Curriculum Transformation:
Integrating Health Literacy Teaching in Medical Education

Cliff Coleman, MD, MPH
Oregon Health & Science University
colemanc@ohsu.edu

“Communication works for those who work at it”

-- John Powell, composer
IOM health literacy report, 2004

“Health professionals and staff have limited education, training, continuing education, and practice opportunities to develop skills for improving health literacy.”

“Professional schools and professional continuing education programs in health and related fields, including medicine, dentistry, pharmacy, social work, anthropology, nursing, public health, and journalism, should incorporate health literacy into their curricula and areas of competence.”

(Neilsen-Bohlman et al, 2004, p161)

Literature review (2011)

- Healthcare professionals lack adequate knowledge, skills and attitudes
- Many best practices for effective communication with low health literacy patients are not routinely used
- Training is effective

(Coleman, 2011)
Curricula proliferating
◦ Stand-alone
◦ Series
◦ Integrated

Development of curricula slowed by lack of educational competencies

(Coleman, 2011)

(Coleman & Appy, 2012)
Methodology

- 2010 survey of 133 Deans of US allopathic schools
- 63 responses (47.4% response rate)
  - 69% public; 31% private
  - 76% urban; 14% suburban; 10% rural
- 44 schools (72%) require health literacy
- Median hours of instruction = 3 hours

(Coleman & Appy, 2012)

HL Teaching in US Family Medicine Residency Programs

- 138/444 (31%) U.S. family medicine Residency Directors
- 58 (42%) reported requiring health literacy
- 2–5 hours of instruction over 3 years
- Overwhelming agreement that increasing health literacy training for medical students and residents would help improve residents’ clinical skills.

Health literacy competencies

The knowledge, skills and attitudes which health professionals need in order to address low health literacy among consumers of health care and health information

(Coleman, Hudson, & Maine, 2013)
### Results

62 competencies and 32 best practices accepted after 4 rounds

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<th>Competencies</th>
<th>Round One</th>
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(Coleman, Hudson, & Maine, 2013)
Health Literacy Expert Prioritization Consensus study

▶ 25 health literacy experts with diverse professional experience
▶ Q-sort rating methodology
▶ Ranked the 32 HL practices

(Coleman, Hudson, & Pederson, unpublished)

Health Literacy Expert Prioritization Study – Preliminary Results: Tier 1

1. Routinely uses a “teach back” or “show me” technique to check for understanding and correct misunderstandings in a variety of health care settings, including during the informed consent process

2. Consistently avoids using medical “jargon” in oral and written communication with patients, and defines unavoidable jargon in lay terms

3. Consistently uses a “universal precautions” approach to oral and written communication with patients

(Coleman, Hudson, & Pederson, unpublished)
Health Literacy Expert Prioritization Study – Preliminary Results – Tier 1

4. Consistently elicits questions from patients through a “patient-centered” approach [e.g., “what questions do you have?”, rather than “do you have any questions?”]

5. Routinely emphasizes one to three “need-to-know” or “need-to-do” concepts during a given patient encounter

6. Routinely uses short action-oriented statements, which focus on answering the patient’s question, “what do I need to do” in oral and written communication with patients

7. Consistently negotiates a mutual agenda with patients at the outset of encounters

(Coleman, Hudson, & Pederson, unpublished)

Health Literacy educational effectiveness

- Mackert and colleagues (2011)
  - Improved self-perceived knowledge, and planned behaviors among non-MD volunteers

- Coleman & Fromer (in press)
  - Improved self-perceived knowledge, and planned behaviors among MD and non-MD mandatory attendees
Long-term effectiveness: Medical Students

(Coleman, Peterson-Perry, & Bumsted, in press)

Long-term Effectiveness: Residents

(Preliminary results)

(Coleman, Garvin, Sachdeva, Kobus, Peterson-Perry, unpublished)
The OHSU Experience Curriculum Transformation:

Guiding principles

- Moving from systems-based to case-based curriculum
- Organized in 7 blocks of related systems
- Clinical & science “threads” run longitudinally
- Compressing pre-clinical curriculum to 18 months
- Competency-driven

(Coleman, Garvin, Sachdeva, Kobus, Peterson–Perry, unpublished)
Health Communication Thread

- General health communication
- Health literacy
- Culturally responsive care
- Limited English proficiency
- Motivational interviewing
- Shared decision making
- Special communications (bad news, “difficult” patients, adolescents, etc)

The “habits” model

4 domains tracked during multiple simulated patient encounters through pre-clinical curriculum:

- Habit 1: Make a positive connection
- Habit 2: Establish an agreed upon agenda
- Habit 3: Facilitate understanding
- Habit 4: Confirm understanding
Habit 2: Negotiates shared agenda

- Elicits the patient’s full set of concerns at the outset (Tier 1 practice)

- Negotiates an agreed upon agenda which addresses the patient’s main concern(s) and expectations (Tier 1 practice)

Habit 3: Facilitates understanding

- Speaks slowly and clearly

- Provides high-priority “need-to-know” information first, when educating patients or making recommendations (Tier 1 practice)

- Avoids jargon / uses plain language (Tier 1 practice)

- Summarizes the plan for addressing the patient’s main concern(s)
Habit 4: Assesses understanding

- Asks “what questions do you have?” (Tier 1 practice)
- Uses “teach back” to confirm understanding (Tier 1 practice)

References–1


Coleman C, Fromer A. “A Health Literacy Training Intervention for Physicians and Other Health Professionals.” *Family Medicine*, In press


References –2


Coleman C, Peterson–Perry S, Bumsted T. Long-term Effects of a Health Literacy Curriculum for Medical Students. Family Medicine, in press

Mackert M, Ball J, Lopez N. Health literacy awareness training for healthcare workers: improving knowledge and intentions to use clear communication techniques. Patient Education and Counseling, 2011;85(3):e225–8