

## **DiversityRx - Webinar #4**

### **Health Literacy: Using a Self-Assessment Tool to Guide Quality Improvement in Primary Care**

February 4, 2010

#### **Implementation of the Toolkit (General Questions)**

**Q: Is there a database of questions for patients? Some patients may not know what to ask, others forget the questions.**

Yes. The Agency for Healthcare Research and Quality has a database of questions as part of their Questions Are the Answer program, located at [www.ahrq.gov/questionsaretheanswer/](http://www.ahrq.gov/questionsaretheanswer/). There are lists of questions for particular situations (e.g., planning surgery), as well as a Question Builder (<http://www.ahrq.gov/questionsaretheanswer/questionBuilder.aspx>) that allows patients to select and print out questions they want to ask their doctor at the next visit.

**Q: A Deaf patient can simply "copy sign" the interpreter. How do you move "repeat back" to "teach back?"**

Interesting question. I'm not sure what the best approach should be with a deaf person. The teach back should be considered a way to have a patient show that they understand. Sometimes, I worry about 'parroting back' which doesn't display understanding. Sometimes the best approach is to have someone 'show back' what they will do when they get home. The underlying principle is to confirm understanding.

**Q: did you warn patients that you were going to ask them to repeat back at the end of the visit, or alert them that you were trying something new?**

In general, no. But, the point is that we would only do teach back with items that are really important to remember. So, it is also a way to emphasize the importance of a topic.

**Q: Patient wait time is a good opportunity for quest/surveys but most patients don't want anything that is too long or takes too much time. What is a good choice for a survey that is very short/brief?**

Survey length can affect whether a patient is willing to fill out a survey. The CAHPS Item Set for Addressing Health Literacy ([http://www.cahps.ahrq.gov/content/products/HL/PROD\\_HL\\_Intro.asp?p=1021&s=215](http://www.cahps.ahrq.gov/content/products/HL/PROD_HL_Intro.asp?p=1021&s=215)) is not short. One strategy might be to break the survey up so you aren't asking every patient every question, but still cover all the questions. Another strategy would be to select the items related to health literacy practices you've decided to focus on.

**Q: For Laura - Which tools did your practice implement to more effectively engage patients during phone calls (reminder calls, triage nurse calls, etc.)? How was implementation different for phone versus person-to-person encounters?**

Laura's practice has not taken on this aspect of care yet. Not that it isn't important, but just has not been addressed yet.

**Q: Do you think you will get buy-in from community physicians as compared to clinics or medical center practices. How do you think these tools will fit into the Practice Improvement segments of the new 20 credit CME. In our work in the field health literacy was essential to comprehension. Most Spanish-speaking people were at sea even in their own languages and thus needed explanations over and over again in all aspects of what is happening. More literacy ends up in greater competence and confidence in the longer run.**

Several practices in our testing were community based private practices. They joined the project because they realized how important health literacy was for their patients. This toolkit is designed to be done in a practice improvement environment. It could work well in the context of performance improvement CME.

### **Type of Setting the Toolkit Can Be Implemented In**

**Q: How do you see the assessment tools working in the Medical Home and also in PI CME.**

Some of the PCMH pilots have expressed interest in the toolkit and it helps to meet several of the principles of PCMH. As above, it is a good tool for use in PI CME.

**Q: Is this tool utilized for a facility that does not have a health literacy program already or could a facility that has a program already benefit from this toolkit?**

Both types of facilities could use this toolkit. It allows you to enter the program at any level of content expertise and level of resources.

**Q: Question For Cindy: Is there a similar tool available for inpatients?**

We have not developed a toolkit for inpatient settings. However, many parts of the current Toolkit are applicable to the inpatient setting. As you heard on the Webinar, Laura Noonan has started applying some of the tools from the Toolkit in an inpatient setting.

**Q: I can see how this could be used in education! Did you test the tool or could it be tested in health educational centers such as physicians' training and schools of nursing?**

We have not tested this, but the questioner is correct. It could be very helpful in educational contexts.

**Q: Has anyone tested this toolkit process with research participants and their investigators?**

Not this Toolkit. However, AHRQ has tested the AHRQ Informed Consent and

Authorization Toolkit for Minimal Risk Research (<http://www.ahrq.gov/fund/informedconsent/>), which is designed to address health literacy issues in obtaining informed consent and HIPAA authorization from research subjects, particularly those with limited literacy. The AHRQ Informed Consent and Authorization Toolkit for Minimal Risk Research includes instruction for obtaining confirmation of understanding through Teach-back and other ways to improve the informed consent process, as well as English and Spanish sample forms that follow health literacy principles.

## **Evaluation**

**Q: If we use the tool is there a website you want feedback to be given (to collect for research purposes or to revise sections)?**

We would love to hear about your experience using the Toolkit. You can email Cindy Brach at [cindy.brach@ahrq.hhs.gov](mailto:cindy.brach@ahrq.hhs.gov) or [darren\\_dewalt@med.unc.edu](mailto:darren_dewalt@med.unc.edu).

**Q: Do you have analysis tools to calculate results when done?**

We answered this on the air. We specifically avoided a scoring system as that would give a false level of precision on the instrument. It would also lead to misinterpretation of results. The idea of an assessment like this is to reflect on each item to decide what can be done better.

**Q: With the tool kit is there an evaluation component with each section to compare with patient charts to see if there was improved patient care/ just not sure how the evaluation piece works.**

The toolkit recommends tools to use to assess clinic performance. We mentioned on the call the HL CAHPS which could be used serially to assess performance.

## **Pre-Assessment**

**Q: What self-assessment tools are available for PROs and physicians, i.e. those in most standard use?**

The toolkit mentions the HL CAHPS as an assessment of practice performance.

**Q: I have not heard what methods were used to assess readability --did you do any work with the REALM tool?**

REALM does not assess readability of written materials. REALM assesses an individual's reading ability. Toolkit 11: Design Easy-to-Read Material refers Toolkit uses to a variety of readability formulas, but notes that following health literacy principles in design and formatting are at least as important in developing accessible materials.

**Q: What tools (if any) were used to assess patient confidence in goal setting?**

An Action Plan Form, included in the appendix to Tool15: Make Action Plans, asks patients, “How sure am I that I can do this?” and the patient responds on a scale of 1 (Not Sure) to 10 (Very Sure).

**Q: What were some of the challenges in implementing this assessment?**

All clinic sites that did it as a team found it very useful. When only one person from the clinic does the assessment, there appeared to be less insight into the clinic operations.

**Q: Were there any pre-implementation assessments of sites? What tool used? How was the baseline established?**

The only pre-implementation assignment was to complete the assessment and discuss with the health literacy team the priorities for implementing tools.

**Methodology**

**Q: How did you select the 8 practices? Did you assess their readiness to take the next step? If yes, how?**

We sent out an invitation to all practices in the North Carolina Network Consortium Research Network. For those who expressed interest, we followed up to explain the project and the expectations. So, this was a select group of practices that expressed interest in the idea.

**Q: Did Laura implement the tools on her own with her team or was there a liaison with DiversityRx?**

There was no liaison with DiversityRx, as the Health Literacy Universal Precautions Toolkit was not a DiversityRx project. Toolkit developers did provide implementing practices with some support. They conducted an initial site visit, which included a brief primer on conducting rapid quality improvement using Plan, Do, Study, Act (PDSA) cycles. Toolkit developers also may have provided some support during phone calls designed to collect the practice’s reactions to the Toolkit and experiences with implementing them.

**Q: Were there any RNs involved in developing this tool?**

Nurses from several of the practices contributed to evaluating and modifying the tools.

**Literacy Levels**

**Q: What about adjusting for altered health literacy? Or literacy altered by drugs, emotional trauma, etc?**

Patients can have a variety of conditions that interfere with their ability to understand and use health information. The point of universal precautions is to consider health literacy barriers in any circumstance regardless of our assumptions about a patient's educational background.

**Q: I work professionally with health literacy issues, but also am looking at this from a cancer patient's perspective. My general health literacy would test very high, but, if I am on drugs e.g. specifically chemo, how do you adjust for that within the scope of testing in advance? My test results would actually give the wrong impression in this case. Patients on chemo and other drugs often lose the ability to comprehend and synthesize at the same levels.**

This is one of the reasons I say that health literacy is a "state," not a "trait," and why we advocate universal precautions. Any person can experience limited health literacy, whether because of medication, stress, or other circumstances that limit their ability to obtain, understand, and use health information.