Increasing Health Literacy Awareness Throughout the Continuum of Care

Community Health Worker Health Literacy Curriculum Blueprint

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Health Literacy at a Glance

Literacy impacts health knowledge, health status, and access to health services. Health literacy includes the ability to understand instructions on prescription drug bottles, appointment slips, medical education brochures, doctor's directions and consent forms, and the ability to negotiate complex health care systems.

- Health Literacy (one of many definitions):
    - Office of the Mayor, New York City
      Health literacy is the ability to read, understand and act upon health-related information. Health literacy also refers to the capacity of professionals and institutions to communicate effectively so that community members can make informed decisions and take appropriate actions to protect and promote health.

- General Literacy:
    - An individual's ability to read, write, and speak English at a competent level

- Scope of the Problem
    - 20% of American adults (50% of Medicare/Medicaid recipients) read at or below the 5th grade level
    - Most health care materials are written above the 10th grade level
    - Nearly 90 million Americans have only basic or below-basic health literacy skills

- Cost of the Problem
    - Poor health outcomes
    - Many visits to the hospital for the same issue
    - $106-238 billion lost each year due to low

- Some of the Reasons
    - Reliance on written word for patient education and instructions
    - Increasingly complex health system
        - Growing self-care requirements
        - Many health care providers and specialists involved in care
        - More services performed in out-patient settings
        - More tests and procedures
        - Numerous forms to be completed by patient
        - More medicines available
        - More ways to obtain medicines (chain drug stores, mail-in, online, etc)

Low Health Literacy Function and Health Care Outcomes

A thorough literature review was conducted by DeWalt, D.A. and Pignone, M.[1] to understand the relationship between low health literacy and health care outcomes. The selected research articles used instruments to measure health literacy, seemed to have measured basic reading skill. For the chart below, the word literacy is used. The studies examined are placed in one of the three categories: health behaviors, knowledge or comprehension, and screening and prevention.

Health Behaviors		
Authors	**Population**	**Result**
Kaufman et al.[2] Fredrickson et al.[3]	Mothers and likelihood to breastfeed their babies.	Both studies suggest that mothers with lower levels of literacy are less likely to breastfeed their babies.
Williams et al[4]	Asthma patients having correct metered dose inhaler (MDI) technique.	Those with higher literacy had better MDI technique based on a measurement of the number of steps performed correctly.
Knowledge or Comprehension		
Authors	**Population**	**Result**
Kalichman and Rompa[5]	HIV-infected individuals living in Atlanta, GA.	Lower literacy was associated with less understanding of the meaning of CD4 counts and viral load; lower literacy was associated with less disease and treatment knowledge.
Spandorfer et al[6]	Impoverished inner-city patients at an emergency department in Philadelphia.	Reading ability was the best predictor of comprehension of discharge instructions.
TenHave et al[7]	Community members coming to a cholesterol screening at a local supermarket.	Higher literacy was associated with more "heart healthy knowledge."
Screening and Prevention		
Scott et al[8]	Medicare managed care health enrollees	Patients with inadequate literacy had 1.4 times the odds of not having had an influenza immunization than patients with adequate literacy.

Low Health Literacy Function and Health Care Outcomes

References

1. DeWalt DA, Pignone M. Health Literacy and Health Outcomes: Overview of the Literature. Chapter Authors. Understanding Health Literacy: Implications for medicine and public health. Schwartzber JG, VanGeest JB, Wang, CC eds. American Medical Association 2005:205-227.

2. Kaufman H, Skipper B, Small L, Terry T, McGrew M. Effect on literacy on breast-feeding outcomes. *South Med J.* 2001;94:293-296.

3. Fredrickson DD, Washington RL, Pham N, Jackson T, Wiltshire J, Jecha LD. Reading grade levels and health behaviors of parents at child clinics. *Kansas Med.* 1995;96:127-129.

4. Williams MV, Baker DW, Honig EG, Lee TM, Nowlan A. Inadequate literacy is a barrier to asthma knowledge and self-care. *Chest.* 1998;114:1008-1015.

5. Kalichman SC, Rompa D. Functional health literacy is associated with health status and health-related knowledge in people living with HIV-AIDS. *J Acquir Immune Defic Syndrom Hum Retrovirol.* 2000;25:337-344.

6. Spandorfer JM, Karras DJ, Hughes LA, Caputo C. Comprehension of discharge instructions by patients in an urban emergency department. *Ann Emerg Med.* 1995;25:71-74.

7. TenHave TR, Van Horn B, Kumanyika S, Askov E, Matthews Y, Adams-Campbell LL. Literacy assessment in a cardiovascular nutrition education setting. *Patient Educ Couns.* 1997; 31:139-150.

8. Scott TL, Gazmararian JS, Williams MV, Baker DW. Health literacy and preventive health care use among Medicare enrollees in a managed care organization. *Med Care.* 2002;40:395-404.

Existing Health Literacy Curricula

Community Health Workers and Front line Clinical Staff

The health literacy curriculum will be designed for community health workers (CHW) and front line clinical staff. They play a unique role in public health, serving as a link between the health care provider and the community, providing basic health education and referrals, and support and assistance in navigating the health and social service system. Their impact on low health literacy can be two-fold: supporting patients as they surmount the barriers leading to optimal health care outcomes, and representing the voice of the community as they address these barriers within the healthcare system itself. The curriculum will also benefit front line clinical staff - medical assistants, dental assistants, state-tested nursing assistants, outpatient clinical and medical office support staff. Through them, the patient is confronted with the paperwork necessary to receive healthcare - intake, assessment, prescription assistance, insurance coverage and take-home instructions.

Community health workers live in or are familiar with the community they serve. An important role that community health workers play to bridge the gap between the patient and the health care system is by facilitating empowerment and advocating on the behalf of the patient. "Empowerment links individual strengths with proactive behaviors to effect social change". Zimmerman & Rappaport, 1988. This curriculum will expand empowerment skill building and techniques to transfer those skills to the participants' clientele. "People must be able to advocate for themselves as they are increasingly seen as active consumers rather than passive recipients of treatment and care" *Osborne, H. (2004) Health Literacy from A-Z. Sudbury, M.S.: Jones & Bartlett Publishers.*

This curriculum will also provide the content and skills in communication to assist the community health worker and front line clinical staff in effectively interacting with a variety of clients, their families and a range of healthcare providers. Communication

skills are part of the community's culture and have cultural implications that can affect client communication in obtaining optimal healthcare.

We identified substantial gaps in health literacy trainings for health and allied health professionals. The majority of existing health literacy curricula is designed primarily for nurses and physicians. While the content addresses health literacy components, the perspective is not aligned with the roles and responsibilities of our intended audience. Current health literacy curricula include our focus points of communication and empowerment but are designed to the medical community. We will adapt and expand the communication and empowerment components to meet the needs of CHWs in their unique role in building trusting relationships with their clients. Most trainings are designed to inform and to increase providers' awareness about low-level health literacy patients. There are tools designed for patient empowerment, but nothing that links these tools to the patient. CHWs can facilitate that link. Providers and community health workers can jointly share the task of addressing low health literacy barriers to optimal health care.

Existing Health Literacy Curricula

Health Literacy Curricula at a Glance

Source	Intended Audience	Highlights	Points to consider
AMA Foundation Health Literacy and Patient Safety: Help patients understand	*Nursing *Physicians *Clinical & medical staff *Program administrators	*Literacy statistics *Impact on healthcare cost *Compelling video	*Assumes audience knows medical terminology *Assumes audience is providing direct patient care
HRSA – Unified Health Communication Approach; Addressing Health Literacy, Cultural Competency, Limited English Proficiency Online Course	*Nursing *Physicians *Health care providers *Program administrators	*Comprehensive topics; -Health literacy, cultural competency and limited English proficiency *Job Aids	*Online course, users are self-motivated to learn *Medical focused; clinical trials, malpractice suits, etc. *Quizzes to review information
OSU/Area Health Education Center Clear Health Communication Program Online Module	*Program directors/administrators *Health & Education Professionals	*10 modules with articles and resources for further reading	*Online module, users are self-motivated to learn *Not interactive with learner
The CDC's Community Health Worker's Sourcebook; A Training Manual for Preventive Heart Disease and Stroke	*Community Health Workers *CHW Trainers *Health Educators & Professionals *Nursing/Clinical staff *Program administrators	*Aimed at primary target audience – CHWs *Handouts are user-friendly *Format of instruction is conversational *Cultural understanding is encouraged for each of the 15 chapters	*Assumes audience has had basic CHW training *Sourcebook is not for Train-the-trainer purposes

Health Literacy Across the Continuum of Health Care

Health literacy is a broad topic which is present at every point along the continuum of health care. The Joint Commission recognizes that "low health literacy levels and ineffective communications can compromise patient safety". The Commission identified key areas which require much attention:

- Entry to the health care system
- Health care encounter
- Transition, standardize the approach to "hand-off" communication
- Self-Management

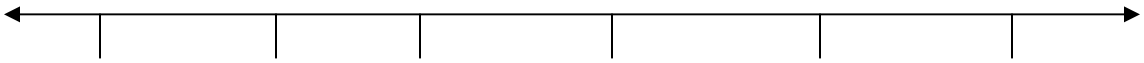
Within each of these areas, CHW and front line staff have a role to help decrease health literacy barriers.

Health literacy efforts, targeting CHW and front line staff, increases awareness of health literacy throughout the continuum of care. CHW have proven to be effective in "improving access to and use of health care, including preventive health and chronic disease management; increasing health knowledge and improving health indicators", Family Strengthening Policy Center. This Policy Brief Number 14 reviewed many CHW studies and stated the purpose for CHWs is to "create bridges to close gaps in families' health resources and overall community access to health care".

This curriculum development project is one of the first steps in an effort to increase health literacy awareness through out the continuum of care. Other efforts at St. Vincent Charity Hospital include:

- Health Literacy Committee formed in February 2007.
- 70 Patient Education documents have been revised for readability at grade eight or below by Project: LEARN.
- Navigation Tracer of Hospital completed by Project: LEARN students.
- 10 Health Literacy Awareness Classes made available to all staff and community members.

Health Literacy Across the Continuum of Health Care



Awareness Access Screening Diagnosis Treatment Quality of Life

Point on Continuum of Care	Health Literacy Component	Example
Outreach, Health Awareness & Health Education, and Risk Reduction	*Written material *Sources of health information *Acting on health information	*H1N1 information presented at a 5th grade reading level. *Use teach-back method.
Access & Navigation	*Intake Forms *Insurance/Benefit forms *Schedule Appointment *Signage *Phone tree design	*Post clear and easy to read signs in plain language such as, have X-Ray and Radiology on same sign.
Prevention & Screening and Primary Care	*Postings for screenings & vaccines *Office visits *Informed Consent	*Limit number of messages per visit *Encourage clients/patients to ask questions
Diagnosis	*Tests *Test results letters sent to clients/patients *New information	*Partner with client/patient for shared decision-making. *Encourage client/patient to have friend or family member present.
Treatment and Chronic Care & Disease Management	*Surgery *Prescription medicines labels *Self-care instructions	*Review medicines regularly *Individualize self-management education
Quality of Life Diet & Nutrition Physical Activity Palliative Care General Wellness & Protection	*Nutritional content on food labels *Exercise plans *Newspaper and magazine articles	*Have communications & messages that fit audience *Engage clients/patients to advocate for their own safety

Planning Process

From 2007 through 2009, these planning years were spent reviewing the health literacy literature, becoming familiar with best-practices, and researching health literacy curricula. A significant finding that surfaced through curricula review validated the need for a curriculum adapted to the needs of our target audience.

A development team, consisting of key grant staff, community health workers from Community Outreach Department and other agencies, and front-line medical staff assisted in curricula review, edited the survey tool, and served as an advisory board, providing insight into clinical interaction with patients and both hospital-based and issue-specific community health worker roles.

Collaboration/Partners

- Cleveland State University, Center for Health Equity, provides leadership to advance the understanding of health disparities and their resolution through interdisciplinary research.

- Ohio Community Health Worker Association, recognized by the National Association of Community Health Workers, establishes and supports community health workers as professionals who are an integral part of the health and human services system.

- MomsFirst Program strives to reduce racial disparities in maternal/child health, provide access to pre- and post-natal care, and address perinatal depression within the City of Cleveland. They provide outreach services to high-risk pregnant and postpartum women and teens in Cleveland.

- Cuyahoga Physician's Network is a group of community physician practices delivering medical care in neighborhoods throughout Northeast Ohio.

- Health Education Consultant is an Associate Professor of Health Education, Department of Health, Physical Education and Dance, Cleveland State University.

- Project: LEARN, an adult learning education organization, in collaboration with St. Vincent Charity Hospital, Nursing Education Department.

Challenges

Our planned program start was delayed by five months. When we presented our plan to develop and administer surveys and convene focus groups the program evaluator strongly

suggested that we seek IRB approval and to obtain Protecting Human Research Participants certification. These activities were not included in the initial planning timeline and delayed our initial start time.

Each team member received Human protection certification. We developed a survey tool and obtained St. Vincent Charity Hospital IRB approval. The program evaluator then suggested that we use his survey tool for our project. This necessitated further IRB processing, because his research project had not been included in our original application.

The amount of research and literature review involved took more time than expected. We had hoped to identify a health education consultant earlier in the project.

Survey Results

Surveys and focus groups administered in 2008 - 2009 revealed the extent of our target population's current knowledge of health literacy, their perspective on the relevance of health literacy to their work, and strategies they may be using to support their patients' needs. The following data was collected by staff at St. Vincent Charity Hospital. This data summary was prepared by the Center for Health Promotion Research at Case Western Reserve University in response to the data questions that were formulated by St. Vincent Charity hospital. It should be noted that this is a basic summary of the data that was collected from the surveys; the results do not test for significance and should be interpreted with caution. Listed below are three summaries from the results.

- **Has the intended audience been exposed to the term "Health Literacy"**

The majority of survey respondents (78%) had heard of "health literacy" prior to completing the survey. However, "health literacy" was a new topic to one out of every five (22%) respondents.

- **What has been the extent of their exposure?**

About half of the participants heard about health literacy through in-service trainings (53%). Others heard about health literacy through their work or professional experience (22%) and two participants (4%) had heard about health literacy through the media (i.e. television or newspaper). The remaining 22% had never heard about health literacy.

- **Methods used to check patient understanding**

Survey participants were asked which methods they use to check client/patient understanding of health information and were given a options including: 1) ask clients if they understand the information you just gave; 2) ask clients if they have questions; 3) use teach- back methods (asking client to re-describe or re-demonstrate information in their own words); 4) unsure; and 5) other. Participants were instructed to choose "*the methods that you use most often*", allowing them to pick multiple responses. Among front line staff members, 63% indicated using teach back methods, 50% reported asking clients if they have questions, and 50% reported asking clients if they understand the information. Among community health workers, 43% indicated using teach back methods, 48% reported asking clients if they have questions, and 30% reported asking clients if they understand the information.

Health Literacy Curriculum Blueprint Introduction

This document serves as a blueprint for a health literacy train-the-training curriculum. It is an outline of fundamental health literacy components and skill development tools, specifically designed to address the roles of our intended audience. It keeps the community health worker and frontline clinical staff workforce abreast in a critical public health issue. The blueprint reflects the design of the curriculum as a resource for preparing trainers to teach.

Our choice of a train-the-trainer approach was intentional. Not only does this approach empower community health workers and frontline clinical staff to have an opportunity to teach their peers, but also: by training others trainers will have the opportunity to master the curriculum material in order to apply it to their community context (Health); the related information would be more relevant to their roles; and by training one key person to train others in the organization it creates a repository of knowledge within the organization. This approach has a multiplier effect in reaching those ultimately responsible for client services and organizational protocols. By applying the Socio-ecological Model, the participants will have the capacity to effect individual and interpersonal levels as well as the community and organizational levels.

This Curriculum Blueprint outlines the suggested content for a comprehensive health literacy curriculum and workshop, tailored to the needs of community health workers and frontline clinical staff.

Curriculum and Workshop Goals

- Increase awareness of health literacy components and implications to participants work.
- Increase the use of health literacy skills among community health workers and frontline clinical staff.
- Create a health literacy curriculum that is relevant to community health workers and frontline clinical staff.

- Provide community health workers and frontline clinical staff with health literacy tools to help their clients achieve better health outcomes.

Curriculum Blueprint Components

The blueprint is divided into four sections: Health Literacy, Communication, Cultural and Community Understanding, and Empowerment. Each section has learning objectives, content description, tools, and resources. Information is presented in an outline format.

Socio-ecological Model

The Socio-ecological Model outlines how the health status of an individual is influenced not only by the attitudes and practices of that individual, but also by their personal relationships, as well as community and societal factors. The model describes multiple levels of intervention, beginning with individual level change and culminating with societal change. In other words, this model identifies five levels of influence for health-related behaviors and conditions: individual, interpersonal, organizational, community, and public policy. These levels are described as such:

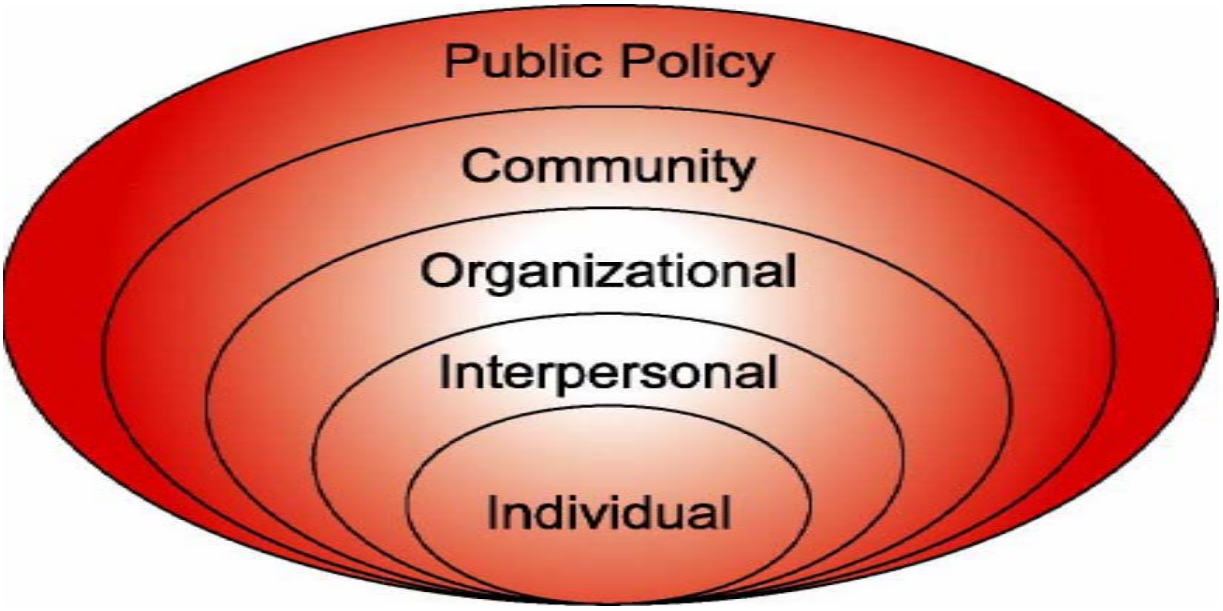
- **Individual:** Personal beliefs, attitudes, behaviors or characteristics that influence health status.
- **Interpersonal:** A person's family, friends and peers who have the potential to shape a person's behaviors and range of experiences.
- **Organizational:** Areas and organizations where social interactions occur, including schools, workplaces, churches and neighborhoods that influence a person's health.
- **Community:** Relationships among or between community agencies.
- **Public policy:** Larger scale influences on health such as public policies (local, state, and national laws), or religious and cultural beliefs.

On the individual level, our knowledge, attitudes, beliefs, and skills effect our behavior. Beyond the individual level many external forces (interpersonal, organizational, community and policies) influence those individual factors. The most effective approach leading to healthy behaviors is a combination of efforts.

This model is an example of an ecological perspective, which emphasizes the interaction between, and interdependence of, factors within and across all levels of a health problem. When we work in our community to establish better health outcomes, we may run into a number of bumps in the road. Barriers to healthy behaviors are shared among the community as a whole. As these barriers are lowered or removed, behavior change becomes more achievable and sustainable. Once we are able to actually see how interpersonal relationships are interwoven and influence one another, we should be able to start developing strategies that will encourage behavior changes. The most effective approach leading to healthy behaviors is a combination of the efforts at all levels – individual, interpersonal, organizational, community, and public policy.

Notice that the core or foundation of the model is the individual. For this reason, the Socio-ecological Model should be considered when training participants. A train-the-training approach has the capacity to effect individual and interpersonal levels as well as the community and organizational levels. The curriculum content should be connected to the different socio-ecological levels:

- **Individual** – The participant's experience in the workshop.
- **Interpersonal** – The participant and their relationships with their clients/patients.
- **Organizational** – The participant conducts a workshop at their respective agencies to provide in-services.
- **Community** – Various agencies communicate with each other about health literacy efforts, sharing best practices and lessons learned.
- **Public Policy** – Societal change.



The train-the-trainer approach to this training has the potential to change the health literacy landscape. Health literacy awareness may penetrate on all levels - from a client/patient using Ask Me 3 in the doctor's office, to a national effort to ensure all health education materials are health literate.

Health Literacy

Learning Objectives: The learner will be able to

- Describe the importance of having a health literacy understanding
- Relate the current different health literacy definitions to his or her work
- Name health literacy barriers that affect clients/patients health status
- Describe ways to reduce clients/patients health literacy barriers

Content: *This section provides an overview of health literacy, with an emphasis on skill development. Health literacy issues are addressed from a public health perspective. This training is focused on awareness and practical application.*

Section I. Health Literacy Description

1. Why learn about health literacy?
    - Health literacy affects health status more than age, income, employment status, educational level and racial or ethnic group.
    - Health literacy levels can change over an individual's lifetime and depends on both individual factors and the overall situation:
    - Client/patient communication skills with their doctor/provider
        - Literacy skills – reading, writing, comprehension, math
        - Oral/verbal skills
        - Non-verbal skills
    - Client/patient knowledge of health topics
        - Medical terms
        - Healthcare terms
        - Biology – Anatomy and physiology
    - Culture
        - How a client/patient thinks and feels about their health
        - How a client/patient responds to recommendations for lifestyle change and treatment
        - How a client/patient respond to changes in health status and health outcomes
        - How a client/patient communicates with their doctor
    - Requirements of the health care system
        - Literacy skills
        - Health care system access skills
        - Health care system navigation skills
    - Situations
        - Relationship dynamics between client/patient and doctor
        - Emotional state - underlying stress, fear, anxiety, distrust of health system
        - Physical or mental impairment due to illness

- Permanent or temporary disabilities

- Health Care System changes over time
  - How many doctors/providers does a person see?
  - How many pharmacists or chain drug stores does a person use?
  - How many forms does a person have to complete?
  - Are health care services provided in in-patient or out-patient settings?
  - How many medicines are available?
  - How much time can a doctor/provider spend with a client/patient?
  - Where does a client/patient find health information?

Section II. Health Literacy Definitions:

1. US Department of Health and Human Services 2000, Healthy People 2010, and Unified Health Communication Approach
   - Health literacy is the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.
2. Office of the Mayor, New York City
   - Health literacy is the ability to read, understand and action upon health-related information. Health literacy also refers to the capacity of professionals and institutions to communicate effectively so that community members can make informed decisions and take appropriate actions to protect and promote health.
3. Institute of Medicine (expanded definition)
   - Health literacy is based on the interaction of individuals' skills with health contexts, the health-care system, the education system, and broad social and cultural factors at home, at work, and in the community.
4. Discussion Point – How do the different definitions apply to your work, to your agency, and to the community?

Section III. Health Literacy as it relates to health outcomes and health status

1. People with low health literacy:
   - Experience more preventable hospital visits and admissions
   - Use more hospitalization and emergency services
   - Fail to seek preventive care
   - Are significantly more likely to report their health as "poor"
   - Cost the health care between $106-$236 billion dollars a year

Section III. Adult Literacy

1. Health literacy study; *Inadequate Functional Health Literacy Among Patients at Two Public Hospitals*

- 33% of the patients were unable to read basic health care materials
- 42% of the patients could not understand directions for taking medication on an empty stomach
- 26% of the patients were unable tot understand information on an appointment slip
- 43% of the patients did not understand the rights and responsibilities section of a Medicaid application
- 60% of the patients did not understand a standard informed consent form

2. Types of Adult Literacy
    - Fundamental literacy
        - Reading, writing, speaking and computing abilities
        - Vocabulary and grammar abilities
    - Scientific literacy
        - Understanding scientific concepts
        - Understanding technology
        - Understanding scientific uncertainty and rapid changes in the field
    - Civic literacy
        - Judging sources of information
        - Judging quality of information
        - Knowing where and how to access information
        - Knowing how to advocate for oneself and others
        - Understanding the relationship between one's actions and the larger social group
    - Cultural literacy
        - Recognize, understand, and use the collective beliefs, customs, world view, and social identity of diverse individuals to interpret and act on information abilities

3. Adult Literacy and Health Literacy Connection
    - A client/patient's literacy level does not always equate to his or her health literacy level. A client/patient may have high fundamental literacy but be affected by situations that lower his/her health literacy. Clients/patients can also have low fundamental literacy, but high health literacy.
        - Examples:
        - A college graduate with a degree in physics does not understand that taking multiple over-the-counter medicines at the same time can be harmful
        - A retired librarian does not understand how Medicare works
        - A single mother with less than a 6th grade education understands how to manage her daughter's diabetes and ask specific questions about her most recent blood sugar tests.

Section IV: Health Literacy tasks and Essential Health Activities

1. Health literacy tasks and potential barriers to achieving better health outcomes fall along the continuum of health care; awareness, prevention, diagnosis, treatment, and quality of life. These points on the continuum of health care align with many public health efforts:
    - Health promotion – enhance and maintain health
    - Health protection – safeguard health
    - Disease prevention – screening and early detection
    - Health care & maintenance – seek care from doctor
    - Health care system navigation – access services

Section V: You can't tell by looking

1. Ways to identify limited health literacy clients/patients.
    - Understanding the clients/patients you serve
    - People that are more likely to have low literacy and/or low health literacy skills:
        - Elderly
        - Low-income
        - People born in United States but speak English as a second language
        - People who are deaf or hard-of-hearing
        - People who did not finish high school
        - People with learning disabilities
        - Recent immigrants to the United States who do not speak English
        - Unemployed
    - Behaviors that may mean low literacy and/or low health literacy
        - Incomplete or incorrect forms
        - Not following medication directions or instructions
        - Take medicine incorrectly
        - Not able to describe how to take medications
        - Does not know what the medication is for
        - Missed appointments
        - Show up for appointment on the wrong day and time
        - Seeks medical attention when very ill or emergent care is needed
        - Does not ask questions
    - Responses to receiving written information
        - "I forgot my glasses. I'll read this when I get home."
        - "I forgot my glasses. Can you read this to me?'
        - "Let me bring this home so I can discuss it with my children."

- Feelings that low literacy or low health literacy levels clients/patients may experience:
    - Fear
    - Hiding the fact that they can't read
    - Scared
    - Embarrassed
    - Defensive
    - Low self worth
    - Helplessness

Section VI: How to address health literacy problem?

1. Reflect on earlier discussion point, health literacy is a shared responsibility among many individuals and groups:
    - Client/Patient
    - Community Health Worker & Frontline Clinical Staff
    - Doctors & Nurses
    - Health care providers & professionals
    - Health care institutions
    - Government
    - Business
    - Education
    - Media
    - Community
    - Society
        - Discussion Point – Explore health literacy as a shared responsibility; how to make access to health care & services and health activities easier for clients/patients to achieve?
2. Health education and client/patient encounter guidelines
    - Slow down
        - Spend time understanding client's/patient's concerns
        - Set goals together
    - Use plain, non-medical language
        - Living room language – creates a conversation between community health worker & frontline clinical staff with a client/patient
        - Simple words
    - Show or draw pictures
        - Make a map from parking lot to clinic destination
        - Use a calendar-format for an exercise chart
    - Limit the amount of information provided
        - Each encounter should have one or two points for the client/patient will need to know

        - Information should be relevant to client's/patient's current situation
        - Provide information that the client/patient needs to know, not information that is nice to know
    - Repeat important points

3. Use easy-to-read written materials
    - User-friendly layout
    - Pictures convey the message
    - Clear message – what is the goal?
    - Manageable information
    - Tailor message for audience
    - 6th grade reading level or lower
    - Clear font
    - Action oriented
    - Focus on "need-to-know" & "need-to-do", not nice to know information
        - Clients/Patients with high education and income still prefer brief, simple, easy to read materials
        - What do you prefer?
    - Reflection from earlier section, how does current situation affect your ability to comprehend information?
    - Include intended audience in development process

4. Confirm client's/patient's understanding of your message
    - Use Teach-Back method
        - Does client/patient explain or demonstrate message?
    - Ask, "tell me your understanding"
    - Ask, "how will you describe this to your family"
    - Ask open ended questions
    - Avoid asking:
        - Do you understand?
        - Do you have any questions?
    - Do not rush client/patient to explain
    - Do not become annoyed or bored with client/patient

5. Encourage clients/patients to ask questions
    - Ask Me 3 – Program Example
        - Empower client/patient to ask doctor these three questions
        - What is my problem? (Diagnosis)
        - What do I need to do? (Treatment)
        - Why is it important that I do this? (Benefit in Context)

6. Create a shame-free environment – community and clinic environments
    - Offer to read information to client/patient
    - Tell client/patient what to expect during encounter/appointment
    - Help client/patient prepare for encounter/appointment

- Ask client/patient to bring friend or family member
- Address any other individual client/patient needs

Section VII: Health Literacy, moving forward

1. Not all clients/patients want to, or can, participate in their health and medical decisions. Questions for you and your agency to address:
    - How do you see health literacy as a barrier to health status and health outcomes?
    - How does your agency see health literacy as a barrier to health status and health outcomes?
    - Is it a priority?
    - Is there time/money/resources to address health literacy?
2. Community Health Worker and Frontline Clinical Staff Role:
    - Client/Patient Self management teaching
        - Lifestyle – diet, physical activity
    - Motivational Interviewing
        - Assess client/patient readiness for change
        - Goal setting
        - Focus on strengths
        - Assess family and community supports
    - Explore Cultural/Community Influences
        - Clients/patients health beliefs
    - Advocacy
        - Het client/patient feel comfortable to ask health care team questions
        - Help client/patient make and keep referral appointments – health and social services
    - Group Meetings/Classes
        - Coordinate client/patient meetings
        - Teach health education class
        - Facilitate exercise class
        - Assess group dynamics for community change and community capacity

NOTES

Note pages are suggested at the end of each section. Space should be provided to write key words, concepts, and relevant take-aways.

This space can also provide participants questions for reflection and individual and small group activities.

Health Literacy
Tools/Job Aides/Resources

Health Literacy Tasks and Essential Health Activities

Health Activities	Focus	Materials Adults are Expected to Use	Tasks Adults are Expected to Accomplish
Health Promotion	Enhance and maintain health	Label on a can of food or recipes. Articles in newspapers and magazines Charts and graphs such as the Body Mass Index**.** Health education materials	Purchase food Prepare a dish from a recipe Plan exercise Maintain healthy habits [nutrition, sleep, exercise] Take care of one's health and that of family members
Health Protection	Safeguard health of individuals and communities	A newspaper chart about air quality A water report in the mail A health and safety posting at work A label on a cleaning product	Decide among product options Use products safely Vote on community issues Avoid harmful exposures
Disease Prevention	Take preventive measures and engage in screening and early detection	Postings for inoculations & screening Letters [test results] Articles in newspapers and magazines Graphs, charts	Take preventive action Determine risk Engage in screening or diagnostic tests Follow up

Health Care & Maintenance	Seek care and form a partnership with a health professional such as a doctor or dentist or nurse	Health education Health history forms Labels on medicine Develop plan for taking medicine as described Health education booklets Directions for using a tool such as a peak flow meter Schedule and keep appointment	Seek professional care when needed Describe symptoms Follow directions Measure symptoms Maintain health with chronic disease [follow regimen, monitor symptoms, adjust regimen as needed, seek care as appropriate]
Navigation	Access needed services, and get coverage and benefits	Application forms Statements of rights and responsibilities Informed consent forms Benefit packages	Locate facilities Apply for benefits Fill out forms Offer informed consent

This table is drawn from: Rudd RE, Kirsch I, Yamamoto K. *Literacy and Health in Americ*a. ETS Policy Report #19. Princeton NJ: Educational Testing Services. 2004.

Selected Websites

- http://www.askme3.org/PFCHC/about.asp
  Ask Me 3 patient education program. Partnership for Clear Health Communication.

- http://www.healthliteracymonth.org
  Health Literacy Month is a grassroots campaign that promotes the need for understandable health information.

- http://www.nifl.gov/mailman/listinfo/Healthliteracy
  ListServ. The purpose of this list is to provide an on-going professional development forum where literacy practitioners, healthcare providers, health educators, researchers, policy makers, and others can discuss literacy issues in health education programs and in health care settings; health education efforts being undertaken within literacy programs; literacy screening measures being piloted in health care settings and the readability of health materials.

- http://www,iom.edu/CMS/3809/4636/4290.aspx
  Institute of Medicine (IOM) Report: Priority Areas for National Actions: Transforming Health Care Quality. A comprehensive document illustrating areas of improvement.

- http://healthliteracy.osu.edu/modules
  The Ohio State University AHEC Health Literacy Program offers comprehensive professional development and continuing education in the field of health literacy. The program has been developed by Dr. Sandra Cornett, Director of the OSU/AHEC Clear Health Communication Program, and a national leader in health literacy training
- http://www.health.gov/communication/literacy/default.htm
  Quick Guide to Health Literacy. U.S. Department of Health and Human Services. Strategies and action-oriented tools are user-friendly for program directors and program managers.
- http://www.wisconsinliteracy.org/
  Wisconsin Literacy's vision is to strengthen Wisconsin's workforce, families and communities through literacy. We pursue that vision by supporting adult, family and workplace literacy programs statewide through program and resource development, information and referral, training, and advocacy.

Selected Publications

Institute of Medicine of the National Academies. *Health Literacy: A Prescription to End Confusion*. National Academy of Sciences Washington D.C., 2004

Johnston Lloyd, Linda. Health Literacy Resource List U.S. Department of Health and Human Services Health Resources and Services Administration Promote Health Literacy, Improving Health Literacy and the Language of Health. Date unknown.

Osborne, Helen. *Health literacy from A to Z: practical ways to communicate your health Message.* Sudbury, Mass: Jones and Bartlett, c2005.

Schwartzberg, Jg., VanGeest, J.B., Wang, C.C (editors). *Understanding Health Literacy, Implications for Medicine and Public Health*. American Medical Association: United States of America Library of Congress, 2005 .

Zarcadoolas, Christina, et al. *Advancing health literacy: a framework for understanding and action.* San Francisco, CA: Jossey-Bass, 2006.

Communication

Learning Objectives: The learner will be able to

- Describe the basic communication process
- Appreciate the value of empathic listening and effective feedback
- Assess the communication needs of your audience and adjust your verbal and nonverbal message accordingly
- Tailor your message to your audience.

Content

This training is designed to enhance communication and interpersonal skills, address community-specific communication needs, effective oral communication, the role of nonverbal cues, and ways to match your message to your audience.

Section I. Basic components of communication

1. Sending and receiving messages
    - We sometimes focus exclusively on the information that we want to relay. The listener may understand your message, understand only a portion of your message, or miss your point entirely—even though you believe that you transmitted the information accurately.
    - Listening is the basis of effective communication and entails much more than just hearing sound.
    - Active listening involves listening with empathy.
        - Make a conscious decision to listen and concentrate on what your client/patient is saying.
        - Use your imagination and enter their situation. Try to imagine his or her point of view; hear thoughts, beliefs and feelings.
        - Demonstrate methods for responding to problems of others with empathy and support
        - "So you are pretty frustrated with trying to lose weight," or "Many of my clients also have difficulty fitting exercise into their lives."
2. Differences between the sender and receiver affect the odds of successful communication.
    - Attitudes. How different are the attitudes between the sender and the receiver?
        - The doctor stresses that your client needs medication to control their high blood pressure. Your client isn't experiencing any symptoms and doesn't like to take

medication. How much attention will he/she give to what the doctor is saying?

- Information levels. Is the sender or receiver significantly more informed than the other?
    - How often do you feel "patronized" by a health professional? Why do you think that is? Do you feel that your concerns are truly heard? Do you feel comfortable saying that you don't understand?
- Communication skills. The greater the difference in the sender's and the receiver's communication skills, the less likely it is that communication will be successful.
    - Which of these show greater communication skill: "Upon request, to obtain from the facility in charge of his care, the names and specialty, if any, of the physician or other person responsible for his care or the coordination of his care;" or "Tell you the names and the role of the people caring for you."
- Social systems. If the sender and receiver do not share a similar social system, successful communication is more of a challenge.
    - Your client is a new immigrant. At her first appointment, the doctor prescribes medications and refers her to a specialist. Your client, who states that her health is important to her, promises that she will follow the doctor's treatment plan. When you follow up with her, she has not. She states that her husband was not present at the doctor's office, and that she looks to him to make important decisions.

3. Differences in communication styles often create an extra challenge.
    - Your shy & diffident client/patient hesitates to ask questions; one who is outspoken & assertive may be labeled "difficult"; a medical assistant uses medical terminology with patients to show professionalism.
4. Differences in previous experiences create a filter through which we hear the world - inference, judgment, and generalization
    - Consider what previous experiences with the health care system have been and what attitudes are toward different health problems.
        - A newly diagnosed hypertensive patient who has heard that the medication can cause impotence will be reluctant to fill the doctor's prescription.
5. Cultural differences impact how a message is sent as well as the manner in which a message is received.
    - How do culture, the media and people influence what a person thinks about people who have infectious or chronic diseases such as cancer or HIV/AIDS?

Section II. Communication and Health

1. Health communication is about helping your clients/patients make informed health decisions and participate fully in recommendations to improve their health
2. How communication affects health outcomes
    - Poor health communication can lead to poor health outcomes
        - Your diabetic client has cut out sugar from her diet, because having diabetes means your sugar is high. Having heard the "Five Fruits and Vegetables a Day" public health message, she eats unlimited amounts of fruit believing that this is healthy for her.
        - As soon as I walk into the doctor's office, they hand me a clipboard with sheets of paper on it. There are lots of people in the waiting room. I'm too embarrassed to say out loud that I can't read well. So I don't go to the doctor."
3. Poor health communication can lead to mistrust.
    - Disregard for a client/patient's health literacy level, culture and language skills can lead to misunderstandings and mistrust.
4. Person-centered thinking.
    - Finding a balance between what is important to the person you support and what is important for them to know or do for their health
        - If it's not important to the person, they are very unlikely to do anything the healthcare provider suggest

Section III. Role of the CHW in Health Communication

1. Role as a liaison between the healthcare provider and client/patient.
    - "The doctor suggested that you walk 30 minutes a day. I know that your neighborhood isn't safe to walk in. Let's think of places that you can walk in the apartment building. Can you take the stairs?"
2. Serves to support and reinforce the relationship between patient and doctor/clinic staff.
    - "Mr. Jones, with your permission, I will let the clinic know that you are having trouble getting your medication."
3. CHW serves to bring cultural/community understanding to the message
    - "Dr. Jones, I am making an appointment for Mrs. Santana. Her husband will accompany her. It is important that her husband be present when you discuss a treatment plan."
4. The CHW must be accurate in translating health information into plain language

Section IV. Effective Health Communication Techniques

1. Communication is 55% Visual.

- Printed material: The layout of the text, the font used, the photos or drawings all have either a positive or a negative effect on what is communicated and how well it is understood.
- Pictures or models
  - Pictures and examples should reflect the target community.
- Demonstrations, videos, podcasts
- Nonverbal Body Movement
  - Body Language – posture, body position, eye contact
  - What a person is saying is different than what their stance, facial expression and attitude convey.

2. Communication is 37% Vocal.
   - The speed of a person's speech, the volume, and intonation (questioning, angry, excited)
3. Communication is 7% verbal
   - The actual message or words.
4. Successful interaction techniques
   - OARS = 0pen-ended questions, affirmations, reflective listening, summaries
     - Shifting focus. Client: "I know that if I go to the doctor, they're going to find something wrong and I'll end up in the hospital." CHW: "Well, you said that your feet were so swollen that you couldn't go to the store. Let's get those swollen feet taken care of so you can get around."
     - Simple reflection. Client "I hate giving up all my favorite foods just because the doctor says." CHW "Yes, I know it's very hard giving up foods that you enjoy." Client "It sure is, though I know that they're not good for me."
   - Empathy. Willingness to understand (and experience) the Client's thoughts, feelings, and struggles from the Client's point of view can help build a solid relationship.
     - "So you are pretty frustrated with trying to lose weight," or "Many of my clients also have difficulty fitting exercise into their lives,"
5. Understanding from the patient's/client's perspective
   - Ask their ideas about their illness or health issue
   - Ask their expectations of you
   - Explore and acknowledge their beliefs, concerns or expectation about their health issue
   - Watch and listen for non-verbal/verbal cues that will alert you to readiness to come to a solution
   - Work together to make decisions toward resolving the issue

Section V. Plain Language

1. Plain language means written or oral communication that's clear and easy to understand

- Avoid medical jargon.

Don't Use	Use Instead
sodium	salt
exposure to	risk of getting
enroll	join
chronic	long-term
assistance	help

- Shorter sentences and words
- White space – at least 1 inch margins
- Clear headings – large type and bold
- Lists and bullet points
- It is *never* appropriate to use children's materials for adults, even if the reading level is suitable.

2. Living Room Language - speaking as if you are visiting with friends and family in your home and talking about health
    - Use common words and explanations. Using shorter, everyday words increases understanding
    - Tell stories – relate the information to everyday life examples
    - Emphasize health behaviors instead of medical facts
        - Discussion point – Using medical terminology increases my professionalism. I am respected more by the doctors and especially by my clients/patients.

3. Testing for Readability
    - Allows you to make sure the reading level of your material matches the reading skills of your client.
        - If you are unsure, a readability level of grade 5 or 6 is recommended
    - Readability tests measure only the number of syllables (or letters) in a word, and the number of words in a sentence.
        - Readability Index of this paragraph scored at the 12th grade level: Qwerty uiopas dfg hjkl zxcvb nmqw ertyuio pas dfghj klzxcvb nmq werty ui opas dfgh jklzxc vbnm Qwertyuiop as dfgh jklz xcvbn mqwe rtyui opas dfghjk lzx cv bn m. Qw ertyu iopas dfghj klzxcvb nmqwert yuiopasdf ghjk lzxcv b nmqw ert yuiop asdf gh jk lzxcvbn m. Qwerty uiop asdfg hjklz xcvbn mqwe rtyuiop asdfgh jklzxcv bnmq wert yui opa sdfgh jklzxc vbnm qwerty uiopas.
    - SMOG Readability Index
    - FOG Index

Section VI. Adult Learning Styles

1. Adults expect and enjoy independence.

- Your clients will learn best through encouragement and nurturing. Guide them to making their own choices using discussion and listening techniques.

2. Adult's need to know why. They decide for themselves what is important.
   - It will help to discover your client's life goals and then relate the health behavior education directly to the goals.
     - "Mrs. Jones you said that you wanted to visit your grandchildren this summer. It is important that you follow your diet, so that you remain healthy."

3. Adult's draw upon past experiences to make decisions, and may have fixed viewpoints.
   - "They gave me that blood pressure medicine the last time, and I didn't like the way it made me feel. I'm just not going to take it if they give it to me again."

4. Adults tend to be problem or task centered.
   - In health behavior modification, focus on the client's presenting issues.
     - I know that you want me to get a mammogram, but right now my tooth hurts. Can you help me find a dentist?"

5. Adults will validate the information you give them based on their beliefs and experience.
   - "Both my parents smoked, and they both lived to be 90. I don't see any reason to quit."

Section VII. Limited English Proficiency (LEP)

1. A person with limited English proficiency does not speak English as a primary language.
   - Has a limited ability to read, write, speak or understand English.
   - Has less access to primary care, less likely to go to follow-up appointments after receiving emergency care, less likely to understand diagnosis, medications and follow-up instructions, less satisfied with care received
2. A person with Limited English Proficiency will have poor health outcomes due to language barriers that cause inaccurate or incomplete communication of information, or inaccurate or incomplete understanding of information communicated
3. Health assistance is sometimes provided through translated written materials
   - It is important to insure that the translated materials are in Plain Language and follow recommended readability guidelines
   - Translated written materials should never be a substitute for oral interpretation.
4. Language assistance through graphic materials (pictures)
   - These materials usually provide pictures of needed services or characteristics of illness (FACES pain rating scale)
   - It is important that the graphic materials avoid symbols that may be open to interpretation. Only universal symbols should be used.

5. Language assistance through interpreters
    - Always use a trained interpreter (preferable certified in health interpreting) vs. a friend or family member
    - Interpreted message must be accurate. There should be no side conversations that are not interpreted for both sides to understand. The interpreter should not add opinions.
    - The interpreted message must be understood. Both the healthcare provider's message and the interpretation should be delivered in plain language, using common words and explanations.
    - An interpreter provides cultural relevancy to the message

Communication
Tools/Job Aides/Resources

Assessing your Listening Behaviors

Adapted from "Effective Communication" Independent Study Handbook
FEMA. Dec, 2005.

Read each item and then check the box indicating how frequently you actually use this skill when talking with others. Remember, this is a self-assessment, so be honest!		
	Usually Do	**Do Sometimes**
1. I try to make others feel at ease when I am talking with them.	☐	☐
2. I try not to think about other things when listening to others.	☐	☐
3. When I listen, I can separate my own ideas and thoughts from the speaker's.	☐	☐
4. I can listen to others with whom I disagree.	☐	☐
5. I try not to form a rebuttal in my head while others are talking.	☐	☐
6. I observe others' verbal and nonverbal behaviors.	☐	☐
7. I let others finish speaking before I begin talking.	☐	☐
8. I listen to what others say rather than assume that I know what they are going to say.	☐	☐
9. I concentrate on others' messages rather than on their physical appearance.	☐	☐
10. As I listen, I figure out how others are feeling.	☐	☐
11. I ask others to clarify or repeat information when I am unsure what was meant.	☐	☐
12. I can remember the important details of what others tell me during conversations.	☐	☐
13. I restate information given to me to make sure that I understand it correctly.	☐	☐

How to Use the Fog Index

The underlying message of The Gunning Fog Index formula is that short sentences written in Plain English achieve a better score than long sentences written in complicated language.

The ideal score for readability with the Fog index is 7 or 8. Anything above 12 is too hard for most people to read. For instance, The Bible, Shakespeare and Mark Twain have Fog Indexes of around 6. The leading magazines, like Time, Newsweek, and the Wall Street Journal average around 11.

1. Select a short passage and count the number of words. For a lengthy document, select several different passages and average the Fog Index.

2. Count the number of sentences within the passage.

3. Count the number of big words (3 or more syllables). Exclude words in which "es" or "ed" form the third and final syllable, hyphenated words like "state-of-the-art", and compound words like "newspaper."

4. Calculate the average sentence length by dividing the number of words by the number of sentences.

5. Calculate the percentage of big words by dividing the number of big words by the number of words, and multiplying by 100.

6. Add the average sentence length to the percentage of big words and multiply that result by 0.4; that's the Fog Index score.

The SMOG Readability Formula

SMOG Readability Formula estimates the years of education a person needs to understand a piece of writing

How to Use the SMOG Formula

1. Count 10 sentences in a row near the beginning, in the middle, and near the end of your material for a total of 30 sentences.
   > In long sentences with colons or semicolons followed by a list, count each part of the list with the beginning phrase of the sentence as an individual sentence.

2. Count every word with three or more syllables in each group of sentences, even if the same word appears more than once.
   > Words with hyphens count as one word.
   > Proper nouns are counted.
   > Read numbers out loud to decide the number of syllables.
   > Count abbreviations as the whole word they represent.

3. Add the total number of words counted. Use the SMOG Conversion Table I to find the grade level.

SMOG Conversion Table I

Word Count	Grade Level
0-2	4
3-6	5
7-12	6
13-20	7
21-30	8
31-42	9
43-56	10
57-72	11
73-90	12
91-110	13

SMOG Conversion Table II

# of Sentences	Conversion #
29	1.03
28	1.07
27	1.1
26	1.15
25	1.2
24	1.25
23	1.3
22	1.36
21	1.43
20	1.5

111-132	14	19
1.58		
133-156	15	18
1.67		
157-182	16	17
1.76		
183-210	17	16
1.87		
211-240	18	15
2.0		

Use this formula and SMOG Conversion Table II for material containing less than 30 sentences, but not less than 10 sentences.

1. Count the total number of sentences in the material.

2. Count the number of words with 3 or more syllables.

3. Find the total number of sentences and the corresponding conversion number in SMOG Conversion Table II.

4. Multiply the total number of words with 3 or more syllables by the conversion number. Use this number as the words count to find the correct grade level from Table I.

Adapted by Dr. Sandra Cornett, Director, OSU / AHEC Health Literacy Initiative, Office of Outreach & Engagement, The Ohio State University College of Medicine, present on Health Literacy, from the original work: McLaughlin, G. (1969).

Flesch-Kincaid Grade Level Readability Test

Originally formulated for US Navy purposes, this Formula is best suited in the field of education

Step 1: Calculate the average number of words used per sentence.

Step 2: Calculate the average number of syllables per word.

Step 3: Multiply the average number of words by 0.39 and add it to the average number of syllables per word multiplied by 11.8.

Step 4: Subtract 15.59 from the result.

A score of 5.0 indicates a 5^{th} grade-reading level;
5.0 – 6.9 = 6^{th} grade reading level
7.0 – 7.9 = 7^{th} grade reading level
8.0 – 8.9 = 8^{th} grade reading level
and so on.

Substitute Word List

Information taken from: University of Utah Health Sciences Center

Since health writing usually uses technical terms, it is helpful to the reader to use shorter words whenever possible. Here is a list of words that are commonly found in health literature. Using the substitute word instead of the technical word will help lower the readability level of your material. This list was adapted from:

ability - skill
accomplish - carry out
alternative - choice
ambulate – walk
annually – yearly
apply - put on, use
approximately – about
assist – help
attempt- try
available – ready
bacteria – germs
cell culture - tissue study
cerebral hemorrhage – stroke
cessation - stop, pause
chorionic villi – tissue
cognizant – aware
communicate – talk
compassion – pity
competent – able
completion - end, finish
conclusive – final
contact – call
contraceptive - birth control
contusion – bruise
conversion – change
coronary thrombosis - heart attack
correspond – agree
decrease - make less, reduce, lower
deficit – shortage
delete - strike out
demonstrate – show
detect – find
detrimental – harmful
develop - arise, occur
diagnosis - problem, condition
diminish - get less, slow down
discoloration - change in color
disconnect - undo
discontinue - stop
dressing - bandage
due to the fact that -because
dyspepsia - indigestion
elevate - raise
eliminate - get rid of
embolism - lump of blood, clot
encourage - urge
endeavor - try
difficulties - problems, trouble
excessive - too much
experience - feel
facilitate - help, ease
feasible - can be done
frequently - often
fundamental - basic
generate - produce
guarantee - backing, promise
hazardous - risky
humid - damp
humorous - funny
identical - same
illustration - picture
impair - harm
inadvertent - careless
inadvisable - unwise
incision - cut
incorrect - wrong
independent - free
indication - sign
ineffectual - useless
inform - tell

inhibit - check, hinder
initial - first
initiate - begin, start
injection - shot
innovation - change
instrument - tool
institute - set up
intention - aim
interrupt - stop
laceration - cut, tear
lenient - mild
locality - place
manifest - clear, plain
minimal - smallest
modification - change
nebulous - hazy, vague
notification - notice
numerate - count
nutrient - food
obligation - duty
observation - remark
observe - note
obvious - plain
occurrence - event
opportunity - chance
option - choice
palatable - pleasing
penetrate - pierce
perforation - hole
permission - consent
physician - doctor
present - give
principal - main, chief
project - plan
qualified - suited
recognize - know, accept
recuperate - get well
rehabilitate - restore
saturate - soak
scarlatina - scarlet fever
segment - part
sensation – feeling
several – many
similarity - likeness
similarity - likeness
similar - like
situated - placed
status - state
stimulate - excite
sufficient - enough
sustenance - support
sutures - stitches
tear of ligament - sprain
technicality - detail
termination - end
therapy - treatment
ultimate - last, final
uncommonly- rarely
understand - know
unequivocal - clear
unfounded - groundless
unnecessary - needless
until such time - until
utilize - use
varicella - chicken pox
visualize - picture
voluminous - bulky

Substitute Word List p.2

Information taken from:
University of Utah Health Sciences Center

Learning Assessment
Questions and Observations

Answers to the questions in this table will help you individualize teaching. They reveal an understanding of the person's experiences with health care, learning needs and readiness, learning styles, health and cultural beliefs, comprehension and application of the information. Ask only a few questions during each interaction so you don't overwhelm the person.

Categories	Questions / Observations
Previous Health Instruction & Experience in Health Care	Please tell me about your health problem (illness). How can I help? What do you know about _____? What have you been told about your condition? What have you been doing for your condition (illness) in the past? (now)? What are you most interested in learning now? What would you like to learn first? What do you need to know before you do ____? (self-care) How have you and your family been dealing with your condition? How should a person be treated for this condition? What questions do you have?
Learning Needs / Readiness to Learn	What do you want to know more about? What does your health problem do to you? How does it work? Why do you think it started when it did? How severe is your health problem? How long do you think it will last? What do you think will be the major effects of your health problem on you and your family? What have you been doing for yourself to care for your condition? What kinds of problems do you have when doing this care? What things will help or hinder your care at home?
Health Beliefs & Cultural Practices	What do you think caused your health problem? What bothers or concerns you most about your health problem? What issues have your health problem caused you? What do you fear most about your health problem? What does your health problem mean to you? What kind of treatment do you think you should receive? What are the most important results you hope to get from this treatment? Who in the family / community gives you health advise? How does your family help?
Comprehension & Application of Health Information	What don't you understand as well as you would like to? Do you usually follow directions as given or do you change them to suit yourself? What helps you understand and remember what you have read or learned? Once you understand something, to what extent do you try to use the information or apply it to everyday situations? What do you think would happen if _____? What would you do if _____? How would you know if _____? Who would you call if _____? How would you explain your condition and treatment to _____? How confident are you, on a scale of 1 to 10, that you can ____? How confident are you, on a scale of 1 to 10, that you will _____?

Adapted from The Ohio State University. AHEC Clear Health Communication Program.

A Sample of Universal Symbols used in Healthcare Settings

Ambulance Entrance
Ingreso de Ambulancias

Billing Department
Departamento de Facturación

Cardiology
Cardiologia

Care Staff Area
Area del Personal de Cuidado

Chapel
Capilla

Diabetes (Education)
Diabetes Educacion

Emergency
Emergencia

Family Practice Clinic
Clinica de Practica Familiar

Immunizations
Inmunizaciones

Infectious Disease
Enfermedades Infecciosas

Intensive Care
Cuidado Intensiva

Internal Medicine
Medicina Interna

Pediatrics
Pediatria

Pharmacy
Farmacia

Physical Therapy
Terapia Fisica

OB Clinic

Selected Websites

- http://lincs.worlded.org/docs/culture/index.html
  Culture, Health, and Literacy: A Guide to Health Education Materials for Adults with Limited English Literacy Skills. Julie McKinney and Sabrina Kurtz-Rossi

- http://www.healthdisparities.net/hdc/html/home.aspx
  HRSA Knowledge Gateway

- http://babelfish.yahoo.com/
  Online Language Translator

- http://www.lep.gov/
  Federal Interagency Working Group on Limited English Proficiency

- http://www.healthlaw.org/library/item.118835-Language_Services_Resource_Guide_for_Health_Care_Providers_Oct_06
  Language Services Resource Guide for Healthcare Providers

- http://www.plainlanguage.gov/
  Plain Language Action and Information Network (PLAIN)

- http://www.health.gov/communication/literacy/quickguide/healthinfo.htm
  U.S Department of Health and Human Services. Office of Disease Prevention and Promotion. Quick Guide to Health Literacy: Improve the Usability of Health Information.

- http://www.wwcd.org/action/AMPU/crosscult.html
  Working on Common Cross-cultural Communication Challenges. Marcelle E. DuPraw, National Institute for Dispute Resolution and Marya Axner, Consultant in Leadership Development & Diversity Awareness

Cultural and Community Understanding

Learning Objectives: The learner will be able to

- Define key concepts in cultural and community understanding
- Describe the evidence for health disparities
- Describe how culture shapes health beliefs and values
- Describe how culture affects health-seeking behaviors and decision making

Content

In this training we hope to provide an understanding of how both culture and community can shape attitudes regarding health. True competence will require an ongoing openness to and willingness to acquire more knowledge of the populations that you serve.

Section I. Definitions of terms

1. Cultural and community understanding
    - Culture consists of socially learned behavior patterns, beliefs, and values that shape how we act, think, and respond.
        - They form our customs, courtesies, rituals, manners of interacting with others. roles, relationships, and expected behaviors
        - We may choose to ignore or obey these influences.
    - A community is defined as people living in the same locality, or who share a common experience. People are either placed or choose to live in a community.
        - Often, we impose the label of "community" on a population because of certain characteristics or identifiers: Black community, HIV community, GLBT community, medical community, cancer community, senior community
2. How culture impacts health communication and delivery
    - Clients have diverse information needs, including those related to cultural differences, language, age, ability and literacy skills that affect their ability to obtain, process, and understand health information and services.
    - Race, ethnicity, bias, linguistic access (LEP), health disparities
    - Culture/community colors what I tell you about my health, what I tell my doctor, and what kinds of questions that I may be comfortable being asked

3. Cultural/community implications of health prevention and referral to appropriate services/programs

- A person's culture can affect: how health care information is received, how rights and protections are exercised, what is considered a health problem, who provides treatment for the problem, what types of treatment should be given.

Section II. Self-assessment of cultural beliefs, biases and values

1. Self assessment begins with a desire not to allow biases to keep us from treating every individual with respect.
2. Awareness of personal beliefs, biases and values
   - We also bring our own cultural backgrounds, values, beliefs, and biases to work with us.
3. How this awareness can influence client /patient interactions.
   - Assessing our positive and negative assumptions about and reactions to others.
   - Understanding the implications of these reactions
   - Negative consequences to healthcare of insensitivity, lack of respect, bias & discrimination
   - Discussion point: "We treat everyone equally!" – but should everyone get the same treatment? How would cultural differences influence a person's "equal treatment"?

Section III. Awareness of the role of culture in health

1. Culturally define values & belief systems related to health & mental health
   - Cultural strengths, assets, & resiliencies within diverse populations and communities
   - How beliefs and values influence interpersonal interactions
2. Culture vs. individual expression
   - Affect of stereotypes and generalizations on client relationships and health outcomes
   - Determining the client's health and healing beliefs
     - Kleinman's Nine Questions
3. Cultural factors that influence communication with the client
   - Nonverbal communication and cross-cultural misunderstanding: Facial expressions, head movements, hand and arm gestures, personal space, eye contact, and touching
   - Gender bias and professional status
4. Assessing your cultural and community understanding skills
   - Overview of Cultural Competency Framework
     - Cultural & community understanding, attitude, knowledge and skills
   - Seven Stage Model of cultural competency development

- From the lowest level to the highest: Fear, denial, superiority, minimization, relativism, empathy, integration

Section IV. Health Literacy and Some Special Populations

1. Health literacy needs of older adults and the deaf community
2. Significant barriers pose increased risk to adverse health outcomes
3. Awareness of stereotypes and generalizations
4. Sensitivity to cultural, language, and other differences among the older adults you serve.
5. Challenges of older adults – visual and hearing impairment, cognitive challenges
6. Utilizing the local deaf community

Section V. Compare and contrast health models

1. Contrast & compare the Western Health model to the Native American, African-American and Eastern Model
2. Traditional medicines and healing practices
   - Home remedies
3. Cultural perspectives of illness & disability
   - Eastern approach considers health as a balanced state versus disease as an unbalanced state
4. How culture/spirituality shapes health-seeking behaviors and decision making
5. Presenting the best healthcare options while respecting client's beliefs

Section VI. Evidence for disparities in health care quality and outcomes

1. Disparities in health & mental health among racial & ethnic groups
2. Economic, environmental, social, & cultural factors that are known to contribute to health & mental health disparities of racial & ethnic groups
3. Literacy and health care
4. Stereotyping, bias, discrimination and racism in health and social service systems
5. Viewing of "Unnatural Causes" or highlights and recommendations from the Institute of Medicine report "Unequal Treatment"

Cultural and Community Understanding
Tools/Job Aides/Resources

Kleinman's Nine Questions

> What do you call your problem? What name does it have?

> What do you think caused your problem?

> Why do you think it started when it did?

> What does your sickness do to you? How does it work?

> How severe is it? Will it have a short or long course?

> What do you fear most about your disorder?

> What are the chief problems that your sickness has caused for you?

> What kind of treatment do you think you should receive?

> What are the most important results you hope to receive from this treatment?

LEARN Model

Use to get a sense of the culture of your client, what is most important to them, and what they are willing to do

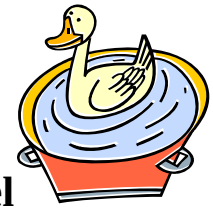
L—Listen

E—Explain

A—Acknowledge

R—Recommend

N—Negotiate



BATHE Model

Use to inquire about the social context and to build a relationship based on support of where the client is

B—Background *"What is going on?"*

A—Affect *"How do you feel about that?"*

T—Trouble *"What about the situation troubles you?"*

H—Handling *"How are you handling it?"*

E—Empathy *"That must be very difficult for you"*

C R A S H Model

Represents the values necessary to cultural and community understanding

C—Consider culture
Recognize the importance of your client's cultural values and beliefs and the role they play in all interactions

R—Respect
Show respect by not stereotyping and using appropriate verbal and nonverbal communication

A—Assess and affirm
Assess health beliefs, health knowledge and health literacy. Affirm and recognize positive values in other cultures. Affirm personal experience.

S—Sensitivity and self-awareness
Be sensitive to specific issues within each culture that might cause offense or lead to a breakdown in communication. Be aware of your own biases and how they may affect interactions.

H--Humility
Accept that developing cultural and community understanding takes a lifetime of willingness to learn.

ETHNIC Model

Affirms spiritual/religious beliefs related to illness

E—Explanation "What do you feel the problem is?"

T—Treatment "What have you done to treat it?"

H—Healers "Have you sought advice from traditional healers?"

N—Negotiation Negotiate options that incorporate your client's beliefs

I—Intervention Determine the best intervention with your client's input

C—Collaboration Collaborate with your client's family, clergy, community resources

Selected Websites

- http://www.dimensionsofculture.com/home/traditional_asian_health_beliefs_and_healing_practices
  Dimensions of Culture. Cross Cultural Communications for Healthcare Professionals Traditional Asian Health Beliefs and Healing Practices

- http://www.asha.org/NR/rdonlyres/E7805A1A-CCD2-4A35-B84A-ED889318EFA0/0/personalreflections.pdf
  Cultural Competence Checklist: Personal Reflection American Speech-Language-Hearing Association.

- http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=1238216
  Eastern and Western Approaches to Medicine. Western Journal of Medicine. 1978

- http://www.ahrq.gov/consumer/5tipseng/5tips.htm

Health Literacy and Cultural Competency. Ways You can Help Your Family Prevent Medical Errors! U.S. Department of Health and Human Services. Agency for Healthcare Research and Quality.

- http://www.healthinfotranslations.com/health_information_translations.php
  Health Information Translations

- http://www.asaging.org/cdc/issue_briefs/Issue_brief_4.pdf
  Live Well Live Long Health Promotion and Disease Prevention for Older Adults . Issue Brief 4 Cultural Competence and Health Literacy. Making Your Health Promotion Program Accessible to Diverse Groups of Older Adults. American Society on Aging.

- http://www.cancer.org/docroot/ETO/content/ETO_5_3X_Native_American_Healing.asp
  Making Treatment Decisions. Native American Healing American Cancer Society.

- http://www.health.gov/communication/literacy/olderadults/default.htm
  Quick Guide to Health Literacy and Older Adults. U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion.

- http://www.cancer.gov/espanol

National Cancer Institute En Espanol – Spanish language website

- http://www.fda.gov/ForConsumers/ByAudience/ForWomen/FreePublications/default.htm
  U.S. Food and Drug Administration: Women's Health, Health Information Available in Cambodian, Chinese, English, Hmong, Japanese, Korean, Laotian, Polish, Russian, Samoan, Spanish, Tagalog, Thai, and Vietnamese.

- http://www.unnaturalcauses.org/about_the_series.php
  Unnatural Causes: Is inequality making us sick? Produced by California Newsreel with Vital Pictures, Inc.

Selected Publications

Inclusion: Realizing the Promise. Available from Susan G. Komen for the Cure. A Franklin Covey publication. 2008

Empowerment

Learning Objectives: The learner will be able to

- Define empower
- Describe the ways that people can change their health behavior
- Evaluate health information
- List potential questions clients/patients can ask their doctor and nurse

Content

This training aims to help workshop participants understand self-empowerment and how to empower their clients/patients to gain and maintain personal health ownership. Empowerment helps provide application of health literacy concepts and techniques to an individual's behavior.

Section I. Definitions

1. Empower – 1) To invest with power and 2) To equip or supply with an ability; enable
2. Empowerment – "process by which individuals and groups gain power, access to resources and control over their own lives. In doing so, they gain the ability to achieve their highest personal and collective aspirations and goal" (Robbins, Chatterjee, & Canda, 1998, p. 91).
3. Self-efficacy – belief that one is capable of performing in a certain manner to attain certain goals. Self-efficacy relates to a person's perception of their ability to reach a goal.

Section II. Empowerment Concepts

1. Empowerment reside in the person
2. Does not blame for lack of resources and power
3. Rejects that problems develop because of personal deficiencies

Section III. Intrapersonal Level Empowerment

1. Builds self-efficacy
2. Builds personal consciousness
3. Decreases self-blame
4. Assumes personal responsibility

Section IV. Roles of community health workers and frontline clinical staff:

1. Link clients/patients to resources so that it enhances their self-esteem and problem solving skills

2. Help clients/patients gain the knowledge necessary to have ownership of their health status and health decisions
3. Help clients/patients recognize and identify their own strengths
4. Help clients/patients understand their own self-determination in achieving self-efficacy and empowerment
5. Act as a broker to seek to educate their respective agency about the barriers that the people they serve encounter

Section V. How people can change their health behavior based on different health models

1. Behavior is a function of specific health beliefs (Health Belief Model)

This model focuses on the beliefs and attitudes of the individual.

- Components: threat, outcome expectations, and self-efficacy
- Threat
    - Perceived susceptibility "I could get it."
    - Perceived severity "The consequences of getting it would be serious."
- Outcome Expectations
    - Perceived benefits of performing a behavior "If I wash my hands often, I can prevent getting a bad cold."
    - Perceived barriers of performing the behavior "Washing my hands takes too long."
    - Belief that the benefits of performing a behavior outweigh the consequences of not performing it before behavior change will occur "I'd rather wash my hands often than get a bad cold."
- Self Efficacy (later addition)
    - Belief that one can perform a behavior, even under difficult circumstances "I know I can do this."

2. In order for someone to change behavior, that person must have an intention to change. (Theory of Reasoned Action, TRA)

- A person's behavioral intention depends on the person's attitude about the behavior and subjective norms
- Components: Attitudes toward the behavior and subjective norms about the behavior
- Attitudes Toward The Behavior
    - Belief regarding performing behavior, based on positive or negative consequences (outcome expectations, decisional balance)
      "Exercise is good for my health, but it takes up too much time."
    - Evaluation of the consequences to performing behavior
      "It's important to me to not gain too much weight."
      "Exercising everyday is not worth all of the time it takes for me to get to the gym."
- Subjective Norms About The Behavior

- What significant others think about performing the behavior
  "My friends think exercising is a good thing."
- Motivation to perform behavior based on subjective norms
  "Since my friends think I should exercise, I guess I'll ask them if I can exercise with them."
- What attitudes and beliefs toward the behavior, along with the perception of what significant others think an individual should do, influence intentions toward behavior.
  "I'm not too crazy about exercising, but my friends are at a healthy weight, and my friends really want me to exercise with them."

3. A person's behavior is dynamic, and influenced by both personal and environmental factors. (Social Cognitive Learning Theory)

- Behaviors are learned through direct experience or by modeling others' behaviors through observation.
- Components: Self efficacy and outcome expectancies
- Self Efficacy
  - A person's belief about his/her ability and confidence in performing a particular behavior, and belief that it can be done even under difficult circumstances.
    "Even when we're really tired and my family wants fast food for dinner, I can talk them into making something healthier at home."
- Outcome Expectancies
  - A person's belief about the positive or negative consequences of performing a particular behavior. It will be performed to the extent that it will lead to a positive outcome.
    "I heard that keeping frozen vegetables at home can help me and my family have healthier dinners, so I buy them and try to keep a bag in my freezer."
  - Practicing new behaviors through observation and modeling are important components of this theory, as well as providing support for provisional tries.

4. Behavior occurs in a series of stages. (Transtheorectical Model/Stages of Change)

- A behavior change does not happen in one single step. A person will move through a series of stages.
- Components: Precontemplation, contemplation, action, relapse, maintenance and relapse.
- Precontemplation
  - No intention to change behavior; not aware of risk, or believe behaviors don't place them at risk.
    "I have no desire of starting an exercise program."
- Contemplation

- Recognizes behavior puts them at risk and is thinking of changing, but not committed to making that change.
  "I might consider starting an exercise program but I am not ready to start yet."

- Preparation
  - Person intends to change behavior sometime soon and is actively preparing.
    "I want to start exercising and I bought a new pair of tennis shoes and workout clothes, and I researched several nearby recreation centers to find out their hours."
- Action
  - Person has changed behavior recently, with change having occurred in a relatively recent time period (i.e., 6 months).
    "I will make it my goal to exercise regularly 3-5 days/week for 20-60 minutes a day."
- Maintenance
  - Person has maintained behavior change for a long period of time (> 6 months), and has adapted to the change.
    "Exercise is now a habit and I will continue to incorporate it in my schedule in the future for the long-term."
- Relapse is a normal process in one's attempt to change behaviors.
  "I went on vacation for a week and have difficulty getting back into an exercise routine. I am going to review my goals and see how I can start exercising again."

5. A person receives and accepts a health message at different time intervals (Diffusion of Innovation)

- Explains how new ideas, products, and behaviors become norms at all levels: individual, interpersonal, community, and organizational. Diffusion is the process by which the new idea or behavior gains acceptance in a community.
- Components: Communication channels, opinion leaders, time and process required, social network to link members, and categories of adopters.
- Communication Channels
  - For dispersing the innovation or new message.
    Word of mouth, telephone, Internet, newspaper, newsletters, flyers, role-model stories
- Opinion Leaders
  - Visible, respected people who can assist in disbursing the innovation or message. (A well-respected neighborhood health clinic stays open until 9:00pm to meet the needs of the community.)
- Time and Process Required
  - For the innovation to reach community or group members
- Social Network to Link Members

- Diffusion process aided by social networks
  Peers, significant others, family, friends, clinics, hospitals

- Categories Of Adopters
  - Innovators – first group of people to adopt an innovation; willing to take risks, young, very social, have the closest contact and interaction with other innovators.
  - Early Adopters – second group of people to adopt an innovation; have high social status, have financial lucidity, advanced education, and more socially forward than late adopters.
  - Early Majority – adopt an innovation over time; have above social status, and in contact with early adopters.
  - Late Majority – adopt an innovation after the average member of the society; have high degree of skepticism, below average social status, and very little financial lucidity.
  - Laggards – last to adopt an innovation; have an aversion to change agents, tend to be advanced in age, focus on traditions, lowest social status, and lowest financial fluidity, in contact with only family and close friends.

- Best practices for applying diffusion of innovation model:
  - Compatible with an individual's needs
  - Flexible enough to be used in a variety of situations
  - Reversible if people want to return to previous practices
  - Advantageous when compared with alternatives
  - Simple enough for people to understand and adopt
  - Cost efficient, with the perceived benefits outweighing the costs

Innovators Early Adopters Early Majority Late Majority Laggards

6. A social action process that promotes participation of people, community, and organizations in gaining control over their lives in their community. (Empowerment Theory/Popular Education)

- Empowerment is not characterized as achieving power to dominate others, but as power to act with others to bring about change.
- Components: Targets for change, 3-stage method for participatory education, 5-step questioning strategy used by facilitator.
- Targets For Change
  - Individual level
  - Group, agency, or organizational
  - Structural; within a larger organizational or societal setting
- 3-Stage Method For Participatory Education

    - Listening, understanding the felt issues of the problem in the community
    - Participatory dialogue, among all members in the group
    - Action, envisioning positive change during the dialogue
    - Process-driven, rather than task oriented
- 5-Step Questioning Strategy Used By Facilitator
    - Describe what participants see and feel
    - Define the many levels of the problem as a group
    - Share similar experiences from their lives
    - Question why the problem exists
    - Develop action plans to address the problem
- Role of community health worker and front line clinical staff: guide discussion from the personal, to social analysis and action level, through the use of codes (pictures, poems, stories, slides, role plays, etc.), and 5-step questioning strategy

Section VI. Evaluate health information sources

1. Clients/patients can access health information via the Internet, media sources (radio, T.V., and newspapers) and other venues. These resources are intended to help clients/patients decide if the health information they have found or were given credible and reliable.

- Health related news and information is highly available
- Health information can be inaccurate from what appears to be a trusting source
- Resources
    - Evaluating Internet Health Information: A Tutorial from the National Library of Medicine
    - Is this health information good for me? National Network of Libraries of Medicine Pacific Northwest Region

Section VII. Empowerment Tools

1. There are many health literacy tools designed to help clients/patients become comfortable to ask their doctor questions.

- Clients/patients have a right to ask the doctor and health care team questions to gain understanding and to make informed decisions regarding their health care.
- Clients/patients are encouraged to be involved in their own health care.
- Resources
    - "How to get the most from your doctor visit" AMA Foundation
    - Ask Me 3 – Partnership for Clear Health Communication
    - Questions are the Answer – Agency for Healthcare Research and Quality

Section VIII. Skill Building

1. It is important for the workshop participants to identify their own strengths and to identify the strengths of their clients/patients. These skill building exercises will assist in cultivating a relationship between the worker and client/patient.
2. Assessing personal and clients/patients strengths
    - Components: Defining strengths, strength-based assessment, and discovering strengths
    - Defining Strengths
        - What have people learned about themselves and others
        - Personal qualities, traits, and virtues
        - What people know about the world around them
        - Talents people have
        - Cultural and personal stories
        - Pride
        - The community
        - Spirituality
    - Strength-based Assessment
        - Give primacy to the clients' perspectives
        - Believe the clients
        - Discover what the clients want, their aspirations, goals, and dreams
        - Direct the assessment toward personal and environmental strengths
        - Make the assessment of strengths multidimensional
        - Discover the clients' uniqueness
        - Use language the clients can understand
        - Avoid blaming
        - Avoid cause-and-effect thinking
        - Avoid diagnosing and labeling
    - Discovering Strengths
        - Survival questions: How have you managed to overcome/ survive the challenges that you have faced? "What have you learned about yourself and your world during those struggles?"
        - Support questions: Who are the people that you can rely on? Who has made you feel understood, supported, or encouraged?
        - Exception questions: "When things were going well in life, what was different?"
        - Possibility questions: What do you want to accomplish in your life? What are your hopes for your future, or the future of your family?
        - Esteem questions: What makes you proud about yourself? What positive things do people say about you?
        - Perspective questions: "What are your ideas about your current situation?"

- Change questions: What do you think is necessary for things to change? What could you do to make that happen?

3. Motivational Interviewing
   - Motivational interviewing is a client-centered, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence.
   - Components:
     - Motivation to change is elicited from the client, and not imposed.
     - It is the client's/patient's task to articulate and resolve his or her ambivalence.
     - Direct persuasion is not an effective method for resolving ambivalence.
     - The counseling style is generally a quiet and eliciting one.
     - The worker is directive in helping the client to examine and resolve ambivalence.
     - Readiness to change is not a client trait, but a fluctuating product of interpersonal interaction.
     - The relationship between a community health worker/frontline clinical staff and the client/patient is more like a partnership or companionship than expert/recipient roles.
4. Referral Readiness
   - Community health workers and frontline clinical staff often refer clients/patients to other agencies. This tool helps them have a better understanding of the referred agency and their client/patient readiness to receive services.

Empowerment
Tools/Job Aides/Resources

Evaluate Health Information
Sample

MedlinePlus Guide to Healthy Web Surfing

What should you look for when evaluating the quality of health information on Web sites?
Here are some suggestions based on our experience.

Consider the source--Use recognized authorities

Know who is responsible for the content.

Focus on quality--All Web sites are not created equal

Does the site have an editorial board? Is the information reviewed before it is posted?

Be a cyberskeptic--Quackery abounds on the Web

Does the site make health claims that seem too good to be true? Does the information use deliberately obscure, "scientific" sounding language? Does it promise quick, dramatic, miraculous results? Is this the only site making these claims?

Look for the evidence--Rely on medical research, not opinion

Does the site identify the author? Does it rely on testimonials?

Check for currency--Look for the latest information

Is the information current?

Beware of bias--What is the purpose? Who is providing the funding?

Who pays for the site?

Protect your privacy--Health information should be confidential

Does the site have a privacy policy and tell you what information they collect?

Consult with your health professional--Patient/provider partnerships lead to the best medical decisions.

Client/Patient Empowerment Tools
Example

How to get the most from your doctor visit
Ask us, we can help!
The doctor and office staff are here to help you get the most from your visit.

- Ask questions! Doctors and other healthcare professionals want you to understand your condition and learn how to manage it.

- Preparing for your doctor visit can help. Make a list of questions before you see the doctor.

- Take along a friend or family member to your doctor visit. He or she can also help you write down and remember what the doctor says. You can refer to these notes later at home.

- Be sure to report anything to your doctor that doesn't seem quite right. Tell your doctor about any new or different symptoms you may be having.

- Before you leave your doctor's office, make sure you understand what the doctor has told you.

- If you have any questions about your doctor visit after you get home, call the office and ask to speak with someone who can answer your questions.

- Take all your medicines to each doctor visit. This means prescription medicines as well as over-the-counter (OTC) medicines. OTC medicines include vitamins, minerals, and herbal preparations.

American Medical Association Foundation – Patient Safety Training

Ask Me 3
Every time you talk with a doctor, nurse, or pharmacist, use the **Ask Me 3** questions to better understand your health.

1. What is my main problem?

2. What do I need to do?

3. Why is it important for me to do this?

When to Ask Questions
You can ask questions when: you see your doctor, nurse, or pharmacist.

You prepare for a medical test or procedure.
You get your medicine.

What If I Ask and Still Don't Understand?
Let your doctor, nurse, or pharmacist know if you still don't understand what you need to do.
You might say, "This is new to me. Will you please explain that to me one more time?"

Who Needs to Ask 3?
Everyone wants help with health information. You are not alone if you find things confusing at times. Asking questions helps you understand how to stay well or to get better.

Partnership for Clear Health Communication

Do You Know the Right Questions to Ask?

Improving health care quality is a team effort. You can improve your care and the care of your loved ones by taking an active role in your health care. Ask questions. Understand your condition. Evaluate your options.

1. What is the test for?
2. How many times have you done this?
3. When will I get the results?
4. Why do I need this surgery?
5. Are there any alternatives to surgery?
6. What are the complications?
7. Which hospital is best for my needs?
8. How do you spell the name of that drug?
9. Are there any side effects?
10. Will this medicine interact with medicines that I'm already taking?

Agency for Healthcare Research and Quality

Community Health Worker/Frontline Clinical Staff
Skill Building Example

Checklist for Making Successful Referrals

- ❑ I have an adequate understanding of the client's situation and perceived needs.
- ❑ The client and I have talked about how to prioritize these needs and what options exist to help address them.
- ❑ He or she is willing and ready to be referred.
- ❑ We have discussed what issues might make it difficult for him or her to follow through with the referral.
- ❑ I am familiar with the agency to which I am referring the individual, including its cultural appropriateness, eligibility requirements and services.
- ❑ The agency has the *capacity* and *willingness* to serve people experiencing a client similar to one I want to refer, in a knowledgeable and respectful manner.
- ❑ I have a working relationship with at least one staff person at this agency who can provide useful information and help advocate for the client.
- ❑ I have considered whether or not to accompany the client based on the individual's:
  - Ability to negotiate complex social situations
  - Ability to provide and receive information
  - Ability to tolerate waiting
  - Level of ambivalence about seeking help
  - Interpersonal style (passive to argumentative)
- ❑ If the person is going alone, I have provided sufficient information and "coaching" to help make the referral successful.
- ❑ I have made a plan to follow up with the client to see how things went and to determine next steps.
- ❑ I have a backup plan if this referral fails to work out for any reason.

Selected Websites:

- http://www.npsf.org/askme3/
  Ask Me 3 provides information for health providers, patients, large-scale implementers and the media. It is sponsored by the Partnership for Clear Health Communication. Health literacy affects health status more than age, income, employment status, educational level and racial or ethnic group.

- http://www.nlm.nih.gov/medlineplus/webeval/webeval.html
  Evaluating Internet Health Information: A Tutorial from the National Library of Medicine
  This tutorial teaches you how to evaluate the health information that you find on the Web.

- http://medicalcenter.osu.edu/patiented/materials/pdfdocs/general/pro-staf/makemost.pdf Making the most of your visits with your doctor. Copyright, (2/21/2008) Division of Nursing, James Cancer Hospital & Solove Research Institute, The Ohio State University Medical Center

- http://www.ahrq.gov/questionsaretheanswer/
  Questions are the Answer. U.S. Department of Health & Human Services, Agency for Healthcare Research Quality provides videos and doctor visit question checklist for clients/patients.

Selected Publications:

Becker, J., Kovach, A.C., and Gronseth, D.L. Individual empowerment: How community health workers operationalize self-determination, self-sufficiency, and decision-making abilities of low-income mothers. Journal of Community Psychology. Volume 32 Issue 3 Pages 327-342. Published 2004.

Next Steps for Train the Trainer Workshop

Method for Delivery

The curriculum is designed for trainers and is based on a train-the-trainer format that orients them to the curricular content, guides them in using the materials to design their own training programs, and expand their skills for facilitating programs for community health workers and frontline clinical staff. The train-the-trainer method was selected as the best vehicle to disseminate health literacy information to reach the widest possible audience and because it lends itself to automatic sustainability efforts.

The train-the-trainer format process involves the following:

- The facilitating agency administers and provides the initial training to first tier participants.
- First tier participants are asked to conduct a training within a given time frame at their home agency and network of peers.
- This second tier of participants then continues the process to disseminate the information to a wider audience.
- Trainers are asked to give attendance sheets and evaluation forms to the facilitating agency.
- The facilitating agency follows up with all training participants for technical support and other training guidance.

Recommendations for Train-the-Trainer Delivery and Next Steps

- To increase participants' confidence level in the subject matter, the facilitating agency provides opportunities for further health literacy trainings.
- Training participants are encouraged to train their peers for better receptivity of the material.
- The curriculum should be designed in a modular format to enable trainers to selectively choose content based on staff needs and time constraints.
- Incentives encourage trainer buy-in and higher trainer rates.

- Potential trainers should be involved in the planning process to design a program and identify incentives that will maximize trainer follow through.
- Expectations of the trainers should be made clear from the onset of the project.

A kick-off event bringing area health and human service agencies together to introduce health literacy will increase participation and buy-in.

Evaluating Your Training Program

Adapted from Cultural Competency for California Public Health Staff: Train-the-Trainer State Partnership Project, 2004.

- Goals of Evaluation
    - Assess extent to which learners acquired new knowledge, awareness, and skills
    - Measure learners' ratings of self-efficacy in integrating training content into work activities
    - Track behavior change by assessing how training content is being integrated into daily work
    - Gather feedback about effectiveness of training and trainer

- Types of Evaluation
    - Formative evaluation: used to provide feedback to the trainer about which curriculum components are working and which are not. Can help assess the strengths and weaknesses of materials.
    - Summative evaluation: looks at results or outcomes of a program to determine the extent to which the program met the stated goals and objectives. Outcomes include change in knowledge, attitudes and behavior; policies initiated or other institutional changes.
    - Process evaluation: assessment of procedures and tasks involved in implementing a program.
    - Process or program evaluation: focuses on how the program was implemented and operated.

- Evaluation Methods
    - Qualitative: interviews, focus groups, analysis of open-ended responses
    - Quantitative: surveys asking questions which can be statistically tabulated and analyzed, frequently using a scale, check list, or yes/no responses

Planning Your First Health Literacy Train-the-Trainer Workshop
TRAINER REPORTING FORM
Sample

Your name: _____

Name of your organization: _____

Name of organization trained: _____

Contact person: _____

Address: _____

Phone number: _____e-mail: _____

Date of Training: _____ **Training format:** ☐ **1 hour**
☐ **4 hours**
☐ **6 hours**
☐ **Other**

Number of participants: _____

Who was this training provided to? *Please check all that apply:*

____ People who work within my own organization

____ Other Community Health Workers

____ Other Front Line Clinical Staff

____ Other

Was an evaluation administered? ____No ____Yes

a. Briefly describe any positive experiences and highlights of the training:

b. Briefly describe any barriers or problems you encountered while facilitating the training (*for ex., was the material organized well?, were the resources helpful?)*:

c. Do you have any suggestions for improvement of the training materials?

Please mail or fax this completed form with copies of completed Post-Training Evaluations to:
Facilitating Agency Phone: 216-555-5555
Address Fax: 216-555-555
City
Attn. Name

Train-the-Trainer

Health Literacy Workshop

[Sample]

Pre-Training Evaluation Form

Location:

Date:

	Strongly Disagree	Disagree	Agree	Strongly Disagree
1. Health literacy means that you know a lot about health.	1	2	3	4
2. The health issues of those with low health literacy are different from those with high health literacy.	1	2	3	4
3. Those with low health literacy often experience discrimination when they seek healthcare.	1	2	3	4
4. Those with low health literacy are not as likely to have all their health needs met.	1	2	3	4
5. Many healthcare providers do not fully understand the health needs of those with low health literacy.	1	2	3	4
6. People may avoid healthcare when they cannot find a culturally sensitive doctor or clinic.	1	2	3	4
7. My professional behavior is influenced by my cultural background.	1	2	3	4
8. My attitudes about education may have an impact on how I treat those who are less educated.	1	2	3	4
9. A patient's cultural background has a significant impact on how she thinks about her health and healthcare needs.	1	2	3	4
10. People with different cultural and community backgrounds seek and utilize healthcare in different ways.	1	2	3	4
11. Those with low health literacy may be more likely to encounter barriers to obtaining healthcare.	1	2	3	4
12. With my clients/patients, I display nonjudgmental body language and words.	1	2	3	4
13. When I see a new client/patient, I assume she is literate unless she tells me otherwise.	1	2	3	4

	Strongly Disagree	Disagree	Agree	Strongly Disagree
14. I think clients/patients would prefer that I not ask if they can read – they will tell me if they want me to know.	1	2	3	4
15. I would not consider a college graduate to have low health literacy.	1	2	3	4
16. Knowing the health literacy level of a client/patient is essential for me to provide adequate care.	1	2	3	4
17. I am adequately trained to address health care concerns with clients/patients who have low health literacy.	1	2	3	4
18. I use language that is appropriate to the culture of my clients/patients.	1	2	3	4
19. I know where to find resources that will help me enhance my services to those with low health literacy.	1	2	3	4
20. My workplace addresses low health literacy issues.	1	2	3	4
21. The reading level of the people I serve is considered when selecting health education materials.	1	2	3	4
22. I am confident in my ability to recognize people with low health literacy skills.	1	2	3	4
23. I have the tools and the skills to address low health literacy barriers.	1	2	3	4

Other Comments:

_____

_____

Train-the-Trainer

Health Literacy Workshop

[Sample]

Post-Training Evaluation Form

Location:

Date:

Please rate the quality of the workshop in the following areas (Circle one):

	Poor	Fair	Good	Excellent
1. Usefulness of the information	1	2	3	4
2. Teaching methods	1	2	3	4
3. Pacing of information	1	2	3	4
4. Effectiveness of instructor	1	2	3	4
5. Helpfulness of the handouts	1	2	3	4
6. Helpfulness of skills building exercises	1	2	3	4
7. Helpfulness of the video(s)	1	2	3	4
8. Length of the training	1	2	3	4

9. What about the workshop did you find most valuable?

10. What did you find least valuable?

11. How could the workshop be improved?

12. I plan to provide a Health Literacy Train-the-Trainer Workshop within the next 6 months:

    ☐ Definitely ☐ Doubtful

    ☐ Considering it ☐ No

13. I plan to take the health literacy information back to my agency and encourage the use of it:

    ☐ Definitely ☐ Doubtful

    ☐ Considering it ☐ No

Based on your previous experience and what you learned today, please circle one number for each statement:

	Strongly Disagree	Disagree	Agree	Strongly Disagree
1. Health literacy means that you know a lot about health.	1	2	3	4
2. The health issues of those with low health literacy are different from those with high health literacy.	1	2	3	4
3. Those with low health literacy often experience discrimination when they seek healthcare.	1	2	3	4
4. Those with low health literacy are not as likely to have all their health needs met.	1	2	3	4
5. Many healthcare providers do not fully understand the health needs of those with low health literacy.	1	2	3	4
6. People may avoid healthcare when they cannot find a culturally sensitive doctor or clinic.	1	2	3	4
7. My professional behavior is influenced by my cultural background.	1	2	3	4
8. My attitudes about education may have an impact on how I treat those who are less educated.	1	2	3	4
9. A patient's cultural background has a significant impact on how she thinks about her health and healthcare needs.	1	2	3	4
10. People with different cultural and community backgrounds seek and utilize healthcare in different ways.	1	2	3	4
11. Those with low health literacy may be more likely to encounter barriers to obtaining healthcare.	1	2	3	4
12. With my clients/patients, I display nonjudgmental body language and words.	1	2	3	4
13. When I see a new client/patient, I assume she is literate unless she tells me otherwise.	1	2	3	4
14. I think clients/patients would prefer that I not ask if they can read – they will tell me if they want me to know.	1	2	3	4
15. I would not consider a college graduate to have low health literacy.	1	2	3	4
16. Knowing the health literacy level of a client/patient is essential for me to provide adequate care.	1	2	3	4

17. I am adequately trained to address health care concerns with clients/patients who have low health literacy.	1	2	3	4
18. I use language that is appropriate to the culture of my clients/patients.	1	2	3	4
19. I know where to find resources that will help me enhance my services to those with low health literacy.	1	2	3	4
20. My workplace addresses low health literacy issues.	1	2	3	4
21. The reading level of the people I serve is considered when selecting health education materials.	1	2	3	4
22. I am confident in my ability to recognize people with low health literacy skills.	1	2	3	4
23. I have the tools and the skills to address low health literacy barriers.	1	2	3	4

Other Comments:

References

"Advances in Health Literacy" Executive Summary. National Conference American College of Physicians Foundation. Philadelphia, PA. 2007.

Agency for Healthcare Research and Quality. "Questions are the Answer." *U.S. Department of Health and Human Services (DHHS).* Accessed July, 2009. <http://www.ahrq.gov/questionsaretheanswer/>

AMA. "Health Literacy Train-the-Trainer Program." *AMA Foundation*. 28 Jul 2006. 2 July 2007. <http://www.ama-assn.org/ama/pub/category/8037.html>.

Anderson, J.E., and Rudd, R. "Navigating Healthcare: Both educators and medical professionals have roles to play in making healthcare more accessible to all." *Focus on Basics: Connecting Research and Practice.* 27 July 2007. NCSALL. Accessed July, 2007. <http://www.ncsall.net/?id=1156>

APHA CHW SPIG 2005 New and Emerging Roles for CHW's New York City CHWs' Perspectives on the Balance Between Institutions and Communities PowerPoint Presentation, December 2005. Catalani, C. & Findley, S. Columbia University; Matos, S. & Rodriguez, R. CHW Network of New York City; Pennachio, M. New York State Department of Health

Arnold, C. "Health Literacy: Understanding Problems and Clinical Strategies for Improvement." Louisiana State University Health Sciences Center. PowerPoint Presentation. June 20, 2008.

Aspirus Wausau Hospital. "Patient/Family Education: Author's Guide." *Wausau Medical Library Patient/Family Education.* Revised 2006. Aspirus. Accessed July 2009. <http://www.aspiruslibrary.org/literacy/AWHGuide.pdf>

Brach, C. and Fraser I. "Can Cultural Competency Reduce Racial and Ethnic Health Disparities: A Review and Conceptual Model." Medical Care Research and Review. Volume 57 Supplement 1. (November, 2007): 181-217.

Bronheim, S. "Cultural Competence: It All Starts at the Front Desk." *National Center for Cultural Competence.* Georgetown University Center for Child and Human Development. Centers for Excellence in Developmental Disabilities. Accessed July, 2009. <http://www11.georgetown.edu/research/gucchd/nccc/documents/FrontDeskArticle.pdf>

Busch, N.B. & Valentine, D. Empowerment Practice: A Focus on Battered Women. AFFILIA, 15 (1), p. 82-95. 2000.

Center for the Health Professions, The. "A Framework for Teaching Cultural Competency: A Curriculum for Trainers of California Public Health Staff." Appendix. Sept 2004

Centers for Disease Control and Prevention. "Program Operations Guidelines for STD Prevention Community and Individual Behavior." Accessed July, 2009. <http://www.cdc.gov/std/program/partners.pdf>

Clinical Management: Diabetes Community Health Workers Project. OWTI Training Model for Community Health Workers in Diabetes Self-Management PowerPoint Presentation. October 2007. Developed by the Outreach Worker

Training Institute of Central Massachusetts Area Health Education Center, Inc.

Committee on Health Literacy, Board on Neuroscience and Behavioral Health. "Health Literacy: A Prescription to End Confusion." *Institute of Medicine of the National Academies.* 2004 National Academies Press. Accessed July, 2009. <http://www.nap.edu/openbook.php?isbn=0309091179>

"Cultural Self-Assessment Teaching Tools, Strategies, and Resources. " *National Center for Cultural Competence Curricula Enhancement Module Series.* Georgetown University Center for Child and Human Development. Centers for Excellence in Developmental Disabilities. Accessed July, 2009. <http://nccccurricula.info/assessment/D4.html>

Dorsett, Betsy M. "Issue Brief 4. Cultural Competence and Health Literacy. Making Your Health Promotion Program Accessible to Diverse Groups of Older Adults." *Live Well Live Long Health Promotion and Disease Prevention for Older Adults*. 2006. American Society on Aging. Accessed July, 21009. <http://www.asaging.org/cdc/issue_briefs/Issue_brief_4.pdf>

"Effective Verbal and Written Communication with Other Cultures." *Clear Health Communication Program*. The Ohio State University Medical Center College of Medicine, Area Health Education Center. Accessed July 2009. <http://medicine.osu.edu/ahec/8485.cfm>

Family Strengthening Policy Center, Policy Brief. An Initiative of the National Human Services Assembly. Community Health Workers: Closing Gaps in Families' Health Resources. Policy Brief No 14. March 2006.

Gutierrez, L.M., Parsons, R.J. & Cox, E.O. *Empowerment in Social Work Practice: A Sourcebook.* Pacific Grove, California: Brooks/Cole Publishing Company. 1998.

"Health DATA Train the Trainer Project." *UCLA Center for Health Policy Research*. 1-3.

"Health Literacy Limited for Many Americans." *Healthcare 411.* U.S. Department of Health and Human Services Agency for Healthcare Research and Quality. Podcast 18 June 2008. HRSA. Accessed July, 2009. <http://healthcare411.ahrq.gov/radiocastseg.aspx?id=801&type=seg>

Heller, Darryl. "Train the Trainer: Darryl Heller, Affordable option brings knowledge in-house." *TechSoup.* 11 Oct 2002. 2 Dec 2008. <http://www.techsoup.org/learningcenter/training/archives/page10082.cfm>.

Hilts, L. & Krilyk, B.J. "Write readable information to educate". Hamilton, Ontario: Chedoke-McMaster Hospitals and Hamilton Civic Hospitals. (1991).

Ide, Elizabeth. "RE: Removing the Barriers." E-mail to Patricia J. Terstenyak. 6 Feb 2008.

Lee, J.A.B.. *The Empowerment Approach to Social Work Practice: Building a Beloved Community* (2nd ed.). New York: Columbia University Press. 2001.

"Motivational Interviewing: resources for clinicians, researchers and trainers." *The Mid-Atlantic Addiction Technology Transfer Center: Motivational Interviewing Resources, LLC.* Accessed July, 2009. < http://www.motivationalinterview.org/ >

Mutha, Sunita, and Carol Allen. "Cultural Competency for California Public Health Staff: Train-the-Trainer State Partnership Project." *The Center for the Health Professions, University of California.* Sept 2004.

National Patient Safety Foundation Press Release. "New Report Estimates the Cost of Low Health Literacy Between $106 - $236 Billion Dollars Annually." *National Patient Safety Foundation*. 10 October 2007. Accessed July, 2009. <http://npsf.org/pr/pressrel/2007-10-11.php>

Orfaly, Rebecca A, et. al. "Train-the-trainer as an Educational Model in Public Health Preparedness." *Journal of Public Health Management Practice.* Nov (Suppl) (2005): S123-S127.

Osborne, H. *Health Literacy from A-Z.* Sudbury, M.S.: Jones & Bartlett Publishers. 2004.

Partnership for Clear Health Communication. "Ask Me 3." *Program Partnership for Clear Health Communication at the National Patient Safety Foundation. Accessed July, 2009.* <http://www.npsf.org/askme3/>

Potter, L. "Strategies to Assist Low-Literate Health Care Consumers." *Health Literacy Fact Sheets.* August 2005. Center for Health Care Strategies, Inc. July, 2009. <http://www.chcs.org/publications3960/publications_show.htm?doc_id=291711>

Robbins, S.P., Chatterjee, P., & Canda, E.R. *Contemporary Human Behavior Theory.* Boston: Allyn & Bacon. 1998.

Ross, Martha, and Kathy Patrick. "Leaders Among Us: Developing a Community Health Worker Program in Washington, DC." *The Brookings Institution*. Oct(2006): 1-10.

Rudd, R. Literacy and Health, *Health Literacy PowerPoint Presentation.* Harvard School of Public Health, National Center for the Study of Adult Learning and Literacy.

Rudd RE, Kirsch I, Yamamoto K. *Literacy and Health in Americ*a. ETS Policy Report #19. Princeton NJ: Educational Testing Services. 2004.

School of Social Welfare, The. "Assessing Strengths: What are Strengths?" *The University of Kansas, Lawrence Campus*. Accessed July, 2009. <http://www.socwel.ku.edu/Strengths/about/assessingStrengths.shtml>

"Sharing Health Information Effectively Through Plain Language Writing". Cleveland Reads Workshop for the Cleveland Department of Public Health. February, 2009

"Simply Put: Scientific and Technical Information". 2nd ed. Centers for Disease Control and Prevention. Office of Communication. Atlanta, Georgia. April, 1999.

Skeff, Kelly. Transcript from session. "Successful Models of Faculty Development Train the Trainer Model."

Turner, F.J. (ed).. *Social Work Treatment: Interlocking Theoretical Approaches* (4th ed.). New York: Free Press. 1996.

The Joint Commission. "What Did the Doctor Say?:" Improving Health Literacy to Protect Patient Safety. Oakbrook Terrace, Illinois: The Joint Commission. 2007.

"Unequal Treatment: What Health Care Providers Need to Know About racial and Ethnic Disparities in Healthcare." Report Brief. *Institute of Medicine of the National Academies.* 25 May 2005. Accessed July 2009. <http://www.iom.edu/CMS/3740/4475/4175.aspx>

"United Health Communications 101: Addressing Health Literacy, Cultural Competency and Limited English Proficiency." *U.S. Department of Health and Human Services.* Health Resources and Services Administration. 26 February 2009. HRSA. Accessed July, 2009. <http://www.hrsa.gov/healthliteracy/training.htm>

Van Brackle, L. and Lawrence, W. *Plain Language Institute: Handouts and Resources for Community Organizers, Health Advocates and Literacy Providers.* Literacy Assistance Center. New York. 2009.

Zimmerman M. & Rappaport, J. Citizen participation, perceived control, and psychological empowerment. American Journal of Community Psychology. 1988 Oct; 16 (5):725-50.