Education Break Out Session Notes
Kentucky Health Literacy Summit
February 26, 2010

Response to the Vision Statement:

In general, the response was not very positive. Objections included:

1 Did not like, 'envision.' Preference for something stronger, such as 'will create.'
2 Did not like, 'Commonwealth.' Preferred, 'State.'
3 Did not like, 'literacy.' Felt it was demeaning and that we should use language that is more clearly descriptive of all that in implied by, 'health literacy.'
4 The 3x5 cards with participant ideas were collected and turned in at the registration desk.

Results of Break Outs by Continuing, Community and Health Professions Education:

Format was to address the four questions as follows:

1 What is the current status?

2 Where we should be?

3 Who are the relevant partners?

4 Can initial action items be identified?

Continuing:

Willing to work: Seth Anderson, Luta Garbat-Welsch, Jim Norton

1. What is the current status of health literacy? **> Mostly informal**
    - Integrated into current medical curriculum (gme, nursing, ce)
    - Experts interact with practitioners
    - Informal education framed in different ways other than CE i.e. happening, but not as CE e.g. Cultural competency, medical interpretation
    - Corporation/business-sanctioned professional development activities e.g. humana training programs, etc.
2. What should the status of health literacy currently be? **> More formal and integrated**
    - Required for license certification
    - Interactive and dynamic
    - Inter-professional
    - Online/easily accessible
    - Real-life scenarios e.g. ama video
    - Culture change in professions
    - CE addressing practice systems issues
3. Who should be involved in the working group? **> Inter-disciplinary, with funding sources and PATIENTS!**

- Professional associations
- CE organizations
- Patients who are affected (!)
- Researchers to determine needs assessment
- HCPs
- Academic health centers
- State government/DPH
- Health communication/information experts
- Funding sources
- Vulnerable populations and their advocacy groups

4. What are the action steps? **> Build a CE product**
    - Formally contact professional associations for needs assessment
    - Build an interprofessional CE product accessible online

Community:

Willing to work: Carlos Marin, Jessica Fisher, Carol Brinkman, Kristin Leighton, Emily Beauregard

I. What is current status in health literacy

a. Essentially group discussed need to educate community on "health literacy" or increase awareness of the issue and challenges and available programs
b. Term "health literacy" needed to be defined at community level and marketed
c. Health Literacy to much of an "academic theme"

II. What should our status in health literacy be?

a. Teaching people (patients) to act as consumers, to ask questions
b. Lengthy discussion regarding lack of awareness and resources at community level

III. Whom to invite to a working group? (Indentify potential partners)
Groups discussed organizations to be considered as possible partners for continued community education

a. Public Health Centers ; primarily Consumer Science Agents
b. Federally Qualified Health Centers (FQHCs)- because of their target population or clientele
c. Indentified community coalitions that have an expressed interest
d. Private or public entities that offer worksite/wellness programs
e. Foundation For A Healthy Kentucky
f. Kentucky Dept of Education
g. Policy Makers
h. KET
i. Public Libraries/Adult Ed programs

IV. What are projects/action steps that could be taken?

a. Identify local “Literacy Councils”, do they exist, if so, where?
b. Utilize Community Lay Health Workers such as Promotoras or Homeplace in outreach and education efforts
c. Organize community forums to obtain response from communities for educating health care providers on health literacy.
d. Identify tools available for providing education on health literacy. Is there an “inventory” of such tools available?
e. Offer community education on baseline data referring to impact of health literacy.
f. Health Literacy Committee should clarify “what’s the next step” and convey to persons that attended conference.

V. Priority
   a. Offer community education on baseline data referring to impact of health literacy.
   b. Identify tools available for providing education on health literacy. Is there an “inventory” of such tools available?
   c. Organize community forums to obtain response from communities for educating health care providers on health literacy

Health Professions:

Willing to work: Jim Ballard, Jeff Knott, Jim Cecil, Bill Betz, Carol Murch, Julie Brock, Cathy Vellotta

Current status:

There is little, if any, recognition of health literacy in the curricula of the various health professions programs, nor is it addressed adequately in coursework on patient communication. The group felt that even if it were included as a curricular element that there is a need to encultureate the faculty and administration into seeing the importance of teaching students about HL.

Where we should be:

The group agreed that HL should be included in the curricula of health professions education programs and should be enriched by including faculty development. However, they believe it should be part of an overarching curricular component that incorporates related constructs. It was agreed that it should be included in current or developing cultural competence and health disparities curricula. Moreover, it should be evidence-based and enriched by interprofessional collaboration. For this to occur it must begin with buy-in by the deans and other leaders within the educational institutions to counter a tendency to see HL as something to be “checked-off” as “covered”. There must be a budget for this to occur and to be taken seriously.

Partners:

There was a suggestion to partner with the KIOM to gather needed data, both quantitative and qualitative. Subsequent curriculum development should be done collaboratively among professions and include members of senior leadership, faculty staff and opinion leaders within the institutions. We should look to national leaders such as Andrew Pleasants and John Vernon for models.

Action steps:

The process for HL curricular development must begin by garnering buy-in from institutional leadership. However, for this to happen we need data. The data should include the cost of poor HL to the state, at the county level, in terms of patient outcomes and dollars. As such, the group agreed that the first step is to begin gathering this data.