Health literacy: how nurses can make a difference

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ABSTRACT

Objective
To be a call to action to nurses and all health professionals to implement proven effective evidence based strategies that can decrease health literacy demands on health consumers, and improve health outcomes and the provision of safe person-centred health care.

Primary argument
Health professionals, specifically nurses, are important providers of health information to health consumers. They influence the health literacy demands placed on health consumers through the way they organise, present and communicate information (Australian Commission on Safety and Quality in Health Care, 2014). All health professionals need to be cognisant of the range of effective strategies they can implement to reduce the health literacy demands on health consumers through effective interpersonal communication, health materials in the written and visual formats and the creation of health literate environments to improve health outcomes and the provision of safe care.

Population measurements of functional health literacy levels (Australian Bureau of Statistics 2008) indicate that 59 per cent of the Australian population aged 15 to 74 years did not achieve an adequate health literacy skill level to meet the complex demands of everyday life and work in a knowledge-based economy.

Conclusion
An understanding by all health professionals of the concept of health literacy, and the evidence based strategies they can implement to decrease health literacy demands on health consumers is imperative to enhancing the involvement of health consumers in their care, improving health outcomes and in the provision of safe health care.

INTRODUCTION

A previous article by Johnson (2014a) in the Australian Journal of Advanced Nursing introduced the concept of health literacy by providing an overview of key literature about (1) understanding health literacy as a concept and (2) the importance of health literacy to health care. This current article will build on that previous article and introduce a range of evidence based strategies that all health professionals, including nurses, can implement to decrease the health literacy demands on health consumers through interpersonal communication, printed information and the creation of a health literate environment.

The Australian Commission on Safety and Quality on Health Care (ACSQHC 2014) has recently published a statement on health literacy and its importance to improving the safety and quality of health care and health outcomes for health consumers. They have defined health literacy into two components:

- **Individual health literacy** is the skills, knowledge, motivation and capacity of a person to access, understand, appraise and apply information to make effective decision about health and health care and take appropriate action.

- **The health literacy environment** is the infrastructure, policies, processes, material, people and relationships that make up the health system and have an impact on the way in which people access, understand, appraise and apply health-related information and services (p.2).

Health literacy is a complex phenomenon that has moved from a narrow conceptual focus on an individual consumers' health literacy skills and abilities to being more multi-faceted, where consumers' skills and abilities interact with cultural, family, media, community resources, health system, health care provider, environmental and structural influences (Squires et al 2012; Martin et al 2011; Berkman et al 2010; Jordon et al 2010; Paasche-Orlow and Wolf 2007).

Low individual health literacy has repeatedly been linked to health consumers having difficulties comprehending, recalling and acting on health information provided by health professionals (McCarthy et al 2012a; Jordan et al 2010). It has been estimated that health consumers with low individual health literacy are between one-and-a-half and three times more likely to experience an adverse health outcome (DeWalt et al 2004). Low health literacy is a significant problem in Australia. Population measurements of functional health literacy levels indicate that 59 per cent of the Australian population aged 15 to 74 years did not achieve an adequate health literacy skill level to meet the complex demands of everyday life and work in a knowledge-based economy (ABS 2008). Although low levels of health literacy is disproportionate in certain demographic groups, such as the elderly, people from non-English speaking backgrounds (in an English speaking society), and people with low general literacy; low levels of health literacy affects all segments of the population (Berkman et al 2010; DeWalt et al 2010). Health literacy levels are considered to be dynamic in individuals. Berkman et al (2010) argue that consumer's health literacy levels can change as they gain experience with the various health circumstances and choices that they face.

Research has identified that nurses overestimate a consumers' health literacy by six to one (Dickens et al 2013). A study by Kelly and Haidet (2007) identified that doctors incorrectly identified consumer's health literacy levels 40% of the time and overestimated consumer's health literacy levels. Even in non-stressful clinical encounters many consumers are reluctant to admit that they don't understand, and feel compelled to follow the recommendations as they understand them, rather than seek clarity (Dickens et al 2013; Martin et al 2011; Baker et al 1996; Parikh et al 1996). A study by Turner et al (2009) concluded that paediatricians were aware of health literacy-related problems when communicating with consumers, but reported underutilising enhanced techniques known to improve communication. This finding is also supported by Castro et al (2007)

who concluded in their study that doctors caring for patients with limited health literacy employ unclarified jargon during consultations. McCarthy et al (2012b) in their study found that health professionals did not utilise communication techniques to improve communication with consumers in emergency departments, even though they knew the techniques were effective and easy to implement. Schwartzberg et al (2007) reported that fewer than 40% of health professionals used the 'Teach-Back' technique when communicating with consumers, despite knowing it was a well-established way of assessing consumer comprehension of information and was endorsed by the National Quality Forum as one of 34 'safe practices'.

It is imperative that all health professionals adapt their practice to utilise proven strategies that respect the needs of consumers to be communicated with in a way that assists them to understand and use that information. The Australian College of Nursing (2013 p1) states "Supporting consumer health literacy is a central part of contemporary nursing practice....It is often nurses who provide education to and advocate for patients, and who deliver and clarify health information provided by other health care professionals". This article will introduce to a range of effective evidence based strategies that all health professionals, including nurses, can implement to decrease the health literacy demands on health consumers.

DISCUSSION

There are two focus areas where health professionals can make a difference to decrease the health literacy demands on consumers. These reflect the definition of the ACSQHC (2014) definition, where the focus is individual health literacy and the organisational context.

Individual Health Literacy

There are two intervention areas for health professionals to decrease the health literacy demands on individuals. These are (1) effective interpersonal communication and (2) health materials in the written and visual formats.

Ensuring Effective Interpersonal Communication

Effective interpersonal communication between health professionals and consumers is fundamental for safe and high quality care. Effective communication failure is one of the most commonly cited causes of adverse events and complaints about health care (ACSQHC 2014). The way health professionals organise, present information, and communicate with consumers can help to reduce health literacy demands and lead to improved health outcomes (Berkman et al 2011).

There are a range of evidence based interpersonal communication strategies that are effective for health professionals to use in clinical practice to improve interpersonal communication. Health professionals are urged to be aware of the concept of health literacy and to utilise a range of these communication strategies in clinical practice with all consumers (ACSQHC 2014; Dickens et al 2013). There is a strong argument for health professionals to assume that all consumers may have difficulty understanding information, and create an environment where consumers of all literacy levels can thrive. This is in preference to health professionals trying to assess if individual consumers have low health literacy or not (De Walt et al 2010). De Walt et al (2010) call this a Universal Precaution approach. This refers to taking specific actions to minimise risk for everyone when it is unclear which consumers may be affected.

Berkman et al (2011) and Sheridan et al (2011) conducted systematic reviews to examine interpersonal communication interventions that would mitigate the effects of low health literacy. This evidence has been summarised in Box 1.

Box 1. Summary of Evidence of Interpersonal Communication Interventions to Mitigate the Effects of Low Health Literacy

- Using plain language to communicate health information, instructions and choices.

- Using essential information first and by itself.

- Using consistent denominators for presenting risk and benefit information.

- Adding icon arrays to numerical information. Icon arrays ('pictographs') are more effective than bar or pie charts at communicating risk and reducing cognitive biases in risk perception.

- Adding video to verbal information.

- Presenting information so that the higher number is better.

- Presenting numerical information in tables rather than text.

Educative and recall interpersonal communication strategies such as Teach-Back, Show-Me, and Ask-tell-ask have all proven to be effective (ACSQHC 2014; Dickens et al 2013; Berkman et al 2011). Teach-Back and Show-Me are easy techniques for health professionals to learn and to use, and are effective strategies for engaging all consumers, including children and young people, in clarifying information and correcting misunderstandings. Teach-Back is a method where health professionals provide information in small segments of information to consumers and then they ask the consumer to state in their own words the key points of the discussion. The cycle continues until the health professional is certain that the key messages have been delivered and understood (Jager and Wynia 2012). Show-Me is where the health professional asks the consumer to show them how they do something important to their care. For example, show how and when they take their medication, how they do a dressing or how they give an injection. Ask-tell-ask is similar to Teach-Back in that the health professionals *asks* the consumer to describe their current issue, *tells* the consumer in simple language the information they need to know, and then *asks* the consumer what they have understood (ACSQHC 2014).

Other effective strategies include, encouraging questions, follow up phone calls from health professionals with consumers to check the key messages they have understood from discharge communication, and encouraging a support person to accompany consumers during interactions with health professionals have been proven to be effective strategies (DeWalt et al 2010). Teach-to-Goal is effective with communicating complex health information with people with chronic health conditions and is based on mastery learning. It recognises that with repetition most consumers can achieve mastery (Baker et al 2011).

Dickens et al (2013 p.54) has synthesised the evidence for successful interpersonal communication with consumers and provided the following 'tips' in Box 2.

Box 2. Tips for Successful Interpersonal Communication

- Use the active voice, where the subject of the sentence is performing the action.
- Be interactive and avoid long monologues.
- Be considerate towards listeners and announce topics, call the consumer by name and provide information in little stories that the consumer can relate to.
- Give 'need to know' rather than 'nice to know' information. Provide information in three to five small segments in each session and reinforce important information.
- Focus on the consumer and use everyday language familiar to them and provide a context for the information that the consumer can relate to.
- Be mindful of language complexity. Speak in short sentences of fewer than 15 words, use words with fewer than three syllables and decrease medical jargon.

It should be appreciated that personal contextual issues such as culture, education, gender and language will have an effect on interpersonal communication (ACSQHC 2014).

HEALTH MATERIALS IN THE WRITTEN AND VISUAL FORMATS

Health material in the written and visual formats can include information such as consent forms, fact sheets, pamphlets, written instructions, diagrams, and medication information. Printed information tailored to consumers' needs, and developed with the involvement of consumers, can help to address health literacy needs by ensuring the information is relevant to consumers' needs, readable and understandable (Coulter et al 2006). Brothersone et al (2006) found printed information with pictorial aids increased consumer comprehension by 27% compared to those without pictorial aids. Printed information should use plain language and be written at a reading level of fifth grade or below. There are several formulas that can determine reading level of printed information. The most widely used and recommended is SMOG by McLaughlin (1969). However, the true test of readability is consumer feedback (Coulter et al 2006).

Other strategies that have proven to be effective include personalising written health information (Coulter et al 2008) and providing a combination of verbal and written information to reinforce key health messages (Johnson et al 2003). The Cochrane Systematic Review by Johnson et al (2003) concluded that printed discharge information, when combined with verbal information by health professionals, was more effective in improving consumer knowledge and satisfaction, than just the provision of printed information alone or verbal information alone.

The provision of timely, well written health information, which supports consumers to gain knowledge and participate in decision making, is one strategy to enable the sharing of information and power. Information and education developed specifically for people with low levels of health literacy can be effective as an aid to communicating health information and complex care needs (Coulter et al 2008).

ORGANISATIONAL CONTEXT

The concept of 'health literate organisation' was first identified and defined by Rudd and Anderson (2006). A health literate organisation is defined as an organisation that recognises miscommunications are common and can negatively affect a consumer's health care experience and outcomes. A health literate organisation makes it easier for people to access, navigate, understand and use health information and services (Rudd and Anderson 2006). The environment of a health service represents the health literacy expectations, preferences and skills of those providing information and services (Rudd 2010). Health professionals have a significant role in working with consumers to create a more health literate organisation.

Some of the health literacy demands on consumers are in the form of physical aspects of the health service, such as signage and design. At the same time, access to and navigation of a health service involves the use of a broader range of print materials which include, rights and responsibilities pamphlets, medical history forms, health information pamphlets/booklets, medication information, and consent forms. In addition, the interpersonal communication with health professionals is of critical importance, as is the health service's website and social media presence (Rudd and Anderson 2006).

In recognition that health services required guidance in their health literacy efforts the Institute of Medicine in the United States of America developed 10 Attributes of a Health Literate Organisation (Bach et al 2012). Bach et al (2012) determined that health services that embody these 10 Attributes create an environment that decreased health literacy demands on consumers, and enables consumers to access and benefit optimally from the range of health care services. Bach et al (2012) state the list of attributes is by no means

exhaustive, but rather represents an attempt to synthesise a body of knowledge and practice, supported by the state of the science in the young field of health literacy. The 10 Attributes are:

1. Has leadership that makes health literacy integral to the mission, structure and operations of the healthcare organisation.

2. Integrated health literacy into planning, evaluation measures, patient safety and quality improvement.

3. Prepared the workforce to be health literate, and monitors progress.

4. Included populations served by the organisation in the design, implementation and evaluation of health information and services.

5. Meets the needs of populations with a range of health literacy skills while avoiding stigmatisation.

6. Uses health literacy strategies in interpersonal communication, and confirms understanding at all points of contact.

7. Provides easy access to health information and services, and navigation assistance.

8. Designs and distributes print, audiovisual and social media content that is easy to understand and act on.

9. Addresses health literacy in high-risk situations, including care transitions and information about medicines.

10. Communicates clearly about what is covered by health plans and what individuals will have to pay for services (Bach et al 2012 p.3).

The purpose of the 10 Attributes is for health services to assess their organisational performance against each attribute. Where deficits are identified the health service can develop plans for action. For the Australian context, Thomacos and Zazryn (2013) have developed a self assessment tool for Australian health services based on the 10 Attributes of a Health Literate Organisation. This tool can be used by Australian health services to rate their performance against the 10 Attributes, which can then be used to guide organisational improvements.

In addition to the 10 Attributes to guide health services to understand the requirements to be a Health Literate Organisation, Rudd (2010) developed a 'Health Literacy Environment Activity Package: First Impressions and Walking Interview'. This Activity Package can assist health services to begin to understand some of the characteristics of their organisation that assist or hinder a consumer's ability to physically navigate their way to, and about, the health service. This Activity Package was adapted to an Australian context and trialled by Johnson (2014b). The First Impressions Activities consists of three tools that focus on first impressions shaped by a phone call to the health service, a visit to the health service's website, and a walk to the entrance and to predetermined destinations around the health service. The First Impression Activities are a consumer engagement strategy that can bring 'fresh eyes' to examining the health literacy environment of a health service to identify ways to decrease the health literacy demands on consumers (Johnson 2014b).

CONCLUSION

An understanding by health professionals of the concept of health literacy, and the evidence based strategies they can implement to decrease health literacy demands on health consumers is central to enhancing the involvement of health consumers in their care, and improving health outcomes and the provision of safe health care. This article is a call to action for health professionals, especially nurses, to respect the health literacy needs of all consumers and to implement proven effective evidence based health literacy strategies for individuals and the organisational context.

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