



HEALTH LITERACY PRACTICES IN PRIMARY CARE SETTINGS: EXAMPLES FROM THE FIELD

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ABSTRACT: Low health literacy is widespread among U.S. patients, yet limited research has been done to assess the effects of health literacy practices designed to combat the problem, particularly among safety-net providers in primary care settings. This report presents findings from a 2005 study in which the Association of Clinicians for the Underserved first did an online survey of health care facilities across the country and then followed it up with visits to five selected sites for staff and patient interviews. The study identified five health literacy practices that staff considered especially valuable for their group's patients and potentially applicable to other clinics: a team effort, beginning at the front desk; use of standardized communication tools; use of plain language, face-to-face communication, pictorials, and educational materials; clinicians partner with patients to achieve goals; and organizational commitment to create an environment where health literacy is not assumed.

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EXECUTIVE SUMMARY

One might think that “health literacy,” defined by the Institute of Medicine as the ability to read, understand, and act on health information, is something we could take for granted in this technologically advanced society. On the contrary, health *ill*iteracy—or, more discreetly stated, low health literacy—is widespread. Patients with low health literacy are at greater risk of misunderstanding treatment recommendations, having problems in accurately taking prescription medications, and experiencing lower health status and poorer health outcomes.

Although low health literacy can affect all populations, it is a particular problem among those of modest financial means, many of whom are older adults or people with limited education or English proficiency. Patients’ inadequate levels of health literacy may therefore be especially challenging to clinicians serving as safety-net providers in primary care settings. Yet limited research has been conducted on the scope of the “health literacy practices” employed by front line providers and on how they are meeting the needs of their patient populations. (“Health literacy practices” refer to all patient-centered care activities and protocols involving assessment of patients’ health literacy or actions taken either to improve their low health literacy or minimize its negative consequences.)

Study Goals and Methods

This report aims to help fill the void by identifying health literacy practices that safety-net providers commonly use to improve communication with patients during clinical visits. The report focuses in particular on five promising practices identified during a two-phase descriptive study conducted by the Association of Clinicians for the Underserved (ACU) in 2005. In the first phase, ACU invited primary care clinicians and health care facilities across the country to report, by means of an online survey, the health literacy practices they used with their patients to assist them in understanding their health conditions, treatment options, and treatment plans.

In the second phase, five primary care sites were selected, from the online-survey sample pool of 678 respondents, to participate in more detailed analysis. Selection criteria included diversity of facility type, geographic location, and population served. ACU then visited these five sites to gather additional information. In-depth, face-to-face interviews were held with clinicians and other facility staff, and a sample of adult patients from each of the five sites was interviewed as well.

Promising Health Literacy Practices in Primary Care Settings

The online survey and the site visits revealed five health literacy practices that staff considered especially valuable for their group's patients and potentially applicable to other clinics:

Promising Practice 1: A team effort, beginning at the front desk

Clinicians felt that the entire care team, from reception area to checkout, should be involved. Each team member has an obligation to know if the patient is challenged by health literacy issues and to share this information, formally or informally, with other members. In that way, the care team can work collaboratively to meet the patient's needs. In providing the patient's health care per se, physicians should not act alone but also rely on physician assistants, nurse practitioners, medical assistants, clinical pharmacists, nursing staff, and other members of the care team to restate directions and explanations concerning treatment plans and medication dosing and to provide patient follow-up.

Promising Practice 2: Use of standardized communication tools

Clinicians responding to the online survey, as well as those who participated in the interviews, generally have had little exposure to, and lack knowledge of, formal communication strategies. They report that they usually do not use Teach Back, Ask Me 3, or Motivational Interviewing (see [Appendix D](#) for discussion of these strategies). Yet, when explaining the strategies they do use, they articulate an adaptation of one or a combination of these formal techniques. Meanwhile, clinicians who expressly use Teach Back, Ask Me 3, or Motivational Interviewing report that these techniques are quite effective at improving communication.

Promising Practice 3: Use of plain language, face-to-face communication, pictorials, and educational materials

Clinicians in the online survey tended to report that certain common-sense approaches were quite effective at improving their communication with patients. These include:

- Use of plain language, free of medical jargon
- Sitting face-to-face with the patient
- Use of simple diagrams or pictograms to illustrate explanations
- Use of educational materials geared to low health literacy individuals.

The clinicians interviewed often spoke about repeating their directions and recommendations, just to be sure they are being heard, and frankly asking patients whether they understand

their treatment plan, purpose of any medications, and the dosing of those drugs. Similarly, the care teams and administrators at the facilities visited recognize the value of having forms and educational materials on hand that are culturally and linguistically targeted to each population group they serve and are at the appropriate literacy levels.

Promising Practice 4: Clinicians partner with patients to achieve goals

Clinicians at some health facilities conduct literal goal-setting with their patients and collaborate to achieve those goals. The process necessarily includes patients' agreement to work toward specific goals as well as formal mechanisms for verifying whether patients understand and are pursuing their treatment plans, prescriptions, and dosing.

Promising Practice 5: Organizational commitment to create an environment where health literacy is not assumed

Health literacy practices are most successful at health care facilities that have infused them as part of the operating philosophy, provided in-service training and new-employee orientation, and perhaps even participated in a research study on health literacy.

The Patients' Perspectives

Interviews with patients were conducted during the site visits in order to discern how they felt about communication with their clinicians there. These patients expressed satisfaction with the care site and its clinicians, who seemed to be concerned about them and carefully listened to them. They connect with these providers, build relationships with them, trust their treatment recommendations, and, to the extent possible, seek them out regularly for continuity of care. In addition, patients said that if they are engaged in partnership with their clinicians they feel a high level of confidence in their ability to manage their medical conditions at home.

Barriers to Implementing Health Literacy Practices

Administrators and clinicians alike—both in the online survey and site visits—were optimistic about ultimately realizing their goals regarding health literacy practices. They also, however, cited some potential barriers, of which the most commonly mentioned were:

- Staff members' belief that low health literacy is not a problem or is considered low-priority when compared with other problems
- Staff members' belief that there is not enough time to implement a health literacy program
- Their concern that the health facility does not have the monetary resources to implement a program.

Recommendations

This report's findings suggest that patients can receive high-quality patient-centered care regardless of any difficulties they may initially have with low health literacy. Toward that end, the report offers 12 recommendations grouped into three distinct categories:

- Prepare clinicians for health literacy practices through their health professional training, both formal and informal
- Improve quality of care in primary care settings
- Advance the research agenda

The report's recommendations are thus directed at clinicians, the health care facilities where they work, their sources of training, and the researchers (as well as the organizations that fund them) who study the outcomes of patient literacy practices.

HEALTH LITERACY PRACTICES IN PRIMARY CARE SETTINGS: EXAMPLES FROM THE FIELD

INTRODUCTION

One might think that “health literacy,” defined by the Institute of Medicine (IOM) as the ability to read, understand, and act on health information, is something we could take for granted in this technologically advanced society. On the contrary, health *ill*iteracy—or, more discreetly stated, low health literacy—is widespread. In its 2004 report *Health Literacy: A Prescription to End the Confusion*, the IOM documents that 90 million individuals, nearly half of all American adults, failed to meet its definition.¹ The problem, moreover, is deeply embedded and not easy to remedy. The U.S. Department of Education reported in 2006 that very little change had occurred in the national level of health literacy over the 11 years between its studies.²

Not surprisingly, many individuals with low health literacy have difficulty managing chronic illnesses.^{3,4,5} According to a study of such patients with diabetes, they were less likely to have effective glycemic control and more likely to report vision problems.⁶ Similarly, other studies show that low-health-literacy patients are less likely to share in decision-making about prostate cancer⁷ or to adhere to anticoagulation therapy.^{8,9}

Generally speaking, patients with low health literacy are at greater risk of misunderstanding treatment recommendations, having problems in accurately taking prescription medications, and self-reporting lower health status and poorer health outcomes.^{10,11} Consequently, they have a 52 percent greater risk of being hospitalized.¹² It is estimated that nonadherence, or failure to take medications, results in 125,000 deaths annually and costs an estimated \$100 billion in treatments and lost productivity.¹³

STUDY GOALS AND METHODS

Although low health literacy can affect all populations, it is especially problematic among those of modest financial means, many of whom are older adults or people with limited education or English proficiency.^{8,9,10} Patients’ inadequate levels of health literacy may therefore be especially challenging to clinicians serving as safety-net providers in primary care settings.

Yet limited research has been conducted on the scope of the “health literacy practices” employed by front-line providers—in community health centers (CHCs), federally qualified health centers (FQHCs), free clinics, or integrated public health

departments, for example—and on how they are meeting the needs of their patient populations. Previous health literacy studies have mostly been disease-specific and focused on hospital-based settings. (“Health literacy practices” refer to all patient-centered care activities and protocols involving assessment of patients’ health literacy or actions taken either to improve their low health literacy or minimize its negative consequences.)

This report aims to help fill the void by identifying health literacy practices that safety-net providers commonly use to improve communication with patients during clinical visits. The report focuses in particular on five promising practices identified during a two-phase descriptive study conducted by the Association of Clinicians for the Underserved (ACU) in 2005. In the first phase, ACU invited primary care clinicians and health care facilities across the country to report, by means of an online survey, the health literacy practices they used with their patients—especially those in underserved, uninsured, or underinsured adult populations—to assist them in understanding their health conditions, treatment options, and treatment plans.

In the second phase, five primary care sites were selected, from the online-survey sample pool of 678 respondents, to participate in more detailed analysis. Selection criteria included diversity of facility type, geographic location, and population served. ACU then visited these five sites to gather additional information about the facilities’ existing health literacy practices and to assess the degree to which they improve interaction and communication between the patient and his or her clinical team.

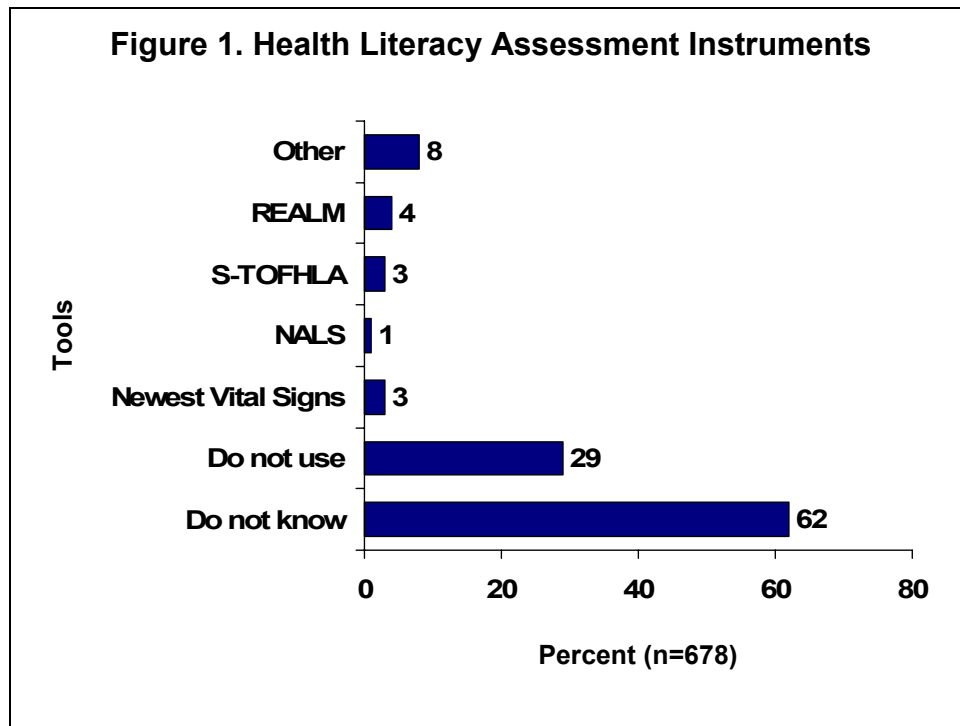
In-depth, face-to-face interviews were held with physicians, nurse practitioners, nurses, pharmacists, medical assistants, physician assistants, chronic-disease educators, and *promotoras* (Hispanic-community outreach workers) as well as administrators and front-desk staff. The ACU researchers’ aims were to learn about the kinds of health literacy practices that clinicians tended to use the most; the communication techniques that patients seemed to respond to best; and the providers’ perceptions of patients’ ability to manage their care when at home.

A sample of adult patients from each of the five sites was also interviewed, with several purposes in mind: to learn their perceptions of clinicians’ abilities to communicate with them at an appropriate level; to determine whether such interactions helped patients successfully manage their care; to ascertain whether clinicians’ health literacy practices increased patient trust and confidence; and to assess patients’ perceptions about quality of care. (For a more detailed description, please see the project methodology in [Appendix A](#).)

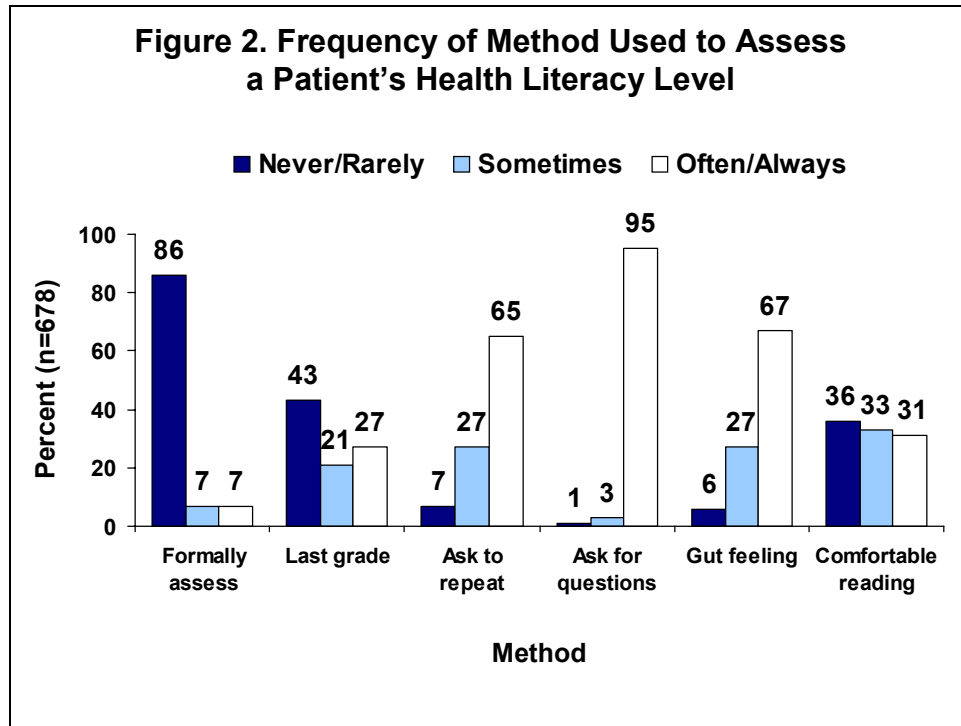
Sites that agreed to participate represented Federally Qualified Health Centers (FQHCs) and federally funded Community Health Centers (CHCs) in urban, suburban, rural, and frontier areas. They included:

- Ajo Community Health Center (Frontier, FQHC)
Ajo, Arizona
- Center for Family Health (Suburban, FQHC)
Jackson, Michigan
- Ferguson Adult Health Center of the Cherry Street Health Services (Suburban, CHC)
Grand Rapids, Michigan
- Community Health Partners, Inc. (Rural, FQHC)
Livingston, Montana
- Parkland Health and Hospital System, East Dallas Health Center (Urban, FQHC)
Dallas, Texas

While personnel at these clinics were glad to identify the practices they engaged in under the rubric of health literacy, in most cases these techniques were adapted or improvised, as opposed to being formal methods. Such methods are actually small in number, including: the Newest Vital Signs test for assessing patients' health literacy levels; the Rapid Estimate of Adult Literacy in Medicine (REALM); the short form of the Test of Functional Health Literacy in Adults (S-TOFHLA); the National Adult Literacy Survey (NALS); and a few other more informal techniques developed by clinicians at particular groups primarily for use in their facility. In any case, practitioners at the five visited sites made little use of the formal techniques, as shown in Figure 1, in large part from lack of knowledge. Although most clinicians felt it was their responsibility to assess the literacy levels of their patients, very few of these providers knew of or used formal assessment tools to determine them.



Even those clinicians familiar with validated assessment instruments tended to use other, more informal strategies to assess the literacy levels of their patients (Figure 2). They took histories, provided questionnaires, engaged in conversations with patients, asked if they understood the instructions, and asked the patients to repeat them. Some clinicians, though fewer in number, relied on the last grade completed or patients’ response to being comfortable with reading as indicators of their ability to understand. Clinicians often reported simply relying on their gut feelings—in response to patients’ behaviors, questions asked, characteristics, and attitudes—to determine individuals’ levels of health literacy. Such approaches rely on the clinicians’ interpersonal skills to build relationships with their patients that are open, communicative, and trusting. While these types of relationships are strongly encouraged and support patient-centered care, development of practical evidence-based tools would be useful as well to help standardize health literacy practices.



PROMISING HEALTH LITERACY PRACTICES IN PRIMARY CARE SETTINGS

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The front-desk and triage personnel, for example, play an important role in setting a positive tone for the visit, as these staff members are the people who patients see when entering and leaving the clinic. They assist patients with filling out paperwork and guide them to where they need to go. At times, the front-desk personnel also serve as a liaison between patients and the care team by listening to patient feedback at checkout. At Community Health Partners (Livingston, Mont.), patients are given clipboards so that they may take notes during their visit; any unanswered question can be addressed prior to leaving the clinic. In some clinics, such as Ajo Community Health Center (Ajo, Ariz.), patients are given forms that encourage them to express any outstanding concerns or to compliment (or complain about) individual staff members, as appropriate.

Physicians typically do not act alone in providing the health care per se. They also rely on physician assistants, nurse practitioners, medical assistants, clinical pharmacists, nursing staff, and other members of the care team to restate directions and explanations concerning treatment plans and medication dosing and to provide patient follow-up. At the Center for Family Health (Jackson, Mich.), staff frequently telephone patients, especially young mothers or elderly individuals with cognitive disabilities, shortly after a visit in order to ensure that medications and other recommendations are understood and being carried out.

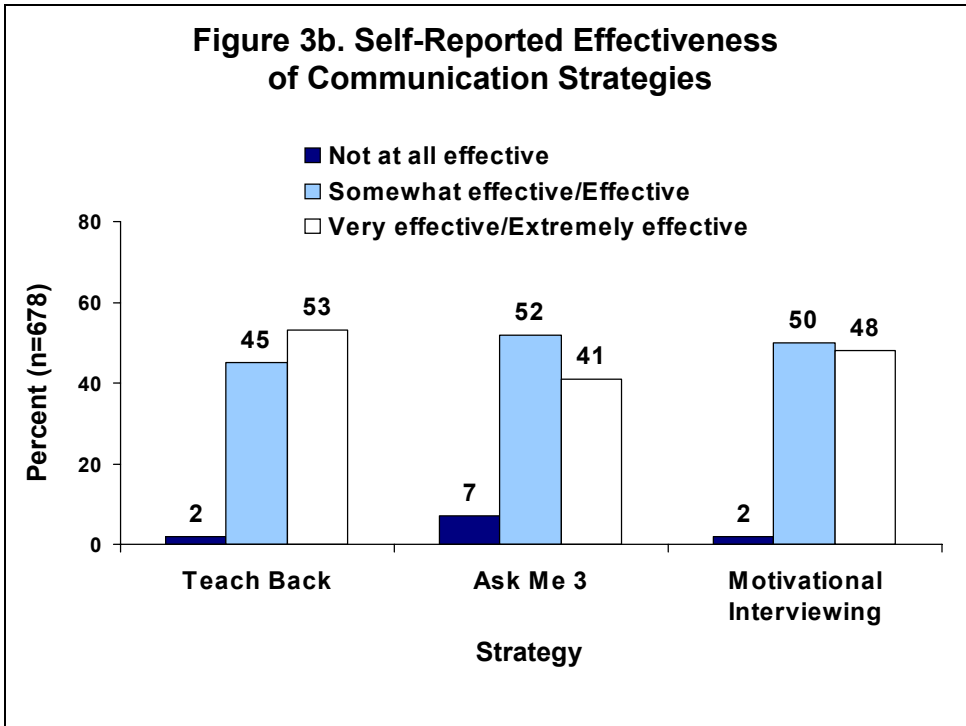
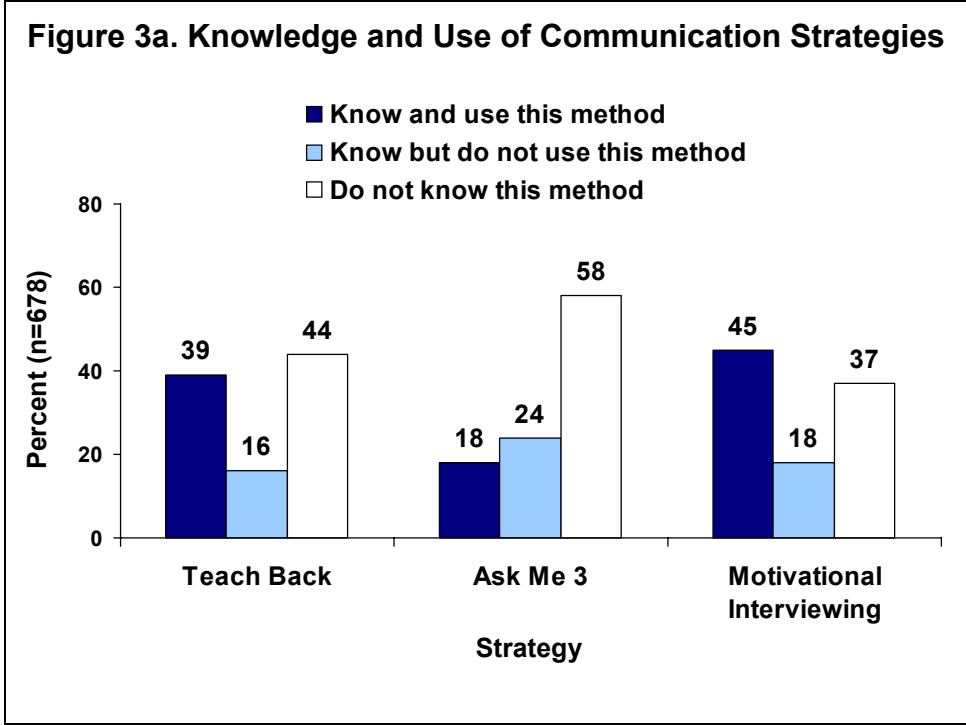
One clinician stated, “If patients don’t understand what’s going on, they won’t know why they have to do the things we are telling them to do and will most likely not do them.”

A patient at the East Dallas Health Care Center is greeted by a clinical staff assistant, who administers a Learning Assessment and a Psychosocial Screening to help clinical staff members understand the patient’s level of health literacy and his or her stress level. The assistant’s review of the patient’s filled-out paperwork also serves in part as a literacy assessment. Immediately following the visit with the provider, a nurse meets with the patient to review the treatment plan and answer any questions. At discharge, the clinical staff assistant also checks, one last time, to determine whether there were any unanswered questions the patient may have felt uncomfortable asking the doctor or nurse.

Promotoras at Ajo Community Health Center assist nursing staff with patient check-in processes, help provide explanations to the patients, and offer information on chronic diseases. They are also available to help patients with eligibility requirements for Medicaid and other types of assistance for the uninsured, decipher health plan requirements, or fill out paperwork such as Medicare Part D applications. If a patient is diagnosed with diabetes, he or she is often accompanied to a diabetes educator (a registered nurse) or a *promotora*, who can spend more time with the patient, further explain the treatment plan, and provide information about diabetes self-management (including basic nutrition guidelines).

Promising Practice 2: Use of standardized communication tools

Clinicians responding to the online survey, as well as those who participated in the interviews, generally have had little exposure to, and lack knowledge of, formal communication strategies. As shown in Figure 3a, they report that they usually do not use Teach Back, Ask Me 3, or Motivational Interviewing (see Appendix D for discussion of these strategies). Yet, when explaining the strategies they do use, they articulate an adaptation of one or a combination of these formal techniques. Meanwhile, clinicians who expressly use Teach Back, Ask Me 3, or Motivational Interviewing report that these techniques are quite effective at improving communication, as shown in Figure 3b.



At East Dallas Health Care Center, clinicians report using the Teach Back method to ensure that patients understand their treatment plan, to help them set goals for their health, and to support the patients in reaching those goals. At Community Health Partners, clinicians are trained in and encouraged to use the Teach Back method and

Motivational Interviewing, together with drawings and plain language, to communicate health information to patients. Staff has also adapted the Ask Me 3 approach to make it clinician-driven: instead of the patient being required to ask the clinician three questions, the clinician asks the questions in order to encourage dialogue and determine what the patient wants to focus on during the visit.

The Health Literacy Committee at the Center for Family Health is currently in the process of implementing the Ask Me 3 strategy by encouraging patients to ask their clinician questions that will help them better understand their health and increase compliance with treatment. Meanwhile, the committee is encouraging clinicians to use the Teach Back method to verify that patients have understood their treatment plan. Among the clinicians responding to the online survey, as well as those participating in the interviews, those who use Motivational Interviewing report that this technique is effective with their patients.

Whether they use these formal techniques or not, clinicians are most familiar with the following four communication strategies:

- Health-education materials designed for patients with low reading levels
- Individualized health-education sessions for patients with low health literacy
- Giving patients the opportunity to bring a family member or friend to the appointment
- Using dedicated health literacy specialists at the health facility.

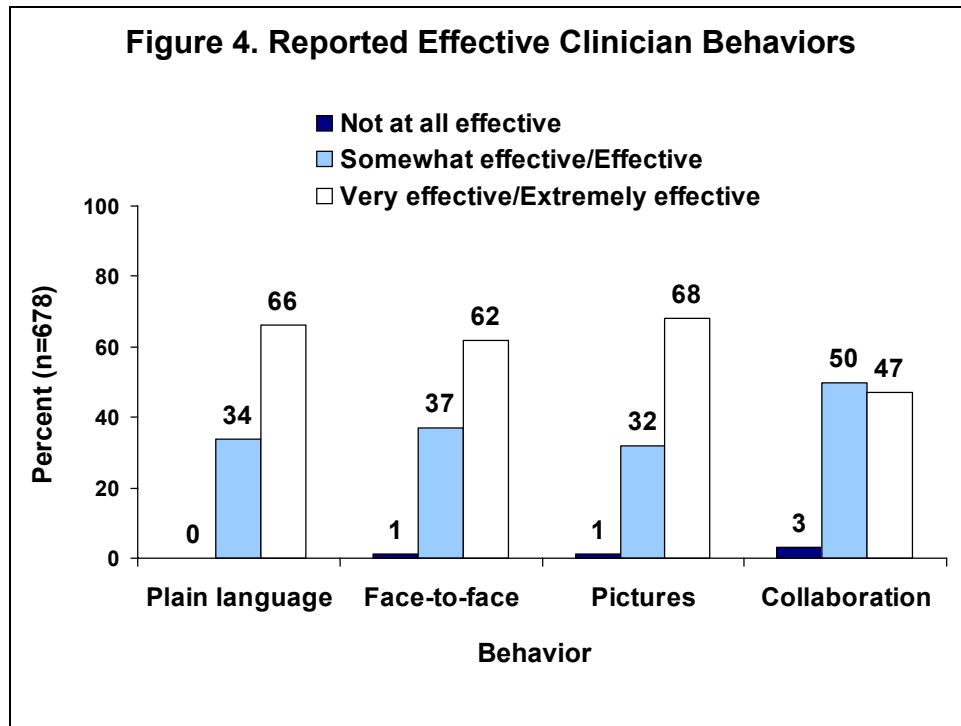
The five clinics visited did not have a dedicated health literacy specialist available on-site, but outreach workers and other staff members often assumed this role. Health facilities also employ other strategies, such as making referrals to a social worker, to assist patients with low health literacy.

Promising Practice 3: Use of plain language, face-to-face communication, pictorials, and educational materials

Clinicians in the online survey tended to report, as shown in Figure 4, that certain common-sense approaches were quite effective at improving their communication with patients. These approaches include:

- Use of plain language, free of medical jargon
- Sitting face-to-face with the patient

- Use of simple diagrams or pictograms to illustrate explanations
- Use of educational materials geared to low health literacy individuals.



The clinicians interviewed often spoke about repeating their directions and recommendations, just to be sure they are being heard, and frankly asking patients whether they understand their treatment plan, purpose of any medications, and the dosing of those drugs. To increase the likelihood of such comprehension, Ajo Community Health Center clinical staff members are trained to use everyday language and avoid jargon (or clearly define it) with their patients. At the Ferguson Adult Health Center of the Cherry Street Health Services (Grand Rapids, Mich.), providers are allowed 30-minute visits with patients. This not only offers the parties a better opportunity to build their relationships but also gives patients more time to get their questions addressed.

Similarly, the care teams and administrators at the facilities visited recognize the value of having forms and educational materials on hand that are culturally and linguistically targeted to each population group they serve and are at the appropriate literacy levels. At Ajo Community Health Center, a fourth-grade literacy level is generally applied when translating forms or devising curricula for any type of patient education. Much of that education is done in group format, which helps build peer support and widens the information’s reach.

The Center for Family Health has developed several health-education brochures targeted to its patient population. The center has also revised the forms that patients are asked to complete; the aim of these revisions was simplicity, both in language and layout. Welcome letters, as well as letters sent to patients for billing purposes, have also been revised to use simpler language and design. And all printed educational materials are reviewed by a Health Literacy Committee for literacy levels, as well as cultural and linguistic appropriateness, before being placed in display racks. Bulletin boards in the waiting rooms are also carefully placed and composed to achieve maximum visibility and impact on the patients while not overloading them with too much information.

“The better you understand your body and its illness,” said one clinician, “the better you are able to change and take care of yourself.”

At Parkland Health and Hospital System (Dallas, Tex.), the patient-education specialist and the Housewide Patient/Family Education Committee have created many of the facility’s own patient education materials—at a fourth- or fifth-grade literacy level, in English and Spanish, and using appropriate graphics and page layout. These materials have been compiled in a *Materials Catalog* that is now accessible through the Parkland Web site (www.parklandhospital.com), as well as through the Parkland Intranet. A quarterly newsletter informs all staff throughout the Parkland system of new and updated materials that can be ordered in quantities through the print shop. In addition, the patient-education specialist and the committee have developed a manual, called *Patient Education Procedure* that outlines health literacy practices and provides resources, such as health literacy education handouts, for staff. These handouts, some of which are available on the Website, include “Choosing and Writing Materials for Patients with Low Health Literacy,” “Determining the Reading Level of Your Material,” “Graphics for Patient-Education Materials,” and “Guidelines for Teaching Patients with Low Health Literacy,” among others.

Promising Practice 4: Clinicians partner with patients to achieve goals

Certain health facilities’ clinicians conduct goal setting with their patients and work together to achieve the goals. At the beginning of a clinical visit at the Cherry Street Health Services’ Ferguson Adult Health Center (FAHC), the medical assistant asks the patient to select one health goal from the “Patient Goal Contract,” which graphically displays a range of choices such as losing weight or reducing stress. The patient may also opt for a personal goal that is not on the list. From that point on, FAHC clinicians and staff partner with the patients to help them reach their goal; and once it is achieved, they help them set and endeavor to reach another one. FAHC has also created “Taking Care of

My Health,” a pocket-sized record of A1c levels (for the benefit of people with diabetes), cholesterol levels, and blood-pressure levels that allows patients to see the progress they are making and, it is hoped, motivate them to continue pursuing their goal.

Each of the health care facilities visited has instituted a mechanism for verifying whether patients understand their treatment plans, prescriptions, and dosing. At FAHC, the medical assistant is central to that verification. Before patients are seen by a clinician, they not only set or reaffirm their goal with the medical assistant but also go through a review in which they tell the assistant how and when they take their medications. Patients are asked to bring all their medications to each visit for this purpose. Once the provider sees the patient, the medical assistant returns to the exam room to review the treatment plan, ask the patient to state what he or she is going to do at home, and ask if any questions remain.

A visit to Community Health Partners (CHP) starts with the patient’s check-in, where initial health information is gathered by a patient-visit coordinator or medical assistant. After the provider visit, a nurse immediately follows up with the patient to summarize the visit and make sure that he or she understood what was discussed with the clinician. At this time, patients can also be directed to other on-site services or programs such as Pharmacy, Behavioral Health, or Learning Partners. CHP also employs a case manager who helps patients navigate the health care system.

Promising Practice 5: Organizational commitment to create an environment where health literacy is not assumed

In some health care facilities, health literacy practices were established because administrative leadership supported their integration throughout the clinic. Physicians themselves have often admitted that they were not familiar with health literacy concepts or practices until they joined a health care facility that had infused it as part of the operating philosophy, provided in-service training and new-employee orientation, and perhaps even participated in a research study on health literacy. At other clinics, health literacy practices began as a result of clinicians’ previous involvements elsewhere—in other health “collaboratives,” perhaps, where providers used established communication techniques with their patients. Regardless of the impetus, clinicians are increasingly realizing that there is a link between a person’s health literacy and his or her health.

Because posters and flyers that decorate the walls of clinics’ waiting rooms and hallways can instill anxiety in patients who are unable to read or understand medical jargon, the Center for Family Health removed them. In that way, staff was helping to

create a nonthreatening environment, where literacy was not assumed and true communication and trust building could occur. The center's current policy is that any materials posted on the walls must first be reviewed for their literacy level as well as their cultural and linguistic appropriateness.

"If a doctor is unable to communicate with a patient," a clinician points out, "then the patient has little chance for disease-management success and is unlikely to make healthful lifestyle or behavioral changes."

The bulletin board in the waiting room at Community Health Partners (CHP) uses simple words and actual objects stapled onto the board to graphically communicate self-management tools to patients. CHP has also designed a graphic message, posted in all exam rooms, that encourages patients to become engaged in managing their own health. Each exam room also contains a clipboard so that patients may write down questions while they wait for their doctor or take notes during the visit.

Two of the primary care health facilities visited have created work groups or committees focused on some aspect of health literacy such as materials development, patient education, or staff training. For example, the Housewide Patient/Family Education Committee (HP/FEC) at the Parkland Health and Hospital System in Dallas is made up of representatives from numerous departments—including but not limited to Day Surgery, Pharmacy, Nursing, Emergency Room, Physical Medicine, Respiratory Care, and Dietetic Services—which facilitates coordination of materials throughout the patient care areas. The committee, in collaboration with Parkland's patient-education specialist, has developed the *Patient Education Procedure*, a guide to assessing a patient's learning needs, setting goals, and implementing a teaching plan. The committee also oversees patient-education activities throughout the Parkland system.

The Center for Family Health has created a Health Literacy Committee, made up of representatives from each department, which meets monthly. The committee focuses on three main strategies: creating a nonthreatening environment for patients by simplifying and reducing signage; developing simplified forms and health-education materials; and training the center's staff to communicate more effectively with low-health-literacy patients. For example, it has developed an extensive health-literacy training module, which includes the American Medical Association's Low Health Literacy video. This training is provided at the periodic all-staff retreats.

As primary health care centers engage more and more in health literacy activities, they are establishing orientation sessions for new employees as well as providing training

for other staff. At orientation, all new hires of Cherry Street Health Services (CSHS) learn about low health literacy and its implications, in part through a shortened version of the health-literacy training module developed by the Center for Family Health. Currently, CSHS is working to make health literacy a core competency for all employees; the clinic currently has a self-study module that it plans to use for health-literacy recertification each year.

At CHP, new employees receive two hours of health-literacy training as part of their orientation, and all staff members have to complete 32 hours of motivational-interviewing and patient-self-management training. This facility is unique in that it is physically connected to Learning Partners—an adult-education center that provides basic education, GED preparation, ESL, and Even Start Family Literacy education—which benefits patients and medical staff alike. All patients interested in improving their health literacy, and education in general, are welcome to participate in the Learning Partners’ programs. Learning Partners’ staff routinely attend CHP staff meetings in order to help integrate health-literacy awareness into the clinical setting.

CHP staff members are trained to provide patient-centered care and to engage patients in learning more about their particular health conditions. Clinicians are trained as well in formulating treatment plans with patients’ priorities and degree of readiness for change in mind—meeting the patients, so to speak, “where they are.” Lunch and Learn workshops, covering a wide range of clinical topics, are offered to staff, and the importance of health literacy is regularly stressed during staff meetings. CHP’s goal, it maintains, is to employ health literacy practices with every patient, every time.

In cooperation with the HP/FEC, Parkland’s patient-education specialist has developed an hour-long health literacy training that all new nurses receive as part of a two- to four-day orientation. They are given an overview of patient education in general and trained in the elements of working with low-health-literacy patients in particular. The nurses are informed about different patient-education materials and resources available at Parkland, as well as how to select appropriately from among them and, when indicated, to create their own materials.

Each quarter, a daylong training session on the “Process of Patient Education” is offered to staff at Parkland. This training includes techniques for communicating with low-health-literacy patients. Once a year, a class on how to create picture boards is also provided. Picture boards are tools, used in numerous medical departments that graphically display health care–related words or terms while also defining them in four different languages: English, Spanish, Vietnamese, and Khmer (Cambodian).

Once a year, Ajo Community Health Center staff members receive training in cultural competency and diversity issues. The staff also receives external team-building and cultural sensitivity training.

THE PATIENTS' PERSPECTIVES

Interviews with patients were conducted during the site visits in order to discern how they felt about communication with their clinicians there. These patients expressed satisfaction with the care site and its physicians, and they spoke of friendly clinical staff that seemed to be concerned about them and carefully listened to them. Patients said they appreciated clinicians who walk into an exam room with a smile, greet them, and seem happy to be there. They connect with these clinicians, build relationships with them, trust their treatment recommendations, and, to the extent possible, seek them out regularly for continuity of care. In addition, patients said they feel comfortable in recommending their doctor to a family member or friend. They also noted a sense of clinician accountability that they said is a motivator for them to take better care of themselves.

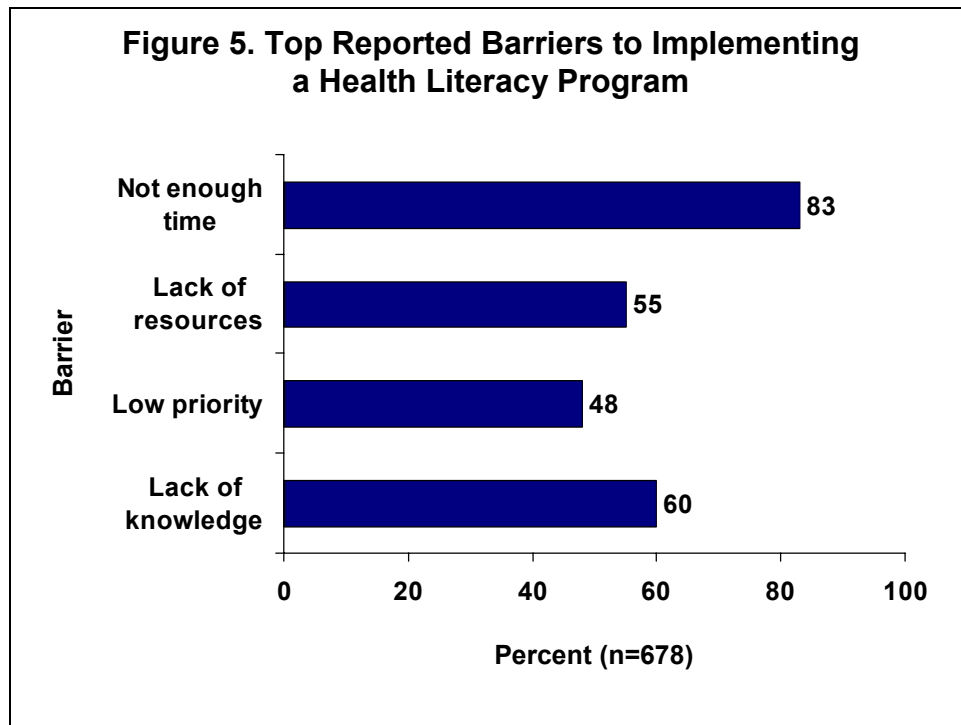
Patients stated during the interviews that if they are engaged in partnership with their clinician they feel a high level of confidence in their ability to manage their medical conditions at home. This result may be linked to patients' reports that they always understand the instructions given to them by their clinicians, who do not use words they cannot understand. Patients said that when something is confusing, they feel comfortable about asking questions, in part because they have enough time during visits to do so. Patients also report that they rarely leave the facility without their questions having been answered by a member of the clinical team.

It is difficult to know how much of clinicians' instructions these patients do in fact understand. But it is their *perceived* understanding, combined with their trust in and comfort level with the clinical team that increase the patients' self-efficacy and produce the high levels of confidence reported during the interviews.

Some of the patients routinely expressed displeasure with seeking care elsewhere—such as hospital emergency rooms, specialists, and other health care facilities—and they said that they always initially seek care from the site of our interview before turning to another health facility. Patients who indicated such displeasure with other health facilities reported that they did not feel cared about or trust the providers there and would not seek medical services from them again.

BARRIERS TO IMPLEMENTING HEALTH LITERACY PRACTICES

Among the primary-care health facility administrators queried both during the site visits as well as in the online survey, the majority said they were only in the initial phases of integrating health literacy practices into the operations of their facility. Much work remains to be done, they acknowledged, to improve patient health literacy levels and clinician-patient communication. Although administrators and clinicians alike were positive about ultimately realizing these goals, they also cited some potential barriers, the most common of which are shown in Figure 5.



The Belief that Low Health Literacy Is Not a Problem or Is Considered Low-Priority When Compared with Other Problems. Administrators thought that the biggest barriers to implementing a health literacy program were: the lack of staff awareness that low health literacy is a problem; and, if staff did recognize the problem, their view that it has a low priority. According to many administrators, physicians tend to emphasize problems needing immediate attention during the clinical visit, especially with acute-care patients.

Actually, clinicians ranked health literacy as a much higher facility priority than did their administrators. The clinicians, thought that the organizational and operating framework in place at the health care facility limited their use of health literacy practices.

Members of the clinical teams maintained that administrative leadership is uniquely placed to make staff—the whole staff—realize the value of integrating health literacy practices into the facility’s routines. The clinicians felt that if health literacy practices are not incorporated throughout the facility, the impact of one clinician’s efforts may wane once the patient leaves the exam room. Moreover, operating policies and procedures need to be institutionalized at the facility if health literacy practices there are to be sustained.

The Belief that There Is Not Enough Time to Implement a Health Literacy Program.

Some clinicians in the study argued that they have limited time with patients and that use of any health literacy practice might reduce their ability to diagnose and treat. However, according to Schillinger, the Teach Back method in the clinical encounter does not significantly increase time with the patient. As clinicians become more proficient at this method, Schillinger believes, the clinician may in fact streamline the way in which he or she interacts with the patient—and the ways in which messages are given and verified may become more efficient as well as more effective.^{14,15}

The Concern that the Health Facility Does Not Have the Monetary Resources to Implement a Program. Administrators and clinicians alike expressed worry about the funds needed to support health literacy programs at facilities that are already strapped for cash. But while significant monetary resources may be necessary for staff training, needed investments in health literacy practices are relatively minor. Moreover, the benefits of such innovations in the clinical environment—development of new patient intake forms and written health education information, for example, or the engagement of patients to understand their medical conditions, treatment plans, and medications—would appear to far outweigh their modest costs. Unfortunately, few studies have been undertaken to create the business case for health literacy.

RECOMMENDATIONS

The health care system must work to assure that patients receive high-quality patient-centered care regardless of any difficulties they may initially have with low health literacy. This report’s findings suggest that this goal is achievable and that health care providers have specific roles to play. Recommendations include:

Prepare Clinicians for Health Literacy Practices through Their Health Professional Training, Both Formal and Informal

- Clinicians have a responsibility to create environments that support relationships for mutual understanding and decision-making, regardless of the patient’s level of

formal education. They should therefore be required to participate in continuing education or other in-service training—specifically targeting communication and interpersonal-relationship skills—that enhances their competencies in encouraging patient-centered care and patient self-efficacy. Moreover, clinicians should be periodically recertified in these core competencies.

- Health-professional curricula should infuse communication skills and core competencies in health literacy beginning in the first year of training and continuing throughout the entire formal-learning period. In addition, service learning should incorporate the crosscutting issues of health literacy, communication, and cultural competency.

Improve Quality of Care in Primary Care Settings

- The awareness of staff, administrators, and other stakeholders should be raised so that their health care facility sustainably integrates health literacy practices into the organization's culture, policies, and procedures.
- Clinicians need to use plain language during patient visits and simplify complex explanations in order to help patients understand their conditions and make informed decisions about their care.
- Facilities should make health-literacy educational opportunities available for front-desk staff and other nonclinical personnel so that they recognize patients requiring additional support because of low health literacy. Such training enables nonclinical staff to serve as a liaison between the patient and the clinical team.
- The health care facility should seek the input of community advocates, consumers of services, and *promotoras* in developing policies and procedures that support health literacy and quality of care.

Advance the Research Agenda

- Clinicians use informal techniques to learn the general health-comprehension level of the patient but are often unwilling to administer formal assessment tools. In-depth analyses should be made to compare the utility and effectiveness of informal versus formal methods as well as to better understand clinician's frequent reluctance to use the latter.
- Clinicians' health literacy practices during the clinical visit, as well as patients' health outcomes, need to be examined within the context of the organizational environment. The degree to which the health literacy policies and procedures of a

facility need to be systemically integrated and institutionalized should also be documented.

- Evaluation of current promising practices should be conducted to further the development of evidenced-based techniques and tools.
- Health literacy measures should be created for evaluating the effectiveness of specific health literacy techniques.
- Studies should be conducted that examine the health outcomes of patients for whom English is not the primary language and whose care, delivered by English-speaking medical practitioners, relies on interpreters' services.
- Studies should be conducted that examine the health literacy levels of interpreters in English-based primary-care settings to ensure that they accurately communicate health information to patients whose primary language is not English.

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APPENDIX A. STUDY METHODOLOGY AND LIMITATIONS

The Association of Clinicians for the Underserved (ACU) conducted a two-phase exploratory study targeted at clinicians and other health professionals who provide services to underserved, uninsured, and underinsured adult populations in primary care settings. In Phase 1, ACU used an online survey instrument that identified clinicians and health care facilities across the country that were actively participating in health literacy practices or related activities. Clinicians and administrators reported the ways in which they assessed the health literacy levels of their patients and any techniques they used to help patients understand their health conditions, treatment options, and treatment plans.

During the two-month period in which survey data were collected, SurveyMonkey.com was accessed 935 times by individuals interested in the survey. The total sample size was 678. From this sample, ACU identified health care facilities that appeared to have health literacy practices of interest. The majority of survey respondents were physicians (32%), nurses/advanced practice nurses (25%), and administrators (16%) working in Federally Qualified Health Centers in urban settings.

Site selection for the in-depth interviews was based on geographical location, completeness of the survey, and the inclusion of contact information. A pool of 61 potential health facilities was then selected, and ACU contacted each of them by telephone or e-mail. The aim was to conduct an initial assessment of the health literacy practices they used and to gauge their interest in being visited and having their clinical teams and a sample of patients interviewed.

The pool was then narrowed to five health care facilities, from which qualitative data were collected through in-depth, face-to-face interviews with clinical team members and administrators. From these sessions, ACU gathered information about the kinds of assessment tools clinicians used most often, the communication techniques that patients seemed to respond to best, and their perceptions of patients' abilities to manage their care when in the home environment. ACU also interviewed a sample of adult patients from each of the sites to learn their perceptions of clinicians' abilities to communicate with them at the appropriate level, provide answers to their questions, and generally help them achieve success in managing their care. ACU also wanted to determine whether clinicians' practices increased patients' trust and confidence and improved their perceptions about quality of care.

National Health Literacy Advisory Committee, Expert Consultants, and Supporting Organizations

The ACU convened a group of practicing safety-net providers and other health professionals with expertise in primary care, health literacy, cultural competency, and communication. This Health Literacy Advisory Committee advised ACU on each phase of the project. (See [Appendix B](#) for a roster of the committee’s members.) In addition, ACU enlisted the guidance of health literacy experts such as Dean Schillinger, M.D., and Rebecca Sudore, M.D., both of the University of California, San Francisco. And two members of the Health Literacy Advisory Committee—Sharon Youmans, Pharm.D., from the University of California, San Francisco, and Anita Hawkins Smith, Ph.D., of Morgan State University School of Public Health and Policy—lent their expertise in preparing the application for IRB review and in conducting qualitative data analysis.

Prior to the funding of the grant, ACU enlisted the support of some 23 health and health-related organizations and clinical networks to assist in the promotion and dissemination of the Phase 1 survey instrument and to write letters of support to potential funders of the study. These groups, along with new supporters of the study, sent the survey (or notice of availability of the survey) to their constituents through member listservs, electronic newsletters, and Web sites.

Phase 1

Online Survey

The online survey instrument was adapted from the Midwest Clinicians’ Network Health Literacy Survey and the 2002 Interpersonal Processes of Care Questionnaire (IPC-I) developed by the University of California, San Francisco. The survey instrument was pilot tested in three health care facilities by primary care clinicians, and format revisions were then submitted to the IRB for approval. The survey instrument was made available on the Internet through SurveyMonkey.com, an online survey provider.

Phase 2

Site Visits

The ACU made five site visits to primary health care facilities that had reported using what appeared to be innovative health literacy practices. The purpose of the visits was to gather additional information about these facilities and to observe how their practices supported patient-centered communication, helped to improve interactions and communication between patient and clinical team, and enhanced the quality of care.

In-Depth Interviews

Each facility designated a staff member to serve as point of contact for ACU and be responsible for inviting clinicians and patients to participate, voluntarily, in the interviews. While the number of participants at a health facility depended on its size, configuration, and organizational system, ACU research staff interviewed an average of eight members of the clinical team at each site. They included physicians, physician assistants, medical assistants, nurses, nurse practitioners, clinical pharmacists, dietitians, social workers, greeters, front-desk and triage staff, *promotoras*, WIC and outreach workers, administrators, clinic and office managers, and staff-development and educational consultants. As clinicians responded to the open-ended interview questions, they were asked to reflect on their English-speaking adult patients and more specifically on two categories of patients: those who comply with treatment recommendations and are managing their medical conditions at home; and those who have difficulty complying with treatment recommendations and have difficulty managing their medical conditions.

ACU staff interviewed an average of six patients per site. Patient inclusion required that the individual be an adult who had been seen in the clinic during the past 12 months, did not have a visual, hearing, or mental health condition that would limit participation in the interview, and used English as his or her primary language at home. Patients were recruited based on availability. Two of the sites prescheduled patients for the interviews, while the other three sites recruited patients as they arrived for their appointments.

A total of 29 patients—18 women and 11 men—were interviewed at the five sites. Their educational levels ranged from less than fifth grade to college graduate, with a majority of the patients having completed a high-school grade or had some college. Most had been longtime patients at their health care facilities.

Study Limitations

Certain survey limitations should be noted. The study design called for self-reporting—by clinicians, health professionals, and health and health-related organizations. As with any self-reported information, the data collected in the study were based on respondents and interviewees reporting their opinions and personal knowledge. In addition, ACU partnered with some 23 health and health-related organizations that willingly promoted and disseminated the online survey to its members and constituents. As a result, it is difficult to assess the total reach of dissemination as well as the total universe of sites using health literacy practices.

The study did not include sites that may have been conducting health literacy or patient-centered communication activities not generally viewed at present to be within the context of health literacy. Because it is a relatively new concept, community-based organizations and safety-net providers unfamiliar with the terminology of “health literacy” often do not consider their activities under its rubric even if they in fact address it. Consequently, the survey appears directed to those practitioners familiar with health literacy and who, when appropriate, labeled their clinical activities as such.

During Phase 2, five sites were visited and their clinical teams, administrators, front-desk staff, and patients were interviewed. But given the limited budget available to conduct in-depth interviews, it was difficult to capture a broad geographical distribution of sites pursuing health literacy practices. Moreover, because all the patient participants interviewed during the site visits were volunteers, it is important to note that selection bias might have affected the findings from these sessions.

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* Because of changes in professional positions, these individuals were unable to continue as members of the Health Literacy Advisory Committee.

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APPENDIX D. COMMUNICATION TOOLS

The following health literacy practices are being used by primary care health facilities—usually adapted to their own needs and, often, not by name—to improve communication and assist patients in managing their chronic conditions:

Ask Me 3—Patient Version

A client-directed strategy created by Pfizer’s Partnership for Clear Health Communication, Ask Me 3 encourages patients to ask their clinician three important questions during the clinical visit: What is my main problem? What do I need to do? And why is it important for me to do this? While this strategy aims to empower patients to be active participants in the decision-making on treatment options and care plans, it is important that clinicians be receptive to patients asking questions and that their responses be in language that the patient understands. (*Pfizer*)

Ask Me 3—Clinician Version

Instead of waiting for the patient to ask the above three questions, clinicians can ask their own: What is your main problem today? What do I need to do for you concerning this problem? And why is it important to you? The focus is thus on what the patient, as opposed to the clinician, is interested in. Either way, whether patient-driven or clinician-driven, this approach can stimulate conversation. But to be a true dialogue, it must be at a literacy level that ensures the patient’s understanding. (*Pfizer concept modified by Community Health Partners, Inc.*)

Motivational Interviewing

Motivational interviewing is a directive client-centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence. Compared with nondirective counseling, it is more focused and goal-directed.¹⁵ (*Rollnick and Miller*)

Teach Back

This practice, developed by the American Medical Association as a part of its Health Literacy Toolkit, is designed to verify that the patient understood what the clinician was saying: after explaining a diagnosis or treatment plan, he or she asks the patient to explain it all back. As such, Teach Back is a good tool for determining whether the clinician was successful in communicating with the patient at an appropriate literacy level. (*American Medical Association*)

Teach to Goal

During the clinical visit, the patient is given the opportunity to select a goal from a “Patient Goal Contract,” which graphically displays a range of choices related to the individual’s condition. Once the patient has chosen a goal—increasing exercise, for example, or checking one’s feet daily—the clinical staff works with the patient to identify steps toward reaching that goal and to provide support along the way. For goals related to blood pressure, A1c (for diabetes), and cholesterol levels, patients are given a pocket-sized card that helps them keep track of their progress. Once patients achieve a goal, they select another goal and the process begins again. This approach encourages patients to be active participants in their health care, facilitates their communication with clinicians, and serves as a tool to assess health literacy and understanding. *(Technique is used by the Ferguson Adult Health Center of the Cherry Street Health Services.)*

Reflective Listening

In this approach, the clinician closely listens to what the patient says in order to detect any stress or anxiety reflected in tone of voice or manner, assess the patient’s level of health literacy, and identify issues that he or she considers important. From this, the clinician gains empathy and rapport with the patient, checks understanding of what is being discussed, and can decide how best to proceed with the patient’s care. *(Stems from work done by Carl Rogers, who developed client-centered therapy.)*

Return Demonstration

Return Demonstration, a practice similar to Teach Back, is used when teaching patients a new skill—for example, in self-checking his or her blood-glucose level with a glucometer. The clinician demonstrates the procedure using the equipment and then asks the patient to conduct the demonstration for the clinician. This process may have to be repeated during follow-up visits to ensure that the patient has developed adequate competency. *(An educational tool adapted by clinicians, especially nurses.)*

RELATED PUBLICATIONS

Publications listed below can be found on The Commonwealth Fund's Web site at www.commonwealthfund.org.

[*Access to Specialty Care and Medical Services in Community Health Centers*](#) (September/October 2007). Nakela L. Cook, LeRoi S. Hicks, A. James O'Malley et al., *Health Affairs*, vol. 26, no. 5.

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