Hello and welcome to our Merge series webinar, Health Literacy and Clear Communication: Fundamentals of Empowerment Through Health Information. Our presenter today is Dr. Cliff Coleman. Dr. Coleman is a national and international expert in the field of health literacy. His award-winning work focuses on improving health literacy and clear communication training for healthcare professionals through systems approaches, including curriculum design and evaluation. Cliff is an associate professor of family medicine at the Oregon Health and Science University, OHSU School of Medicine, where he serves as clinical threads director for education on health, communication, professionalism and ethics. In 2021, Cliff became the inaugural Doris and Mark storms chair and compassionate communication at the OHSU Center for Ethics in Health Care. Cliff practices at OHSU is Richmond clinic, a federally qualified health center in Portland. He received his bachelor's in psychology from Dartmouth College, a Doctorate of Medicine from Stanford University, and completed a dual residency in family medicine and public health and preventive medicine at OHSU with a Master's of Public Health from Portland State University in 2004. My name is Kristen doll. I'm a program manager at the Human Development Institute at the University of Kentucky. My pronouns are she her hers. As a short visual description, I am a late 40s white female with long blonde hair, I'm wearing a brown shirt, black glasses and I have a blue background with the HDI logo. On behalf of Merge, I would like to thank you for taking time to be here today. The controls are located at the toolbar at the bottom of your zoom window. Please use the chat feature if you have any comments or technical issues and we will do our best to assist you. Please use the Q&A to submit questions for our presenter. We will hold questions for the Q&A towards the end of the webinar. There's a hand raising feature you can use if you need assistance from the Merge team. Other than those presenting the webinar, everyone is muted, and camera access is turned off. You can turn on captions from the Zoom toolbar by clicking the CC button and selecting Show subtitles or select view full transcript for running transcript of the captions. You can also change the size of the caption text by selecting subtitle studies. ASL interpreting services are being provided to access the services on the toolbar to click interpretation. Or you might have to click the More button with the three dots. Under watch choose the sign language channel, a floating window will appear, and you can resize and move this window to your comfort. The content shared in this webinar are the views and opinions of the presenter and do not necessarily reflect those of the Administration for Community Living, or the University of Kentucky. You will receive the slides resources and links to the recording of today's webinar via email resources are being shared and chat throughout the webinar as well. This webinar is being recorded and will be available on the Merge website. Your feedback is important to us when you exit the webinar today and evaluation will appear in your browser. We will also send the evaluation via email, we ask you to complete the evaluation so we can improve a future webinars. And now I'll turn it over to Dr. Coleman.

Thank you, Kristen, thank you so much. I'm so pleased to get to be with you here today. And I'm in Portland, Oregon with 10am here. So good afternoon, but I'm still celebrating my morning, had a nice wet bike ride into work this morning, which was very refreshing as I'm feeling kind of invigorated and ready to have a good conversation with y'all here today about this topic of health literacy, which is something that I spend about 100% of my time thinking about but I know that there's a wide variety of experiences with this topic. And I and having done a lot of the research myself, I'm aware that there's likely some of us on the webinar today who know a lot about this topic and likely some who may not know much at all about this topic. So, I think that'll help us have a nice rich conversation toward the end, I hope. Let me share my slides. And so, see, this looks that you're seeing all that all right. And I kind of don't know how to get rid of this toolbar at the top, but I hope that it'll go away on its own. Alright. So, at first I wanted to just say that. During this conversation, I hope that I will be presenting this information in a really inclusive kind of way when I'm talking about health care and clear communication I'm really trying to make sure that all of us feel included in this in this conversation. So, any person who works in a healthcare setting, health care delivery, health services, social services delivery, who's working with patients, or clients or caregivers, or the public in general, is communicating through often spoken communication or read and or written communication. And I hope that we will all recognize our roles in this. But I also am aware that we have folks on the call today who don't work in the field of health care or, or social services. And I think it'll be maybe helpful for all of us to at moments during this talk today to think of ourselves in most in the times when we ourselves have been patients. We've all been patients at some point, or will be at some point. And everything that I'm going to be talking about here today, can be thought of from both perspectives, and I. So I hope that we'll all recognize our shared experience in the need for clear communication and the power for clear communication to help us develop more empowered ability to use healthcare and health services. So, our objectives, I've got three things I'm going to try to achieve today, I want to help us, as a group anticipate health literacy challenges that are faced by patients and caregivers describe some reasons why what I'll call a universal precautions approach is really needed. And it's currently not the standard in the in the health care industry. And then we'll, I'll drill into some kind of five key best practices to help us develop better communication skills right away things we can start using tomorrow. To do that, I'll go through the outline here, we'll touch a bit on just health literacy basics to do a little bit of level setting for us, make sure we all have a common starting foundation of understanding. And I'll talk about this idea that I mentioned about universal precautions for health communication, and then get into those just five best practices that will introduce a little bit today, those are going to be reminders around the use of qualified medical interpreters, the use of plain non jargon language, the avoidance of information overload, the ability to, to elicit clarifying questions, and the ability to use a teach back technique to recognize when we've been whether we've been clear communicators or not. So, help literacy Basics. I'm gonna start with a quote from George Bernard Shaw, who said, the greatest problem with communication is the illusion and has occurred. And this is really going to be a theme for us today, this idea that what looks like good communication on the surface, generally speaking, is concealing lots of misunderstandings, gaps in information, unanswered questions. And so, I'm going to come back to this theme as we go through the talk today. Let's start with a definition. For health literacy. I'm going to actually show two definitions eventually. But for now, we're going to talk about this idea around personal health literacy. This is an individual person's health literacy or their abilities to get information, understand it, and then act on it. And I'm going to give some examples of that. And then we'll talk about the flip side of things here, which is organizational health literacy, which is how do people who work in health care communicate in a way that empowers patients and caregivers. So, I'll start with a little bit of data here, I'm going to show this fairly busy slide, but I'll talk us through it a little bit. These are what I'm going to present here a data from the US Department of Education, who did a study called the National Assessment of Adult Literacy. And you can see from the from the reference or the citation down here that from 2006. This is a little bit old. But I'm going to tell you why I'm why I believe that it's still accurate. The US Department of Education used to every 10 years go out and do a nationally representative survey of adults in the United States. And they would go they would give the in this case they gave over 19,000 people across the country. A reading comprehension test like many of us have taken before where you have page after page of questions you read the read the question then have a multiple choice or a fill in the blanks answer. And all of the questions in this in this study involves some sort of material that was related to health information. So, they were passages that had been taken from brochures about healthcare or other things like that. Some of the questions were really easy to answer, and some were very hard to answer. And there were lots and lots of them. And so, when, when a person goes through this whole booklet of questions, and when you do that over 19,000 people, you get a good picture of what kind of baseline health literacy skill set that the population has. Now, what we're looking at here in this top bar, are the percentages of the US population estimated this percentages, we have 14% 22% 53%, and 12%. And these are correlate to skill levels on this health literacy test. So, 14% of adults in the United States scored in the below basic skill level on health literacy, meaning they could answer some of the very simple questions, but had a harder time with a little bit more with a little bit more difficult or challenging type of questions. The next group 22% could do a little bit better, where we call it kind of in the basic skill set, could answer a little bit harder questions. But generally speaking, these two groups together, did not have the baseline literacy based skills to deal with the typical usual kind of communication that that people experience when they come into a healthcare environment, the way people are going to speak to you the way the written materials that you're going to receive the forms that you're going to need to fill out all of that this these two groups 14% plus 22%, that's a total of 36% had really low, low health literacy skills at baseline. Now, the rest of the population 53% had intermediate or kind of middle of the road scores, and 12% had proficient or very high health literacy scores. But it's important to recognize that even for these folks with the higher skills at baseline, think about what happens to us when we are under a lot of stress, what happens to our ability to think and remember and make decisions when you're sick. Or if you're or you're in pain, or you're worried or scared about what's happening to you or your loved one, your ability to process new information, particularly complicated health information goes way down. And so even for this group, these groups, health literacy skills can go down during times when we need them the most. And so, the take home message from this slide is that, that a third of adults in the United States have low health literacy at baseline, but all adults in the United States can have low health literacy when they need it most. Now, literacy itself is a very complicated construct. And we're not going to go through all of the details of it. But I just want to highlight some of the literacy based demands that the healthcare system puts on patients routinely. So

we've been talking about reading, writing and reading skills that that test that we just that I was just showing, these are kind of print literacy skills, and we can think about some of the demands that that we put on patients and caregivers related to this. So, for example, things like filling out forms, or understanding consent forms if someone needs something done to them. Understanding prescription labels, which I'm going to show examples of, in a moment, figuring out the dosages on over the counter medications, following written instructions, benefiting from brochures, these types of things all require reading and writing skill levels, or skills. And there's this idea about numeracy, which is the use of numbers in general communication. And I'll show some examples of that. And how difficult that can be for many people. For example, anytime a prescription is written, there's a numeracy or a math problem embedded in that that we can talk about. And then there's this. Moving over to the left here, there's this idea of spoken communication or oral literacy, listening and speaking skills. And we can think about some of the demands that we put on people in those areas. For example, if a person wants to get an appointment at a, at my clinic, they have to call and go through a phone tree, right? They get answered a question and they say, you know, you get three or four or six different options at numbers, you have to press, you have to work your way through this whole system, which requires a lot of listening skills to be able to successfully manage. persons need to be able to describe their symptoms. So, they need a vocabulary that has some variety of different adjectives to describe what they're feeling in order for their healthcare team to understand what to do next. People need to be able to understand the vocabulary and the language that they're hearing back from their healthcare team as well. And I'll show some examples of this. So, you can think of a lot of other examples, I'm sure as well. And then there's this over far on the far left here, this this notion of cultural and conceptual knowledge, which is essentially what does a person know? What have they learned? And in this case, what have they learned through their literacy skills through reading primarily, what we know from our education colleagues is that young children, kindergarten up to third grade are so spend those first few years of their schooling learning to read. So, they're looking at, or they're or experienced, experiencing written language. And then learning to decode that and turn that into meaning after third grade. Young children have been through adults basically spend the rest of their lives generally reading to learn. So, taking that skill that was developed early on, and using that to develop knowledge in other areas, right, learning about history and learning about human biology and all the other things that we as humans learn about requires literacy based skills. And whether those are written, written, if a person is experiencing that written communication through visual reading, or whether they're hearing it, those are, those are all related skills. So, we saw this during the pandemic, where it became important to have conversations with people about germ theory, this idea that there are these things that are too small for us to see, viruses that can get into our bodies, replicate within our bodies, make us sick, then get out of our bodies and go into somebody else's body and make them sick. And that germ theory is based as rooted in an educational experience, which is done literacy based experiences. And for many people in the United States, that piece of conceptual knowledge was missing. And it became very difficult to be to even have a conversation about ways of preventing infection when people didn't necessarily have that foundational knowledge, right to be able to talk about face coverings and why those could be important, social distancing, and why that could be important. Handwashing, vaccination, all those things, all of those conversations required a foundational knowledge that many people lacked that and that was all literacy based. Now, one of the one of the things about one of the reasons why we have this illusion of clear communication or illusion that good communication is occurring, that I mentioned earlier, is that most people, the United States, can read a written word. In the United States, on average, about one to 2% of adults don't read at all, and would be considered illiterate. About 98% or so. Can Read, can read. Now the question is, what can they do with that information? So, this is a fairly elegant study where these researchers took a group of adults, I gave them a reading comprehension test, and found out what grade level a person was reading at. And if a person if the if these volunteers were reading at a sixth grade reading level or less, they kept them in the study, and they sent the rest of the people home. So these are fairly lower skilled readers. And then, in a private room, a researcher sat down with a person individually, and they handed them a real prescription pill bottle. And they asked them if they wouldn't mind try to read the label out loud. So, in this in this group of volunteers 71% correctly read verbatim the instructions which said take two tablets by mouth twice daily, then the researchers that will create thank you now if you wouldn't mind telling me or showing me how would a person take this medication over the course of a day. And in this case, only 35% of this of these folks could actually demonstrate the skill. So even though they could read the words, they had a difficulty translating those into action, that reading comprehension is missing. Oh, you've tried to get this about a year. I'm going to just show you a short clip three and a half minutes or so of some patients talking about their experiences in healthcare. And what I want to have us paying attention to is the way they're describing what it felt like to not understand and some of the language that they're using to describe that experience

I was sick a lot. I was sick a lot, because I probably missed dosage and didn't realize that I was in hospital a lot. When they did give me medicine, I didn't take it right, I admit to it. I just didn't understand them. And I didn't have the nerve to ask them the right way of doing it. I just didn't have the nerve to ask them. And I didn't want anyone to know, I couldn't read. We

had a child that was physically handicapped, that I had to do physical therapy, and I would show up on Tuesdays, instead of Thursdays for the appointment, I would be exercising the wrong side of the body.

I had an abscess in here one time, well, I had to fill out forms and have been fill out. So I didn't go I come back home. I ended up having to go to the emergency room that night because it reversed

Can you imagine what it's like? You'd be in a patient is sick. And you know that you have limited skills, okay? And you're talking to an intelligent doctor like yourselves, and these people or are using words that you really don't know, because they're not speaking in layman's terms? Okay, most doctors or just presuming that everybody's intelligent as they are. And that is just not the case. So, what you do you come out of that, that that room that examination room with this intelligent woman or man thinking? God, I hope I don't make a mistake with my medicine because I did not understand anything he or she said to me.

The heart caps one capsule. That's wrong on caps. caps that? I don't know this. twice, twice daily. Okay, so what so how would you take this? When I see is that on that tell you how to take it and say take it twice daily, but it don't say what's on the table? And tell me which one is which and what you take?

That looks like medicine that he gave me for the morning. I take that little pill. So this is the trials. This is lithium in it? Yeah, that's lithium. Okay.

And what do you take that medicine for?

Don't ask me, he puts me on, and I just take it. Okay. Anything he tells me to take off, take it. Okay.

I went into the gynecologist and complained about part of this not working correctly. And he said we can repair that. Great. I didn't ask all the right questions. When I showed up two weeks later at the admissions office at the hospital, they put enough papers in front of me, I bet there were five papers that I needed to sign. Well, I wasn't going to say excuse me, but I don't read really well. And I certainly don't read fast. And I'm concerned with some of these words. To me, it was lines and circles over sheets and sheets and sheets. And I wasn't going to reveal my sense of stupidity. So, I signed everywhere. They told me to sign never read it. And then a couple weeks later in the follow up office visit, the nurse said how are you feeling since your hysterectomy? Now I acted as normally as I could. Inside my mouth fell open. And I thought to myself, how could I be so stupid as to allow somebody to take part of my body? And I didn't know.

All right. Obviously, there's a lot that we could unpack from all of these stork shared stories. What I really want to focus in on is just a couple of things here. One was what was we heard earlier we heard a woman talking about. She used the words Intel, or she was referring to her own intelligence. She used the word intelligence you said you're in a room with a woman or man, an intelligent woman or man who says as soon as you're just as intelligent as they are, these are her words. She's linking understanding health information to intelligence. And rather than just a differences in education or experience, right, this woman here, her words where she said she didn't want to reveal her sense of stupidity. She used the word stupidity. Again, referring to not understanding what's going on. Right. What we're seeing in this is we see this in other studies is that patients equate not understanding health information with their intellect, with intellect with intelligence and So we can so it's. So, it's fairly easy to imagine why a person would hide the fact that they don't understand something because they don't want to be judged as not being smart. Now, those of us who work in healthcare, I think, can recognize that this isn't an intelligence or intellect issue. It's an education, if difference. But that's not how patients and caregivers experience it. That's not how they feel it. And so that feeling is really important. And that's a very strong motivator for this, again, this illusion of good communication. These folks in the video here talk about how they sat there and listened, and hoped that they were going to be able to figure out what was going on, but recognize that they didn't know what they were confused and didn't understand what was what was happening. But didn’t let the person that was talking to them and just didn't record they didn't show that to that person. Right? They, they hid it from them. Now. Now, we know that low health literacy is really linked to a whole bunch of adverse outcomes or worse outcomes. So, we compare groups with lower health literacy groups with higher health literacy, we see that the lower health literacy group is a lot less likely to use prevention, or preventive services like vaccinations and cancer screenings and those kinds of things. They're less likely to understand what their medications are, what they're for, and how to take them as directed. They're more likely to experience chronic disease like diabetes and high blood pressure, which is on really an unfortunate irony here that the folks who need the health literacy skills to self-manage a chronic illness are more likely to experience lower health literacy from the beginning, they're more likely to have trouble navigating the system, just figuring out how to use this complicated system of ours. They're more likely to use emergency services than primary care services. We heard the man in the video saying he just had an earache, and he made it to the clinic. But then he got intimidated by the paperwork. And he left and eventually came back to the emergency room. People with lower health literacy are more likely to wait and put off care until it's more serious. And so, when they do present to care, they're more likely to require hospitalization for their problem for whatever it is, because of waiting and trying to write it out. After hospitalization there and leaving the hospital, these folks with lower health literacy are more likely to be readmitted to the hospital within 30 days due to difficulties in managing whatever their problem had been. Unfortunately, they're also more likely just to die from all from all-cause mortality or from heart disease. This is especially true in older adults. And more and more evidence confirming that health literacy is a better predictor of racial and ethnic health disparities than our more traditional measures of socio economic status, which are generally years of education and income. Measuring health literacy is a better measure of the quality of a person's education. Now we could talk about health literacy and disability specifically. And I'll just start by saying there is a very limited amount of research that's been done in this area, it's really inadequate to make some sort of clear conclusions here. And so, this would be a call for additional research in this area, which will be very important for us. In one study that did look at general disability versus no disability, people who identified as some having some type of disability without being specified, what kind compared to people who did not identify as having a disability, there was no, there were no differences in average health literacy skills between those two groups. So that is the one piece of data that I do think we can say with some confidence. But that is a that that group who identifies with having one or more disabilities, of course, is a very diverse group. And there are many different types of disability to consider here. And so, a number of authors have hypothesized or presumed that people who identify as having an intellectual disability will likely experience lower health literacy on average as well, that's been a presumption but as one author has put it, we don't really have the data to support that at this moment. And so again, there's a lot of room for to improve our understanding in this area. Now, that's so now I'm going to take us back to it and remind us of our original definition of health literacy for an individual, but now I'm going to add the Oregon As a national health literacy piece to this, so organizational health literacy is how well our institutions and the people who work in the for those institutions present information in order to make it accessible to individuals, for them to be able to find it and understand it and use it to their advantage. All right. So, what we what we have is really a dynamic system here where on the left hand side of this diagram, we have this yellow arrow that's just that's representing an individual person's personal health literacy skills. And we remember that that person's health literacy skills can go up and down, depending on how they're doing what's going on in their life that day, if they're feeling sick, scared, hurt, it's gonna go down. On the right hand side of this diagram, we have this much larger red arrow, which is representing the demands the literacy and communication demands, the healthcare system puts on people, and it's this arrow is intentionally larger to represent the fact that virtually every time a patient or caregivers is seeking services, the information that they're receiving is kind of overloading their capacity at that moment. So, we're going to talk about how can the system and the people who work in the system, provide clear communication, shrink this arrow, lower barriers to understanding and make it easier for patients and, and families to benefit from health information. So, the first and probably most important piece to that is this idea around universal precautions for health communication. Now, if you work in a healthcare environment, you're probably familiar with this term universal precautions as it relates to bodily fluids. So, we talk about how you can't tell by looking what, who, which person's blood might contain something in it that could make you sick. And so, if you're cleaning up some blood, you use a universal you treat it as if all of it can make you sick, because you just can't tell right? So, you use all the protections that you that you that you have available? Well, we could think about that same sort of analogy for health communications, where the studies show us that we really can't tell who is understanding us and what they're understanding what they're taking away from the communication. I'll show you some of the studies about that. But we can't tell. And so, if we can't tell, we need to assume that everyone can have trouble understanding health information. And I can personally for myself, say like I that's relatable to me, I as a doctor, I still can feel confused when I'm when I'm the patient, or when I'm there with a loved one listening to another health care professional. So let me talk about a little bit just kind of summarize the reasoning behind this. And then I'll sort of explain what universal precautions would look like. So, the rationale or the reasoning for this approach are a few things. Number one, we've already talked about that low health literacy is super common, right? We know that a third of adults have low health literacy right at the start at the baseline, and under their best testing conditions. But we also know that all of us everyone can have low health literacy at any given moment. And so, it's incredibly common. We also know from a bit of what I've told you here, but from also from other studies, that people actively hide the fact that they don't understand and for good reason, because they don't want to be judged, as in their own words, being not smart, right or quote unquote, stupid.

We know from other studies that I haven't shown you that we that healthcare professionals literally cannot tell with any reliability, who's understanding them, or what their understanding. We have some screening tools that have been developed out there. And if you're a person who's looked through the literature, you'll see lots of screening tools available. There's really concerning reasoning, why we should not be using these in a clinical environment. They're useful for research purposes, they're not appropriate for and clinical settings. And lastly, all the available data that we have says that everybody wants clear, easy to understand health information, even people with high education and high health literacy prefer when their health information is presented in its simplest form. So, these are the reasonings why a universal precautions approach is recommended. And let's talk just a bit about what that would be. What is it? So, it's assume it starts from the assumption that everyone can have difficulty understanding their health information. It says we should be using clear communication practices, which include things like plain language, which I'm going to talk about in a moment, and we should be using that as our baseline default starting position. For every encounter with every patient and caregiver, every single time, we should always just start with the simplest easiest to understand messaging. And then if we do that, we're going to be helping support patients dignity, autonomy, and safety. And we're going to be doing that for everyone across the board, not just folks with high health literacy and high and high education. So, in order to, to practice this, this universal precautions approach, we need some specific, some specific best practices that support that, that universal precautions. So, I'm going to highlight a few of those for you these come from some consensus studies that I participated in where we identify, we're trying to identify the variety of clear communication best practices that will help patients and caregivers lower those barriers to understanding. Alright, and what we came up with, as we identified actually 32 sort of best practices, communication approaches, I'm not going to show you the 32, I'm going to show you sort of the top five. And we're just going to briefly touch on each of those just to give you a sense of what those are all about. So, the five that I'll talk about are these we're going to remind ourselves about the use of qualified medical interpreters, we'll talk about using plain non jargon, language, avoiding information overload, eliciting clarifying questions from patients and caregivers, and then using the Teach Back technique to make sure that we've been clear in our communication. So, the first one here, qualified medical interpreters. So, we've been talking about health literacy for kind of average, US adult right in the US in the, in the United States, the average adult is spoke English as their first language, and does not use interpretive services. What we can imagine, however, is that every everything that we've been talking about so far, which creates problems for people who do not who are native English speakers, or does not use, interpretation services, those, those issues are going to be magnified for people who do you who do use language services, right. And that includes people who learn English as a second or other language people who use American Sign Language interpretation. So now we know the law says we have to be using interpreters and providing them free of charge to anybody who wants one our needs. But in practice, what we see is that a lot of the times when people are not providing qualified or people who are trained as interpreters, very often, in practice, what we see is people using friends and family, as interpreters and patients oftentimes asked for that, right will say, you know, I brought, I brought my cousin with me here to interpret, I really would prefer if they would do it, which kind of makes sense. If you want somebody who's got your best interests in mind, you know, is going to is not going to steer you wrong right. Now, I'll talk a bit more about that in just a second. But that's, that's that path of least resistance is, is quite a problem for us. What we know from the studies is that when we when we use these lay interpreters, untrained or unqualified interpreters, compared to using a qualified interpreter, we see a lot of really, really significantly worse outcomes. And we really are contributing to health care inequities when we're not involving a qualified interpreter. So, what we see is that lay interpreters are sorry, qualified interpreters reduce communication errors, they increase understanding comprehension, they reduce the use of unnecessary testing, like getting an MRI rather than just talking to a person. They reduce the risk of adverse or bad outcomes. They increase adherence to treatment plans. In a hospital environment, they reduce the length of stay, which is an important financial incentive for hospitals. In fact, they also reduce the risks of 30 day readmission rates to hospitals. So, another good reason why hospitals should help promote the use of qualified interpreters and patients alike, the use of qualified interpreters more, they're more satisfied. Lastly, the use of qualified interpreters reduces the chance that we're going to be sued for causing some problems for some person. So, lots of great reasons for using qualified interpreters. But yet we don't necessarily We do it all the time. In fact, we oftentimes fail to use qualified interpreters. So, what we would say in our group here, we try to a, use a qualified interpreter anytime a person has a language other than English listed as their as their preferred language in their medical record. But I also teach in our program that we should use other clues to when an interpreter would be important. And one of those that that I that we try to promote is, when a person brings someone with them to serve as an interpreter, that's an important cue for us to not just accept that. So, if a person brings in their family member, and says, you know, I really would prefer if my cousin here would be my interpreter, we, we need to resist that urge to just accept that as the easiest path of least resistance, but also validate the fact that this person wants this trusted family member to be with them. So, what I would say is we do we teach, this is how we teach it here, we say it's try to say, validate the person, I'm really happy you brought your loved one, this is going to be very helpful for us. In addition, I would like to add in a professional or qualified interpreter. And we'll use your cousin to help make sure that we're all on the same page here and that the interpretation is going as well as it can possibly go. So, we work as a team. And so that helps us achieve the best quality communication that we can hope for. So, we'll stop on that stuck thought, and we'll move on to the next best practice. But we may have some able to talk more about that in the question answer period. The second best practice is the use of plain non jargon language, or at least defining jargon when it is necessary. And so, this is we could have a whole hour long talk on more than an hour long talk on this. And this is a very deep and rich area for us to work on. Quality Improvement. medical jargon is essentially that specialized language that healthcare professionals learned in their formal training or on the job, those shortcuts that we learned that slang that we learned that we use with each other. And the terminology that we use to be precise, when we're talking about some medical issue with colleagues. The problem is that it becomes so second nature that it just spills over into our conversations with patients and caregivers. And most of the time, I would say 90% of the time, the jargon that we hear when we go out and listen to people is really unnecessary is creating barriers to understanding that don't need to be there. Occasionally, jargon is important. And is it something that we can we need to work with a patient on and teach to help them be more empowered on something but for the most part, almost all jargon is unnecessary.

Now, jargon is super complicated, we won't get into the details of it. There's lots of different kinds of jargon, I'm just showing you a variety of here, technical jargon words like glucometer, these are words that only really have any significant meaning. And when we're thinking about a healthcare context, we've got quantitative jargon, which are things like unlikely or excessive, these aren't medical terms, but they, when they're used in a medical context, they require some, some medical or healthcare experience to really know what they mean, or how they're being used. And then there's this Lage ARD, which are term words or phrases that have one meaning inside a healthcare environment and maybe a totally different meaning or a subtly different meaning outside of a healthcare environment. Classic examples are things like positive and negative. So, in a healthcare environment, when your test comes back negative, that is usually great news right? Outside of healthcare, anything that's negative is usually bad. And kind of vice versa. In health care, when your test comes back positive, that's often bad news. Outside of healthcare, anything that's positive is usually positive. Right? So, lots of examples we can think of here. Let's take a listen to quit less than a minute here. We'll listen to some folks on the streets of New York. Describing what they think that word hypertension means. Hypertension is a technical jargon word for high blood pressure. But let's just listen to what these

describe to me what hypertension is. I'm guessing it's when you're really hyper tense. I have no idea.

Nobody sounds bad. Hypertension will be over activeness in the muscles says is it when you stress the muscle or something like that, actually in the mind Navy Now, I potential disorder. I don't have it though. The proper hypertension will be overactive, stressful this is something like that.

So, so if we were to go out in any community and ask people, have you ever heard of the word hypertension? A whole bunch of people would say, Yeah, I've heard of that. And then if we said, well, what is it, a whole bunch of people would not be able to explain it in the way we, you know, in a health care or accurate kind of understanding. So just one example, of a jargon term. Let me show you some other examples. These are pictures of, we call whiteboards or dry erase boards, these are in hospital rooms here at my hospital. There's no identifiable patient information on any of these. But just to show you just how easy it is for people to use jargon without even thinking about it just have so second nature. This up in this upper right upper left corner, this patient's reason for visit says hypoglycemia. But I I'm quite sure that anyone who has ever experienced hyperglycemia didn't call it that they probably called it low blood sugar. And so, we could have put that on the board instead. This next person's active issues include syncope. And again, I'd say anybody who's ever experienced syncope probably doesn't call it that they probably said they passed out. This in the middle of the screen here, this person's diagnosis is FX humerus, R with a circle around it side effects is shorthand for fracture. Humerus is the big bone in the arm. And R with a circle around it means right so this is a right arm, a broken right arm. Why didn't we just say that, you know, because we didn't think about it because jargon is comes to naturally. And I won't go there's a whole bunch of other examples in here. I won't go through for now, but you have them in your, in your slides. Another example this, these are prescription refill requests that came to me for a patient of mine. And this top prescription here is a medicine called Eliquis. Also known as Apixaban. It said on the label take one tablet by mouth twice a day to prevent thromboembolism. So, I had my patient with me in the exam room and I said, you know, because I because this is what I do. I said well, what's the thromboembolism? And he said, I don't know. And I said, Well, what if I told you that that you're taking this medicine to prevent a blood to prevent a stroke? And he's like, Ooh, I should probably take that one, huh. And I think yeah, probably should take that one. But so, I so we changed it to so now the label says to prevent stroke. The second medicine on your duloxetine is an antidepressant that's used to treat depression, anxiety and pain. And the instructions on it said take one capsule by mouth once daily via feeding tube for chronic musculoskeletal pain. The nurses and other clinicians in the group today will recognize it, that taking it by mouth via feeding to probably doesn't work very well. I'm also irritated by the fact that musculoskeletal is misspelled here as musculoskeletal. But beside that, I asked him what is musculoskeletal pain? And he just said pain? And I said well, why don't we put it on the label. I said I don't know. So, let's change it to the you're taking this for your back pain. Let's make it say that. So just more examples of jerk, right? Now we're gonna move on to the third item on our list here, which is avoiding information overload. Now, information overload is what I'm doing with you all right now, which is I'm giving you so much information so fast, that you're, you're having to focus very hard on my, on what I'm saying right now, so much so that probably most of you couldn't tell me what was on the slide, two slides ago or anything before that, you'll have to go back if you want to go back and remind yourself of those, you're gonna have to go back and look at those slides or watch the video as a reminder, because that's how our working memories work. Now, the same thing happens in a clinical environment or healthcare environments as well, where we give so much information that people can't hold it on their heads. And so let me show you some of the implications for that. So, so help it so information overload happens when there's too much information coming too fast, it tends to go up with age and other factors. Now, when this has been studied, when we look at how much a person can retain or remember after, like, say a typical clinic visit, on average, patients will remember half 50% of what was talked about in an office visit or in a clinic visit. They'll remember on average half the trouble so that's problematic right already, but now There's more problems with that. One of those is that you don't actually know which half the person is going to remember it, there's no guarantee, they're going to remember what you think is the most important half of the information, because people key in on different things based on what they're worried about and what they're listening for. The other piece to that is that of the half that they do remember, half of that they remember wrong. Okay? So now what's really happening is after a typical visit at my clinic, a patient on average is going to remember one quarter 25% of the information correctly when they leave the place. So, I as a clinician should be really careful about not putting on extra information out there that's going to confuse or get in the way of remembering what I think is the most important stuff. So, I'm going to try to select the amount of information I'm gonna give. And then at the end, I'm going to do a few tricks. All right, I'm going to summarize what I think are the key most important items. But I'm going to do that in a specific way, by answering what we consider sort of patient's three main most important questions. Number one, what is my main problem? I'm going to try to answer that in the summary, your main problem is bronchitis or, you know, lung infection or something. The next question is, what should I do about it? What are you recommending I do about this? And you know, I might say, I'm recommending you use this inhaler for a few days. And the third piece is, why are you recommending that? Why is doing this important? And I would say, you know, this inhalers gonna make you feel better, it's going to help you not cough so much. And they can decide then what to do with that that's a motivating piece to this. When we answer these three questions, it makes them memorable for the person. It organizes what would took 20 minutes to kind of arrive at it also makes it easy for them to carry that information away, understand what's being suggested, but actually why and whether or not they actually want to follow through on it. Our fourth best practice here is encouraging people to ask clarifying questions. We know people are sitting in front of us and listening carefully and paying attention when we know internally, they have questions that are going unanswered. We need to figure out ways to help people feel comfortable, safe to actually ask some clarifying questions. One, one important part of that we'll get to. So, the data that are out there, there's not a lot of research on this, actually. But the studies that have been done. So just for the most part, people just don't ask a lot of questions, right? And I think we now are seeing why we know now that if a person's feeling threatened by that feeling of inadequacy, or foregone intelligence or feeling, quote, unquote, stupid about not recognizing or understanding something, they're gonna protect themselves, right? They're not going to reveal that by asking some question that they think is gonna make me look quote unquote, dumb or something like that. So, we could try to figure out some ways to help people feel empowered to ask questions, obviously, we want to present ourselves in an open, nonjudgmental way. But we can there's some other tricks that we can employ here. So first of all, if you're like me, like most of us, we watched, are our teachers and our peers, our colleagues, eliciting questions through a standard way of saying, basically, do you have any questions? This is like the most common way that people try to elicit questions. Do you have any questions? This is what's known as a closed ended phrase, do you have any questions? It's really, the only response to this is really yes or no. Right? And as we're seeing, many people are gonna choose to say no, even if they are confused, even if they recognize and have formulated a question in our head, they may not feel safe or confident in asking it. So, they're gonna say, No, I don't have any questions. Thank you so much for your time. So, we're going to flip this a little bit instead, and we're going to use an open ended phrase, we're gonna say, what questions do you have? Right? Think about? Listen to how that sounds so much more inviting, in many ways, right? It also requires the person to say something other than yes or no. Now, they might still say, I can't think of any questions right now. That's okay. Right? They still may not feel comfortable. That's okay. We can still work with that. But at least we haven't put up that barrier from the very beginning by giving them a closed ended phrase. Now, similarly, we want to be able to check for understanding at the end. And maybe a better way to phrase that is we want to check to make sure that we have been clear in presenting some health related information that has been internalized in a in an adequate way that that person is going to be able to use it and do something with it. The Teach Back technique is the way that we can do this. So, teach back

is, is kind of similar to that idea about eliciting questions. Most of us were taught and watched others, eliciting understanding by saying something like, so do you understand? Does that sound alright to you? Do we have a good plan? Right? These are closed ended phrases, people are going to either say yes or no. And again, just like before, people are generally going to say, Yes, I understand. Yes, this makes sense. Yes, this is a good plan, right? Because even if they're confused, they don't want to show that. Right. So, by asking it in this way, we're really setting ourselves up for a kind of a false response from the patient. Instead, we're going to use a teach back technique, which is going to use more of an open ended process here, we're going to say, You know what, I have just shared a lot of information with you. I'm not always clear. This is a lot to take in, I want to make sure that I've done my job. Well, if you wouldn't mind, in your own words, telling me back the plan, right? This is a teach back. There's some other neat, clever ways to do this. You could say, how would you explain this plan to your partner? In the aversion of sort of the show me technique, which is related is can you show me or describe to me how are you going to take this medication? How are you going to use this inhaler? How do you use this machine? Okay, so this is really the only way to know if we've been clear which parts of our message have landed and have landed accurately, and the person's leaving with a with a reasonable understanding of to go home. That's the only way to know, the Teach Back technique has been really promoted as a top safety practice. It's been shown in a in a in a clinical study, to not take any more time than the usual way that we end clinical encounters takes about one minute to do a teach back takes about one minute and a clinical encounter in the in the other ways that we tend to do that. studies have linked use of Teach Back with improvements in patients knowledge and understanding improvements in their adherence to treatment plans, improvements in their self-management of chronic disease, like heart failure, improvements in disease control, like better control of diabetes, and improvements in feelings of self-efficacy and ability to take to take on one's own care and hire at a higher level. So, all good things for Teach Back. But it's just not used that off. And it maybe there's some intimidation, and maybe it's difficult to get started. Maybe people feel awkward, asking someone to tell them back something. So, we need to put the onus on ourselves. And remember, I need to be sure that I was clear. Could you tell me back the plan and if the plan comes back? not accurate enough, we really take ownership for that we say, “You know what, I am sorry. I know, I didn't explain that as clearly as I wish I had let me try again.” Right? This only takes a few seconds to do this, it doesn't add length to the visit. Let me show you just one example of a way that I that we could use a teach back and this is me talking with an actor playing the role of a patient. I'm going to ask her to tell me back the plan while I'm typing a visit summary at a clinic. So, here's that example.

Now, to make sure I've done my job well explain things clearly. If you will tell me back the plan. I'm going to type it and visit summary here and then I'll send that home with you.

Okay?

All right.

Okay. For your blood pressure, what are we going to do for that?

I’m going to do some tests to check out…

Okay. That’s right, some tests today. And then what?

You're going to call me with the test results.

Yep, that’s right. I’ll call you, okay.

And then - oh, you want me to come back in a week, I think.

A week or two.

A week or two, okay. And then - so, do I need to make an appointment for that?

You’ll make that appointment before you leave today.

Okay. And one to two weeks is fine.

Okay.

Okay.

All right. So that's just one way, there's lots of different ways to do it. The key here is that it takes some practice, this is a skill and people need to try it out. it and get comfortable with it. And that takes some repetition. So, we suggest if you're working in a clinical environment and you're worried about how this is going to go, we suggest trying it with maybe the last patient on your schedule, so that you can feel free to, if you're concerned about timing and things like that, but it does take some, some practice. And so, people do need to build in a plan for developing this kind of skill. I'm gonna stop there. I want to thank you all for your attention and for allowing me to join you for this really important initiative. And if there's a list of references at the end of these slides, and I will just click through them now just for those who are looking at this on that video, and thank you so much