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Health Literacy and Discharge Planning in Social Work Practice

Michele Munzner
Walden University

Walden University

College of Social and Behavioral Sciences

This is to certify that the doctoral study by

Michele Munzner

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Dr. Debora Rice, Committee Chairperson, Social Work Faculty
Dr. Elizabeth Walker, Committee Member, Social Work Faculty
Dr. Kristin Richards, University Reviewer, Social Work Faculty

Chief Academic Officer and Provost
Sue Subocz, Ph.D.

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Abstract

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Michele Munzner

MSW, University of Houston, 2009

BS, Sam Houston State University 1998

Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

Low health literacy is a public health crisis, currently, there is limited research on social worker engagement with the low health literate patient. The research questions for this study examined health literacy knowledge in medical social workers and how their MSW curricula built their knowledge of health literacy. It also explored challenges that arise when discharge planning for patients with low health literacy. It also asked what social workers can do to aid patients with limited health literacy during the discharge planning process. This basic qualitative research study used criterion sampling and was informed by the socioecological model. Data collection used 2 focus groups of 12 medical social workers comprised of 11 females and 1 male. Data analysis occurred by categorizing the data then classifying the data into themes based on the research question. Key findings include: (a) social workers have a medium to high level of health literacy; (b) MSW curricula would benefit from health literacy knowledge; and (c) challenges occur in discharge planning with people with low health literacy that include overall knowledge and attitudes of health literacy, sociodemographic variables, and lack of preventative health. Recommendations include standardizing healthcare social worker roles and providing educational opportunities in MSW curricula on health literacy. Implications for social change include improved health outcomes, empowering individuals to take personal responsibility for their healthcare which in the long run can help them overcome chronic disease and other health related anomalies. Social change may be seen with hospital health literacy screening to reduce hospital readmissions decreasing individual healthcare costs and reduce societal healthcare costs.

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I would like to take the opportunity to thank those individuals who encouraged me to pursue my dreams.

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Section 1: Foundation of the Study and Literature Review

Health literacy encompasses the capacity to read and comprehend health information, inclusive of the ability to effectively access, acquire, process, and act upon the information to make informed decisions creating personal empowerment (Findley, 2015; Lane, Huntington, Satterly, Rubinstein, Keefe, & Student Researchers, 2017). Nearly 26% of Americans have low health literacy (Mitchell, Sadikova, Jack, & Paasche-Orlow, 2012). Researchers have shown that low health literacy is associated with substandard quality of care, poor health outcomes, and harmful health behaviors (Findley, 2015; Liechty, 2011). Hospital readmissions within 30 days of discharge occur 1.67 times more often in patients with limited health literacy than patients who have reasonable health literacy at an annual cost between $106 to $238 billion (Liechty, 2011; Mitchell et al., 2012). Researchers have shown that low health literacy hampers patients' comprehension of discharge instructions including 23.6% misinterpreting medication information and 39.6% not attending arranged follow-up physician appointments (Mitchell et al., 2012).

Social workers are an integral part of the health care team to provide patients with a safe discharge plan, appropriate community resources, and aid in ameliorating the impact of negative social determinants (Rowlands, Shaw, Jaswal, Smith, & Harpham, 2017). Low health literacy is strongly associated with the social determinants of limited education, unemployment, low socioeconomic status, and limited English-speaking proficiency which can affect an individual's ability to understand and comprehend health information and ultimately make appropriate health decisions (Rowlands et al., 2017).

These determinants exhibit special challenges for social workers. However, low health literacy can be improved upon with increased skills in communication, the development of skills to counteract limited health literacy, and improvement in a patient’s social support system (Rowlands et al., 2017).

There is limited research in social work literature which address the role of social work in low health literacy (Lane et al., 2017). Medical social workers assess and screen patients in the hospital which include health literacy screenings; however, the referral process to social workers is flawed due to limited resources and ineffective screening of health literacy creating a gap where social workers can enhance their practice (Lane et al., 2017). In this study, a gap in social work practice was addressed to understand social workers’ knowledge of health literacy as it relates the issues and challenges that medical social workers’ encounter in discharge planning with patients with low health literacy.

In Section 1 of this study, the purpose of the study will be outlined with the problem statement, purpose statement, and research questions followed by a description of the research design and a conceptual framework for the study accompanied with the proposed data collection and analysis. Section 1 culminates with a review of the literature and a summary of the primary points of section one.

Problem Statement

The social work practice problem of this doctoral study is how patients’ low health literacy hampers effective discharge planning for medical social workers. Low health literacy can result in ineffective discharge planning for social workers (Lane et al., 2017). A failed discharge occurs when an individual is readmitted to the hospital within

30 days of discharge thereby increasing healthcare costs and squandering of valuable resources (McMahon, 2014). Individuals with low health literacy are not always identified thus creating a lack of documentation in their medical record regarding their literacy status contributing to poor outcomes (Wallace, Perkhounkova, Bohr, & Chung, 2016).

Medical social workers in the acute care setting are tasked with screening and assessing patients, which includes a patient's health literacy skills (Lane et al., 2017). However, the identification of low health literacy is often overlooked resulting in more hospital admissions and increased readmissions rates (Wallace et al., 2016). The current literature provides interventions to alleviate low health literacy. However, there is a gap in social work research on social worker involvement in this task suggesting an infusion of education may be needed for appropriate social work interventions (Lane et al., 2017). Health literacy is a combination of tasks including reading, writing, and communication with healthcare providers that must take a biopsychosocial approach which provides an excellent opportunity for social workers to take on an increased role in aiding patients to increase effective discharge planning and reduce hospital readmissions (Lane et al., 2017). Often, the important task of educational empowerment is relegated to the nursing staff, despite the training and skills that social workers encounter during their education, suggesting an increased role for social workers in the hospital setting is needed to alleviate health literacy issues and improve health outcomes and reduce hospital readmissions rates (Findley, 2015).

There is a plethora of research offering suggestions to alleviate issues surrounding low health literacy; however, the social work literature is absent on the role within the hospital setting for medical social workers. The suggestions offered in the literature by other healthcare professionals include providing materials to patients written at the fourth to sixth grade level, providing culturally relevant materials, and health coaching (Liechty, 2011). Additionally, using methods such as the Ask Me 3 communication device teaches patients to ask three vital questions of their physicians (Liechty, 2011). The Ask Me 3 intervention engages the patient and family by asking: “1. What is my main problem? 2. What do I need to do? 3. Why is it important for me to do this?” to help them understand more fully their care requirements (Liechty, 2011, p. 104). Social workers in the healthcare setting may have the opportunity to take a more active role in health literate practices if additional research is undertaken.

Health literacy has been a public health concern for decades with limited health literacy costing millions of dollars yearly (Lane et al., 2017). Researchers from multiple disciplines have researched health literacy and suggested interventions; however, the social work literature has limited scholarship in the health literacy arena. This study with the social work practice problem of how patient’s low health literacy hampers effective discharge planning for medical social workers will build upon current research and add to the social work literature in health literacy.

Purpose Statement and Research Question

This study aims to promote ethical practices outlined by the National Association of Social Workers (NASW) by working to improve social work practices associated with effective discharge planning. The purpose of this study was to explore medical social workers knowledge of health literacy, assess the challenges medical social workers encounter in discharge planning with patients with low health literacy, and elicit suggestions to improve discharge practices for medical social workers. The research questions posed are:

RQ1. What is the current state of knowledge regarding health literacy in medical social workers in a large metropolitan city in Texas?

> RQ1a. How do these medical social workers describe their MSW curricula in building their knowledge about health literacy?

RQ2. What challenges arise for medical social workers when discharge planning for patients with low health literacy?

> RQ2a. How are sociodemographic variables factors in the challenges medical social workers face when discharge planning with patients with low health literacy?

RQ3. What can medical social work professionals do to aid patients with limited health literacy during the discharge planning process?

Answers to these research questions may provide a better understanding of medical social workers’ knowledge of health literacy and the practice problem of how patients’ low health literacy affects effective discharge planning for medical social workers through eliciting responses from medical social workers regarding their interactions with patients in the acute care hospital setting in a large metropolitan city in Texas. I seek to understand the social work practice problem through obtaining a frame of reference from medical social workers by gaining insight from their clinical practice.

Defining key terms and concepts provides a foundation to build my research. Medical social workers are defined as social workers who work in the acute care setting to include short-term acute care hospital, long-term acute care hospital, and acute rehabilitation hospital. Health literacy has multiple definitions and contains complex constructs. Health literacy is defined as "the cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand, and use information in ways to promote and maintain good health" (World Health Organization, n.d., p. 1). Understanding key definitions provide a solid premise for basic qualitative research.

This study may contribute to advance social work professional practice by enhancing social workers' knowledge and professional development in the arena of health literacy. This study may also enhance social workers problem-solving proficiency with patients with low health literacy by spotlighting techniques used by other professionals to incorporate into their clinical practice. The NASW Code of Ethics (2017) cites that it is an ethical responsibility to the social work profession to maintain the integrity of the profession by promoting and maintaining a high standard of practice as well as increase the social work base of knowledge. This study may increase the social work base of knowledge regarding individuals with low health literacy and effective discharge planning practices. Research outcomes are anticipated to inform social work practice by identifying current levels of knowledge regarding health literacy and identify current challenges in discharge planning resulting from low health literacy.

Nature of the Doctoral Project

The research methodology used for this research study is basic qualitative research to discover participants’ experiences using focus groups (Korstjens and Moser, 2017). Focus groups provide an opportunity to allow a moderator to use a semistructured interview with open-ended questions (Linhorst, 2002). The qualitative design has been selected because the focus is exploring individuals subjective accounts and perceptions of their experiences which aligns with the purpose of this study to explore medical social workers knowledge of health literacy and assess challenges which are encountered when discharge planning with patients with low health literacy (Korstjens & Moser, 2017). The use of focus groups, ranging in size from six to 10 participants, aligns with the purpose of this study and research questions by providing an outlet designed to stimulate discussions amongst professionals to explore, identify, and elicit suggestions related to health literacy (Linhorst, 2002).

Focus groups garner multiple benefits such as providing an efficient method to interview multiple subjects resulting in a more cost-effective approach to research (Onwuegbuzie, Dickenson, Leech, & Zoran, 2009). The use of a group process provides a nonthreatening environment that may stimulate ideas not accessible using alternative research methods increasing the chances of spontaneous responses and may yield additional data (Linhorst, 2002; Onwuegbuzie, 2009). This study engaged two focus groups using criterion sampling from a social worker association in a large metropolitan city in Texas. An email was sent to the members explaining the purpose of the study to solicit for volunteers. Those individuals expressing an interest received a follow-up email to explain the study further. Those selected were provided with dates and times to choose from to empanel the focus groups.

The focus groups were audio recorded for transcription. I also took notes during the session for added detail. The analysis of transcribed data provides the most rigorous form of analysis (Onwuegbuzie et al., 2009). Amberscript was used to transcribe the data from audio to text. The transcribed data used in conjunction with focus group notes made by me creates a complete picture of the focus group interactions (Onwuegbuzie et al., 2009). The data was analyzed using a three-step process. The first step was to break-down the data into smaller sets of information to encode the data with descriptors (Onwuegbuzie et al., 2009). The second step was to place the encoded data into categories, and the third step was to develop themes for these categories (Onwuegbuzie et al., 2009).

Significance of the Study

This study addressed a gap in the social work literature regarding social worker’s knowledge of health literacy and identify how low health literacy impacts social workers’ effective discharge planning. This study solicited ideas for improved social work practices in the area of health literacy to improve hospital discharge planning practices. Health literacy has not garnered attention in social work research thereby identifying a gap in the literature (Findley, 2015). Social workers are tasked with assessing patients in the hospital setting including skills associated with health literacy, however, in the fast-paced acute care setting this task is often overlooked (Lane et al., 2017). Interventions, such as Ask Me 3 and Internet Health Coaching, designed to provide education to patients and families in health literacy, are often discouraged amongst social workers in favor of nursing professionals handling educational tasks (Findley, 2015 & Liechty, 2011). Social workers may have the opportunity to increase their presence in health literate practices and improve discharge practices by helping patients to make better decisions regarding their health (Lane et al., 2017).

This study's findings may contribute to the overall social work knowledge by understanding how low health literacy adversely affects hospital discharge planning by social workers. The potential implications for social change include increasing health literate practices to increase the effectiveness of hospital discharge planning which can result in more patients being compliant with their treatment regimens, decreased hospital admissions, and reduced societal costs associated with hospital readmissions.

Theoretical and Conceptual Framework

The theory that guided this study is the socioecological model. "The socioecological-model is a multi-tiered systems approach to understanding individual behaviors as embedded in different interacting social contexts" (Morse et al., 2014, p. 51). The primary focus of the socioecological model is that individuals are impacted by interconnected external factors associated with their physical and social environments (McCormack, Thomas, Lewis, & Rudd, 2017). The nesting within this model contains five levels: microsystem, mesosystem, exosystem, macrosystem, and chronosystem (Kilanowski, 2017; McCormack et al., 2017; Rider & Montgomery, 2001). The microsystem is the individual’s everyday life including family, friends, neighborhoods, and cites that an individual is influenced more strongly by those in his immediate surroundings (Kilanowski, 2017; McCormack et al., 2017; Rider & Montgomery, 2001). The mesosystem expands the microsystem to the individual’s family; the exosystem expands to social structures including the workplace and institutions; the macrosystem expands to social, political, and cultural value systems, and the chronosystem adds the dimension of time to the model (McCormack et al., 2017; Rider & Montgomery, 2001). Engaging multiple levels of the model provides a greater opportunity for the socioecological model to shape health behaviors and foster change needed to increase health literacy (McCormack et al., 2017).

The socioecological model, when considered for health literacy as a barrier to discharge planning, expands the focus of health literacy past the individual to examine health information delivery, educational materials provided, and communication skills between the individual and their healthcare professional (McCormack et al., 2017). Behavioral change can be more effectively realized when multiple levels of interventions engaging an individual’s personal, social, and environmental determinants are used (Sahranavard-Gargari, Hosseini, & Ahmadi, 2018). Individuals and families need to be aware of their personal health history and be able to communicate this information effectively while understanding feedback provided by healthcare personnel (Rider & Montgomery, 2001). Systems ecological theory may enhance these needs by engaging the microsystem, mesosystem, and exosystem to integrate individual, family and institutional systems (Chen et al., 2018; Rider & Montgomery, 2001).

Interventions within the socioecological model include using plain and simple language, clear communications with easily identifiable principles, visual displays, educational sessions on health, and providing decision aids for the patients and families (McCormack et al., 2017). Additionally, using the teach-back methodology which requires an individual to state in their own words their discharge instructions, support groups, patient-centered communication, and engaging social networks can aid in interpersonal levels of influence (McCormack et al., 2017). The socioecological model relates to this research because medical social workers must use the biopsychosocial approach to engage patients and to understand the whole patient to provide effective interventions.

Values and Ethics

The National Association of Social Workers Code of Ethics (2017) is designed to promote professional ethics in the social work profession. The core values emphasized in this study are service, dignity and worth of the individual, and the importance of human relationships (National Association of Social Workers, 2017). This study may aid in guiding social workers in ethical practices. The principle of service speaks directly to helping people in need by addressing social problems (National Association of Social Workers, 2017). The principle of dignity and worth of the individual speaks to the promotion of self-determination to increase an individual’s capacity to both address and change their needs (National Association of Social Workers, 2017). The principle of the importance of human relationships speaks directly to the engagement of individuals in the change process (National Association of Social Workers 2017). Medical social workers may aid in addressing the social problem of health literacy by engaging patients, families, and other healthcare professionals to enact positive change.

Review of the Professional and Academic Literature

A thorough review of the current literature was performed with a focus on literature published within the last five years. The literature reviewed identified the relevance of the social work practice problem and substantiated the need for this study. I used the Walden Library to search for articles using the following keywords: (a) health literacy, (b) social work, (c) social workers, (d) social workers and health literacy, (e) hospital readmissions and health literacy, and (f) discharge planning (Appendix C). The databases selected within the Walden Library was set to “all” so that there could be a comprehensive search. The literature review included only peer-reviewed articles to ensure the use of scholarly research. The purpose of this study was to explore medical social workers knowledge of health literacy, assess the challenges medical social workers encounter in discharge planning with patient’s with low health literacy, and to elicit suggestions to improve discharge practices for medical social workers and the selection of databases illuminated the gap in the social work literature regarding social work and health literacy.

There are multiple studies that address low health literacy (Findley, 2015; Lane et al., 2017; Rowlands et al., 2015; Wallace et al., 2016). Unfortunately, there is limited research identified in the literature regarding the role of social work professionals in this field. To compensate for the limited research findings, this basic qualitative research study is using studies encompassing other healthcare professionals with attributes of low health literacy which show relevance to my study. For example, Wallace et al. (2016) found that it is necessary to identify individuals at risk for low health literacy upon admission to improve growing hospital readmissions rates. Nearly 36% of adults displayed health literacy knowledge that was either basic or below basic levels when asked to perform basic health-related tasks such as reading a pamphlet (Champlin, Mackert, Glowacki, & Donovan, 2016).

Other researchers found that increased acuity of care in the acute care hospital setting decreases health literacy levels increasing the likelihood of misunderstandings with discharge instructions (Coleman et al., 2013). Findley (2015) discussed that empowering patients through education is a key task of social workers; however, this task is often overlooked and relegated to others on the healthcare team. Additionally, Findley (2015) suggests that there are effective social work interventions to engage patients and communities based on their education in theory-based practice. However, multiple other studies do not address social work practice as it relates to health literacy, an oversight which was addressed with this study.

Defining Health Literacy

The most widely accepted definition of health literacy is that which is published by the World Health Organization. This definition is cited as “the cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand, and use information in ways to promote and maintain good health” (World Health Organization, n.d., p. 1). Rikard, Thompson, McKinney and Beauchamp (2016) found that expanding the definition to include the National Academy of Medicine’s health literacy definition was more appropriate. This definition includes the capacity of an individual to not only understand the information but their capacity to obtain and process the information (Rickard et al., 2016).

Lane et al. (2017) further expanded the definition by using the U.S. Department of Health and Human Services definition which includes accessibility of healthcare and the ability to read the information to include numbers. Rowlands et al. (2017) found that health literacy encompasses the ability to access, understand, and act upon health information to make appropriate health decisions, however, there are multiple aspects of health literacy which must be realized to facilitate patients in achieving adequate health literacy. The lack of a primary definition of health literacy is problematic in measuring health literacy as well as conducting research in this area (Jordan, Buchbinder, & Osborne, 2010). The varying definitions of health literacy can cause confusion when conducting research suggesting an encompassing definition would provide a sounder bedrock from which to draw for social research to include research in the social work literature.

Health literacy contains multiple facets which must be explored to fully understand the concept of low health literacy. Health literacy encompasses psychological, social, and political activities (Chinn, 2011). There are three levels of literacy which must be examined when considering health literacy: basic or functional literacy, communication and iterative literacy, and critical literacy (Chinn, 2011). Basic or functional literacy encompasses reading and writing skills including knowledge of their health conditions and proposed outcomes (Chinn, 2011). Communication includes social skills necessary to receive information and garner meaning from the information and apply the information accordingly (Chinn, 2011). It is essential to understand the different facets of health literacy to dissect this important issue and engage social work professionals in identifying challenges with patients discharge planning related to low health literacy.

Organizational Involvement in Health Literacy

The identification of health literacy issues is absent in many facilities. Initiatives to identify individuals with low health literacy require additional staff time and training as well as a commitment to change on the institutional level which requires funding that facilities do not have (Liechty, 2011). The psychosocial assessment including the identification of health literacy issues is a primary role of social workers in the healthcare setting; however, this is not always tasked to social workers, and it is not possible for a social worker to visit each patient in the hospital setting (Findley, 2015). This identifies a gap in the literature to provide health literacy assessments for hospitalized patients. Medical social workers may have the opportunity to increase their professional visibility by adapting processes to aid in the identification of health literacy issues to aid patients in making informed health decisions (Lane et al., 2017).

Assessing hospitalized patient’s health literacy is essential in providing care that is appropriate and allocating necessary resources to ensure patient understanding; however, health professionals can lack the awareness and perception required to interpret when a patient has low health literacy (Louis, Arora, Matthiesen, Meltzer, & Press, 2017; Naccarella, Osborne, & Brooks, 2016). Hospitalized patients have admission assessments completed by the nursing staff and adding health literacy screenings may be more time consuming; however, introducing a brief verbal health literacy screening tool can aid in triaging those with limited health literacy (Louis et al., 2017). Hospitals can take the initiative to perform health literacy screens. Louis et al. compared three health literacy screening tools among 261 participants and found that while each of the three tools measured different aspects of health literacy, the instrument that is administered verbally, Brief Health Literacy Screen (BHLS), was easily administered and identified low health literacy in 35% more cases. The results suggest that incorporating the BHLS into the initial patient assessment can identify those with low health for additional educational interventions which can be guided by medical social workers.

Discharge Instructions

The complexity of hospital discharge instructions is often not understood. Increased patient acuity in conjunction with pressure to reduce hospital stays has increased patient expectations in self-care post discharge with detrimental effects to include readmissions and inability to follow treatment and medication regimens resulting in substantially increased costs (Coleman et al., 2013). Patients who are readmitted to the hospital are often labeled as non-compliant with their treatment which can sometimes be attributed to low health literacy when discharged with a lack of understanding of what actions they need to perform (Coleman et al., 2013). There has been limited social work research related to health literacy despite their experience working with marginalized populations (Lane et al., 2017).

Wallace et al. (2016) assessed health literacy using the Newest Vital Sign health literacy testing tool in a study comprising 70 individuals ranging in age from 33 to 91 years accompanied by the Patient-Perceived Readiness for Hospital Discharge (Pt-RHDS) and the Nurse-Perceived Readiness for Hospital Discharge (RN-RHDS) to compare health literacy and individual versus nursing staff readiness for discharge. Wallace et al. (2016) found that there is a discrepancy between perceived and actual health literacy in relation to discharge readiness. Additionally, hospitalized patients are often under stress and feign understanding of their condition to leave the hospital resulting in poor health outcomes (Wallace et al., 2016). Multiple suggestions are made to ensure understanding of medical instructions at discharge such as Ask me 3 and increasing communication; however, there is a lack of identification in the social work literature on medical social workers' role in increasing health literacy skills (Lane et al., 2017; Liechty, 2011; Wallace et al., 2016). Increasing scholarship which can recognize the role of medical social workers in increasing the understanding of hospital discharge instructions may aid in professional development.

Medical social workers in the acute care setting engage in multiple tasks with most hospital settings using the social work professional for discharge planning. Social workers are tasked with assessing individuals which includes the identification of those individuals with low health literacy suggesting that increased participation in aiding patients in taking a more active in their healthcare is essential (Lane et al., 2017). Lane et al. cited that social workers often relied on other health professionals to ensure patients' understanding of their discharge instructions. Patients who discharge from the hospital without understanding the multiple facets of their instructions are at increased risk of readmission to the hospital making it crucial that health literacy is assessed.

Discharge instructions include information about an individual's diagnosis, disease process, medication, and follow up appointments (Pilcher & Flanders, 2014). It is imperative that an individual understand the information provided to follow their treatment regimen (Pilcher & Flanders, 2014). Filling prescriptions when someone does not understand what medication they are taking or how to read the instructions is futile and can result in noncompliance to medical treatment (Pilcher & Flanders, 2014). Inadequate explanation of discharge instructions leads to misunderstandings and according to Pitcher and Flanders (2014),

> When people do not understand information or the rationale for health care instructions, they are more likely to miss appointments, not follow through with having medical tests and procedures, make more self-care errors, and have difficulty managing their own care. (p. 151)

Failure to educate effectively can result in negative outcomes. Involvement of medical social workers in engaging patients and families to understand discharge instructions could increase a patient's health literacy and decrease negative outcomes.

Sociodemographic Determinants

There are multiple psychosocial barriers identified in the literature related to health literacy skills. The effects of low health literacy increase the chances of health disparities based on socioeconomic status, marginalized populations by race or gender, and limited educational attainment (Rowlands et al., 2017; Wallace, 2014). Christy et al.

(2017) performed a cross-sectional study of 416 individuals aged 50 to 75 years receiving care at both a federally qualified health center (FQHC) and a health department using multiple measures to gain an understanding of the prevalence of being at risk for low health literacy. Their analysis showed that 36% of this sample group was at risk for low health literacy (Christy et al., 2017). Additionally, the analysis revealed specific psychosocial and sociodemographic variables put them at risk for low health literacy (Christy et al., 2017). Demographic and psychosocial factors contributing to low health literacy are racial/ethnic differences, being male, inability to work, lack of social support, language barriers, and religious beliefs (Christy et al., 2017). One unintended finding from the Christy et al. study showed beliefs among certain religious groups put individuals at an increased risk for low health literacy among those who had a reliance upon religious beliefs to make medical decisions. Christy et al. recommended further study into low health literacy among religious groups as well as further study with pre-test and post-test interventions to see if an intervention increased health literacy.

Socioeconomic status. Low socioeconomic status is associated with increased health disparity (Rikard et al., 2016). Rickard et al. examined data from 14,952 respondents greater than 18 years old from the 2003 National Assessment of Adult Literacy (NAAL) with specific focus on age, sex, ethnic status, health literacy, social class, and perceived social resources. Rickard et al. performed a multivariate analysis on weighted descriptive statistics from this multi-stratified cluster sampling to discover that lower income households score lower on measures of health literacy that those with a higher income. Rickard et al. found that increasing median income by $1000 increased health literacy assessment scores by one-quarter percentage point. A significant finding from the Rickard et al. study is that social resources, such as marriage, civic engagement, and social interaction, improved health literacy assessment scores. Rikard et al. noted that further research on interventions concerning social resources and personal empowerment would take strides in improving the health literacy body of knowledge.

Similarly, Knighton, Brunisholz, and Savitz (2017) found that there is a correlation between low socioeconomic status and low health literacy. Knighton et al. performed a study using United States Census Bureau block groups in Utah in conjunction with NAAL data resulting in 17,466 respondents to determine that individuals living in at risk communities experiencing a lower socioeconomic status have lower health literacy scores. However, the correlation in this study was small due to the limitation of one state's census block groups. One unintended finding is that individuals with a lower socioeconomic status living in at risk communities engage in riskier health decisions, use emergency rooms more than higher socioeconomic groups, and experience decreased health outcomes (Knighton et al., 2017).

Levy and Janke (2016) studied access to care and health literacy using data analyzed from the longitudinal Health and Retirement Study (HRI) as well as a supplemental survey created to measure access to care created by the study authors. Levy and Janke's final data set contained 7,142 participants measuring four access to care variables: affordability, difficulty finding a provider, information availability when sick, and other. The study results showed that 24.20% of the sample had low health literacy and within this category, 10.49% were uninsured and 31.86% delayed care with cost being a factor in 12.77% of care delays (Levy & Janke, 2016). Accessing care for individuals with low socioeconomic status due to the inability to afford insurance coverage increases demands on emergency rooms (Levy & Janke, 2016). Levy and Janke called for further research in health literacy to expand the lens of inquiry about access to care and health literacy to include additional factors such as health outcomes, social support, and available health care resources.

Individuals living in poverty are at increased risk of mortality, experience a more rapid decline in their health at an earlier age, and experience higher levels of disability than those who are not living in poverty (Wallace, 2014). Low socioeconomic communities may have increased environmental toxins accelerating chronic disease onset and subsequent exacerbations of their conditions (Fink-Samnick, 2018). Individuals who are socioeconomically disadvantaged experience lower levels of health literacy and are in danger for suboptimal health outcomes.

Education. Lower educational attainment is associated with lower levels of health literacy (Cutilli, Simko, Colbert, & Bennett, 2018). Limited health literacy is associated with a high school education or less than a high school education (Bakker, Koffel, & Theis-Mahon, 2017; Cutilli et al., 2018). Individuals with limited educational attainment are less likely to have knowledge regarding preventative health measures which could improve their overall health (Feinberg, Tighe, Greenberg, & Mavreles, 2018).

Rowlands et al. (2017) performed a multiphase qualitative study with 27 participants who had recently attended either a community health literacy course or an adult basic literacy course using semistructured interviews and focus groups to develop the journey to health model. The model was used for the third stage of their study using 7 participants in a focus group which concluded that low health literacy is a modifiable social determinant of health. Wallace (2014) cited that individuals who have attained a higher level of education have increased cognitive processing ability and are able to assimilate medical information easier; however, their knowledge of medical terms may be limited, and they may not appropriately link the effectiveness of behavioral choices and health.

Racial, ethnic, and cultural determinants. Racial and ethnic minorities have decreased levels of health literacy and experience higher rates of health disparity in the United States increasing their risk factors for morbidity and mortality rates (Nguyen & Reardon, 2013; Rikard et al., 2016). Health literacy among older immigrants has been correlated with increased risk of chronic conditions such as diabetes and heart failure resulting in poorer health outcomes (Gracie, Moon, & Basham, 2012). Immigrants face the increased challenges of language, lower income resulting in higher poverty levels, and inadequate health insurance (Gracie et al., 2012).

Health literacy testing measures are primarily developed and utilized with English speaking individuals (Nair, Satish, Sreedharan, & Ibrahim, 2016). Cultural differences, such as those seen in middle eastern cultures, place a high value on family versus personal autonomy in their largely patriarchal society (Nair et al., 2016). Nair et al. sought to create and test the Eastern-Middle Easter Adult Health Literacy (EMAHL13) scale using a multi-phase study with an expert panel, focus group of 10 individual's followed by a pilot testing study at a multi-cultural center. Nair et al. concluded that this health literacy measure would prove useful in this patriarchal society allowing for the assessment of low health literacy providing the opportunity to allow for equitable healthcare access. Newly developed health literacy test measures that are culturally competent can allow social workers in the healthcare setting to acquire additional clinical skills and improve their practice.

Low health literacy among Latino immigrants can result in a reduced quality of care (Calvo, 2016). Calvo randomly selected 4,013 from stratified listings from the Pew Hispanic Center and Robert Wood Johnson Foundation Hispanic Healthcare system to interview to gain an understanding of health literacy as it relates to quality of care as an indicator in this population. In this population, 51.7% did not have a high school diploma, 7.7% had a college education, 56.3% reported inadequate health literacy, and 63% reported trouble understanding the written materials provided (Calvo, 2016). The researchers found that health literacy resulted in better prediction of health outcome that either income or education which was consistent with other literature (Calvo, 2016).

Limited English Proficiency. Discharge instructions are primarily delivered in English and those with limited proficiency in the English language have difficulty comprehending instructions, discharge with less knowledge of their disease process, and have a high level of non-compliance with their treatment regimen (Findley, 2015). “Limited English proficiency refers to anyone age 5 or older who reported speaking English less than ‘very well’” (Batalova & Zong, 2017, p. 1). According to Batalova and Zong, approximately 60% of households report speaking a second language in the home.

The population subset reporting limited English proficiency is 40% (Bataloya & Zong, 2017). Limited English proficiency can lead to the patient not understanding their diagnosis, treatment plan, and treatment regimen resulting in substandard care and increased health disparities (Green, Rosu, Kenison, & Nze, 2018). Limited English proficiency can also result in unnecessary hospital readmissions for chronic health conditions as a result of misunderstandings in disease management with medications and symptomology associated with when one should seek emergency care in a hospital (Betancourt & Tan-McGrory, 2014).

The link between health literacy and psychosocial factors facilitates the identification of those with limited health literacy to create an opportunity for interventions that focus on the individual's specific needs (Christy et al., 2017). Medical social workers' education and training in the biopsychosocial approach to treatment provides them with unique tools to aid in overcoming psychosocial barriers; however, there is little research in the social work literature as it relates to the medical social worker role in psychosocial barriers as they relate to health literacy.

Social Workers' Role in Discharge Planning

Medicare defines discharge planning as "the process used to decide what a patient needs for a smooth transition from one level to another. This is done by a social worker or other health care professional" (Centers for Medicare and Medicaid Services, 2006). Hospitals vary in the assignment of the discharge planning role to either the social worker, nurse case manager, or a collaborative approach using a combination of both (Eaton, 2018). Medical social workers are part of the interdisciplinary healthcare team;

however, recent decades have noted an encroachment on social work roles and is causing the scope of the social worker role to be questioned (Sims-Gould, Byrne, Hicks, Franke & Stolee, 2015).

Kadushin and Kulys (1993) performed a study of 36 hospitals with 80 social workers to gain an understanding of time spent on their activities of assessment, coordination, documentation, counseling, and linkage to services. Kadushin and Kulys cited that social workers were historically ambivalent about discharge planning being part of their professional repertoire and felt that the task of discharge planning was primarily for concrete services. Social workers complete a psychosocial assessment, meet with patients and families to encourage engagement, and coordinate a patient's psychosocial needs with the medical team (Kadushin & Kulys, 1993).

Holliman, Dziegielewski, and Teare (2003) delineated the similarities and differences between nurse case manager discharge planning and social work discharge planning. Holliman et al. performed a qualitative study of 178 respondents from 58 hospitals that were members of the Alabama Hospital Association using two primary instruments: The Discharge Planning Activity Inventory (DPAI) and Social Work Activity Inventory (SWAI). This study noted variances in income, work setting differences and specialization differences (Holliman et al., 2003). The Holliman et al. study concluded that while social workers perform discharge planning, it is incumbent upon the social work professional to use their training and practice expertise to educate other healthcare professionals in increasing their awareness of the role of the social worker and to engage in policy and practice research to prove the effectiveness of social work practice in discharge planning (Holliman et al., 2003).

Identifying an individual's psychosocial needs with a psychosocial assessment is a primary task of social work in the hospital setting (Lane et al., 2017). Health literacy is a skill that is learned, and social workers can identify individuals with limited health literacy when performing their assessment. The identification of health literacy issues provides an opportunity for social workers to engage and educate patients and families to increase these skills (Christy et al., 2017). Social workers are natural educators; however, many consider patient education as a clinical task and defer this task to other health professionals (Findley, 2015). Liechty (2011) stated that a social workers education makes them uniquely well suited to the promotion of health literacy and increasing patient competency. In addition to educating patients, social workers engage patients by empowering them to advocate on their own behalf with health care professionals (Bronstein, Gould, Berkowitz, James, & Marks, 2015). Social workers could initiate health literacy screenings, create appropriate interventions, and engage patients and families in their healthcare decisions. However, research is limited in the roles and responsibilities of medical social workers on these tasks.

MSW Education

Masters prepared social workers learn a myriad of skills in the classroom and during their field education. Healthcare relies upon interdisciplinary teams to coordinate care within the hospital environment, so it is imperative that the interdisciplinary and interprofessional team approach be introduced during the social workers education

(Bronstein et al., 2015). An infusion of education on the concepts of health literacy, available resources, and measurement tools into an educational institutions health social work curriculum would broaden the scope of their education and allow for potential mastery of some of the tools used (Liechty, 2011). Ensuring educational opportunities with health literacy in the social work curriculum can aid in the professional development in the workplace

Social work education provides for specializations to garner knowledge about fields of practice; however, postgraduate access to advancing research with online access to evidence-based practice research is absent in many institutions (Wheeler & Goodman, 2007). BSW and MSW programs, postgraduate clinical training programs, professional certifications, and continuing education must continue to strive for a means to ensure social work professionals are informed of evidence-based practice and emerging research in social work (Wheeler & Goodman, 2007). Additionally, it is incumbent upon medical social workers to actively engage in the development of their own knowledge (Wheeler & Goodman, 2007). Prey, Ardal, Chevalier, Sulman, and Savage (2013) call for a cultural shift within the social work profession to increase research engagement among hospital social workers.

Educating other health providers is paramount to the beneficial use of social workers in various healthcare settings. Rehner, Brazeal, and Doty (2017) provided a case study based The Gulf Region Health Outreach program receiving medical settle funds following the Deepwater Horizon disaster in 2010. These funds allowed for the creation of an integrative care model to implement mental health services into a primary care setting where the core functioning was to consider psychosocial impediments in behavioral healthcare and how these interplay in client well-being (Rehner et al., 2017). Educating medical staff members to immediately refer to the social worker after a medical visit was key to providing services and relationship building amongst medical providers (Rehner et al., 2017).

The healthcare industry continues to evolve with the advent of the Affordable Care Act (ACA) providing for a recent surge in research related to Integrated Health Care (IHC) (Held, Mallory, & Cummings, 2017; Jones & Phillips, 2016; Mattison, Weaver, Zebrack, Fischer, & Dubin, 2017). IHC is showing favorable signs of fusing fragmented delivery of services to a more patient-centered approach across disciplines and is emerging as the treatment of choice in many service organizations (Held et al., 2017; Mattison et al., 2017). IHC focuses on the intersecting relationship between the domains of behavioral, mental, and physical health (Mattison et al., 2017). The change in healthcare delivery spotlights to need to deliver social work education that expands knowledge and skills and increases learning experiences requiring social workers to learn supplemental knowledge regarding the physical aspects of disease (Held et al., 2017; Mattison et al., 2017). Models of education in graduate programs must expand themselves with the necessary tools to prepare social work students for practice within integrated health care settings to become effective members of IHC teams (Mattison et al., 2017).

Medical social workers in the acute care setting are assigned many complex tasks. Discharge planning is one role that can be ineffective in the presence of individuals with limited health literacy. The literature provides multiple explanations for low health literacy. However, social worker involvement in health literacy is an identified gap in the literature. This study explored medical social workers knowledge of health literacy and assessed the challenges medical social workers encounter in discharge planning with patients with low health literacy to gain an understanding of how patients low health literacy hampers effective discharge planning for medical social workers. Additionally, this study solicited suggestions from medical social workers to improve discharge practices for medical social workers.

Summary

This basic qualitative research project identified three research questions related to social workers, discharge planning, and health literacy. In discharge planning, the roles and responsibilities of medical social workers need to be clearly understood as it relates to patients with limited health literacy. Medical social workers often take a diminished role in patient education leading to a blurred expectation of their role in health literacy (Findley, 2015). Multiple researchers suggest solutions to limited health literacy, however, there is a gap in the social work literature regarding the role that social workers can undertake with patients with low health literacy (Christy et al., 2017; Findley et al., 2015; Lane et al., 2017). This study will fill this gap in the research.

Section 2: Research Design and Data Collection

Low health literacy is a multifaceted problem resulting in increased hospital admissions, hospital readmissions, and ineffective use of available resources. The social work practice problem of this study is how patient's low health literacy hampers effective discharge planning for medical social workers. This section contains three subtopics: research design, methodology, and data analysis. The research design section discusses the design of basic qualitative research, provides a restatement of the practice problem, and discusses how the purpose of the study aligns with the methodology selected. The methodology section discusses basic qualitative research by using focus groups including the anticipated participants and the recruitment strategy, and how this aligns with the identified practice problem. The data analysis procedures will be identified, and ethical procedures will be discussed.

Research Design

The social work practice problem addressed through this research was to gain an understanding of how patients low health literacy hampers effective discharge planning for medical social workers. The research questions posed in this basic qualitative research study are:

RQ1. What is the current state of knowledge regarding health literacy in medical social workers in a large metropolitan city in Texas?

RQ1a. How do these medical social workers describe their MSW curricula in building their knowledge about health literacy?

RQ2. What challenges arise for medical social workers when discharge planning for patients with low health literacy?

RQ2a. How are sociodemographic variables factors in the challenges medical social workers face when discharge planning with patients with low health literacy?

RQ3. What can medical social work professionals do to aid patients with limited health literacy during the discharge planning process?

In this basic qualitative research project, I wanted to gain an understanding of the challenges and issues that make up ineffective discharge planning for medical social workers with patients of low health literacy and social workers identification and response to individuals with low health literacy.

The nature of this study was to focus on how medical social workers encounter challenges with discharge planning with patients with limited health literacy by providing background information through a literature review of limited health literacy and insight into how this effects medical social worker discharge planning. The overarching approach is to improve the knowledge of medical social workers regarding their roles and responsibilities during the discharge planning process as it relates to health literacy using focus groups using semi-structured interviews. This basic qualitative research study may enhance the knowledge that medical social workers have of health literacy and how it affects discharge planning. This basic qualitative research study may provide a better understanding of the clinical social work issue and to foster change in the acute care hospital discharge planning process relating to limited health literacy.

The purpose of this basic qualitative research study was to explore health literacy and discharge planning in social work practice. This aligns with the proposed qualitative focus group methodology by providing a group environment that fosters the exchange of ideas among professionals.

Health literacy has multiple definitions. For this study, health literacy is defined as "the cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand, and use information in ways to promote and maintain good health" (World Health Organization, n.d., p. 1). The medical social worker is defined as a social worker in an acute care setting. Clarifying terms and definitions provides the consumer of the research a greater understanding of the concepts being studied.

Methodology

Qualitative research is used when a researcher wants to gain an understanding of individuals experiences and perceptions accompanied by the meanings of attachment to the experiences and perceptions (Moser & Korstjens, 2017). This research study used the qualitative study design with a domain of life experience, the area of inquiry is surrounding the individual's experiential world, and the focus being individuals making sense of their world by providing insightful renderings of subjective experiences (Korstjens & Moser, 2017). The selection of the design fits with this study by recruiting medical social workers engaged in discharge planning and the shared experience of patients with low health literacy (Moser & Korstjens, 2018)

The use of focus groups in social science research creates an environment conducive to stimulate an exchange of ideas on a specific topic (Linhorst, 2002; Moser & Korstjens, 2018). Focus groups as a data collection method allows for the examination of varying experiences and perceptions of participants (Moser & Korstjens, 2018). The use of a group process provides a nonthreatening environment that may stimulate ideas not accessible using alternative research methods increasing the chances of spontaneous responses and yield additional data (Linhorst, 2002; Onwuegbuzie et al., 2009). Basic qualitative research using focus groups provides a methodology for practice improvement by gathering evidence through critical reflection to implement changes (Koshy, Koshy, & Waterman, 2011). The focus group provides an economical approach to engage multiple participants to gather data in a cohesive environment fostering feelings of safety where there is a likelihood of candid responses that may otherwise be missed (Onwuegbuzie et al., 2009). The focus group aligns well with this study as it provides for the exploration and assessment of challenges and provides an environment for eliciting ideas from social work professionals

The data was collected through the facilitation of two focus groups comprised of 6 participants each. The use of two focus groups provided the opportunity for comparative analysis (Margioni & McKerchar, 2013). The participants filled out a demographic questionnaire (Appendix A). The focus group then commenced with a semi-structured questionnaire (Appendix B) to allow for a higher level of group interaction. The questions focused on the research topic using an interview guide to ensure each focus group was asked the same questions. The anticipated length of time of the focus group was 90 to 120 minutes. The focus group was audio recorded using an audio tape recorder accompanied by note taking of key points. The group was encouraged to provide additional information regarding their experiences in ineffective discharge planning to add depth to the topic and enhance the results to elicit ideas for positive social change. The participants confidentiality was maintained by assigning a number to their demographic information so that only the researcher is aware of their identity. The facilitator minimized harm to the participants by keeping the group focused and not allowing an individual to hijack the focus group while ensuring to engage introverts (Moser & Korstjens, 2018; Taylor, 2016).

The sampling method that was employed is criterion sampling from a medical social work association in a large metropolitan city in Texas as the participants must meet the predefined criteria of practicing medical social work (Moser & Korstjens, 2018). The sampling was also purposive, however, the more prominent criteria for inclusion is the experience of the participant with patients with low health literacy and the challenges associated with discharge planning (Moser & Korstjens, 2018). The participants of the study were medical social workers and this association provided an expansive membership from which to draw a sample of participants. The distribution list of the association was sent an email detailing the project and asking for a reply email if they are interested in participating. A follow-up e-mail was sent to participants to provide further information. From this sample, 20 participants were selected and placed into two focus groups comprising 10 individuals each. The focus of the research is was ineffective discharge planning among patients with low health literacy making this association an excellent choice from which to sample as the individuals are all medical social workers. Focus groups typically consist of six to ten participants using the group process to probe and enhance conversations to glean added information (Linhorst, 2002). It was anticipated that a ten-member focus group would be used to provide the maximum number of participants to stimulate discussion and add depth to the information gathering regarding challenges associated with discharge planning with patients with limited health literacy. However, due to time constraints of potential participants the focus groups contained six members.

The instrumentation that was used is a demographic worksheet accompanied by a list of semi-structured interview questions. The use of semistructured questions allowed for participants to interface more freely and engage in unscripted conversation to elicit more spontaneous responses adding depth to the research. The guidelines used for the development of the questions was to brainstorm the potential topics, then to sequence the questions from general to specific, concluding with ensuring the questions were open-ended (Moser & Korstjens, 2018). The questions were developed with the purpose of this study at the forefront of thought. The review of the literature revealed limited social work scholarship in the arena of health literacy resulting in the need to garner information to explore the participants knowledge of health literacy, assess the challenges medical social workers encounter in discharge planning, and solicit suggestions to improve practice.

Data Analysis

The audio recorded data collected was transcribed word for word to search for patterns in the data. The analysis of the data starts with the coding process which must be systematic to increase the trustworthiness of the research (Mangioni & McKerchar, 2013). The coding of the data involves organizing the data into categories and themes thereby identifying concepts while searching for similar and distinctive features within the data (Mangioni & McKerchar, 2013). Amberscript was used to transcribe the data from audio recording to text.

The data was analyzed using a three-step process. The first step was to break down the data into smaller sets of information to encode the data (Onwuegbuzie et al., 2009). The second step was to place the encoded data into categories (Onwuegbuzie et al., 2009). The third step was to develop themes for the categories (Onwuegbuzie et al., 2009). This process, constant analysis, allows me to realize both intergroup and intragroup saturation (Onwuegbuzie et al., 2009) Constant analysis is also a technique to increase the internal validity of the research (Magioni & McKerchar, 2013).

Quality criteria measurement in qualitative research is identified by trustworthiness which directs the question as to whether the findings of the research can be trusted (Korstjens & Moser, 2018). Trustworthiness is measured through credibility, transferability, dependability, and confirmability (Korstjens & Moser, 2018; Tracy, 2010). The strategy that was used for credibility in this study is member checking which entails “feeding back data, analytical categories, interpretations, and conclusions to those from whom the data were originally collected” (Korstjens & Moser, 2018, p. 3). This technique strengthens the data by providing the opportunity for participants to view the data from a different lens than the researcher (Korstjens & Moser, 2018). Additionally, the results will reflect depth of description and tangible details (Tracy, 2010). The strategy that will be used for transferability is to use thick description which entails adding context to the experiences to increasing meaningfulness to the reader (Korstjens & Moser, 2018). The strategy that was used for dependability and confirmability was to ensure an audit trail which involves transparency and providing a description of the steps taken during the research from the start of the project to the reporting of the findings (Korstjens & Moser, 2018). Using the aforementioned strategies during this basic qualitative research study will provide for trustworthiness.

Ethical Procedures

Social science research must follow ethical procedures (Clark, 2009). Informed consent is the bedrock of sound ethical research guidelines (Clark, 2009). Each participant received information regarding the research in the initial email to solicit potential participants. Those individuals who responded to the email received a follow-up email to further detail the research. Individuals interested in participating were logged then notified of participation. Once notified, the participants were provided with a consent form for review and signature. The consent form provided a brief description of the study, the purpose of the study, procedures that were completed, and provided sample questions. Additionally, the consent form details the voluntary nature of the study, the risks and benefits, payments offered, privacy guidelines, and Walden University’s approval to proceed with research with study number 05-03-19-0674397. The last section details obtaining consent and asks the participant if they have a firm enough understanding to provide consent to participate in the study. This procedure protects the individual to ensure they understand they can stop participation at any time.

This study provided participants with confidentiality as outlined in the privacy section of the consent form. Any identifying or personal information shall not be shared. The data will be stored on my personal password protected computer for five years as required by Walden University. A backup of the data will be stored on a password protected external hard drive for five years as required by Walden University. The data will be destroyed by reformatting the computer hard drive and external hard drive to the manufacturer's original computer formatting. Additionally, the demographic data sheets and transcripts from the focus groups will be shredded and disposed of. I am the only individual who will have access to the data as I am a single researcher.

Summary

This basic qualitative research study using focus groups explored medical social workers knowledge of health literacy and assess the challenges that medical social workers face when discharge planning with persons of limited health literacy. Research is designed to answer questions with qualitative research increasing knowledge in a specific context (Joshy et al., 2011). This basic qualitative research study will encompass two focus groups created from members of a medical social workers association through purposive sampling. Qualitative research using focus groups provides a non-threatening environment to allow like-minded professionals to gain a better understanding of the focus group topic and hopefully improve clinical social work practices (Linhorst, 2002).

The collected data was analyzed using the three-step process with constant analysis to increase trustworthiness. Credibility, transferability, dependability, and confirmability will be addressed using member check, contextual detail, and thick descriptions (Korstjens & Moser, 2018). Upon completion of data collection and analysis, the findings will be disseminated in the next section.

Section 3: Presentation of the Findings

The purpose of this study was to explore medical social workers knowledge of health literacy, assess the challenges medical social workers encounter in discharge planning with patients with low health literacy, and elicit suggestions to improve discharge practices for medical social workers. The research questions posed were:

RQ1. What is the current state of knowledge regarding health literacy in medical social workers in a large metropolitan city in Texas?

> RQ1a. How do these medical social workers describe their MSW curricula in building their knowledge about health literacy?

RQ2. What challenges arise for medical social workers when discharge planning for patients with low health literacy?

> RQ2a. How are sociodemographic variables factors in the challenges medical social workers face when discharge planning with patients with low health literacy?

RQ3. What can medical social work professionals do to aid patients with limited health literacy during the discharge planning process?

The data was collected through the facilitation of two focus groups comprised of six participants each. Participants were solicited through a medical social work associations e-mail distribution list. Those participants who replied to the solicitation were contacted via e-mail to further explain the purpose of the study. Participants who remained interested in participating were provided with a selection of two focus groups to participate in. The participants were provided with the informed consent form to complete. A demographic questionnaire was filled out by each participant and the focus group was started. Each focus group was 120 minutes in length providing ample time to complete the semi-structured questions and allowing each participant to elaborate on the topic and interact with other participants to add depth to the discussion.

This section contains two subtopics: data analysis techniques and presentation of findings. Data analysis techniques describes the time frame for data collection which encompasses recruitment and response rates. Additionally, the data analysis procedures will be discussed accompanied by the validation procedures and an explanation of the limitations of the study. The findings will report the descriptive statistics that characterize the sample, report an analysis of the findings organized by research questions including how these findings answer the research question culminating with a discussion of unexpected findings.

Data Analysis Techniques

After receiving Walden University's Institutional Review Board (IRB) approval, study number 05-03-19-0674397, data collection commenced with a solicitation e-mail to members of a medical social work association in a large metropolitan city in Texas. The initial response from this first e-mail solicitation was 15 individuals. A second e-mail solicitation was sent which garnered seven additional individuals. These 22 individuals were contacted and provided additional information regarding the study. The individuals were provided with a potential date and two time slots for participation. The focus groups were scheduled resulting in two groups of 10 individuals each. Schedule conflicts and no-shows provided each focus group with six participants on the scheduled day. This phase took 33 days to complete. The length of the first focus group was 1:45 and the second focus group was 2:10. Each participant was given a pseudonym to capture their voice and protect their confidentiality.

The data was encoded from audio recording to text using Amberscript. The data was then manually put into categories by research question resulting in three subsets of data. Data set one related to research question one speaking to the knowledge of health literacy of medical social workers in a large metropolitan city in Texas. A sub-question was related to their MSW educational experience as it relates to the curriculum and knowledge building for health literacy. Data set two related to research question two discussing discharge planning challenge related to low health literacy and the socioeconomic variables associated with low health literacy. Data set three related to research question three discussing what social workers can do to aid patients with low health literacy in the discharge planning process. Within the data categories, the final step was to develop themes. Unexpected findings were categorized separately with themes within this category.

Quality measures in qualitative research include trustworthiness which is measured through credibility, transferability, dependability, and confirmability (Korstjens & Moser, 2018; Tracy, 2010). A reflexivity journal was maintained to allow for reflection and allow me to debrief and capture any areas of bias. The participants were provided with a summary of the research findings for member-checking to increase the study’s credibility. Participant review by member checking strengthened the data by providing a different viewpoint than that of the researcher (Korstjens & Moser, 2018).

One limitations of this study was the use of only two focus groups. If the study had incorporated additional focus groups more social workers could have been involved in identifying barriers to discharge planning for individuals with low health literacy. A second limitation was the size of the focus groups. Initially each focus group consisted of 10 members, however, due to circumstance each focus group ended up with only six participants.

Findings

The social worker focus group participants (*N = 12*) included one male and 11 females. The racial breakdown was ten Caucasians, one African American, and one Caucasian of Hispanic descent. There was a wide range of practice experience. Their years of practice were differentiated by actual practice years and medical social work practice years which were broken down into four groups as follows: one to five years, six to 10 years, 11 to 20 years, and greater than 20 years. In terms of actual practice years, five social workers practiced one to five years, one social worker practice six to 10 years, three social workers practiced 11 to 20 years and three social workers have practiced more than 20 years. In terms of medical social work practice years, six social workers practiced one to five years, three social workers practiced six to 10 years, one social worker practiced 11 to 20 years and two social workers practice more than 20 years. This distinction in actual practice years versus medical social work practice years allowed me to understand their other practice affiliations to ensure the discharge planning difficulty with persons of low health literacy was from their medical social work experience.

The demographic worksheets that the participants filled out asked their primary duties within their work environment. The following duties were identified: community resource information and referrals to resources, adjustment to disability, ordering medical equipment, arranging outpatient services, meeting with families regarding adjustments in transition to home, adult and children's protective services referrals, homeless person placement, explain insurance options, Medicaid applications, referral to out-patient mental health facilities, transportation information and referrals, find patients primary care physicians and make appointments, evaluate barriers to discharge and overcome them, education regarding postacute settings and referrals to postacute settings, disability applications, aid in medication procurement for both insured and uninsured individuals, helping patients find non-medical help in their home, providing limited education to patients, crisis intervention, brief psychosocial interventions for mental health patients, and advocating for the patient with the interdisciplinary team.

Knowledge and Attitudes about Health Literacy

The participants were asked to rate their knowledge of health literacy on a four-point Likert scale with available responses of none, low, medium, and high. Five identified with high health literacy knowledge, six identified with medium health literacy knowledge, and one identified with low health literacy knowledge. Their self-reported knowledge was important to answer research question one.

Research question one posed: What is the current state of knowledge regarding health literacy in medical social workers in a large metropolitan city in Texas? This group of social workers primarily reported a medium to high level of health literacy. Meg made multiple observations regarding health literacy citing that

> An individual's level of health literacy has much to do with their education and upbringing, that the knowledge people receive is often times media driven and not always accurate, and some medical professionals are entitled and get offended when you question them.

Jack stated that "health literacy at the lowest level is understanding your own medical history and what's going on with your body and a higher level of health literacy is understanding how the whole medical system works together" which prompted Carol to cite that "health literacy is basic knowledge of your rights and responsibilities regarding your health". Julie stated that "health literacy is understanding the forest through the trees and educating the trees which are the patients." Cathy stated that much of the knowledge that social workers gain on health literacy is from on the job training and acting as a "translator of medical knowledge" when a patient has received information they do not understand. Wendy stated that "often times physicians only parlay the minimum necessary information in terms that patients do not understand so a social worker will try to fill in the gaps of information and make what they have been told understandable." Cathy piggybacked on this by stating that "sometimes an individual's health literacy is affected by the timing of the information they receive on a diagnosis as they are in shock and the information must be repeated and explained in terms the patient understands." Additionally, this participant cited that "shock is real" and when hearing negative information sometimes the patient cannot hear you as they are in overload requiring a larger sense of empathy to their situation which is “social work territory.”

Research question 1a asked “How do these medical social workers describe their MSW curricula in building their knowledge about health literacy?”. Meg self-reported a high level of health literacy, however also noted that she had never heard the phrase health literacy in her years of schooling or practice which speaks to lack of inclusion of health literacy information in MSW curricula. June stated that programs vary amongst social work schools and when I graduated there was not a healthcare tract to learn this type of information. Meg noted that as far as curriculum including health literacy “social workers need to know what it is and how it affects their practice, and this was not introduced in my MSW program.” Cathy stated that “there is a fine line between training versus education and much of the knowledge gained by medical social workers is on the job.”

Nancy noted a general lack of medical knowledge being taught in social work curriculums and that practice courses should at least contain health literacy as a concept because having low health literacy negatively impacts nearly every aspect of a patients care.

Jack noted that in their program there was a lack of education on medical terminology, diseases, and community resources. Jack also stated that when I interned at a hospital during my program, I had to educate myself and I carried a pocket medical dictionary in one pocket and a medical terminology book in my other pocket in order to look up the information I did not know. This participant identified that this type of initiative is lacking in many social work professionals who expect to have much of the information fed to them without having to work to gain the knowledge.

Pam stated that medical information and knowledge of specific medical social work duties, responsibilities, and respective medical knowledge is acquired through their internship, however, also cited that field practicum professionals are often times too busy to ensure that interns acquire the necessary knowledge to be a competent medical social worker and impart the basic necessary knowledge to do the job but expect the student to take initiative to learn much of the information themselves.

Carol stated that “there should be a licensure for medical social workers to show competence in this practice setting.” Martha noted that their MSW curriculum did not teach the concepts of health literacy but felt that “co-teaching and learning from the various disciplines with the hospital such as pharmacy, therapy, and nursing would broaden their knowledge base more effectively.” Suggestion for improvement were echoed by all participants to include providing in-services on health literacy such as in a lunch and learn series, incorporating medical terminology and education on overall health into the current curriculum, providing education to field instructors on the necessary skills and knowledge a medical social working must acquire and ensure they are learning this information, advocating for a tract on healthcare social work, and advocating for an advanced licensure to ensure competence in this area of practice.

There was a consensus among many of the participants that there is a lack of social work supervision in facilities. Participants identified this issue because there are few facilities with social work departments. Jack reported that “if some type of leadership development courses were available, there may be an opportunity for social workers to advance in the workplace to leadership positions.” Julie reported that “social workers in facilities do not have appropriate support when their departments are managed my registered nurses which can keep social workers from fully realizing their potential in the acute care setting.”

Social workers enter their MSW programs and are taught many core items however specialization introductory training, such as that for healthcare social workers, is often lacking in MSW curriculum. This places a larger burden on the field practicum instructor as the student is entering the internship without some of the knowledge and skills they need to function in this environment. Subsequently, many healthcare facilities no longer have social work departments resulting in lack of supervision in the workplace by social workers.

Challenges associated with Discharge Planning and Low Health Literacy

Research Question two posed: What challenges arise for medical social workers when discharge planning for patients with low health literacy? The focus groups first identified what defines low health literacy and the ramifications of low health literacy as this relates to the challenges that arise. Multiple challenges in discharge planning were cited by the focus group participants to include a lack of understanding of what insurance does or does not cover, preventative health measures, access to care, medical knowledge, and available resources. In respect to what insurance covers, Pam cited

> People hear what they want to hear. For instance, if someone is wanting to know if a skilled nursing facility (SNF) is covered by their insurance, they hear that they have

100 days that are covered with Medicare but neglect to understand that the first 20 days are covered at 100% and the remaining days have a co-pay so you have to education them on this fact, usually multiple times.

Multiple other participants echoed this concern and Martha added that “patients seem uncomfortable calling their insurance companies to understand their benefits and many times are expecting the social worker to do that for them.”

In respect to preventative health measures Wendy cited that low health literacy is associated with “willful ignorance” and the lack of basic knowledge about the body. Ariel piggybacked by citing that “information used to be passed down from parents to kids as far as basic knowledge but in current times this doesn’t happen as it did when we were growing up.” Preventing disease starts with basic knowledge that individuals are not learning. Nancy stated that:

> We are bombarded with commercials for cheap and easy food and when you eat fast food for a lot of years this affects the body composition and creates an undue burden on the body which contributes to diabetes, high cholesterol, and hypertension. Decades of poor nutrition has caused childhood obesity and a lifelong struggle with weight control and chronic illness.

Jack stated that “many individuals on Medicare are not taking advantage of the yearly wellness exam offered by Medicare which can also provide screenings for disease.” There was a large consensus between the groups that preventative health contributes to low health literacy because this takes one constant medical professional out of their available physician resources.

In respect to the challenge of available resources Wendy noted that “sometimes the simplest things like helping to pay for medications goes unnoticed.” Ariel cited “people with no insurance are used to trying to figure out how to pay for things, but when troubles arise for the patients with insurance, patients seem helpless to help themselves.” Access to resources is one job function that social workers in many settings excel, however, with providing the information to the patients there must also be an educational component, and this is sometimes lacking when resources are provided. Mary stated that:

> Access to healthcare for uninsured patients needs to include how to access the Affordable Care Act plans, Federally Qualified Health Clinics (FQHC), sliding scale clinics, and a variety of medication procurement resources and many of the resources provided in this arena are lacking all of the necessary details. Challenges in discharge planning are encountered daily.

Ariel stated:

> I visited a patient in the room after a physician had been in and they were so overwhelmed that they had no idea what was communicated. I had to go out and have the physician go back in the room and explain it to her again.

Social workers are skilled at interpersonal communication by way of their specialized training. This represents an opportunity for social workers to take the lead on ensuring patients with low literacy can effectively communicate with their healthcare team by providing education on communication skills.

Sociodemographic Variables and Health Literacy

Research Question 2a posed: How are sociodemographic variables factors in the challenges medical social workers face when discharge planning with patients with low health literacy? Sociodemographic variables are among the largest challenges to discharge planning with individuals with low health literacy. Sociodemographic variables identified by the research participants included low socioeconomic status, cultural, racial and ethnic variances, varying age groups, limited English proficiency, access to healthcare, and education.

Socioeconomic status (SES) affects individuals in different ways. Individuals who have a low SES struggle financially and learn to go without many things or learn to buy cheap substitutes. Jack identified that one reason for the decline in an individuals health is their access to “good food” and cited that “many individual’s in a lower income bracket cannot afford healthy food and end up purchasing cheap food substitutes which include cured meats, junk food, and a limited selection of healthy fruits and vegetables”. Julie noted that access to grocery stores in poorer neighborhoods is lacking with many dollar type stores being built in these areas and do not always provide good food selections. Mary cited that many other countries shop daily or every few days at markets so they can obtain healthier and fresher foods which reduces their inclination toward chronic disease and obesity. Martha cited that:

> Many individuals have to choose between paying for basic necessities such as rent and utilities and paying for healthcare and this creates an undue burden on emergency departments as some individuals are using the emergency room as their primary care doctor.

Working for low wages causes individuals to make hard choices, however adding some education on resources available to aid them with basic necessities is something a social worker can do on a regular basis when low SES is a cause for low health literacy. Access to care, regardless of the reason, causes a burden for both the patient and the healthcare system. June noted that the minimum wage barely covers the cost of living resulting in touch choices being made by consumers between rent, food, utilities, and medical care. There was a consensus among the participants that access to medical care for individuals for lower socioeconomic status is limited. Martha noted that:

> Health literacy plays an important role in access to care when purchasing a health plan because individuals do not understand what they are buying and they purchase plans thinking their everyday health needs are going to be met but do not understand the concept of deductibles, co-pays, and catastrophic only coverage leaving them in despair when a medical issue arises.

The primary cultural, racial, ethnic challenge that was identified is there is a distrust of the medical system for those individuals who are not in the country legally. Carol stated that “Hispanics are distrusting of medical establishments especially if they are here illegally as they are afraid of deportation.” Social workers often try to convince someone here illegally and needing medical attention that they will not be deported based on their hospital stay. There was an observation regarding health literacy in the United States and other countries so far as obesity and chronic illness in that there is less instance of these two items in other countries. They further observed that other countries individuals often eat fresher food and less fast food and cured meats.

The age of individuals with low health literacy varies. There was a consensus among the participants that younger people were more ambivalent regarding their health and healthcare choices whereas baby boomers who are aging into retirement were more concerned and spent more time researching their medical issues. Mary noted that "the older elderly patients knew less because many of them were not technologically savvy and didn't have the social support to help them and they didn't know how to look up the information themselves." Meg noted that "age makes a big difference in the level of health literacy that an individual has."

Education can play a factor in an individual's health literacy given the complexity of information contained within healthcare. However, Julie noted that "I have seen individuals with an eighth-grade education knows more than someone with a master's degree when it came to their health." Social workers provide resources to patients and many of them are not written for low health literate individuals. Ariel noted that "I sometimes give patients materials made by my organization and I wonder if they can understand it but figure that if the hospital creates it, it must be right." While age can be a factor in the level of health literacy an individual is capable of, their initiative and self-determination can negate the potential age issue.

Limited English proficiency is a large barrier to effective discharge planning with individuals who have low health literacy. Jack noted that "even when you use a translator phone you are not sure if the information is being translated effectively and if the patient is understanding what they are being told." Carol noted that "just because they are getting information translated to them, you are unclear if it is culturally competent because language is not culture.” Often, we fail to recognize when someone doesn’t completely understand what they are being told. Cathy noted that “many healthcare professionals, social workers included, are ambivalent to literacy of the English language let alone whether they are health literate.”

Sociodemographic variables play a large role in health literacy. Low health literacy can be caused by lack of funds, lack of education, limited English proficiency, and lack of capacity to understand what you are being told. Social workers have the opportunity to increase their awareness of health literacy so that individual’s with low health literacy can be identified.

Social Worker Interventions

Social workers are educated on the creation of interventions based on the patient’s current situation. It is incumbent upon social work professionals to seek education regarding health literacy and create appropriate interventions to aid in their care, aftercare, and continued health practices. Research Question three posed: What can medical social work professionals do to aid patients with limited health literacy during the discharge planning process? The social work profession is in a good position to take a lead on health literate practices and need to become involved in interventions to increase overall health literacy, especially to increase health literacy for those individuals identified with low health literacy. Wendy stated that as social workers “we need to listen to people more because they want to be heard because often we are rushed in the assessment process in the fast-paced acute care environment.” Pam stated that:

> The need to provide education on communication skills to the patients to be able to effectively discuss their medical conditions with physicians and nurses. Communication skills like writing down questions to ask so that during conversations with health professionals the patients are not flustered by the barrage of information that they forget the questions they have.

Individuals are conditioned to think that they must trust everything that medical professionals tell them and not to question what they are being told. June reported that “we need to empower patients to question the care they are getting and to ascertain if the procedures being done are necessary.” Wendy reported an excellent example of a patient that hospital hopped and was having some of the same tests done at multiple hospitals not aware that they could ask the facility to request clinical documentation from another facility to negate the need to run the same testing procedures. Mary noted:

> Social workers must advocate for patients to speak up for themselves versus speaking up for them because this intervention will allow individuals to take more control of their healthcare and learn the needed skills to manage their illness proactively instead of reactively.

Patients who take a more active role in their care experience better outcomes, reduced hospitalizations, and reduced readmissions.

The group participants were asked if their organizations screened for health literacy. Two participants noted that their facilities had a health education department and screened for health literacy, one participant noted that their facility screened for health literacy and the nurses provided any needed education, eight participants noted that their facility did not screen for health literacy, and one participant reported that they did not know if their facility screen for health literacy. Cathy noted that "at the organizational level the bottom line is more important sometimes than ensuring that the patients are educated properly." Mary noted that "if hospitals routinely screened for health literacy that there would be an increase in the percentage of those identified as low health literate thereby flagging individuals for social work interventions." Nancy reported that "support groups and ensuring that organizations are using patient-centered communication would increase patient literacy and reduce misinterpretations upon discharge from the hospital." Advocating for organizational change is a task that social workers can become involved in. Carol cited:

> Social workers are in a unique position to understand the psychosocial aspects of an individual's low health literacy and using this knowledge can provide organizations with the ammunition needed to provide health literacy screenings to patients as it can affect the bottom line with reduce readmissions.

Organizations have the opportunity to do the right thing with health literacy, they just need justification to take the next step.

Social workers require continuing education to remain licensed. Ariel noted that continuing education can involve education on health literacy, improving health literacy, and using this education to improve their practice skills. Carol noted:

> It is important to aid individuals by providing patients with education that is understood and able to be followed and maintained outside of the hospital and advocating for increased presence in this area is important as social workers are

> natural educators by nature of our advanced education which can allow patients to exercise their self-determination and maintain their dignity at the same time.

Martha noted that “social workers need to take more professional pride and increase in their footprint in the workplace and engage in more outside of the box thinking to improve their practice skills.” This involves educating other health professionals within their work settings on their value to the interdisciplinary team. Nancy noted:

> I have worked in many environments and in each one has the social worker is performing different duties so it is no wonder that other healthcare professionals may not be aware of the value of social workers.

The varied nature of social work functions among various institutions provides the opportunity for social workers to educate patients on multiple facets of the healthcare industry. However, despite the focus group participants having a medium to high level of health literacy, screening for health literacy was not identified in any of their job duties. Cathy noted that “social workers can provide in-services to other employees on the importance of health literacy and increasing the awareness that the instructions given to patients may not be understood because they are talking over the patients head.”

Social work as a profession can take an important role in improving low health literacy. Advocating for themselves in the workforce to provide additional education to patients and families on topics that would traditionally be done by nursing staff such as disease processes and home management of a disease can improve their clinical skills and increase their visibility in the workplace. Additionally, educating other health professionals on the importance of health literacy, identifying those with limited health literacy, and ensuring that they are aware that the education they provide to patients needs to be at a level that is understood.

Unexpected Findings

Preventative medicine is not a new concept. Taking care of yourself is something that most individuals learn throughout their life. One unexpected finding was the strength of the position on preventative medicine that the focus group members identified. Jack reported that “some people are so laissez faire about their health that they can tell something may be wrong but don’t do anything about until their condition gets unmanageable.” Julie reported that “people need to be held accountable for their decisions and starting with education on preventative medicine can play a key role in their accountability.” Social workers can work with patients so that they can be held accountable to take action on their own health, use the preventative measures that are available to them, and maintain a healthy lifestyle.

A second unexpected finding was that 10 of the 12 participants echoed that a national licensure for medical social workers is needed with standardized practices. Jack noted that “unless there is a standardization for how social work clinicals practice in the acute care setting, each setting with have the latitude to educate them as they see fit sometimes with little regard to their special skill set.” The focus group participants did not feel their MSW curriculum prepared them for “real world” practice with concrete knowledge of what a medical social worker does, and the field practicums did not always prepare them appropriately.

A third unexpected finding was the amount of role ambiguity that is experienced by social workers between acute care settings. This create confusion from other healthcare professionals and patients alike as different facilities have their social workers providing different functions but are the same type of facility.

Summary

Social workers have a medium to high level of health literacy suggesting that they are perfect candidates to take on a leading role to combat low health literacy. However, the social workers within the focus groups do not feel that their MSW curriculum prepared them to enter medical social work. There are many factors that contribute to discharge planning challenges with low health literate individuals such as health knowledge and attitudes, sociodemographic variables such as low SES, cultural, racial, and ethnic variables, access to care, and age group. There is a high level of social worker role ambiguity which causes confusion for patients and health professionals alike. There are multiple interventions suggested such as ensuring patient centered communication, advocating for health literacy screenings, working with patients on communication skills, and advocating for better curriculum education. Social workers have the opportunity to take a leading role in the fight to reduce health literacy concerns and ensuring they are appropriately educated is an excellent place to start. The next section will address the studies application of professional ethics in social work practice, recommendations for social work practice, and implications for social change.

Section 4: Application to Professional Practice and Implications for Social Change

The purpose of this study was to explore medical social workers knowledge of health literacy, assess the challenges medical social workers encounter in discharge planning with patients with low health literacy, and elicit suggestions to improve discharge practices for medical social workers using basic qualitative research with focus groups.

A key finding in this study was that social workers do exhibit a medium to high level of health literacy, however their vast array of job duties does not necessarily include educating patients to improve low health literacy. Education on various topics is a key component of many social worker's job duties. However, ascertaining if an individual has low health literacy and creating subsequent interventions to improve an individual's literacy status is absent in the social worker's practice due to either insufficient training or availability of tools in the workplace at their disposal. A related finding is that workplaces stymie the duties of a social worker so many of the social workers believe they are not clinical and duties on educating patients are delegated to other health professionals. These findings inform social work practice to advocate on their own behalf in the workplace to provide patient education on low health literacy, educate health professionals on their abilities, and take action to maintain their own health literacy by taking the initiative to continue to educate themselves on low health literacy to create opportunities for social workers to take the lead in alleviating low health literacy.

Another key finding is that there is a lack of social work supervision available in case management departments. Many acute care settings no longer have social work departments and social workers are reporting to directors of case management who are registered nurses. This contributes to the role ambiguity across settings as well as diminishes the role that the social worker can perform.

The findings extend the knowledge in clinical social work by highlighting that social workers do have a medium to high level of health literacy. Despite having this knowledge, a social worker is not often used to educate individuals with low health literacy which can be caused by role ambiguity. The findings spotlight the need for defined roles and responsibilities in the healthcare setting.

Applications to Professional Ethics in Social Work Practice

Social workers are guided by the NASW code of ethics (NASW, 2017). The code of ethics is emboldened with values which include service, social justice, dignity and worth of the person, importance of human relationships, integrity, and competence (NASW, 2017). The social work practice problem of this doctoral study is how patients' low health literacy hampers effective discharge planning for medical social workers. The NASW values which embody this social work practice problem are service, social justice, dignity and worth of the person, and competence (NASW, 2017).

The ethical principle associated with the value of service cites "social workers' primary goal is to help people in need and to address social problems" (NASW, 2017, p. 5). The social problem of low health literacy reverberates throughout society. Social workers working with discharge planning can engage patients with low health literacy daily. Helping individuals with a discharge plan that is understood and easily followed draws upon a social workers' training and knowledge and allows a social worker to address the social problem of low health literacy. Individuals with low health literacy often fall between the cracks and it is a social workers ethical obligation to ensure that they are identified and appropriately educated in order to prevent poor health outcomes. Additionally, overcoming the discharge planning challenges that a social worker encounters, such as sociodemographic issues and access to care, helps the individuals in need as well as addresses the social issue of low health literacy which can also benefit society in reducing overall healthcare costs.

Addressing low health literacy may require social workers to advocate within a system that has limited funds. Organizational involvement in the identification of low health literacy is absent in many institutions and social agencies. Ensuring low health literacy is identified in order to help those in need can aid in the bringing the problem to the forefront so a call to action can be elevated. The NASW (2017) code of ethics value of service guides the issue of low health literacy by reminding social workers that helping those in need is a primary goal, even those individuals who take their health for granted and make poor health decisions as the social worker also values an individual’s self-determination.

The ethical value of social justice cites “social workers challenge social injustice” (NASW, 2017, p. 5). Health literacy is a social injustice as the issue perpetuates itself from setting to setting. Promoting knowledge to other social workers, individuals with low health literacy, and other health professionals can aid in advocating for an increase in overall health literacy thereby increasing the health literacy of those with low health literacy which promotes better outcomes, reduces overall healthcare costs, and can raise national awareness to this topic. Social workers can strive to provide low health literate individuals with needed knowledge in disease education, disease management, and communication skills to create a better understanding of the healthcare system thereby removing some of the barriers to discharge planning experienced with individuals who have low health literacy.

The ethical value of dignity and worth of the person cites “social workers respect the inherent dignity and worth of the person” (NASW, 2017, p. 5). Social workers have the opportunity to engage clients with low health literacy, increase their learning capacity, and create viable opportunities for change by empowering them to learn to address their individual needs. Engaging clients with low health literacy starts with the identification of their literacy deficiencies in a culturally competent manner. Social workers have considerable education on cultural competence and are ideal candidates to seek solutions to promote self-determination in low health literate clients while providing solutions that allow them to be “cognizant of their dual responsibility to clients and to the broader society” (NASW, 2017, p. 6).

Social workers have the capacity to display empathy with clients who may be embarrassed by their lack of knowledge and provide them with the skills necessary to increase their awareness of health literacy through education and enhanced communication skills. Ensuring that patients are educated about their options in a caring and respectful manner creates a trust between practitioner and patient that can provide for increased success in the discharge planning process. Social workers can take a more active role in educating patients by promoting their skills within their workplace and amongst other health professional. This advocacy can increase their visibility in the workforce to enhance the patient experience, decrease discharge planning challenges, and maintain the dignity and worth of the individual.

The ethical value of competence cites “social workers practice within their areas of competence and develop and enhance their professional expertise” (NASW, 2017, p. 6). Medical social workers learn many of their skills with on the job training. However, this training can be disjointed and varies considerably between employment sites. This is not to say that social workers practice outside of their scope of practice. There is an old phrase which says that you don’t know what you don’t know until you don’t know it. Learning on the job creates different levels of competence between social workers at difference facilities as there does not appear to be standardized training in medical social work in an acute care facility. Social workers can learn about health literacy and aid low health literate individuals by culturally competent means in an ethnically diverse environment while maintaining dignity and respect. Social workers must strive to develop new skills, allocate time for educational opportunities, and increase their professional expertise in the area of health literacy.

Social work is a profession bound by values and ethical principles. The findings of this study will impact social work practices by projecting a lens on low health literacy and the need to take action to combat it. Critically thinking about one’s own level of health literacy and how this can affect discharge planning practices is key to social workers taking a more active role in combating this social issue. This relates to professional ethics by providing opportunities to learn new skills and increase professional knowledge. New knowledge can be disseminated to other social workers and then applied in the workplace to elevate the presence of social workers in the acute care environment. The subsequent knowledge base attained can aid social workers in their commitment to clients to promote increased well-being, promote self-determination, and increase their ability to provide relevant interventions to clients with low health literacy.

Recommendations for Social Work Practice

Social work roles and responsibilities in the healthcare field vary from setting to setting. These variances occur due to the business models in the workplace for the application of social work duties. One recommendation is a call to action to require standardize healthcare social work duties. This will not only alleviate some of the social work role confusion in the acute care setting but also provide social workers with the needed visibility to showcase their skills that can assist patients with low health literacy removing some of the challenges associated with discharge planning of low health literate individuals.

Clinical social work practitioners can learn about health literacy and how to identify low health literacy individuals. This is within their scope of practice regardless of the area of practice. Identifying individuals with low health literacy is the first step in alleviating the challenges associated with discharge planning with low health literate patients. Social workers can then create an intervention to help their patient such as identifying the issue to the interdisciplinary team, creating opportunities to assist the patients communication with the healthcare team, and ensuring that when they discharge from their facility that patient understands what they must do for follow up care. Ideally, there would be at least one post discharge follow up phone call, however, budget conscious workplaces do not build this needed task into their case management models.

A social worker has many skills that are not allowed to shine in the workplace. Many facilities use social workers for only “social problems” identified by nurses and physicians for which they get referrals such as homelessness, mental health issues, community resource referrals for various issues, and providing resources for uninsured clients. This does not consider that social work professionals are natural educators. Jack noted that many social workers are so busy handing out lists of resources that they forget about providing needed education on those resources or are so time constrained that they are unable to take the time to delve further into the clients sociodemographic inequalities so they are missing educational opportunities. Social workers must advocate for themselves in the workplace to shine a spotlight on the skills they can do, such as educating patients on disease processes, disease management, and the importance of preventative medicine.

Social work education for master’s level social workers consists of many required courses, a handful of electives, and an internship. Social work colleges have constraints as well regarding course offerings. However, adding educational opportunities in health literacy and medical terminology can assist all social workers, not just those that have planned to enter healthcare social work. A social work student entering a field placement in an acute care setting may or may not be exposed to this information depending on the depth of knowledge their preceptor has. This can be a disservice to the intern when trying to locate a position at another acute care setting as roles and responsibilities vary from facility to facility. There is core knowledge that is imparted to the intern such as post-acute settings and their requirements, requirements for durable medical equipment, crisis management, and knowledge of what insurance does or does not cover. However, knowledge of medical terminology, health literacy, and chronic disease may not be part of their practicum experience. The curriculum taught in the social work college may not completely prepare a social work student to enter the medical field with all the knowledge that they need to have suggesting an area of opportunity for social work colleges to provide an additional specialized tract. This will be especially important as the baby boomers are aging with more chronic disease than ever before and growth for medical social workers is expected to increase.

The findings from this study will impact my own social work practice by taking the initiative to learn more about health literacy, increase my knowledge of screening for health literacy, and advocate in the workplace for health literacy screenings to identify individuals with low health literacy upon admission to an acute care setting. Additionally, as an advanced practitioner I am prepared to take on additional roles within my acute care facility to become actively involved in projects to ensure patients are appropriately educated prior to discharge to prevent hospital readmissions. I am also taking the lead on a project to educate hospital personnel regarding low health literacy and the detrimental effects this social issue has on hospitalizations and hospital readmissions and the necessary steps the interdisciplinary team must take to successfully integrate literacy screenings.

Transferability relies on the use thick of description to add context to the individual experiences to increasing meaningfulness to the reader (Korstjens & Moser, 2018). Individual experiences related in focus groups would vary based upon the social worker make-up of the focus group panel, however the findings do transfer to the field of clinical social work practice by providing a spotlight on experiences so that other clinical social workers in the field can contemplate this issue. Shining a spotlight on an important social issue such as low health literacy provides a bedrock for further discussions on creative interventions to alleviate this issue. Additionally, clinical social workers in the field can create a different lens to view the issue and learn to advocate on behalf of these clients as well as create opportunities for the growth of their own professional practice experience by understanding the current state of low health literacy and identifying ways within their environment to aid low health literate clients.

The broader field of social work can find this study useful by understanding that health literacy is a major social issue impacting individuals, families, and society. Low health literacy reverberates throughout every field of social work practice. On the practice level, it is essential that social workers understand that identifying low health literacy individuals can occur in any setting with subsequent education of client and family to aid in alleviating the issue. Additionally, having a firmer grasp of the sociodemographic variables associated with low health literacy can provide useful information to social workers and provide them with the needed information to provide appropriate interventions for their clients. Furthermore, social workers can aid clients in communication skills with their healthcare providers, bring forth client literacy deficits to an interdisciplinary team, and empower the client to use their self-determination to meet their healthcare needs. On the research level, practitioners can engage in research to prove the usefulness of health literacy screenings and aid in research efforts to improve discharge planning practices for individuals with low health literacy. On the policy level, social workers can advocate to incorporate literacy screenings at all levels of practice as well as advocate with the council for social work education to include health literacy as a vital part of the social worker education.

The primary limitations of this study are that the focus groups solicited social workers in one geographic location and there were only two focus groups conducted. Had more focus groups been conducted, additional details could have been solicited to add more depth to the conversations regarding knowledge of health literacy, the impact of discharge planning challenges, and garner ideas about how social workers can become more involved in this social issue. A recommendation for further research would be to engage various geographic regions to determine if the same challenges to discharge planning with individuals with low health literacy persist between alternative geographic locations. Another recommendation would be to solicit a wider range of practitioner experience for the focus groups, however, remain vigilant to not exclude based on level of experience. A strength of the current study regarding the curriculum experience could provide another recommendation of asking further questions regarding their curriculum during their master education as well as soliciting further ways to incorporate medical social working educational opportunities into current social work programs.

Dissemination of the knowledge regarding this project relies upon social workers taking an active part in continued education. One way to disseminate the knowledge is to propose to speak or do a poster presentation at a conference. This would allow for the dissemination of the knowledge as well as provide a needed infusion of education regarding health literacy. The NASW local conferences solicit for proposals to speak at their conferences and are typically looking for a range of topics to provide to their attendees. A second way to disseminate the knowledge would be to submit an article for publication. A peer reviewed journal such as Health Care Social Work would be an excellent venue to disseminate the knowledge produced in this project. Both dissemination of knowledge ideas has the capacity to reach a broad audience.

Implications for Social Change

Recognizing limitations in clinical social work practice and overcoming these limitations can have an impact for positive social change. Identifying challenges and barriers to discharge planning with individuals with low health literacy can affect positive change at the micro, mezzo, and macro levels of social work practices. On the micro level social workers can identify individuals with low health literacy and provide interventions to overcome challenges to discharge planning. This can have an impact on their personal well-being, improve health outcomes, and empower individuals to take personal responsibility for their healthcare which in the long run can help them overcome the possibility of chronic disease and other health related anomalies. On the mezzo level social workers can advocate within their organizations for positive social change by advocating for health literacy screenings. Changes in health literacy screening policies can reduce costs to the organization and the individual, reduce hospital admissions, and reduce hospital readmissions. On the macro level social workers can advocate for national social work organizations to disseminate information regarding health literacy, require education in the social work curriculum and continuing education, and work with other health professional organizations to include their expertise in health literacy. Each level of involvement has the capacity to reduce overall healthcare costs for individuals, businesses, and society as overcoming health literacy challenges benefits everyone.

Summary

Low health literacy is a social issue which causes nearly $200 billion dollars annually affecting 26% of the population. Social workers in the acute care setting have a medium to high level of health literacy, however their knowledge and skills are often overlooked in favor of other healthcare professionals. Low health literacy screenings are often lacking in many facilities which exacerbates the challenges social workers encounter with discharge planning with individuals with low health literacy. Challenges encountered include overall knowledge and attitudes of health literacy, sociodemographic variables, and lack of preventative health. Social workers often feel unprepared to enter into the field of medical social work as there is a lack of education within the MSW programs regarding medical terminology, disease education, and practice knowledge within the healthcare field. Social workers are natural educators and embracing their skills and training can allow them to take a more visible role in the healthcare setting to alleviate the social issue of low health literacy.

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Appendix A: Participant Demographic Questionnaire

1. Name: ____

   (this information will be kept confidential and replaced with a number identifier)

2. How many years of MSW practice experience do you have? _______________

3. Gender: Male Female Transgender

4. Age: _____

5. Participant Work Setting: ____

6. What is your role in the discharge planning process at your workplace?

   ____

   ____

   ____

   ____

7. Rate your knowledge of health literacy:

   1) High 2) Moderate 3) Low 4) None

8. Does your workplace screen for health literacy? Yes No I don't know

9. Do you speak a language in addition to English? Yes No

   If so, which language(s)

   ____

10. What is your race / ethnicity? ____

11. What do you believe is the greatest reason for hospital readmissions and why?

    ____

    ____

Appendix B: Semi-Structured Interview Questions for Focus Groups

1. What is health literacy?
2. What defines low health literacy?
3. Who is responsible for screening an individual's health literacy in the acute care setting? *Explain to me how this is done in your setting.*
4. Do you know how to screen for health literacy issues?
5. What are some broad categories of issues? (provide examples if needed - such as low education, low SES, limited social network, and limited English proficiency). *Explain your response*
6. What challenges does low health literacy create for social workers in discharge planning? *Can you elaborate on this with an example?*
7. What can social workers do to improve an individual's health literacy? *Can you elaborate on this with an example?*
8. How can social workers improve discharge planning by getting involved in health literacy initiatives at their workplace? *Please provide examples of your ideas*

Appendix C: Key Terms and Definitions

Discharge Planning: An important part of the treatment planning process ensuring the continuity of care between hospital, other facilities, and the community

Health Literacy: the cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand, and use information in ways to promote and maintain good health

Hospital readmission: An admission to the hospital within 30 days of a discharge from the hospital.

Low Health Literacy: The degree to which individuals have the capacity to obtain, process, and understand basic health information and services for appropriate health decisions.

Medical Social Worker: A social worker who works in an acute care hospital setting.

Social Work: any of various professional activities or methods concretely concerned with providing social services and especially with the investigation, treatment, and material aid of the economically, physically, mentally, or socially disadvantaged.

Social Worker: Noun form of social work