‘Older Person Health Literacy Support: A Role for Homecare Workers?

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Abstract

Approximately 60% of Australian adults do not have adequate levels of health literacy (HL) to manage their own health and health care. There are clear links between low HL levels and poor health outcomes, and ‘at risk’ groups include people with cognitive impairment and the elderly. One means of improvement may be found in the rapidly growing paid homecare workforce, whose direct and frequent contact with older Australians (i.e., clients) positions them to provide extensive HL support. This two-phase study examines homecare worker (HCW) experiences in health literacy when providing assistance to their clients. In Phase One, a self-reported cross-sectional survey collected data from 75 HCWs in two Australian homecare organisations. To further explore survey responses, one-to-one semi-structured interviews were held with nine HCWs in Phase Two. Overall, HCWs in the study reported being regularly asked by their clients for HL support e.g., health advice, attending appointments, health professional liaison, health system navigation. HCWs expressed concerns about their clients’ HL, yet were cautious about providing this kind of support and sought a more explicit articulation of their role. HL levels of the HCWs themselves were unconvincing. Targeted HL education and training was requested by the majority of HCWs and suggestions made for a curriculum and pedagogies that might best achieve this. To promote a health literate approach to older person care, the study proposes a versatile training framework for application across a range of in-house HCW training programs.

Introduction and background

Health literacy

Health Literacy (HL) generally refers to the ability of a person to access, understand, appraise and apply information to make decisions and take action to manage their health and health care (Nutbeam, 2008). Approximately 60% of adult Australians have low levels of HL (Australian Commission on Safety and Quality in Health Care [ACSQHC], 2014), with older and/or cognitively impaired people at particularly high risk (Berkman, 2011). There are clear between low HL and poor health outcomes e.g., less likelihood of accessing primary health care services, increased admission to hospital, increased adverse events such as self-medication errors (ACSQHC, 2014; Berkman, 2011). These factors impact on quality of life, morbidity and mortality (Adams, Appleton, Hill et al., 2009) and also place increased economic strain on health care systems (ACSQHC, 2014). Consequently, improving HL levels of the Australian population has been highlighted as a national priority (ACSQHC, 2014).

Home care workers

One means of improving HL for vulnerable groups may be healthcare professionals (Johnson, 2014; Saunders, Palesy & Lewis, 2018). More specifically, unlicensed home care workers (HCWs) have the potential to significantly impact the way older Australians navigate the health care system and make effective health-related decisions (Stone, Sutton, Bryant, Adams & Squillace, 2013). HCWs tend to be lower skilled and employed in place of nurses to perform a range of tasks for their clients such as personal care (e.g., bathing, toileting), domestic duties (e.g., shopping, housework) and community access (e.g., attending appointments, recreational activities) (Chomik & MacLennan, 2014b; Palesy et al. 2018). Australia's ageing population, combined with more and more older people choosing to remain in their own homes for care (Chomik & MacLennan, 2014a) have positioned paid

HCWs as one of Australia's fastest growing workforces (Palesy, Jakimowicz, Saunders & Lewis, 2018; Productivity Commission, 2011), and their direct and frequent contact with older clients positions them as the 'eyes and ears' of the home care sector (Stone et al., 2013). Clients consider them as trusted professionals who are a reliable source of health-related information (Ifkovich, Lawson, Fraser & Mason, 2013).

However, a concern here is that they themselves may lack the HL skills which enable them to promote and maintain the good health of their clients. Many HCWs report that finding information is challenging and time-consuming, and they receive insufficient education to effectively support their clients (Ifkovich et al., 2013). There are also concerns over how these workers are currently trained and prepared to provide this kind of support. Formal qualifications are not mandatory for entry into home care work (ANF, 2009), and even when offered, formal training varies between training providers in terms of course content, delivery, duration and practical experience (ASQA, 2013; Lawn et al., 2016). Moreover, these programs may not develop the necessary expertise among HCWs to ensure adequate client HL (Naccarella, Osborne & Brooks, 2016). Yet with the necessary skills and knowledge, there is great potential for HCWs, as a large and direct care workforce, to positively impact on HL and health outcomes for their clients.

Aim

The research reported here sought to understand HCWs' experiences of providing HL support to their clients. The central premise is that while clients rely on HCWs for HL support, the type of support being provided is not clear, nor is whether HCWs feel comfortable and/or prepared to assist their clients to access, understand, appraise and apply information to make

decisions and take action for their health and health care. Four main questions guided the study:

1. What are HCWs' perceptions of their clients' HL levels?
2. Are HCWs asked to provide HL support?
3. Do HCWs consider themselves to be equipped to provide HL support?
4. What HL education and training gaps exist for HCWs and how might they be addressed?

Methodology:

This mixed method study was underpinned by a constructionist approach. Data were collected in two sequential phases. Phase One used a survey design to collect quantitative data and Phase Two used semi-structured interviews to collect qualitative data from HCWs about their HL experiences.

Phase One

A self-reported cross-sectional survey (hard copy or online) was used to collect de-identified data about the experiences of HCWs and health literacy. The Home Care Worker Health Literacy Scale was developed for this research. This 20-item tool uses a 5-point Likert scale. Respondents were asked to mark their experience as Strongly Disagree, Disagree, Undecided, Agree or Strongly Agree. This instrument was informed by the nine domains of health literacy established by Osborne, Batterham, Elsworth, Hawkins and Buchbinder (2013) to guide questioning and facilitate multidimensional analysis of HL levels of the general population. These domains are: feeling understood and supported by healthcare providers, having sufficient information to manage own health, actively managing own health, social support for health, appraisal of health information, ability to actively engage with healthcare providers, healthcare system navigation, finding appropriate health information, and

comprehension of this information (Osborne et al., 2013). Demographic and occupational data collected included age, gender, language, country of origin, education level, experience and previous occupation. At the end of the survey, respondents were asked if they would like to participate in the semi-structured interview that comprised Phase Two of the study, to further explore and expand upon their HL experiences.

Seventy five respondents from two homecare service providers in Australia (NSW and QLD) took part in the survey. The majority were female (77.3%) with 75.9% of all respondents aged 40 or over. 81.3% of respondents were born in Australia while 97.3% of all respondents learned English as a first language. The highest level of education for the majority of Home Care Workers was a Diploma/Certificate (53.3%) while 12% had completed a Bachelor Degree. The majority of respondents were employed on a permanent, part-time basis (62.7%). The majority of HCWs (68%) had worked in areas outside of administration, education, management and nursing. In terms of gender, ethnicity, education levels and employment type, the demographics of the survey participants are representative of the Australian home care landscape (Palesy et al., 2018).

Data analysis was performed using SPSS Statistics Version 23.0. Descriptive methods were used to measure respondent demographic data. Bivariate correlations were conducted to explore inter-relationships between sample characteristics and their experiences. A significance level $\alpha<.05$ was established.

Phase Two

A semi-structured interview guide was developed for this second phase. Questions further explored and expanded responses around HCWs' experiences in providing HL support, key

HL needs and priorities and how best to meet them. Of the 75 HCWs who completed the survey in Phase One, nine HCWs agreed to be interviewed as part of Phase Two. Interviews were conducted over the telephone and lasted on average 24 minutes in duration.

Transcribed interview data were imported into NVivo Pro 11 and analysed using a general inductive approach in accordance with principles described by Thomas (2006). Categories and subcategories (i.e., themes) were identified that constituted the preliminary findings. A second researcher independently analysed the data and developed a second set of categories and themes based on the research aim, to enhance the credibility of the findings. Further analysis and discussion between the two researchers was done to establish the extent of overlap, reduce redundancy and develop a more robust set of categories and themes. The results were discussed regularly until consensus was reached.

Ethical considerations

This study followed the principles outlined in the Declaration of Helsinki (2004). Ethical approval was obtained from the University's Human Research Ethics Committee (HREC ETH17-1114). Support for the research and approval to recruit the HCWs was obtained from the managers of the two participating home care service providers. Flyers with information about both phases of the study, including information about informed consent, were distributed to all HCWs. Consent was obtained from HCWs before proceeding with data collection.

Study limitations

The small sample sizes (Phase One n = 75; Phase Two n = 9) may render the generalisability of the results as uncertain, however the cohort represents a microcosm of HCWs in Australia.

In view of the small samples, trialing and honing of data collection tools ensured that comprehensive data was collected from each participant (Blaikie, 2009). Findings of this unique and small-scale study should be viewed as tentative and exploratory.

Phase One findings:

Table 1 (overleaf) signposts three main findings: firstly, there is a need to improve health literacy levels of Australian home care recipients (e.g., responses to Questions 6 and 9). Secondly, HCWs' perceptions of their own health literacy positions them as a potential resource for improving health literacy of their clients (e.g., Questions 7 and 10), and finally, a targeted education and training program for HCWs may be a useful means of improving the health literacy levels of both workers and their clients (e.g., Questions 19 and 20).

Phase Two findings:

Three overarching categories that emerged from the interview data were around: (a) the type of HL support provided to clients; (b) enablers and barriers to providing HL support; and (c) HL training needs. These categories and associated sub-categories, along with number of reporting sources and supporting quotes from interviewees are presented in Tables 2, 3, 4, 5 and 6.

Table 1 Home Care Worker Survey Summary

	Question	Agree		Disagree		Strongly Agree		Strongly Disagree		Undecided	
		Freq	%	Freq	%	Freq	%	Freq	%	Freq	%
1	I feel that my client is understood and supported by his/her health care providers (e.g., doctor, pharmacist, hospital, community nurse etc.)	40	53.3	5	6.7	11	14.7	0	0	19	25.3
2	As a home care worker, I feel confident in dealing with my client's various health care providers	45	60	4	5.3	16	21.3	1	1.3	9	12
3	I feel that my client has sufficient information to manage his/her own health	29	38.7	14	18.7	2	2.7	3	4.0	27	36
4	In my role as a home care worker, I feel that I have sufficient information to manage my client's health	29	38.7	17	22.7	8	10.7	1	1.3	20	26.7
5	I feel that my client takes steps to actively manage their own health	36	48	14	18.7	2	2.7	4	5.3	19	25.3
6	My client has previously asked me for health advice	46	61.3	11	14.7	3	4.0	7	9.3	8	10.7
7	In my role as a home care worker, I feel confident in providing health advice to my clients	30	40	17	22.7	5	6.7	5	6.7	18	24.0
8	I feel that my client is able to read and comprehend the health information provided to them	14	18.7	26	34.7	0	0	8	10.7	27	36
9	My client regularly asks me to interpret or explain the health information provided to them	31	41.3	23	30.7	2	2.7	10	13.3	9	12.0
10	In my role as a home care worker, I feel confident in interpreting or explaining health information to my client	35	46.7	13	17.3	4	5.3	5	6.7	18	24
11	I have observed my client asking relevant questions of their health care providers	29	38.7	23	30.7	1	1.3	7	9.3	15	20
12	My client has asked me to attend appointments with them and ask/or ask for information on their behalf	31	41.3	20	26.7	3	4.0	9	12.0	12	16
13	I feel that my client has the skills to successfully navigate the health care system	12	16	26	34.7	0	0	13	17.3	24	32
14	My client has asked me for assistance with navigating the health care system	30	40	23	30.7	1	1.3	10	13.3	11	14.7
15	I feel confident in navigating the health care system on behalf of my client	36	48	16	21.3	3	4	3	4	17	22.7
16	I feel that my client is able to find reliable health information	25	33.3	21	28	1	1.3	6	8	22	29.3
17	My client has asked me to find health information for them	33	44	27	36	0	0	6	8	9	12
18	I feel that my client is able to understand health information well enough to know what to do	17	22.7	23	30.7	0	0	8	10.7	27	36
19	I would like to have more knowledge and skills to be able to promote the good health of my clients	41	54.7	1	1.3	19	25.3	1	1.3	13	17.3
20	A brief education or training program would help to improve my skills and knowledge for promoting the good health of my clients	38	50.7	3	4	24	32	1	1.3	9	12

Table 2: HL Support Provided by HCWs

Type of support	Total no. of sources reporting	Sub-themes/ no. of sources reporting	Sample responses
Health-related appointments with clients	**7**	Making appointments on behalf of clients (7); attending the appointment with the client (6); reiterating/interpreting advice from health professional (4); ensuring follow up (4)	"…having me there…I could listen to the doctor and hear what he was saying very much helped because I could explain it later, what [the client] had forgotten." "…I go to [the client's] medical appointments and I make his appointments."
Providing health advice to clients	5	General health advice (5); dietary advice (4); medications (4); advice about specific health conditions (3); fitness (2); navigating health system (2)wound care (1); sexual health (1);	"[the client would] be eating something in particular and they'd want to know if it was healthy, or what a good alternative would be." So I…explained to [the client] the importance of taking [medication] to keep the cholesterol at a level where it may help prevent heart attack…to give her the confidence…to take it."
Referral of client to external health care professionals	5	Referring to GP (5); other health professionals (e.g., community nurse, pharmacist) (5); ambulance services (2)	"[Clients have] talked to me and said is there something else I can take, and I've said you have to go and see your doctor and then he'd refer you to what else to take." "…in my role at the moment, I'd…get some support from a dietician, or [ask the client if they], have a GP that [they] really respect, or…have a look on the internet and see what it says…"
Researching health-related information on clients' behalf	5	Medications information (4); information around specific health conditions (3); phoning an organisation for information on client's behalf (1)	"I've had one client specifically ask me if I could do research on care facilities in the area, what sort of ones there were." "There was a Diabetes Foundation thing down in Victoria. So I rang them up and they sent me all the info out and I had a big chat [to the client] about it…"
Client advocacy	2	Supporting self-management (2); speaking up on behalf of client (2)	"…we do go to doctor's appointments and stuff like that. We do go…if they need to go to the chemist we go to the chemist with them…but we get them to actually ask…because it's all about them…it's not about us." "being in [hospitals] with [clients] and they're scared…and I'm dealing with the nurses .."

Table 3: Enablers for HCWs' Provision of HL Support

Enabler	No. of Sources	Sample Responses
Being clear about job description and scope of practice	7	"I know that I could get into trouble and I don't want my clients to follow advice that's not qualified, you're not qualified for that".
		"…in terms of professional and personal boundaries…I'm…there for a specific role, and crossing that line isn't always good…it's a hard balance…"
Organisational support	6	"...if you don't know you have to refer it on to someone…the key worker or management."
		"I know I can get on the phone and speak to the coordinator and just run it by them. It wouldn't be a problem. You're never really alone."
Having a comprehensive background/history of the client	5	"…when it comes to…personal care, it would be good to have more of an understanding of [the client's health history]."
		"…I think you need to have an awareness of what their weaknesses are when it comes to their health so that you can be aware of that when you're with them in case something goes wrong."
Previous work/life experience	5	"…I haven't always been very happy with my diet and with experience…I feel like if I give them this [advice] it is not going to be damaging."
		"…I…am constantly explaining to [the client] every day why he's taking it [medication] and he will ask what are the effects of thyroid and I will explain that to him, and the only reason I can do that is because I have thyroid."
Clear policies and procedures	4	"Just follow procedure. Company policy, just follow that. You know. They don't really want me to go on about what medication is to these clients, just here it is. Follow procedure, it's the safe way really just follow policy. So, I don't try and breach that ever really cos you just steer yourself into a rocky road really."
		"I've got an approach, it keeps you safe really. I'm very firm on being – if you stick to policy, you can keep yourself safe really. You know they're there as much to protect you as well."

Table 4: Barriers for HCWs' Provision of HL Support

Barrier	No. of Sources	Sample Responses
Uncertainty about job description and scope of practice	3	" I don't know if it's really in my job description to contact healthcare providers on behalf of [my client]…" "…we do have all of the - you know, the roles and responsibilities when you get to work and everything, but we are so heavily involved in their lives, and often we're getting more insight into their lives than the nurse, or the chemist, or the doctor. But then we're still not able to provide that medical advice, because of the restrictions of our role…and we don't often know, ourselves, to provide to the client, and whether we can provide that information."
HCWs' low HL levels	3	"[I] had a client and I had felt a bit…like I was out of my depth and I didn't know what to do, so I think that…it's probably not really in my ballgame." "…I don't have much experience myself…I don't always go to the doctor's, go to the hospital…I'm not always around those environments."
Limited time with client	3	"I'm still learning and getting to know people. So it's hard to know, and I'm only seeing them once a week if that…I think that makes me feel a little less confident about knowing how to say things." "…You're not going to the doctor appointments every time. I think if I was more involved, I would definitely feel that I had a place to make a suggestion or to be more informed, but often you're not always that involved with them."

Table 5: HCWs' Training Curriculum Needs

Curriculum	Number of Sources Reporting	Sample Responses
Managing challenging behaviours	6	"…how to…handle people with different behaviours or how to speak to people…how touch helps and the tone of your voice and body language and all of that sort of thing..." "…my main interest at the moment lies in the area of dementia, the behaviours, how to deal with different behaviours with people…"
Boundaries and scope of practice	4	"…it would be good to have a bit more of a clear understanding of…what advice we can and can't provide." "…it often does get blurred where you sit amongst the doctor, the chemist, the hospital, the nurse. Because we are fully involved, but we're a little bit blurred, so…maybe getting a more clear understanding of where we can and can't provide advice…"
Medications	3	"I feel I don't have enough information…It's all changing constantly…there's also a lot of stuff we don't have enough information on, so fully understanding all the medication stuff." "I must admit when I first started the job the medications stuff was a nightmare.. very scary. Being relied on by someone for their medication potentially could kill them, you know."
Sexual health	2	"…sexual health and stuff like that…if I'm looking at a person holistically, and that's part of their world, I mean, as a [HCW]…would I feel qualified to talk to someone about their sexual health?"
Health system navigation	2	
Orientation to the HCW role	2	
Wound care	1	"I sort of wanted to know…what clients can access through different medical places, or what their - funding, or programs, if there's things out there for them that we can suggest."
Health promotion	1	
Medical terminology	1	"I wish I knew some better techniques to help, really help [clients] understand the consequences, and maybe support them in making healthy lifestyle choices…"
First aid	1	
Ageing process	1	

Table 6: HCWs' Training Pedagogical Needs

Pedagogies	Number of Sources Reporting	Sample Responses
Face-to-face	5	"You can see that you are not alone and what you're experiencing is what everyone else is experiencing." "I think I'd be better with face to face training because you can ask questions there and then."
Discussion and interaction	5	"…some [HCWs] will come up with an example and you can relate to it…I can imagine that sometimes people might be out there thinking…if anyone else has experienced this." "I get a lot more out of the interactive sessions. Or I feel like I need to learn more. I need to take it more seriously when there's a bit of accountability than if…I can just do it in my own time and there's not going to be any feedback…"
Incorporating real client scenarios or case studies	4	"I know I learn well when I've got something to apply it to." "…as long as there's no names and stuff like that – confidentiality…but if you're relating something that's actually happened…"
Group work	3	[It's good if we]…all get into little groups…and have like focus groups as well…even if we get together in a big group settings and then split off into different groups" "Also, maybe like putting things in practice, so after the group training going away and putting things, and then coming back and meeting again, and seeing how these things have been successful or not successful." "…they give us the booklets to take home with all that information…and quite often some exercises and questions and things at the back to do. I'm happy to do that sort of stuff. I'm not big on where you've got to be up and interactive, play role and all that sort of thing."

Discussion

Findings suggest that HCWs in this study felt that many of their clients were struggling with HL, and HCWs were providing HL support to their older clients upon their request. The types of support outlined in Table 2 are all consistent with Nutbeam's (2008) definition of HL, i.e., these workers were assisting their clients to access, understand, appraise and apply health information to manage their own health and health care. However, while HCWs in this study actually wanted to provide HL support, and some of them felt confident in this area, they were concerned about working outside their role description and responsibilities. At times, some considered themselves to be ill equipped to provide sound HL support to their clients, often relying on their own life experience to support clients. These findings raise two concerns, firstly around whether the scope of the HCW role extends to HL support and secondly, how to ensure that HCWs are educationally prepared to ensure that they are providing accurate HL support.

HL scope of practice

The role of the Australian HCW mainly extends to providing assistance with personal hygiene, housework and accessing the community – not HL support (Palesy et al, 2018). This represents a missed opportunity, not only to improve health outcomes for clients but also for the HCWs themselves, their families and their communities (Muramatsu, Yin & Lin, 2017). In countries such as the US, health promotion and health coaching programs integrated into the HCW role have improved the health of both older clients and their HCWs (Muramatsu et al., 2017; Russell, Mola, Onorato, Johnson, Williams et al., 2017).

Formal inclusion of HL support in the HCW scope of practice could also provide more opportunities for career advancement in a role that is typically limited and characterised by

high turnover and staff shortages (Palesy et al., 2018; Russell et al., 2017). The 'community health worker' tag could be included in the role i.e., individuals with no formal medical education who coach individuals in managing their own health and assist with health care system navigation (Hartzler, Tuzzio, Hsu & Wagner, 2018; Rosenthal, Brownstein, Rush, Hirsch, Willaert et al., 2010). In this way, there is the potential to positively influence clients' health outcomes e.g., better diets, diabetes management, arthritis management, blood pressure control (Katigbak, Van Devanter, Islam & Trinh-Shevrin, 2015; Muramatsu et al. 2017; Rosenthal et al., 2010).

Consequently, better scoping of the HCW role in terms of the HL support they can and cannot provide is needed. Consideration should be given to whether or not HL support can be incorporated into the existing HCW role (Muramatsu et al., 2017; Russell et al., 2017) or if it should be standalone 'community health worker' role (Rosenthal et al., 2010; Katigbak et al., 2015). In any case, making explicit the HL component of the HCW role in a workforce which is growing exponentially, stands to improve outcomes for clients (i.e., better health), HCWs (e.g., career advancement and health outcomes) and their employers (e.g., reduced staff turnover, improved workplace health and safety, financial imperatives).

HL education and training

Education and training for HCWs also needs to be considered. HCWs in this study wanted training in all kinds of home care provision e.g., managing challenging behaviours, boundaries and scope of practice, medications, not just HL support. The supports the fact that HCWs are strongly committed to training and up-skilling for their roles (King et al., 2013; Lawn et al., 2016). However, despite the positive outcomes reported e.g., quality of care for clients, improved emotional wellbeing of HCWs (Clarke, 2015), greater job satisfaction and

workforce retention (Lawn et al., 2016) training is neither uniform nor mandated in the Australian home care sector (Palesy et al., 2018), and a core HL curriculum checklist for HCWs does not exist (Saunders et al., 2018). HL training programs for their HCWs have been trialed in the US with some success (Muramatsu et al., 2017; Russell et al., 2017). However, the financial constraints of many Australian home care service providers and the subsequent ad-hoc approach to training (Palesy, 2017), combined with a largely casualised HCW workforce with high staff turnover rates (Palesy et al., 2018), imposing HL training on top of what is already offered to HCWs is likely to be challenging. For these reasons, rather than delivering standalone HL training, developing and applying some kind of training checklist for designing and delivering all other in-house training might be a workable solution.

A training checklist for improving HL support

The desired curriculum and pedagogies reported by the HCWs in this study, along with the broader literature on Australian HCWs (e.g., Palesy et al., 2018) have been used to draft a checklist which could be applied to all kinds of HCW in-house training sessions for improving health literacy. Our checklist consists of eight key areas for consideration outlined and justified in Table 7.

Table 7: Proposed Training Checklist for Improving HCWs' HL Levels

Key area	Rationale and Intended Outcomes
Consultation with HCWs in training design	Ascertain types of challenges commonly encountered; ensure that training meets their HL and other training needs; increased job satisfaction by giving HCWs some ownership of training; may lead to reduced staff turnover and organisational costs
Consultation with clients	Gain an idea of type of support issues experienced; ensure that training meets their HL and other service needs (i.e., person-centred care); increased satisfaction by giving clients ownership of their support; improved health outcomes for clients
Outline HCWs' personal boundaries and scope of practice in relation to the training topic	HCWs will have a clear understanding of what they can and cannot provide in terms of HL support and the training topic; increased job satisfaction; positive health outcomes for clients if HCWs know when to refer
List key organisational contacts relevant to the training topic	Provide organisational support for HCW; improved communication with organisation likely to lead to increased job satisfaction; better health outcomes for clients
List available services and networks relevant to the training topic	Improved HL for both HCWs and their clients; better health outcomes for both
Including relevant scenarios and group work	Ensure relevance to work setting; build on existing knowledge; incorporate preferred pedagogical approach as per study findings; allow networking; improved HL
Build in strategies to check understanding of the topic	Improved HL for HCWs and their clients; better health outcomes for both
Evaluate of effectiveness of the training.	Check understanding of information; continuous improvement of curriculum and pedagogies; improved HL for HCWs and their clients; better health outcomes for both

Incorporating these areas into any HCW training is directly aimed at improving HL for clients. Other benefits of using this checklist may be increased HL of HCWs, so together with their clients, the current statistic of 60% of Australian adults with acceptable HL levels (ACSQHC, 2014) may be increased. HCWs who attend highly relevant classroom training that encourages interaction and discussion are more likely to transfer this training to their workplaces, which has the potential to improve care and health outcomes for clients (Palesy, 2017). HCW job satisfaction and staff retention may also increase (Palesy et al., 2018). Clear boundaries in relation to each training topic, along with supervisor support to apply HL training is also more likely to lead to improved outcomes for HCWs, clients and organisations (Palesy, 2016).

The next step in implementing this training checklist will be a Delphi Study (proposed for 2019) which aims to seek industry consensus from a panel of up to 15 experts in the home care sector. Once consensus has been reached, the checklist will be ready for testing in a pilot with one or several home care service providers.

Conclusion

Concerns have been reported about the inadequate health literacy levels of the general Australian adult population, and improving health literacy has been highlighted as a national priority. The rapidly expanding paid home care sector positions HCWs as a valuable resource with potential to improve HL outcomes for clients. HCWs are already providing HL support to their clients, although the scope of their role is yet to be fully articulated and it is unknown whether they have sufficient skills and knowledge to provide competent HL support. Research is needed to scope out the role and ascertain HCWs' HL levels. Although desirable, training may not be the solution in a sector which is highly resource-constrained. The

proposed HL checklist which can be applied to all kinds of HCW training may serve to enhance existing in-house training and bridge the HL gap. Refining and testing of this checklist will also be the focus of further study.

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