IMPROVEMENT PROGRAMS

Melanie Phelps

NC Medical Society

Health literacy is an integral piece of quality improvement programs. Effective communication can avoid medical errors and improve healthcare quality. Health literacy is not only communication between the patient and provider, but among the healthcare staff. All stakeholders—providers, payers, employers, public health, patients, and families—have a role in improving health literacy.

Public payers, such as the Center for Medicaid and Medicare Services and CCNC, have developed a number of initiatives to address inefficiencies in the system. Private payers, such as the SHP, Blue Cross Blue Shield, and large employer groups, have adopted a Bridges to Excellence model. Physicians are assessed on their communication skills and self-management support. The programs aim to collect both process measures and outcome measures. In addition, the NC Medical Society and the Appalachian Regional Commission have excellent resources for patients.

We seem to be moving away from informed consent forms toward a process where the patient is engaging in a dialogue with the provider. For end-of-life care, we have developed a form designed to encourage communication between providers and patients about the kind of care they prefer. For cardiac care, we have a discharge contract in which patients and doctors go over treatment regimens and patients sign their agreement.

Comments/Questions

The discussion began with ideas for getting providers to understand the broad concept of health literacy (i.e., we all suffer from health literacy at some point). Providers' attention can be gained from incentives tied to outcomes. The number one reason for complaints to the NC Medical Society and for lawsuits is poor communication. To engage physicians, they must have tools for simplifying their practice. A simple and consistent message is important. Providers need another provider to tell them how to do it, and model it for them because they listen to each other more than they listen to outsiders. However, if something is not at the top of a physician's priority list, it will not get done unless someone else, like a patient educator, is hired to do it. The problem is that many practices cannot afford to pay a patient educator.

BEST PRACTICES IN NORTH CAROLINA

Sandy Diehl, MPH

Dept. of Health and Behavior and Health Education, UNC-CH

Our intervention is a health literacy initiative for English as a second language (ESL) students. Adult education is an appropriate venue for health literacy initiatives because adult education: reaches all 100 counties in North Carolina, is usually open entry, provides a friendly environment to learn and practice, employs instructors that have expertise in literacy, and is meant to improve functional skills. This intervention was aimed at students at the high beginner level. The teaching method included social learning. The curriculum is based on information gathered from community health centers and ESL students. We use cartoons and stories to explain interactions with health professionals. We use the phonebook to explain what services to expect from different health practices. Students carry a card in their wallets that explains their location and their personal information in case of an emergency. Students were interested in health for a few sessions but not for the entire four month course. We are in the final stages of our pilot and are conducting an impact evaluation. We have a pre-test/post-test design in 11 North Carolina counties. Improvements are more significant in women than in men even when attendance is controlled for in the measures.

Comments/Questions

The discussion began with questions about literacy tests. Community colleges use the CASAS literacy test to assess and divide students into classes. The Task Force wondered why the initiative improved curriculum knowledge but not S-TOFLA scores. The S-TOFLA was administered in English and is very difficult for ESL students. It takes 100 hours of instruction to improve reading one grade level. Finally, the discussion turned to

the flexibility of the program. The program is designed to be flexible so that teachers can use the structure as is or adjust it to meet their needs.

Steve Davis

Green County Health Care

Green County Health Care (GCHC) is a migrant community health center, which also provides services in camps and fields. The outreach program has 28 staff members including professional and lay health workers, AmeriCorps members, and mid-level providers. Last year, GCHC served over 17,000 Spanish-speaking patients. Initially, GCHC thought that having bilingual providers and staff was sufficient, but they realized that working with patients involves more than overcoming language barriers. Focusing on language differences may undermine efforts to reach out to groups with different cultural beliefs. A survey of patients revealed that nearly 80% of patients wanted to see a curandera (traditional healer) before coming to GCHC. Providers have to understand the healing beliefs of the population they are serving. Mr. Davis built a relationship with the traditional healer, Doña Gineveva, and is now in his third year of an apprenticeship with her. Rather than focusing on what GCHC believes are the needs of the community, a needs assessment is done with the first group of migrant workers to arrive and then a mid-year assessment is completed.

Comments/Questions

The discussion began with questions about emergency room use. GCHC health educators teach the community about what warrants an emergency room visit and what warrants a clinic visit. GCHC has not been able to determine if there has been a decrease in emergency room visits because it serves a 12-county area. The discussion then turned to questions about outreach. Mr. Davis has consulted with and presented to hospital staff, private practitioners, and other types of providers. GCHC also presents to local growers at agricultural meetings, the Department of Labor, and other organizations that work with migrant populations. It was suggested that GCHC should collaborate with medical anthropologists to disseminate the information GCHC has gathered.

Mary DeCoster, MPH

Durham County Health Department

We offer prenatal classes for Latino women in Siler City in a de madre a madre (mother to mother) educational format. We use photo novellas to share information about what mothers should expect and to help them navigate the healthcare system. The facilitator reads a page and then promotes discussion about the issue. The facilitators have a variety of backgrounds, and they have to adapt to their groups' needs. Because there are often discrepancies in class, culture, and education of bilingual individuals and the populations they serve, miscommunication and mistrust can arise. As a result, it is very important for facilitators to listen and use a supportive style of sharing information. Some of the other benefits of our initiative included social support, empowerment, transportation, and physical help.

Comments/Questions

The discussion focused on transportation and funding issues. Some women carpooled, and the class was offered at a variety of times. Some classes were supported by volunteers and grant money. The program has been trying to make a business case for their model, showing its cost-effectiveness and the benefit of the intervention.

Sarah Verbiest, MSW, MPH

UNC Center for Maternal and Infant Health

We focus on improving the quality of care for high risk pregnancies. We are often dealing with vague or rare diagnoses. A team comprised of OBGYN nurses, patient educators, and other professionals help assist the physicians in guiding the patients through the process. The team goes on rounds with physicians and attends meetings with specialists so the team can better assist the patients. There are times when patients are not ready to accept information or do not understand information; the team supports the transfer of information from providers to patients. The Duke Endowment and Kate B. Reynolds provided funding for the care team and bilingual providers with the goal of increasing referrals and quality of care.

Comments/Questions

The discussion focused on how we can incorporate the need for patient navigators into the Task Force recommendations.

DISCUSSION

We need to bring the payers together to determine which pieces will have the biggest impact and how to use the models we heard today to improve the medical system. We should develop pilots to evaluate the cost-effectiveness of these programs before we create a model for funding them.

To translate knowledge into practice, we need to enhance collaboration between adult literacy programs, community-based organizations, and healthcare organizations. We should use existing structures, such as home visits and well child care, to facilitate the use of new tools in outreach organizations. Financial cost is a major barrier to implementing these programs. CCNC might have the billing capability to have a point-person in each region for these types of programs. We need to figure out how to pay for group visits. The current billing system deters patient education. Public health may be the way to provide patient education outside of provider offices. Models that educate consumers need to be careful not to overlook consumers who do not seek out care.

Sometimes a language barrier is a benefit because it forces the provider to focus on methods of communication. It is important to remember that compliance should not be the only goal. Some patients might understand and still not make the choices their providers want them to make. Because programs may have different effects in different communities, pilot studies need to compare not only new versus existing services but also programs in different settings (e.g., rural versus urban areas).

In terms of provider training, research shows that providers who receive training in certain skills during their education are more likely to use those skills than providers who receive that same training after they are practicing. On the other hand, providers that find a way to incorporate techniques into their practices need to serve as role models for new providers that are struggling to apply techniques in the real world. We need to identify champions of health literacy skills in local communities.

Recommendations

Pam Silberman, JD, DrPh

President & CEO

NC Institute of Medicine

- Encourage organizations to share information with each other
 - A lot of good information has been developed by different organizations (e.g., the State Employees' Health Plan's work on health education).
 - Work collaboratively with Adult Basic Education, health literacy councils, etc.
 - Coordinate messages across providers and payers so people are getting consistent messages
- Make the health literacy process an important tool in quality improvement initiatives
 - There needs to be better outreach to providers so they understand the connection between health literacy and quality improvement.
 - Focus on skills development for providers (e.g., teach back, communication skills)
 - Model skills for providers and give them time to practice
- Use different strategies (such as patient navigators, health dialogue, Adult Basic Education, and group education) to prepare patients and families to communicate with physicians
 - Encourage the use of trained health educators and figure out how to pay for them
 - Emphasize that health literacy is about more than understanding specific health problems; people have to understand health systems and where to go for care
- Realize that cultural awareness and listening are important; work with patients "where they are" (e.g., State Employees' Health Plan, Green County, Adult Basic Education)
- Use different educational settings to augment traditional health education
 - Make connections and coordinate across settings by utilizing group settings, group education process, outreach workers, and *promotores*