Health Literacy:
Effective Client Communication and Education
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Hello, and welcome to Social Work at Continued.com. My name is Farzana Chowdhury and I will be your moderator for this online course. It is my pleasure to welcome today's session titled health literacy, effective client communication and education, by Dr. Kathleen Weissberg. Dr. Weissberg has 25 plus years of practice and has worked in longterm care as a researcher educator, and has established various programs in nursing facilities, including palliative care, adult sexuality, falls management, dementia care, and staging. She provides continuing education support to 6,000 therapists nationwide as director of education for select rehabilitation. In addition, Dr. Weissberg has lectured nationally and at the state level and has authored publications of dementia quality care. Without further ado, I'm gonna turn it over to Dr. Kathleen Weissberg.

Thank you so much for that introduction. And for those who are tuning in and listening in to this session thank you so much for being here for what I think is a really important topic. If you think about health literacy, we know the definition, it's the ability to read, to compute, to understand, to act on health information, primarily to make informed decisions about one's health. And we know that low health literacy is a serious threat to the wellbeing of individuals who might be seeking out medical care. As we look at clinical practice, there's this increased diversity of course of our clients. And with that, we may observe that our communication skills possibly could be less effective with people from different backgrounds, different from our own. So it's our idea in this course to give an overview of health literacy, we're gonna talk about some techniques for clear and effective communication, verbal and written communication, particularly for those who are from other cultures, talking about easy to read health materials, some assessment tools that maybe you can use to make sure that the people with whom you are working, understand what you're all about, what the services are that you're providing, what are the services are that are available to them. And most importantly, that they have the skills that they need to access to understand, to use that health information.
So with that introduction, let's quickly go through some disclosures. You can certainly read the slide here. They are, I have no relevant nonfinancial relationships to disclose. I have received an honorarium for presenting. We're not gonna focus exclusively on any specific product or service. And as you know, this course is being presented by Continued Social Work. So these are the objectives for today’s session. We will define health literacy, recognize health literacy concepts including some relevant statistics, identify some appropriate assessment tools to evaluate health literacy levels, recognize factors that influence health literacy. And then finally describe some techniques that the practitioner can utilize to facilitate health literacy in his or her practice. And when I use the term practitioner, just more of an FYI that's any practitioner. So you as a social worker can certainly use this. You also can teach others, maybe it's nursing, maybe it's therapy, maybe it's even healthcare practitioners, medical practitioners to use some of these same tips and strategies.

So with that, let's start with an introduction. And I think we need to start by going over a few basic definitions so we’re all on the same page. Starting with literacy, that is the ability to understand, to use reading, writing, speaking, other forms of communication, as ways to participate in society, to achieve your goals, to achieve your potential. Now health literacy, which is obviously what we’re here to talk about, is the degree to which individuals have the capacity to obtain, to process, to understand basic health information and services that they need to make appropriate health decisions. Now, we know that health literacy is dependent on a lot of things and we’ll be going through what it is dependent on. Individual factors, systemic factors, so things within that individual things within society, within the environment, within the healthcare setting, perhaps where that person is receiving their services. And it can be dependent on the communication skills of the professionals that that person comes into contact with, of laypersons that they come into contact with. Our knowledge, our professional knowledge, or even the lay knowledge of health topics. And we’ve all probably been
there at some point in time where someone's trying to explain something to you and you're listening. You're like, "That's just not correct. I know better."

We make mistakes and we don't always have all of the correct knowledge. Certainly based on culture. Based on the demands of the healthcare situation that person is in, the public health system again that they're in, are they in a hospital? Is it a teaching hospital? Is it a community hospital? Is it the physician's office? And certainly the demands of the situation or the context and recognizing too, that that situation, depending on what it is could cause a lot of stress, let’s say it's a surgery or a situation that is very dire is very severe, that's going to impact health literacy, maybe even a little bit more than a situation where you're just getting a regular checkup or a regular physical from your physician. And we obviously know too that health literacy is going to affect an individual's ability to navigate that healthcare system. Filling out forms, locating providers, locating services, I don't know about everybody else listening, but I'm in healthcare and I struggle to fill out my forms every year to obtain my healthcare, to fill out... I just recently changed healthcare providers and I had to fill out all new paperwork. It really is a challenge. And I’d like to think I have good health literacy. So imagine if you didn’t. It’s also going to affect someone’s ability to share their information, their health history with their providers. What is important? What should I share? What shouldn’t I share?

Engaging in self care and chronic disease management. And we'll talk a lot about this, but having low health literacy definitely impacts that. We see that individuals with low health literacy don't use all of the preventative services that are available to them in most communities. And certainly to understanding mathematical concepts. And it says probability and risk here, but we can extrapolate that even to mathematical concepts like taking your blood pressure or knowing if you take your sugar levels, your insulin levels, knowing whether or not to take medication or not take medication. So that again, that's impacted by their health literacy. And that's kind of a nice segue into what
Health literacy involves those numeracy skills. So calculating your cholesterol, maybe your cholesterol level, your blood sugar level, measuring out your medications, whether it’s a certain number of pills or you have to cut them in half, or it’s a liquid form, maybe you’re measuring medications for your child and it’s in liquid form. Understanding nutrition labels. I mean, all of that requires math skills. Trying to choose between health plans or trying to compare prescription drug coverage. Calculating a premium, figuring out what your copay is. Even if you’re on Medicare, Medicaid, what have you, what is your deductible? So all of that is numeracy. And it’s not necessarily math and how well you did in math and how good you are at algebra and all of that, but it’s just basic numeracy skills.

Now, in addition to basic literacy skills, health literacy also requires knowledge of health topics. So people with limited health literacy oftentimes don’t have the knowledge, or sometimes they have some knowledge, but it’s not the correct knowledge. It’s misinformation about the body, about the nature and causes of diseases. And without that, sometimes they don’t understand fully the relationship between lifestyle factors like diet and exercise and other types of things, medications, and what the outcome would be on their health. To continue on health information, obviously can overwhelm even persons with advanced literacy skills as I just said. Medical science progresses very, very quickly. And what we see sometimes is that what people may have learned about health or biology during their school years, or maybe even during college or something, often becomes outdated. We forget it, or it’s incomplete. It’s been updated. Moreover, as we already said, health information that is provided in a stressful or an unfamiliar situation is very much unlikely to be retained.

So and again, we’ve all been there. My husband was just recently at the hospital for a medical procedure and at the discharge getting the discharge instructions, it was just rapid fire, not even at him, at me because he was still under a bit of sedative, but it is this rapid fire, and it’s very, very difficult sometimes to understand that and process all
of that. Now we know that low literacy is a global crisis that affects everyone. And again, that’s why it’s so important to address the issue and confront those facts head on. Quite simply, the responsibility is ours as healthcare professionals to communicate in plain language, and we’ll be talking about what that means here in just a second. Without having very clear communication, we can’t expect people to adopt the healthy behaviors to adopt the recommendations that we champion to access the services that we’re talking to them about. When people receive very accurate, easy to read, easy to use information about a health issue, about a service about what’s available, the better able to take action to protect and promote their health and wellness.

So here’s plain language. Plain language is a strategy for making both written information and oral or spoken information easier to understand. And it’s a really important tool for improving health literacy. Plain language is communication that we can understand any user can understand the first time they hear it, the first time they read it. And within reasonable time and effort, a plain language document is one where somebody can find what they need. They can understand what they find. They can act appropriately on that understanding. And most importantly, the first time they don’t need to take it to someone else have it re-read and reread, and re-read, it’s very simple, easy to use. The key elements of plain language means organizing information, so the first and the most important points come first. Breaking down the complex information into things that are understandable chunks. So rather than these huge paragraphs, just small snippets of information. And again, just giving the need to know information, not the all there is to know information. Using very simple language, defining the technical terms and using an active voice, which we’ll talk a little bit more about as we go on. Also recognize with plain language that what is plain to one reader or one set of individuals, may not be plain to others. And I think we inherently know that. But we don’t always think that as we develop educational materials and brochures and different things like that. So we have to know who is the audience that this material is going to. And many times if we can have them test it out, we can test
out those materials before we develop them during development, afterward, make sure that they’ve met their mark. That's very important.

And we’re talking about written materials here, but remember that speaking plainly is just as important as writing plainly. So we want to use plain language when we talk about verbal messages. So avoiding jargon, explaining the technical terms, explaining medical terms, those sorts of things. So let’s switch gears a little bit and talk about the incidents and the statistics related to low literacy. More than 36 million adults in the United States cannot read, write, or do basic math above a third grade level. And that's pretty staggering. Low literacy if you look at it, it costs the United States $225 billion or more every single year and nonproductive work in the cost of crime and the loss of revenue due to unemployment or underemployment in some cases. $232 billion each year in healthcare costs alone are linked to low literacy. And again, we'll talk a little bit more about what that means again, that means people maybe not following through on recommendations, not taking those preventative measures. And if you think about it every year, about 2 million immigrants come to the United States and about 50% of those lack of high school education and lack proficiency in English, which is the primary language that a lot of our materials and such are developed in.

Now, a study conducted on health literacy back in 2005, by Campinha-Bacote found that patients who were surveyed... of the patients that they surveyed 43% did not understand the rights and responsibilities section of a Medicaid application. 26% were unable to understand information on an appointment slip or an appointment card like from an outpatient clinic or a medical appointment. 60% didn’t understand a standard informed consent and extrapolate that to HIPAA types of compliance materials and such. 33% were unable to read basic healthcare materials. And 42% could not comprehend directions for taking medications on an empty stomach. And again, those are some pretty staggering statistics. Now we know that a low health or limited health
literacy will affect most adults at some point in their lives, unfortunately, there are some disparities in prevalence and in.

So there are certain populations that are more likely to experience limited health literacy now just caution. They are more likely to experience limited health literacy. Not saying that they will, not saying that it’s an absolute that they will have this, but they are at greater risk than other individuals. And this would be adults over the age of 65, recent refugees or immigrants, individuals, or people with incomes at or below poverty levels, racial and ethnic groups other than white, individuals who have less than a high school degree or a GED, and then non native speakers of English are at greater risk than other segments of the population. Again, staggering, nearly nine out of 10 people in the United States have limited health literacy and experienced difficulty using health information to effectively manage their health and their healthcare. That's again, pretty staggering. That's 90%. And there's this discrepancy between the health literacy level of the healthcare professional and that of an individual receiving health services. And this is one of the big reasons why we have poor communication in health and healthcare. We, as the healthcare practitioners have a totally different level of literacy. And I don't think we always do, but it’s not uncommon to see us, just assume, "Oh yeah, of course they understand that. Of course they get that because we do." And we assume sometimes that it is just very much common knowledge and that's not the case. And it’s also really important to know that a person's education is not a good predictor of his or her health literacy. In fact, since almost 90% of individuals have limited health literacy, individuals of every race, age, income, education are going to be affected.

And again, I'll tell you some personal stories as we go along. My mother and father, both college graduates, have worked their whole lives, and they do in fact have limited health literacy. There is a struggle for them, they're aging now. It’s a struggle for them to figure out their Medicare claims to figure out their paperwork. And again, so
education is not a good predictor. Now for these reasons, the Health and Human Services Agency for Healthcare Research and Quality or AHRQ, recommends that we adopt universal precautions and that approach. And we're very familiar with that obviously, as it relates to infection control. But this is an approach in which we assume that most individuals will struggle to understand health information. And we present materials in a way that will accommodate all levels, not just the higher levels. Remember too the literacy skills are a very strong predictor of health status and even stronger than age, income, employment status, education, racial ethnic group, health literacy is so important.

Now again, too, you're not gonna be able to identify individuals who have limited literacy. They may speak well. They may look very well educated. They don't tell anyone oftentimes about any difficulties that they're having with reading and writing. So again, that's why you want that universal precautions approach and assume that everybody you come in contact could possibly have difficulty understanding the health information that you were presenting. And to reduce the risk of communication errors, you just simplify all of your communication and then confirm comprehension for individuals. And we'll talk more about that in a second. Now, are there signs of low literacy and illiteracy? Of course there are. Poor compliance with treatments or appointments, watching or mimicking others, not knowing the names of regularly scheduled or regularly used medications or regular tests that they have done. Making excuses for not reading something that you put in front of them. "Oh, I forgot my glasses. I left them at home, or I'll just take this home with me and I'll have my wife take a look at it for me." Maybe bringing someone with them who can read and they give that to them. You can see them sometimes vocalizing or having sub vocalization when they read, you see their mouth moving, or they have confusion or frustration that maybe they don't show per se, but you can kind of see it in their face when they are reading.
And some other signs. And again, we can read the slide together here, behaviors. The registration forms have mistakes. They're not taking their meds. They don't follow through with recommendations. Here's some of those responses, "I forgot my glasses. Can you read this to me?" And then responses maybe about medication or about a regimen that they should be doing for their health. They can't name it, they can't explain it. They don't have a down the schedule, the frequency, those sorts of things. So again, that might be a good sign that they have low literacy. So what's the impact between health literacy and health outcomes. So we've already kinda hit on some of this, but these are the details. Preventative services. According to a lot of research studies that again, you can see posted here, persons with limited health literacy skills are more likely to skip important preventative measures. Like mammograms, like pap smears, like a flu shot or a pneumonia shot or other vaccines that they should have. Even down to the level of like prenatal care, they may not be attending all of their appointments with their OB GYN as they should be. Now comparing those two individuals with adequate health literacy skills, studies have shown that individuals who have limited skills enter the healthcare system when they're sicker. So they're not taking care or not using the preventative services, so when they do finally come into the healthcare arena, they are generally sicker.

Additionally, individuals with limited health literacy skills are more likely to have chronic conditions and they are less able to manage them effectively. So patients with high blood pressure, diabetes, asthma, HIV AIDS, et cetera, who have limited health literacy skills have less knowledge of their illness, less knowledge of how to manage it and manage it appropriately. Now we also know that limited health literacy skills are associated with an increase in preventable hospital visits and admissions. Again, studies have demonstrated a higher rate of hospitalization and use of emergency services among patients with limited health literacy skills. So they're going to the ER, as again, opposed to a preventative appointment maybe with again, the OB GYN or with their regular medical professional. Additionally, studies demonstrate that
individuals with limited health literacy skills are significantly more likely than individuals with adequate health literacy skills to report their health as poor. So when asked, they’ll say that their health is poor.

Going on, individuals with limited health literacy skills make greater use of services designed to treat complications of the disease. And as we already said, less use of services designed to prevent complications. Studies demonstrate a higher rate of hospitalization, as we already said, and use of emergency services. And that then translates into higher healthcare costs, obviously not just for that individual, but for the community at large. And then finally, and I think this is a really important one, low health literacy may have a negative psychological effect. One study. I don't remember which one of the two that's listed here, found that those with limited health literacy skills reported a sense of shame about their skill level. They are in fact ashamed of what they are or are not able to understand, read, write, et cetera. And moreover, won't tell people about it. So they hide their reading, their vocabulary difficulties primarily to maintain their dignity. So what's our role? What are we supposed to do here? Well, we're gonna tell you, right? So if you think about, and again, practitioner, this is any practitioner in healthcare at any level. I think we all have an opportunity. We all have a role in assisting to make sure, to ensure that all health related information, all education that we give to our patients, to individuals who come to us for service match that person's literacy abilities, their cultural sensitivities, their verbal, their cognitive, their social skills, match it up. And again, think about it, I mean, how many times have you been talked to, let's take healthcare out of it again, I'll tell you a story. I had to call an accountant the other day for something. And it just went right over my head. Some of the lingo that he was using some of the terminology. And I said, "Okay, hold on backup. I don't quite understand that." You have to match what it is that you're telling that person to what it is that they're going to understand, and then of course, to what's important to them.
The objectives that were set in the Healthy People 2020 campaign that came out from the Department of Health and Human Services included ensuring that we all as practitioners have appropriate communication and education skills to help enable everyone to gain access to and understand our services. Again, that includes information and education for self management, for optimum health and participation. Again, we can too facilitate health literacy. And we'll talk about that here in just a second. We in healthcare, again, in our roles, we are linked because again, think about what you do on a day to day basis. You are stressing the importance of capacity and function and participation empowerment. We look at things in our background using a very holistic approach. We're very client centered. We teach. We use different information, different methods to teach that. And we are strong proponents of access to services and equity issues. So we are perfectly poised to address literacy obviously in our practice. So how can we do it? How do we integrate health literacy into the practice? Well, first of all, obviously you're here, so you'll be informed about health literacy, know how to recognize it.

So identifying challenging health literacy information. Learn about ways that you can integrate it into your day to day practice. We already said this don't assume that everyone, all of your clients are going to understand what they're told, even if they nod their head, even if they say they can read it, even if you... what's that old saying that it takes seven times to really understand something. Even if they say the first or second time, "Yeah, yeah, I got it, I got it." Go back over it. We can't assume that they truly do have that. Recognize of course, the powerlessness, the shame, the sense of failure that people will feel related to this. And of course identify your client's characteristics, their knowledge, their teaching preferences, their skills, their beliefs, their culture, their barriers, and work within those. We also know that individuals who have low literacy levels are usually reluctant to ask questions and they're really skillful at hiding their problems. Now, although diverging opinions exist about whether or not we can truly
evaluate their health literacy, we have to recognize that there are individual barriers, there are societal barriers to promotion.

So, functional declines associated with aging impacts health literacy. The lack of reading and writing proficiency, low levels of formal education, lack of health, knowledge and skills, a different mother tongue or cultural beliefs, living with disabilities and social stigma certainly impact health literacy. And then experiences maybe that they've had in their early childhood. And I think what we're talking about there is really the impact of trauma on what that does to somebody's health. So just recognizing trauma informed care. We can also standardize the practice to health literacy. So this really is focusing on our ability to take into account an individual's health literacy level during any intervention or any interaction that we have with them. So in addition to being informed, most of our national professional associations, regulatory licensing bodies, they also contribute to developing professional standards, position statements that help again, to incorporate this directly into your practice. And in fact, every employee, everybody you interact with on the work side may value health literacy. And we can certainly talk about that as it relates to a facility's policies and goals or an organization and employer's goals. We wanna consider health literacy too by making that information accessible. So this refers to the ability of us as the practitioner to improve how we maze, make information available, how we educate, how we use information. So again, we already talked about this a little bit, but adapting that information to the circumstances, showing how it's relevant. We'll talk about that in just a moment.

Communicating in a comprehensive way, using more than one way of exchanging information. So you're not gonna get everything verbally. Maybe we have to use gestures or pointing or signage or something else, some of our non-verbals. Combining oral instructions with written information again, in very clear, simple language for a future reference. Doing a lot of demonstration, audio-visual aids. Using
a very structured educational approach to understand what motivates your client to personalize your approach. And then certainly using demonstration, as I just said, experimentation, repetition, all of those things to increase the effectiveness of what it is that we’re trying, not necessarily just to teach, but also to communicate to others. We’ll talk more about this as we go along. And actually, maybe we'll just pull out that handout now, but designing written information, and there is a handout associated with today's session where it talks about how you can make your message clear. We'll dive into this a little bit more toward the end too, but you want to design your written information in an active voice, the same way that you talk. Clear, simple language using common short words, short sentences, 10 words or less, avoiding the technical terms, the value judgment words, the jargon, the abbreviations. If you need to use something, give an example, use the same words throughout. Using pictures or drawings. And we'll talk more about that here in just a second.

Be interactive have recaps. So let's recap where we've been before we go on or something. Put the most important message first and then personalize that information. Also, limit the number of messages that you give to someone. Avoid the lengthy lists, create short lists, maybe just three items or five items or something like that. You want bullets, no commas, because that's very difficult to read. When we are communicating, it's important to tell the audience what they need to do, not what they shouldn't do. So always again, framing it in the positive, highlighting the positive, the shoulds, not the should nots. Help them to understand what they're gonna get out of the information. What's in it for me. So again, designing it for them. When you're communicating, communicate just as if you were communicating to a friend. And that's your word choice, that's your intonation, that's your reflection. If you're writing it down, write it down as if you are writing a note to a friend. Respect your audience, don't talk down to them, don't preach to them because if you do, they're probably not gonna follow through. They're just gonna throw your stuff in the garbage. Certainly choose words too that have just a single definition or a single connotation. Individuals who have
limited health literacy skills may have difficulty trying to figure out what you mean based on that context. Using analogies, I think is really great or storytelling. And we'll probably talk about that another time. But people will remember, "Oh yeah, so and so was telling me..." and this story, and that will stick to them. So when you make it personal and you can do something that's familiar that will certainly help.

Limiting statistics, so I just had some statistics, but if you have to talk about numbers, use generalities. So most, many, half, making it a little more general. Using symbols sparingly, limiting your use of quotation marks. Again, it's just fluff on the page a lot of time. And using visuals. And I think we'll talk about this again on another slide later on, but again, showing what you want the person to do, not what you don't want them to do, accentuating the positive. And I think it's really important to, whatever visual you use, it needs to be meaningful to what it is that you're trying to convey. So if it's a real life event or something that you want them to do, maybe it is a photo that you share, maybe it's a cartoon, but recognize that not everybody's gonna have the same sense of humor. So you may offend someone if you use that. Maybe it's a simple line drawing a pen illustration that will get your point across. I think what you don't wanna use is use things like clip art and things like that, that look really cute on a page, but don't necessarily add anything to what it is that you're trying to communicate. And we'll get, we'll talk a little bit more about that as we go into the end of the session. Also communicating effectively. Announce the subject, convey the message, ask them to say it in their own words. It's super simple three steps. What they remember about the information, what they remember about the methods taught, and this is a teach back type of technique. And what it does and we'll again, I think it comes up on another slide as well, but it gives them an opportunity to tell you what they understand. And if they don't understand it fully, if there is a misunderstanding, you can correct it and put it in the correct perspective.
We can also use the Ask Me 3. So I love this. What is your main problem today? What do I need to do for you concerning this problem? And why is it important to you? I love this because it's very, very much open-ended and it's an opportunity for them to again, put it in their own words. What is their understanding? Why are they here? And what can you do about it? Do they even understand who you are and what you're all about? Why you're there to help them. Additionally, help clients make optimal use of health services. Again, by integrating this, we increase quality of our communication. We increase the quality of our competencies. And again, I already mentioned this, but using anecdotal information from everyday life, because they're definitely going to remember that. They're not gonna remember the bullet list and all the other stuff, but they will certainly remember that. And again, don't overburden our clients with information or recommendations. You wanna tell them everything, I get that, but you just need to select a few key points that are most important to clinically. And then hopefully you have an opportunity to follow up at other sessions where you can continue to provide information, but at this point it has to be the most important information they need to know.

We can also strengthen our interactions. And I think we probably do this anyway. I think this is intuitive, but encouraging people to ask questions, remember if I do have low health literacy, I'm hesitant maybe to speak up or ask those questions. Certainly take an understanding attitude. Don't blame them, create a shame-free environment. And I think we would do that anyway. And maybe increase the time that you spend on giving information. Speak more slowly, repeat it if necessary, observe, listen, and really observe. Because again, that person is gonna nod and shake their head and say, "Yeah, yeah, I got it." Their face may tell a totally different story. Stay quiet, give them an opportunity to organize their thoughts, to identify what their issues are and to formulate their questions. And sometimes this is really tough to do. As I said, my parents are aging and I'm their only child right now, my brother has since passed away. And so trying to sit there and give them information and work through things
sometimes can be really frustrating. And you have to sit back and say, just be patient, give them time. And I think we can do the same thing with our clients. We probably do it. We're probably harder on our families, I think, than we are on our clients. Certainly increase your own cultural competency. We've been talking about that. You respect differences. You're open to learning. You're willing to admit that there's more than one way to look at the world. Certainly follow up on your interventions, follow up on any recommendations or anything that you suggested to somebody to say, did they follow up like you told them to, or like you ask them or encourage them to do, is bring me a better word. See if they have any questions. And involve not only the client, but your families in treatment.

Okay, just a few more here. We can certainly intervene to increase the client's health literacy. So this specifically involves interventions that focus on improving their health literacy levels. So, maybe we point them into a certain thing on the internet that may help them with their reading and their writing skills. Maybe we teach them in some way knowledge about health and its determinants, what they can do to improve their own living conditions. Maybe we just encourage them to read. Maybe they take a local literacy program that we recommend to them. I think above all, we can certainly foster empowerment using our client centered approach, which I know we do, give them the confidence in their ability to take more control over their lives. That empowerment, maybe they've never really been given that, but it makes them responsible for taking care of their own health for making decisions. And again, being really engaged in their care. And maybe again, it's just up to us to help find ways that they can do that. And then we can collaborate. I think this is the last one. We have an important advocacy role in influencing the goals of our health facilities, of the places where we work, the places where we interact regarding health literacy, participating actively in public health initiatives and research. We can again go a long way to helping raise awareness among everybody else in organizations and other clinical settings, other stakeholders, support
staff, managers, community partners, et cetera. So we have a great opportunity to provide some education.

So let’s talk about effective communication with diverse population. So it’s a little bit of a cultural competency here as well. We are facing new communication challenges every single day as we work with individuals who are of an increasingly diverse patient population. So effectively gathering information from individuals that we work with, it fosters individualized care, it demonstrates culture understanding, and it’s critically important. We know that communication is influenced by cultural values, by attitudes, by beliefs. And if we are going to be effective, that involves providing healthcare related information to an individual, as I’ve already said, and I’m gonna repeat it probably 17 more times, in a way that’s understandable to them, in a way that is accessible to them. That helps to increase their knowledge, doesn’t shame them, doesn’t make them feel bad about themselves. It’s gonna be useful to them. It’s meaningful. It’s purposeful again with our goal of positively influencing their health behaviors, their health attitudes. So how do we go about doing that? Well, first of all, let’s do some definitions. Communication. We know that communication can involve any of these. Verbal. Again, that’s one on one, it’s oral to get a shared meaning. Nonverbal. And this is so, so critically important. It’s gestures, it’s facial expressions, eye contact, body language. It’s written using symbols letters, numbers, what have you. And when we interact, we need to use all of these. And remember too, that linguistic characteristics can also include the language that somebody speaks, written or sign the dialect or regional variant, their literacy levels and more.

Now communication and a trusting relationship, obviously between that individual and the health care provider are critically important to providing quality care. Research shows that individuals with communication needs often have poor health outcomes. They have trouble following medical advice. They’re less satisfied with their healthcare experiences than individuals who don’t have communication barriers. It’s also
important to understand and recognize that everybody who enters the healthcare system has their own unique illness experience. We’ll talk about this a little bit more in a second. You can learn a whole bunch about a person just by adopting skills and communication techniques that are nonjudgmental really foster that communication between you and that individual, you consider cultural beliefs. If you just sit back and listen to their story and listen to what they’re telling you and really understand, it’s amazing, the information that you can glean. Compared to patients who were just told what to do, patients who are encouraged to really discuss their perception of illness, their expectation for treatment, what their ideas about their illness and health are, they experienced a greater sense of control, they feel more involved, they have less anxiety, and they accept the hospital routines, their treatment schedules that much more. When a patient cannot describe an experience of illness, you can’t communicate effectively with them, then you lack that basic connection that you need to provide appropriate care. So you’ve gotta figure out how to make sure that happens.

So with that in mind, there are some communication models out there, and there is a handout again, that’s available to you related to this in the handouts related to this session. But there are these communication models that can help you provide or facilitate patient centered care. They promote effective communication in cross-cultural encounters, and you should become familiar with them and comfortable using them in daily practice. And by doing so, and again, I’m not saying these are the end all, be all cultural guys, these are just a few that I found in the literature. But in doing so, what you can gain is a better understanding really about the person's perspective about their illness, again, in light of social, cultural, historical, all of these other factors that contribute to that experience. So we’re gonna go through these just very quickly. There are four of them. The first one is Andrew’s and Boyle’s transcultural nursing assessment guide. That’s quite a mouthful. Now, the authors of this model reviewed a variety of different trans cultural theories and models and research. And they found that a comprehensive cultural assessment is the foundation for culturally and
linguistically competent nursing care. And while this was initially designed for nurses, there is significant applicability to really every discipline in healthcare to help us really to gather relevant patient data.

So if you happen to have the handout in front of you, I am not gonna read it at you, but there are a few in here, like related to communication. What language do they speak at home? What’s their fluency level in English? Regarding cultural sanctions and restrictions. How is modesty expressed? Do they have any very specific cultural beliefs about certain things? What are their health related beliefs and practices? Maybe do they rely on cultural healers? Looking at social networks, which I think is critically important for a social work. Who's within their social network and in their household? How does the family participate in the promotion of health? What are the patient’s attitudes, their values, their beliefs about their illness? And we can certainly go on and on. I mean, that's certainly some of them, but again, it's a good way to really tap into the way I'm gonna say it, what makes this person tick as it relates to their health and their illness and why they might be coming to us?

There's three other communication models. The next one is the LEARN model by Berlin and Fowkes proposed in 1983. So these are obviously all, a little bit old, but still very, very much applicable. And this is a framework for listening. Listen with sympathy, understand their perception. E stands for explain, explain your perception of the problem they bring to you. A stands for acknowledge. Acknowledge and discuss differences in similarities between your perception, their perception. R is recommending some sort of treatment and N is negotiating an agreement. And you may not be recommending treatment per se, but you certainly could be recommending again, some sort of service that is available for this person. Now the BATHE model is the next one. And this provides... it’s a mnemonic obviously for understanding the psychosocial context of that patient’s experience. And there are questions that you ask. There's very simple questions. They're about the B, background. What's going on
in your life.? And again, very open ended to get anything. It doesn’t have to be health-related. You just wanna know, what's going on in your life. The A in BATHE has is affect. How do you feel about what's going on or what is your mood about that? How do you feel about that? T is trouble. What about this situation trouble you the most? And H, how are you handling it? And E is empathy. That must be very difficult for you. And then you then launch into whatever, again, treatment or recommendations you would have.

And then finally, the ETHNIC model. This is a framework really for culturally competent clinical practice. And again, it’s based on questions to draw out information about a patient’s explanation of illness, their treatment, their healers, and to support negotiation, intervention, collaboration about treatment. And one appeal of this specific model is that it doesn't frame the patient's beliefs as exotic or different. Again, it frames them as really everything is quote unquote normal. So again, there's questions in here. So E stands for explanation. Why do you think you're having these symptoms? Do you know anyone else who have this problem? Have you heard about it? Have you read about this problem? T relates to treatment? Is anything... are you eating or drinking anything on a regular basis to stay healthy? Tell me a little bit about that. What kinds of treatments or medicines have you already tried? H relates to healers? Have you sought advice from any alternative and you maybe you wouldn’t use alternative or folk healers, but obviously that realm. N is negotiation. Well, what options are acceptable to you? What do you want to achieve from all of this? How can I help you to do that? Intervention Is I. What is the best intervention for you? And then finally, C is collaboration. How can your family members, other healthcare members, healers, community resources, recognizing that in many cases, the community is very, very strong around that patient. How can we all work together for you? Now the reality is, as you are communicating, you could inadvertently offend someone, but you just recover and you move along. You explain how that misunderstanding occurred. You apologize to that person for the offense. Offering a very sincere apology can help you, can help
that person to find a way to address the situation and communicate a little bit better. We've all done it, open mouth insert foot, right? And you use that opportunity to say, "I am truly, sorry. I did not mean to offend you. Help me to understand, educate me, teach me." And that person just opens up. I mean, you know this, they open up, they shine. They love to be able to do just that for you.

So let's switch gears yet again. I wanna talk a little bit about language assistance services. So just has a brief overview language assistance includes interpretation of verbal communication, and then translation of written documents. And we obviously do this to get a better understanding and provide a common language so that again, we can communicate and understand each other. We know the communicating in different languages, particularly during a healthcare encounter can lead to a lot of confusion. It affects quality of care, the decisions that that person may make about their treatment, their understanding, worst case scenario their compliance with their treatment regimens. So we have to have mutual understanding between healthcare providers, clinicians, practitioners, patients, to get effective clinical encounters. Now language assistance can certainly help provide quality care to all patients by facilitating effective communication, particularly anybody with the communication need let's be honest. Including someone with limited English proficiency, or low English proficiency. It's just gonna help you to do your job better. When you and your patients can really understand each other, you're going to deliver better quality care, better quality services, because you truly understand what it is that your patient needs. Now with language assistance, individuals are more likely again, you can read the slide, understand their conditions, understand their treatment plans, understand their recommendations and follow them. And rate their care satisfactorily. I mean, we're not necessarily here to talk about that, but surely anybody that we work with is going to want good satisfaction surveys at the end of any sort of an encounter.
So again, language assistance services, it's interpretation and translation. Now note, and I think this is intuitive, but the term interpretation is used for oral or sign messages, and translation would be used for written messages. They require two totally different skill sets. Interpretation is strong listening skills and speaking skills, translation involves reading and writing skills. Trained interpreters are those people who can communicate fluently both with the patient and the healthcare provider, and these ones can provide valuable assistance during any sort of interaction and obviously improved quality of care, particularly for individuals with limited or low English proficiency. In addition, just look at your written materials, intake forms, consent forms, patient education materials can be developed or translated into another language for that individual to provide health information and education. In the full time job that I work, we have just recently started translating a lot of our education materials for quote unquote, healthy living. So a lot of those preventative medical types of things, translating those into multiple languages again, so it's more accessible to everyone. Graphics and signage that can be equally as important because they also help to ensure that patients with limited English proficiency can understand instructions they can navigate through the healthcare system.

Now, when language assistance services don’t exist, or they're minimal, the resulting language barriers can create a lot of challenges. They have been shown to impact access to healthcare services at a lot of different entry points from just having health insurance, to receiving basic preventative and specialty care. It may jeopardize somebody's comprehension of their diagnosis, their treatment, the followup care. It may diminish the quality of care and can certainly lead to adverse clinical outcomes. And it can increase healthcare costs due to inefficiencies. And research suggests Perkins in 2003, did a research study that suggested that language barriers can impede access to health services as much as if not more than the lack of health insurance can. So we focus a lot on having health insurance language in many cases is even a bigger barrier. So interpreting facilitates communication obviously between two
or more individuals who don't speak the same language. You can read the definition here, it’s the process of understanding and analyzing a spoken or signed message, re-expressing that message faithfully, accurately and objectively in another language, taking the cultural and social context into account. And that comes from the National Health Law Program from 2010.

Interpreter services should be provided again, if somebody has limited English proficiency. Maybe we provide this somebody has hearing loss. That's not necessarily a health literacy issue, but certainly somebody who can't hear, maybe can't understand what we're trying to tell them. Maybe some other characteristic that would make it hard for them to hear or to understand the conversation, instructions that we're giving to them, advice, other oral communication, et cetera. And again, remember that limited or low English proficiency status is that limited ability to read, to speak, to write or to understand English. Now the types of interpreters that are out there again have different skills. Which include, but are not limited to, as we already said, proficiency in both the language of the patient, the language of the provider, and typically the provider is English, cultural competency. And I think this is really important, the ability to work in stressful situations. And I know we'll talk about this again on another slide, but, interpreters can be recruited from a lot of different places. You don't necessarily have to pay for an interpreter or an interpretation services, you may be able to recruit them from bilingual staff members. If you know that that person will meet the other qualifications and interpret very honestly and fairly, maybe there's dedicated staff interpreters. If you do wanna go outside the organization, there are contracting agencies, maybe community volunteers.

The important piece though, is that we have to assess their language skills first, they have to be appropriately trained to provide interpretation services. We don't want just somebody doing interpretation if they've not necessarily been trained. The use of somebody who's untrained or minors, and we'll talk about minors on another slide,
family, friends, maybe ad hoc clinical staff, we do wanna avoid that. Because what we see there is poor quality of care. Oftentimes conflicts of interests, mixed agendas. And we see that a lot with family members, and higher rates of interpreter errors that can unfortunately lead to some very severe clinical consequences. And we'll come back to that here in just a second. Now to improve communication again with individuals, we want to try to make written materials available in other languages, through the translation of existing English language materials. Keep in mind though that translated written materials should never substitute for oral interpretation, if oral interpretation is more appropriate. So what that’s saying is that if what we’re trying to communicate, what we’re trying to convey or say is best done verbally orally, then we want to go with that. Don't convert something over to a written document if it is something that should be presented in another way. You remember when we look at translated materials, it’s your signage, it’s your applications, it’s consent forms. Maybe it’s marketing brochures, maybe it’s just a health information that you’re providing. Maybe it’s resources that we’re providing to someone. Medical or treatment instructions, exercise instructions, those sorts of things. Anything really can be translated. And in determining what types of written materials to develop, again, you gotta go back to knowing your audience. That’s why we talk so much about culture, identify the audience, what’s their literacy level, what’s their culture, what’s their language.

The other thing is that if you are going to translate and I'm learning this firsthand, because I’m doing so much more of it now, you want to go through a rigorous review and something that we call back translation. So when we translate one direction, we wanna go backward. Back translation is this process where one translator translates a document into a target language, and then a second independent person translates it back into English to double check that the appropriate meaning is conveyed. So again, giving you my own personal example, I am fluent in Spanish, and somebody that I worked with is as well. And we have been doing this back and forth where he translates it over to Spanish, and then I take it from Spanish back over to English to
make sure that it does in fact say what it's supposed to say. And it’s really interesting because oftentimes it doesn’t particularly in the healthcare arena, we all know this, we have words and phrases and different things that we use in healthcare that in other language, there is no equivalent. So you have to try to figure it out. And it’s kinda tricky sometimes. And although appears you could just go out on use Mr. Google or whatever to use technology for translation services. And that looks really, really easy. We can’t overemphasize the use of professionally translated materials. Oftentimes again, what you get on that technology on that electronic side is not always accurate. If possible, avoid translation altogether with and develop materials if you can, with the intended audience rather than translating, it’s not always possible that that's always going to be your ideal.

Now, sometimes too, in developing your written materials, it’s helpful to use symbols. You can see on this slide a lot of these are very familiar. These came from Hablamos Juntos, a Robert Wood Johnson program and they are universal healthcare symbols. That again, can help our patients feel much more comfortable and confident within a healthcare settings. They may not understand what the words say, but they will certainly understand that symbol and that signage and guiding them in a direction. We can also use graphics cards. And probably a lot of you are familiar with this. These are the Wong Baker Faces Pain Rating Scale. So oftentimes we say on a scale of one to 10, what’s your pain, et cetera. You could use this, the, the faces. In fact, I just had my daughter at an orthopedist appointment and we actually use this because this was more meaningful to her. So we’re talking more adults here, but again, think about kids as well. This is really helpful for those who maybe are not literate, maybe have developmental or cognitive impairments, maybe it's somebody with dementia or something like that. Keep in mind too, just backing it up while these are really wonderful tools. It may not be universally appropriate to every culture. So you may have to find something that is more appropriate.
So now, if you can't get the written materials created in the original language, you have somebody who speaks a dialect of Russian or a dialect of German or something, and you can't get them in that language, there are some other options out there for you. Again, using trained internal bilingual staff members as translators, is it your ideal? No. But it'll certainly work to convey your message. Again, maybe you hire a translation company, maybe you collaborate with the community of the target audience. And I've done this in the past where you work in an area where it's very predominantly one or another culture. Those individuals within that culture are really happy to help oftentimes and are willing to volunteer their time to help you to develop some of those materials. So don't ever hesitate to ask. You can certainly purchase translated materials. There are certainly web based resources, obviously with the caveat that we just talked about. And you can research other resources. Some of the state Medicaid programs, insurance companies oftentimes have patient education materials in different languages, pharmaceutical companies as well are starting to do a lot more of this. But whatever the source remember, they have to be evaluated, make sure that they correctly state the health information that they are intended to provide, and that they're appropriate for the intended audience. Again, their literacy level, their culture, their language.

Again, if you are gonna use a translator, make sure that they have the appropriate qualifications. Previous education training experience. They have a command of both the English language and the language again, into which the material will be translated. And they're familiar with medical terminology because that's probably what we're gonna be using. Maybe not medical per se, but healthcare types of terminology, so we wanna make sure that they are familiar with that, and they're able to translate those terms for that person for us. And I already just said this involving the community. It's a wonderful opportunity, not just to develop materials, but then also to check your materials. So as you're developing translated materials, have them review them. "Hey, do these meet the community needs? Do we reflect the differences in the dialect the
culture? Are they appropriate for the community, for the culture, the education, the literacy level?" And they'll give you that honest feedback. It's a nice way to have set of checks and balances. You wanna make sure that these materials you're developing are accurate, they're useful, and that they accurately reflect the patient's culture, accurately reflect their lifestyle. And again, many individual facilities or hospitals, communities, whatever we'll post signage regarding the right to an interpreter. These need to be posted in a language that's appropriate for the culture or the community of the clients that are served. And we have to provide these as a complete aside. It's something that I run into again, in my regular work that people will come to me and say, "Oh, I needed to do X, Y, Z assessment. The minimum data set, or I need to do a PHQ nine or whatever it is, and the person can understand English, what do I do?"

Well again, we have to provide interpreter services. They have the right to that interpreter. So it's not something that we can just say, "Oh, I can't do the assessment, or I can't provide that for you." It's critically important. And again, maybe that's not your responsibility or your role, but you need to go know who to go to, to ask for that if in fact you've identified that as a need or as an issue. And we will oftentimes see individuals come to us with the I Speak cards, if you will, with a phrase in different languages and that person then communicate to others in the language that they speak. So they can communicate to us, be able to tell us what they speak.

So continuing on, and this comes from OCR, 2003, the interpreter qualifications. They need again, demonstrate proficiency, ability to communicate information accurately in both languages, identify the appropriate mode of interpreting to the extent necessary, any specialized terms, any specialized concepts, particular words, or phrases, they need to be able to understand those and convey those. As I said earlier, there's a lot of times words that just don't have a parallel in another language. And personally, I think these last three are critically important. Understanding confidentiality... I can't say it, confidentiality and impartiality rules. They are there strictly to interpret. Understanding regionalisms, dialects differences in language use, and most importantly,
understanding what their role is. And we'll talk about the interpreter roles on the next slide, but understanding what their role is without shifting into any other roles. And that's particularly why you don't want to use family or children or something because they oftentimes do that shift. Now there are three main interpreter roles. The first one is the conduit, and this is the most basic, it's the default role. It's the one that we're traditionally used to. The interpreter conveys verbatim in the target language what has been said by the other, in the source language. So one person says something we just translate it. There's no additions, there's no emissions, there's no editing, there's no polishing, there's no slant to it, there's no interpretation to it, it is just verbatim, here is what that other person said. And that's what we would want to see.

The second role if somebody called a culture broker. And this is an interesting role, and I have seen this one played out in healthcare in the past. This person provides a necessary cultural framework for understanding the message that's being interpreted. So that could go either way from the host side or to the patient side, but understanding the culture, understanding the meaning behind it. And again, it gives you that sense of the perspective of where that patient oftentimes is coming from. And then finally the clarifier, again, one that we do see being used where that interpreter explains, or they make word pictures, so they use a lot of different words, two or three sentences, whatever to try to describe what it is that we have a word for, but they don't have the equivalent word for in their own language. Or where there's a linguistic equivalent that wouldn't be understood by the patient. And then they check for understanding. And I think these sometimes are really important because again, of some of the jargon that we utilized. Obviously in our setting, the preferred role, the normal role, the most frequently utilized role is that of the conduit.

Now I already kind of mentioned this, but child interpreters can create a lot of unique problems. And this practice is highly discouraged as there's a lot of negative consequences that can occur with the use of children as interpreters. And I would even
extrapolate that again, having gone through it now, personally. Do children in general getting any health information or are they the person who should be getting that? Because what we oftentimes see is that second one editing the child intentionally leaves out information, maybe to spare that parent from suffering. Thinking... And that creates a huge burden on the child, even an adult child, to be perfectly honest with you, but this is really talking about younger children, but it does, it sets up possibly a conflict of interest. Using minors again, role reversal that that child ends up having to process the information to that parent, provide support for that parent when it really should be the opposite way around. And oftentimes again, there are mistakes made. There's no guarantee that that child will truly understand the intended message even when they say they do. And again, I know this slide is referring to minor children, but I think probably all of us could agree somewhere along the line we've seen even an adult child get the message and only interpret part of it, trying to spare mom or dad some of the details, some of the anguish or the pain or any sort of burden.

So again, we just have to be very, very cautious about who we include as an interpreter. Now, if you're gonna use an interpreter, typically this is what we call a triadic interview between you, the patient, the interpreter. Now, again, you are interviewing, or you are speaking with treating, interacting with the patient. So you face them, you speak directly to them. The interpreter should be unobtrusive. We obviously know they're there, but they shouldn't be the focal point. Prior to the session, it's always wise to meet with the interpreter, clarify the purpose of the visit, establish the ground rules. What are the acceptable roles? What should we expect from this visit? And just a few things to keep in mind, make sure the interpreter and the patient speak the same language. They speak the same dialect. That's so important obviously recognizing even in the United States, think about it, how many different dialects and words and phrases there are to describe things. Give the interpreter a brief summary of the patient and what's going on in this situation. Establish with the interpreter, the goals for the session. You need to insist on a sentence by sentence interpretation.
That’s really important. You don’t want to say something for three minutes and then have the interpreter summarize it. You want it to be word for word. Explaining obviously that the interpreter is not to answer for the patient. However, that interpreter can certainly interrupt or intervene. If you’re saying something and then they translate back and the person doesn’t understand, they can certainly jump in and ask questions to get additional clarification or understanding about a concept or a point. As you are documenting wherever it is that you’re documenting, you would want to include the name of the interpreter in your notes and indicate that that person was present in your session.

It sounds simple and basic, but you might actually have to ask the interpreter to teach you how to correctly pronounce the individual’s name, making sure that you can in fact pronounce their name. Nothing is more offensive I don’t think, than somebody who doesn’t get your name right. Who doesn’t say it correctly or spell it correctly. We wanna give that person obviously that dignity. Remember that you, as a healthcare provider, you are the healthcare provider, not the interpreter, and you are responsible for that interview. Speak slowly, clearly, simple, straightforward as we said before, plain language, avoid the metaphors, avoid jargon, avoid slang. Clearly explaining sort of medical terminology. And that’s again, where that word picture may need to come into play, where you have to truly explain that. And we’re talking about translation here, but let’s take it back to health literacy. That a lot of people may not understand the medical terminology or what a procedure is. And that we may have to really try to break that down and explain it. Allow the time the interpreter to ask open ended questions, to clarify what the patient is saying. Allow time for questions, clarification’s being aware of your own shortcomings and certainly verify understanding by having them repeat what they’re told to do, why they’re told to do it, what their resources are, what our expectations are. It goes back to the teach back. Here I’ve told you this information, now, clarify it back to me. And what that does, it helps you first of all, to
make sure that you have good communication skills, but it also helps to make sure that that interpreter is interpreting correctly.

Okay. So let's pause now. And talk just a little bit about readability tools. This is one of my favorite parts of the session. Starting out just by saying, did you know? 75 out of every 100 Americans can read at the sixth grade level without difficulty. And what does that mean? So a fourth to sixth grade level of reading is readable by most adults. When we jump up to seventh or eighth grade, that's readable by about half, maybe a little more. High school and above is readable by few adults. And the reality is, many of the things that we develop as practitioners, as education tools, as communication tools, what have you, most of the time are at high school and above. And it's not something that really is readable based on literacy and or health literacy of our clients. So as clinicians, as practitioners, whatever we wanna call ourselves, we need to provide education to our clients. And this helps them to be involved in their treatment decisions. It helps them to follow a treatment plan. It helps them to obtain resources, obtain services, do what they need to do. We obviously need to be mindful of their literacy skills, their reading ability, their comprehension. The reality is we can in fact, formally assess their reading ability. And we're gonna show you here in just a second, a few quick reading assessments to do that. We can also informally discuss with clients, their previous level of schooling, what their educational achievement was, what do they feel is their perceived reading ability, obviously doing so in a way that is still very much dignified. But we can certainly ask those types of questions and kind of go down that path, trying to figure out where they are in their ability to read and to understand.

Now there are two very common readability tools. And then I also throw Microsoft Word in here because it’s one that I use quite a bit. So there's the Fry Readability Formula. And actually we'll just go there. The Fry Readability Formula assigns an approximate grade level reading to a passage of text. Now the formula depends on the
vocabulary and the sentence structure of the text, not the organization of the text and not the content. And I don't know if anybody's ever used this one before, what you do is once you plug this information and I don't have this one actually up here, but it's available out in the public domain, but once you plug your reading passage in there, it gives you a graph and it plots you on that graph the average number of sentences, the average number of syllables and the graph measures the reading levels from first grade to college. So you can see throughout the course of your passage that you plug into there, where it is on that graph. Now, this is a way just really, again, to assess the health literacy level of the education materials or marketing materials, pamphlets, forms, whatever we're giving them, so that then we can come back and modify it to fit the recommended reading level of the client based on their health literacy assessment.

Now, before I go on, I just wanna make a comment about that. Ideally you would assess the client, determine what their level of reading ability is, and then develop those materials specific to that person and their level. That's the ideal. I'm not sure that we all have the time and the resources and such to do that. So typically what you'll see suggested is develop your materials to be read by anybody and everybody. So again, back to that fourth to sixth grade reading level, which if you've never done that, I will tell you it's actually pretty tough to do, to try to find the right words, to get it down to that level when we're so used to using certain other words. Now the second one that we're gonna talk about as a Flesch-Kincaid. And this is one that we see used quite a bit, and you can see the website for it there. This uses seven different popular readability formulas, so it's not just one formula. And it calculates the average grade level, the reading age and the text difficulty again, based on sample texts that you dump into it. This is considered one of the oldest tools, but yet it's incredibly reliable. And we're gonna give you just a sample here.

So this passage, I found this, I travel the country quite a bit teaching, and I found this in a hospital in California, and it was a handout related to hip surgery. And it was
published for patients who are receiving surgery at this particular hospital. So it states, "The rate of medical complications following hip replacement surgery is extremely low. Serious infections, such as a hip joint infection, occur in less than 2% of patients. The most common cause of infection occurs when bacteria enter the bloodstream during dental procedures, urinary tract infections, and skin infections. After your surgery, you should take antibiotics before having any dental work or surgical procedure performed. Blood clots in the leg veins or pelvis are the most common complications of hip replacement surgery. These clots can become life threatening if they move to the brain, lungs or heart. however, your orthopedic surgeon will have a blood clot prevention plan that includes medication and support stockings. If you do experience any symptoms of blood clots, you should call your surgeon immediately. Your doctor and nurse will discuss what symptoms to look for."

Sorry, this is a little lengthy. But this is... it was both a handout, and then I also found a copy of it online for their patients.

When I ran this through the Flesch Kincaid, and we'll pause for a second if you wanna take a guess, but when I ran it through the flesh Kincaid, it came out at an 11th grade level, which is pretty high. Again, go back to the list that we had just a few seconds ago, that's gonna be readable by very few people, very, very few adults. And I'm sure every one of us who read that passage as we read it together, thought, "Okay, yeah, I totally get that." Of course we do because we work in health care. Now we revised it, at least parts of it.

Here's the revision. "Most people who have hip surgery have less pain. They can get back to doing things they need to do like getting dressed, bathing and walking. After surgery, you will not be allowed to do certain things like play certain sports or jog. Before surgery, you need to see your doctor who will tell you if surgery is safe for you. You will be in the hospital for surgery and it will only take a few hours. You will usually stay in the hospital for a few days. After surgery, you will feel pain in your hip. The nurses will give you something to help with the pain. Exercise is important and you
need to start moving as soon as you can." And this is not the exact same passages with different part of it. What you probably notice though, as I'm reading it, notice the difference in the sentence structure, how much shorter these sentences are. And obviously there's a difference in words. So when we run this one through the Flesch Kincaid, we are looking at a fifth grade level. So that is something that, again, we look at and probably say, "Okay, that seems a little basic." But that is something that would easily be understood by pretty much anybody you would give it to.

So I love that again, when you start developing your stuff, if you don't wanna use one of these, we're gonna show you how to use Microsoft Word, but it's great when as you're developing materials and education to run it through their. Microsoft word, if you don't realize this, it's definitely out there, they have a feature within there. And I think most of us use this for word processing or something that. There is a feature that gives you the comprehensive count that tells you your words, your paragraphs, your characters, your sentences. And I think it actually also gives you averages, the number of sentences per paragraph, the number of words per sentence. It gives you a readability level, the passivity, and it also gives you that Flesch Kincaid, the one that we just talked about. If you're not sure where to find it, if you look in your options, if you go under proofing, this is where you would have spellcheck and that sort of thing. If you get down to where that arrow is, where it says when completing spelling and grammar, if you go down, check grammar, et cetera, show readability statistics. If you just put a little check in that box again, I'm not making a plug for Microsoft Word, but I'm just saying that I think a lot of us use this and this would be a really easy thing to do.

So you put a little check in that box and after you get done spellchecking, you get your readability statistics. Now, obviously this is all blank because there was nothing in the document, but you can see words, characters, averages, et cetera. So it'll give that to you. And you can highlight a very specific passage that you want to do a readability
statistic on. You can do the whole document, whatever it is that you choose to do. I
will tell you personally, cause I use this quite a bit. I actually surely do it paragraph by
paragraph so that because if you go through the whole thing and it tells you that it's
11th grade, the whole thing could be 11th grade, or it could just be one paragraph. If
you go through it in smaller chunks, it will help you to kind of tease out, narrow down
what it is that maybe is a little too high level. So, okay. So those are your readability
statistics. And now we'll talk about some very specific health literacy assessment tools.
And some of these are pretty interesting. So we're gonna start and before I begin, just
to say that each one of these that I'm just gonna talk about now, are available to you in
the public domain. So I didn't put copies of them on your handouts, cause you can
certainly go out and grab these.

The first one is the TOFHLA the Test of Functional Health Literacy in Adults. And this
measures the functional literacy of our patients and it uses real life healthcare
materials. So the patient is given an education information card or form, they're given
prescription bottle labels, there's a registration form, and then there are instructions for
how to complete a diagnostic test that they might, it's a sample type of diagnostic
tests. It's not obviously their test, but a sample of such. Now this assesses two main
constructs, numeracy, which we talked about earlier on. So like managing your
cholesterol and the number side of things, and then reading comprehension. There's
67 items. And the numeracy scale looks at reading and understanding numbers of 17
items there. And then the comprehension scale, looking at reading and understanding
healthcare related passages and understanding the recommendations or something
that would be in there that has 50 items in it. And I don't believe, I don't think I put an
excerpt up here, but there's also two additional versions of this. And there's the
TOFHLA-S which is a Spanish translation, and the S-TOFHLA, which is the short form.
Personally, I think they should have renamed this somehow because I get confused
myself, but that's just me. The short form they S-TOFHLA takes about 12 minutes to
administer. So that’s pretty short that we could do pretty much in any session that we had with an individual.

Now this next one is super short. It’s called the REALM, the Rapid Estimate of Adult Literacy in Medicine. And there is also the short form, it’s the REALM- SF. It’s a seven item word recognition test. And it provides a clinician, a practitioner with a valid quick assessment of an individual’s health literacy. It’s been validated, it’s been field tested. And a lot of different research settings has excellent agreement to the original form is a 66 item instrument in terms of words and such that’s in there. So it’s 66 item on the original REALM, the short form is a seven item and they have excellent reliability and validity between the two and agreement as it relates to grade level assignments. So this is the REALM. We just ask the person, read these seven words and you determine yes or no, can they read them. Behavior, exercise, menopause, rectal, antibiotics, anemia, and jaundice. And obviously some of those are very medical in nature and some of them are not. Depending on how many they can read, if they can read none of them, their grade range as it relates to reading is third grade or below. They’re not going to be able to read most low literacy materials. They may need to have everything given to them orally. They may need to have video tapes or audio tapes or demonstration or pictures, illustrations, those sorts of things. And we’re probably going to need to repeat those many times. Now, again, I don’t know impossibly, you could translate or not translate, but develop materials and a third grader below, but I think that’s gonna be very, very difficult to do. So you would have to alter the way that you interact and or provide education to that person.

Now of those seven words, if they get between one and three of those words, they have between a fourth to sixth grade reading level. So they will need low literacy materials. Again, this is where that Flesch Kincaid is perfect because you can run a passage through there and set it up so that it is around a fifth grade reading level. They may not be able to read prescription labels. I mean, you can't really change those. And
that's not something that is going to be at a lower grade level for reading. If they can get four to six of the words, they will be at a seventh to eighth grade reading level. They will struggle, unfortunately, still with most education materials. But this is that level where if you developed low literacy materials around again, a fifth or sixth grade reading level, this person isn't going to be offended by it. They probably wouldn't necessarily notice that there is a difference. So again, that's where we say, develop at a mass level, and certainly other people will be able to utilize that as well. If they get all seven of the words, they're probably at a high school or above, and they should be able to read all of the patient education materials.

Now, this next tool, I think this is the last one that we review is really cool. I love this one. It's called the Newest Vital Sign. It's a reasonably new tool that has been designed to quickly and simply assess an individual's health literacy skills. We can administer this in about three minutes. Right now it's available in English and Spanish and you'll get to see it here in just a second. The individual that you're working with has given a specially designed ice cream nutrition label to review, and then we ask a series of questions about it. And based on the number of correct answers, we can assess their health literacy level. And again, we're not just about assessing where here to alter or adjust the way that we communicate with that individual to make sure that they understand. This was developed by Pfizer. And again is available in the public domain. There is the assessment tool, there's an entire assessment booklet that goes along with it that you can go out and download and utilize. And they strongly obviously encourage us to utilize it. And they call it the Newest Vital Sign. I don't even know if it's in here, if we say it, but just like a nurse would go in and take blood pressure and their pulse ox and their pulse and what have you, it's the Newest Vital Sign. If it only takes two or three minutes to administer, it's something that we can do as we do all of their vital signs.
Now again, anyone can use this as long as you're trained. So a nurse, social work, therapist, medical professional can administer this. And you ask the patient obviously to participate. And useful, and this comes directly from the booklet. We're asking our patients to help us learn how well patients can understand the medical information that doctors give to them or that we give to them. Would you be willing to help us by looking at some health information and then answering a few questions about that information? Your answers will help our doctors, our nurses, our social workers, whomever, you wanna insert there, learn how to provide medical information or information in ways that our patients will understand. This will only take about three minutes. So you're asking them, you're inviting them to participate along with you. So at that point they hopefully agree. And that's when you hand the nutrition label over to the patient and the patient can and should retain that nutritional label throughout the entire administration of the NVS, the Newest Vital Sign. They can refer to it as often as they would need. This will make more sense when we start going through the questions, but we start asking the questions and there are six of them, one by one giving the individual as much time as they need to refer back to the nutritional label and answer the questions. There's no maximum time for them to answer all of the questions. Again, the average time for all six is about three minutes, but if the patient is struggling with the first or second question after two or three minutes, the likelihood is that they do have limited literacy and you can probably stop the assessment.

Now, again, this will make more sense when we start going through the questions. But you ask the questions in sequence and you'll continue even if the patient gets the first few questions wrong or any of the questions wrong. If they answer question five wrong, however you don't ask question six. It'll make sense in a second. You can stop asking the questions if they get the first four correct. With four correct responses, the patient almost certainly has adequate literacy. And you can just stop the assessment at that point. Now we can't prompt the patient who can't answer a question, and this is a standardized assessment. So of course we know that. Prompting obviously would
jeopardize the accuracy of the test. If they're stuck or they're struggling, we can just say, "Well, let's just go onto the next question." We also can't show the score sheet to the patients. And of course, they're always curious, "How am I doing? What's going on?" And if they asked to see it, we just have to say, "I can't show you that because the answers are on here. Showing you the answered with spoil the whole point of asking these questions, obviously." And then also we shouldn't tell the individual if they've answered correctly or incorrectly, and again, they'll ask and you just have to say, "I can't show you the answers until you are finished, but for now, you're just doing fine. Let's go on to the next question. Let's continue the assessment." So again, I think that's pretty intuitive as it relates to a standardized assessment.

So you're gonna give one point for each correct answer, and there's a maximum of six points. Again, if you do the whole assessment, you could obviously stop at four if you wanted to. A score of zero to one suggests that there's a high likelihood so 50% or more of limited literacy. A score of two to three indicates the possibility of limited literacy. And again, that's where at that level you can certainly put those materials in a lower level of literacy and they're probably not going to be offended by it. A score of anywhere between four and six, almost always indicates that the person has adequate literacy. So you might be wondering as we're going through this, why an ice cream label? What in the world does that have to do with literacy and how has it a predictor of the ability to understand medical instructions and medical education? When you look at a patient's ability to read and to analyze any kind of nutritional label, not just an ice cream label, it requires that person to have some analytical skills and conceptual skills that they need to understand and follow a medical provider's instructions. These skills, and there are three of them, and we'll go through them here in just a second, are defined as understanding or applying words and that's prose, numeracy or numbers, which we've been talking about and then forms or documents. And again, we'll show you some examples here in just a second, whether you're reading a food label, whether you're following medical instructions, you're reading education, whatever it
happens to be the patient still needs to remember some numbers, make some mathematical calculations, identify and be mindful of different ingredients that could potentially be harmful to them. And then not only that, not just identify, not just remember, not just make the calculations, most importantly, they need to make decisions about their actions based on the given information. You can think about it in a healthcare situation, okay, we’ve taught the person how to do their finger stick because they have type 2 diabetes. But if they never know how to make a decision based on that information, it’s only one half of the equation. So again, that’s what we’re testing through this.

Do you remember the different types of literacy, our pros, numeracy, and documents? So the first one is prose. A clinical example, the patient has scheduled some blood tests and has been told in writing to fast the night before the tests, we do that. Nothing by mouth, after midnight. On the ice cream label, the patient would need that same type of skill, that prose literacy skill to read the label and determine if they’re able to eat the ice cream, if in fact, they are allergic to peanuts. The next type of literacy is numeracy. And the clinical example here, a patient is given a prescription for a new medication that needs to be taken at a certain dosage twice a day. If we look at the ice cream label, numeracy is, would be shown by the patient needing that same skill to calculate how many calories are in a serving of ice cream. And then finally the document or the form literacy. The clinical example, a patient is told to buy a glucose meter and use it 30 minutes before each meal, and before going to bed, if the number is higher than 200, that patient should call their physician’s office. From the ice cream label, the patient would need that same type of skill to identify the amount of saturated fat in a serving of ice cream and how that will affect their daily diet if they do or if they don’t eat it.

So let’s go through the actual assessment. And if you have the handout, you probably already have the answers, but I’m gonna ask you to not look at the answers and try to,
as you’re listening to this, go through the questions as I read them and see if you can and get the answer. So question number one, take a look at the label. And if you eat the entire container of ice cream, this is your ice cream label, how many calories will you eat? So think about that for a second. And then we'll go on to question number two, which is if you are allowed to eat 60 grams of carbohydrates as a snack, how much ice cream could you have? So again, take a moment and think about that.

Question number three, your doctor advises you to reduce the amount of saturated fat in your diet. You usually have 42 grams of saturated fat each day, which includes one serving of ice cream. If you stopped eating ice cream, how many grams of saturated fat would you be consuming each day? And I'll read that one one more time 'cause that's a long one. Your doctor advises you to reduce the amount of saturated fat in your diet. You usually have 42 grams of saturated fat each day, which includes one serving of ice cream. If you stopped eating ice cream, how many grams of saturated fat would you be consuming each day? Question number four, if you usually eat 2,500 or 2,500 calories in a day, what percentage of your daily value of calories will you be eating if you eat one serving of ice cream? Again, if you usually eat 2,500 calories in a day, what percentage of your daily value of calories will you be eating if you eat one serving? And then question number five, pretend that you are allergic to the following substances. Penicillin, peanuts, latex gloves, and bee stings. So question number five. Is it safe for you to eat this ice cream? You are allergic to penicillin, peanuts, latex gloves, and bee stings. And then if you answered no to that question, I would say, why not? If you answered yes to that, I would skip question six.

So here are those questions again. So if you eat the entire container, how many calories will you eat? There is only one answer 1000, that's the only answer that's loud. Next question, if you’re allowed to eat 60 grams, how much could you have? Any one of the following is correct; one cup or anything up to a cup, half of the container. If the patient says two servings, you would then say how much ice cream would that be if you were to measure it into a bowl? Again, you’re trying to get to a cup measurement.
Question three. If the doctor advises you to reduce your saturated fat, how much would you be consuming? There's only one answer and that is 33. Next question, if you usually eat 2,500 calories, what percentage would you be eating if you had one serving? Again, the answer is 10% and that's the only correct answer. Question five. Is it safe for you to eat this ice cream if you are allergic to those items, and the answer is no. And only if they respond no to question five, why not? Because it has peanut oil. So now that probably makes a little bit more sense why if they answer number five incorrectly, you would not answer question six.

So I don't know about the rest of you, the first time I took this, I was actually at a conference when I learned about this and I just thought it was the neatest assessment. And I struggled with some of these because you really do have to think, I mean, I got the right answers, but it takes a little bit of time to think. So again, it should only take about three minutes, but if you go back to the levels, it's a high predictor. It's a very good predictor of that person's literacy. Again, if they only got two to three, they probably have limited literacy. Anything between four and six, they're probably good to go. So this is just a recap of those assessments. So there's the TOFHLA. The initial, the original TOHFLA takes anywhere between 22 and 25 minutes. The short form, it takes about seven minutes. The REALM, the short form of the REALM takes about one to two minutes, and then the Newest Vital Sign, the NVS takes about three minutes. And again, there’s probably more out there than even these, but they're available in the public domain. They're pretty easy, pretty simple to administer. And the point being you want to figure out where is this person's reading level? What is it excuse me, that they can understand, maybe not understand, so that the whole goal is to alter your approach to them for education, communication, et cetera. Okay.

So in this last section, we're gonna talk a little bit more about effective verbal and written communication. I know we hit on some of this already. We're gonna go back through some of this because I think this is really the crux of what we're talking about.
So if we’re kind of building, we have to understand that literacy can certainly be an issue. We have to figure out where that person is, take that into account, bring it into their own language. And with the end goal, again, developing materials that they’re gonna be able to understand, that they’re gonna be able to follow through on, that they’re gonna be able to use. That makes sense. That’s our goal, because if we don’t do that, then their interaction with the entire healthcare system, their interaction with us is all for not. So I come back to this particular tool and obviously I love it. It’s one that I use in my own clinical practice. It’s technically an educational program. It encourages our patients, our families, so we can ask it of them, but they can ask it of us as well, to say it back to their providers, to really understand their health conditions and what do they need to do? What do they need to understand in order to stay healthy? And it’s, again, it’s three questions. We ask three of them, they ask three of us. What is my main problem? What do I need to do about my problem? And why is it important for me to do this? This was actually a designed by health literacy experts. And they Ask Me 3 is again intended to help our patients really to become more active members of their healthcare team. Again, think about a lot of our patients. I use patient client individual. I use them all interchangeably, but think about the people who come to us that are just kind of going with the flow, and they’re just doing what they’re told sometimes maybe they’re not, but they’re not really involved. They’re not collaborating in their health care. They’re just going along for the ride, doing what they’re told to do. This helps them again to just really be a more collaborative partner. This provides this platform to improve the communication, to get everybody on the same page, to get everybody with the understanding between the patient, the families, the healthcare professionals, et cetera. And I think it too also helps us to develop patient centered goals.

So, again, I’m a therapist by background and I tell our therapist all the time, it’s not their goals, it’s the patient’s goals. It’s that client’s goals. We may think that they need to do X, Y, and Z, but that’s not the most critically important thing to them. It’s something else entirely. So again, I think the Ask Me 3 helps that. Teaching back.
Again, if we’re not already doing this, I would be pleasantly surprised. I think we do this anyway. We ask back trying to get an assess what that person understands. So the client repeats back the information in their own words, helping to show what their understanding is of what we just talked about or what we just taught. And again, I use this to assess my own communication skills and it’s not just with my patients, I do this a lot of times. I even do this with my kids. “What do we just talk about there? You got it?” That kind of thing. And I think it depends on your audience, how you ask the question. But it could just be as simple as, "Tell me what you understood. I wanna make sure that I’ve clearly explained to you what I need you to do for X, Y, Z plan. I wanna make sure that I’ve clearly done that, can you tell it back to me. Can you tell me how you’re gonna do your exercises. Or what’s your plan when you go home? How are you gonna handle getting to and from your doctor’s appointments? How are you gonna handle getting to, and from the grocery store?" That sort of thing. "Can you show me how you’re going to do your exercises? Can you show me how you would fill out this form." Or whatever it happens to be. But again, it’s tell, show, do. And it’s what we’ve always done to make sure that we have that understanding.

Continuing on, let’s talk again, more specifically, we kinda hit some generalities earlier, but let’s talk a little bit more specifically about how we’re going to develop materials. Starting with content and organization. When somebody reads something, we’re putting out education materials, we’re putting out a brochure, whatever it happens to be, we’ve gotta make sure that the purpose is immediately outlined, it’s immediately clear to the reader. And this is a great homework exercise. When we’re done, listening to this, go back and look at some of those materials that you’re utilizing. Is that message crystal clear in the very first sentence or is it kind of buried in there? Do we have some fluffy stuff introducing the message. And then we finally get to the heart of the message. And if that’s the case, you missed your mark, you missed your audience because you have to have it front and center. They may not get down to paragraph two or paragraph three. We also need to make sure that the content is balanced. It’s
accurate. It’s up to date. We obviously don’t want one sided. If you can pull, I mean, I
wouldn’t recommend putting a references necessarily, but pull from the latest and
greatest evidence. And if you wanna make sure that it’s up to date, whether you put it
down in the bottom corner, you save the file, however you wanna do it, put a
publication date, put a revision date, et cetera. And I'm sure everybody’s gone through
that at some point in time where you see a form or you’re using something, "Where’s
this from? Who made this? Where did this come from?" And you have no idea cause
there’s no date on it. So you wanna make sure that you do that.

Provide how-to information of relevance to the readers situation. And part of this just
might be, I think about the education materials that I develop and I'm working on, I
would love to put out this, material that covers everything that that patient needs or
that, if I'm educating a nurse or somebody else that it’s a one stop shop, but let's be
honest, that's gonna be a really big handout. It's going to be voluminous. Maybe we
break it down into really, really small chunks, small little handouts, just on one topic,
rather than trying to get every single topic into one handout. And maybe over the
course of your visits or the course of your time with an individual, you’re able to give
them more and more handouts, but again, keep it simple. Isn’t that what they always
say? Keep it simple, silly or whatever the KISS thing stands for. I don’t remember off
the top of my head, but keeping it simple. When we look at organization again, use
subheadings, maybe a question and answer format. That’s one of my favorites. So
question, how will blah, blah, blah, affect my heart rate? Answer, and there it is, again,
in very easy to understand language. Using subheadings, using bullet points, using
some summaries again, no commas, keep your lists very, very short. Those sorts of
things. When we look at layout and illustrations, we’ve talked a little bit about this, but
use ample white space. That is really important because if you see, even when you’re
putting together a PowerPoint, if anybody’s ever done that, you’re always told don’t
put more than X number of bullets on one specific page, because it’s just too much
information. And you tune it out. So you have to have a good amount of white space.
You wanna use serif typefaces. What is that? And I think it's probably on another slide where we talk about it too. But the serif typefaces are the ones that have the little hooks, the little feet on the bottom of the letters. And this is not one of those, I don't believe that we have in this handout, but Times New Roman is one of those. So I know sometimes we love the cutesy looking fonts and the pretty fonts and such, but they're oftentimes very difficult for someone who has visual difficulties to read. I mean, take a literacy and such out of it, if I have visual issues, we struggle. You want a minimum 12 point font size. Again, the tendency sometimes is to make it smaller, to get it to fit on the page, but that's not your best bet. You wanna go minimum 12 sometimes 14 is even better and making your headings even larger. And you want good contrast between the text and the background. And as you can see on the handout here this slide black on white is always going to be your best. I know we sometimes get kinda cute and we try to do white on black, or we do, black or white on neon green, or some somebody said green was really good for clients with dementia whatever, black and white is gonna be your best contrast.

And again, if you think about not just readability, but vision, think about disease processes. I mean, we haven't really talked about that, but if I do have dementia or I have Parkinson's or something like that, my contrast sensitivity, my ability to see decreases. So we wanna make it as easy as possible for that person to read that. Avoid capitalizing all the letters in the words, that's a big, no, no. You want to... and we probably say it on another slide, but you want to use the text, it should look just like reading a book, whatever the text a book would look like. You wanna avoid italics and those sorts of, again, fancy kinds of fonts, because they're difficult to use. I don't use the Roman numerals largely because those are not very well understood. And they just tend to blend into the language that's around it. I don't know, did we talk about... Yeah, we'll talk about it on the next slide.
Illustrations. We’ve already talked a little bit about this, but make them instructive, make them culturally appropriate, but only if it truly augments the message. If it’s just gonna be something kind of cutesy to put in there to fill space, to add color to the page, leave it out. Because it’s not going to help your message. If you are going to use any sort of illustrations, you want to position those next to the text, to which they refer. I oftentimes see particularly in education materials where they’ll have text on one page and then the photo that goes along with it on the next page. And an individual who again, has issues with literacy is not going to necessarily pick up on the fact that that photo on page four is actually going along with the text that’s on page three. So you want it to be next to, not even under and certainly not on the next page. And certainly clearly label all of those illustrations that you may be putting in there. Language. We’ve already talked a little bit about this. But just kind of reiterating. Aim for fifth to sixth grade reading level. Clear, simple common language, short sentences, short words. Remember you wanna limit the number of messages here, engage your audience, give them the most important information, tell them what they need to do, explain to them why it’s important. Again, stick to one idea at a time, skip the nice to know, and just really focus on the need to know. Again, remember people with limited reading skills, they’re gonna forget items if you put too much in there, if you make a really long list, if you do have a long list and you have a ton of stuff that you gotta get in there, then your best bet is to break it into subheadings or different pages. Avoid your jargon, and then define any specialist terminology.

So if you have any terminology that is very specific to your setting or your client population or something that you want them to do, certainly define that out. Remember, keep it short. Using words and we may talk about this on another slide, I apologize, but use words with just one or two syllables, if at all possible, because those are gonna be easily readable by most of your folks. Keep your sentences between eight and 10 words. So again, keep it short, keep your paragraphs to about three to five sentences. If you do need to use jargon again and such, define it, define
the term first using whatever mechanism you need to do that, and then explain it. Remember too, as you are choosing language, be very consistent with your word use. So if you do excuse me, introduce a word and it becomes familiar, or you know what words are familiar to this audience, utilize those throughout the entire text. Don't switch back and forth. Don't go out and find a synonym for that word. Use the same word every single time, because that will easily be understood. And again, remember too, as we're talking about this as just a good point to bring in, and we're talking about written language here, but apply these same rules when you're talking about video or audio materials, if you're doing a demonstration or if you're doing a slideshow kind of like this. We already said this, write in the active voice and write in the second person. Because again, that's going to be easily understood. Limit your use of symbols. Again, what is meaningful and natural for one audience could be completely confusing for someone else. It could be misleading.

So if you're gonna use symbols, you wanna pretest those. We already talked about mathematical concepts. Things like risk and normal and range and people don't necessarily understand what that stuff means. So we want to limit that as well. If you have an acronym, you want to explain what that acronym is, spell it out. What does it mean? Help that person understand it. You can then use it from that on out. And again, I'm a therapist we use ROM, for Range Of Motion. Of course, I know what that is, you guys probably know what that is. MDS Minimum Data Set or CMS Centers for Medicare and Medicaid. The people that you're talking to do not necessarily know that. So certainly define all of that. Some other tips. I think we've talked about this plain English, make every word count, cut out the fluff, be clear, be brief, keep it simple again, using positive words. You wanna use the word do, not do not. Again, focus on what they should do, not what they shouldn't do. We already said using short lists and bullets, not the really long sentences, very concrete familiar words. Again for an individual who has limited English proficiency or who has limited health literacy, some of those analogies, those similes, those metaphor, some of the abstract that we
sometimes talk in, sarcasm, those sorts of things, it’s not going to be understood and could very well be offensive. So we wanna stay away from that.

And again, one or two syllable words, if possible, I think we already mentioned that. Follow your grammar rules. This is one I drive my kids knots because I police their grammar quite a bit. It should be just like a sentence, put your subject and your verb together. Make sure that whatever you are has a subject and a verb just as we would talk. Use vivid, active verbs. So your action words, if you can. Again, short, simple sentences, very few personal pronouns. Stay away from that if you can, the we, you, et cetera. Maybe you can, if you’re trying to get across a point where it’s conversational, but again, a lot of times particularly because people choose the pronouns that they would like to be referred to as and you’re wise to just stay away from that. Few -ing words. The part of symbols and the gerunds and the infinitives, and keep out the prepositional phrases. Again, keep it clean, keep it simple.

A couple of other things we’ve already talked about these, I think a few of these, the way your texts looks greatly affects its readability. So choose the appropriate font style and the size will certainly help you to create health communication materials that are easy to read. So I already said 12 to 14 points. For anything less than 12 points, that’s gonna be too small for most of your audiences. Even if they have readers or something. Individuals who are older are going to have trouble seeing or reading, they’re gonna maybe need larger print. For your headings, use a font size at least two points larger than the main text size. If your main text 12, you’re gonna want it to be 14 to 16 at the very least. And there’s again, use your fonts with serifs. The serif makes the individual letters more distinctive and it’s a brain thing. It actually makes it easier for our brains to recognize those letters more quickly as we read across the page. So again, they’re easier to read than the sans-serif fonts, and going back to Microsoft Word or whatever word processing program that you’re using. If you look down through that font list, oftentimes it’ll say sans-serif. So if you never knew what that
meant, that’s what it means. Those particular fonts do not have the little feet on them. A couple of the things that I think we’ve already talked about some of these, don’t use the fancy or the script lettering. It looks pretty, but it’s really difficult to read. Use both upper and lower case letters. Don’t use all caps. All caps are really hard to read. And for a lot of people, they interpret that as that you’re shouting out them particularly our younger individuals we might be working with.

Use grammatically correct punctuations. So commas where they need to be, semi-colons, periods, exclamation points, what have you. I’m one of those people, I sent a text message with appropriate punctuation. So again, it’s gonna be easier to read. Your brain looks for that for a stoppage in the sentence or a pause in the sentence. If you’re going to emphasize a word you wanna use bold type to emphasize. Limit like the underlining and the italics, again, very difficult to read. Bold type is going to be your best or make it larger, that would work as well. And then we already talked about using dark letters on a light background because the light text on a dark background is very, very difficult to read. I think we already talked about illustrations and I don’t know, do I have another slide? No, I don’t. But I just wanna go back over very quickly some of the illustrations, just to highlight a couple of other things. Simple things, avoiding all of the unnecessary details, stay away from your abstract that could easily be misinterpreted. That’s a big thing with your visuals is that they’re oftentimes misinterpreted. We already talked about labeling them, but you also probably wanna put a label with a caption near the related text so again that person knows what’s going on there. And again, one message per visual. Don’t try to get a lot of information into one picture, just stick to one message.

And again, I go back to this and it’s critically important. Make whatever you are doing culturally relevant, culturally sensitive, make it meaningful to that person. I think that’s what we’re talking about. That’s why you do your assessments to kind of figure out where they are. So with that, we are, I think just about at time. I put my contact
information on this slide. Should you have any additional questions following the presentation, don’t hesitate to reach out that is my email. I’d be more than happy to answer those questions. And then I think as our final slide, just some more information about cultural competence. For more information, there is a resource there for you, the standards and indicators for cultural competence in social work practice. You obviously have the link there on the slide where you can grab that out of the world wide web for more information about cultural competence. And I think that wraps us up for the session. So I would just wanna thank everybody for listening in as you’ve been listening in and I’ll turn it back over to our moderator.

- [Katrinna] So Kathleen such great information. I have one question for you. You showed us tons of wonderful tools that we could use. So I was wondering, especially as we think about cultural competence and different cultures, are those two tools applicable with different cultures or individuals who English may be a second language?

- [Kathleen] That’s a great question. And I appreciate you asking it. With the readability or the low literacy tools, a lot of those have not been translated. So if language is a barrier, they’ve been translated into Spanish and a few others, but are not readily accessible in a lot of the other languages. As far as culture is concerned, I’m gonna just give my opinion on it, take it for what it’s worth. If you look at those assessment tools, they’re really asking about a United States health care type of arena. So if you go back to the REALM of for example, the words that were on there, jaundice and exercise and behavior and such, those are very, I think very specific to our, what we wanna call our healthcare culture. So I don’t know that it necessarily takes those into account, but if you go back to the cultural frameworks that we talked about, those definitely do. Those taken into account every culture. So I think it would probably take some digging maybe to find something that is maybe a little more culturally appropriate. Maybe there is something out there and or something that could be
translated, but they are standardized. They kinda can't be changed in their current format. I haven't seen anything though that that looks at any additional culture specifically. So I don't know if that answers the question. But I believe, just based on what they look like, they're really talking about our own United States health care type of setting.

- [Katrinna] Thank you. That definitely answers the question and definitely gives more perspective in how we would need to supplement these tools when working with individuals across cultures and from different language backgrounds. So thank you so much for that.

- [Kathleen] Yeah. And I would agree with that. And I think, again, being a practitioner myself, I use a lot of these tools, and I like the word choice that you have supplement, because I think we do need to supplement with some of the other things that we're doing to again, figure out. And we're not really talking about cultural competence per se, in this session, but to figure out where are they coming from? What is their perception of illness? What is their perception of health? And again, I'll use the phrase what makes them tick. I think we have to do supplement with all of our other tools that we have at our disposal.

- [Katrinna] Exactly. For social workers we like to refer to it as having that tool box of just tools, because we do have to sometimes have this great assessment, but then we reach in that tool box and supplement it with something that's gonna be more appropriate for that client. So thank you so much-

- [Kathleen] 100%.

- [Katrinna] For that information.
- [Kathleen] You're very welcome. Thank you.

- [Farzana] Okay. Thank you so much, Dr. Weissberg for sharing your knowledge and expertise with us. Having the ability to effectively communicate with clients is very important and understanding a client's level of health literacy is essential to effective communication. This webinar has provided numerous tools that social workers can utilize to not only determine a client’s level of health literacy, but tools that can be used to enhance communication with clients and ultimately have a positive impact on client outcomes. Again, thank you for joining us on Social Work at Continued.com.