



Health Literacy: *The Road to Improved Health Outcomes*

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ABSTRACT

Although millions of Americans are able to navigate city streets, bus routes, and malls, many do not have the skills to manage their health and negotiate our health-care system. Low formal education levels, older age, ethnic and racial minorities, rural location, and poverty are some factors associated with increased rates of limited health literacy. Limited literacy impacts health behaviors, decisions, and, ultimately, outcomes. This article reviews health literacy research and discusses practical ways to improve health literacy in practice, including the Agency for Healthcare Research and Quality's toolkit for health literacy.

Keywords: health literacy, health outcomes, patient education, provider communication

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Health literacy has been identified by the Institute of Medicine (IOM),¹ World Health Organization (WHO),² the Joint Commission, and the Agency for Healthcare Research and Quality (AHRQ)³ as a significant problem impacting health outcomes. Health literacy is defined as “the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.”⁴ Risk factors for limited health literacy (LHL) include age, genetics, ethnic and racial minority, language, educational status, socioeconomic status, and environment, which includes rural location and underserved areas.¹

However, all segments of the population may experience some health literacy challenges when trying to navigate the ever-increasing complex healthcare system. The Agency for Healthcare Research and Quality (AHRQ) has released a toolkit to help make positive changes to improve health literacy at the practice level. While the topic of health literacy is not new, sadly, nursing's contribution to the health literacy literature has been limited,

even though patient education and advocacy are a core focus of nursing practice.

Nurses can play an instrumental role in promoting better understanding of health information and advocate for interventions to promote health literacy and improve health outcomes. This article reviews the problem of LHL and provides suggestions for evidence-based quality improvement that incorporates recommendations from the AHRQ toolkit.

Healthy People 2010 and the Healthy People 2020 draft objectives⁵ provide a road map for the nation to achieve the goals of health promotion and disease prevention. The two comprehensive goals outlined in the document are to increase quality and years of healthy life and eliminate health disparities.⁶ Although still in draft form, Healthy People 2020⁵ initiatives mirror concern for provider and patient communication clarity, as well as call for research to improve health communication. To achieve the goals of reducing health disparities and extending the quality and quantity of life, changes in health behavior are often necessary. Health literacy has

been described as the “currency” for improving the quality of US health, healthcare, and health outcomes.⁷ The IOM has made the use of understandable health information one of its priorities.¹

Today’s healthcare environment is complex and requires increased patient responsibility to navigate various systems, make health decisions, and follow therapeutic plans. Even people who have above-average literacy may find navigation overwhelming. Most health materials are written at higher levels than most adults can understand. Low formal education levels, older age, ethnic minorities, rural location, and poverty are associated with increased rates of LHL.⁷ This is both an individual and population problem, therefore, interventions must address both.

EPIDEMIOLOGY

Health literacy improvement is central in achieving the six components of high-quality healthcare outlined in the IOM’s report “Crossing the Quality Chasm”: safety, effectiveness, efficiency, timeliness, patient centeredness, and equitable treatment.⁸ Illiteracy, or the inability to read, contributes to LHL. However, health literacy includes the broader definition of being able to manage personal health. It is estimated that only 12% of the 228 million US adults have the skills to manage their own healthcare adequately.⁹ LHL is associated with lower use of preventive services, increased hospitalizations, and poorer health outcomes.¹⁰⁻¹² Health disparities are exacerbated by a complex healthcare system, aging populations, low health literacy rates, and increasing rates of chronic diseases.¹³

Several system-level factors contribute to the problem of limited literacy. Contributory factors include medication complexity, short office visits, increased self-care demands, care fragmentation, and insurance paperwork.¹⁴ Today’s healthcare system requires patients to take increasingly more responsibility for managing their health. The challenges increase as treatment decisions are more and more complex. Within the framework of complexity, LHL has been found to relate to delayed diagnoses, poor adherence to treatment regimens, and increased morbidity and mortality.^{15,16} Treatment regimens require more time and explanation and are often difficult in busy primary care practices. Discharge instructions and patient education materials may be difficult for patients to understand. Treatment adherence and patient follow-up, which are often inadequate, are impacted by LHL.

Primary providers are often charged with the role of gatekeeper to direct and coordinate an individual’s care. However, patients may see numerous specialists. Plans of care may not be effectively communicated between specialists and generalists, thus contributing to duplicate services and medication errors. Patient/provider communication breakdown is compounded when the patient has LHL skills, as the patient often relays information between providers. For example, the patient may not understand the reason or necessity for referral, and therefore a comprehensive evaluation does not occur or, worse, misinterpretation causes errors to ensue.

Patient access to care may also be hampered by complicated insurance application, referral, and reimbursement forms. Consent forms developed for provider legal protection may not be readable and understandable by the patient. Therefore, consent forms may not truly provide informed consent.

Providers frequently make broad assumptions about their patient’s ability to comprehend information. Graduating from high school, for example, does not guarantee a patient can read at a 12th-grade level. A 5th- to 6th-grade reading level is recommended for most patient-education materials.¹⁷ Cotugna, Vickery, and Carpenter-Haeefe¹⁸ found that half of health-education materials reviewed were written above the 8th-grade level. Healthcare providers often use medical jargon, which is a foreign language to people outside of health services. In addition, the fast pace of busy primary care practices does not allow adequate time to assess and improve patients’ understanding. LHL is also confounded by cultural and language differences in the US. Furthermore, many providers have not been educated in ways to enhance patients’ understanding.

However, health literacy is not just about written materials; health literacy is also about accessing healthcare and preventive services, understanding diagnoses and treatment regimens, and possessing the ability to act on health information to improve overall health (Figure 1).^{19,20}

IMPACT OF LHL

The consequences of LHL result in declines in our nation’s health status. LHL is associated with increased rates of hospitalization and poorer health outcomes.²¹ According to the IOM’s report, “Health Literacy: a Prescription to End Confusion,”¹(p. 81) LHL consequences include increased economic costs in health services,

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