

Improving Health Literacy Knowledge, Behaviors, and Confidence with Interactive Training

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ABSTRACT

Background: Ensuring that health care professionals are knowledgeable about the influence limited health literacy has on health outcomes and how to apply health literate strategies is crucial to transform quality and safety in care settings. Although many organizational efforts to address health literacy have focused on hospital settings, few have focused on primary care. The designation of a patient-centered medical home requires the need to address integrating health literacy and the training needs of primary care settings. **Brief description of activity:** An interactive health literacy training intervention was developed, implemented, and evaluated for 25 primary care clinics. This included an online educational module, in-person application activities, and a sustainability plan to continue skill building, reinforce behaviors, and support practice. **Implementation:** Using a descriptive pre- and post-training design, three survey measures were used to rate health literacy knowledge, behaviors, and confidence levels of more than 475 primary care staff. A pre-training survey was completed prior to completion of an interactive online health literacy module and attendance at an in-person training session which followed. A post-training survey was then completed. Sustainment activities, including lunch and learns, and reinforcement activities by clinic leaders, were initiated to promote use of the strategies in practice. A 1-year follow-up survey was then administered to measure sustainability. **Results:** The interactive training intervention improved primary care staff's knowledge, behaviors, and confidence in using health literacy strategies with patients and families. Common barriers and facilitators around the use of these strategies were also identified. **Lessons learned:** Careful consideration should be taken when developing health literacy training to ensure it will be effective, efficient, and sustainable. Using elements that facilitate the transfer of training to practice will help improve success. Addressing barriers and promoting facilitators, as well as integrating and connecting health literacy strategies with existing organizational goals and initiatives offer additional ways to reinforce and sustain the practice change. [*HLRP: Health Literacy Research and Practice*. 2022;6(2):e113–e120.]

Plain Language Summary: Clinic staff can improve how they provide information and education to children and families. Interactive training about health literacy led clinic staff to (1) know more about health literacy, (2) use health literacy strategies more, and (3) feel more confident using health literacy strategies. Training over time, supporting staff, and connecting to organizational goals are important for sustainment.

Pediatric health care professionals play a critical role in ensuring children and families receive, understand, and can use health information. Clear communication is essential to prevent errors and parental misunderstandings (Burgener, 2017). Ensuring parents clearly understand the importance and steps necessary for health-related tasks such as preventive screenings, routine well-child visits, and immunizations will help promote optimal child health and development (Davis et al., 2013). Understanding health literacy and its

influence highlights the need for and importance of using clear communication. Health literacy is the ability to obtain, process, understand and use health information for oneself or others (Ratzan & Parker, 2000). It is estimated many adults experience health literacy challenges, with only 12% having *proficient* health literacy skills (Kutner et al., 2006). Parents with low health literacy have poor preventive care for their children and worse child health outcomes (Sanders et al., 2009). Numerous studies have shown the effect health

literacy can have on parental understanding of medication administration, chronic disease management, and post discharge care instructions (Glick et al., 2017, 2019; Morrison et al., 2019). In addition, poor communication compromises patient safety and leads to patient and family dissatisfaction (Burgener, 2017; Vermeir et al., 2015). Most parents will encounter health literacy challenges in the health care setting (Morrison et al., 2019; Yin et al., 2009).

BACKGROUND

Ensuring health care professionals are knowledgeable of health literacy principles and how to implement them in practice will help improve clear communication, ensuring patients and families receive understandable and accessible health information (Institute of Medicine, 2004, U.S. Department of Health and Human Services, 2010). Many health care team members often lack training in health literacy, lack knowledge of ways to improve communication, and fail to use clear communication practices routinely when providing care (Barrett et al. 2008; Coleman, 2011; Coleman et al., 2013). Others may overestimate one's own skills and assume their care instructions are understood and clear (Coleman & Fromer, 2015; Mackert et al., 2011; Synnot et al., 2019). Support and training are needed to help health care professionals better understand health literacy and ways to address it with clear communication strategies (Coleman, Hudson, & Pederson, 2017; Vermeir et al., 2015). Although there is no formal recommendation on how best to deliver this type of training, most recommend using a variety of modalities when teaching about health literacy (Coleman, 2011).

Most organizational efforts to address health literacy have focused on hospital settings. However, health literacy effects outcomes across the care continuum, including prevention, acute illness, and chronic care management (Morrison et al., 2019). With the shift from high-cost hospital stays to services provided in primary care settings (Porter & Lee, 2013), ad-

ressing health literacy in this area is needed. Placing value on and implementing structures to improve safety and the patient experience, both of which are met using health literacy strategies, contribute to the value-based care model. In addition, as many primary care practices work toward patient-centered medical home (PCMH) designation, implementing health literacy best practice can contribute to efforts toward reaching PCMH certification (Brega et al., 2015).

DESCRIPTION OF THE INTERVENTION

This article describes the development, implementation, and evaluation of an interactive training intervention for primary care staff on health literacy. The goal was to determine the effect of this training, along with sustainability efforts, on the use of health literacy strategies in the primary care practice setting.

INTERACTIVE TRAINING INTERVENTION

An educational plan was developed and learning objectives were identified. Participants were to be able to (1) define health literacy, (2) explain the effect of low health literacy, (3) describe four key strategies to facilitate clear communication (using plain language in written and verbal communication, using limited number of forms, limiting information, and checking for understanding by using teach back), and (4) apply these strategies in their role and practice. Building on recommendations from prior studies, components for the interactive training intervention included a basic training module, in-person "booster" training sessions, and a sustainability plan (Klingbeil & Gibson, 2018; Kornburger et al., 2013). Training design incorporated learning methods and factors, including active engagement, retrieval practice, and feedback, which served to drive behavior, improve retention, promote meaningful learning, and help transfer training to practice (Grossman & Salas, 2011; Karpicke, 2012, 2016). A timeline was created that identified the necessary steps of

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the educational plan and measurement points along the way (Figure 1).

Organizational support was provided by the Director of Quality and Safety for Primary Care Services, President of Primary Care Services, and the Chief Medical and Safety Officer at the institution. Development of training materials was done in collaboration with the organization's Education Department. Facilitators who conducted the training sessions and provided support to staff post training were chosen based on the ability to incorporate these additional tasks into their current roles. No financial funding was required for staff participation in the training because it was incorporated into existing training venues. Prior to implementation of this project, Institutional Review Board approval was obtained.

SAMPLE AND SETTING

Four hundred and seventy-five primary health care team members initially participated in the primary care health literacy interactive training intervention, as part of PCMH designation. This included all staff from 25 primary care clinics associated with a Midwest tertiary care, 290-bed Magnet designated academic, pediatric health care organization. Participants included customer service representatives (20%), medical assistants (14%), nurses (31%), clinic leaders (managers and supervisors) (6%), advanced practice providers (APPS) (5%), physicians (20%), office staff (2%), and other clinic roles (2%). Over time, additional employees were trained when they joined the clinic workforce, receiving health literacy training and participating in sustainment activities as part of new employee orientation and onboarding activities.

IMPLEMENTATION

Basic Training

Primary care staff were first asked to complete *Health Literacy and Clear Communication*, an interactive online health literacy module. This module was assigned to all clinic staff, including providers, and all disciplines were expected to complete by designated due dates. This evidence-based module was created in partnership with the organization's Education Department. Content covered the definition of health literacy, impact of low health literacy, and strategies to facilitate clear communication with patients, clients, and families, taking less than 30 minutes to complete. An automatic email was sent to participants upon completion of the online module, asking them to complete a quick assessment. This one directional email included two brief situation examples that encouraged ap-

plication of the health literacy strategies to boost retention of information.

Booster Sessions

To further build on this learning, staff were requested to attend an in-person "booster" training session, held during clinic staff meetings, approximately 1 to 2 months after completion of the online module. These 30-minute active learning sessions reinforced the health literacy concepts learned in the online training. Reflective questions, games, and discussions allowed for specific examples based on roles to be acted out and reviewed. Nursing supervisors and clinical practice coordinators (registered nurses serving as clinical leads) were trained in person to help lead these booster training sessions in their respective clinics. A facilitator guide, in-person training, and co-facilitation support was provided to help ensure effectiveness, consistency, and comfort with content delivery. Because the learning sessions were multidisciplinary, there was an opportunity for individuals to learn more about others' interactions with patients and families regarding tasks they may not be familiar with. Not only did this facilitate learning of others' roles within the clinic, but it also offered the opportunity to use similar approaches to standardize patient and family interactions. These sessions also helped identify barriers to utilization of health literacy principles and potential solutions to address them.

Sustainability Efforts

Over the next year, additional strategies were used to continue skill building, reinforce behaviors, and support practice. Initial results of the training intervention were shared with the primary care leadership team, highlighting the barriers currently identified by staff. Leaders were encouraged to support staff with check-ins and connecting use of the strategies to current initiatives. Educational reinforcement was implemented. Flyers promoted use of the health literacy principles in clinics and lunch and learn sessions were held. These focused on clinic specific scenarios that allowed staff further opportunities to practice the health literacy strategies and explore how they could improve care and patient and family experience. New staff orientation was redesigned to include assigning the basic training module as part of their onboarding. A teach back competency was developed as an expected behavioral tool to use with families during care. Standard documentation templates in the electronic health record referred to the use of health literacy strategies, like Teach Back, in visit notes. Recognition and practice support

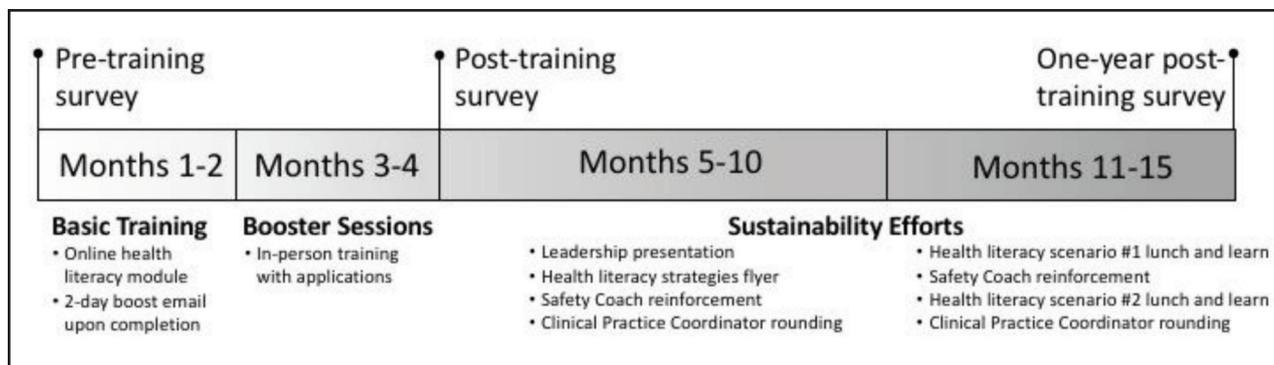


Figure 1. Interactive training intervention timeline.

was provided by safety coaches and clinical practice coordinators. These individuals rounded with staff, asked questions, encouraged self-reflection, and provided coaching and positive feedback to their peers.

METHODS

A descriptive pre- and post-training design was used, with three survey measures used for evaluation. Survey questions asked participants to rate their knowledge of health literacy, use of health literacy strategies, and confidence in their use in practice (Coleman & Fromer, 2015; Coleman et al., 2016; Mackert et al., 2011). Surveys consisted of multiple choice, 5-point Likert scales, and open-ended questions (Table 1). The first survey measure was a pre-training survey used to gather baseline knowledge of health literacy. This was administered 2 weeks prior to starting the educational initiative. Participants were asked to complete a post-training survey after completion of both the online module and attendance at an in-person booster training session. This allowed time for staff to use the new skills in their roles. This survey included identical survey questions to the pre-training survey and an evaluation of the health literacy training (basic training module and booster training session). Twelve months after the education began, a final 1-year follow-up survey was administered to measure sustainability of health literacy strategies in practice. Identical questions were used in the post and follow-up survey, and asked staff to only complete if they participated in the health literacy training and sustainment activities. Surveys were administered electronically, and participation was voluntary and anonymous. Emails were sent to all staff with a link to the appropriate survey. One to two email reminders were sent during the open survey time window for each survey, encouraging staff to complete the survey.

Data from the surveys were analyzed as proportional data for the percent of each question answering strongly agree (awareness questions), very frequently (techniques),

or very confident (confidence). A chi-square test was used to compare the proportions to pre-training (pre-training vs. post-training) and (pre-training compared to 1-year post-training). Narrative answers collected on the surveys were categorized into themes for result presentation.

RESULTS

Two hundred and ninety pre-education surveys (61% response rate, 290 of 475), 165 post surveys (37% response rate, 165 of 448), and 203 1-year follow-up surveys (39% response rate, 203 of 527) were completed. The distribution of pre-training survey completion by role was customer service representatives (22%), nurses (34%), medical assistants (9%), APPs (5%), physicians (18%), managers (8%), office staff (2%), and other staff (2%) including lab techs, clinic coordinators, and psychologists. The distribution of the employee's role during survey windows mirrored the distribution of employee roles at the initial training. The distribution of employee roles in post-training and 1-year post-training survey completion was similar in distribution.

Primary care staff reported significantly increased knowledge of health literacy (37.9% *strongly agree* pre-training; 67.9% post-training; $p < .01$), the meaning of patients and families having low health literacy (34.8% *strongly agree* pre-training; 64.8% post-training; $p < .01$), the health outcomes associated with low health literacy (33.8% *strongly agree* pre-training; 62.4% post-training; $p < .01$), and knowing whether patients and families understand after participating in the training intervention (14.8% *strongly agree* pre-training; 33.3% post-training; $p < .01$). The increased knowledge persisted to 1-year post-training for all categories of knowledge (health literacy term 61.1%; meaning for patients 56.2%; health outcomes 55.2%; knowing patients understand 28.6%; $p < .01$ for all comparisons to pre-training).

Frequency of staff use of health literacy techniques was also assessed before and after training (Figure 2). After

training, staff reported limiting information significantly more frequently (pre-training, 15.2%, post-training, 29.1%; $p < .01$), which was maintained at 1-year post training (26.1%; $p < .01$). Staff reported limiting use of forms higher post-training (pre-training, 16.9%, post-training, 24.2%; $p = .05$) but did not persist to 1-year post-training (22.7%; $p = .11$). Checking for understanding was not significantly improved after initial training (pre-training, 21.4%; post-training, 26.1%; $p = .25$); however, was significantly improved at 1-year post training (29.1%; $p = .05$). No improvement was seen in plain language (pre-training, 44.1%; post-training, 50.9%; 1-year, 51.2%; $p = .16$ pre-training vs. post-training; $p = .12$ pre-training vs. 1-year post-training).

Staff confidence in using health literacy techniques significantly improved with a higher percentage of staff rating very confident post-training (pre-training, 22.8%; post-training 40%; $p < .01$).

The confidence was maintained at 1-year post-training (32.5%; $p < .01$).

Staff reported behavior change in how they assessed for understanding and solicited questions with patients and families. Significantly less staff reported using closed ended questions post-training and 1-year post-training ($p < .01$ for all comparisons) (Do you understand? pre-training, 33.4%; post-training, 21.8%; 1-year post-training, 22.7%) (Do you have questions? pre-training, 79.7%; post-training, 53.3%; 1-year post-training 65%). Significantly more staff reported using other techniques after training (pre-training, 38.6%; post-training, 61.2%; $p < .01$), which was maintained at 1 year (1-year post-training, 52.2%; $p < .01$). The other techniques individuals reported using a free text response included using open ended questions and teach back.

TABLE 1
Pre-Post Training Knowledge, Behavior, and Confidence Survey

Domain	Survey Statements and Questions	Responses
Perceived Knowledge	I know what the term health literacy means I understand what it means to have low health literacy I understand the health outcomes associated with low health literacy I am good at knowing whether my patients and families understand what I tell them	Strongly disagree to strongly agree
Perceived behaviors	Use plain, non-medical language Use forms (letter, surveys, questionnaires) in limited ways Limit the amount of information provided and focus on "need to know" Check for understanding of information by using teach-back or show-me techniques	Never to very frequently
Perceived confidence	I can apply and individualize these techniques to meet the needs of the patients and families we see in our clinic	Not confident at all to very confident
Assessing for understanding	How do you ask patients, clients, and families to assess their understanding? Check all that apply	Do you have questions? Do you understand? Other (free text)
Information clarification	Since learning about health literacy, have there been times when you were able to clarify information or correct misunderstandings?	Free text
Facilitators	What helps you use health literacy strategies in your role?	Free text
Barriers	What barriers prevent you from using health literacy strategies in your role?	Free text

Since learning about health literacy, staff were asked to identify if there were times when they were able to clarify information and correct misunderstandings. Post-training, 70% of staff and at 1-year post-training, 82% of survey participants indicated they were able to clarify and correct misunderstandings within the primary care setting. Most misunderstandings corrected included medications, including doses, frequencies, refills, and inhaler usage and immunization questions (Table A). Other topics needing clarifications included forms, appointments, care instructions, and in-office care.

Survey questions also probed for comments related to barriers and facilitators around the use of health literacy strategies in practice. Staff identified barriers preventing them from using health literacy strategies in their role including (1) lack of time, (2) language and cultural barriers,

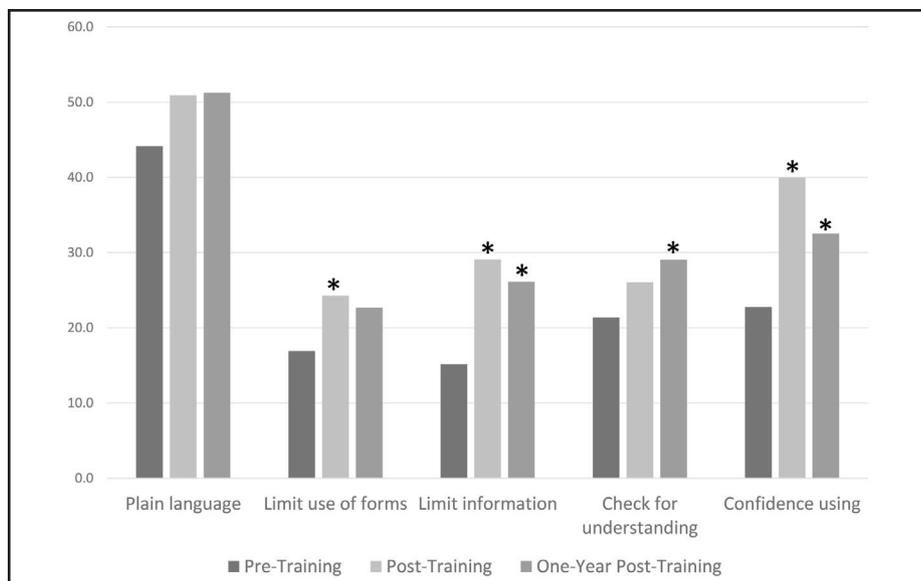


Figure 2. Health literacy behaviors and confidence. * $p < .01$ compared to pre-training using chi-square testing.

(3) perceived parent or family disinterest, (4) uncertainty of how to use health literacy techniques, (5) forms, and (6) perceived role constraints (**Table B**). Potential facilitators for using health literacy strategies include (1) having the correct tools and materials, (2) a supportive clinic culture, (3) reminders, (4) practice, (5) time, and (6) support from other staff (**Table C**).

LESSONS LEARNED

This interactive health literacy training intervention improved primary care staff members' knowledge, behaviors, and confidence in using health literacy strategies with pediatric patients and families. Staff surveys identified common barriers and facilitators around the use of these strategies in the clinic setting. The findings specifically illustrate the importance that use of the strategies in primary care could have on preventing misunderstandings related to medications, immunizations, and preventive care.

Findings from this study show results similar to other studies, highlighting improvements in staff knowledge and behaviors after health literacy educational interventions (Coleman et al., 2016; Kaper et al., 2019; Mackert et al., 2011). Despite an emphasis on all health literacy techniques in this training, reported use of plain language showed no improvement post training. Because respondents already indicated this as the highest use technique pre-training, there may have been less opportunities for improvement.

Other studies have not reported sustained improvements in health literacy knowledge and behaviors past 6 months (Coleman et al., 2016; Coleman, Peterson-Perry, et al., 2017). The success of this study in sustaining improvement illustrates educational training requires continual attention to hardwire practice change rather than being completed once (Klingbeil & Gibson, 2018; Kornburger et al., 2013; Ramani et al., 2019). Incorporating elements into the educational design which facilitate the transfer of training to practice will help improve success (Grossman & Salas, 2011; Karpicke, 2012,

2016). The use of real health literacy stories and safety events may have helped to motivate people in the usefulness and value in using health literacy strategies in the clinics (Grissinger, 2014). Creating realistic practice scenarios relative to the primary care environment also allowed for a better likelihood participants could view how health literacy principles could be applied. Connecting learnings to the actual health care workplace, with opportunities for application and practice have been recommended (Saunders et al., 2019). Check-ins with staff and coaching by clinical practice coordinators and safety coaches offered additional opportunities to provide peer support and reinforce behavior change (Cropper et al., 2018).

Health literacy training is important for all health care team members because patients and families will receive communication from a variety of staff (Mackert et al., 2011). All roles were included in this training, emphasizing that everyone plays a part in ensuring clear communication regardless of role. Participating together allowed opportunities to see the potential effect each role could have and served to unite all clinic staff to improve their practice together.

Because most health care settings do not commit the monetary resources to implement a health literacy training program, this article demonstrated creative ways to train staff effectively and efficiently, without incurring additional training costs. Integration and connection

of health literacy strategies with existing organizational goals and future training can further reinforce and sustain learning without added expense.

STUDY LIMITATIONS

Several limitations to this study should be noted. Survey participant numbers dwindled from the initial pre-survey numbers. Staff turnover may have contributed to this; however, new staff onboarding included this training. With only 37% and 39% of staff responding to post-training and 1-year follow-up surveys, respectively, a potential for response bias exists. Those staff who felt the training was more useful and began using the health literacy techniques may have been more likely to respond to those surveys. Measurement tools included self-reported surveys and did not involve actual observation of a practice change. Survey questions had not been validated; however, their use in previous studies and in this practice evaluation allowed opportunities to find differences and improvements after the training took place. Time limitations and changes in the organizational vendor for patient and family experience data did not allow for inclusion of the patient and family perspective. The ability to evaluate our survey findings by employee role was limited by the small sample size in several of the categories (APPs and other office staff). Future work should include an evaluation of the effect on patient and family outcomes. It would also be advantageous to determine if there was a reduction in nurse triage calls placed by families to receive clarification or follow-up information related to a visit after the health literacy training was implemented. The authors hypothesize utilization of health literacy strategies would result in less call backs to repeat or clarify information provided at the clinic visit.

CONCLUSION

Educating pediatric health care professionals in health literacy is a necessary step to promote safety and improve care in all settings, including the primary care setting. Thoughtful consideration should be given when developing this education to ensure it will be effective, efficient, and sustainable. Training frontline staff should also address barriers and promote facilitators around the use of health literacy strategies as part of planning. For primary care staff, additional learning opportunities tied to organizational improvement efforts around immunizations, medication safety, experience, and no-show rates can continue to make the case for incorporating health literacy into everyday practice.

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Table A Types of Information Clarified or Corrected

	Illustrative Quotes
Medications	<p>“Misunderstanding regarding possible side effects of antibiotics that were already explained, but parents still had questions.”</p> <p>“Put dosages in regular measurements, understand when different strengths of prescription would ease proper administration.”</p> <p>“Prevented family from mixing up rescue inhaler with maintenance inhaler.”</p> <p>“Amount of medication to give and how often it can be given, when return appointment is needed for medication refills.”</p> <p>“Explaining dosages on orders putting it in terms the patient understands.”</p> <p>“Clarifying generic vs. brand name medication, mg vs. mL.”</p>
Care instructions	<p>“During the discharge process, making sure the patient/parents leave knowing what they need to do in taking care of their child.”</p> <p>“Another common question that needs further explanation is fever management.”</p> <p>“Taking a proper temperature.”</p> <p>“Corrected understanding of the child's care plan given by MD - what to do first/second/third and reiterated why the steps follow an order.”</p> <p>“A family was confused about what to follow up on from the doctor's instructions. I explained the information more clearly.”</p>
Immunizations	<p>“I have clarified information re: immunizations and what to watch for after receiving vaccines;”</p> <p>“Parents wondering about a chicken pox vaccines. Explained on immunization records, varicella is the chicken pox vaccine.”</p> <p>“Just go more in depth and give examples of immunizations”</p> <p>“When a second half of a immunization was due.”</p>
Forms	<p>“A patient was unaware what a consent for treatment was. I was able to explain to them in easy terms what it meant and they felt better about signing the consent.”</p> <p>“Paperwork for mychart.”</p> <p>“By reading consent forms to legal guardians who cannot read but are embarrassed to tell anyone that information.”</p> <p>“When asking about consents or the forms we hand out at the front desk.”</p>
Appointment	<p>“When clarifying a time of an appointment that a patient may have misunderstood.”</p> <p>“Clarifying appointment types, vaccine schedules etc.”</p> <p>“In telephone triage relaying referral to Endocrine, mom was confused about Endocrine meaning.”</p>
In office care	<p>“Clarification of weight gain in baby - based in grams vs. ounces.”</p> <p>“Language barriers, unable to help find the word to describe a symptom.”</p> <p>“Explaining what BM means in a way the parents could understand.”</p> <p>“When you say positive strep, sometimes parents are like what does that mean. So you can clear it up by saying the patient has strep or the patient does not have strep; simplify the terms.”</p>
Insurance	<p>“Utilizing plain language when discussing health insurance information to a patient.”</p> <p>“Regarding guarantors, insurance questions.”</p>

Table B Barriers to Using Health Literacy Strategies

	Illustrative Quotes
Lack of time	<p>“Time. Office visits are usually 15 minutes which included physical exams, shots, questionnaires, etc. there never seems to be enough time to provide the appropriate information to families.”</p> <p>“More time with the patients, feeling so rushed to room the next one or to get back to the doctors.”</p> <p>“Very complex situations, especially those with limited time windows to explain necessary information/education.”</p> <p>“Time is a barrier. When you are in a hurry or multitasking, it can be difficult to use teach back and other methods to ensure understanding.”</p>
Language and cultural barriers	<p>“Language barriers can be challenging even with interpreters.”</p> <p>“Language barriers are difficult (when there isn’t an interpreter present, often times on incoming phone calls).”</p> <p>“In situations where there are language differences it is often difficult to gain an understanding from both sides of communication. Even with an interpreter at times it is difficult to assess understanding.”</p> <p>“Not having all forms in needed languages.”</p>
Patient or family disinterest	<p>“Patient not receptive to teaching.”</p> <p>“Parental issues: stress from social determinants of health, sleep deprivation of parent, parental mood, parent desiring to look “good” as a parent and not having literacy issues.”</p> <p>“Parents in a hurry, and refusing to teach back information to me.”</p> <p>“Parents distracted or unable to focus, such as when they have multiple children at visit or a lot going on in the room.”</p> <p>“When parents are distracted or are on their phones.”</p>
Difficulty using health literacy techniques	<p>“Wanting to provide adequate explanations and not “dumbing things down” too much.”</p> <p>“Not trying to be condescending by asking patients to repeat what I said.”</p> <p>“Figuring alternative ways to explain complex things.”</p> <p>“Not knowing how to explain things in another way.”</p> <p>“Shifting from talking with health professionals to families. When I speak to MDs I don’t use plain language. So I sometimes stumble as I try to adjust.”</p>
Forms	<p>“There are so many forms! We have a form for asthma, ADHD, depression, post-partum depression, M-CHAT, ASQ, MyChart sign ups, release of protected medical information, flu consent; it’s overwhelming to families I’m sure.”</p> <p>“Need to use forms for screening purposes.”</p> <p>“The use of forms – we are required to give patients certain forms and it is hard to limit form use.”</p>
Role constraints	<p>“Working with families over the phone in most cases, it is easier face to face to verify if they understand what is taking place.”</p> <p>“There is not a “teach back” possibility for most of my job functions.”</p> <p>“The providers wanting to be the ones to do most of the teaching and educating. Sometimes there is an overlap or too much info given which can overwhelm the families which makes it harder for the nurses.”</p>

Table C Facilitators to Using Health Literacy Strategies

	Illustrative Quotes
Having the correct tools and materials	<p>“Simple worded forms.”</p> <p>“Access to interpreter.”</p> <p>“Handouts with pictures, short videos.”</p> <p>“Teaching sheets available to use that are written in simple, need to know language.”</p> <p>“Having hand-outs in plain language in a variety of language choices.”</p> <p>“Explanations of services in plain language.”</p> <p>“Triage protocols help use health literacy on the phone because it guides us with the instructions in plain language.”</p>
Supportive clinic culture	<p>“Being a smaller clinic getting to know our patients and how they like to receive information.”</p> <p>“Making sure that our environment is welcoming.”</p> <p>“Positive role models/examples from colleagues.”</p> <p>“Working with residents in clinic, I am conscious of ways to simplify information for families that they may not have awareness of (i.e. saying medication measurements or other instructions in plain language, avoiding medical jargon in teaching).”</p> <p>“The team I work with.”</p>
Reminders	<p>“Reminders to use appropriate language/communication skills.”</p> <p>“Continuing education/reminders.”</p> <p>“Simple reminders to myself to assess patient's understanding at the end of each appointment.”</p> <p>“Reminders/refreshers like this booster session.”</p> <p>“Posters hung around clinic that remind me of concepts and language.”</p> <p>“Reminder notes in my office.”</p>
Practice	<p>“I have always done it and learning it in nursing school is what helped me the most.”</p> <p>“Trainings.”</p> <p>“Examples of patient teaching interactions.”</p>
Time	<p>“Having adequate time with families. Proper teaching can't happen when there isn't appropriate time or staff coverage.”</p> <p>“Having time to spend with patients to complete education without feeling rushed (not always possible).”</p> <p>“Having enough time to fully explain things and use extra methods.”</p> <p>“Being able to have the time with the families reviewing the AVS Very important to use when teaching about new medications or techniques for parents to use.”</p>
Support from other staff	<p>“Reaching out to other medical staff such as the PCP or nurse to clarify for patient families when they have questions.”</p> <p>“In my position I help families in all different ways and areas. If I can't find an answer I reach out to family services or directly go to clinic or providers for some handouts, information.”</p>