Health Literacy Support for Australian Home-Based Care Recipients: A Role for Homecare Workers?

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This paper has not been submitted to any other journal for review. The authors declare no conflict of interest. This research did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors.

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Abstract

Clear links have been established between low health literacy (HL) levels and poor health outcomes. One means of improvement may be found in the rapidly growing paid homecare workforce, whose direct and frequent contact with aged/disabled care recipients positions them to provide HL support. This study examines Australian homecare worker (HCW) experiences in HL when providing assistance to their care recipients. A self-reported cross-sectional survey collected data from 75 HCWs. They reported concerns about their clients' HL, yet were cautious about providing support in this area. HL levels of the HCWs themselves were unconvincing, and the majority requested targeted education and training. Further research is needed into HL levels of both HCWs and care recipients, client demographics, the types of HL support being requested of HCWs, a more detailed scoping of the HCW role, and the curriculum and pedagogies which may comprise a HL education and training program for HCWs.

Keywords

Health literacy; home care worker; care recipient; health care; education; training

Introduction

The term ‘health literacy’ first emerged in the early 1970s in the field of public health, where it developed in the context of preventative health, health education and promotion (Simonds, 1974). While it is a concept that has evolved overtime and general consensus about its meaning remains unrealised (Pleasant 2016), health literacy (HL) generally refers to the ability of a person to understand, appraise and act on health information in making effective health care decisions (Nutbeam, 2008).

Australia, the United States (US), Asia and Europe report that approximately 60% of adults do not have adequate levels of HL to manage their own health and health care (Australian Commission on Safety and Quality in Health Care [ACSQHC], 2014; Estacio, McKinley, Saidy-Khan, Karic, Clark et al., 2015; Sørensen, Pelikan, Röthlin, Ganahl, Slonska et al., 2015; U.S. Department of Health and Human Services 2008). As health information and systems become increasingly difficult to navigate (ACSQHC, 2014), clear links have been established between low HL levels and poor health outcomes (ACSQHC, 2014; Berkman, Sheridan, Donahue, Halpurn & Crotty, 2011). For example, people with low HL levels are more likely to seek emergency care and/or be hospitalised, less likely to access public health services such as breast screening and vaccinations, and less likely to read and understand labels to take their medications correctly (Berkman et al., 2011). High risk/vulnerable groups include people with cognitive impairment and the elderly. These factors adversely affect quality of life, morbidity and mortality (Adams, Appleton, Hills, Dodd, Findlay et al., 2009; Berkman et al., 2011) and place increased economic burden on health care systems (ACQHC, 2014). Consequently, improving HL levels has been flagged as an international priority (ACSQHC, 2014; Poureslami, Nimmon, Rootman & Fitzgerald, 2017).

Central to improving HL levels of vulnerable groups is the role of healthcare personnel as a key source of information and capacity building for patients and families (Johnson, 2014; Saunders, Palesy & Lewis, 2019). More specifically, the unlicensed homecare worker (HCW) has the potential to significantly impact the way frail older people and those with disabilities navigate the health care system and make decisions that positively impact on their health (Stone, Sutton, Bryant, Adams & Squillace, 2013).

An ageing global population opting to remain in their own homes for care, and associated cost efficiency in home-based care provision, has resulted in a rapidly expanding paid homecare workforce (Chomik & MacLennan, 2014a; Palesy, Jakimowicz, Saunders & Lewis, 2018). Known by various terms such as home health aides, personal care attendants/aides/workers/assistants, direct care/support workers/assistants, carers/care assistants (Australian Nursing Federation [ANF], 2009), this work is usually performed by female, middle-aged, low-paid workers, with many from minority backgrounds (Boerma, Kroneman, Hutchinson & Saltman, 2013; Palesy et al., 2018; Markannen, Quinn, Galligan, Sama, Brouillette et al., 2014; Manthorpe & Martineau, 2008; Stone et al., 2013). The homecare sector is a highly politicised, poorly regulated, resource-constrained environment where HCWs are often held in low esteem, competing and negotiating with and amongst the needs of various stakeholders such as the client, their families, qualified nurses and allied health professionals, managers, co-workers and the wider community (Markannen et al., 2014; Stone et al., 2013). In Australia, HCWs tend to be lower skilled and are employed in place of health professionals such as nurses (Chomik & MacLennan, 2014b), yet their direct contact with care recipients who are frail aged, disabled and/or have chronic, debilitating illnesses positions them as the ‘eyes and ears’ of the homecare 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).

Of concern, however, is that HCWs 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). Formal qualifications are not usually mandatory for entry into homecare work (ANF, 2009) and when offered, formal training programs vary between training providers in terms of course content and delivery, are largely too short, and allow insufficient time in a workplace for sufficient skills development (ANF, 2009; Australian Institute of Health and Welfare [AIHW] 2015; Aylward, Keat, Stolee & Johncox, 2003; Lawn, Westwood, Jordans, Zabeen & O'Connor , 2016), including development of the necessary expertise for client HL support (Naccarella, Osborne & Brooks, 2016).

Aim

The overall aim of this study was to examine Australian HCWs' HL perspectives when providing support to their clients. The central premise is that paid homecare is one of Australia's fastest growing sectors as older Australians and people with disabilities increasingly remain in their own homes for care. What is not known, however, is whether the homecare workforce has the knowledge and skills to assist their clients to understand, appraise and act on health information (i.e., HL), or whether this kind of support is actually required.

This central premise informed three main categories of questioning to guide the study: (i) HCWs' perceptions of their clients' HL levels (i.e., their ability to understand, appraise and act on health information); (ii) HCWs' views of their own HL as part of their role; and (iii) HCWs' perceived HL knowledge/skills gaps and the need for education or training in this area. Data collected and analysed in relation to these three categories provides some

insight into HL levels in the homecare sector and proposes key recommendations to support improved HL levels of HCWs and their clients in the future.

Method

Study design, sample and data collection

This mixed method study was underpinned by a constructionist approach. This paper presents Phase One of the study, which used a survey design. The second, qualitative phase involved semi-structured, individual interviews and is reported elsewhere (Palesy & Jakimowicz, 2019). A self-reported cross-sectional survey was used to collect data about the experiences of HCWs and HL. Respondents were recruited from two homecare service providers in Australia; in New South Wales and Queensland, employing 80 and 150 HCWs respectively. HCWs were either employed casually or permanent part time, supporting both frail aged and people with disabilities with a range of tasks such as personal care (e.g., bathing, toileting), mobilisation, domestic duties (e.g., cleaning, shopping) and community access. We used purposive criterion sampling to obtain a respondent sample of HCWs with varying length of experience.

Data were collected over a six-week period aiming for maximum participation opportunity. Respondent information sheets were distributed to HCWs at both sites either by email or hardcopy. Surveys were offered as either online or hardcopy and were anonymous. Hardcopy surveys, once completed, were returned to the investigators in a secured envelope.

Instrument

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 adapted specifically for HCWs from the nine domains of HL 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). For our questionnaire, questions were not posed specifically to determine HL levels, but simply to gain insight into HCWs' experiences with HL in providing support to their clients, including HCWs' education and training needs in relation to HL, and also to guide questioning in the semi-structured interviews which comprise Phase 2 of this study. Demographic and occupational data collected included age, gender, language, country of origin, education level, experience and previous occupation.

Data analyses

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.

Ethical considerations

All respondents were offered information and the opportunity to speak with the primary investigator. Completion of the survey was taken as consent to participate. Survey participation was anonymous. The magnitude of potential risk to survey respondents was calculated at the level of inconvenience (e.g., time taken to complete survey) or discomfort only (e.g., feeling upset, helpless or embarrassed at being asked to recall situations where clients asked for health advice and they were unable to assist). To address the risk of

inconvenience, survey respondents were advised that they could discontinue the survey at any time. It was considered that the risk of discomfort would be unlikely, because HCWs are regularly asked to recall client situations through a variety of means e.g., daily communication books, regular team meetings, one-to-one consultations with homecare service coordinators. So, these potentially uncomfortable situations are addressed by organisations in a timely manner. Ethical approval was granted by the University's Human Research Ethics Committee (HREC).

Study limitations

The small sample size (n = 75) may render the generalisability of the results as uncertain, however the cohort represents a microcosm of HCWs in Australia. The results of this study could not examine causal relationships as it was an observational study. However, the causal effects were not the aim of this research; the aim was to examine Australian HCWs' HL perspectives when providing support to their clients.

Results

Respondent demographics

The survey instrument was delivered to 170 HCWs, and a total of 75 HCWs completed the survey (response rate 44%). 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 HCWs 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 reported appear to be representative of both the Australian and international homecare landscape (Boerma et al., 2013; Markannen et al., 2014; Manthorpe & Martineau, 2008; Palesy et al., 2018; Stone et al., 2013).

Overall results

A summary of responses to all 20 questions in the survey is provided below in Table 1.

Insert Table 1 here.

Table 1 signposts three main findings: firstly, there is a need to improve HL levels of homecare recipients (responses to Questions 1, 3, 5, 6, 8, 9, 11, 12, 13, 14, 16, 17 and 18). Secondly, HCWs' perceptions of their own HL positions them as a potential resource for improving HL of their clients (responses to Questions 2,4,7,10 and 15), and finally, a targeted education and training program for HCWs may be a useful means of improving the HL levels of both workers and their clients (responses to Questions 19 and 20). These three findings are presented in more detail in subsequent Tables 2, 3 and 4. First, in Table 2, HCWs' perceptions of the HL of their clients are presented.

Insert Table 2 here.

Overall, client HL experiences reported by HCWs were varied. For example, they considered that their clients had good relationships with their health care providers (e.g., doctor, pharmacist, hospital, nurse), with over two-thirds of HCWs reporting that their clients were understood and supported (Question 1 – 68%). However, less than half of HCWs had observed clients asking relevant questions of health care professionals (Question 11 - 40%) and many had been asked by their clients to accompany them to appointments (Question 12

– 45.3%). Moreover, well under half of the survey respondents felt that their clients were actively taking steps to manage their own health (Question 5 – 38%). In terms of accessing and interpreting health information, HCWs' responses revealed significant gaps in clients' HL. For example, while 41.4% of HCWs reported that their clients had sufficient information to manage their own health (Question 3), only 26% of HCWs considered that their clients were able to find reliable health information (Question 16), and 33% of HCWs had been asked to assist with finding information (Question 17). Concerns were also reported about clients' ability to read, comprehend (Question 8 – 14%) and act accordingly on health information (Question 18 – 17%), and one-third of HCWs had been asked to interpret information on their clients' behalf (Question 9 – 33%). Moreover, only 12% of HCWs felt that their clients had sufficient skill to navigate the health care system (Question 13), and almost one-third of HCWs (31% - Question 14) had been asked for assistance of this kind.

In summary, two main themes emerged from HCWs views of their clients' HL. First, HCWs may have a role to play in acting as an advocate or intermediary between clients and their health care professionals. Second, there appears to be discrepancy in how home-based clients access, interpret and act on health information, and how they navigate the Australian health care system, which may also be addressed by up-skilling the HCW role. The suggestions here, however, may be dependent on the existing levels of HL of HCWs, which are now reported in Table 3.

Insert Table 3 here.

Survey responses reported in Table 3 suggest that in their HCW roles, respondents were cautious about supporting their clients' HL. While almost half of the HCWs had been asked for health advice (Question 7 – 49%), confidence in providing this advice (Question 7 – 37%), interpreting health information (Question 10 – 39%) and navigating the health care

system (Question 15 – 39%) was unconvincing. However, 61% of HCWs felt confident in dealing with their clients' health care providers (Question 2). These responses suggest two points: perhaps HCWs are uncertain about whether the scope of their role allows them to provide this kind of support to their clients, or indeed, HCWs actually do lack HL. While both of these points are worthy of further research and consideration, questions about HCWs' HL training needs, reported now in Table 4, were designed to shed further light on this issue.

Insert Table 4 here.

Responses in Table 4 show that HCWs were overwhelmingly in favour of HL training. 80% of survey respondents indicated that they would like to have more knowledge and skills for promoting their clients' good health (Question 19), and 82% agreed with the suggestion of a brief training program to achieve this (Question 20). These results could be interpreted in three ways: first, HCWs have identified a gap in their HL knowledge and skills; second, providing HL support to their clients is something that they would like to be able to do; and third, HCWs are committed to training and up-skilling for their roles.

In summary, survey findings suggest a need to improve HL levels of homecare recipients, including access, understanding and acting on information, and health system navigation. Many HCWs have been asked by their clients for HL support, and indeed, they may be well placed to provide this kind of assistance and improve health outcomes for their home-based clients. However, it is unknown whether the scope of their homecare role permits HL support, or whether actually they have the skills/knowledge to do this. Increasing HL skills/knowledge, including through education and training, has been highlighted by the majority of the survey respondents as beneficial for improving the HL levels of both workers and their clients.

Discussion

For care recipients to make effective decisions and take appropriate actions in relation to their health and health care, not only they need an adequate level of individual HL, but also an environment which supports and empowers them (ACSQHC, 2014). Thus the discussion here identifies the gaps and opportunities for improving both individual HL (i.e., home-based care recipients) and the health environment (i.e., the HCW workforce)

Health literacy levels of homecare recipients

HCWs' responses in this study indicated inconsistencies in how their clients access, interpret and act on health information, and how they navigate the Australian health care system. These responses appear to be consistent with both national and international statistics regarding HL, where approximately 60% of adults lack the skills/knowledge to manage their own health and health care (ACSQHC, 2014; Estacio et al., 2015; Sørensen et al., 2015; U.S. Department of Health and Human Services 2008).

In terms of improving HL for health care consumers (including homecare recipients), research has focused on the readability of written materials (e.g., Rudd, Anderson, Oppenheimer & Nath, 2007) and the provision of information about specific conditions and treatment (e.g., Williamson & Martin, 2010). Moreover, research on the impact of low HL on health outcomes has been most frequently conducted in the area of medications (ACSQHC, 2014). Poor understanding of medications, misinterpretation of medication instructions and low compliance with medication regimes have all been linked to adverse health outcomes (Berkman et al., 2011). In particular, there are links between low HL and failure to adhere to oral anticoagulant therapy regimes, increasing the risk of bleeding and stroke (Diug, Evans, Lowthian, Maxwell, Dooley, Street et al., 2011).

HCWs in this study reported issues for their clients in locating, understanding and then acting appropriately upon health information. However, the survey responses did not allow for any elaboration of the kinds of information that HCWs had been asked to find and interpret on behalf of these individuals. HCWs also reported concerns with their clients' ability to navigate the health system, yet there was no scope to explore the specific scenarios or difficulties encountered by homecare recipients. Moreover, no questions were asked of HCWs about the health status or health outcomes for clients when challenged by HL. Consequently, further research is needed around homecare recipients and HL: levels of literacy, client demographics, specific situations where HCWs have been asked for support and the kinds of health outcomes for homecare recipients likely to be seen in relation to HL levels. Collecting this kind of data may assist in identifying those who are most at risk, specific areas of concern (e.g., medications, certain illnesses), and strategies for improving HL, including commonly encountered scenarios in which HCWs may be able to provide support.

Health literacy levels of HCWs

Survey questions in the research reported here were designed to gain insight into HCWs' HL levels, yet the data was not persuasive either way. Respondents felt confident in some areas (e.g., liaising with health professionals), but were cautious about providing health advice, suggesting that perhaps HCWs were unsure about the scope of their roles, or lacked HL themselves.

Healthcare personnel have been identified as key in improving HL of those in their care (Johnson, 2014; Saunders et al., 2019). In Australia and indeed many other countries, HCWs comprise the largest component of the paid homecare workforce, spending more time with clients than any other health care worker (Palesy et al., 2018; Stone et al., 2013). For the most

part, however, the role extends to assisting with personal hygiene, domestic duties and social assistance (Palesy et al., 2018). Therefore, the current scope of the role is limited and does not officially extend to providing HL support, which may explain why HCWs are cautious about providing assistance of this kind. The Australian College of Nursing (ACN) emphasise the importance of clarifying the roles and responsibilities of those involved in health care (2013). They suggest that while health care professionals themselves may understand the distinctions between roles (e.g., nurses, doctors), it is not always clear to clients who they should approach for particular services or health needs.

Accordingly, more research is needed around clarifying the HCW role and responsibilities, to ascertain if indeed the scope could include HL support. An important consideration here, is whether adding to the scope of a role which is already highly politicised, poorly regulated, resource-constrained and often devalued is ethical, and if so, how this could be managed to ensure HCWs' wellbeing. Turnover rates in the homecare sector due to working conditions, stress and burnout are already high (Palesy et al., 2018), and consequently adding even more to the HCW role could further jeopardise the sector's stability and contribute to an already vulnerable workforce.

HCWs often receive little formal preparation or training for their roles, and education levels of these workers vary internationally, from entry level to post-school qualifications (AIHW, 2015; Aylward et al., 2013; Boerma et al., 2013; Manthorpe & Martineau, 2008; Palesy et al., 2018). Consequently, the HL levels of HCWs may indeed be as inadequate as those of the general population (ACSQHC, 2014; Estacio et al., 2015; Sørensen et al., 2015; U.S. Department of Health and Human Services 2008). Conversely, their higher levels of education may indicate that their HL levels are high which places them in a prime position for providing this kind of support. In any case, there needs to be some consideration of the

appropriateness of HCWs to take of HL support, and the risks this poses to already vulnerable care recipients.

Processes for measuring HL are complex and lack a coordinated approach (Saunders et al., 2019). However, validated tools currently in use include the Four Habits Model to assess health professionals' communication skills with patients (Grice, Gattas, Sailors, Murphy, Tiemeir et al., 2013) and the Short Test of Functional Health Literacy in Adults (S-TOFHLA) (Baker, Williams & Nurss, 1995). Therefore, further research could measure the HL of HCWs by adapting or using a validated tool.

Health literacy training and education for HCWs

Respondents in this study overwhelmingly called for more education and training to assist in improving their clients' health. This is consistent with Ifkovich et al., (2013), whose case study on the health information and education needs of homecare recipients found that HCWs wanted to provide HL support, but were insufficiently prepared for this role. Moreover, Australian HCWs report a strong commitment to training and up-skilling for their roles (King, Mavromaras, Wei, He, Healy et al., 2013; Lawn et al. 2016), which further supports the research reported here.

Targeted training and preparation for the HCW role has been linked to better quality of care for consumers (Clarke, 2015), improved emotional wellbeing of HCWs (Clarke, 2015), greater job satisfaction and workforce retention (Lawn et al., 2016). However, training programs for HCWs tend to be ad-hoc. Larger organisations offer more systematic training programs, while smaller agencies tend to provide fewer hours of training, and others receive no formal preparation for their roles at all (Aylward et al., 2003; Palesy, 2017). In any case, brief training sessions, (requested by the majority of survey respondents here), may be effective for HCWs in preparing them for their roles (Palesy, 2017). What is important,

however, is the curriculum (i.e., the content and ordering of educational experiences) and the pedagogies (i.e., how these experiences may be delivered and enriched) (Palesy, 2017). Consequently, if HL support is to be included in the HCW role, research is needed into the type of HL training/education program that may support HCWs to support their clients, and the pedagogies which are best suited for these programs.

Conclusion

In conclusion, concerns have been reported about the inadequate HL levels of the general adult population, and improving HL has been highlighted as priority. An increasing number of aged/disabled people choosing to receive care in their own homes has resulted in the exponential growth of the paid homecare workforce. In view of their direct and frequent contact with their care recipients, HCWs are being asked to provide HL support to their clients, yet it is not known whether the scope of their role extends to this kind of support, or if they have sufficient HL knowledge/skills to provide competent assistance in this area. However, the sheer numbers of HCWs and their position at the frontline of homecare suggests an untapped resource which has genuine potential to improve health outcomes for clients. Therefore, further research is needed into the types of HL support being requested of these workers by their clients, care recipient demographics, HL levels of both HCWs and their clients, scope of the HCW role, and the required HL knowledge/skills that may best assist HCWs to have a positive impact in this area.

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Table 1 Home Care Worker Survey Summary

	Question	Strongly Agree (5)	Agree (4)	Undecided (3)	Disagree (2)	Strongly Disagree (1)	Mean
		Freq (n = 75)	Freq (n = 75)	Freq (n = 75)	Freq (n = 75)	Freq (n = 75)	
1	I feel that my client is understood and supported by his/her health care providers (e.g., doctor, pharmacist, hospital, community nurse etc.)	11	40	19	5	0	3.76
2	As a home care worker, I feel confident in dealing with my client's various health care providers	16	45	9	4	1	3.95
3	I feel that my client has sufficient information to manage his/her own health	2	29	27	14	3	3.17
4	In my role as a home care worker, I feel that I have sufficient information to manage my client's health	8	29	20	17	1	3.35
5	I feel that my client takes steps to actively manage their own health	2	36	19	14	4	3.24
6	My client has previously asked me for health advice	3	46	8	11	7	3.36
7	In my role as a home care worker, I feel confident in providing health advice to my clients	5	30	18	17	5	3.17
8	I feel that my client is able to read and comprehend the health information provided to them	0	14	27	26	8	2.63
9	My client regularly asks me to interpret or explain the health information provided to them	2	31	9	23	10	2.89
10	In my role as a home care worker, I feel confident in interpreting or explaining health information to my client	4	35	18	13	5	3.27
11	I have observed my client asking relevant questions of their health care providers	1	29	15	23	7	2.92
12	My client has asked me to attend appointments with them and ask/or ask for information on their behalf	3	31	12	20	9	2.99
13	I feel that my client has the skills to successfully navigate the health care system	0	12	24	26	13	2.47
14	My client has asked me for assistance with navigating the health care system	1	30	11	23	10	2.85
15	I feel confident in navigating the health care system on behalf of my client	3	36	17	16	3	3.27
16	I feel that my client is able to find reliable health information	1	25	22	21	6	2.92
17	My client has asked me to find health information for them	0	33	9	27	6	2.92
18	I feel that my client is able to understand health information well enough to know what to do	0	17	27	23	8	2.71
19	I would like to have more knowledge and skills to be able to promote the good health of my clients	19	41	13	1	1	4.01
20	A brief education or training program would help to improve my skills and knowledge for promoting the good health of my clients	24	38	9	3	1	4.08

Table 2 Home Care Workers' Perception of Clients' Health Literacy Levels

	Question	Strongly Agree (5)	Agree (4)	Undecided (3)	Disagree (2)	Strongly Disagree (1)	Mean
		Freq (n = 75)	Freq (n = 75)	Freq (n = 75)	Freq (n = 75)	Freq (n = 75)	
1	I feel that my client is understood and supported by his/her health care providers (e.g., doctor, pharmacist, hospital, community nurse etc.)	11	40	19	5	0	3.76
3	I feel that my client has sufficient information to manage his/her own health	2	29	27	14	3	3.17
5	I feel that my client takes steps to actively manage their own health	2	36	19	14	4	3.24
8	I feel that my client is able to read and comprehend the health information provided to them	0	14	27	26	8	2.63
9	My client regularly asks me to interpret or explain the health information provided to them	2	31	9	23	10	2.89
11	I have observed my client asking relevant questions of their health care providers	1	29	15	23	7	2.92
12	My client has asked me to attend appointments with them and ask/or ask for information on their behalf	3	31	12	20	9	2.99
13	I feel that my client has the skills to successfully navigate the health care system	0	12	24	26	13	2.47
14	My client has asked me for assistance with navigating the health care system	1	30	11	23	10	2.85
16	I feel that my client is able to find reliable health information	1	25	22	21	6	2.92
17	My client has asked me to find health information for them	0	33	9	27	6	2.92
18	I feel that my client is able to understand health information well enough to know what to do	0	17	27	23	8	2.71

Table 3 Home Care Workers' Perceptions of their own Health Literacy in relation to Client Support

	Question	Strongly Agree (5)	Agree (4)	Undecided (3)	Disagree (2)	Strongly Disagree (1)	Mean
		Freq (n = 75)	Freq (n = 75)	Freq (n = 75)	Freq (n = 75)	Freq (n = 75)	
2	As a home care worker, I feel confident in dealing with my client's various health care providers	16	45	9	4	1	3.95
4	In my role as a home care worker, I feel that I have sufficient information to manage my client's health	8	29	20	17	1	3.35
6	My client has previously asked me for health advice	3	46	8	11	7	3.36
7	In my role as a home care worker, I feel confident in providing health advice to my clients	5	30	18	17	5	3.17
10	In my role as a home care worker, I feel confident in interpreting or explaining health information to my client	4	35	18	13	5	3.27
15	I feel confident in navigating the health care system on behalf of my client	3	36	17	16	3	3.27

Table 4 Home Care Workers' Health Literacy Training Needs

	Question	Strongly Agree (5)	Agree (4)	Undecided (3)	Disagree (2)	Strongly Disagree (1)	Mean
		Freq (n = 75)	Freq (n = 75)	Freq (n = 75)	Freq (n = 75)	Freq (n = 75)	
19	I would like to have more knowledge and skills to be able to promote the good health of my clients	19	41	13	1	1	4.01
20	A brief education or training program would help to improve my skills and knowledge for promoting the good health of my clients	24	38	9	3	1	4.08