Prioritization of Health Literacy Best Practices for Health Professionals: A Consensus Study

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Introduction

While much is known about the adverse effects of low health literacy (HL) on patients, many health care professionals do not receive formal training in this important area of health services delivery.[1] New educational competencies have recently been published, outlining a comprehensive list of knowledge, skills and attitudes which health professionals should possess with respect to health literacy.[2] While the publication of this set of competencies marks an important milestone in efforts to address low health literacy in the U.S., the list of competencies – arrived at through a consensus process among a diverse group of health professions educators – is too long and lacks the prioritization needed to be useful to health professions educators. This work aims to prioritize a comprehensive list of health literacy practices, which can then serve as the foundation for a prioritized list of health literacy educational competencies for students of the health professions.

Methods

Study design: Expert consensus group using a Q-sort methodology.

Participants: 25 health literacy experts (determined by publications, years in field, job title, and/or peer referral) attending two national health literacy conferences (Institute for Healthcare Advancement Conference and the Health Literacy Research Conference VI) in 2014.

Consensus method: Q-sort is a validated technique for gathering quantitative information about qualitative data.[3] We gave each health literacy expert a 'deck' of 32 cards, on each of which was printed a previously identified health literacy practice (p1-p32),[2] and asked them to place each card on a blank Q-sort array based on IMPORTANCE, defined as "the potential to have the greatest positive impact for the greatest number of patients." Each Q-sort column is assigned a point value (9 = most important, through 1 = least important). A mean and standard deviation were calculated from each point assignment for each health literacy practice for each of the 32 completed Q-sorts were analyzed.

Results

Figure 1: Composite Q-sort based on mean ranking of 32 health literacy practies

Top 8 Most Important			16 Average Importance			Bottom 8 Least Important		
p28 (6.9)	p14 (6.9)	p10 (6.0)	p25 (5.9)	p18 (5.5)	p15 (4.8)	p20 (4.0)	p17 (3.4)	P29 (2.5)
	p23 (6.2)	p2 (6.0)	p9 (5.8)	p13 (5.4)	p11 (4.6)	p32(3.9)	p31 (3.2)	
	p19 (6.2)	p3 (6.0)	p5 (5.7)	p7 (5.3)	p22 (4.5)	p8 (3.9)	p21 (3.1)	
		p1 (5.9)	p26 (5.7)	p12 (5.2)	p6 (4.3)	p16 (3.6)		
			p27 (5.6)	p24 (5.1)	p30 (4.2)			
				p4 (5.0)				

Figure 1: Heath literacy practices arranged in a Q-Sort array based on their rank-order mean score. This figure is a composite representative of all 32 Q-sorts completed by our expert panel. Each practice is represented by a "pXX" correlated to practices in Table 1 followed by the mean rating in "( )".

Example above:

- Practice P28 = most important
- Practice P18, P13, P7 = equally average importance
- PracticeP29 = least important

Data Analysis: Mean ratings for each practice were compared using Student's t-tests for two-tailed results.

Table 1: 32 Prioritized Health Literacy Practices

Rank Group	Rank Order	Key	Health Literacy Practice	Average Q-Sort value	SD
1	1	p28	Routinely uses a "teach back" or "show me" technique to check for understanding and correct misunderstands in a variety of health care settings, including during the informed consent process	6.9	1.3
	2	p14	Consistently avoids using medical "jargon" in oral and written communication with patients, and defines unavoidable jargon in lay terms	6.9	1.2
	3	p23	Consistently elicits questions from patients through a 'patient-centered' approach (e.g. "what questions do you have?" rather than "do you have any questions?")	6.2	1.2
	4	p19	Consistently uses a 'universal precaution' approach to oral and written communication with patients	6.2	2.6
	5	p10	Routinely emphasizes one to three 'need to known' concepts during a given patient encounter.	6.0	2.1
	6	p2	Consistently negotiates a mutual agenda with patients at the outset of encounters	6.0	2.0
	7	p3	Routinely recommends the use of professional medical interpreter services for patients whose preferred language is other than English	6.0	1.9
	8	p1	Consistently elicits the full list of patient concerns at the outset of encounters	5.9	2.1
2	9	p25	Routinely ensures that patients understand at minimum 1) what their main problem is, 2) what is recommended that they do about it, and 3) why this is important.	5.9	2.1
	10	p9	Routinely uses short action-oriented statements, which focus on answering the patient's question, "what do I need to do" in oral and written communication with patients.	5.8	1.1
	11	p5	Routinely uses verbal and non-verbal active listening techniques when speaking with patients	5.7	1.7
	12	p26	Consistently locates and uses literacy-appropriate patient education materials, when needed and available, to reinforce oral communication, and reviews materials with patients, understanding or highlighting key information.	5.7	1.2
	13	p27	Routinely "chunks and checks" by giving patients small amounts of information and checking for understanding before moving to new information.	5.6	1.6
	14	p18	Routinely conveys numeric information such as risk, using low 'numeracy' approaches, such as through examples, in oral and written communication	5.5	1.5
	15	p13	Routinely makes instructions interactive, such that patients engage the information, to facilitate retention and recall	5.4	1.9
	16	p7	Routinely elicits patients' prior understanding of their health issues in a non-shaming manner (e.g. asks "what do you already know about high blood pressure?")	5.3	1.6
	17	p12	Routinely selects culturally and socially appropriate and relevant visual aids, including objects and models, to enhance and reinforce oral and written communication with patients.	5.2	1.7
	18	p24	Routinely anticipates and addresses navigational barriers within health care systems and shares responsibility with patients for understanding and navigating systems and processes	5.1	2.2
	19	p4	Consistently speaks slowly and clearly with patients	5.0	1.7
	20	p15	Consistently follows principles of easy-to-read formatting when writing for patients including the use of short sentences and paragraphs, and the use of bulleted lists rather than denser blocks of text, when appropriate.	4.8	1.6
	21	p11	Routinely uses analogies and examples, avoid idioms and metaphors, to help make oral and written information more meaningful to patients	4.6	1.4
	22	p22	Routinely assesses adherence to treatment recommendations, and root causes for non-adherence, non-judgmental, before recommending changes to treatment plans	4.5	1.9
	23	p6	When preparing to educate patients, routinely asks about patients' preferred learning style in a non-shaming manner (e.g. asks "what is the best way for you to learn new information?").	4.3	2.0
	24	p30	Routinely arranges for timely follow-up when communications errors are anticipated	4.2	1.7
3	25	p20	Routinely conducts medication reconciliation with patients, including use of 'brown bag' medication reviews, when called for during regular duties.	4.0	1.3
	26	p32	Routinely documents in the medical record that a 'teach back,' or closed communication loop technique has been used to check the patient's level of understanding at the end of the encounter.	3.9	1.4
	27	p8	Routinely puts information into context by using subject headings in both written and oral communication with patients	3.9	1.4
	28	p16	Routinely writes in English at approximately the 5th-6th grade reading	3.6	1.7
	29	p17	Consistently writes or re-writes ("translates") unambiguous medication instructions when called for during regular duties	3.4	1.7
	30	p31	Routinely refers patients to appropriate community resources for enhancing literacy and/or health literacy skills (e.g. Adult Basic Health Literacy Education) within the context of the therpaeutic relationship	3.2	1.8
	31	p21	Routinely encouraged and facilitates patients to carry an updated list of their medications with them	3.1	1.1
	32	p29	Consistently treats the diagnosis of limited health literacy as 'protected health information' requiring specific 'release of information' for disclosure	2.5	1.4

Table 2: Expert agreement on the top 8 health literacy practices (n=25)

Rank Order	Key	Health Literacy Practice	# of expert participant (≥7 Q-Sort points)	%
1	p28	Routinely uses a "teach back" or "show me" technique to check for understanding and correct misunderstands in a variety of health care setings, including during the informed consent process	16	64
2	p14	Consistently avoids using medical "jargon" in oral and written communication with patients, and defines unavoidable jargon in lay terms	15	60
3	p23	Consistently elicitis questions from patients through a 'patient-centered' approach (e.g. "what questions do you have?" rather than "do you have any questions?")	9	36
4	p19	Consistently uses a 'universal precuation' approach to oral and written communication with patients	14	56
5	p10	Routinely emphasizes one to three 'need to known' concepts during a given patient encounter.	12	48
6	p2	Consistently negotiates a mutual agenda with patients at the outset of encounters	12	48
7	p3	Routinely recommends the use of professional medical interpreter services for patients whose preferred language is other than English	10	40
8	p1	Consistently elicits the full list of patient concerns at the outset of encounters	10	40

Discussion

- This study used health literacy experts to assign relative importance to items on an existing list of health literacy best Practices.
- The previously-derived list was developed through a separate consensus process.

Conclusions

- Previously identified health literacy best practices can be prioritized in terms of relative importance for generic healthcare professionals, using a public health perspective.
- Educational competencies underlying these practices have been identified.[2]
- Top-rated practices may represent the most important fundamental health literacy training areas for all healthcare professionals
- Prioritization may differ when specific health professions or specific patient populations are considered.
- Lower ranked items should not be viewed as unimportant
- Health professions educators should consider allocating teaching resources toward Group 1 practices first.

References

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