LC

DIABETES IN SPECIAL & VULNERABLE POPULATION:
Learning Collaborative

Diabetes Continuum of Care: Impact of Health Literacy on Patients' Diabetes Management and Self-Care

Tuesday, March 2nd, 2021
8 am HT / 11 am PT / 1 pm CT / 2 pm ET

Welcome!
We will begin in a few minutes

ABOUT THE LEARNING COLLABORATIVE

Diabetes affects more than 34 million people in the United States. Multi-tiered efforts to prevent, treat and manage diabetes are critical in reducing the burden of diabetes, particularly for special and vulnerable populations, which have unique characteristics that affect culturally and linguistically competent health care access and utilization. According to 2018 Uniform Data System (UDS), diabetes poses a unique challenge for the HRSA Health Center Program because 1 of 7 patients has diabetes and nearly 1 in 3 of those has uncontrolled diabetes.

To elevate the national conversation around diabetes, **14 National Training and Technical Assistance Partner (NTTAP) organizations** formed the Special and Vulnerable Populations Diabetes Task Force to engage health centers, Primary Care Associations (PCAs), and Health Center Controlled Networks (HCCNs) to increase knowledge of effective strategies that address diabetes among people experiencing homelessness, residents of public housing, migratory and seasonal agricultural workers, school-aged children, older adults, Asian Americans, Native Hawaiians and Pacific Islanders, LGBTQIA+ people, and other health center patients.

This Fall's national learning series is **sponsored by HRSA** and will take a deeper dive into issues related to patient health literacy, community engagement, and team-based care.

For information about the Diabetes National Learning Series, visit **chcdiabetes.org** today.

Special and Vulnerable Populations Task Force Members:

For more information on our NTTAP Partners, visit chcdiabetes.org

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Diabetes Continuum of Care: Effective Service Delivery Approaches to Improve Health Literacy

NCA Faculty

Colleen Velez
Associate Director of
Corporation for Supportive Housing (CSH)

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CSH

NCHPH
National Center for Health in Public Housing

MHP Salud
OUTCOMES-DRIVEN
EXPERIENCED
INNOVATIVE

Diabetes Continuum of Care: Effective Service Delivery Approaches to Improve Health Literacy

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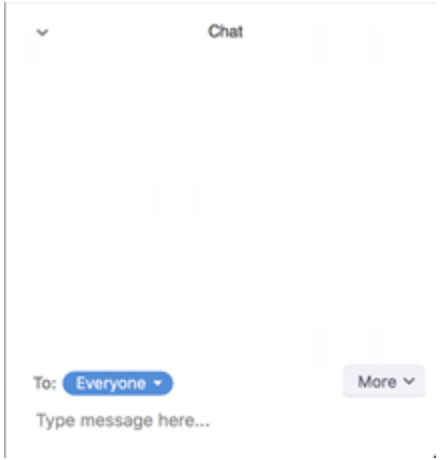
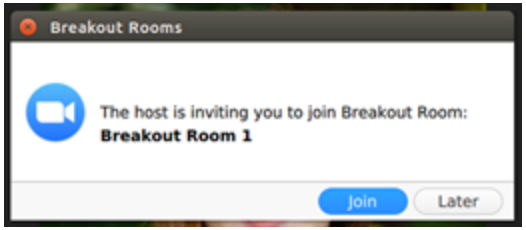
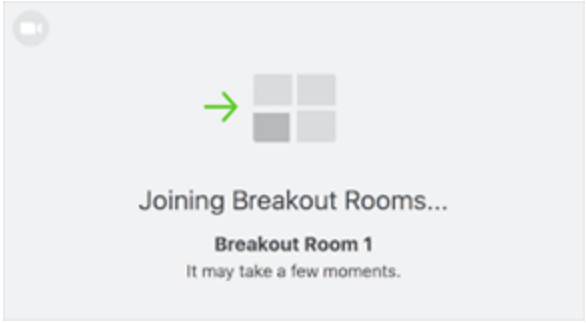
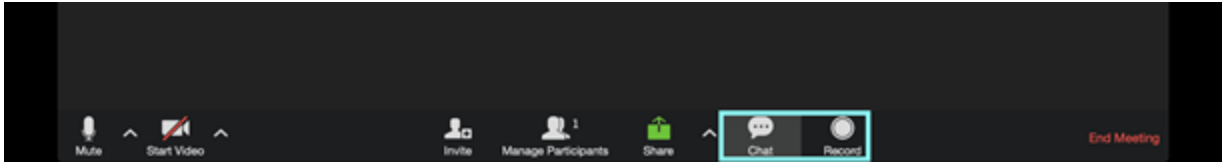
Zoom Features









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Learning Collaborative Overview

LC

Diabetes Continuum of Care: Communication Strategies to Bridge the Diabetes Health Literacy Gap

Overview of the LC & Timeline

- Participants are expected to attend all sessions. Everyone will have access to the slides, and resources. An email will be sent out shortly after the first session
- CME/CNE credits are available. You need to attend all sessions to qualify for CMEs/CNEs.
- After each session, participants will be provided with reflection questions to prepare for the next session.
- You will receive a reminder for the next session the Friday before
- Learning collaborative sessions will be 1.5 hours with opportunity for small group discussion

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Diabetes Continuum of Care: Communication Strategies to Bridge the Diabetes Health Literacy Gap

Overview of the LC & Timeline

Session #1: Overview of the impact of Health Literacy on Diabetes- **Feb. 2nd, 2021**

Session #2: Association between Health Literacy, Diabetes Knowledge, and Self-care Behaviors- **Feb. 16th, 2021**

Session #3: Health Literacy: Diabetes Prevention and Self-management **-March 2nd, 2021**

Session #4: Opportunities for Technology: Internet and Telehealth**- March 16th, 2021**

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NTTAP Overviews

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OUTCOMES-DRIVEN
EXPERIENCED
INNOVATIVE

MHP Salud is a national nonprofit organization with over 35 years of experience developing, implementing, and evaluating community-based, culturally tailored Community Health Worker (CHW)/Promotor(a) de Salud programs and promoting the CHW model through training and consultation services.

Mission

MHP Salud promotes the Community Health Worker(CHW) profession nationally as a culturally appropriate strategy to improve health and implements CHW programs to empower underserved Latino communities

Vision

Our populations and their communities will enjoy health without barriers.

Training and Technical Assistance (T/TA)

MHP Salud provides T/TA to FQHCs and other healthcare organizations wishing to start or strengthen their CHW Programs

- Virtual and on-site trainings for CHWs, Program Supervisors and Professions Working with CHWs
- Technical Assistance/Consulting on design, evaluation, and optimization to support the various stages of the implementation process of a CHW program

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Impact of Health Literacy on Patients' Diabetes Management and Self-Care

CSH is a national non-profit organization with a mission to advance housing solutions that promote integration among public service systems to deliver three powerful outcomes:

- Improve the lives of vulnerable people
- Maximize public and private resources
- Build strong, healthy communities across the country

Our lines of business include program consultation, training, technical assistance and lending as a community development finance institution.

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Impact of Health Literacy on Patients' Diabetes Management and Self-Care

Our Mission:
NCHPH provides training and technical assistance to strengthen the capacity of federally-funded health centers to increase access to health care, eliminate health disparities, and enhance health care delivery for the millions of residents of public and assisted housing.

The goal is to increase the capacity and improve the performance of HRSA supported health center programs and other safety net providers in meeting the specialized health care needs of the public housing residents. The National Center for Health in Public Housing has developed materials for training and education, disseminated best practices and mentored new grantees.

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Session 3 Learning Objectives

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Impact of Health Literacy on Patients' Diabetes Management and Self-Care

LEARNING OBJECTIVES

1. Health Literacy: Verbal and Written Communication Strategies
2. Review how to Develop an Action Plan
3. Discuss how to Improve Medication Adherence

Case Study

Patient Information

Patient Name: JK

Sex: Male

Patient ID: 987654321

Age: 65 years

Race: Hispanic

Height: 68 in (172.72 cm)

Weight: 180 lb; BMI 27.4 kg/m2

Today’s Date: March 2, 2021

Occupation: Carpenter

Verbal Communication

- Use plain non-medical language
- Use common words that patients use in conversations
- Slow down/speak clearly
- Limit content (limit information to 3 key points)
- Repeat key points
- Confirm whether the patient understands

- <u>Tools:</u>
  - Teach back
  - Chunk and check

Teach Back Method

- Studies have shown that 40-80 percent of the medical information patients receive is forgotten immediately and nearly half of the information retained is incorrect.

Chunk and Check

Written Communication

- Use easy-to-read materials that are at the 5th to 6th reading level
- Use short, simple sentences
- Avoid words of more than two syllables
- Limit content to key/most relevant information
- Limit medical jargon
- Review health education materials with patients
- On forms, use check boxes, instead of asking patients to write responses
- Bold key words

- Tools:
  - Electronic assessments: Use electronic tools to assess reading level of written material; a number of tools are available at http://www.readabilityformulas.com/free-readability-formula-tests.php

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Understand the Role of Easy-to-Read Materials

- Practices often ask patients to fill out forms or provide them with written materials to read. With 36% of the U.S. adult population having limited health literacy skills, it is likely that many of your patients don't understand all of the written materials they receive. Assessing, selecting, and creating easy-to-understand forms and educational materials can help you improve patient comprehension.

Understand the Role of Easy-to-Read Materials

In short, clear an easy-to-read material has several benefits for the reader:

- to find what they need,
- understand what they read, and
- and do what they need to the first time they read it

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Understand the Role of Easy-to-Read Materials

As a rule, you help readers when you:

- Write short sentences.
- Use active voice.
- Use everyday words and pronouns (when appropriate).

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Understand the Role of Easy-to-Read Materials

- Plain Language

Plain language makes it easier for everyone to understand and use health information. Although plain language is a familiar idea, many organizations don't use it as often as they should. The Plain Writing Act of 2010 requires federal agencies to train staff and use plain language when they communicate with the public.

Understand the Role of Easy-to-Read Materials - Practices

- Train a staff member to evaluate the quality of materials you give to patients.
- Identify poor-quality materials.
- Select better materials.
- Consider alternatives to written materials.
- Use the Internet
- Provide materials in languages your patients speak
- Create new materials to fill gaps, and revise homegrown materials that need improvement
- Resources:
  - https://www.cdc.gov/other/pdf/everydaywordsforpublichealthcommunication.pdf
  - www.plainlanguage.gov

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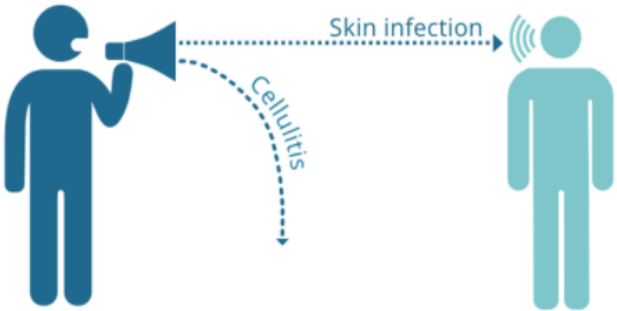
Easy to Read Materials

- Use Simple Language
- Some examples could be:
  - Smoking cessation - stop smoking
    Diet - what you eat and drink
    Referral - being sent to see someone else



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Easy to Read Materials

- Visual Aids:

Include pictures and avoid unnecessary details

- Use models
- Use photonovelas, easy-to-read stories (comic books); photos instead of pictures
- Use videos

- Tools:
  - Online videos: Most patients have access to the Internet; there are numerous online videos (e.g., YouTube) illustrating important and common patient education topics; an example of a humorous education video on colonoscopy preparation is available at https://www.youtube.com/watch?v=H7V5bmyk8BU
  - Photonovela Diabetes & Depression: https://youtu.be/3cq8ZlUTJz4
  - Photonovela Prediabetes

https://youtu.be/yMBJtm9a39U

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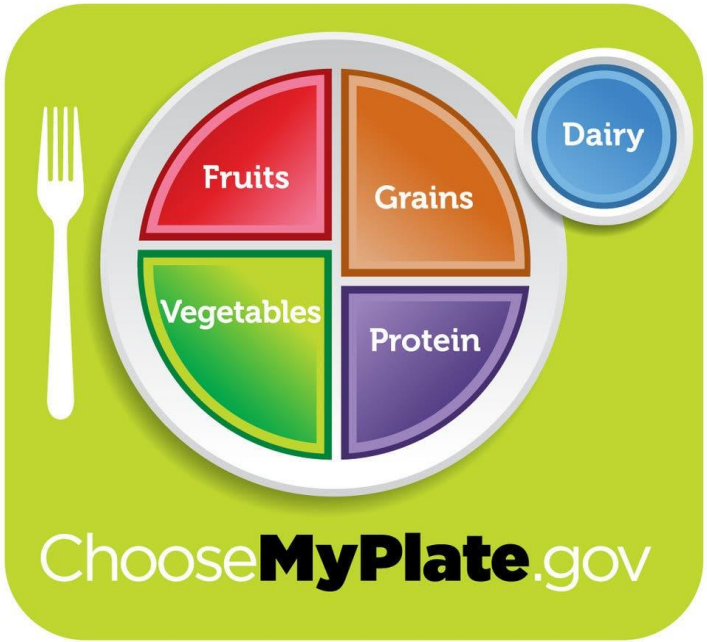
Use Pictures



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Routinely offer help with paperwork

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Review how to Develop an Action Plan

- Collect assessment data
- Review the primary care health literacy assessment
- Discuss opportunity for improvements

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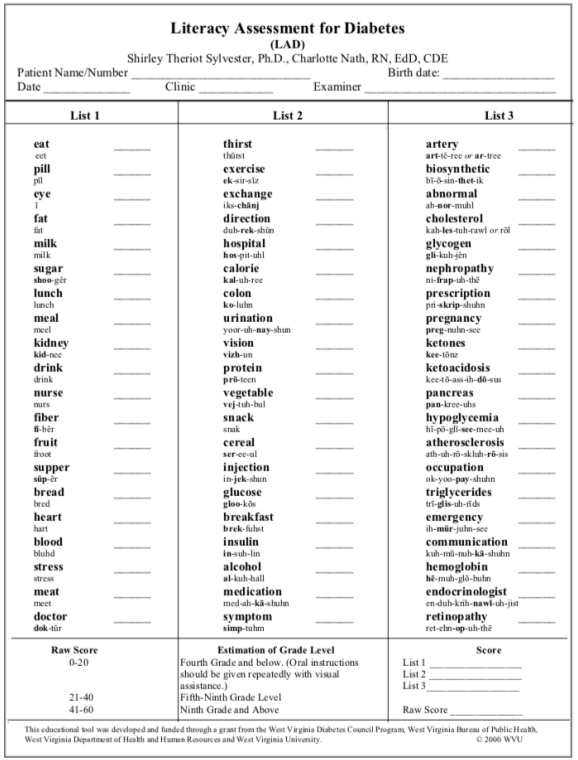
Literacy Assessment for Diabetes



Literacy Assessment for Diabetes
(LAD)

Shirley Theriot Sylvester, Ph.D., Charlotte Nath, RN, EdD, CDE

Patient Name/Number _____ Birth date: _____
Date _____ Clinic _____ Examiner _____

List 1		List 2		List 3	
eat eet	_____	**thirst** thûrst	_____	**artery** **art**-tê-ree *or* **ar**-tree	_____
pill pil	_____	**exercise** **ek**-sir-sîz	_____	**biosynthetic** bî-ô-sin-**thet**-ik	_____
eye I	_____	**exchange** iks-**chânj**	_____	**abnormal** ab-**nor**-muhl	_____
fat fat	_____	**direction** duh-**rek**-shûn	_____	**cholesterol** kah-**les**-tuh-rawl *or* rôl	_____
milk milk	_____	**hospital** **hos**-pit-uhl	_____	**glycogen** **glî**-kuh-jên	_____
sugar **shoo**-gêr	_____	**calorie** **kal**-uh-ree	_____	**nephropathy** ni-**frap**-uh-thê	_____
lunch lunch	_____	**colon** **ko**-luhn	_____	**prescription** pri-**skrip**-shuhn	_____
meal meel	_____	**urination** yoor-uh-**nay**-shun	_____	**pregnancy** **preg**-nuhn-see	_____
kidney **kid**-nee	_____	**vision** **vizh**-un	_____	**ketones** **kee**-tônz	_____
drink drink	_____	**protein** **prô**-teen	_____	**ketoacidosis** kee-tô-ass-ih-**dô**-sus	_____
nurse nurs	_____	**vegetable** **vej**-tuh-bul	_____	**pancreas** **pan**-kree-uhs	_____
fiber **fi**-bêr	_____	**snack** snak	_____	**hypoglycemia** hî-pô-glî-**see**-mee-uh	_____
fruit froot	_____	**cereal** **ser**-ee-ul	_____	**atherosclerosis** ath-uh-rô-skluh-**rô**-sis	_____
supper **sûp**-êr	_____	**injection** in-**jek**-shun	_____	**occupation** ok-yoo-**pay**-shuhn	_____
bread bred	_____	**glucose** **gloo**-kôs	_____	**triglycerides** trî-**glis**-uh-rîds	_____
heart hart	_____	**breakfast** **brek**-fûst	_____	**emergency** ih-**mûr**-juhn-see	_____
blood bluhd	_____	**insulin** **in**-suh-lin	_____	**communication** kuh-mû-nuh-**kâ**-shuhn	_____
stress stress	_____	**alcohol** **al**-kuh-hall	_____	**hemoglobin** **hê**-muh-glô-buhn	_____
meat meet	_____	**medication** med-uh-**kâ**-shuhn	_____	**endocrinologist** en-duh-krih-**nawl**-uh-jist	_____
doctor **dok**-tûr	_____	**symptom** **simp**-tuhm	_____	**retinopathy** ret-ehn-**op**-uh-thê	_____

Raw Score	Estimation of Grade Level	Score
0-20	Fourth Grade and below. (Oral instructions should be given repeatedly with visual assistance.)	List 1 _____ List 2 _____ List 3 _____
21-40	Fifth-Ninth Grade Level	
41-60	Ninth Grade and Above	Raw Score _____

This educational tool was developed and funded through a grant from the West Virginia Diabetes Council Program, West Virginia Bureau of Public Health, West Virginia Department of Health and Human Resources and West Virginia University.

- https://healthliteracy.bu.edu/documents/37/Literacy%20Assessment%20for%20Diabetes%202-00.pdf

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The Rapid Estimate of Adult Literacy in Medicine (REALM).

Patient Education Workshop

Assessing the Literacy Skills of Your Adult Patients

You can quickly determine your patient's literacy with this oral reading and recognition test, known as the Rapid Estimate of Adult Literacy in Medicine (REALM). It measures a patient's ability to pronounce 66 common medical words and lay terms for body parts and illnesses. To use the REALM, follow these five steps:

1. Give the patient a copy of the following lists of words. (Keep a copy for yourself.)

List 1		List 2		List 3	
Fat	Cancer	Fatigue	Miscarriage	Allergic	Gonorrhea
Flu	Caffeine	Pelvic	Pregnancy	Menstrual	Inflammatory
Pill	Attack	Jaundice	Arthritis	Testicle	Diabetes
Dose	Kidney	Infection	Nutrition	Colitis	Hepatitis
Eye	Hormones	Exercise	Menopause	Emergency	Antibiotics
Stress	Herpes	Behavior	Appendix	Medication	Diagnosis
Smear	Seizure	Prescription	Abnormal	Occupation	Potassium
Nerves	Bowel	Notify	Syphilis	Sexually	Anemia
Germs	Asthma	Gallbladder	Hemorrhoids	Alcoholism	Obesity
Meals	Rectal	Calories	Nausea	Irritation	Osteoporosis
Disease	Incest	Depression	Directed	Constipation	Impetigo

2. Ask the patient to read aloud as many words as she can, beginning with the first word on List 1. When she comes to a word she cannot read, tell her to do the best she can or say, "blank," and then go on to the next word on the list.

   If the patient takes longer than five seconds to read a word, prompt her to move on by saying, "blank," and pointing to the next word on the list. If the patient begins to miss every word, ask her to pronounce only those words she knows.

3. On your copy of the lists, keep score of the patient's answers. Next to each correctly pronounced word, write a plus sign (+). After each word that was not attempted or was mispronounced, write a minus sign (-).

Murphy, P. & Davis, T. (October 1997). When low literacy blocks compliance. *RN*, p. 61.

- https://healthliteracy.bu.edu/documents/37/Literacy%20Assessment%20for%20Diabetes%202-00.pdf

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Review how to Develop an Action Plan

- Set your health literacy improvement goals
- Use the Primary Care Health Literacy Assessment to identify the tools
- Decide how you will implement the tools you have chosen.
- Develop a clear and written action plan
- Define who will be responsible
- Set time-specific, achievable objectives.
- Establish measures
- Track your progress

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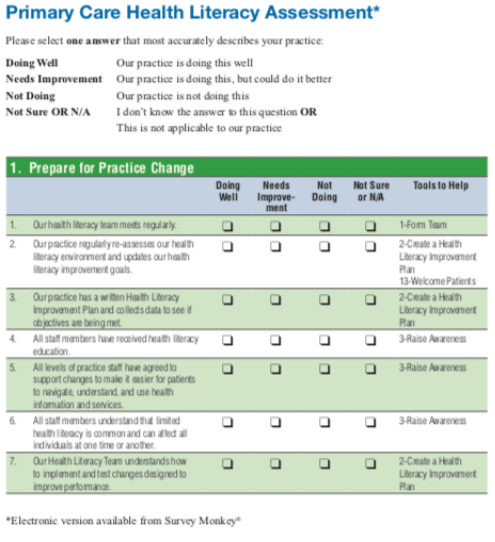
Primary Care Health Literacy Assessment Tool

- Prepare for practice change
- Improve spoken communication
- Improve written communication
- Improve self-management and empowerment
- Improve supportive systems
- Source:
  - https://www.ahrq.gov/sites/default/files/publications/files/healthlittoolkit2_3.pdf



Primary Care Health Literacy Assessment*

Please select **one answer** that most accurately describes your practice:

Doing Well	Our practice is doing this well
Needs Improvement	Our practice is doing this, but could do it better
Not Doing	Our practice is not doing this
Not Sure OR N/A	I don't know the answer to this question **OR** This is not applicable to our practice

1. Prepare for Practice Change

		Doing Well	Needs Improvement	Not Doing	Not Sure or N/A	Tools to Help
1.	Our health literacy team meets regularly.	❑	❑	❑	❑	1-Form Team
2.	Our practice regularly re-assesses our health literacy environment and updates our health literacy improvement goals.	❑	❑	❑	❑	2-Create a Health Literacy Improvement Plan 13-Welcome Patients
3.	Our practice has a written Health Literacy Improvement Plan and collects data to see if objectives are being met.	❑	❑	❑	❑	2-Create a Health Literacy Improvement Plan
4.	All staff members have received health literacy education.	❑	❑	❑	❑	3-Raise Awareness
5.	All levels of practice staff have agreed to support changes to make it easier for patients to navigate, understand, and use health information and services.	❑	❑	❑	❑	3-Raise Awareness
6.	All staff members understand that limited health literacy is common and can affect all individuals at one time or another.	❑	❑	❑	❑	3-Raise Awareness
7.	Our Health Literacy Team understands how to implement and test changes designed to improve performance.	❑	❑	❑	❑	2-Create a Health Literacy Improvement Plan

*Electronic version available from Survey Monkey®

Supportive Systems:

- Link patients to non-medical support
- Link patients to health and literacy resources in the community
- Train all staff on health literacy awareness and communication principles
- Limit paperwork and redundant forms
- Offer help with forms

- Tool:

Agency for Healthcare Research and Quality Health Literacy Universal Precautions

Toolkit: http://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/literacy-toolkit/index.html

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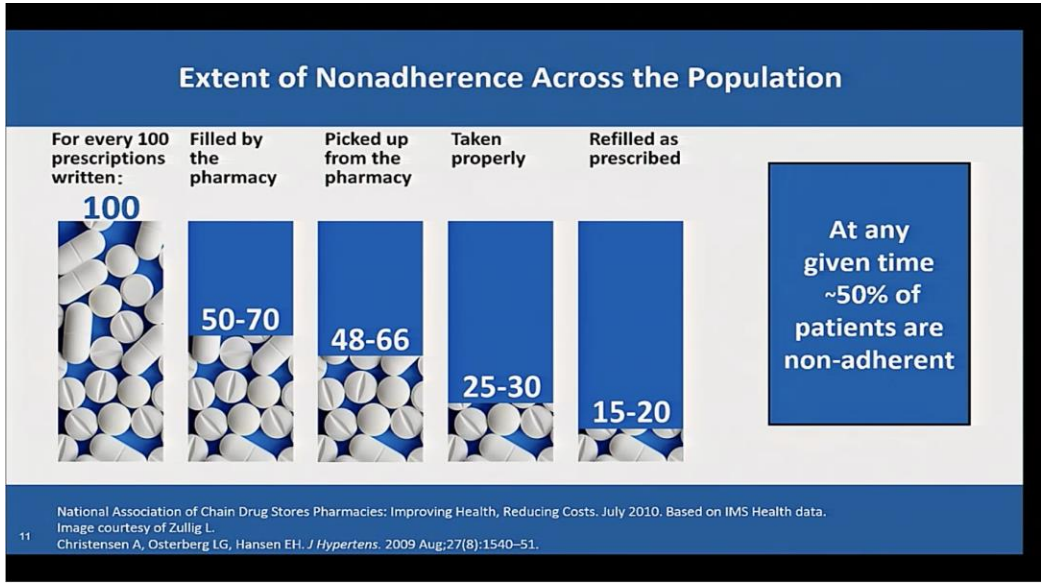
Discuss Medication Adherence



Source: https://www.youtube.com/watch?v=sEMCR7LchcA

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Discuss Medication Adherence

- Provide written or typed medication lists
- Ensure medication review and/or reconciliation for all patients at all encounters
- Offer different methods for medication organization, such as pillboxes
- Create an action plan, outlining steps the patient can take to attain a health goal
- Create an action plan, outlining steps the patient can take to attain a health goal

- <u>Tools:</u>

- "Before you leave today, I want you to tell me the main problem we talked about, what you need to do next, and why it is important for you to do what we planned."

- "Brown bag" review of medications: Ask patients to bring in all of their medications and supplements to appointments so that you can verify what they are taking, answer their questions, identify any errors or interactions, and assist with adherence

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Medication Adherence II

- Assess understanding of medication adherence
- Ask patients how they remember to take their medication
- Write precise instructions for taking a medication; for example, give specific times instead of using vague instructions such as twice daily
- Encourage patient participation: open-ended questions (what questions do you have?)
- Encourage patients to bring a list of 2-3 questions to appointments

- <u>Tools:</u>
  - Ask me 3: Encourage patients to know 3 things before leaving the encounter:
  - What is my main problem?
  - What do I need to do?
  - Why is it important for me to do this?

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Contact Information

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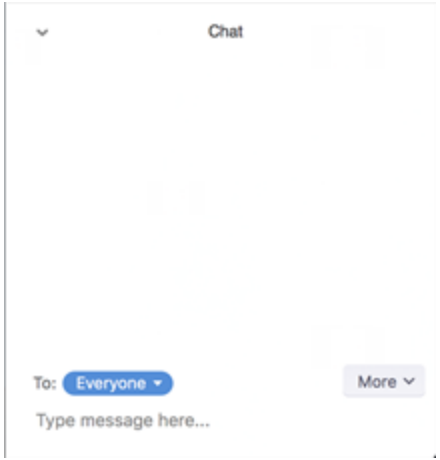
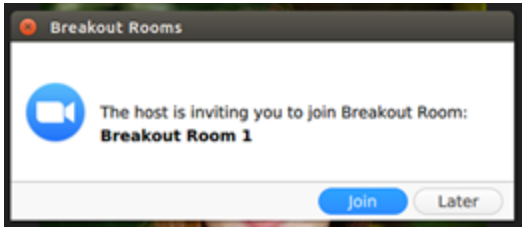
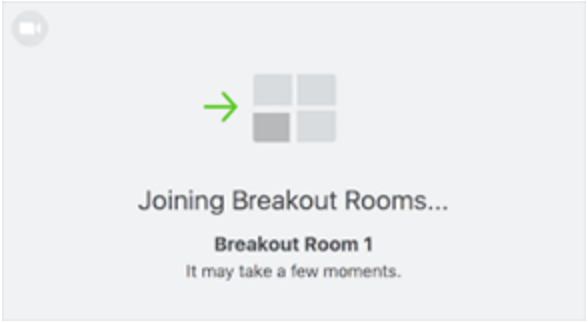
Breakout Sessions

Zoom Features







Case Study

- **Chief Complaint: "**I just moved to live with my son and need to find a doctor."
- **History of Present Illness:**

JK is a 65-year-old Hispanic man who has recently switched his care to your clinic since his move to live with his son. He has had diabetes for 10 years and has a history of hypertension and elevated cholesterol. He is at your clinic today for his intake visit and to have his care established. He states that he is compliant with his medications. He checks his feet regularly since he works carpentry jobs and stands a lot. He has noticed some tingling in his feet recently. He can explain the signs and symptoms of hyperglycemia and hypoglycemia, but has not experienced either recently. His diet has not changed, and he is aware of the need to limit carbohydrates.

LC

Impact of Health Literacy on Patients' Diabetes Management and Self-Care

Breakout Session Questions

- What additional medical information would you like to know about JK before offering diabetes education?
- How would you measure his health literacy level?
- In addition to assessing his health literacy level, What other sociodemographic risks would you like to know?
- What resources (printed, visual) would you use?
- What diabetes complication needs to be addressed?

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Take-home Questions

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Impact of Health Literacy on Patients' Diabetes Management and Self-Care

Reflection Questions

Between now and the next session (March 16th), reflect on the following questions:

+

THANK YOU!

For information about the Special and Vulnerable Populations Diabetes Learning Collaborative, visit **chcdiabetes.org** today.

Feel free to contact our NTTAP collaborating partners and speakers from today's webinar:

Jose Leon- jose.leon@namgt.com
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Hansel Ibarra- hibarra@mhpsalud.org
Selenia Gonzalez- sgonzalez@mhpsalud.org

At the end of this webinar, please complete the evaluation form. Your feedback is greatly appreciated