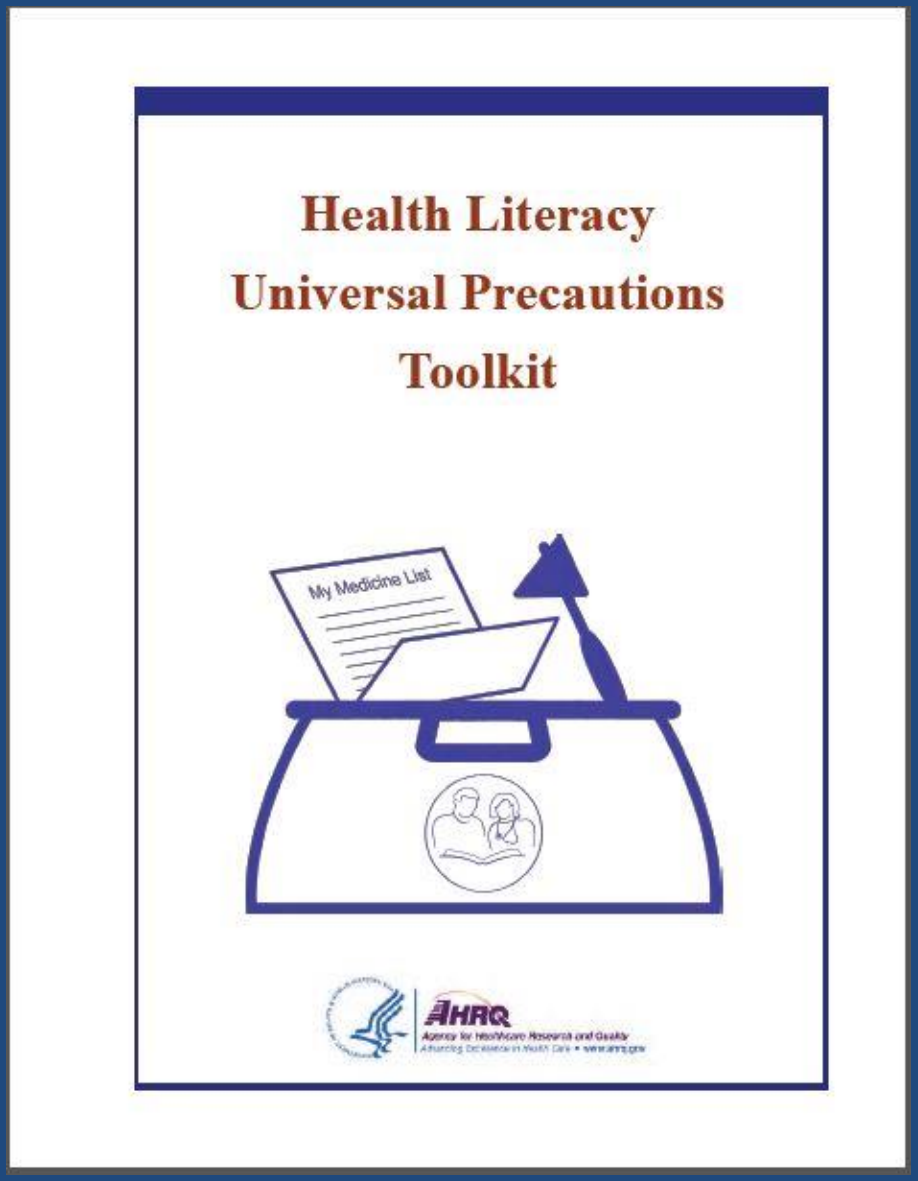

DEMONSTRATION OF THE HEALTH LITERACY UNIVERSAL PRECAUTIONS TOOLKIT: LESSONS FROM THE FIELD

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Overview

- Health Literacy
- AHRQ Health Literacy Universal Precautions Toolkit: Demonstration Project
- Methods
- Results
  - facilitators to implementation
  - barriers
  - help provided
- Implications for toolkit revision

Background: What is health literacy?

health literacy

noun / ˈhelth ˈli-t(ə-)rə-sē

: capacity to obtain, process, and understand basic health information and services to make appropriate health decisions

Background: Outcomes of Low Health Literacy

Limited Health Literacy

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- Lower knowledge of health & disease management
- Limited use of preventive care
- Medication non-adherence
- Lower self-reported health status, higher mortality rates, increased use of emergency and inpatient care

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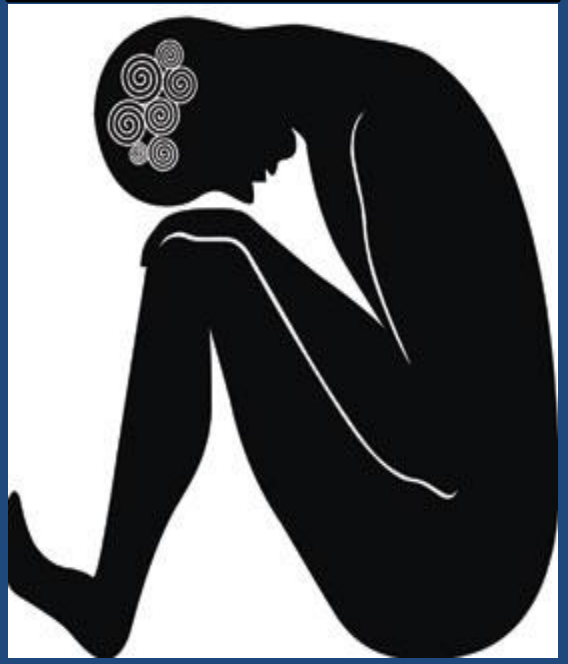
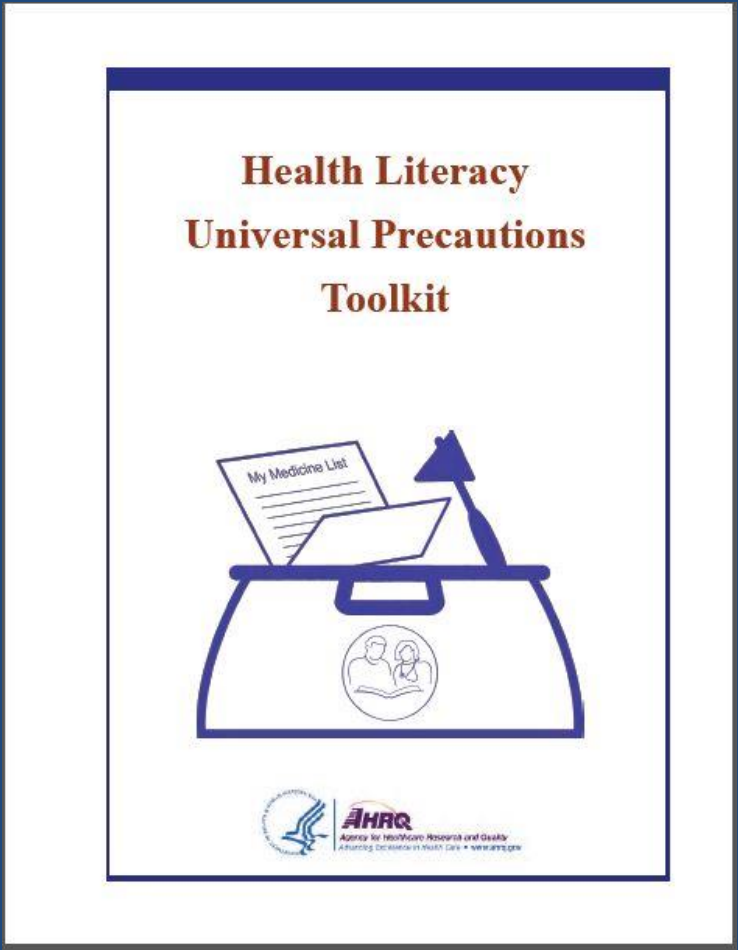
Poor health outcomes



Background: AHRQ Health Literacy Universal Precautions Toolkit

Purpose: provide primary care practices with step-by-step guidance and tools for assessing and making changes to their practices' health literacy environments



Assumption: <u>all</u> patients may have some type of health literacy-related barrier regardless of:

- education level
- socioeconomic status
- race/ethnicity

The Toolkit includes 20 tools that address practice systems and behavior related to four health literacy domains:

Spoken Communication

Self-management & Empowerment

Written Communication

Supportive Systems

Demonstration of the Health Literacy Universal Precautions Toolkit

Demonstration conducted 2013-1014 in 12 primary care practices in the U.S

The primary objectives of the demonstration were to:

1. Examine changes practices were able to make by implementing toolkit

2. Develop a refined version of the toolkit

Methods

Toolkit implemented in 12 diverse primary care practices motivated to improve their communication with and support for patients of all health literacy levels

Practices were assigned 4 tools to implement from the Toolkit:

- All practices implemented Tool 1 (Form a Team) and Tool 2 (Assess Your Practice).
- Practices were then assigned to implement two additional, “practice-specific” tools.

Methods

- Implementation took place over a 5-6 month period from July 2013 to January 2014.
- Data were collected to support a thorough examination of the implementation process and to identify needed toolkit revisions.
- During implementation qualitative data were collected through check–in calls conducted by Technical Assistance Providers (TAP's) at 2, 4, 8, and 16 week time points.

Methods

- Check-in-call transcripts were independently coded and analyzed by 3 research team members.
- These were further analyzed and themes extracted through an iterative process until saturation was achieved.

- Analyses focused on 6 topic areas:
  - rationale for form of implementation activities conducted by practices
  - whether practices used Quality Improvement (QI) strategies during implementation
  - specific problems practices encountered
  - whether practices were able to troubleshoot these problems
  - problems that remained unresolved
  - assistance that could be provided by the technical assistance providers

Results

- Several factors facilitated and served as barriers to tool implementation.

Results: Factors Facilitating Tool Implementation

- **Strong practice leadership**
  - Important to have a champion throughout implementation

- **Raise Staff Awareness & get buy-in early**
  - get **all** staff on board early

- **Conceptually link tools together**
  - practices able to link tools together did better

Results: Factors Facilitating Tool Implementation

- **Link tool implementation to other practice QI priorities such as PCMH accreditation.**

"You mention buy-in, I'm sure in the back of their [staff and providers] head they may be asking, 'What's in it for me?' If you are going to put time into something, you kind of want to reap some benefit from it besides just more work. Ultimately it comes down to 'Are we getting reimbursed for the time?' It is the right thing to do for patients, but what really drives change is increased revenue. So I know in terms of turning our practice into a Patient Centered Medical Home, we will be incentivized to do a lot of these things. So that can be a driving force to improve health literacy in our practice."

Results: Barriers to Tool Implementation

- **Competing demands/staff capacity**
  - Already feel over-extended
  - Loss of staff

- **Organizational & technological limitations**
  - *Have to be mindful of larger organizational rules and systems*

Results: Barriers to Tool Implementation

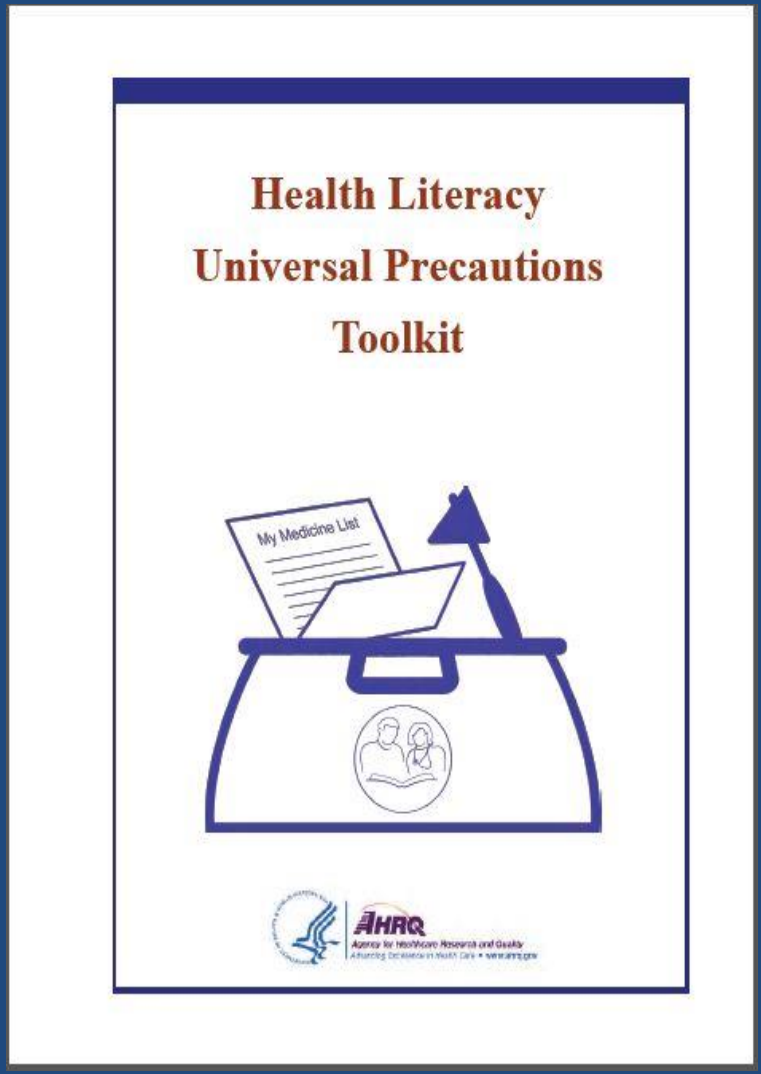
- **Lack of familiarity with toolkit**
  - Several practices did not read or implement key parts of toolkit as encouraged
- **Lack of experience with QI methods**
  - Limited use of QI methods hampered ability to carry out implementation activities
- **Toolkit limitations**
  - Aspects of the toolkit e.g. length, extent of guidance, types of resources provided

Results: Types of Technical Assistance Needed & Provided

- Support troubleshooting implementation barriers
  - Acted as “sounding board”
- Support assessing/evaluating implementation activities
- Maintaining accountability

Implications for toolkit revisions

- Shorten the tools
- Provide concrete suggestions for how to track/evaluate progress
- Provide examples of how to include non-clinical staff in tool implementation
- Highlight areas where tool implementation may link to accreditation



Limitations of demonstration

- Practices had an approximate 6-month implementation period. It is likely we did not capture implementation activities that would take longer to plan and execute.
- Implementation data we received were based on verbal reporting of activity, and were not independently verified.
- We purposefully constrained the amount of assistance provided. We cannot know for sure what additional assistance practices might have requested had there been no limits.

Conclusion

- Obtaining early staff “buy-in,” strong practice leadership, and conceptually linking tools to one another or other QI efforts facilitates toolkit implementation.

- Toolkit needs to be shorter, provide better guidance on how to evaluate progress, include non-clinical staff in it’s narrative & highlight connection to other transformative activities.

Questions?

Thank you!