

# *Working with Low-literacy Seniors*

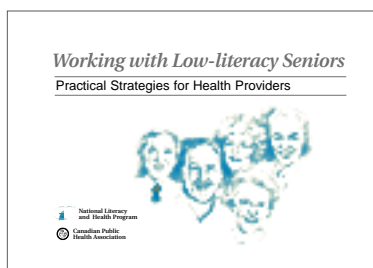
Practical Strategies for Health Providers



National Literacy  
and Health Program



Canadian Public  
Health Association



## ***Working with Low-literacy Seniors***

Practical Strategies for Health Providers

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### **The Canadian Public Health Association**



The Canadian Public Health Association (CPHA) is a national, independent, not-for-profit, voluntary association representing public health in Canada with links to the international public health community. CPHA's members believe in universal and equitable access to the basic conditions which are necessary to achieve health for all Canadians.

CPHA's mission is to constitute a special national resource in Canada that advocates for the improvement and maintenance of personal and community health according to the public health principles of disease prevention, health promotion and protection and healthy public policy.

### **National Literacy and Health Program**



The Canadian Public Health Association's (CPHA) National Literacy and Health Program promotes awareness among health professionals of the links between literacy and health.

People with low literacy skills may not understand what health professionals tell them. They may not be able to read health information. Some may not use health services, except in an emergency.

CPHA's National Literacy and Health Program provides resources to help health professionals serve clients with low literacy skills more effectively. The program focuses on health information in plain language and clear verbal communication between health professionals and the clients they serve. The National Literacy and Health Program is funded by the National Literacy Secretariat.

# *Working with Low-literacy Seniors*

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**National Literacy  
and Health Program**



**Canadian Public  
Health Association**

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# PART 1 *What's in this Guide?*

**T**his easy-to-use guide has been designed to highlight the special needs of low-literacy seniors<sup>1</sup> within the health system. The practical strategies offered here are intended to help health providers<sup>2</sup> serve this important group of clients<sup>3</sup> more sensitively and effectively.

**Part 1** provides a brief overview of the issue.

**Part 2** outlines the basic facts you should know about low literacy and its impact on the health and well-being of seniors.

**Part 3** describes practical strategies that health providers can use to better serve older people with low literacy.

**Part 4** contains both a bibliography of resources that will help you find further information on the subject and a list of plain language health information that addresses the specific health concerns of seniors.

## Why Read this Guide?



### Fast Fact

Almost 5 out of every 10 Canadians, and 8 out of every 10 Canadians aged 65 and over, have serious literacy limitations.

People who can read well tend to assume that everyone else can also read adequately. Unfortunately, this isn't true

Current research shows that 48% of people in Canada have real trouble with everyday reading demands. This proportion rises to 80% among seniors.<sup>4</sup> That means that more than 1.6 million



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older Canadians have serious problems understanding print materials. As the population ages, there will be more and more seniors who have problems reading.

Low literacy can have a profound impact on peoples' understanding of their health care needs and options, as well as their ability to provide care for others. However, by the time they've reached their senior years, most adults have developed wisdom and resilience, which they've tapped into to overcome many challenges. These strengths also help clients deal with literacy limitations.

This guide lets you reflect on how low literacy affects the seniors you work with. It will build on your existing knowledge and skills so that you can do an even better job providing health services to older clients who have difficulty reading and writing.



### **Viewpoint**

Health care experts...have, for the most part, ignored a huge problem that may be too obvious to notice: You must be functionally literate to navigate the health system.

Dr. Stephen Somers, *Health Literacy*,  
*Proceedings of a National Conference*, June 3, 1997, p. 1.

## **Low Literacy as a Barrier to Good Health**

There has been a growing recognition in recent years that people with limited literacy have poorer health and are often at a significant disadvantage in the health system. This largely invisible group faces many barriers to good health and good health care. (See Appendix 1 for more details on the relationship between literacy and health.)

People with low literacy skills are one of the most vulnerable groups in the health system. Individuals, organizations and institutions may unknowingly discriminate against such people and thus fail to provide equitable access to vital benefits or services. The onus must be on each health provider to become aware of the issue and help remove the obstacles to quality care for clients with limited literacy.

## **Low-Literacy Seniors and Health Care**

In 1995, there were 3.6 million seniors in Canada, making up 12% of the population. Seniors constitute one of the fastest growing population groups in the country. Between 1981 and 1995, the number of people aged 65 and over rose by 50%.<sup>5</sup>

You may be surprised to learn how many of your older patients have difficulty understanding important information about their health. Most don't broadcast their literacy limitations due to embarrassment, fear and shame. They just cope quietly.

Seniors with low literacy skills face the same challenges posed by the aging process as older adults with no literacy limitations. While many seniors remain healthy and happy well into their senior years, illness, disability, deteriorating faculties, isolation, declining mobility and diminished independence are facts of life for others.<sup>6</sup> The daily struggle to make sense of the written and spoken word makes it even harder for those with low literacy to deal with such difficulties.

Many older adults need easy-to-understand health information in order to manage their health and make healthy lifestyle choices. They also require it in their roles as family caregivers and community volunteers. The inability to understand vital information, such as medication labels, safety warnings and patient education instructions, can result in serious harm to the self and others.

In one case, a 67-year-old woman was admitted to hospital because her diabetes and high blood pressure were so poorly controlled that her life was

threatened. Afterwards, it became obvious that she didn't know how to take her medicines and couldn't read her prescription labels. Not only did this place her life at risk, but it also imposed a considerable and needless cost on the health care system.

Low-literacy seniors are often too embarrassed or intimidated to ask health providers to clarify information they aren't sure about. Such difficulties can be averted if the simple, effective techniques outlined in this guide are used to help patients handle their regimens.



### **Viewpoint**

Illiteracy is crippling for an older adult who must cope with the changes that occur with the process of aging, including the loss of a spouse, relatives and friends, retirement, acquiring age-related benefits and health problems.

Trudy Lothian, *Older Adults, Literacy and Social Networks*,  
1996, p. 3.

With the proportion of seniors in the population rising at an unprecedented rate, and chronic illnesses increasing, aging is one of the most significant issues confronting the health care system today. The challenge presented by seniors and low literacy is likely to become even more critical in the future.



## My Story

I've made a lot of bad mistakes because I couldn't read well. I know I gave my husband (who is 72) way too much aspirin many times. I just couldn't get the amounts to add up right. He had stomach bleeds like you wouldn't believe. He had a very bad heart condition and he almost died each time. He'd pass out at home here and he'd be taken to the hospital. His blood pressure would be right down from the loss of all that blood. The doctor could never figure out why this was happening and I never told her. Finally, my sister, who is a nurse, figured out what I was doing and helped me get it right. When you can't read, you just keep making all these terrible mistakes.

Adult learner, 64

## Plain Language Writing and Clear Verbal Communication

Research has shown that using plain language and clear verbal communication techniques can be of great benefit to low-literacy clients, and indeed, to all clients. These techniques stress the importance of simplicity, clarity, friendliness and relevance in health-related communication.

Used well, these techniques can make print information easier to read and verbal information easier to understand. They boost the odds that people with limited literacy skills will be able to

participate fully in their health care. They help individuals who are caring for others to more readily access the facts they need. They can also benefit the literate client whose ability to absorb medical details is temporarily lessened by shock or illness.

You can find a detailed description of these techniques in the manual produced by the National Literacy and Health Program (NLHP) called *Easy Does It! A Health Communication Training Package*.<sup>7</sup>

## The National Literacy and Health Program

Becoming conscious of the problem is the first step. Fortunately, a number of programs have been set up to raise awareness of the critical links between literacy and health. One of these is the National Literacy and Health Program run by the Canadian Public Health Association. Working in partnership with 26 national health associations, the aim of the National Literacy and Health Program is to help health professionals across Canada better serve clients with low literacy skills.

Having effective tools with which to address the problem is the second step. The National Literacy and Health Program produces resources that health providers can use to break down some of the barriers confronting clients with limited literacy skills.

# PART 2: *The Facts*

## Low Literacy in Canada

In the past, most people thought of literacy in simple terms. A person could either read and write, or they couldn't. The number of Canadians who were illiterate was generally assumed to be fairly small.

More recently, research has shown there is no precise cut-off point between literacy and illiteracy. We are beginning to understand that literacy is more than the ability to recognize or decode words. It also involves being able to comprehend text and use reasoning in order to function adequately in our increasingly information-based society.

To respond to this reality, today we speak of "functional literacy." This is a more flexible concept which reflects the fact that the knowledge and skills needed to cope in everyday life change over time and vary between communities and societies.

From this perspective, we now know that many people don't have the reading, writing and numeracy skills needed to function well in daily life, even though they may have been taught these skills in school. They may be able to read a series of words

on a page but be unable to grasp their meaning because they can't link one word to another or one sentence to another.

The magnitude of the literacy problem in Canada was brought to light in a rather startling manner in the 1987 Southam Literacy Survey. It showed that 4.5 million people (or one in four adults) did not possess a minimum level of functional literacy as measured by reading tests.<sup>8</sup>

It has always been a challenge to measure literacy. Earlier studies estimated the number of illiterate people in the population by counting those with less than grade nine education.<sup>9</sup> This method was not an accurate measure of literacy for two main reasons. First, because educational systems vary widely, grade nine education is not the same across Canada, or between Canada and other countries.



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Second, reading and writing skills can be gained outside school, and can also be lost over time. As a result, this method does not pick up those with less than grade nine education who are functionally literate or those with more than grade nine education who aren't functionally literate.

In the 1990s, our understanding of literacy has become more sophisticated, and so has our capacity to measure it. This is due in large part to the work done by Statistics Canada on the International Adult Literacy Survey (IALS). The first IALS report, a comparative study on adult literacy using data from seven Organisation for Economic Co-operation and Development countries, was published in 1995.<sup>10</sup>

The IALS report defines literacy as an individual's *ability to understand and use information*. By testing the ability of a random sample of participants to deal with different kinds of printed text, the survey measured literacy on three scales.

- Prose literacy, e.g. reading newspapers, books and manuals;
- Document literacy, e.g. reading job applications, maps and train schedules;
- Quantitative literacy, e.g. balancing a cheque book or completing an order form.

The IALS report divided literacy into five levels and determined the proportion of Canadians that fell into each one.

#### **Level 1: Very low literacy skills—22% of Canadians**

Readers were able to correctly locate one piece of information in a text at least 80% of the time. For example, a Level 1 task was to determine the maximum duration recommended for taking aspirin, based on the instructions printed on an aspirin bottle.

Canadian adults who read at Level 1 have very low reading skills and are generally aware that they have a reading problem.

#### **Level 2: Low literacy skills—26% of Canadians**

Readers were able to locate one or more pieces of information and compare and contrast this information in a short text at least 80% of the time. For example, a Level 2 task was to identify a short piece of information about the characteristics of a garden plant, from a written article.

Canadian adults at Level 2 can read, but not well. They avoid situations in which they would need to read unfamiliar texts. For example, if new safety procedures were introduced in the workplace in print format, Level 2 readers may have difficulty understanding the information.

**Level 3: Adequate literacy skills—33% of Canadians**

Readers were able to correctly identify, compare and contrast several pieces of information located in different paragraphs at least 80% of the time. For example, a Level 3 task was to read a set of four movie reviews and state which was the least favourable.

Canadian adults who read at Level 3 are generally considered to have the **minimum** required literacy skills for today's workplace.

**Levels 4 and 5\*: Excellent literacy skills—20% of Canadians**

Readers were able to correctly provide several answers from abstract texts which contained *distracting* information not relevant to the question, at least 80% of the time. For example, a Level 4 task was to answer a brief question on how

to conduct a job interview, requiring the reader to read a pamphlet on recruitment interviews and integrate two pieces of information into a single statement. A Level 5 task was to use an announcement from a personnel department to answer a question that used different phrasing from that used in the text.

Canadian adults who read at Level 4 and 5 have the ability to integrate several sources of information or solve complex problems and can meet most of the literacy demands of today's knowledge-based society.

The key message for health providers is that almost half of all Canadian adults have low literacy skills that prevent them from fully participating in many aspects of daily life, including the health system. Chances are that a substantial number of your patients have a hard time understanding the health information you provide.

*\*Once analysis of the IALS data began, it became clear that there was such a small proportion of the population at the highest level (Level 5), that the distinction between Levels 4 and 5 could not be supported with the available sample size. IALS analysts have combined these levels to ensure the statistical reliability of results.*

### **The Links Between Literacy and Health: Recent Research**

A 1995 study of emergency room and chronic care patients revealed a clear link between literacy and health. This ground-breaking study used the Test of Functional Health Literacy in Adults to measure the health literacy of 3,000 patients in Atlanta, Georgia and Los Angeles, California. The study found that:

- People with low literacy skills were twice as likely to say that their overall health was poor than were those with adequate literacy skills.
- People with low literacy skills had trouble with oral communication as well as with written communication. Fewer than 40% of emergency room patients knew their diagnosis immediately after seeing their doctor. Low-literate patients knew fewer than 40% of the names and just over 40% of the purposes of their medications compared to 60% of literate patients.
- Patients with inadequate literacy were more likely to be hospitalized and were more likely to have two or more hospitalizations. When differences in such factors as age, sex, socioeconomic status, and health status were taken into account, the risk of hospitalization for this group was 52% higher than for those with adequate literacy.
- More than 80% of the Atlanta patients over 60 were identified as having low literacy skills. This suggests that the age group with the most health problems is also the least able to deal with them.

*Health Literacy, Proceedings of a National Conference, Washington, D.C., June 3, 1997, pp. 4-7.*

## **Seniors and Low Literacy**

Older Canadians have much lower levels of literacy and education than their younger counterparts. Fully 80% of seniors have some degree of trouble with everyday reading demands (Levels 1 and 2 from the IALS study—low and very low literacy skills—combined).<sup>11</sup> The people in the oldest age groups have the lowest levels of both.

Many older adults have had few chances to gain the skills and knowledge needed to deal with written materials. About 40% of Canadians 65 and older have less than grade nine education.<sup>12</sup> We also know that immigrant seniors are somewhat more likely to have limited reading skills in English or French than non-immigrants, especially if they came to Canada as adults.<sup>13</sup>

Broken down further, more than half (53%) of those over 65 are in the very low literacy category (Level 1) on the prose scale (e.g. straight text).<sup>14</sup> Fifty-eight percent (58%) are in the very low literacy category (Level 1) on the document scale (e.g. forms, maps, etc.).<sup>15</sup>

By the time they become seniors, people with low literacy skills have acquired a variety of strategies to compensate for, and often conceal, their inability to

grasp written information. They can be extremely resourceful at finding ways to avoid print and emphasize verbal communication. They have established effective habits and routines and rely on well-developed memories to help them deal with the world around them.

As well, seniors often come to depend on people close to them to interpret complicated print material. As they age, and these people die or move away, they are compelled to turn to others—often health and social service providers. Feelings of inadequacy previously lessened by the presence of a trusted “literate helper” may resurface at a time of life marked by many difficult changes and adjustments.

Is low literacy among older Canadians a problem that will go away as today’s seniors are succeeded by a better educated group? While it would be nice to think so, Canadian statistics hold little hope of this.

Tomorrow’s seniors will fare only somewhat better than today’s. Of adults aged 56 to 65, 64% have low literacy skills (Levels 1 and 2 combined), as do more than 50% of those aged 46 to 55.<sup>16</sup> These individuals will all be over 65 in the next 20 years. Given that roughly six million people will be 65 or over by 2016,

the health system should be prepared to meet the needs of seniors with low literacy for many years to come.<sup>17</sup>



### **My Story**

I never learned to read properly because I was dyslexic and back in those days nobody picked that up. When the teacher was teaching the ABC's, I wouldn't know whether the tails of the "b's" went up or down. While I was figuring this out, the rest of the class had gone on to the next four letters. I never got the basics. I spent several years in Grade 1 and they pushed me on to Grade 2. I went to Grade 8 three or four times.

Adult learner, 64.

## **Low Literacy and Seniors' Health**

Canadian seniors are living longer than ever before. Although many continue to enjoy good health as they age, many others are forced to contend with some type of challenge to their well-being. Illness, chronic conditions, injury and disability all create a need for health and social services.



### Fast Fact

A study of simple prescriptions found that only one prescription instruction was understood more than 90% of the time - “take one tablet daily.” Every other instruction was misunderstood by more than 46% of patients, including “take one tablet twice daily” and “take two tablets daily.”

G.A. Holt et al., *Patient Interpretation of Label Instructions*,  
American Pharmacist 1992: NS32; 58-62.

The latest statistics (1995) show that the average 65-year-old today will live about half their remaining life expectancy (18 years) with some form of disability.<sup>18</sup> Seniors with a disability most often said they had trouble with mobility, agility and hearing.<sup>19</sup>

Of all seniors living in a private household, 81% reported at least one chronic health condition. The likelihood of being diagnosed with a chronic health condition rises with age - 86% of those 75 and over living outside of an institution had a chronic health condition.

Almost 40% of all non-institutionalized seniors indicated that a chronic health condition restricted their activity to some extent.<sup>20</sup> Common conditions included arthritis or rheumatism, high blood pressure, back problems, chronic heart problems,

food or other allergies, cataracts and diabetes.<sup>21</sup> The ability to read and understand medical instructions is particularly important in the effective management of chronic illnesses.

We don’t know the exact number of seniors with low literacy using health services. However, since we do know that low literacy and certain health conditions are both more common among older Canadians, we can safely conclude that a fairly large number of seniors who come into contact with the health system will have trouble reading.

Low literacy intensifies other difficulties linked to aging to make it hard for many seniors to manage their own health, care for others, and make the best use of health services. Literacy problems can result in unnecessary follow-up visits and hospitalization.

More research is needed, but it appears that improving communication with vulnerable low-literacy seniors can help avoid needless use of the health system and conserve scarce resources.

### Problems with medication use

Let’s turn now to a vital issue that affects many seniors with limited literacy. Older adults are more

likely to have conditions that need to be treated with medication. Canadian seniors take more medication than any other segment of the population. Studies show that they are given between 28% and 40% of all medications prescribed.<sup>22</sup>

Up to 50% of patients do not take their prescription medicine as prescribed. As many as 10% of seniors take drugs prescribed for others, and more than 20% take drugs not currently prescribed.<sup>23</sup> About one out of four hospital admissions for patients aged 50 and over are caused by medication problems.<sup>24</sup> When seniors use medication inappropriately, they can experience negative side effects, adverse drug reactions and a higher risk of falls and injuries. People suffer, and health care costs rise.



### **Fast Fact**

“Lack of compliance” may be no more - and no less - than the inability to read or to understand complex verbal instructions.

Literacy and Health Project: *Making the World Healthier and Safer for People Who Can't Read*, 1989, p. 33.

Many seniors take several prescription and over-the-counter drugs at the same time. In 1994/95, 10% of Canadians aged 65 to 74, and 13% of those aged 75 and older, were multiple-medication users; that is,

they reported that they had taken five or more drugs during the two days before their interview for the National Population Health Survey.<sup>25</sup>

This increases the possibility of making errors that result in adverse reactions. As the number of different medications and doses increase, the more difficult it is to follow a medication regime.

It is vital to recognize the roles that limited literacy and age-related factors play in non-compliance. One study found that 60% of older patients had problems reading medication labels.<sup>26</sup> When low-literacy seniors fail to take their medications as prescribed, it is often because they misinterpret or forget the medication instructions and can't decipher or understand the information on the label.



### **Fast Fact**

One study found that a significant number of people 60 and older could not read the print on some labels because the letter width was too compressed and the letter height too short. Another study showed that people had to have eyesight much better than normal to read most labels on 25 over-the-counter drugs.

Dixie Farley, U.S. FDA Web site,  
<[http://www.fda.gov/fdac/features/1997/497\\_otc.html](http://www.fda.gov/fdac/features/1997/497_otc.html)>

Patients who aren't sure how to take their medications are often reluctant to approach a health professional for clarification. Almost half of seniors accept prescriptions without asking any questions about side effects, dosage, when to take the medication or the availability of alternatives.

If you have patients who persistently fail to cooperate with their treatment plan, it would be wise to check their level of understanding of your instructions. They may have literacy problems that you don't know about.

## Your Legal Liability as a Health Provider

What happens when a person who has trouble reading is handed a lengthy consent form before an operation without any explanation? All too often, they sign it without really knowing what they've agreed to.

All health providers have a responsibility to obtain informed consent from patients before medical treatments or procedures. When low-literate patients are involved, it is vital to make sure that consent is truly informed. A signed consent form does not necessarily mean you have obtained informed consent.



### Fast Fact

Most consent forms can be read and comprehended independently by only about 20% of adults.

U.S. study cited by Terry Davis, Health Literacy, *Proceedings of a National Conference*, June 3, 1997, p. 8.

Failing to communicate clearly enough with patients about the risks, benefits and alternatives to treatment while obtaining informed consent can have grave consequences for patient and provider alike. There have been recent cases in Canada and the United States where the poor communication practices of health providers prior to treatment have led to accusations of professional negligence and court actions.

Several court cases have held in favour of the plaintiffs. In one case (Smith v. Tweedale, 1995), the B.C. Court of Appeal upheld a lower court ruling that a gynecologist had breached his professional duty by using language that left his patient in doubt about the permanence of the sterilization procedure he proposed, and then performed.

Why take unnecessary risks? Using the techniques described in Part 3 of this guide may help ensure your communication is well understood by your patients, regardless of their literacy levels.

# PART 3:

## *Practical Strategies for Health Providers*

### Serving Low-Literacy Clients: A General Approach

**P**aying attention to low literacy should be a key component of a patient-centred model of health care. This approach recognizes and respects the knowledge, beliefs, needs and experiences of clients.

As a health provider, there are two main ways to look at the issue of assisting low-literacy patients. The first is to try to identify these patients and provide them with information that is specially adapted to their needs.

The second is to make a point of using simple and clear language (both written and verbal) when communicating with all patients and to make sure that your messages have been understood. Given that almost half the general population, and 80% of seniors, have trouble understanding some health information, the second approach has proven to be the most effective.

Trying to identify patients with literacy problems is harder than you might think. Low literacy is rarely obvious. You can't tell by a person's appearance or by talking to them.

Many older adults are embarrassed by their literacy problems and go to great lengths to disguise them from everybody, including health workers. This is a matter they usually want to keep confidential.

They may try to cover up their inability to read in many ingenious ways. When asked to read or write, they may say that they forgot their glasses, or that they will read information or complete forms at home.

Administering literacy assessment tests is time-consuming and impractical, and can make patients feel uncomfortable and ashamed. Also, as we've seen, asking clients the grade levels they attained in school won't tell you much about their literacy levels, especially in the case of seniors.



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The solution is to always provide health information in clear, simple and easily understandable language and check to see that it is understood. This will go a long way toward giving each and every one of your clients access to the health care support they are entitled to.

### **Red Light, Green Light**

Literate patients have the green light to fully access the health care system: they can fill out forms, read pill bottles, understand appointment slips and test instructions, and apply for insurance.

Marginally literate patients must proceed with caution: they're a little unsure of what they read, and must be careful not to make mistakes.

Patients with inadequate literacy skills are simply stopped—by forms, pill bottles, and informational brochures.

Dr. Mark V. Williams, Health Literacy, *Proceedings of a National Conference*, June 3, 1997, p. 5.



### **Viewpoint**

As I learned more about literacy, I began to wonder how I could identify non-readers. Then I realized that really wasn't the issue. I had to change how I presented information so that I could be sure of reaching everyone.

Health provider quoted in *Teaching Patients With Low-Literacy Skills*, 1996, p. 151.

### **Equitable Access to Health Information: A Serious Commitment**

We encourage all those in the health system to make a commitment to ensure that all Canadians have equitable access to information that is crucial to their health and safety, regardless of whether or not they can read well.

Equitable access means that vital information is provided to individuals in ways that ensure the information is understandable and useful to them regardless of their literacy and learning styles. It also means adapting information to take into account other social and cultural factors—including age, gender, socioeconomic status, language and cultural background.

Literacy and Health Project: *Making the World Healthier and Safer for People Who Can't Read*, 1989, p.43.

## Using Plain Language Writing and Clear Verbal Communication with Low-literacy Seniors

Over the last 15 years, plain language writing and clear verbal communication techniques have become increasingly popular with health providers concerned about giving all clients equal access to information. In addition to outlining these general techniques, which work well with low-literacy seniors, we've included suggestions for meeting the special needs of older people.

### Plain Language Writing

*Plain language writing* is a way of organizing and presenting written information so that it makes sense to its intended audience. Plain language is a relative, rather than absolute, term. Material is in plain language when it can be read and understood by the group of people it is designed for.

Plain language health information is information that is easily readable, useful, and geared to low-literacy health care consumers. It can be used for labels, instructions, consent forms, information sheets, booklets, books and posters.

Although using plain language will help many people with low literacy skills to better understand text-based material, there will still be clients who aren't able to deal with the written word at all. There will be others who don't find print a preferred or trusted means of obtaining information. So, while important, improving the readability of written information cannot be the final solution to the problem of low literacy.<sup>27</sup>

Health information must be presented in a wide variety of ways that empower the patient. For those who cannot read at all, it is necessary to use non-written forms of health communication. These can include pictures, symbols, demonstrations, audiotapes, and the new multimedia technology.<sup>28</sup> Participatory approaches such as photo-essays have proven effective. Storytelling, drama and puppetry have all worked in the international context. More conventional options include structured patient education programs.<sup>29</sup>

Many clients from other countries may not understand English or French well. It is vital to make sure they receive health information in a language they can understand. However, it is seldom enough to translate pamphlets or other instructional material directly into other languages and expect them to make sense to clients from other cultural groups.

Concepts differ by culture just as words do. You will need to adapt the content of the material so that it reflects the logic and experience of people from other backgrounds.<sup>30</sup> Obtaining the assistance of health practitioners and readers from the cultural groups concerned will help enormously in preparing and testing the material.



### Practice Point

#### ***When Dealing with Seniors, Remember...***

- Most older adults experience sensory losses, such as reduction in the adaptability of the muscles of the eye, which makes it difficult to go from light to dark.
- Eight percent (8%) of those aged 65 and older said they could not see well enough to read even with corrective lenses. This was true for 12% of those over 75.
- Ten percent (10%) of people who need a visual aid do not have one.
- Six percent (6%) said they could not follow a conversation, even with a hearing aid.
- Thirty-one percent (31%) who need a hearing aid do not have one.

This information was taken from *A Portrait of Seniors in Canada*, 1997, and *Aging and Society: A Canadian Perspective*, by Mark Novak, 1997, p. 86.

*Plain language writing* starts with a commitment to learn as much as possible about the people you are writing for and requires that you clearly define the needs of your audience so that you can give them the information they will find most helpful. Plain language writing also involves testing your materials before they are finalized to ensure that your intended readers will understand your message.

When health information is too complicated, older clients may become discouraged and lose a sense of self-efficacy (the belief in their ability to accomplish things). They may feel that if something is too difficult to read, it may also be too difficult to do, so why try?

Studies show that self-efficacy is the most important precondition of behavioural change.<sup>31</sup> There is evidence that easy-to-read materials increase compliance<sup>32</sup> in all literacy groups. They have been found to benefit individuals with higher literacy skills as well. Even those with college degrees learn and remember more from simpler materials.<sup>33</sup>

#### ***Check your print information***

##### ***Language***

##### *Does the writing style...*

- connect with the reader's daily life? Stories often can be used effectively to illustrate points.

- have a conversational, friendly and informal tone? It's OK to address your reader as “you” and to use casual words and contractions like “don't.”
- use language appropriate to the audience (familiar, ordinary words)? Try writing “by mouth” instead of “orally.” Try writing “don't do...” instead of “avoid.”
- contain a clear definition of new terms and concepts? Try writing: A chemotherapeutic agent is a drug that fights cancer.
- use short sentences (fewer than 15 words) and a maximum of two clauses per sentence?
- use concrete and specific examples? Try writing “whole wheat bread” rather than “dietary fibre.”
- use the active voice? Try writing: “Take your medicine at every meal” rather than “Medicines should be taken at meal times.”

### **Information**

#### *Is the content...*

- accurate?
- unbiased?
- complete?
- up-to-date?
- gender-sensitive?
- culturally appropriate?
- useful to the reader?

#### *Is the material organized so as to...*

- clearly state its purpose and quickly get to the point?
- build new information on what the reader already knows?
- have a logical flow?
- divide the text into chunks containing a limited number of concepts and facts?
- repeat important ideas?
- use point form/bullet style to highlight and group ideas?
- use clear topic headings that make it easy to find information?
- emphasize behaviours and skills rather than facts?
- contain an easy-to-use table of contents?
- include interactive sections that ask the patient to do something?

### **Design and Appearance**

#### *Does the material...*

- have an appealing cover?
- use dark print on light backgrounds, and avoid the reverse?
- use paper with a matte, non-glossy surface to avoid glare?
- use large enough print—at least 12-point type size to increase readability for older eyes?

- use a plain, clear typeface, preferably serif? (Serifs are the little bars or curls on the bottoms and tops of letters.)
- avoid using all italics or all capital lettering?
- line up the text on the left and leave the right ragged (the way this text is laid out)?
- limit the amount of information on each page?
- use visual cuing devices (such as boxes, arrows, etc.) to direct attention to key content?
- use large margins and plenty of white space between paragraphs?
- use simple illustrations that complement the message?
- avoid combining several different typefaces on the same page?
- avoid using wavy lines (which can appear to move on a page) and other distracting graphic details?

### Clear Verbal Communication

*Clear verbal communication* is a way of speaking that gets the message across.

It starts by finding out what clients already know and builds on that, organizes information in such a way that it can be more easily remembered by patients and explains treatment plans in a way that makes them easier to follow. Because clear

communicators recognize that when clients don't understand information they might not ask questions, it also uses sensitive ways to check to make sure patients understand what has been said.

### *Check the way you communicate*

1. Do you make sure to ask patients about their feelings and perceptions? Do you...
  - ask patients to explain what is bothering them and what they think might be wrong?
  - give patients a chance to tell you how they feel about things?
  - show that you care what they think and feel about their health concerns?
2. Do you take time to organize the messages you want to get across? Do you...
  - decide on the three to five most important points you want to get across?
  - try to convey the most important points at the beginning of the communication?
  - tell your patients what you're going to cover and then give the details?
3. Do you choose your words carefully? Do you...
  - use common words in place of jargon? Try saying "eat" instead of "ingest."
  - explain new words in the context of a sentence; for example, "Anticoagulant medication" makes your blood thinner.

- show what an unfamiliar word looks like in a pamphlet?
4. Do you pay attention to the possible hearing difficulties of seniors? Do you...
    - speak slowly?
    - speak distinctly?
    - face the person as you speak?
  5. Do you demonstrate, as well as describe, health procedures? Do you show patients how to...
    - count pills?
    - measure dosages?
    - calculate food portions?
    - check blood sugar levels, etc.?
  6. Do you check that your patients understand what you say...
    - by asking open-ended and specific questions? Don't ask "Do you understand?" but "What do you do when you run out of medication and you're still sick?"
    - by asking patients to restate instructions in their own words?
  7. Do you offer print information in plain language as a back-up and reminder? Do you...
    - go over written information with the patient, asking him/her to underline the most important points?

For more detailed information on this topic, please see Appendix 2 as well as the manual produced by the National Literacy and Health Program called *Easy*

*Does It! A Health Communication Training Package.*

You may also want to order the 20-minute video entitled *Face to Face: A Video Guide on Clear Communication for Health Professionals*. Through vignettes of real situations in the lives of health professionals, the video dramatizes common communications breakdowns between patients and providers, and tells you how to prevent them.<sup>34</sup>

**Pay special attention to medication issues**

For a variety of reasons, low-literacy seniors may be unwilling to ask health practitioners about the medications they are prescribed. Many were taught that questioning the advice of professionals indicates a lack of respect. This places the onus on health providers (especially doctors, nurses and pharmacists) to take the time to ensure that older people understand how to use their medications safely and effectively.

It is important to fully explain the medication regime and ensure that seniors have a thorough understanding of how and when to take medications, and about the potential dangers of non-compliance. They also need to know about potential side effects, important food restrictions and the availability of alternate non-drug therapies.

When dealing with low-literacy seniors, you should not assume that if clients don't ask questions, they understand what you're saying. Give instructions on taking medications clearly and simply and then *check the client's understanding*. You might want to say something like:

*I want to be sure I didn't leave anything out that I should have told you. Could you tell me now how and when you are to take this medicine, so we can both be sure not to make a mistake?*

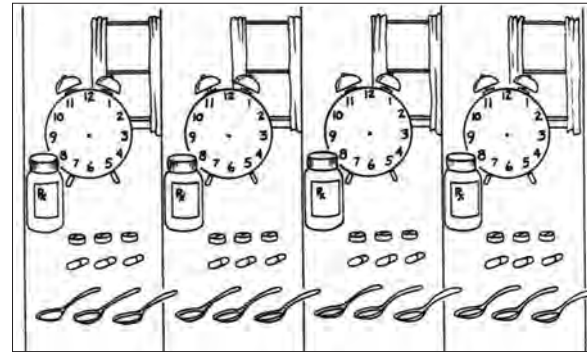


### My Story

I have a system [for keeping track of my 12 different prescription drugs]. If I get new drugs, I ask the druggist what they're all about, and that's how I can take them. I got little cups that I put my medication in for all day. Those little medicine cups from the hospital...I line them up, then I put my medication in—what I need for the morning time, what I take at dinner time...When I check if they're still there, I know I didn't take them.

Adult learner, aged 71

Consider using well-designed charts and visual aids to explain medication schedules and help patients keep track. Research has shown these to be very beneficial. Mechanical aids for dispensing the right amounts of medication such as dosettes and unit-dose blister packaging can also make it more likely that patients will follow their regimen.



Reminder sheet that the patient marks and takes home.

Source: *Do You Understand?* Literacy Volunteers of America, 5795 Widewaters Parkway, Syracuse NY 13214-1836



### Viewpoint

Dietitians, diabetes educators, nurses, and others on the front-line doing patient education seem to be most aware of the inadequacies of many health materials and educational processes. Many describe their jobs as interpreters of what the doctor has told the patients.

They describe a common scenario. The doctor explains everything, gives the patient a handout, and then asks: Do you have any questions? The patient usually says no. They know they wouldn't understand the answer anyway and they can tell by looking that they can't read the handout. The doctor leaves the room and the nurse comes in. The patient then says: What did he say? and the nurse explains it in plain English.

It would be great if doctors had more time to come to training and also more time to talk with patients in their practices.

Literacy Educator



## Practice Point

### **Helping Clients Manage Their Medications**

#### **What works**

- a record that lists each medication, the day and times it should be taken, and a space to check off each one as it is taken; this should use pictures for non-readers
- putting pills in a dosette—a container that has separate compartments for each day of the week
- unit-dose blister packaging
- packaging and medication instructions with simple, large-print instructions
- easy-to-open bottles (not child-proof containers)
- vertical rather than horizontal labels (Many older people have said that they would have less trouble reading pill bottles if the label were placed vertically rather than horizontally. This way, the user doesn't have to turn the container around in a circle to read the instructions.)
- matching the timing of medication to a patient's daily schedule

#### **What doesn't work**

- lack of enthusiasm on the part of the provider insisting on compliance
- taking a general rather than individual approach
- lack of continuity between providers
- providing too little information or too much information at one time

- providing insufficient information, no follow-up
- failing to use more than one communication channel
- not encouraging patients to ask questions
- not ensuring that the patient understands or can and will follow directions

Adapted from Carl Salzman, *Medication Compliance in the Elderly*, *Journal of Clinical Psychiatry* 1995; 56; pp.18-22.

Encourage seniors to take an active role in managing their medications. Help them develop a handy list of all their medications that can be carried with them at all times. Encourage them to show it to every health professional they deal with.

Bear in mind that other factors also affect the appropriate use of medication by seniors. These include having a first language other than English or French, low income, and limited mental and emotional coping skills. Physical and social isolation—caused by geographic location, physical disability, or lack of transportation services—are other considerations.

## Underlying Goals of Good Health-related Communication with Older Adults

Using plain language and practising clear verbal communication in the health care setting is one sure way to enhance the well-being of older clients so they can live as long and vitally as possible. This, after all, is the underlying goal of providing seniors with health services and information.

Studies show that the traits possessed by long-lived people include: good self-esteem, independence, a purpose in life, and bonds of intimacy with friends, family and significant others.<sup>35</sup> More and more clinical research is demonstrating a vital link between a person's control of his or her life, the psychological supports of that control, and the immune system's resistance to disease or decline.

Being aware of this provides a solid base for a holistic health practice that uses a multifaceted and individualized approach and reinforces the active participation of clients in their own health care. Sensitive health providers can do a great deal to enhance the positive attributes mentioned above in older clients. Here are some ideas.

### Empowering Older Adults

In a well-known study, one group of nursing home residents were given responsibility for making decisions about many details of their lives. They were also given a plant to take care of.

Another group was told that it was the home's responsibility to see that residents were happy and well cared for. Patients in the first group became happier, more active, more alert and improved in health. They spent more time talking to staff and fellow patients. Their death rate after 18 months was 15% as compared to 30% for the other group.

Debra Roter and Judith Hall, *Doctors Talking with Patients/Patients Talking with Doctors*, 1992, p.155.

### Bolster self-esteem

Self-esteem is an essential element of good physical and mental health. It is related to the self-efficacy that people need to feel in order to accomplish things. Older people who have good self-esteem avoid stagnation and feel they have something to contribute to society.

For many, it is a challenge to maintain self-esteem in the face of loss, change, and a subtle or dramatic

deterioration of abilities. The barrage of negative images and stereotypes about aging transmitted by our youth-oriented culture makes this even more difficult.

Health providers can play a key role in bolstering the self-esteem of their older clients. Show clients you are convinced they can learn, change, and take charge of their lives. Choose actions and communications that instill in clients self-acceptance, self-confidence, a sense of mastery and a feeling of being special and unique.

### **Promote independence**

As people age, it is often increasingly difficult for them to maintain independence and control over their own lives. Being as independent as possible is important to many older people and is often critical to their self-esteem and overall well-being. Physical and intellectual deterioration, major or minor, may cause others to take over, whether or not it is really necessary. Institutionalization may further reduce control and increase dependency.

Appropriate social and health care support services, as well as a more supportive environment, can assist older people in staying independent. Health

providers should always be on the lookout for ways to improve the capacity of seniors to function autonomously.

For example, severe back pain can compromise an older person's ability to care for him or herself and can result in their confinement. It is probably more effective, in the long run, to help the client manage pain and maintain independent functioning through exercise, environmental adjustments and deep relaxation while searching for an underlying cause, rather than merely prescribing medication.

If you keep in mind that one of your goals is to empower seniors, what you say and how you say it will show that you believe in their capacity to make their own decisions and take appropriate action. It is important to always treat older people as vital partners in their health care.

### **Reduce isolation**

For a variety of reasons, many seniors are physically and socially isolated. In 1991, 28% of seniors lived by themselves. About 8% of Canadians over 65 lived in special care homes; almost 40% of those aged 85 and over did so. Statistics show that those in institutions tend to suffer from more numerous and more severe

physical disabilities than those who live independently.<sup>36</sup>

The transition from individual living to institutional living is often unexpected. The isolation from larger society, coupled with age-related health and sensory difficulties, can be hard. For some, the experience can be depersonalizing and they can become cut off from friends and family outside the special care home. Institutionalization can have an adverse impact on the self-concept of the chronically ill, older patient who may respond by withdrawing.

Approximately 46% of seniors have some form of disability.<sup>37</sup> For many, this limits their outings as well as their leisure activities and recreation. Also, frailness and declining energy keep seniors from becoming involved in social activities with others. The loss of mobility, like the loss of the ability to drive, can curtail relationships with others and increase isolation.

Isolation has a proven impact on health. Studies have found, for example, that people who feel isolated have three to five times more risk of dying from cardiovascular diseases as individuals who don't feel isolated.<sup>38</sup>

It is important to recognize that, as a health provider, you might be one of the few people that an isolated senior comes into close contact with. Loneliness can be a factor in repeated visits to a health provider. Not only is your interaction an opportunity to provide a health-related service, but it is also an opportunity to provide an older person with a caring, human connection. If you're mindful of this common need among seniors, you can also help your clients find ways to become more linked to others.

#### **Treat the whole person**

Clients go to health practitioners for all kinds of reasons. Sometimes the problem is physical, sometimes it is psychosocial, and often it is a mixture of the two. Good health providers treat their clients, not as diseases, but as “whole” people. The key is to try to ensure that all the client's needs are addressed, including those that tend to be more hidden. If you aren't equipped to do so yourself, it may be necessary to refer the client to others for additional assistance.

New scientific evidence is emerging to support what many know from day-to-day practice—that health is multi-layered, involving complex relationships

between the body, mind and spirit. Emerging fields such as psychoneuroimmunology are revealing that the way people live their lives, what they think, feel, believe and do, all influence health, illness and healing in significant ways.<sup>39</sup>

That's why many experts in health communication insist that it is as important for your clients to "feel" better after an interaction with you, as to "be" better.<sup>40</sup> Health providers who recognize this will always focus on the patient-as-person and will place as much emphasis on "caring" as on "curing."

### **Pay attention to grief and loss**

One key issue to be aware of with most older people is that of loss. It occurs in almost all areas of life and can have a profound impact on all aspects of well-being—physical, mental, emotional and social. Loss in old age differs in significant ways from earlier loss. Many older people are confronted with the loss of a job or role, and all the associations that go with it, some with the loss of good health and sharp faculties, some with a move from the family home, and some with the death of their friends and family members.

Losses seem to be cumulative over the life span. When older people suffer new losses they tend to

relieve previous losses. Understanding the cumulative nature of grief is important when working with older people. Sometimes what appears to be a relatively minor loss of an object, or the death of a casual acquaintance, may trigger intense grief reactions.

Seniors may not feel comfortable enough to raise issues of grief and loss directly. Chances are they will come to the fore in other ways. Grief may be at the root of such problems as sleep disturbances, appetite changes, illness symptoms, anger, fear, guilt and despair, detachment, forgetfulness, and persistent crying and sobbing. An alert practitioner may be able to pick up signals and identify concerns lurking under the surface. Often, just opening the door to the issue and then listening empathetically will be of great benefit to clients. Clients also need reassurance that their feelings of grief are normal.



### **Fast Fact**

- It is not true that aging reduces intelligence or the ability to learn. Age by itself is often the least important factor in cognitive functioning in later life, relative to sociocultural, historical and health-related factors.
- Cognitive speed does decrease with age but accuracy doesn't.
- Aging doesn't affect the ability to reason.

- “Immediate” memory is only very slightly affected by age; tasks involving “recent” memory become more difficult with age; “prospective” memory gets worse with age if reminders aren't used, but there is little change if they are.
- There is little or no change in the ability to pay sustained attention, however it becomes more difficult to pay attention to more than one thing at a time.
- Abilities that depend on knowledge based on experience and amassed over a lifetime (verbal comprehension, social awareness, application of experience) often improve with age.

## **Working with Low-Literacy Seniors: Strategies for Improving Health Communication**

We've already seen how using plain language and clear verbal communication can benefit low-literacy seniors. Following are some additional strategies that should be useful in working with this population. Keeping these points in mind will help you serve older individuals with literacy limitations more sensitively and effectively and will increase their chances of understanding and remembering important health information.

Of necessity, this guide can only contain a brief introduction to the vast issue of health care communication with seniors. You may want to explore it further by taking professional development courses, by talking informally with providers and clients about their experiences, and by reading. The resources listed in the bibliography at the end of this booklet provide a good starting point.



### **Practice Point**

Older adults with poor literacy skills are no different from the rest of the senior population in that they are also experiencing the consequences of the aging process. When communicating with low-literacy seniors, it's always important to be sensitive to the impact of both their literacy limitations and the aging process.

### **Overcoming Barriers...**

Health care communication has three main elements: to gather information, develop a relationship, and convey information. Literacy is only one of many potential barriers to achieving these goals. Other barriers on both sides of the provider-client relationship include the physical, psychological, social, and cultural. These often interact with low literacy to create additional challenges to effective health communications.

On the patient's side, in addition to literacy, there may be barriers posed by past experiences, attitudes, culture, language, educational level, and fear. For the health provider, barriers may be created by lack of time and availability, as well as by social and psychological issues.

This section provides tips on how to overcome these barriers and improve your communication with low-literacy seniors. Recognizing potential obstacles can help you deal with them when they appear in client interactions as well as prevent them from occurring.

### ***Evaluate your attitudes***

It is vital to refrain from buying into negative stereotypes of older people. One study that compared the way physicians dealt with seniors and younger people found that fewer psychosocial issues were discussed in interviews with older patients. When patients did raise them, doctors tended to be less responsive.

Physicians were rated higher regarding the degree of questioning, information provided, and support given to younger compared to older patients. They were less egalitarian, patient, engaged and respectful when dealing with older people.<sup>41</sup>

Another study found that better-educated and more well-off patients received more physician time, more total explanations, and more explanations in comprehensible language than other patients. Ironically, physicians not only gave more information to these patients but they also appeared to go out of their way to offer these explanations in clear, non-technical language.<sup>42</sup>



### **Practice Point**

#### ***Communication should...***

- serve the patient's need to tell the story of his or her illness and the doctor's need to hear it
- reflect the insight and expertise of the patient about his or her condition
- respect the relationship between the patient's mental and physical states
- maximize the usefulness of the physician's expertise
- acknowledge and attend to emotional content
- openly reflect the principle of reciprocity in which the fulfillment of expectations is negotiated
- help participants overcome stereotyped roles.

Adapted from Debra Roter and Judith Hall, *Doctors Talking with Patients/Patients Talking with Doctors*, 1992, p. 5.

## Developing the Relationship...

### ***Create trust through a respectful and caring manner***

The context of health-related communication helps clients to understand and remember vital information. The quality of the provider-client relationship has been shown to have a measurable effect on ensuring patient compliance with treatment plans, promoting satisfaction with providers, and improving health outcomes.<sup>43</sup>

You'll want to make your interaction as welcoming and non-threatening as possible to older people with limited literacy. A first step in establishing effective communication is to develop trust.

Younger practitioners might find that this takes longer than would middle-aged and older ones. They may have internal barriers to working with older people that are linked to fears of aging or unresolved conflicts with parents. They may also need to overcome concerns on the part of clients about age differences. Seniors may regard some health providers as less capable because of youth and inexperience. Sometimes it helps if you say something like:

*You may be wondering if I can really understand what you're talking about since I haven't had the experience of retiring, losing a spouse, having a child die...Although I*

*haven't, there have been many times that I felt sad, scared, or angry. If we get to a point where my lack of experience gets in the way, please tell me and we'll talk about it.*

Such openness on the part of a health provider is likely to generate trust. Trust can also be fostered by showing respect to older adults, taking their concerns seriously, valuing their knowledge and experience, and not patronizing them. Recognize that having limitations doesn't make seniors helpless or incompetent.

A warm and caring manner is important to clients of all ages but is likely to be especially reassuring to older people. Kottler and Brown talk about "the soft smile, soothing voice, relaxed posture, and interested eyes that communicate an authenticity that helps a client to trust, to open up, to feel prized."<sup>44</sup>

### ***Offer a friendly environment for seniors with low literacy skills***

Health providers also need to give careful thought to the setting in which the relationship with a client occurs. You may need to make adaptations to this environment so that it is comfortable and fully accessible to low-literacy seniors.

Health providers who want their offices to accommodate the needs of older people need to consider normal age-related sensory losses as well as the special needs of people with physical

limitations. If you are planning to set up or modify a health care environment, you might want to consult a manual that helps you design for the special needs of seniors.

### **Is Your Office Welcoming to Low-Literacy Seniors? CHECKLIST**

- Is your office fully accessible to wheelchairs and walkers?
- Do you have firm, straight-backed chairs with arms for people to sit in? The soft throw pillows or overstuffed chairs that may appeal to younger people are uncomfortable for people with arthritis and may be almost impossible for them to get in and out of.
- Is your office set up so that clients have their backs to the window to minimize glare?
- Does your building use colour contrasts to highlight stairs and door openings?
- Is the entrance well-lit but not harsh?
- Do you have hand rails and easy-to-use handles on doors and cabinets?
- Do you have fully accessible washrooms?
- Do you guard against pockets of light in hallways that create an uneven effect on walls and floors?
- Do you avoid rough surfaces on walls that can cause skin abrasions?
- Do you refrain from using patterns on the floor that may create optical illusions?
- Do you take steps to avoid a constant source of meaningless sound in group areas? Audio mush created by radios, televisions and machinery can tire and distract older people and make it harder for them to hear. Using fabric textures, pile carpets and soft drapes that dampen background noise will make life a lot easier for your senior clients.
- Have you checked the readability of information in your office or waiting room?
- Are program materials and signs printed in large type with dark print on a light background? Coloured flyers may look attractive but they are difficult for many older people to read.
- Do you have a good selection of plain language health information in your display racks?
- Can your signs be simplified or made clearer by graphics?

Adapted from Carl Salzman, *Medication Compliance in the Elderly*, *Journal of Clinical Psychiatry*, 1995; 56; 18-22.



### **Practice Point**

#### ***What's it like to age?***

A sensory-loss simulation is a good way to increase your sensitivity to the needs of older clients. You can simulate vision loss with a plastic bag taped over your eyes or around your glasses. Typical hearing losses can be simulated by placing damp cotton balls in your ears. Reductions in tactile sensitivity can be simulated by wearing latex gloves or wrapping tape around your fingers. Borrow canes, walkers and wheelchairs and use them to do a tour of your building.

While you're doing this, try going to the bathroom, reading signs and bulletin boards, looking at books and pamphlets, and using the telephone and telephone books. Be aware of what you do, what you think and how you're feeling.

#### ***Provide emotional support***

In any health care encounter, providing comfort and emotional support should always be as important as providing expertise. However, this takes on even greater significance when clients are in transition, in crisis or in pain. Older people in these situations need to know that there are people they can count on to understand and care.

Fear is a main barrier to communication. Being ill or anticipating bad news can create anxiety and dread. Patients who have a stress response to illness do not learn as well as they would under normal circumstances.



### **Practice Point**

#### ***Behaviours to avoid***

One study of health care visits showed that these behaviours on the part of health providers tended to limit communication with clients:

- intentional use of highly technical language
- clock-watching or watching the patient list
- mumbling
- cutting off or interrupting the patient
- tuning out or ignoring a patient when he/she asks a question
- greeting the disease instead of the person
- executing a quick get-away rather than expressing a farewell
- frowning, sarcasm

Debra Roter and Judith Hall, *Doctors Talking with Patients/Patients Talking with Doctors*, 1992, p. 96.

### Gathering Information...

#### *Practice active listening and effective questioning*

Active listening is very important, especially with seniors. The feeling that a health professional does not listen well may reduce a client's willingness to accept his or her guidance.

Detailed studies of doctors' interviews reveal that there is often reason for patient dissatisfaction. One study showed that patients went to a general medicine setting with between 1.2 and 3.9 major complaints. On average, they were allowed to talk for 18 seconds before being interrupted by the physician. Only 23% of patients ever finished their opening statements.<sup>45</sup>

Patients who are allowed to tell their own story in their own words and express their feelings are more satisfied with their doctors and perceive them as more competent. They are also more likely to cooperate with a treatment plan.<sup>46</sup>

Effective questioning is equally vital, especially since so many clients don't ask questions. One study of health care communication revealed that only two to four percent of patients asked any questions about prescriptions while in the physician's office.<sup>47</sup>

### *Assess your forms*

Take a careful look at the forms you require clients to complete. Are all the questions necessary? Are they clear and straightforward? Could they be simpler? Could the information be gathered differently, such as through an interview? When alternatives to written forms are not possible, help should always be offered and clients should be given the choice to accept it or decline it.

### Conveying Information...

It is vital to think about how your overall communication increases your clients' self-confidence and motivation. This can have a great impact on their health status. Patients who perceive themselves as capable of affecting their own health in a positive way may act in a healthier manner, and actually become healthier, than those who lack confidence in their own abilities.<sup>48</sup>

When a patient has a greater sense of participation in medical care decisions through more active, two-way communication, this creates a positive perception of mastery and control over his or her total environment, including health. This produces a more self-confident and powerful life outlook.<sup>49</sup>

**Take time**

Patients over 60 may not process information as quickly as younger patients. Some older seniors may find it difficult to assimilate new information. Thirty-three percent (33%) of non-institutionalized seniors reported problems with cognition—being somewhat or very forgetful or having difficulty thinking.<sup>50</sup> These older clients may need more, not less, time with health practitioners. Those with literacy limitations also need additional time. Taking the time that is needed initially may prevent clients from returning with complications or recurrences.

**Viewpoint**

Health people don't spend enough time explaining what your problems are in a way that you can cope with - if you have difficulties with reading and writing. You are just shoved through.

Adult learner

**Practice Point****More tips on communicating with clients**

- Draw out the full spectrum of patient concerns. (What's been going on since I saw you last?)
- Resist the urge to act too quickly on the first concern expressed. Check for others first. (I know you came in to have your blood pressure checked. Is there anything else that is bothering you that you would like to discuss today?)

- Explore the significance and impact of the problem. Ask explicitly for the patient's opinion, experience, understanding, and interpretation. (What do you think your problem is? Has anything like this happened before? What do you think caused it? What do you think it means? What troubles you most about it?)
- Ask explicitly for expectations. (What do you think I can do that would help?)
- Ask about and respond to patient emotions. (How do you feel about that? What are your concerns? Are you worried about anything related to this condition?)
- Pick up and comment on non-verbal cues. (You seem really anxious. You look very worried.)
- Validate feelings and express empathy. (It's perfectly normal to feel sad about this situation. I would too.)
- Reinforce patient effort. (I want you to know that you are doing a great job of following your exercise routine.)

**Consider alternatives**

Many health providers find it effective to provide information to seniors informally, by talking over a cup of tea, for example, rather than in a formal session. The term that has been coined for this is “by-the-way counselling.” An older person may call or stop by with a routine request, and taking a “while you’re up” approach, ask for help with a more complex problem. Health providers can take advantage of this tendency to approach issues indirectly by having informal drop-in time available,

or by encouraging older adults to be casual in their approach.

### ***Don't avoid difficult topics***

There are many health issues that older clients may need help with but are too embarrassed to raise. Incontinence is a good example. So are impotence and other concerns related to sexuality. Health providers should be aware of these and other related concerns and find sensitive ways to bring them up with clients.

### ***Involve caregivers***

Many low-literacy seniors have long relied on “literate helpers” to cope with the world around them, usually family members or good friends. This is particularly true for older immigrants who have difficulty with English or French. It may be a good idea to ask seniors if they would like to involve these people in discussions of their health issues and treatment plans. They can help the older person interpret and remember important information. One study found that informal social support played a significant role in ensuring that seniors experiencing declines in cognitive functioning adhered to treatment plans.<sup>51</sup>



## **Practice Point**

### ***Cross-cultural communication***

People learn information by adding it to what they already know. When the logic, language and experience of the new information differs too much from their own, individuals are less inclined to accept it and integrate it. This is one key reason that cross-cultural health care communication must recognize cultural variations. When mismatches occur, communication will not be as effective.

#### *For example:*

- Nutrition pamphlets that suggest unfamiliar foods that are difficult to find will not be followed by readers.
- Materials should present cultural images in positive and realistic—not stereotyped—ways.
- Since cultural variations may affect how information is presented, as well as the information itself, you may want to alter the organization, the sequence, or the way in which the information is delivered. This might include giving a little at a time, using stories to instruct, and building on extended family networks.
- Be aware that using humour to lighten the way you convey important information might be misinterpreted as a lack of seriousness or caring.

Adapted from Doak et al, *Teaching Patients with Low Literacy Skills*, 1996, pp. 66-70.

*Be aware of relevant community resources*

In working with clients of any age, all health providers need to consult with other professionals and make referrals from time to time. To be most helpful to older clients, you need to be as familiar as possible with the wide range of community resources available and know how to tap into the elder care network.

In addition to the standard services available to seniors, why not widen your knowledge to include unique services and services for seniors with special needs? Examples might include literacy-related

programs, services for immigrants and members of cultural communities (including language interpretation), physical fitness and recreational programs, as well as social services such as bereavement support groups and the vast array of other self-help groups that exist.

Although there may not be a service to meet all the varying needs of older people, there are generally many more resources available than most older people, their families, or their helpers know about. Make an effort to keep yourself as up-to-date as possible.

# PART 4: *Notes and References*

- 1 The term “senior” refers to people aged 65 and over in this guide.
- 2 We use the term “health provider” to refer to members of all health care and related disciplines including doctors, nurses, pharmacists, dentists, physiotherapists, psychologists, social workers, health care aides, home care workers, etc.
- 3 The terms “client” and “patient” are used interchangeably in this guide.
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- 5 Statistics Canada. Portrait of Seniors in Canada (Ottawa: Statistics Canada, 1997) 11.
- 6 Statistics Canada, Portrait of Seniors 51-80.
- 7 Contact the National Literacy and Health Program at the Canadian Public Health Association, 1565 Carling Avenue, Ottawa, Ontario K1Z 8R1 (613) 725-3769 for a copy of the training manual.
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- 9 Ontario Public Health Association and Frontier College. Literacy and Health Project: Making the World Healthier and Safer for People Who Can't Read, Phase One (Toronto: OPHA and Frontier College, 1989) 20.
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- 11 Statistics Canada, Reading the Future 38.
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- 28 The book Teaching Patients with Low Literacy Skills by Cecilia Doak, Leonard Doak and Jane Root (Second edition, Philadelphia: J.B. Lippincott and Co., 1996) has excellent chapters on how to use visual material and technology (audiotapes, television and interactive multimedia) to impart health information.
- 29 David W. Baker. The Impact of Health Literacy on Patients' Overall Health and Their Use of Healthcare Services, Proceedings of Health Literacy: A National Conference (Washington D.C.: Pfizer, Inc., June 3, 1997) 7.
- 30 Excellent guidance on working in a multicultural environment can be found in Barb Thomas, Multiculturalism at Work: A Guide to Organizational Change (Toronto: YWCA of Greater Toronto, 1987).
- 31 A. Bandura and N.E. Adams. "Analysis of Self-efficacy Theory in Behaviour Change," Cognitive Therapy and Research 1 (1982) : 287-310.
- 32 P. Bradshaw et al. "Recall of Medical Advice: Comprehensibility and Specificity," British Journal of Social and Clinical Psychology 14 (1975): 55-62.
- 33 D. Frederickson. "Study of Parent Comprehension Comparing a Short Polio Vaccine Information Pamphlet with Graphics and Simple Language with the Currently Available Public Health Service Brochure," Pediatrics 1994.
- 34 Contact the National Literacy and Health Program at the Canadian Public Health Association, 1565 Carling Avenue, Ottawa, Ontario K1Z 8R1, (613) 725-3769.
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- 40 Robert Buckman. How to Break Bad News (Toronto: University of Toronto Press, 1992).
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## APPENDIX 1:

# *The Links Between Literacy and Health*

Literacy levels affect people's health at all stages of life. Research has established a definite link between literacy and health that is both direct and indirect. A key study issued by the Ontario Public Health Association in 1989, called *Literacy and Health Project: Making the World Healthier and Safer for People Who Can't Read*, cited numerous ways that literacy affects health. Here is a brief summary.

### **Direct impact**

#### **1. Poor literacy skills can restrict people's access to the information they need to keep healthy.**

Health promotion and prevention information encourages healthy lifestyle choices and warns against health risks. It is often about diet, exercise, or smoking. But it can be about immunization, environmental health, or safety in the home and workplace as well. It also includes education materials designed to teach clients how to handle chronic illnesses such as diabetes, asthma, hypertension and heart disease. Good education can

prevent complications and recurrent visits to the health provider to deal with the same problem.

A great deal of this information is in print form. All too often it is written in a way that makes it very hard for poor readers to understand. This includes general material produced by health and social services organizations as well as media information on how to stay healthy. With the rise of the Internet as a medium for communication, the lack of computer literacy combines with low print literacy to reduce many Canadians' access to health-related facts.<sup>1</sup>

#### **2. Poor literacy skills can prevent clients from properly following key instructions about medications and treatment plans.**

Not only does literacy involve being able to decode words, it also requires being able to understand and reason about words. This is often influenced by a person's familiarity with the context or prior knowledge of a subject.

Health instructions are generally written for skilled readers. They often use complex terms, concepts and constructions. Many words and illustrations may be unfamiliar and confusing to less skilled readers.

Information conveyed verbally may also pose problems to clients with limited vocabularies and poor knowledge of health-related terms and concepts. Clients may not fully understand the diagnosis of their medical problem or what to do about it. What appears to be “non-compliance” may actually be the client’s failure to understand what is expected.

The inability to grasp key information can lead to mistakes that have serious consequences for health and safety. A person who doesn’t understand what is being communicated will have a hard time following medical directions correctly and using medication properly. The result can be overdoses or adverse effects from mixing medications inappropriately. Misunderstanding safety warnings can cause accidents and poisonings.

### **3. Poor literacy skills can stop people from obtaining vital health services and benefits.**

Many people with limited literacy skills don’t know what health services are available in the community or how to gain access to them. In one case, the mother of a young boy who had fallen and cut himself near the eye did not know where to find the nearest hospital and couldn’t read the phone book. Her son almost lost an eye for lack of immediate attention.

Many people avoid dealing with health problems due to embarrassment and anxiety. Many health programs require clients to read and complete lengthy and complicated forms. Fear of filling out such forms can deter people with limited literacy from seeking vital benefits and services. We know of people who don’t have Medicare coverage because they weren’t able to fill out the application forms for health cards. Also, mistakes made as a result of misinterpreting the questions can prevent or delay the timely delivery of benefits and services.

Low literacy skills can also keep people from using health services appropriately. They may have problems keeping track of appointments or following directions prior to tests or surgery. Low literacy has been shown to cause increased numbers of visits to physicians and hospital admissions.<sup>2</sup>

## Indirect impact

The indirect relationship between literacy and health is also very significant. Many studies have concluded that literacy, or education, is a major variable affecting health. Higher levels of education lead to higher income and social status, which are all linked to better health. The factors relevant to the education/health connection include poverty, stress, unhealthy lifestyle practices and dangerous work environments.

### **1. Low literacy tends to be linked to lower levels of education, and as a consequence, to lower incomes and poor health.**

Since good reading skills are needed for nearly all jobs in today's information-based economy, people with lower literacy skills have much less access to adequate work and good incomes. A large proportion of people with limited literacy have great difficulty gaining access to the work force and have to depend on social assistance.

Researchers report that low income leads to poor health in later life. People with low income show poorer health by ages 45 to 64. Health differences between people with low and high incomes show up at all ages in later life.<sup>3</sup>

### **2. People living in poverty are subject to high levels of stress.**

In general, people with limited literacy have limited money, limited options and less control over their lives. This causes great stress which contributes to the risk of ill health. The National Anti-poverty Organization has identified stress as the major health hazard affecting poor people.<sup>4</sup>

### **3. People with low literacy skills are more likely than others to have unhealthy lifestyles.**

Studies show that individuals in this group are likely to smoke more, drink more coffee, have poorer nutrition and exercise less than others. They are also less likely to be aware of and practise such preventive health measures as using seatbelts, having their blood pressure checked, and doing breast self-examination. In addition, they are less likely to have a fire extinguisher, smoke detector or first aid kit at home.

### **4. People with low literacy skills may not be aware of workplace dangers.**

A large number of adults with low literacy skills work in dangerous environments such as the resource and construction industries. People with low literacy

skills are less likely to be aware of dangers at their workplace or their rights under occupational health and safety legislation.

## References

- 1 The point about the Internet is not mentioned in the Ontario Literacy and Health Study which was completed before the Internet burst on the scene. It has been estimated however that 25% of Internet queries are related to health and medicine and physicians are even beginning to prescribe web sites. (S. Junnarkar, Physicians face newly knowledgeable patients as consumers learn on the net, The New York Times, November 19, 1997).
- 2 Julie A. Gazmararian, Health Literacy Conference, Proceedings of Health Literacy: A National Conference (Washington D.C.: Pfizer, Inc., June 3, 1997) 20.
- 3 Mark Novak. Aging and Society: A Canadian Perspective. (Toronto: ITP Nelson, 1997) 79.
- 4 Havi Echenberg. Working Summary of Community-based Literature on Health Inequities (Ottawa: Health and Welfare Canada, 1987).

## APPENDIX 2:

# *More on Plain Language and Clear Verbal Communication*

### A. Plain Language Guides

#### Books (English)

Baldwin, Ruth. (1990) Clear writing and literacy. Toronto: Ontario Literacy Coalition.

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Multiculturalism and Citizenship Canada. (1991). Creating a plain language zone: A manager's handbook. Ottawa: Author.

National Literacy Secretariat. (1991). Plain language: Clear and simple. Ottawa: Minister of Supply and Services Canada.

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## B. Health Information Written in Plain Language

### Books

Petch, Elsie. (1992). Wise use of medications: A health promotion approach to community programming for safe medication use for seniors. Toronto: South Riverdale Community Health Centre.

### Brochures

Centretown Community Health Centre. (1991). Plain facts on health brochure series. Ottawa: Author.

Regina Home Economics for Living Project (Regina H.O.P.E.). (1993). Food fact sheets, shopping skills, & kitchen smarts. Regina: Author.

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\* *This resource bibliography was compiled by the Canadian Public Health Association's National Literacy and Health Program*