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What Do Health Literacy and Cultural Competence Have in Common? Calling for a Collaborative Pedagogy

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Abstract

Limited health literacy is recognized as contributing to racial/ethnic and other health disparities through mechanisms of poor understanding and adherence, and limited access to health care. Recent studies have focused on interventions to address literacy gaps between patients and healthcare providers, focusing on communication techniques and redefining the responsibility for closing gaps. Cultural differences between patient and provider, if left unaddressed, have been shown to contribute to poor health outcomes through misunderstanding, value conflicts and disparate concepts of health and illness. The dual challenges of limited health literacy and cultural differences are likely to increase with an expanding, increasingly diverse and older population. There is evidence that training providers to attend to both issues can reduce medical errors, improve adherence, patient-provider-family communication and outcomes of care at both individual and population levels. The two fields continue to have separate trajectories, vocabularies and research agendas, competing for limited curricular resources. We present a conceptual framework for health professions education that attends simultaneously to limited health literacy and cultural differences as a coherent way forward in training culturally competent providers with a common skill-set to deliver patient-centered care that focuses on health disparities reduction.

Reports from the Institute of Medicine (IOM) have drawn attention to the need for cultural competence curricula in health professions education to address racial/ethnic disparities (Smedley, 2002), documented prevalence and adverse impact of limited health literacy on

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health outcomes (Nielsen-Bohlman, 2004), and focused on the importance of health professionals in addressing health literacy (Brach et al, 2012). Connections between health literacy and cultural competency have been further emphasized and elucidated (Andrulis & Brach, 2007). Low health literacy affects roughly one-third of all U.S. adults, but disproportionately affects racial and ethnic minority populations and people with lower socioeconomic status (Kutner et al, 2006, US DHSS 2010), and contributes to health disparities in these populations. The IOM reports call for practice interventions to reduce well documented disparities resulting from cultural miscommunication and the health literacy gap, and effective training strategies to prepare health professionals to recognize and address these problems. Healthy People 2020, the 10-year national health agenda, discusses both cultural competence and health literacy under its goal to use health communication strategies to improve health care quality and population health outcomes and achieve health equity (healthypeople.gov). Organizations such as the Joint Commission on Accreditation of Hospitals (The Joint Commission, 2007), and the Health Resources and Services Administration (HRSA 2012) have defined the need for further training and provided online resources, linking these areas to critical areas impacting practice.

Recent literature reviews demonstrate progress in both fields (Berkman, 2011, Coleman, 2011; Lie et al, 2011). Although few high quality studies have examined the impact of provider cultural competence training; improvements in knowledge, skills and attitudes can be linked to better patient outcomes (Lie et al, 2011). Basic competency in health literacy principles can be taught, but a direct link between training and improved patient outcomes remains to be demonstrated (Coleman, 2011). Health professional curricula for health literacy and cultural competence are often delivered separately by different faculty, with distinct objectives and evaluations despite common pedagogies around improved patient assessment, and similar communication strategies (Harper et al, 2007). Competencies have been developed for cultural competence training (Lie et al, 2008) and health literacy competencies are being developed. But educational research in each field is being conducted independently despite overlapping constructs and common desired patient outcomes. This makes competitors of educators in the two fields for limited curricular time and teaching resources (Carter-Pokras et al, 2010, Dogra, 2010).

Health disparities are differences in health status or health care that are measurable, unnecessary, preventable, and unjust (Carter-Pokras & Baquet, 2002). Many dimensions of disparity exist in the U.S. (e.g., race/ethnicity, sex, sexual identity, age, disability, socioeconomic status, geographic location). Educators can translate population health evidence into actionable individual provider competencies, using health literacy and cultural competence resources to address unequal access to shared understanding of information between the patient and health professional. *Every health professional can contribute to disparities reduction*, by recognizing the existence of a culture of the health professions as well as their own assumptions and biases, deploying appropriate communication skills and utilizing team resources to recognize, diagnose and address low health literacy and cultural differences.

As we move toward the provision of team-based care delivered through patient-centered medical homes (Grumbach et al, 2009), what can educators do to foster a unified approach

so that professionals can dip into a common training toolbox, e.g. www.thinkculturalhealth.org, with every patient encounter to select the approach best suited to achieve optimal patient outcomes no matter the likely source of disparities? Are there shared communication attributes orstrategies that address both health literacy and cultural competence, and if so, does it matter which 'expert' teaches it? In this paper we seek to present a set of values and a framework to drive teaching and educational research, with the goal of health disparities reduction.

Common Pedagogies

Paper, standardized, or real patient cases are used in health professional teaching as the platform for achieving and delivering learning objectives appropriate for learners' level of training. Cases may form the backbone of a course, as in problem-based learning courses, or supplement didactic teaching. They may be presented 'virtually', as web or paper cases, or in real time. Case-based testing is also employed in board certification and clinical practice examinations to test application of principles to practice. Health professional clinical practice examinations incorporate patient care elements directly into standardized stations scored by trained standardized patients.

Consider a case trigger for curricula addressing chronic disease management, patient-provider communication, adherence and health systems. How would you label the case? Who would teach them? How does it present opportunities for health literacy and cultural competence teaching?

Case: "*Mr. Morales is a 45 year old car mechanic with type 2 diabetes. He was born in Mexico, did not complete high school and speaks English as a second language. He now requires transition to insulin therapy because of failed lifestyle management and oral anti-diabetic medication therapy. His attempts at weight loss were challenged by the need to participate in family social gatherings and to show appreciation for his wife and mother's cooking. His primary care physician had sent him to a dietician who provided him with information about an 1800 calorie diet from the American Diabetes Association. He did not understand the written instructions and did not share them with his wife. He also believes that insulin causes blindness and kidney failure and does not intend to use insulin but will instead use Mexican remedies such as prickly pear, offered by his mother*".

The above case can be adopted for learner teaching and evaluation to address either/both health literacy and cultural competence. Mr. Morales may have a language barrier best addressed by working with a professional medical interpreter and low-literacy universal Spanish language materials. He may have a need for assessment of his diabetes care health literacy, lifestyle management and the role of family within his cultural and health beliefs system. Skills to negotiate with his beliefs about insulin may form the core of case discussion. Communication tools are available from both cultural competence and health literacy toolkits. For example, the Kleinman questions, (Kleinman, 1978) represent skills of Listening, Explaining, Acknowledging, Reviewing and Negotiating (from the L-E-A-R-N model, 2012) using such questions as 'What are the chief problems your sickness has caused for you?' and 'What do you fear most about your sickness?'. Motivational interviewing is

another communication skill model appropriate for lifestyle management. The teach-back technique from the *Health Literacy Universal Precautions Toolkit* (DeWalt, 2010) helps assess patient understanding and shares the theoretical underpinning of the L-E-A-R-N model in eliciting patient understanding before advising. Cases can be built on a didactic foundation of evidence for disparities in health outcomes for patients with limited health literacy; who do not share their provider's beliefs; or who are unable to communicate effectively in English. Such cases are capable of being taught in a multitude of disciplines and professions (e.g., allied health, dental, health education, medicine, nursing, pharmacy, public health, nutrition, occupational therapy). Case templates can be developed for a myriad of conditions and patients, accessible to a host of health professions. Being inclusive of both health literacy and cultural competence learning objectives, such cases acknowledge the important interactions between these two cross-cutting issues (Andrulis & Brach, 2007) and help avoid competition for curricular space. By using common communication tools, such cases also permit streamlined faculty training and make available a larger pool of teachers who can precept or teach and act as practice role models in the clinical environment.

Under the new envisioned paradigm, instead of teaching 'health literacy' or 'cultural competence' separately, faculty would model and teach '*best strategies to improve communication to reduce disparities*' (Wagner, 2005), a 'label' that replaces and transcends 'health literacy' and 'cultural competence'. Evidence may be cited from both literatures for best practice interventions to reduce disparities being discussed, with a menu of choices that might include use of pictograms or language- and culture-appropriate educational videos (Berkman et al, 2011) or health promoters and patient navigators (Lie et al, 2011).

Uncommon Opportunities

Health care reform efforts such as the 2010 Affordable Care Act (ACA) have provided opportunities for health professionals to exhibit health literacy and cultural competencies in their daily practice (Somers & Mahadevan, 2010; Andrulis et al, 2010). For example, the ACA addressed the need to communicate clearly, promote prevention, create medical homes, be patient-centered, and attend to health equity (Somers & Mahadevan, 2010). Identification and acceptance of competencies in each domain is a challenge for educators. Once common competencies are identified, educators will need to pilot and evaluate educational materials and methods to develop those competencies. This provides an opportunity for inter-professional education using a competency-based framework with associated learning activities.

Learners as Beneficiary

The amount of information and number of skills and competencies that health professions learners have to assimilate, regurgitate and demonstrate has exploded with the advent of the internet and availability of new tools (e.g., distant learning, simulation technologies); and burgeoning accreditation requirements. No longer is adding curricular content and time for new topics a viable option. Training strategies must appeal to learners for advocated practices to be adopted for future practice. Longitudinal integration has been embraced as

reflecting the real practice environment where patients present as whole persons within the context of family, community and society. Providers need to astutely demonstrate on-the-job agility and sensitivity to recognize within each patient encounter challenges in bioethics, health literacy, culture and beliefs and family systems, as they recognize, diagnose and manage common diseases By addressing limited health literacy and cultural differences we can potentially capture over 40% (Berkman et al, 2004; Zarcadoolas et al 2006) of encounters in which clinical outcomes may be compromised by poor adherence, medical errors and failure to follow-up. Learner benefits of collaboration between health literacy and cultural competence educators is measured not only in curricular time and effort saved but a more coherent approach that sees the patient, rather than diseases or topics, as the locus of care. Assessment methods can be integrated to reflect options for best clinical outcomes to reduce disparities, as opposed to knowledge or skills specific to health literacy or cultural competence. The below case may be presented as a paper case within a problem-based learning course, a standardized patient test encounter or within a didactic lecture:

Case: "*Mrs. Smith is a 50 year old US-born office clerk with no family history of breast cancer. She believes that mammograms are performed for diagnosis of breast cancer when a breast lump is detected by examination, but has not shared this belief with her provider. When her primary care provider gives her a form for a mammogram after a well-woman visit, she discards it outside the medical office as being irrelevant to her. Questions: What are the obstacles to achieving adherence to mammography guidelines at the patient vs the community level? What communication skills could the provider have used to elicit the patient's beliefs to improve her understanding of cancer screening? What cultural, family and societal factors may influence her decision to participate in screening*? *In what way can her provider reduce disparities in breast cancer screening within the practice?*"'

Health Professionals as Beneficiary

Health care reform efforts have envisioned well-designed and flexible teams working together to improve care processes and outcomes (AHRQ, 2008; Frenk, 2010). Teams will be assessed for their performance (Temkin-Greener et al 2004).There is thus a need for each profession to be knowledgeable of its own and others' cultures, beliefs, practices, jargon, assumptions and strategies. This form of communication embraces tenets in both cultural competence and health literacy for cross-disciplinary communication. What better opportunity for proponents of health disparities reduction to seize the moment of access to multi-professional teams of health learners to teach health literacy and cultural competence in concert (Andrulis and Brach, 2007) as cross-cutting topics common to all health professions training? Our case examples reflect a hybrid of the two fields for both small and large group teaching settings that can involve several health professions learning together around patients, increasing efficiency across educational settings. Such innovative approaches are already in construction and early evolution (Blue et al, 2010). Platforms for introducing common curricula in health literacy and cultural competence include teaching of bioethics (Ethical Force Program AMA, 2006), medical errors (Baker, 2005), and chronic illness (US DHHS, 2010).

Patients as Beneficiary

The 2011 issue of the *Journal of Health Communication* supplement focused on advancing health literacy as a research field with testable theories and conceptual frameworks. A notable comment highlighted the uniqueness of health literacy as being "*applied in very specific health contexts …..by very different individuals (e.g. physicians or patients) with, at times, very different goals*" so that both content and context need to be addressed in the research arena (Pleasant et al, 2011), a comment equally applicable to cultural competency. A common foundation and language for research is needed if we are to develop viable roadmaps for future interventions. We assert that the time is ripe to collaborate across the two fields for the same reason. Educators in health literacy and cultural competence can design more effective interventions to train their learners, optimize translation of training to future practice, and increase precision in measuring patient-centered outcomes of training (Johnson et al, 2011). Such patient-centered outcome measures include patient satisfaction, quality of life, adherence to therapies and clinical indices, which are considerably downstream from training (Betancourt, 2010). Demonstrating training efficacy to improve patient-centered outcomes is a costly proposition that requires large, multi-institutional, cross-disciplinary and long-term follow-up of learners from training to practice (Lie et al, 2011). A joint call for research funding means a greater likelihood of bringing attention to the need for rigorous design and evaluation of training programs. Resources are needed to examine education as an independent intervention to improve health outcomes, and support comparative efficacy studies of educational interventions. Bridging the divide between health literacy and cultural competence training proponents will bring us closer to creating an equitable society through betterment of every health professional's skills with the patient and his/her family and community as primary beneficiaries.

Population as Beneficiary

As our nation's population becomes increasingly diverse, health professionals will become increasingly challenged to understand health literacy levels and cultural values and practices of a diverse population. Evidence-based principles are now considered the foundation of provision of preventive services. Communicating the value of these services will require sensitivity to both health literacy and cultural diversity. Currently use of these services varies in part because of cost (State Health Facts Online, 2010), and in part due to unequal understanding about their value. Health professionals will need to explain value through health literacy and cultural lenses to increase the likelihood that patients understand the benefits and act on that understanding. When an increasing portion of our diverse population use preventive services, society should benefit from reduced health care costs and improved population health.

Disparities Reduction: The Common Goal

Four phases of health disparities research include: 1) identification of the nature and extent of disparities, 2) identification of underlying factors (whether culture or literacy-related) for racial, ethnic and socioeconomic disparities, 3) development and implementation of interventions, and 4) mixed methods approach to evaluation of comprehensive, multilevel

interventions (Thomas, 2011). Emphasis on phases 3 and 4 is particularly needed to support health literacy and cultural competency training. Common research questions for health literacy and cultural competency include:

- How can we link training to improved health outcomes using a universal cross-cutting approach to improve culturally competent care delivery that also addresses limited health literacy? (Fortier, 2003)
- Can communication training focused on understanding in underserved populations enhance patient comprehension and change behavior?
- Do programs that aim to change attitudes have different impact than programs that focus primarily on behavior change?
- What are 'best practices' in health literacy and cultural competency training? What are effective teaching methods? What faculty development is necessary?
- How can we include community stakeholders for health professional training? What is the added value of using patients as teaching partners?

Reliable and valid tools for learner, provider and patient assessment are also needed. Assessment methods of the impact of health literacy and cultural competency training could include observation of patient/provider interchanges using simulated/standardized patients (Learners can provide peer assessments. Simulation videos can use actors in specific scenarios to demonstrate skills. Written skill examinations or quizzes with scenarios and responses, test scenarios (paper case, role play, group discussion), knowledge tests (pre-post, post, delayed post), essay responses, and surveys (e.g., interactive web-based tests) can also be used.

A Shared Vision

Institute of Medicine reports have presented inter-professional collaboration and teamwork (IOM, 2003) as one solution to improve health care quality (IOM, 2001), address health literacy (Neilsen-Bohlman, 2004) and reduce racial and ethnic health disparities (Smedley, 2002). A generation of health outcomes research and new interventions or revised versions of older strategies (Greiner, 2003) to improve quality of care nationwide were initiated. We are now at the crossroads of a new mandate to care for a larger, more diverse U,S, population than ever. Moving upstream from health services research to health professions education as another solution is a logical, positive response to the call to action. What better place to begin than a collaborative of health literacy and cultural competence educators working together to share tools, training strategies and resources for the common goal of health disparities reduction, improved research agendas and outcomes?

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