Diabetes Continuum of Care: Health Literacy: Diabetes Prevention and Self-management

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

Welcome!
We will begin in a few minutes
Zoom Features

Chat

The host is inviting you to join Breakout Room:
Breakout Room 1

Join  Later

Joining Breakout Rooms...

Breakout Room 1
It may take a few moments.
Diabetes Continuum of Care: Health Literacy: Diabetes Prevention and Self-management

Dinamica/Ice breaker

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

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

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

For information about the Diabetes National Learning Series, visit chcdiabetes.org today.
Special and Vulnerable Populations Task Force Members:

AAPCHO
Association of Asian Pacific Community Health Organizations

CSH
Farmworker Justice

Health Outreach Partners
Healthy People. Equitable Communities.

Migrant Clinicians Network

NCAH
National Center for Health in Public Housing

NCHPA
National Health Care for the Homeless Council

NCCAH
National Nurse-Led Care Consortium

NNOHA
National Network for Oral Health Access

School-Based Health Alliance
Redefining Health for Kids and Teens

For more information on our NTTAP Partners, visit chcdiabetes.org
Diabetes Continuum of Care: Health Literacy: Diabetes Prevention and Self-management

NCA Faculty

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

Dr. Jose Leon
Chief Medical Officer

Jamie Blackburn, MPA
Program Manager

CSH

National Center for Health in Public Housing
Diabetes Continuum of Care: Health Literacy: Diabetes Prevention and Self-management

NCA Faculty

Hansel O. Ibarra, MPH
Program Director

Selenia Gonzalez
CHW Resource Specialist

OUTCOMES-DRIVEN
EXPERIENCED
INNOVATIVE

OUTCOMES-DRIVEN
EXPERIENCED
INNOVATIVE
Learning Collaborative Overview
Overview of the LC

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

Timeline

Last-Session #4: Opportunities for Technology: Internet and Telehealth - March 16th, 2021
Health Literacy: Diabetes Prevention and Self-management
Diabetes Continuum of Care: Health Literacy: Diabetes Prevention and Self-management

LEARNING OBJECTIVES

1. Understand the role of easy to read materials
2. Review how to Develop an Action Plan
3. Discuss how to Improve Medication Adherence
Case Study

Patient Information

Patient Name: JK

Patient ID: 987654321

Age: 65 years

Race: Hispanic

Height: 68 in (172.72 cm)

Weight: 180 lb; BMI 27.4 kg/m2

Today’s Date: November 21, 2014

Occupation: Carpenter
Verbal Communication

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

**Tools:**
- Teach back
- Chunk and check
Studies have shown that 40-80 percent of the medical information patients receive is forgotten immediately and nearly half of the information retained is incorrect.
Chunk and Check

Virtual Medical Educators
Everyone can lend a helping hand
Written Communication

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

**Tools:**
- Electronic assessments: Use electronic tools to assess reading level of written material; a number of tools are available at [http://www.readabilityformulas.com/free-readability-formula-tests.php](http://www.readabilityformulas.com/free-readability-formula-tests.php)
Understand the Role of Easy-to-Read Materials

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

- to find what they need,
- understand what they read, and
- and do what they need to the first time they read it
Understand the Role of Easy-to-Read Materials

As a rule, you help readers when you:

• Write short sentences.
• Use active voice.
• Use everyday words and pronouns (when appropriate).
Understand the Role of Easy-to-Read Materials

● Plain Language

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

- Train a staff member to evaluate the quality of materials you give to patients.
- Identify poor-quality materials.
- Select better materials.
- Consider alternatives to written materials.
- Use the Internet.
- Provide materials in languages your patients speak.
- Create new materials to fill gaps, and revise homegrown materials that need improvement.

Resources:
- [https://www.cdc.gov/other/pdf/everydaywordsforpublichealthcommunication.pdf](https://www.cdc.gov/other/pdf/everydaywordsforpublichealthcommunication.pdf)
- [www.plainlanguage.gov](http://www.plainlanguage.gov)
Easy to Read Materials

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

● Visual Aids:
  Include pictures and avoid unnecessary details
● Use models
● Use photonovelas, easy-to-read stories (comic books); photos instead of pictures
● Use videos

● Tools:
  ○ Online videos: Most patients have access to the Internet; there are numerous online videos (e.g., YouTube) illustrating important and common patient education topics; an example of a humorous education video on colonoscopy preparation is available at https://www.youtube.com/watch?v=H7V5bmyk8BU
  ○ Photonovela Diabetes & Depression: https://youtu.be/3cq8ZIUTJz4
  ○ Phonovala Prediabetes ○ https://youtu.be/yMBJtm9a39U
Use Pictures
Routinely offer help with paperwork

Question A.

Question B.
Review how to Develop an Action Plan

- Collect assessment data
- Review the primary care health literacy assessment
- Discuss opportunity for improvements
**Literacy Assessment for Diabetes**

![Image of literacy assessment table]

- [https://healthliteracy.bu.edu/documents/37/Literacy%20Assessment%20for%20Diabetes%202-00.pdf](https://healthliteracy.bu.edu/documents/37/Literacy%20Assessment%20for%20Diabetes%202-00.pdf)
The Rapid Estimate of Adult Literacy in Medicine (REALM).

- [https://healthliteracy.bu.edu/documents/37/Literacy%20Assessment%20for%20Diabetes%202-00.pdf](https://healthliteracy.bu.edu/documents/37/Literacy%20Assessment%20for%20Diabetes%202-00.pdf)
Review how to Develop an Action Plan

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

- Prepare for practice change
- Improve spoken communication
- Improve written communication
- Improve self-management and empowerment
- Improve supportive systems

Source:
Supportive Systems:

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

**Tool:**
Agency for Healthcare Research and Quality Health Literacy Universal Precautions

Discuss Medication Adherence

Extent of Nonadherence Across the Population

For every 100 prescriptions written:
- Filled by the pharmacy: 100
- Picked up from the pharmacy: 50-70
- Taken properly: 48-66
- Refilled as prescribed: 25-30
- 15-20

At any given time, ~50% of patients are non-adherent.

Source: [https://www.youtube.com/watch?v=sEMCR7LchcA](https://www.youtube.com/watch?v=sEMCR7LchcA)
Discuss Medication Adherence

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

Tools:

- “Before you leave today, I want you to tell me the main problem we talked about, what you need to do next, and why it is important for you to do what we planned.”
- “Brown bag” review of medications: Ask patients to bring in all of their medications and supplements to appointments so that you can verify what they are taking, answer their questions, identify any errors or interactions, and assist with adherence
Medication Adherence II

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

**Tools:**

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

Jose Leon, M.D., M.P.H.
Chief Medical Officer
National Center for Health in Public Housing
www.nchph.org
Tel: (703) 812-8822
Email: Jose.leon@namgt.com
Breakout Sessions
Zoom Features
Case Study

● **Chief Complaint:** “I just moved to live with my son and need to find a doctor.”

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

Breakout Session Questions

➢ What additional medical information would you like to know about JK before offering diabetes education?
➢ How would you measure his health literacy level?
➢ What diabetes complication needs to be addressed?
➢ What resources (printed, visual) would you use?
Take-home Questions
Impact of Health Literacy on Patients' Diabetes Management and Self-Care

Reflection Questions

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

➢ Do your health center use any technology in your diabetes management support? What are the types of things that you use?
➢ What has work well in the space utilizing health literacy technology for diabetes management and what has been challenging?
➢ What kinds of supports does your health center need to utilize technology more?
THANK YOU!

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

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

Jose Leon- jose.leon@namgt.com
Jamie Blackburn- jamie.blackburn@csh.org
Selenia Gonzalez- sgonzalez@mhpsalud.org
Hansel Ibarra- hibarra@mhpsalud.org

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