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The GOLD Card: Evaluation of an Instrument to Improve Health Literacy and Promote Patient-Centered Care in Urban Vietnam

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Abstract

Patient-centered care (PCC) is respectful of and responsive to individual patient preferences, needs, and values and ensures patient values guide clinical decisions. Large components of PCC are physician–patient communication and health literacy (HL). Little research has been focused on understanding strategies to promote HL and effective physician–patient communication in developing countries, such as Vietnam. Herein, we conducted a pilot study to assess Vietnamese patients' satisfaction with a PCC intervention (GOLD card). Forty-nine patients were recruited and encouraged to use the GOLD card during their exchange with their physician. Overall, the majority of participants either agreed or strongly agreed that using the GOLD card helped to create a more satisfying doctor visit, improved communication between the physician and themselves, and made them feel comfortable/confident in managing their conditions, and they deemed the card easy to use. In conclusion, paper cards written in the patient's own hand and using a teach-back methodology appear to be practical and effective. The use of simple reminder cards could improve confidence in Vietnamese patients' ability to manage their conditions.

Keywords

teach back; patient-centered care; physician; patient communication; global health; health literacy

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Introduction

Historically, medicine had been largely physician centered (Draeger & Stern, 2014; Laine & Davidoff, 1996; Tennstedt, 2000). This model of care assumed that the medical decision-making process was mainly an interaction among medical specialists, in a top-down approach in which information exchange and decision making were prioritized with physicians on top and were allowed to trickle down selectively to the patient and family (Buchanan, 1978; Kon, 2010). The ethical and medical drawbacks to this model in practice have been elucidated in the academic literature (Häyry, 2002; Kon, 2010; McKinstry, 1992) and therefore a more patient-centered delivery of care has been promoted (Barry & Edgman-Levitan, 2012; Davis, Schoenbaum, & Audet, 2005; Peschel & Peschel, 1994; Stewart, 2003).

The delivery of patient-centered care (PCC) is now a primary focus for health care professionals and medical educators in the United States. Professional organizations as large and diverse as the Institute of Medicine (Bloom, 2002) and the American Academy of Pediatrics (2012) have embraced the concept of patient- and family-centered care over the last 15 years. More recently, efforts to bring and sustain the PCC paradigm internationally have increased (Martin & Félix-Bortolotti, 2014), but many of these efforts have been focused on subspecialty care, such as critical care (Ciufo, Hader, & Holly, 2011; Mammen, Laude, & Costello, 2014) or psychiatry (Cox, 2008; Verbeek, van Rossum, Zwakhalen, Kempen, & Hamers, 2009), rather than on primary care. Often, there is a Western or European focus to international initiatives to introduce PCC (Svavarsdottir, 2006; Winsor et al., 2013).

The literature on the benefits of non-Western PCC is scarce, with serious challenges, particularly in resource-poor countries where health literacy is low and where cooperation between developed and developing countries about best practices has not been ideal (Eguzo & Camazine, 2015). Nevertheless, with attention to culturally sensitive communication, evidence suggests that PCC can be successful (Foster, Whitehead, & Maybee, 2010). Although much has been written about PCC, particularly in the United States, precise definitions have been elusive (Ishikawa, Hashimoto, & Kiuchi, 2013; Robinson, Callister, Berry, & Dearing, 2008). PCC is care that is respectful of and responsive to individual patient preferences, needs, and values and that ensures that patient values guide clinical decisions. The goal of this model is to empower patients to be active participants in managing their care. Research into the clinical effectiveness of PCC has demonstrated better health outcomes with its adoption (Bechel, Myers, & Smith, 2000; Oates, Weston, & Jordan, 2000). In 2001, the Institute of Medicine included PCC as one of the six essential aims of health care systems (Bloom, 2002).

Two large components of PCC are physician–patient communication and health literacy (HL). HL has been defined as "the ability to access, un-

derstand, and use health information in ways that promote optimal health. In other words, HL involves active participation in the uptake and use of information" (Davis, Jones, Logsdon, Ryan, & Wilkerson-McMahon, 2013, p 1124). The use of HL principles is known to deepen cultural inclusion, promote positive health outcomes, and reduce disparities (Baker, Parker, Williams, & Clark, 1998; Berkman, Sheridan, Donahue, Halpern, & Crotty, 2011; DeWalt & Hink, 2009; Nielsen-Bohlman, Panzer, & Kindig, 2004). However, in relation to PCC as a whole, HL is underused and understudied in developing countries, which has had a negative effect on the health of patients in those countries (Atilola, 2015; Rodríguez, Holgado, & Salinas, 2015).

Both HL and physician–patient communication have been extensively studied and correlated with improved health outcomes (Baker et al., 2002; Berkman et al., 2011; Epstein et al., 2005). Studies have also shown that patients in primary care settings strongly want a patient-centered approach (Burman, Robinson, & Hart, 2013; Little et al., 2001); however, the majority of this work has mostly been studied in regions such as the United States and United Kingdom. One study conducted in Pakistan on a pediatric population showed the effectiveness of HL principles on family-centered rounds in the intensive care unit (Ladak et al., 2013). However, to our knowledge, no other peer-reviewed research has been focused on understanding strategies to promote HL and effective physician–patient communication in developing countries, such as Vietnam. Therefore, we conducted a pilot study to evaluate patient attitudes toward a simple intervention (the use of the "GOLD" card) to promote HL and a PCC model in Da Lat, Vietnam.

The purpose of our study was to evaluate patient satisfaction in a developing country with the use of a novel communication intervention (the Going Out with Linked Directives, or GOLD card) focused on increasing PCC and improving patient confidence in managing and understanding a condition after use of the GOLD card. We hypothesized that with effective use of a simple, inexpensive interviewing intervention, patients in our population would be more satisfied with care and more confident with managing and understanding their own condition.

Method

Geographic Setting and Public Health Context

Da Lat is the capital of the Lam Dong Province of Vietnam. Da Lat is located 1,500 m (4,900 ft) above sea level and has a population of approximately 206,105 people. There are three major hospitals within the city borders (Lamdong General Hospital, Hoan My General Hospital, and Pham Ngoc Thach Traditional Medicine Hospital; U.S. Department of State, 2015) and several small clinics scattered throughout the province. With the recent economic

growth in Vietnam (Abrami, 2003), city infrastructures and planning have improved, allowing easier access to hospitals and clinics. However, Vietnam only allocates a small portion of its GDP to health care. In 2012, Vietnam allocated 6.0% of its GPD to health care, compared with 17.1% in the United States and 9.1% in the United Kingdom (The World Bank Group Database, 2012).

Da Lat is one of the larger cities in Vietnam, but compared to health care delivery in larger cities (e.g., Ho Chi Minh City), the delivery of health care here—and even its people—is far too different to generalize. Although Western influences have changed the way of life, customs, delivery of health care, type of patients (tourists), and even the dialect within these cities, Da Lat has remained largely untouched. Health care to these areas is largely more private and Western, with foreign-recruited physicians. Hospitals and clinics in Vietnam, in general, are often overcrowded with a small physician-to-patient ratio (The World Bank Group Database, 2013). Da Lat physicians are afforded only minutes with their patients, and the conversation is largely dominated by the physician, a traditional physician-centered approach. Examination rooms are continuous with the waiting area, and multiple patients are often privy to individual physician–patient interactions. Medical equipment varies in terms of working condition and advancement. The city lacks technical support for its medical equipment and little to no government subsidies to fund the purchase of used and outdated technology. A direct means of purchasing equipment, even with sufficient funds, is another barrier to expanding technological advancement within the hospital. If medical equipment breaks, the physicians typically send their broken equipment to "local mechanics" for repair.

Study Design

Our study was approved by the Wright State University School of Medicine Institutional Review Board and by formal approval of the participating Vietnamese hospital. It was completed as part of an international health curricular elective. The primary investigator (M. H. Nguyen), a native-born Vietnamese-American, recruited 49 patients from Lam Dong General Hospital, an urban public hospital located in Da Lat, Vietnam.

Patients were recruited if they were adults (aged 18–80) from the internal medicine clinic of the hospital, had scheduled an initial visit to be seen by a Vietnamese physician from June 2014–July 2014, and agreed to fill out a survey pertaining to their experience. Participants were given a verbal consent and a cover letter affirming that they had received informed consent. Patients consented with the understanding that their participation would not reflect negatively upon their care, that no personal identifying information would be collected, and that their responses would be blinded to the physician after initial consent. Patients who were illiterate, unable to give consent, or otherwise unable to answer written surveys were excluded from the study. Basic demo-

graphic information (e.g., age and gender) was recorded within the scope of the consent forms and was linked to a study number chosen by randomization (see Table 1).

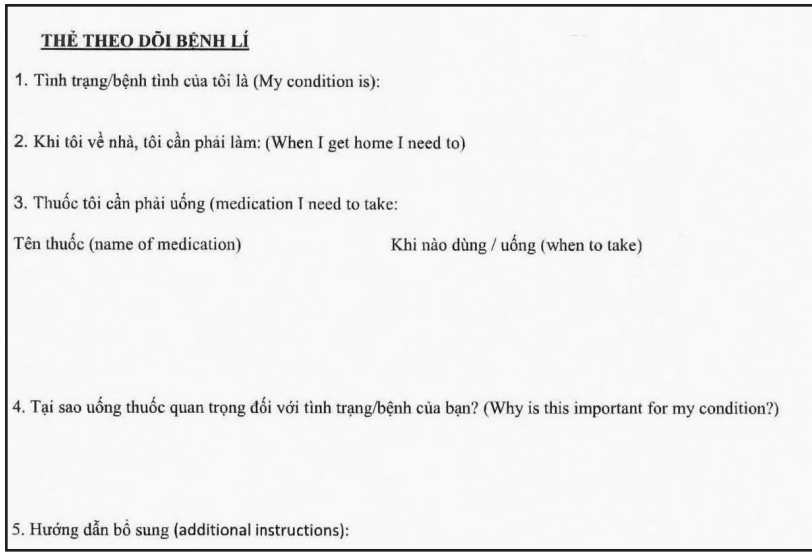
Table 1
Patient Demographics

Variable	*N* (%) or *M* (*SD*)
Gender	
Male	20 (46.5%)
Female	23 (53.5%)
Age (Years)	48.6 (15.3)

Use of the GOLD (Going Out with Linked Directives) Card

GOLD cards (Figure 1) are simple paper cards that contain basic information about the diagnosis and plan after a patient encounter. A GOLD card is a novel intervention; face validity for the card design was obtained through consultation with a group of pediatric hospitalists at Dayton Children's Hospital (Ohio, USA). Of the four physicians involved in the design of the GOLD card, one was a senior professor and medical education specialist, another an expert in in-patient and family-centered rounds, another an expert in HL, and the last an expert in medical education and bioethics (coauthor, A. K. Fernandes). The GOLD cards were written and designed in English initially and then translated by a native speaker (first author, M. H. Nguyen) into Vietnamese and verified for accuracy by the physician at the hospital in Vietnam. We sought to further test their efficacy and practicality in a developing country. GOLD cards cost $0.05 USD to print.

GOLD cards were handed to the patient and discussed with the physician prior to discharge. Specifically, completed GOLD cards have instructions for immediate care of the patient's symptoms upon discharge and for continued care (e.g., finish 3 more days of medicine, change wound dressing every night) that are written in plain language. GOLD cards also contain information about the patient's condition (e.g., high blood pressure) as discussed with the medical care provider and general management instructions (e.g., rest, drink plenty of fluids).



THẺ THEO DÕI BỆNH LÍ

1. Tình trạng/bệnh tình của tôi là (My condition is):

2. Khi tôi về nhà, tôi cần phải làm: (When I get home I need to)

3. Thuốc tôi cần phải uống (medication I need to take:

Tên thuốc (name of medication) Khi nào dùng / uống (when to take)

4. Tại sao uống thuốc quan trọng đối với tình trạng/bệnh của bạn? (Why is this important for my condition?)

5. Hướng dẫn bổ sung (additional instructions):

Figure 1. Vietnamese GOLD card with English translation in parentheses.

At the end of the visit with the physician, each patient, with our help, filled out a GOLD card. We reemphasized key points from the physician instructions to the patient in plain language, asking the patient to then write these instructions on the GOLD card. This method is a modified use of the teach-back method to improve HL; the teach-back method of health communication, in which patients are asked to recall or explain in their own words what has been discussed in an encounter, has been shown to improve HL in a variety of settings in Western countries (Kripalani, Bengtzen, Henderson, & Jacobson, 2008; White, Garbez, Carroll, Brinker, & Howie-Esquivel, 2013). But it has also been shown to improve outcomes in developing countries in initiatives ranging from maternal immunization in Jamaica (Wilson, Mayeta-Peart, Parada-Webster, & Nordstrom, 2012) to diabetes management in Iran (Negarandeh, Mahmoodi, Noktehdan, Heshmat, & Shakibazadeh, 2013). In our study, we asked patients to write down what they understood, which we in turn discussed and verified. Surveys were administered in Vietnamese (Figure 2). English translation of the questions can be found in Figure 3. For the qualitative survey, a 5-point Likert scale was used to ascertain patient satisfaction with use of the GOLD card. The patients were asked to rank their level of agreement or disagreement of the statement using *strongly disagree, disagree, neutral, agree,* and *strongly agree.* Because of small sample size, statistical significance testing could not be performed. We offer our results as descriptive measurements only.

ID nghiên cứu_____ **Ngày Tháng Năm** _____

Phiếu khảo Sát Sự Hài Lòng Thẻ theo dõi bệnh lí

Khảo sát này hỏi về những trải nghiệm của bạn khi sử dụng thẻ GOLD trong khi và sau khi khám bác sĩ. Xin hãy khoanh câu trả lời cho mỗi câu hỏi dưới đây.

1. Tôi cảm thấy sự trao đổi của tôi với bác sĩ đã được tốt hơn sau khi sử dụng thẻ theo dõi bệnh lí

a. Không đồng ý chút nào
b. Không đồng ý
c. Trung lập
d. Đồng ý
e. Đồng ý rất nhiều

2. Thẻ theo dõi bệnh lí đã giúp tôi hiểu rõ hơn về tình trạng/bệnh tình của tôi.

a. Không đồng ý chút nào
b. Không đồng ý
c. Trung lập
d. Đồng ý
e. Đồng ý rất nhiều

3. Với thẻ theo dõi bệnh lí, tôi cảm thấy thoải mái/tự tin hơn trong công việc theo dõi bệnh tình của tôi so với khi tôi không có nó.

a. Không đồng ý chút nào
b. Không đồng ý
c. Trung lập
d. Đồng ý
e. Đồng ý rất nhiều

4. Thẻ theo dõi bệnh lí là một công cụ hữu hiệu nhắc nhở tôi tuân theo sự hướng dẫn của bác sỹ

a. Không đồng ý chút nào
b. Không đồng ý
c. Trung lập
d. Đồng ý
e. Đồng ý rất nhiều

5. Tôi cảm thấy cách sử dụng thẻ theo dõi bệnh lí rất dễ dàng.

a. Không đồng ý chút nào
b. Không đồng ý
c. Trung lập
d. Đồng ý
e. Đồng ý rất nhiều

6. Tôi muốn đề nghị sử dụng các thẻ theo dõi bệnh lí trong mỗi phòng khám.

a. Không đồng ý chút nào
b. Không đồng ý
c. Trung lập
d. Đồng ý
e. Đồng ý rất nhiều

7. Nói chung, việc sử dụng các thẻ theo dõi bệnh lí đã giúp tôi chủ động trao đổi với bác sỹ về bệnh tình hơn những lần khám trước khi sử dụng thẻ theo dõi bệnh lí.

a. Không đồng ý chút nào
b. Không đồng ý
c. Trung lập
d. Đồng ý
e. Đồng ý rất nhiều

Figure 2. Translated Vietnamese survey.

STUDY ID _____ Date_____

GOLD Card Satisfaction Survey

This survey asks about your experience using the GOLD card during and after your doctor visit. Please answer each of the following questions by circling an answer for each question.

1. **I felt the GOLD card improved my communication with my physician.**
    a. Strongly Disagree
    b. Disagree
    c. Neutral
    d. Agree
    e. Strongly Agree
2. **The GOLD card helped me better understand my own condition.**
    a. Strongly Disagree
    b. Disagree
    c. Neutral
    d. Agree
    e. Strongly Agree
3. **I feel more comfortable/confident managing my condition with the GOLD card than if I didn't have it.**
    a. Strongly Disagree
    b. Disagree
    c. Neutral
    d. Agree
    e. Strongly Agree
4. **The GOLD card was an effective tool reminding me to follow my prescribed medical care.**
    a. Strongly Disagree
    b. Disagree
    c. Neutral
    d. Agree
    e. Strongly Agree
5. **I felt the GOLD card was easy to use.**
    a. Strongly Disagree
    b. Disagree
    c. Neutral
    d. Agree
    e. Strongly Agree
6. **I would recommend the use of the GOLD card in a clinical setting.**
    a. Strongly Disagree
    b. Disagree
    c. Neutral
    d. Agree
    e. Strongly Agree
7. **Overall, the use of the GOLD card has helped to create a more satisfying doctor visit than my previous doctor visits without use of the GOLD card.**
    a. Strongly Disagree
    b. Disagree
    c. Neutral
    d. Agree
    e. Strongly Agree

Figure 3. English survey.

Table 2
Survey of Patient Satisfaction With GOLD Card (n = 43)

Survey question[a]	Strongly disagree	Disagree	Neutral	Agree	Strongly agree	Did not answer
1. I felt the communication between me and my physician improved upon using the GOLD card.	0	0	1	31	11	0
2. The GOLD card helped me better understand my own condition.	0	1	0	32	10	0
3. With the GOLD card, I feel more comfortable/confident managing my prescribed medical care than if I did not have it.	0	1	2	34	6	0
4. I believe the GOLD card was an effective tool to remind me to follow my prescribed medical care.	0	0	1	33	9	0
5. I felt the GOLD card was easy to use.	0	0	2	31	9	1
6. I would recommend the use of the GOLD card in a clinical setting.	0	0	3	28	11	1
7. Overall, the use of the GOLD card has helped to create a more satisfying doctor visit than my previous doctor visits in the past (without the GOLD card).	0	0	2	28	12	1

[a]These questions were translated into Vietnamese shown in Figure 2. They are presented here in English.

Results

Forty-nine participants were recruited. Six patients were dropped from analysis because of incomplete surveys. Forty-three (88% response rate) participants were included in the final analysis. Of the 43 participants, 23 were female (53.3%) and 20 (46.5%) were male. The average age was 48.6 years. Table 2 illustrates the results of the patient perspective on a 5-point Likert scale pertaining to their experience with the use of the GOLD card intervention. Overall, 40 participants (93.0%) out of 43 either agreed or strongly agreed that using the intervention GOLD card helped to create a more satisfying doctor visit. Forty-two participants (97.7%) also stated that they believed the GOLD card helped to improve communication between the physician and themselves. A majority of the patients (n = 42, 97.7%) also indicated that using the GOLD card helped them to understand their own condition better. It is also worth noting that patients felt comfortable/confident in managing their conditions with the use of the GOLD card and that the majority also deemed the card easy to use (n = 40, 93.0%; Table 2).

Discussion and Conclusion

In our small pilot study, we evaluated patient perceptions of a PCC intervention (the GOLD card) in an urban city hospital in Vietnam. Our aim was to understand how the promotion of a simplified tool to improve HL could promote PCC in the health care system of a newly industrialized country. Because health care resources are scarce, economic costs of any intervention become critical. Paper cards written in the patient's own hand and use of a teach-back methodology appear to be practical and effective.

Vietnam, with its limited mobility in health care expansion and development within the past decade, has relied heavily on private donations and has few infrastructures and resources to manage the health care of its people. This, in addition to limited research initiatives in the country and a cultural deference to "authority figures," has forced many patients and physicians to rely ultimately on traditional views of communication in medicine, particularly a paternalistic model of medicine. Other contextual factors—often taken for granted in developed countries—may also be barriers to the development of PCC and the use of HL, such as low doctor to patient ratios, crowded and aging physical structures, a lack of privacy between physician and patient, and the slow pace of technology, as we have pointed out. Therefore, we believe that the use of simple reminder cards, such as the GOLD card, could improve confidence in patients' ability to manage their condition and, at least in literate populations, serve as a reminder of medical plans after discharge from office or even hospital visits.

The GOLD card being filled out by the patient, with the help of either the physician or the physician's aide/team member, and then reviewed *with the pa-*

tient in a modified teach-back method creates an environment of patient centeredness and moves the patient–physician team relationship toward a greater level of shared decision making (Kon, 2010). For example, 93% of participants were more satisfied after using the GOLD card and almost 98% felt the cards improved communication between the physician and themselves. Satisfaction and improved communication are hallmarks of the PCC model (Wanzer, Booth-Butterfield, & Gruber, 2004). With respect to the teach-back method, educational success was demonstrated by the majority of patients who understood their condition better (97%) and were more confident in managing their conditions. Although a longer study could have shown improvement in outcomes, we believe this attitudinal shift is a good predictor of future outcomes.

From our point of view, the GOLD card should always be used in conjunction with an oral debriefing either with the physician or a physician's team member. This approach better encapsulates the spirit of patient centeredness, would improve oral and written HL, and would improve patient satisfaction. Although this may make it more difficult to ascertain whether outcomes are improved by the GOLD card alone (or the oral debriefing), we believe this separation is artificial and would eschew use of the cards alone. Furthermore, the GOLD cards can operate in crowded conditions; do not require technology; do not require a physician at each encounter (the patient can fill out the card with the help of a nurse or other team member); and according to 93% of participants, are easy to use. We feel implementing the GOLD card helped overcome some contextual barriers to PCC in this developing country.

Our pilot study had several limitations. With the small sample size and time limits to our study, we can only provide descriptive statistics from the results. We considered adding open-ended qualitative data including patients' own words of their experience in using the GOLD card or participating in the study. However, because of time constraints with each patient, the small recruitment period, and the uncertainty of reaching recruitment goals with added participation burden, we chose to obtain only descriptive results with the Likert-scale survey. Having been successful with recruitment goals for this small pilot study and determining the recruitment flow, we believe that future work could include more questions, more participation, and qualitative data to further strengthen the results.

We also concede that the level of high satisfaction of the intervention could have been culturally confounded by the researcher's perceivable status as an authoritative figure. Albeit this deference would exist for any researcher, we tried to minimize the effect of such deference by having the recruitment conducted with the researcher who is a born native to the location and who speaks and is fluent with the same language, customs, and culture. We also stressed within our cover letter and verbal consent to the patient that their participation should in no way affect their care. Personal information was not collected and

survey responses were coded with a randomized study ID and blinded from the Vietnamese physicians.

Recruitment for this study was from a single, urban hospital (Da Lat General Hospital), and therefore, we can only generalize the results for similar populations. Although Vietnam owes its recent economic successes to its urban cities, the majority of the country still remains very rural, and we did not consider patient perspectives from those areas (who we hypothesize would have stronger cultural deference to authority) in this study. Physician compliance with recruitment and implementation was another issue for completion of the study. As physicians are often inundated with patients in Vietnam, it became a challenge to find working physicians willing and able to help with recruitment and implementation.

Prior to participating in the study, the Vietnamese physician had concerns about the debriefing and waiting for the patient to fill out the card while maintaining the immense workflow. For these reasons, we only asked the physician to have a dialogue with the patient concerning the questions on the GOLD card, and from there, we would take the time burden to debrief and allow the patient to fill out said card aside from the physician's time. Because of this, it may be hard to assess whether the debriefing with the researcher or the GOLD card was the reason for a satisfactory visit. We believe that both the interaction of discussing the questions on the card and the card as a tool to prompt, teach back, and remind patients of important instructions regarding their care are required for increased satisfaction during a visit to a physician.

The purpose of the card is to act as a tool to interject core questions that may need additional time between the physician and patient and to allow the patient to register, process, and write down parts of that discussion on a reminder tool that they can carry home with them. Having the questions on the card and allowing the patients to fill out the card means that a debriefing needs to happen whether it be with the physician or (as in this case) with the researcher. Because of the physician's current resistance to using a foreign tool that has yet been shown to be effective in patient care, we ultimately conducted the debriefing in the hopes that the subsequent results would support and encourage Vietnamese physicians to take up this role in the future.

Future studies should be focused on expanding the sample size of the patient population within urban and rural settings and diversifying the clinical setting to include other complex populations, such as pediatric, intensive care, and obstetrics and gynecologic patients. Use of the GOLD card tool (or similar cards) ideally should be studied over time, with patients asked to bring GOLD cards back for follow-up visits, at which time the cards can be altered with new information. Because of the time constraints of practicing physicians in Vietnam or other developing countries, the use of trained physician extenders or nursing staff to aid patients in completing the GOLD card at discharge could

be implemented and studied, although ideally GOLD cards seem to improve attitudes toward the physician–patient relationship.

Clearly, many economic, political, and cultural factors contribute to the current model of health care in Vietnam, still principally physician centered. Our study is the first study to gauge the interest in and the effectiveness of the GOLD card as a tool to broaden the appeal of particular PCC components of care among the Vietnamese population. Further studies will be required for a more full understanding of the effect, cost effectiveness, or feasibility of providing a PCC model in Vietnam.

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