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Improving the Health Literacy of Rural Elders: An Interdisciplinary Approach

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CHAPTER TWENTY-THREE

Improving the Health Literacy of Rural Elders: An Interdisciplinary Approach

M. Susan Jones, Marilyn M. Gardner, Janelle A. Peeler, Serena Merry Britt, and Marilyn Lewis Graves

Almost 25% of the general population of the United States lives in a rural area. In Kentucky, roughly 15% of the rural population is aged 65 or older (U.S. Bureau of Census, 2000). Elders in rural areas are more likely to be poorer than their metropolitan counterparts and are at risk for being underinsured or uninsured. Long traveling distances to obtain services as well as lack of personal transportation are barriers to seniors seeking health care. Rural elders also have poorer perceptions of their health status and are likely to have a higher rate of chronic disease (Bushy, 2000). Research indicates that health literacy is directly related to health outcomes, length and frequency of hospitalizations, and health care expenditures (Davis & Magilvy, 2000; Kovner & Harrington, 2000). The significant dissonance that exists between rural elder's perception of their health and their actual health status can be lessened by improving their health literacy status. Our purpose of this chapter is to describe an interdisciplinary learning experience for health care professionals aimed at improving the health literacy of rural elders and the challenges and rewards of implementing such a program.

PROGRAM DESCRIPTION: AN OVERVIEW

The Health Enhancement of the Rural Elderly (HERE) project is a federally funded program designed to empower rural elders to maximize their use of the health care system by improving health literacy and fostering strong community relationships. The targeted population for this project were people aged 65 and older living in two south central counties in Kentucky identified as rural and poor. The demographics of the counties indicated similarities in population with each county recording approximately 11,000 residents with 20% of the population of each county living below the poverty level. Residents above the age of 65 comprise 14% to 15% of the total population of each county. Both counties are classified as Health Care Professional Shortage Areas (HPSA, Health Resources & Services Administration [HRSA], 2000).

Western Kentucky University faculty members from the disciplines of nursing, social work, and public health collaborated to implement and evaluate this 3-year multicomponent, interdisciplinary project. One component of the project was the use of an interdisciplinary group of students from nursing, social work, and public health to develop educational modules designed for use with the rural elders. These modules addressed the topics of medications, medical terminology, basic anatomy and physiology, and orientation to medical forms. These modules were designed in an effort to enhance the communication among rural elders and their health care providers.

EDUCATIONAL MODELS: A PROCESS OF INTERDISCIPLINARY DEVELOPMENT

The development of the educational modules evolved over the course of this project. Consequently, the process, which entailed four phases of development (see Table 23.1), served to illustrate the collaborative interdisciplinary effort.

Phase 1: Planning

The first 8 months of the 3–year project were spent in planning, networking with community partners, exploring resources in the targeted rural counties, and organizing an advisory panel of community partners with expertise in elder care. Faculty recruited students from within each of their respective programs to enroll in a three-credit hour "independent study" class. The course was team-taught by three faculty members from

Table 23.1 HERE Project: Phases of Education Module Development

Phase I. Planning
Goal: Explore available resources and network to establish community partnerships

Time	Students involved	Process/Content	Format/Length	Strategies Used/Lessons Learned
Year 1 Semester 1	1 UN 1 USW 1GPH	• networking with community • exploring local resources • organizing advisory panel	F: networking & exploring via letters, e-mails, newspaper advertisement, community visits	S: communication skills LL: need to revisit efforts in connecting with community
Year 1 Semester 2	1 GN	• research intervention locations		S: community engagement LL: certain cultural barriers need be addressed

Phase II. Developing Educational Modules
Goal: Develop series of educational modules addressing identified deficiency areas for rural elders

Year 1 Semester 2	1 UN 3 USW 2 GN 4 GPH	Educational modules developed: • Basic Anatomy and Physiology • Medical Terms • Advanced Directives and Medical Forms • Pharmacology	F: handouts, learning objectives, lesson plans L: 30 - 60 minutes	S: research, record, and present to faculty and advisory panel LL: need for increased oversight; difficulty in merging U and G students

Several strategies were used to implement the educational modules and recruit elderly participants. These strategies included frequent telephone calls, site visits, radio interviews, posting brochures announcing the sessions in church bulletins, newsletters, local newspapers, and using local insiders to gain access.

Again, the class was divided into interdisciplinary teams. Their first task was to incorporate the previous semester's evaluative feedback from the advisory panel and faculty into each module. Next, teams were required to teach the modules to the class and faculty and received substantive critique. Students then implemented the modules at four sites within the target community as part of the project. At each presentation site, the four modules, each lasting approximately 15–20 minutes apiece, were presented.

Based on feedback from students and community members, the project staff decided to share these educational modules with a larger number of rural elders; therefore students began exploring other methods to deliver the educational messages. Because of the short period of time many senior adults are physically able to tolerate sitting through meetings, the modules were condensed and presented in a 2–hour class format and later to a 1–hour class. These modules were presented by invitation at rural churches, rural community centers, community senior citizen centers, and at a statewide leadership conference for women. This change maximized the number of rural elderly receiving the health messages contained in the educational modules. Feedback received from project participants was positive. Participants reported that they considered the information given to be beneficial and indicated that they enjoyed the personal attention given to them in the process of the presentations. It is interesting that as a result of the interactions with the presenters during the group process, the elderly participants were particularly responsive to the discussion of living wills to the point that many immediately requested assistance in completing the forms.

Phase 4: Mass Dissemination

Although the changes in Phase 3 increased the number of rural elders receiving the educational messages, project staff remained concerned about the limited number of elders who participated in the project. Fewer than 10 persons were present at three of the four sessions. The low number of participants was thought to be because rural elder's reluctance to engage in a program offered by someone outside their community. This was further compounded by transportation limitations. Consequently, project staff gave consideration to directing the educational focus to health care providers and disseminating information through other avenues. To address these concerns,

graduate students were recruited for directed study to critically study the content and distribution of the educational modules. As a result of their efforts, the modules were redesigned into four 30-second public service announcements, three 12-minute videos, and three educational pamphlets.

CHALLENGES, REWARDS, AND LESSONS LEARNED

Although the benefits of an integrated interdisciplinary model are both great and evident, challenges arose. Anticipating these challenges and recognizing the rewards was central to successfully meeting the educational goals of such a model. Learning from these challenges contributed to the rich, rewarding outcomes experienced by students and faculty alike.

Student Recruitment

Because students were expected to function within self-managing teams, the search for independent learners and self-starters who were open to working in a multidisciplinary setting was crucial to a successful educational experience. Willingness to work outside their primary area of study and motivation and acceptance of different theoretical models was necessary for success. For the educator, having the time and tools to effectively screen students for these characteristics resulted in a greater number of faculty and student expectations being met.

Many students involved reported that their primary motivation in deciding to participate in the class included an interest in rural health and elders. However, those students who foresaw the advantages of interdisciplinary experiences were open and better prepared for the variety of student interests and expertise encountered. In recording experiences in journals a student wrote, "It will be a good opportunity to work with students from other departments, and I look forward to seeing how the differing disciplines can all contribute to a comprehensive final product."

During the first three phases, primarily recruiting students from the departments of nursing, social work, and public health was sufficient. However, completing the educational pamphlets, public service announcements, and educational videos entailed collaboration with experts outside of these disciplines. Although there were opportunities to effectively use students from areas outside the health professions, efforts to recruit from other disciplines such as communications, speech, and education were met with limited success. If faculty had the time and opportunity to informally engage faculty from other departments, while at the same time educating them on the goals of the HERE project, perhaps the recruitment would have resulted in a better response from students in other areas of study.

Student Preparation

Interdisciplinary learning is very student directed. Within a multidisciplinary system, there is often a lack of common language between professions. The variations in the educational experiences and socialization between professionals contribute to differing perspectives and values, professionally and personally. The existing hierarchy, as well as role competition and turf issues at the university, further exacerbated the current system's inability to function in interdisciplinary teams, instead "causing defined roles to predominate over meeting patients' needs" (Greiner & Knebel, 2003). These obstacles were often present among the faculty and students unless structure was implemented. Providing students with the opportunity to establish objectives and plans to reach them must be balanced with enough direction and guidance to foster student comfort. As experienced in the first year of this project, providing students with only the long-term goals of the project and letting the teams establish specific objectives, resulted in some student confusion, as reflected in this journal entry: "... in the beginning it was very confusing about what was expected for us to do and how we were to work together to develop modules." Such frustration made evident the need for additional faculty support and guidance, especially during the initial stages of the class when there was confusion or incongruity in student-professor expectations.

In subsequent semesters, faculty offered students a detailed syllabus that outlined the specific level of expectations and described assignments and grading criteria with more clarity. As a result, students generally reported a more positive experience and worked independently and more efficiently from the very start.

Group Process

Interdisciplinary learning requires an ability to work effectively in groups. With the HERE project, problems that developed with group activities were not entirely different from those one would find in most group processes. The project team experienced difficulty in scheduling meeting times so that all could attend and participate often.

Initially faculty members were limited in their opportunities to assist students in the resolution of most of these problems because of time constraints. In later semesters, limiting group size as well as developing assignments that were appropriate for the schedules, interests, and living locations of students proved advantageous.

Part of the value of interdisciplinary learning is found in students learning to compromise, assign tasks, be responsible to peers, and problem solve to overcome the challenges of working in a group. Faculty attempting

to intervene and resolve all these problems for the students subtracts from the benefits and experience of group process. During this experience the faculty discovered that lending time, encouragement, and support to the students, as well as assisting them in the exploration of various avenues of resolution, is crucial. Journaling provided an effective means for the students to communicate concerns and reactions as well as to reflect and process thoughts and feelings. Ultimately, this assignment allowed faculty to more easily support, assist, and respond through written feedback.

To best prepare students, reduce frustrations, and limit difficulties, it was imperative for the faculty to initially inform students of the common pitfalls and anticipated problems of group work. This aided in developing strategies to respond to problems as well as enhance student learning. By learning to effectively respond to these particular group challenges, students are likely to be more successful in working with interdisciplinary groups in a professional practice setting. Developing student skills in adaptability is essential for practitioners to effectively work with other practitioners to ultimately maximize patient care in a rural setting.

During various phases of the project's planning, implementation, and evaluation, the faculty members also experienced many challenges experienced by students. As with the students, each HERE faculty member brought to the project specific areas of expertise, interests, and theoretical frameworks. Discussing differences and negotiating solutions capitalized on these individual strengths creating a collaborative and productive work environment. Consequently, the faculty also benefited.

CONCLUSIONS

Engaging students in an interdisciplinary educational model for learning enabled students to understand and respond to such work, while effectively using differing health care theories and orientations. Ultimately, students became aware of the importance of engaging expertise from differing areas while at the same time recognizing their own professional and educational expertise and limits.

Interdisciplinary learning can be a highly effective and greatly beneficial model for education as well as professional practice, but it has its own set of challenges. Working with others within one's primary discipline can be challenging in and of itself; adding group members from other areas of practice and study calls for even greater patience and increased understanding of group dynamics. On the other hand, the rewards can be greater. A student identified the value of the interdisciplinary process as illustrated in this journal excerpt:

> I thought it was a great idea by the faculty committee to split all of the students into groups to focus on different aspects of the module so that each student could assist and build on each others thoughts, views and conclusions on key issues pertaining to important issues about our module.

Despite this particular 3-year service-based, interdisciplinary project's onset of challenges, the project reached the overall goal of conducting multiple interventions within the two-targeted counties. Over the 2-year intervention period, the students encountered many elders who were interested in the topics of the modules. To reach elders who were unable to attend the educational modules, students created public service announcements, informational videos, and brochures. The venue of communication for the public service announcements will involve local radio stations, while the videos and brochures will be distributed to pharmacies, the offices of health care providers, and public libraries. Because of the amount of interest indicated by local elders, funding is being sought so that the project may continue and expand to other rural counties in southern Kentucky.

Although all the students participating in the HERE project shared a common interest of elderly rural health care, their philosophical and theoretical orientations were often different and related to those orientations found within their primary area of study. Facilitating student opportunities to learn and work in a collaborative environment with others from differing backgrounds, experiences, and theoretical bases provided both faculty and students with a rich, comprehensive learning experience reflective of the interdisciplinary nature of today's health care settings.

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CHAPTER TWENTY-FOUR

The Culture of Rural Communities: An Examination of Rural Nursing Concepts at the Community Level

Nancy Findholt

In the late 1970s, faculty members and graduate students at Montana State University-Bozeman College of Nursing initiated a 6-year ethnographic study to explore the health beliefs and practices of rural Montana residents (Long & Weinert, 1989; Weinert & Long, 1987). Several of the concepts that emerged from this research were later validated by a quantitative survey and became the foundation for a theory of rural nursing. These concepts included work beliefs and health beliefs, isolation and distance, self-reliance, lack of anonymity, outsider or insider, and old-timer or newcomer. My purpose in this chapter is to describe how these concepts were manifested over two decades later and at the community-level in three rural communities in Oregon.

The findings that I present here represent a portion of the results I obtained from a study (Findholt, 2004) examining the influence of rurality on community participation in a community health development initiative. Although many researchers have sought to identify the factors that influence community participation, most previous studies have focused on the characteristics of people who participate and those that do not, the reasons people choose to participate, or the characteristics of organizations