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Health Communication: Implications for Diverse Populations

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Abstract

The need for improved communication about health-related topics is evident in statistics about the health literacy of adults living in the United States. The negative impact of poor health communication is huge, resulting in poor health outcomes, health disparities, and high health care costs. The importance of good health communication is relevant to all patient populations, including those from culturally and linguistically diverse backgrounds. Efforts are underway at all levels, from individual professionals to the federal government, to improve the information patients receive so that they can make appropriate health care decisions. This article describes these efforts and discusses how speech-language pathologists and audiologists may be impacted.

Effective health communication is something you, as a speech-language pathologist (SLP) and audiologist, should know about as an expert in human communication and its disorders who works in a health-related field. For most health care providers, it may be more difficult to communicate clearly about health-related issues than you think. And, you may not be as good at it as you would like to be. As a health care professional, you probably take time to talk with your patients and their families. You spend time explaining the problems they are having and which treatments might work. You give them information about their disorder and direct them to Web sites where they can learn more. You take into consideration the unique background and experiences of each individual patient, including cultural and linguistic differences. Your patients likely tell you that they understand and agree to most of what you recommend. There may not seem to be a problem with how you communicate health information.

You might be doing a great job. Or, your patients might simply take the information that you give them and file it away with everything else they are told. Think about it this way: Even people who are highly literate and have high education levels may not understand everything they are told about their health. This is particularly true when they are faced with a sudden event, like an accident or stroke or a new diagnosis, such as a hearing loss. Most people find it difficult to process information when they are surprised, stressed, upset, or angry. This is true for any type of information, not just health information.

Imagine this scenario: You are a HIPAA-covered entity working on a tight deadline to do a risk analysis of the security of your documentation. It is important that you do this analysis and you want to make sure you do it correctly. One issue you need to consider is encryption of protected health information. The Office of Civil Rights directs you to an encryption document from the National Institute of Standards and Technology (NIST) and you read the following description of —full disk encryption or FDE:

FDE software works by redirecting a computer's master boot record (MBR), which is a reserved sector on bootable media that determines which software (e.g., OS, utility) will be executed when the computer boots from the media. Before FDE software is installed onto a computer, the MBR usually points to the computer's primary OS. When FDE software is being used, the computer's MBR is redirected to a special pre-boot environment (PBE) that controls access to the computer. This redirection is depicted in Figure 3-1. The PBE prompts the user to authenticate successfully, such as entering a user ID and password, before decrypting and booting the OS. This is known as pre-boot authentication (PBA). Most FDE products support the use of both network-based authentication (e.g., Active Directory, PKI) and local authentication sources (e.g., locally stored, locally cached from network source) for PBA. (NIST, 2007, p. 3-1)

Some of you may understand most or all of what is written there and will know what you need to do. However, most probably will have to read this a few times and may give up fairly quickly, because it is not easy to understand unless you know the terminology. This could be important information that you need to know to conduct your risk analysis, but since it is hard to understand, you may bypass it and hope that things work out okay.

People often do the same thing with health information. They may understand some of it and may make decisions based upon that limited understanding, rather than having full knowledge upon which to act. Or they may understand little to none of it and —hope for the best.¶ But just as your decisions about encryption could affect the security of your patients' health records and possibly result in fines for privacy and security breaches, there are consequences for making health decisions based upon limited information.

Health Literacy

Understanding and acting upon health information to make health care decisions is most commonly referred to as health literacy. There is ample evidence that poor health literacy is associated with many negative health outcomes. For example, people with limited health literacy are

- Less likely to engage in preventive practices such as screenings and wellness checkups.
- More likely to have chronic diseases and less likely to be able to manage them.
- Sicker when they enter the health care system.
- More likely to report that their health is poor.
- Hospitalized or seen in emergency rooms more often (Office of Disease Prevention and Health Promotion, n.d.).

In addition, poor health literacy has been estimated to cost between \$106–238 billion each year (Vernon, Trujillo, Rosenbaum, & DeBuono, 2007). Health literacy also contributes to health disparities. Research has shown that people from Hispanic origins have lower health literacy than any racial or ethnic group. In addition, people who speak a language other than English or speak English as a second language have lower health literacy skills than those who speak only English. And those who come from lower socioeconomic backgrounds or who rely on federally funded programs such as Medicaid (or had no insurance) typically demonstrate lower health literacy than those with private health insurance (Kutner, Greenberg, Yin, & Paulsen, 2006).

While the term *health literacy* has become popular and is used by many organizations, it is not an exact term. First of all, health literacy is not restricted to the written word. Verbal information is equally or more important in health care and is a fundamental component of health literacy. In

addition, health literacy is not restricted to words, but also to concepts such as numeracy (being able to do mathematical computations based upon written or verbal information) and document prose (being able to use and understand text such as maps, tables, or application forms).

A third common misperception about health literacy is that it is the patient's —problem alone. Doctors, nurses, SLPs, audiologists, and all health care providers also must engage in health literate practices by taking responsibility for how they communicate with patients and adapting their communication to the needs of each individual patient. William Smith (2008) suggested a revision to the definition of health literacy that incorporates this more global responsibility of health literacy as —the degree to which individuals, organizations, and communities have the capacity to obtain, process, understand, and share basic health information and services needed to make appropriate health decisions.

In light of some of the limitations to the term *health literacy*, it may be more appropriate to consider broader terminology, such as plain language or clear communication, and apply that to health situations. Regardless of the terminology used, however, there are many new initiatives regarding health communication that SLPs and audiologists (and all health care providers) need to know about. It is a —perfect storm of events that indicate that even if you are not yet facing a mandate to communicate more clearly and effectively with your patients, you likely will before long.

Professional Responsibility

The ASHA Code of Ethics (ASHA, 2010a) states first and foremost that SLPs and audiologists must —hold paramount the welfare of persons they serve professionally (Principle of Ethics I). Rule H under this principle states that professionals —shall fully inform the persons they serve of the nature and possible effects of services rendered and products dispensed. To be fully informed about services and products, one must understand the information. Simply saying —yes when asked if they understand is not enough. It is your ethical and professional responsibility to provide information in a manner that helps patients understand information about their disorder and treatment options. This is particularly true for individuals with communication disorders who often require adapted communication strategies.

Federal Efforts

Plain Writing Act

Health literacy and clear communication are hot topics at the federal level these days. The most recent event was the passing of the Plain Writing Act of 2010 in October. This law mandates that federal agencies clearly communicate with the public in written documents (excluding regulations). The law includes documents needed to apply for a federal benefit or file taxes, documents that provide information about federal benefits or programs, or documents that explain how to comply with a federal regulation. This law may impact SLPs and audiologists both personally and professionally. At a personal level, you should start seeing improved communications about federal programs and benefits. For example, the information needed to file taxes should be made clearer. At the professional level, SLPs and audiologists working for a federal agency, such as the Veterans Administration, may be required to provide information in plain language. Medicare or Medicaid providers also may start seeing revised communications about those programs. While the Plain Writing Act regulations have not yet been released, all professionals should become aware of this law and information they can access for personal and professional use.

Patient Protection and Affordable Care Act (PPACA)

The recent health care reform legislation addresses the need for consumers to be able to understand their health insurance. For example, one section of the law mandates that the government develop a document for uniform explanation of coverage that will be provided to consumers to help them compare plans and make coverage decisions. The document will outline issues such as deductibles, copayments, coinsurance, and exclusions. The law stipulates that this summary is —presented in a culturally and linguistically appropriate manner and utilizes terminology understandable by the average enrollee (PPACA, 2010, Sec. 2715 (b)(2)). In addition, the law mandates that standard definitions be developed in plain language for common insurance and medical terms, such as the ones noted above, as well as terms like hospitalization, durable medical equipment, rehabilitation services, and hospice services. ASHA has been participating on the working group charged with developing this summary and the definitions as a representative for both health care professionals and consumers with communication disorders.

PPACA mandates the use of plain language in various sections. The government defines plain language as —language that the intended audience, including individuals with limited English proficiency, can readily understand and use because that language is concise, well-organized, and follows other best practices of plain language writing (PPACA, 2010, Sec. 1311 (e)(3)(B)). The regulations specific to these aspects of the law are still forthcoming, but professionals should be aware of these regulations as they may affect information coming from insurers.

National Action Plan to Improve Health Literacy

The Department of Health and Human Services (HHS) recently adopted the National Action Plan to Improve Health Literacy, which outlines seven goals to improve health literacy and suggests strategies that professionals, organizations, and institutions can use to achieve the goals. Some of the stated goals include

- Developing health information that is accurate, accessible, and actionable,
- Promoting changes in the health care system to improve health information, communication, informed decision-making, and access to health services,
- Supporting and expanding local efforts on adult education, English language instruction, and culturally and linguistically appropriate health information services in the community,
- Increasing research into best practices and interventions to improve health literacy, and
- Disseminating and using more evidence-based health literacy practices and interventions (HHS, 2010a).

The underlying principles of this plan will likely resonate with all who interact on a regular basis with people who have a variety of communication skills and difficulties. Namely, that everyone has a right to information that will help them make more informed health decisions and that health services must be delivered in a way that is understandable and supports health, longevity, and quality of life (HHS, 2010b). ASHA again has been at the forefront of rehabilitation professionals as a stakeholder organization for this action plan and is implementing activities within ASHA to support the goals and improve member knowledge of and ability to address health literacy.

Healthy People 2020

Another HHS initiative that addresses health communication is Healthy People 2020 (HP 2020).

First established in 1979, the Healthy People program develops national 10-year health promotion and prevention objectives. These objectives form the basis for many health-related activities and research and are used to gauge how well the country is doing at improving health, reducing disparities, and increasing prevention and wellness.

Health communication was identified in Healthy People 2010 and remains in HP 2020, with Health Information Technology (IT) added. The list of proposed objectives related to health communication and health IT includes to increase the proportion of persons who report that their health care providers have satisfactory communication skills, improve the health literacy of the population, and increase the proportion of persons who report that their health care providers always involved them in decisions about their health care as much as they wanted (HHS, 2010a).

SLPs and audiologists may work in organizations or facilities that incorporate HP 2020 objectives into their work. You also may choose to engage in activities designed to support these objectives. The inclusion of health communication within HP 2020 further underscores the importance of this issue in the provision of high-quality health care.

Centers for Medicare and Medicaid Services

Medicare has long advocated for clear communication to beneficiaries about program enrollment, services, and payment. The Centers for Medicare and Medicaid Services (CMS) developed a toolkit (CMS, 2010) to help providers write clear, effective information for beneficiaries. In addition to addressing health literacy, readability, and web design, this toolkit also includes guidelines for culturally appropriate translations. While writing clear information is not a CMS regulation, they do strongly encourage providers to use this information to improve communication with beneficiaries.

Many Medicaid programs also have health literacy or readability requirements for materials provided to enrollees. According to a survey done by Health Literacy Innovations, 90% of Medicaid agencies have a readability requirement for program-related materials. The majority set the readability standard at the sixth grade reading level (Health Literacy Innovations, 2007). What is not known is how consistently this requirement is applied and if Medicaid providers and other personnel receive any training on how to produce materials that meet readability standards. ASHA members who provide Medicaid services may be required to provide materials that meet the agencies readability standards, but may or may not be aware of that fact.

Clear health communication is also an issue for CMS in developing clinical tools. The Minimum Data Set (MDS) is used to assess residents in skilled nursing facilities and determine resource utilization and reimbursement rates. Prior versions relied more upon observation and proxy report by health care professionals, staff, and other caregivers to complete assessment items and determine care needs. The revised version (MDS 3.0, effective October 1, 2010) recognizes the need for patient-centered care and requires that those residents who can provide input into their care be allowed to do so. This is primarily done via resident interviews, which requires that staff determine how well and reliably the resident can communicate their ideas, wants, and needs.

You can serve as a valuable resource in this regard as the communication expert within the facility. The MDS typically is completed by a nurse with input from other providers; therefore many providers may end up assisting in acquiring the needed information. Good health communication is essential in this case. Residents need to understand what is happening to them and what they are being asked in order to provide meaningful, appropriate, and helpful information. Staff need to be able to adapt their communication to meet the specific needs of each resident to ensure that the best, most appropriate information is gathered from the interview. Residents with communication disorders such as hearing loss or speech or language disabilities present particular challenges and it is with these individuals that you can provide the most assistance. Wisely (2010) outlines the changes to the MDS 3.0 and discusses how communication disorders specialists can play a pivotal role.

Health Literacy as a Universal Precaution

To emphasize the importance of patients understanding and acting upon health information, the Agency for Healthcare Research and Quality (AHRQ), has framed health literacy as a universal precaution (AHRQ, 2010). A universal precaution is a specific action that everyone takes to minimize risks to all patients, such as frequent hand washing to minimize the risk of infection to the health care provider or other patients. By framing health literacy as a universal precaution, AHRQ proposes that clear, understandable, actionable information be provided to everyone, particularly since a person's health literacy is often unknown. It can be argued that health literacy also varies greatly, depending upon the circumstances in which a patient finds him or herself, so all health care providers should strive to be as clear as possible in all communications.

Accreditation

The Joint Commission

The Joint Commission is an independent organization that accredits a wide variety of health care facilities. Joint Commission accreditation reflects adherence to specific performance standards. Standards addressing effective patient communication and cultural competence have existed in various forms over the years but recent Joint Commission efforts have focused more closely on creating standards that seek to further improve how an organization communicates with patients and families, addresses cultural and linguistic differences, and creates an environment supporting patient-centered care. Starting in 2011 (with scoring beginning in 2012), new standards will be implemented to help organizations meet these goals. To assist organizations in implementing these standards, the Joint Commission developed a guide, *Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care: A Roadmap for Hospitals* (Joint Commission, 2010). This roadmap explains the intent of the standards and provides suggestions for how organizations might put the standards into practice. What is most relevant to communication disorders specialists is the emphasis on ensuring that all patients can communicate and be communicated with from admission through discharge. The guide emphasizes the need for clearly written materials, good verbal communication, the use of interpreters and translators, and the provision of adaptive equipment, such as assistive listening devices and augmentative and alternative communication supports. The guide also specifically mentions the need to involve SLPs and audiologists in the planning and implementation of the standards. A more complete description of these standards and how they apply to communication disorders specialists is included in another article in this issue.

URAC

URAC is another organization that accredits a variety of health care facilities. In 2008 they added health literacy standards to their core standards, making them the first accrediting body to do so. Examples of how they incorporate the need for effective health communication include

- Putting consumer materials into plain language.
- Providing training to staff who create consumer materials to ensure the use of plain language and health literacy principles.
- Providing accurate, complete information to patients in language that is easy to understand and act upon (URAC, 2010).

SLPs and audiologists working in URAC-accredited organizations may be asked to comply with these standards and may be able to take an active role in helping the organization implement these standards.

Summary

The need for improved communication about health-related topics is evident in statistics about the health literacy of adults living in the United States. The negative impact of poor health communication is huge, resulting in poor health outcomes and high health care costs. Everyone can benefit from good health communication, including individuals from culturally and linguistically diverse backgrounds. Efforts are under way at all levels, from individual professionals to the federal government, to improve the information patients receive so that they can make appropriate health care decisions. You, as an expert in human communication and its disorders, can play a central role in many of these efforts. At the individual level, you can work to improve your own communication with your patients, first by becoming more aware of who their patients are, including relevant background, experiences, and cultural and linguistic diversity. Then examine how you communicate, what type of information you give out, and which external resources you refer patients to for more information. Strategies, such as those outlined by ASHA (2010b), can then be used to improve patient communication.

At a higher level, you can position yourself as resources to help facilities and organizations implement health communication mandates. In addition, you can work at the local, state, or federal level to ensure that effective health communication with all patients. This is especially important for patients with communication disorders. Regardless of where you work, you are likely to encounter rules or regulations regarding health literacy and patient communication. As a communication disorders specialist, with a special interest in the needs of culturally and linguistically diverse populations, you should embrace your role and seek to assist when you can. It is, after all, fulfilling ASHA's vision to make effective communication, a human right, accessible and achievable for all.

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