Health Literacy, Self Management Goals Made Simple

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What is Health Literacy?

The Joint Commission uses the federal Agency for Healthcare Research and Quality’s definition:

The degree to which an individual has the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.

- Not simply the ability to read.
- Requires a complex group of reading, listening, analytical and decision-making skills and the ability to apply these skills to health situations.
- Affected by illness, age, stress, tiredness, mood and diagnosis so can fluctuate over time.
Health Literacy

Everyone, no matter how educated, is at risk for misunderstanding health information if the issue is emotionally charged or complex.

In almost all cases, physicians and other health professionals, try to and believe they are, communicating accurate information.

In some cases, patients may believe they have understood directions, but may be embarrassed to ask questions to confirm their understanding.
Health Literacy Requirements
Provision of Care Standard 02.03.01

EP 30
The interdisciplinary team identifies the patient’s health literacy needs.

“Note: Health literacy is typically an interactive process, the goal of which is to ascertain the patients capacity to process and understand basic health information needed to make appropriate health decisions”.

EP 31
Patient education is consistent with the patient’s health literacy needs.
Health Literacy Requirements
Provision of Care Standard 02.03.01

**Intent:** Improve communication between health care professionals and patients (and their families)

**Minimal Compliance:** While neither the use of a specific assessment tool, nor the determination of a health literacy level is required, an interactive process or method must be evident.

**Note:** Although one effective approach to evaluate a patient’s understanding of the education/training provided (PC.02.03.01/EP 25) is to ask the patient to repeat back the instructions in their own words (the “teach-back” technique) and to document confirmation in the clinical record, using that approach alone is not sufficient for compliance.
WWW – Assess Health Literacy Needs

**WWW:**
- Who can perform the assessment
- When to perform the assessment
- Where to document assessment results

**Consider:**
- Duration of time for assessment
- Competencies required
- Patient friendly
- Who to assess (patient / caregiver / family)
Health Literacy Assessment Tools

NVS (Newest Vital Sign)

- Consists of a nutrition label and 6 accompanying questions
- Takes approximately 3 minutes to administer
- Assesses literacy and numeracy
- Available in English and Spanish
- High sensitivity for detecting limited literacy
Health Literacy Assessment Tools

REALM-SF (Rapid Estimate of Health Literacy short form)

- 7 item word recognition (Menopause, Antibiotics, Exercise, Jaundice, Rectal, Anemia, Behavior)

- Has been validated and field tested in diverse research setting

- Excellent agreement with the 66 item REALM in terms of grade level

May not feel natural to patients
Health Literacy Assessment Tools

SILS (Single Item Literacy Screening)

- Designed to identify patients who need help with reading health related information

- Asks one question

- Performs moderately well at ruling out limited reading ability in adults and allows providers to target additional assessment to those most in need

Does not address numeracy skills
Identifying Health Literacy Needs

Asking the following targeted questions can help identify low health literacy:

- “Medical terms are complicated and many people find the words difficult to understand. Do you ever get help from others in filling out forms, reading prescription labels, insurance forms, or health education sheets.

- “A lot of people have trouble reading and remembering health information because it is difficult. Is this ever a problem for you?”
Identifying Health Literacy Needs

Another way to assess for low health literacy is to ask patients to read their prescription bottles and then explain how to take their medication.
Identifying Health Literacy Needs

Most people with low literacy skills are masters at concealing their deficit and are often quite articulate in speaking, so it is difficult to realize that a problem exists. However, observing closely and asking the right questions will provide ‘red flags’ that a problem exists with reading and comprehending information.
Behavioral Clues of Low Health Literacy

There are a number of characteristics and behaviors that patients with low health literacy exhibit:

- Patients often make excuses when asked to read or fill out forms. Examples include: “I don’t have my glasses,” “I’m too tired to read,” and “I’ll read this when I get home.”

- Patients may provide an incomplete medical history. Registration forms may have many blanks.
Behavorial Clues of low Health Literacy

- Patients with low health literacy become skilled at listening and they often take instructions literally to avoid mistakes.

- To identify their medications they look at the pills for color, size, and shape, since they can’t read the labels.

- Watching for these behavioral clues of low health literacy combined with asking the right questions can pay large dividends in terms of improving healthcare for patients.
Keys to Success Health Literacy Assessment

- Work as a team to develop a consistent process / policy for assessing health literacy.
- Document the results of the patient’s health literacy assessment in a prominent place in the medical record.
- Build into the patient flow the need to assess health literacy prior to providing care, treatment and education.
- Match the delivery of information and education to the patient’s health literacy.
Health Literacy Additional Resources

Health Resources and Services Administration (HRSA)
http://www.hrsa.gov/publichealth/healthliteracy

National Institute on Health
http://www.nih.gov/clearcommunication/healthliteracy

Agency for Healthcare Quality and Research
http://www.ahrq.gov/health-care-information/topics/topic-health-literacy.html

Health Literacy Precautions Toolkit
http://nchealthliteracy.org/toolkit

Centers for Disease Control & Prevention - Online Training
http://www.cdc.gov/healthliteracy/training/index.html
Self Management Goals
Self Management Goals Requirements

**PC.01.03.01.**
EP 44
Patient self management goals are identified, agreed upon with the patient, and incorporated into the patient’s treatment plan

**PC.02.03.01**
EP 28
The primary care clinician and the interdisciplinary team educate the patient on self-management tools and techniques based on the patient’s individual needs

**RC.02.01.01**
EP 29
The clinical record includes the patient’s self management goals and the patient’s progress toward achieving those goals.
Implementation of Self Management Goals

- Self-Management Goals are expected “when warranted by the patient’s condition”.
- These goals may be **behavioral** in nature (smoking cessation or weight loss), **compliance-oriented** (adherence to medication), or **follow-up related** (completion of referrals).
- Based on types of visits, patients, services, and settings, an organization should determine when and how the three self-management goal-related requirements should apply.
- Surveyors will be expecting to see **consistent application** across an organization’s settings and services, otherwise they may inquire about **relevant policies, procedures, training, and monitoring practices**.
Patient Self Management Goals
Patient-centered not Paper-centered

● Goals need to be something the patient wants to do, not something they are told they should do. It’s their wanting that gives them the motivation to follow through.

● You might say “What one thing would you like to work on to improve your health?” We might be tempted to simply have patients choose from a list of behaviors changes. Paper Centered.

● Self-management “tools,” (pieces of paper) can help educate patients and give them choices of things that would be good to work on, but the goals need to come from the patient, the person who’ll be making the change!
Patient Self Management Goals vs Clinical Goals

- **Clinical goal** – provider’s medical goal for the patient, usually **long term**.
  
  Example: “Patient’s A1C will be less than 9.0”

- **Patient Self Management Goal** – patient’s goal to achieve the clinical goal, usually **short term** and identifies behavior changes.
  
  Example: “I will drink water in place of a can of soda twice a day”
WWW - Self Management Goals

WWW:
- Who can assist the patient in developing SMGs
- When to discuss SMGs
- Where to document SMGs

Tips
- Don't prescribe goals or use checklists
- Include family and caregivers in setting goals
- Have medical assistants ask patients about goals when taking vitals
- Assign staff to follow-up with patients by phone
- Have providers review goals with patients briefly
Making SMART Goals

S - Specific  What am I going to do  (What, when, where, how)
M – Measurable  How will I know when I have got there
A – Achievable  Is this something I can do and in my control? What will I need?
R – Realistic  Am I being realistic? What are the likely problems?
T – Time Bound  Can I do this in a reasonable time frame?
Self Management Goals Worksheets

SMART Goals
People who choose their own goals with support of our office do better with long term diseases. What is the one thing you would like to do to improve your health?

Examples of things you can do include...
- Eating Plan
- Take Medication Properly
- Quit Smoking
- Exercise
- Reduce Alcohol Intake
- Reduce Stress
- Reduce Salt
- Weight Reduction
- Self-Monitoring
- Other

WHAT will you do?

WHEN will you do it?

WHERE will you do it?

HOW will you do it?

On a scale from 0 to 10:
How important is this to you? ______
How confident are you that you can achieve your goal? ______

Things that could make it difficult for you to reach your goal:

My plan for overcoming these difficulties:

Checking your progress toward reaching your goal is important for your success. Our plan to follow-up with you is:

Everyday is a new chance to do something good for yourself!

Specific Measurable Action-oriented Realistic Time-specific (SMART) goals

METAS INTELLIGENTES
Las personas que eligen sus propios metas con el apoyo de su doctor y su equipo médico pueden mejorar las enfermedades a largo plazo. ¿Qué es la una cosa que usted querría hacer para mejorar su salud?

Ejemplos de las cosas usted puede incluye...

- Dieta
- Tome Su Medicina Apropiadamente
- Deje de Fumar
- Ejercicio
- Reduzca La Ingestion de Alcohol
- Reduzca La Sal en Su Dieta
- Perda Peso
- De AutoControl
- Otro

¿QUE haría usted?

¿CUANDO lo haría usted?

¿DONDE lo haría usted?

¿COMO lo haría usted?

¿En la escala de 0 a 10, con que seguridad puede usted conseguir su objetivo?

Las cosas que podrían hacer difícil para usted alcanzar su objetivo:

Tu plan para vencer estas dificultades:

Verificar su progreso hacia alcanzar su objetivo es importante para su éxito. Nuestro plan al seguimiento con usted es:

¡Diario es una nueva oportunidad de hacer algo bueno para usted mismo!
Self Management Goal Setting Techniques

1. **Ask**: Is there something you would like to work on to improve your health?

2. **Guide** development of a short-term goal that is SMART

3. **Gauge the level of importance** and score on a scale of 1 to 10. If rated less than 7, adjust goal to something that is more important to the patient.

4. **Assess Confidence**: Score from 1 to 10 and adjust the goal to something that is 7 or more. A score of 6 or less suggests the goal is too hard. Likewise, if someone scores 10, then this goal is very easy for them and you could check if they wish to make it a little more challenging.
Self Management Goal Setting Techniques

5. **Arrange short-term follow-up.** A phone call, email, or text within one or two weeks of setting a new significant goal and change can make a significant difference to likeliness of achieving it. Help the person problem solve if they are facing barriers or struggling to achieve their goal and action plan.

6. **Document goal in patient/client’s notes and be sure to ask about it at the next visit.**
Tips for Creating a Successful Action Plan

- Begin with something the patient wants to do
- Make the goal reasonable (something the patient can reasonably expect to be able to accomplish this week)
- Strive for a change that is behavior-specific (losing weight is not a behavior; not eating in the evenings while watching television is a behavior)
- Ensure that the plan answers these questions: what; how much; when (think about – which days, what times, how often etc.)
Tips for Creating a Successful Action Plan

● Start when the patient has a confidence level of 7 or greater (this is the belief that they can, and will, complete the goal).

● Identify potential difficulties to achieving their goal

● Help the patient brainstorm ways to overcome potential difficulties.

● Ask the patient if there is someone that can help them in achieving their goal.

● Share your plan to follow up with patient

● Follow up, follow up, follow up
Sample Self Management Goals

Goal 1: Patient identified a goal of drinking water in place of soda twice a day.
Difficulty identified by patient: There is a soda machine at her place of employment.
Plan for overcoming difficulty: Patient will not carry loose change at work.

Goal 2: Patient identified a goal of walking up the stairs to her office.
Difficulty identified by patient: The elevator comes before the stairs.
Plan for overcoming difficulty: Patient will come in through a different entrance that has the stairs before the elevator.
Commitment to Change Foundational to Success

Achievement of Goals' at Six Months

n=282

- **No Formal Commitment to Change**: 4%
- **Formal Commitment to change**: 46%

People making a formal commitment to change 10 times more likely to report meeting goal at six months

**Study in Brief**

- Six-month study of 282 people: 159 making a formal commitment to change and 123 contemplating a specific behavior change; most common goals were weight loss, exercise, and smoking cessation.
- Study participants contacted via phone at two weeks, four weeks, three months and six months to assess progress toward goal.
- Study participants 10 times more likely to report meeting goal at 6 months if formal commitment made.
Self-Management Support Toolkit

Health Navigator

### Resources

<table>
<thead>
<tr>
<th>Resource</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Video explaining Diabetes</td>
<td>Excellent video explaining diabetes, HbA1C and why taking your medicines as directed can help manage your diabetes. <a href="http://www.youtube.com/watch?v=rBKSutqPXCY&amp;feature=player_embedded">Link</a></td>
</tr>
<tr>
<td>Diabetes Section – Health Navigator NZ</td>
<td>Factsheets, educational resources, videos, tools <a href="www.healthnavigator.org.nz/health-topics/diabetes">Link</a></td>
</tr>
<tr>
<td>ADHB Diabetes Centre</td>
<td>Referral, services and staff information. <a href="www.healthpoint.co.nz/default.38695.sm">Link</a></td>
</tr>
</tbody>
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| Diabetes Auckland - Support Groups & Nurse Educators | Wide range of resources, support and educational programmes  
  - [Diabetes Conversations Maps Series](#)  
  - Support Groups across Auckland  
  - Information Centre  
  - Shop  
  - Supermarket Tours |
| Diabetes Project Trust         | Wide range of resources, information sheets – see services directory at the end for information on group programmes [Link](www.dpt.org.nz) |
| Health Mentor Online           | An online self-management programme for people with pre-diabetes  
Also has a log in to access resources for Health Professionals [Link](http://www.healthmentoronline.com/) |
Self Management Additional Resources

Self Management Toolkit:
http://www.healthnavigator.org.nz

Set & Document Self Management Goals Collaboratively
http://www.ihi.org/resources/Pages/Changes/SetandDocumentSelfManagementGoalsCollaborativelywithPatients

AHRQ Self Management Support

SMART Goals a Patient Self Management Tool
https://www.bcbsm.com/pdf/OSP-SMART_Goals

Physician Resource Guide for Patient Self Management
http://www.gpscbc.ca/system/files/phys_resource_guide
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