



Building Health Literate Organizations:

A Guidebook to Achieving Organizational Change, 2nd Edition



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Dedication

This Guidebook is dedicated to Archie Willard, who learned to read in his 50s. He became a health literacy advocate whose humble spirit and inspiring stories contributed to advancing the health literacy field.

Abstract

This updated Guidebook will help any organization that promotes, restores, or maintains health become more health literate. Improving communication, providing easy-to-use educational materials, and making services easy to access are critical to achieving health equity and delivering safe, high-quality care and services. With a focus on organizational health literacy and the intersection between health equity and health literacy, the Guidebook addresses key areas for improvement and provides concrete advice on using health literacy tools and resources. Chapters address three questions: Why make a change? What does success look like? How do I reach my goals? Stories and real-world examples will help you choose a path that works for your organization so you can make progress and build reliable, sustainable organizational health literacy processes.

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Guidebook At-a-Glance

1 | Introduction

This chapter will help you:

- Recognize organizational health literacy as fundamental to equity, safety, and quality in health services and information.
- Identify priorities for organizational health literacy improvement.
- Create organizational change and advance as a health literate health organization based on the Ten Attributes of Health Literate Health Care Organizations.

2 | Overview

This chapter will help you:

- Recognize the historical context, significance, and evolution of the health literacy field in the United States and internationally.
- Engage diverse audiences, including health professionals, policymakers, advocates, educators, community organizations, systems, and others in creating and advancing health literate organizations to improve health outcomes and health equity.
- Use improvement methods and change management models to effect systems change toward organizational health literacy.

3 | Advance Health Literacy and Health Equity

This chapter will help you:

- Understand key terminology related to health equity.
- Understand the link between health equity, social determinants of health, cultural competence, cultural humility, and health literacy.
- Recognize the importance of health literacy in promoting health equity for all.
- Apply equitable and inclusive practices to health care and health promotion, information, and services at every point of contact.

4 | Engage Leadership

This chapter will help you:

- Prepare your leaders through engaging explanations and illustrations of the importance of organizational health literacy.

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- Provide leaders with resources to support integrating health literacy practices into equity, quality, safety, and patient-, family-, and client-centered initiatives throughout your organization.
- Collaborate with your leaders to achieve success.

5 | Prepare the Workforce

This chapter will help you:

- Make the case for all health professionals and staff to understand health literacy and use clear health communication.
- Identify and use client, patient, and family experiences as teaching tools, and recruit health literacy champions.
- Build capacity for clear, effective health communication among all members of your team.

6 | Create a Shame-free Care Environment

This chapter will help you:

- Understand what a shame-free care environment is and why it is needed.
- Make your health setting more welcoming, safe, and patient- or client-friendly to foster dialogue and questions.
- Make it easier for people to find, understand, and use your information and services to manage their health.

7 | Involve Populations Served

This chapter will help you:

- Understand the importance of patient, family, client, and community member involvement, and benefit from the feedback you receive from them.
- Recognize the significant contribution that partnering with adult basic education and English language programs in your community can make.
- Find ways to involve the people you serve and other community-based organizations in your health literacy work.

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8 | Use Clear Interpersonal Communication and Confirm Understanding

This chapter will help you:

- Use, explain, and demonstrate health literacy approaches like plain language, teach-back, and language access services.
- Show how all staff can use clear interpersonal communication skills.
- Get everyone started building health literacy communication habits into their routines.
- Set up systems that make checking for understanding standard practice.

9 | Use Reader-friendly Plain Language Print Materials and Digital Content

This chapter will help you:

- Create reader-friendly plain language information that is easy to understand and act on for the people who come to your organization for services and information.
- Assess information from inside the organization as well as outside sources, including vendors, websites, and publishers, for its fit for your patients and clients.
- Ensure the communication needs of people with learning differences, disabilities, and language and cultural barriers are met to the fullest extent possible.

10 | Case Studies

This chapter will help you:

- Identify strategies to begin implementing organizational health literacy improvements in your setting.
- Describe how health literacy initiatives can help an organization become more health literate.
- Visualize success and apply the Ten Attributes of Health Literate Health Care Organizations to help advance your organization as a health literate organization.

Introduction

1 | Introduction

“Eliminate health disparities, achieve health equity, and attain health literacy to improve the health and well-being of all.”

—Healthy People 2030¹

The health literacy field continues to evolve. What began as years of cumulative research demonstrating the association of limited health literacy with poorer health outcomes led to establishing an official definition of individual health literacy, describing and characterizing evidence, and laying out recommendations for further informing the knowledge base and opportunities for intervention.²⁻⁷ The Ten Attributes of Health Literate Health Care Organizations⁸ and the National Action Plan to Improve Health Literacy⁹ established a foundation for the concept of organizational health literacy and led to expanded health literacy-informed implementation resources and tools.¹⁰⁻¹² More recently, the Healthy People 2030 definitions of personal and organizational health literacy and recognition of the intersection of health equity and health literacy have advanced the field further.¹

The initial 2014 edition of *Building Health Literate Organizations: A Guidebook to Achieving Organizational Change*¹³ included background, resources, examples, and lessons learned to help users work toward becoming a health literate health care organization.⁸ This updated Guidebook incorporates developments in the field and new concepts and approaches to advancing as health literate health organizations to achieve health and well-being for all.¹ It expands beyond health care settings to include all types of organizations whose focus is promoting, restoring, or maintaining health.¹⁴

Equitable, safe, high-quality care depends on clear communication between patients, families, providers, and health systems. Challenges related to social determinants of health and the COVID-19 pandemic made clear that public health is a fundamental component of the health system, also requiring clear communication, and underscoring that health literacy and health equity are intertwined. Increasingly, the health care system, public health, and health-focused community-based organization partners recognize this and work to improve health literacy and reduce health disparities.

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This second edition of the Guidebook is again intended to complement the many excellent current and future health literacy resources to help health entities of any size or type advance as health literate organizations, making “it easier for people to navigate, understand, and use information and services to take care of their health.”⁸ Any organization can strive to become health literate and work to “eliminate health disparities, achieve health equity, and attain health literacy to improve the health and well-being of all.”¹

The ideas and information in this chapter are designed to help you:

- Recognize organizational health literacy as fundamental to equity, safety, and quality in health services and information.
- Identify priorities for organizational health literacy improvement.
- Effect organizational change and advance as a health literate health organization based on the Ten Attributes of Health Literate Health Care Organizations.⁸

**The goal of this Guidebook is to help you in advancing
as a health literate health organization.**

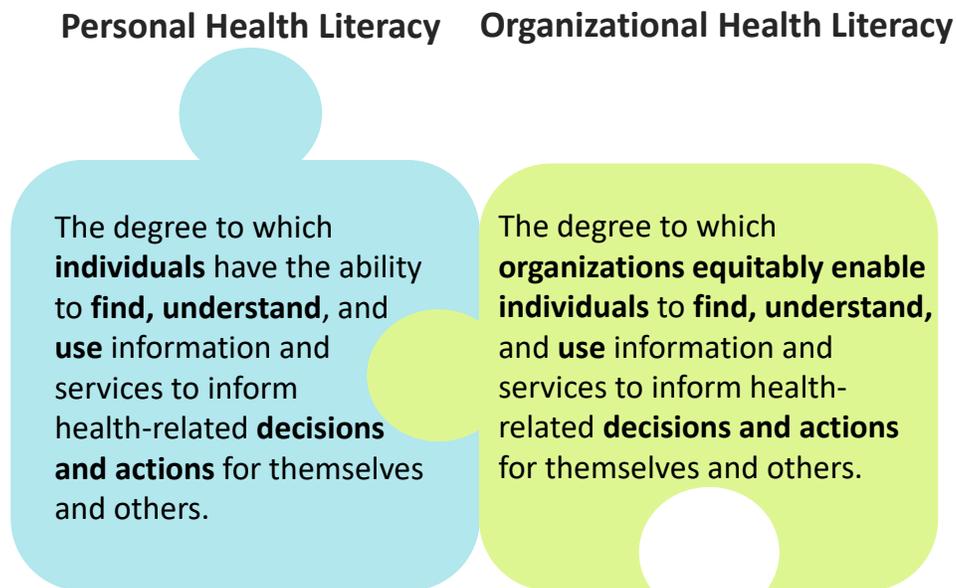
There are many tools, trainings, guidelines, and other resources to help you engage in organizational change to become a health literate health organization; the challenge is to use them effectively, reliably, and sustainably.

What does *effectively, reliably, and sustainably* mean? It means that changes need to be tested and polished on a small scale to be sure they are carried out correctly before they are turned into policy. It means that change needs to reach beyond one provider or one department and take root in the organization itself. Reliably means using health literacy practices the right way *every* time they are needed, regardless of incidental circumstances. It means using resources to change the behavior and culture of health teams and organizations, and *embed* and *spread* these changes throughout the system, whether large or small. Sustainably means the use of health literacy practices does not change over time, and *only* varies when there is new context (like new or different need-to-know information) and not because of variation in, for example, staff or schedules. This requires periodic review and improvement, since context naturally changes over time.¹⁵ Individual and organizational behavior change are essential for all of this.

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What Is Health Literacy?

Figure 1 depicts the new health literacy definition established by Healthy People 2030.¹⁶ It is comprised of personal and organizational health literacy.



Healthy People 2030's two definitions, taken together, constitute health literacy.

The Healthy People 2030 definitions show that while we should continue to engage in helping individuals improve their health skills and knowledge, health organizations should recognize and focus on the importance of system-based health literacy practices to equitably improve communication with the people and communities they serve.

In practice, an individual's health literacy is the result of many things acting together at any given moment. These may include schooling, general literacy, culture, language, personal history, state of mind, illness, medication side effects, eyesight, stress, and degree of trust. "More than just the ability to read and write, health literacy includes the ability to listen, follow directions, fill out forms, calculate using basic math, and interact with professionals and health care settings. It can also include making sense of jargon or unfamiliar cultural norms. Health literacy requires people to apply critical thinking skills to health-related matters."¹⁷

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In addition to recognizing and incorporating the importance of system-based health literacy practices, the new definitions underscore the importance of health equity and actionability. They highlight an obligation that while efforts continue for improving personal health literacy, health organizations have the responsibility to communicate clearly and ensure understanding, especially for those at highest risk for adverse impacts associated with limited health literacy.³ They should use system-based approaches grounded in improvement science so that change and improvement are not reliant on individuals' interests or efforts, but rather embedded in organizational structure, standard operations, and culture. And that learning must be shared across clinical, public and population health, and community-based organization domains, including dissemination processes beyond those in traditional academia.¹⁸

What is a Health Literate Health Care Organization?

In the Ten Attributes of Health Literate Health Care Organizations,⁸ Institute of Medicine Roundtable on Health Literacy members describe a health literate organization as easier for people to use, and critical to delivering patient-centered care. They note that anyone may experience low health literacy and have a hard time understanding and acting on health information when they are sick or confronted with a new diagnosis; and that literacy, language, and culture must all be addressed to reduce health disparities. Since this Guidebook addresses any health-focused organization, we refer to health literate health organizations or health literate organizations, in addition to health literate health care organizations which refers to those providing clinical care. We include all organizations that provide health-related care, services, information, and/or education.



Reprinted with permission from *Ten Attributes of Health Literate Health Care Organizations*, 2012 by National Academy of Sciences, National Academies Press, Washington, DC.

Introduction

A health literate health organization⁸ should demonstrate the following:

1. Has leadership that makes health literacy integral to its mission, structure, and operations.
2. Integrates health literacy into planning, evaluation measures, patient safety, and quality improvement.
3. Prepares the workforce to be health literate and monitors progress.
4. Includes populations served in the design, implementation, and evaluation of health information and services.
5. Meets the needs of populations with a range of health literacy skills while avoiding stigmatization.
6. Uses health literacy strategies in interpersonal communications and confirms understanding at all points of contact.
7. Provides easy access to health information and services and navigation assistance.
8. Designs and distributes print, audiovisual, and social media content that is easy to understand and act on.
9. Addresses health literacy in high-risk situations, including care transitions and communications about medicines.
10. Communicates clearly what health plans cover and what individuals will have to pay for services.

How To Use This Guidebook

This Guidebook is intended to help you advance your health organization—of whatever type—toward attaining each of the Attributes.⁸ Becoming a health literate organization will not happen overnight, and it may seem overwhelming; it is a process. Addressing health literacy in only one or two areas will limit overall progress because health teams exchange information with patients, clients, families, and communities at every point of contact in the health system, and communication can be thwarted anywhere. Even a small error in communication can follow a person throughout their journey, accompanied by the potential for harm.⁵

The first edition of this Guidebook originated from early system work at a large integrated health system, UnityPoint Health (formerly Iowa Health System), and shared health literacy resources, learning, and examples from real-world settings and an adaptable approach to becoming a health

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literate organization. This updated version shares new health literacy definitions, perspectives, approaches, and experiences. Examples come from non-profit, community-based organizations, community health centers, hospitals and health systems, outpatient, and dental settings. Many were partners in Advancing Health Literacy Franklin County, a U.S. Department of Health and Human Services Office of Minority Health-funded effort to advance organizational health literacy through capacity-building and developing infrastructure and sustaining resources. Use the Guidebook as a supporting guide to address health literacy in *your* setting and journey to provide more equitable, safe, and high-quality health care and services.

Terms We Use

Several terms are used in this Guidebook to broaden its applicability throughout the health continuum, incorporate new concepts, and reflect changes in the field.

Health Organization: any organization that impacts health, including, but not limited to: inpatient, outpatient, ambulatory surgery, urgent and emergency care settings, and long-term care facilities; dental settings; pharmacies; public health programs (e.g., WIC) and departments (e.g., local, state); social service organizations; health professions educational institutions; public and private payors; and community-based and other non-profit health-related organizations, e.g., organ donation and immigration and refugee organizations, and food assistance programs.

Health Continuum: any point or interaction at which a person may encounter or interact with an entity that provides health-related care, information, services, education, and financial or other support.

Health System: all entities endeavoring to promote, restore, or maintain health.¹⁴

Health Team(s) or Health Team Member(s): any individual—clinical or non-clinical—who is part of the health system. People in clinical roles treat patients or provide direct patient care, whereas those in non-clinical roles do not provide direct diagnosis, testing, treatment, or care.¹⁹ There are both types of roles in health care and non-health care settings. For example, a registration specialist helps patients who arrive at a clinic but does not provide direct patient care, and a school nurse provides clinical services.

Patients, Families, Clients, and Communities: represents all those served throughout the health continuum. Specific terms may be used selectively or replaced by “person” or “people.”

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Cultural Competence: describes the ability to provide services to patients with diverse values, beliefs, and behaviors. This includes tailoring services to meet individuals' social, cultural, and linguistic needs.²⁰

Cultural Humility: refers to recognition of diversity and power imbalances among individuals, groups, or communities. Cultural humility requires being open, self-aware, ego-less, flexible, respectful, supportive, and self-reflective.²¹

Adult Learner: someone who is taking action to improve their literacy, math, or English language skills. Some work with tutors in an adult literacy program. Others enroll in adult basic education (ABE) or English language learner (ELL) classes.

Key Areas for Improvement

In addition to this Introduction and an Overview chapter, the Guidebook contains the following chapters:

- Advance Health Literacy and Health Equity
- Engage Leadership
- Prepare the Workforce
- Create a Shame-Free Care Environment
- Involve Populations Served
- Use Clear Interpersonal Communication and Confirm Understanding
- Use Reader-friendly Plain Language Print Materials and Digital Content
- Case Studies

Addressing each of these interconnected areas will help you advance toward becoming a health literate organization. This is not a step-by-step process and there is no single starting point. Make progress in all areas for results you can sustain over time. We have observed that focusing on Attributes 1 (leadership), 2 (planning and evaluation), and 3 (preparing the workforce) supports work toward the other attributes.

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Many health organizations use the Model for Improvement,^{12,13} with Plan-Do-Study-Act (PDSA) cycles and coaching, embedding quality improvement approaches into health literacy improvement initiatives or vice versa. That doesn't mean you have to do the same. There are other useful approaches.

We do recommend you start with small steps—small tests of change—to build confidence and buy-in. People learn from small efforts and even—or especially—from small tests that don't go well the first time. Learn from those and try again. A small change in one area can be a big step forward. And small improvements encourage people to do more. A great example is trying a new communication technique with the last patient or client of the day to lessen concern about it taking too much time. As confidence and comfort with this skill are gained, expand to more patients, clients, conditions, and settings. And then share it with colleagues. Use insights from a series of small tests to help leaders understand the importance of continuing to address the changes you are seeking to make.

Each Chapter Addresses These Questions

We organized the chapters to answer these questions:

- Why? Why do you need to address health literacy in this area? Why is it important?
- What? What would success in this area look like? What are intended outcomes? Success may include changes to process, behavior, and attitudes, as well as outcomes.
- How? What tools, resources, and actions can you use to reach your goals? We include stories and real-world examples to help you make progress and build reliable sustainable organizational health literacy processes to advance as a health literate organization.

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The Chapters Address These Attributes

Attributes of Health Literate Health Organizations	Chapter							
	Health Equity	Leadership	Workforce	Care Environment	Populations Served	Interpersonal Communication	Plain Language Information	Case Studies
1. Leadership	X	X						X
2. Planning/Evaluation/ Safety/Quality	X	X						X
3. Workforce	X	X	X					X
4. Include Populations	X				X			X
5. Meet Diverse Needs	X			X	X			X
6. Interpersonal Communication	X		X			X		X
7. Easy Access	X			X			X	X
8. Print/A-V/Digital Content	X						X	X
9. High-risk Situations	X	X				X		X
10. Explain Costs	X						X	X

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Start with Any Chapter

After reading this Introduction, we recommend reviewing the Overview and Advance Health Literacy and Health Equity chapters for more about health literacy and advances in the field, and the intersection between health equity and health literacy. All chapters relate to one another, but each can stand alone. You may be further down the road in some areas than others. A good rule of thumb is to start where you can begin to build early successes.

Ideally, you should work in more than one area at a time. Eventually, you need to be working in all key areas. Each is necessary—but not sufficient—to bring about improvement. For example, the Prepare the Workforce chapter discusses how awareness and engagement through education, training, and personal stories help the health team understand why and how to communicate better with patients, families, and clients; but that is not an end in itself. It has to be coupled with permanent changes in communication behavior.

Form a Team

You can't do it alone. Find a group of people representing varied roles and areas in your organization who can provide diverse perspectives, improvement opportunities, and promising approaches to undertake this exciting work.

Be positive about how you can improve care and services for those you serve and what you can achieve together! Figure 2 conveys the multiple influences and motivating factors described by individuals comprising organizational teams who participated in a health literacy learning collaborative to work toward advancing as health literate organizations.

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we use clear communications practices with everyone—to make sure all patients, clients, and families understand. This is not an add-on; it is part of everyone’s job.

Making sure people understand is simply part of everyone’s job.

Limited health literacy can affect anyone. People may need extra help for various reasons, like trouble reading; language issues; emotional state; lack of familiarity with the U.S. health system; complex eligibility and application guidelines; distraction; or dealing with a complex health diagnosis, condition, and its treatment, management, or consequences. Even people who usually manage well can find it hard to take in information and do what they need to do if they are feeling tired, sick, anxious, or overwhelmed. Being sensitive to health literacy concerns is not dumbing down information. *Everyone* benefits from clearer communication, no matter their background.¹¹

Health Literacy Affects All Aspects of Health Communication

In its report, *Priority Areas for National Action: Transforming Health Care Quality*, the Institute of Medicine (IOM) identifies health literacy and self-management support as “cross-cutting priorities for transforming the quality of health care in the U.S.” Health literacy affects all dimensions of health—preventive, acute, and chronic—and people of all ages.²² It affects direct patient care, the health system, public health, and health-related community-based organization interventions. And improving communication goes beyond improving written materials. It involves changing spoken and unspoken messages and the care environment itself.

Addressing health literacy is everyone’s responsibility, not just those charged with “education.” This includes staff in clinical and non-clinical roles: doctors; dentists; nurses; pharmacists; physical, occupational, speech, and respiratory therapists; dietitians; social workers; interpreters; community outreach and community health workers; care managers; navigators; adult educators; health educators and health professions faculty; teachers; community and patient advocates; home health, rehabilitation, and long-term care teams; scheduling, registration, billing, and transportation staff; those who maintain and protect facilities; and communications teams who manage websites, portals, social media, and navigation. It includes those in laboratories; radiology; risk management; public policy and public relations; and public and private health insurance.

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Health Literacy is Fundamental to Equitable, Safe, High-quality Care

“Health literacy is fundamental to quality care, and relates to three of the six aims of quality improvement described in the Institute of Medicine Quality Chasm Report...”²² Those three aims are safety, patient-centered care, and equitable treatment. Here are examples of how organizational health literacy relates to each.

Safety:

- Using plain language and teach-back during medication reconciliation and Brown Bag Medicine Reviews with patients may help reduce medication errors and increase adherence.
- Reporting, reviewing, and quantifying health literacy-related safety events can inform mitigation and harm reduction.
- Ensuring understanding via plain language and teach-back when distributing naloxone kits in addiction or in other public health programs can help improve outcomes.

Patient- (and Client-) centered care:

- Embedding standard processes for using plain language and teach-back to assess and ensure patients understand their options during the consent process, and engaging in shared decision-making helps them get care they need and want and enhances risk management.
- Improving health professions students’ knowledge about, and confidence and skills in using plain language and teach-back will increase their capacity to empower those they care for and serve with understandable evidence-based information to improve health and well-being.
- Assessing and confirming understanding about when to return for their next vaccine dose and when and where the public health vaccine clinic will take place helps protect people against vaccine-preventable diseases.

Equitable treatment:

- “A robust set of consensus-based clear communication educational competencies and best practices has been identified. Failure to communicate health information in its simplest and easiest-to-understand form unjustly favors people who have more education and higher health literacy. Lack of organizational health literacy and clear communication policies are preventable, structural features of U.S. health care that contribute to systemic racism.”²³

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- Clear communication is key to eliminating health disparities and building cultural and linguistic competence. This includes cultural humility and understanding and responding to cultural and language differences through interpretation, translation, and other services.²⁴
- The Joint Commission includes health literacy tools among resources it recommends for those seeking Health Care Equity Certification. (<https://www.jointcommission.org/what-we-offer/certification/certifications-by-setting/hospital-certifications/health-care-equity-certification/>)

National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care

Principal Standard: Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.²⁴

Involve Those You Serve in Your Health Literacy Work

Involving patients, clients, families, and communities served, including adults with limited literacy skills, is an important attribute of health literate organizations. These people are the experts in knowing what they understand and need. They can guide you in how to communicate more clearly. Listening to and learning from their viewpoints, suggestions, and stories helps in many ways. It teaches you about their experiences of care. It builds passion in the organization for making improvement. And it suggests areas for testing and implementing changes to improve communication.

Some important ways in which patients, families, clients, adult learners, and community members—with the right support—may help advance your organization’s health literacy work are to:

- Co-create, review, and critique written materials and web copy.
- Give input to policies and procedures.
- Do a site walk-through—a navigation interview²⁵
- Co-present health literacy information.
- Act as liaisons to adult literacy and adult basic education programs.
- Model patient involvement for other organizations.
- Share testimonials about positive and negative health communication experiences.

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Help Employees Who Struggle with Literacy

It's important to recognize that some employees may struggle with reading problems or language barriers. Health organizations may assume employees have a certain level of literacy or language skills. When there is a mismatch between what is presented and the employees' ability to understand—during orientation (e.g., benefits selection), training (e.g., safety practices), and ongoing employment updates (e.g., policy or procedure changes)—a door opens for possible disparities or harm to those employees and their families, other staff, and patients or clients. In one example, employees at a hospital lost pay because of not following rules they didn't know existed. This was because handbook policies were written at too high a level for many of the employees.

Employees who understand their roles and responsibilities are better able to:

- Protect people's health and safety.
- Manage their own and their families' health.
- Do their jobs safely and effectively and contribute to the organization's mission.
- Contribute to promoting health equity.

Health literacy practices for employers include using reader-friendly plain language principles in policies, manuals, benefits information, and computer-based learning. And offering opportunities for employees and staff to develop general literacy and English language skills. Contact local adult literacy and adult basic education programs to learn about services they provide and find out how to make referrals to them.

- National Literacy Directory (NLD) - <https://www.nld.org/>
- ProLiteracy Find an Adult Literacy Program - <https://www.nld.org/volunteers/find-a-volunteer-opportunity>

Or try reaching out to local refugee resettlement programs that provide legal assistance, language services, case management, and English language classes. Consider offering on-site reading, math, and English as a Second Language (ESL) programs.

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Make Changes Last

Here are some recommendations for sustaining reliable use of organizational health literacy improvements:

- Educate and train staff and providers. But don't stop there. Education leads to behavior change. And changing behavior is key.
- Align health literacy efforts to major organization initiatives and adapt how you deliver organizational health literacy messages, and the messages themselves, for different audiences. Your audiences may include any or all of these: boards of directors; senior leaders; commissioners; quality committees; medical staff or individual doctors and dentists; department leaders and managers; front-line patient care staff; non-clinical areas like billing, marketing, public relations, language access, and non-clinical support staff; public health nurses, food and safety inspectors, disease investigators, and community health workers; home health staff; and benefits managers.
- Test your changes in varied settings with different people and at all times of the day, week, and year. Learn what works best and solve problems before moving to widespread implementation.
- Ask leaders to integrate health literacy into your organizational mission, initiatives, policies, and procedures. Add related updates to meeting agendas and reports to senior leaders.
- Build reliability by using technology and other tools to make it easy to do the right thing every time; include prompts, reminders, and documentation tools to promote use of health literacy practices.
- Embed your improvements in standard operating procedures like policies, job descriptions, orientation, competency assessments, performance reviews, and merit systems. Use other strategies to be sure improvements will be sustained over time and continually improved.
- Spread your health literacy messages and interventions to strategic points throughout the organization. This will develop health literacy champions to in turn help build knowledge, skill, buy-in, and will.
- Involve patients and clients in the process. Remember, they are the experts in what they do and do not understand and what they need to know.
- Collaborate and share with colleagues within and outside your organization.
- Assess your progress as you go. This is important to sustain change beyond a single project or person. Although the complex nature of health literacy can make it hard to

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measure direct impact on outcomes, you will likely find related measures useful, such as patient, client, or staff satisfaction, and understanding or adherence markers, like keeping follow-up appointments; reducing procedure cancellations, avoidable acute care utilization, readmissions, and duplicative services; or improving vaccination rates, lead screening, and enrollment in services.

Figure 3 - Multiple approaches are needed for lasting organizational health literacy improvement.



Health Literacy in Healthy People 2030

Health literacy is a central focus of Healthy People 2030. Watch this video to learn more: <https://health.gov/healthypeople/priority-areas/health-literacy-healthy-people-2030>



Introduction

Summary of Key Points

- Organizational health literacy is fundamental to equitable, safe, and high-quality health care and services.
- Advancing as a health literate organization means changing how people and organizations behave.
- Use this as a guide, rather than a step-by-step manual. Begin where it makes sense to you and your organization and move forward from there.
- Use whatever improvement or change strategy works best for you; start small and build on your successes.
- Make progress in all areas and embed and spread improvements throughout your organization.
- For results that will last, ensure you use processes to ensure health literacy practices are used for every patient or client, every time it is appropriate. Build infrastructure and use periodic monitoring to be sure your improvements are sustained long-term.

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2 | Overview

“Health literacy has gone from a silent epidemic, not being on the agenda, not on the radar, to experiencing exponential growth and development as a field and as a social movement.”

— Kristine Sørensen, Founder of the Global Health Literacy Academy and First President of the International Health Literacy Association¹

A Brief History of Health Literacy

The fact that many English-speaking adults in the United States could not read well was not widely known, until the 1985 book, *Illiterate America*,² shocked many people. Awareness of limited adult literacy and its resulting effects on people’s lives and health began to spread.

The 1992 National Adult Literacy Survey (NALS) measured the literacy skills of over 26,000 U.S. adults with tasks in three areas—prose (continuous text); document (forms, charts, schedules, tables); and quantitative, often referred to as numeracy (using numbers for tasks like calculating a tip or balancing a checkbook).³

NALS results showed almost half of American adults read at Levels 1 and 2 (at or below 8th grade level) and that some populations were disproportionately affected by limited literacy—people aged 65 years and older, those living in poverty, and certain ethnic or racial minorities.³

Discussions between adult literacy teachers and health educators began, and attention turned to literacy in health settings. Health care providers were especially shocked by these data and increasingly studies documented the mismatch between the literacy skills of U.S. adults and the grade level and associated literacy demands of most health information designed for patients and the public. This was underscored by a 1994 study demonstrating that most adults read three to five grade levels lower than their highest level of educational attainment.⁴

In 2003, the National Assessment of Adult Literacy (NAAL)⁵, administered to over 19,000 U.S. adults aged 16 years and older, assessed health literacy using health-related tasks with four performance levels: Below Basic, Basic, Intermediate, and Proficient. The table shows the percentage of adults scoring at each health literacy level and a sample task for each.

Overview

NAAL Summary

Health Literacy Level	% Population in Level	Sample Task
Below Basic	14%	Tell how often a person should have a specified medical test, based on information in a clearly-written pamphlet.
Basic	22%	Explain why it is difficult for people to know if they have a specific chronic medical condition, based on information in a one-page article about the condition.
Intermediate	53%	Identify three substances that may interact with an over-the-counter drug to cause a side effect, using information on the over-the-counter drug label.
Proficient	12%	Evaluate information to determine which legal document is applicable to a specific health care situation.

Of particular note is that only 12% had what is considered proficient health literacy skills.⁵ This means 88% of U.S. adults, those with below basic through intermediate health literacy levels, would find it difficult to carry out most health literacy-related tasks needed to manage their own or family members' health.

NAAL health literacy data provided impetus for tremendous growth in the field. Many studies documented the prevalence and impact of health literacy on numerous population groups and health conditions. Health professionals, educators, researchers, academicians, and others contributed evidence to establish a solid foundation documenting the challenges associated with limited health literacy.

Overview

In 2004, the Institute of Medicine (IOM) (now the National Academy of Medicine) defined health literacy as “the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions” and shared findings and recommendations to improve health literacy. They found that “health literacy is fundamental to quality care and relates to three of the six aims of quality improvement...safety, patient-centered care, and equitable treatment.”⁶ Collaboration between health educators, adult literacy teachers, and researchers led to curricular efforts in non-formal adult education settings to develop, implement, and test interventions to improve health literacy.⁷

Over time, it became apparent that while improving the health literacy of individuals is important, it is not sufficient. Putting interventions in place so that health information is communicated clearly by everyone throughout the health continuum is equally important. This meant recognizing the role and responsibility health organizations have in making their information and services easier to access and use.⁶

In 2012, members of the IOM Roundtable on Health Literacy published *Ten Attributes of Health Literate Health Care Organizations*.⁸ This document laid out 10 specific attributes of an organization that makes health information and services easier for people to understand and use, with examples of how an organization might achieve those traits. This important publication set the stage for further advances in how we think about and take action to improve health literacy by reducing health literacy barriers.

Healthy People 2030^{9,10} advanced this further by including health literacy as :

- One of its overarching goals:
 - “Eliminate health disparities, achieve health equity, and attain health literacy to improve the health and well-being of all.”
- A foundational principle integral to achieving health equity:
 - “Achieving health and well-being requires eliminating health disparities, achieving health equity, and attaining health literacy.”
- Being comprised of both personal and organizational health literacy!¹⁰

Overview

Healthy People 2030 Definition of Health Literacy

- **Personal health literacy** is the degree to which individuals have the ability to find, understand, and use information and services to inform health-related decisions and actions for themselves and others.¹⁰
- **Organizational health literacy** is the degree to which organizations equitably enable individuals to find, understand, and use information and services to inform health-related decisions and actions for themselves and others.¹⁰

Changes in this second edition of the Guidebook reflect use of the organizational health literacy framework and its application to a broad spectrum of health-related organizations and systems. We explicitly expand its reach to include public health, and community-based and social service organizations and systems that can employ health literacy practices to support the health of patients, families, and communities.¹¹ The Guidebook describes and highlights the intersection of health literacy and health equity, and outlines some health literacy work outside North America, recognizing international expansion in the field.

Who Should Use This Guidebook

Anyone seeking or working to create or support a more health literate organization is among the intended audience. They include, but are not limited to:

- All members of the health care workforce and volunteers.
- All members of the public health workforce.
- Developers of electronic health records.
- Health and health care administrators.
- Health and health care researchers.
- Health care and public health leaders.
- Health educators.
- Health insurance educators or suppliers.
- Health literacy or health equity policy advocates.

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- Health policy makers.
- Health professions educators and faculty.
- Population health managers.
- Quality and performance improvement leaders.
- And many more.

Organizations That May Find the Guidebook Useful

Examples of organizations that can use the Guidebook to help them advance as a health literate health organization⁸ are listed below.

Government-supported Health Centers and Services

- Federally Qualified Health Centers.
- Indian Health Service facilities.
- Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).
- State disability agencies.
- Veteran’s Administration health services.

Health and Health Professions Associations and Organizations

- American Hospital Association.
- American Association of Nurse Practitioners.
- American College of Physicians.
- American Dental Association.
- American Medical Association.
- American Nurses Association.
- National Medical Association.

Health and Health Professions Education

- Accreditation Council for Graduate Medical Education.
- Undergraduate health professions and public health schools.

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Health Care Facilities

- Community and rural health centers.
- Free-standing surgery centers.
- Home health agencies.
- Hospitals and urgent care centers.
- Kidney dialysis centers.
- Long-term care and rehabilitation facilities.
- Mental health centers.
- Pharmacies.
- Public and private outpatient health and dental care settings.
- Tribal health facilities.

Insurance and Payors

- Medicaid and Medicare.
- Medicare Advantage plans.
- Payors and health plans like health maintenance organizations, insurance carriers, and employee-based plans.

Patient Organizations Engaged in Education, Advocacy, and Research

- National Health Council member organizations.
- Patient advocacy organizations like Asthma and Allergy Foundation of America, Epilepsy Foundation, or the Lupus Foundation of America.

Public Health Programs, Agencies, and Organizations

- Local and state public health departments.
- American Public Health Association.
- Community and public health coalitions.
- State public health associations.

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Quality and Accreditation Organizations

- National Committee for Quality Assurance.
- Public Health Accreditation Board.
- The Joint Commission.

Community Support and Services Organizations, and Others

- Community health organizations.
- Emergency food and shelter entities.
- Organ donation organizations.
- Poison control centers.
- Public libraries.
- Schools - to improve health education, student health, and parent communication.

Key Concepts in the Guidebook

Three key concepts—health literacy, health equity, and effective health communication—are foundational to building health literate organizations.

Health Literacy

In addition to organizational health literacy, the view of health literacy has expanded with a new understanding of the multiple contexts in which people need and use health literacy skills.¹² Not only do health care settings have specialized vocabulary and unfamiliar systems, but so do some worksites with their injury prevention programs; grocery stores with food nutrition labels and food safety protocols; and the many public health situations calling for everyday choices related to vaccination, car seat use, smoking, and climate change.

Health Equity

The World Health Organization describes health equity as people being able to attain their full potential for health and well-being.¹³ Awareness of the need for all health organizations and systems to advance health literacy and health equity has grown. A foundational principle of

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the U.S. Healthy People 2030 framework states, “Achieving health and well-being requires eliminating health disparities, achieving health equity, and attaining health literacy.”⁹ Health and well-being lay at the intersection of health literacy and health equity.

Health Communication

Ensuring information is accessible, understandable, and useful is fundamental to health literacy and health equity. Clear health communication is foundational to moving societies toward fulfilling basic human rights and addressing social determinants like access to food and water, education, housing, and medical care.¹⁴ Two health literacy practices—plain language and teach-back—are primary components of effective health communication, especially in times of need and emergency response, and to promote equity.¹⁵

Why is Health Literacy So Important?

Numerous studies document the burden and challenges associated with limited health literacy and underscore the importance of clear health communication.

- Health literacy is fundamental to health equity, safety, quality, and patient- and client-centered care and services.⁶
- Low health literacy is associated with poorer health outcomes among multiple populations, in many settings, and for numerous conditions.^{6,16,17}
- Several studies have documented costs associated with low health literacy in the U.S. and other countries.^{18,19,20} Interventions to improve health literacy have the potential to lower costs, but there are limited data related to specific interventions.²⁰ Research is needed on financial aspects, especially related to organizational health literacy.
- Inadequate health literacy contributes to health disparities and underpins the need for cultural and linguistic competence.²¹
- Limited health literacy also takes an emotional and financial toll on people and their families and caregivers, neighbors, friends, and communities who offer support and assistance. These can be related to uncertainty, fear, not wanting to worry others, and financial concerns.
- Too much health information is too hard to read and understand. Health information comes from many competing sources—traditional media, social media, the internet, marketing, education, consumer protection groups, health systems, and informal networks. Most written health-related information far exceeds the average reading skills of

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most U.S. adults.^{6,22} There are over 3,000 studies showing the mismatch between the reading demands of the information people receive in health contexts and their reading abilities.²³

- Challenges posed by misinformation and disinformation—especially during the COVID-19 pandemic—and Artificial Intelligence (AI) make knowing what is trustworthy difficult and demonstrate the importance of clear communication and ensuring understanding. Unfamiliar vocabulary and high reading levels may lead to distrust, anger, or ignoring information important to people’s health and well-being.
- Health literacy is an ethical issue. There is a relationship between health literacy and the ethical and legal foundation for safe medical practice and patient-centered care.²⁴ Clear communication is vital during high-risk health situations like informed consent discussions, medication changes, and care transitions.⁸ “Patients have the right to understand health care information [they need] to safely care for themselves...Health care providers have a duty to provide information in simple, clear and plain language, and to check that patients have understood the information before ending the conversation.”²⁵
- Stories of miscommunication between health providers and patients, families, and clients illustrate what might happen when people don’t understand. And stories of effective health communication between health team members and those they serve describe how to foster and support understanding.

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Listen to this insightful, caring nurse explaining how she devised a comprehensive clear approach to convey a complex epilepsy medicine dosing regimen. Working with a qualified interpreter, she taught the information to a young patient and her parent and siblings, then confirmed understanding using teach-back.

Watch for the various health literacy strategies and think about how to apply them in your setting.



To watch this video, click [HERE](#) or scan the QR code below.



Literacy and Health Literacy Prevalence Over Time

As noted earlier, the 2003 NAAL found that nearly 90% of U.S. adults lacked the health literacy skills needed to navigate the U.S. health system.⁵ These data are more than 20 years old, but they are still used because they are the only population-level health literacy data available.

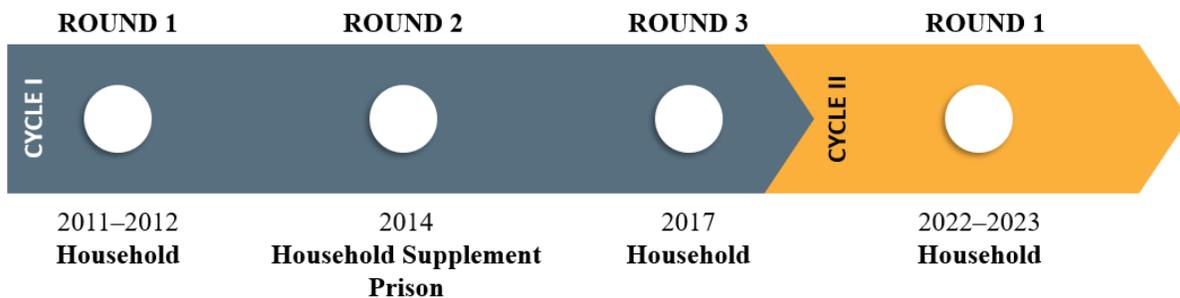
Data from the 1992 NALS³ and the 2003 NAAL were collected 10 years apart. There was little change in their results over that interval. The percentage of the population in the two lowest levels of the NALS and NAAL was 43% and 47% respectively. It is reasonable to assume health literacy skills followed that path as well. And since then, prevalence of various demographic factors associated with limited literacy or health literacy, such as older age, lower socioeconomic status, or immigration/refugee status, has not declined.

It is also helpful to look at more recent data.

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Program for the International Assessment of Adult Competencies (PIAAC)

The Program for the International Assessment of Adult Competencies (PIAAC) (<https://www.oecd.org/skills/piaac/>), while not identical methodologically, provides updated data on literacy and numeracy skills. The PIAAC is the next generation of literacy and numeracy skills assessments and includes items for problem-solving skills in a technology-rich environment. It is an initiative of the Organization for Economic Cooperation and Development. The PIAAC assessed competencies of adults aged 16 to 65 years across participating countries. Domains measured were literacy, numeracy, and digital problem-solving. It is the largest and most comprehensive international survey of adult literacy and numeracy skills ever done and has been conducted in multiple cycles and rounds over time.



Results provide important data and insights on adults' literacy, health literacy, numeracy, and problem-solving skills—those that individuals need to participate in society and that countries need for their economies to thrive. They are a vital tool for policymakers, educators, health professionals, and others as they evaluate and track skills and competencies. Data are used to develop interventions to enhance literacy and equity and promote better health outcomes for diverse populations.

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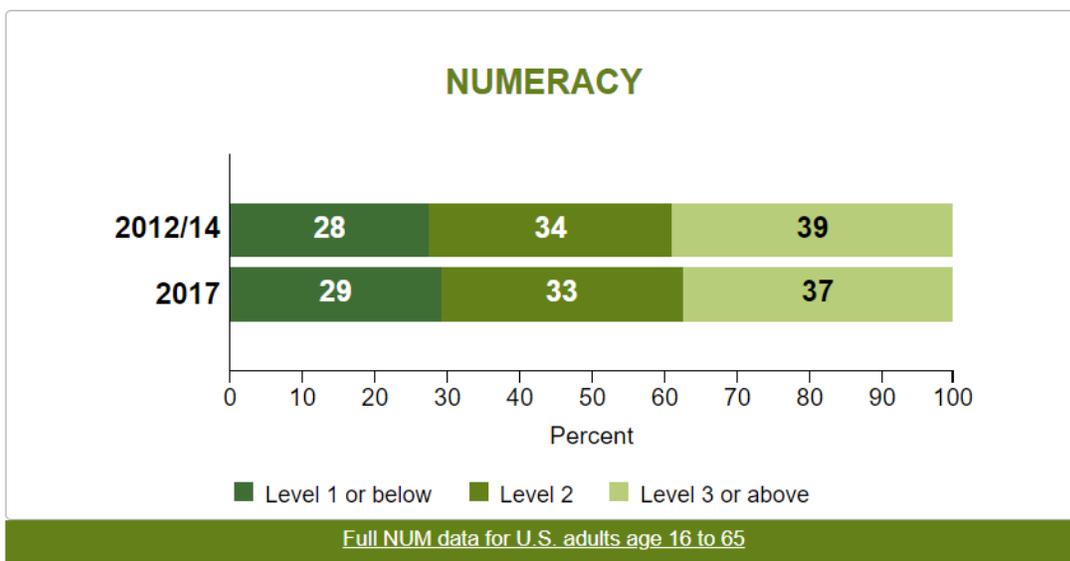
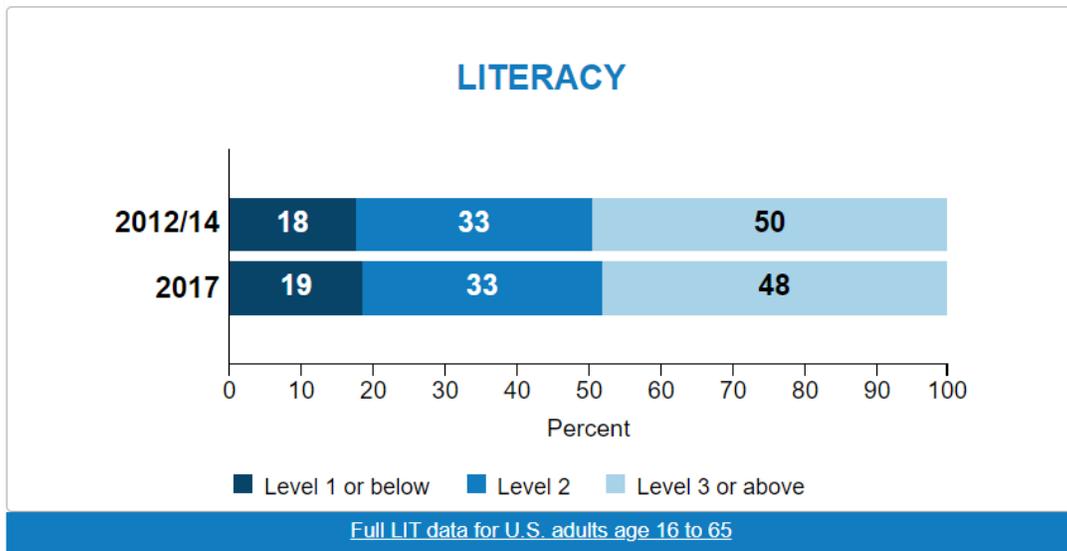
Learn More About the PIACC

- National Results: https://nces.ed.gov/surveys/piaac/national_results.asp
- Assessment Cycles and Results: <https://nces.ed.gov/pubs2014/2014008.pdf>
- Overall design and background: <https://www.oecd.org/skills/piaac/>

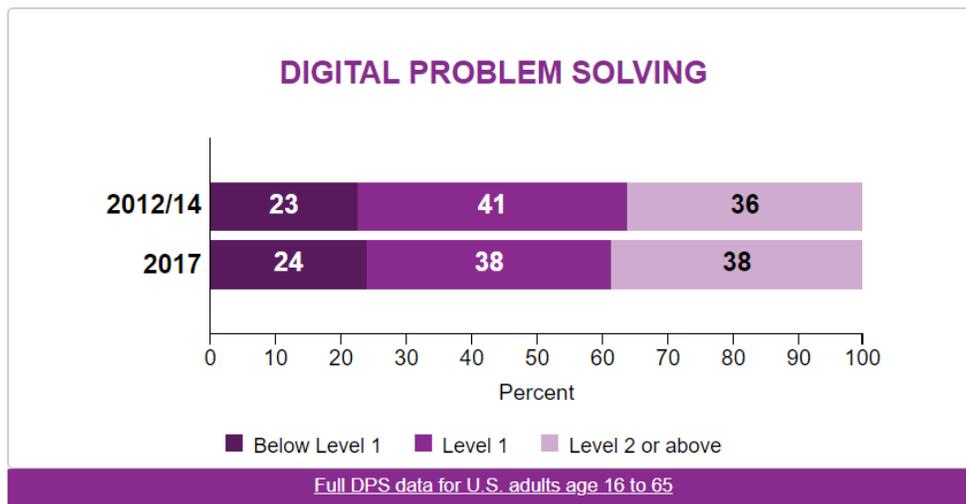
Overview

PIAAC Results - 2012/2014 versus 2017 Survey Rounds*

PIAAC results for literacy, numeracy, and digital problem-solving in the tables below show changes between its 2012/2014 and 2017 survey rounds.



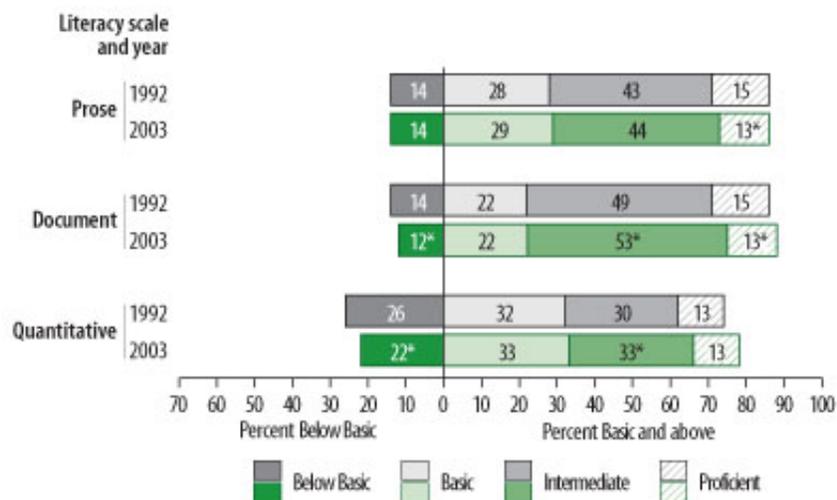
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*Percentage distribution of U.S. adults age 16-65 at levels of proficiency on PIAAC literacy, numeracy, and digital problem solving: 2012/2014 and 2017. https://nces.ed.gov/surveys/piaac/national_results.asp

Looking at the preceding PIAAC data and the NALS and NAAL results below conveys that despite different methodology, including literacy definitions, levels, and categories, overall literacy has not changed much since the 2003 NAAL.

NALS and NAAL Results for Comparison**



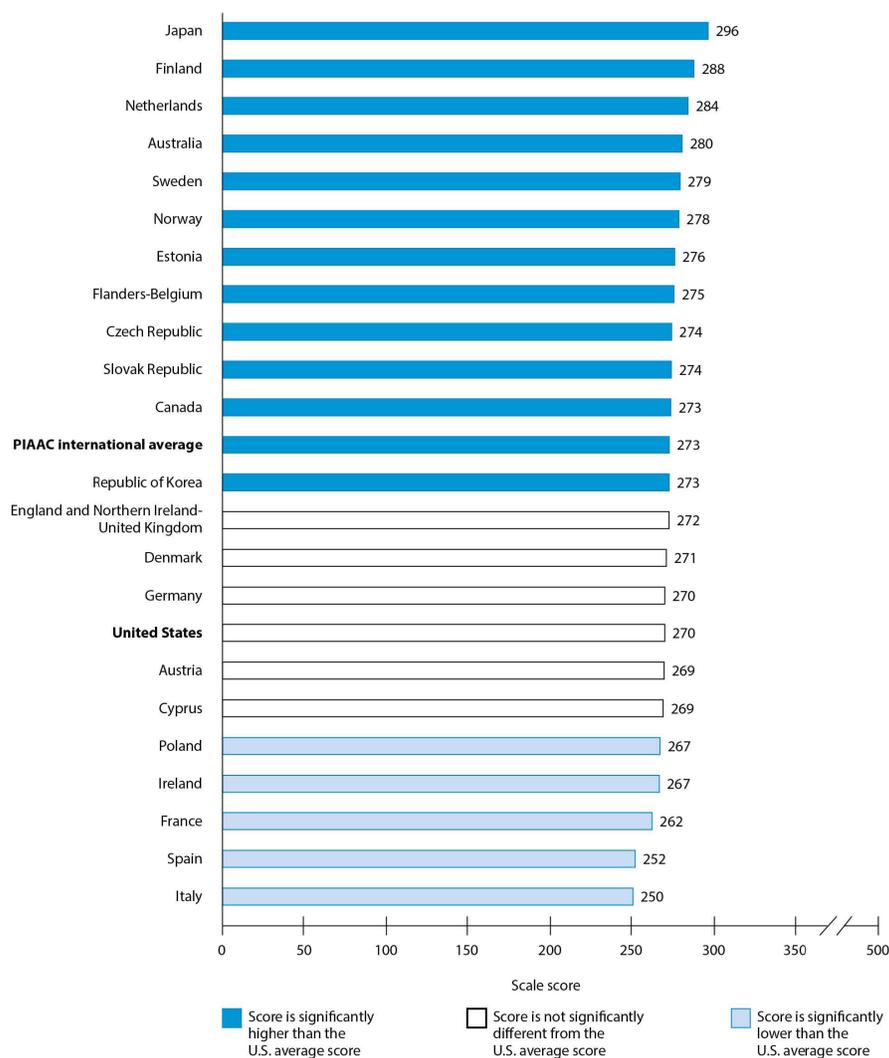
**U.S. Department of Education, Institute of Education Sciences, National Center for Education Statistics, 1992 National Adult Literacy Survey and 2003 National Assessment of Adult Literacy.

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Comparing PIAAC International Results for the U.S. and Other Countries***

Data comparing U.S. PIAAC results with those from other countries can be found at: <https://eric.ed.gov/?id=ED544452>.

The following chart shows the 2012 literacy scores and placement for participating countries, including the U.S., relative to the international average and to each other.



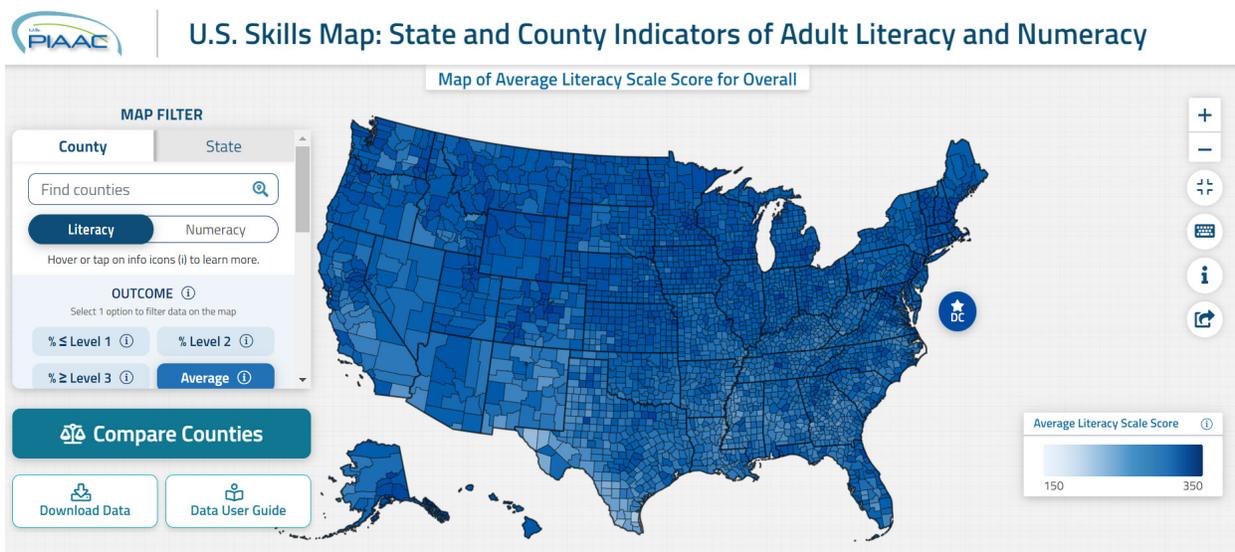
***U.S. Department of Education, Institute of Education Sciences, National Center for Education Statistics, 1992 National Adult Literacy Survey and 2003 National Assessment of Adult Literacy.

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Two U.S. Interactive Literacy Maps

Adult Literacy and Numeracy Skills Map

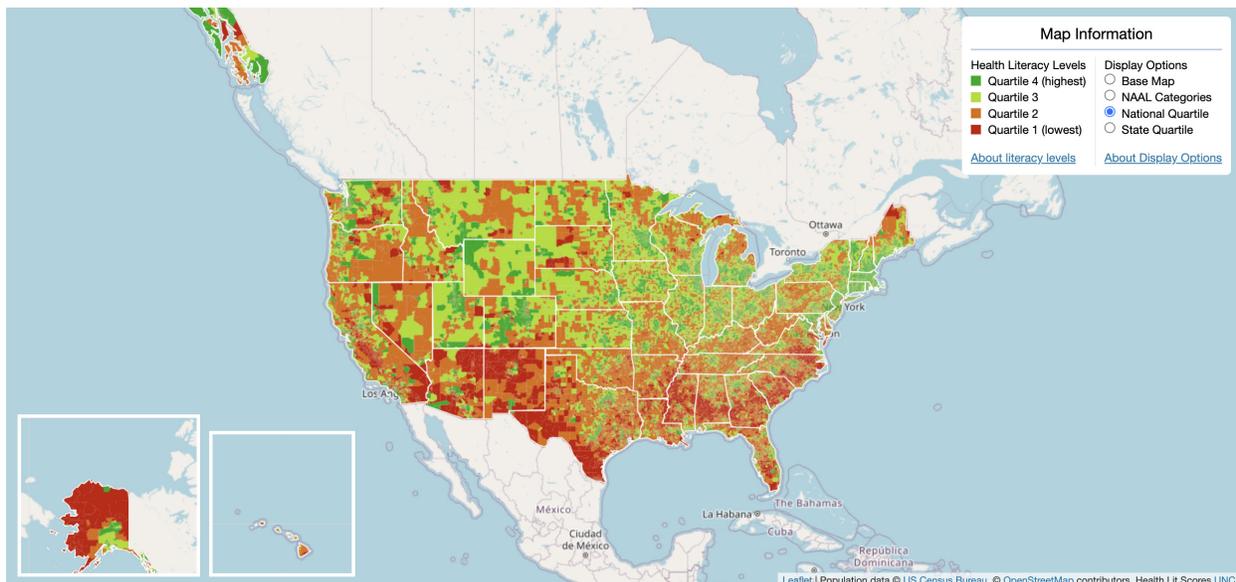
The U.S. Skills Map is an interactive tool for becoming familiar with a geographic area's strengths and weaknesses in literacy and numeracy down to the county level. The map can be helpful in many ways for health literacy advocates, policymakers, grant writers, educators, professors, public administrators, researchers, students, and others. It can be used in discussions and presentations with policymakers and funders to raise awareness, build political support, and secure funding. To help in advocating for local support, use the data at the local (county) level. The map can be found at this website: <https://nces.ed.gov/surveys/piaac/skillsmap/>



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Health Literacy Data Map

The Health Literacy Data Map is another useful interactive tool for becoming familiar with a geographic area's strengths and weaknesses in health literacy, down to the county level. It can be helpful in the same ways suggested above. This map works only with the Firefox browser. It can be found at this website: <http://healthliteracymap.unc.edu/>.



Low Health Literacy Throughout the World

In addition to in the U.S., low health literacy is well-documented throughout the world. Available evidence suggests that nearly half of the adult population in the U.S.,⁵ Europe,^{26,27} and Asia²⁸ has limited or insufficient levels of health literacy. The table below summarizes key findings from a variety of geographic areas.

Overview

Country	Assessment Tool	Key Findings	Comment
Australia	2019 scoping review	Variability in health literacy definitions led to inconsistent measurements and lack of comparability in results. ²⁹	Despite health literacy being a priority in Australia’s national health goals and targets since 1993, health literacy rates remain low.
Canada	International Adult Literacy and Skills Survey, 2003	Average health literacy score is Level 2, Basic.	A significant percentage of adults (60% or 6 in ten) lack the skills to manage their health literacy needs. ³⁰
Europe	European Health Literacy Survey (HLS-EU)	Nearly half the Europeans surveyed have inadequate or problematic health literacy. ²⁷	European countries surveyed include Austria, Belgium, Hungary, Italy, and others; and Asian countries such as Indonesia, Israel, Japan, Taiwan, Vietnam, and others.
New Zealand	Organization for Economic Cooperation and Development (OECD) Adult Literacy and Lifeskills (ALL) Survey	42% of adult New Zealanders aged 16 to 65 years had inadequate literacy and numeracy to manage daily demands they were likely to face.	Improvement in adult literacy and numeracy has been achieved since the 1996 International Adult Literacy Survey (IALS). ³²
Southeast Asia		“Health literacy has been placed high on the agenda in the WHO Southeast Asia Region via the introduction of a health literacy toolkit for low- and middle-income countries to help communities to develop their own solutions.” ^{31,33}	Consists of 11 countries: Indonesia, Malaysia, Singapore, Thailand, Philippines, Myanmar, Vietnam, Brunei, Cambodia, Laos, and East Timor.

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Important Advances in the Last Decade

There is much to learn from progress in the health literacy field:

- The intersection of health literacy with health equity and language equity.
- Professional development opportunities.
- New perspectives, capacity-building, and infrastructure development, especially related to organizational health literacy.
- Broader, wide-ranging collaborations and coalitions.
- New and updated resources and tools.
- Ongoing research, presentations, publications, and other forms of dissemination.

On the next page are examples representing progress in these areas.

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Advances in the Health Literacy Field

- Health Literacy Research and Practice (HLRP) Journal
<https://journals.healio.com/journal/hlrp>
- International Health Literacy Association (IHLA) <https://www.i-hla.org/>
- Institute for Healthcare Advancement Health Literacy Specialist Certificate Program.
<https://learn.healthliteracysolutions.org/HLSCP>
- Many U.S. states and counties have active or growing health literacy coalitions that serve as conveners and offer training and professional development opportunities, topical health literacy conferences, and innovative resources to advance organizational health literacy. <https://www.cdc.gov/healthliteracy/statedata/index.html>
- U.S. Department of Health and Human Services Office of Minority Health grant funding to advance health literacy to enhance equitable community responses to COVID-19.
- The National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care³⁴ <https://thinkculturalhealth.hhs.gov/clas>
- U.S. Health and Human Services Language Access Plan to improve access and support equity and inclusivity to their services for people whose primary language is not English and those with disabilities.³⁵
<https://www.hhs.gov/sites/default/files/language-access-plan-2023.pdf>
- Beyond Translation: Promoting a New National Standard for Equity in Health Materials Translated from English³⁶ - commentary describing language equity challenges in the traditional translation process that are addressed in this proposed new standard.

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Policy Approaches to Advance Health Literacy

Since health literacy is fundamental to health equity, safety, and quality there are many policy opportunities to advance organizational health literacy in health care settings. Policy approaches are also available throughout the health continuum for other health entities and professions. Some initiatives are underway; others present new opportunities to advance health literacy and health equity.³⁷

Federal Policy Initiatives

Federal policy initiatives advance health literacy as an integral component of health care and services to improve health outcomes; increase equity, access, and quality; and reduce costs, for example:

- The Affordable Care Act necessitates people having clear information to choose a health plan and interact with the health system.³⁸
- The National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care provide a blueprint for individuals and health and health care organizations to implement culturally and linguistically appropriate services to advance health equity, improve quality, and help eliminate health care disparities.³⁴ The Standards are named in federal legislation (Title VI of the Civil Rights Act, Americans with Disabilities Act, Plain Language Act of 2010, and Affordable Care Act), some state legislation, and are required for accreditation from the National Committee for Quality Assurance and The Joint Commission. <https://thinkculturalhealth.hhs.gov/clas>
- Health literacy strategies support recognition as a patient-centered medical home.³⁹
- Reimbursement is tied to patient experience survey results like the Consumer Assessment of Healthcare Providers and Services (CAHPS) and Hospital Consumer Assessment of Healthcare Providers and Services (HCAHPS) that include health literacy-related questions.^{40,41}
- National quality and safety goals include lowering unplanned readmissions and associated costs.⁴² Ensuring patients understand what they need to do to manage their own and loved ones' health is fundamental to ensuring safe transitions home and optimizing self-care for increasingly prevalent chronic conditions.

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Accreditation and Quality

Leaders in these areas lend influence when they focus attention on the importance of systems-based approaches to organizational health literacy.

- The Joint Commission states, “...the safety of patients cannot be assured without mitigating the negative effects of low health literacy and ineffective communications on patient care.”⁴³ Various health literacy principles are embedded throughout The Joint Commission standards but lack specificity. This creates opportunities to elevate the importance of health literacy in patient safety, and promote its integration into planning, measurement, patient safety, and quality improvement.⁸
- The National Quality Forum endorses teach-back and plain language, and using reader-friendly documents during the informed consent process as best practices to reduce harm to patients.⁴⁴
- Nursing Magnet recognition includes health literacy as a nurse sensitive indicator.

Health Professions

These health professions domains provide examples of preparing and supporting various health professionals and practice settings in organizational health literacy.

- The American Dental Association promotes adoption of health literacy-informed practices to minimize the risk of miscommunication in the oral health setting. They recommend supporting patients’ efforts to improve their oral health by using strategies that make the dental office environment and health care system easier to navigate. <https://www.ada.org/resources/community-initiatives/health-literacy-in-dentistry>
- The Accreditation Council on Graduate Medical Education includes Interpersonal and Communication Skills as a core competency for physicians in training. <https://www.acgme.org/>
- There are a variety of health literacy training curricula for undergraduate health professions students, graduate medical trainees, and other health care team members.⁴⁵⁻⁵²

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The National Action Plan to Improve Health Literacy

The *National Action Plan to Improve Health Literacy*⁵³ reflects a national commitment to providing health information that is usable for all populations and promotes a vision of a health literate society that:

- Provides everyone with access to accurate, actionable health information.
- Supports life-long learning and skills to promote good health.
- Delivers person-centered health information and services.

The Plan envisions a restructuring of the health care system and invites multi-sector participation. It has seven goals and offers evidence-based and best practice strategies for achieving a health literate society. Its second goal calls for promoting changes in the health care system that improve health information, communication, informed decision-making, and access to health services to meet the communication needs of patients and improve quality.

Improving Organizational Health Literacy Requires System Change

Improvement methods and change management models to effect health systems change include:⁵⁴

Lean Six Sigma:

- <https://catalyst.nejm.org/doi/full/10.1056/CAT.18.0193>

The Model for Improvement and Plan-Do-Study-Act (PDSA):

- <https://www.ihl.org/resources/how-to-improve>

Kotter's 8-Step Process:

- <https://hbr.org/1995/05/leading-change-why-transformation-efforts-fail-2>

AHRQ Practice Facilitation Training Modules:

- <https://www.ahrq.gov/ncepcr/tools/transform-qi/deliver-facilitation/modules/index.html>

Adapt ideas in this Guidebook to fit your organization. Start with what speaks to you and your setting. If you read one chapter and take a small step, that is a step forward. Weave these efforts into the improvement approach your organization uses.

Overview

Using the Model for Improvement

The Model for Improvement⁵⁵ is a simple yet powerful tool used by health organizations to test and implement changes in real-world settings to improve processes and outcomes. The Model for Improvement helps answer three basic questions:

- What are we trying to accomplish?
- How will we know that a change is an improvement?
- What change can we make that will result in improvement?

Testing Changes

Plan-Do-Study-Act (PDSA) cycles guide the tests of change to determine if there is improvement.

PDSA stands for:

- Plan—Develop a plan to test the change.
- Do—Carry out the test.
- Study—Observe and learn from what happens.
- Act—Decide what changes to make to the test for the next cycle.

PDSA cycles break down changes into a series of small tests that can be tried in real working settings. Multiple PDSA cycles in a quick series can lead to successful change that ultimately involves many stakeholders. They make it possible to:

- Learn how to adapt the change to the local environment.
- Allow failures without impacting performance.
- Predict how much improvement might come from the change.
- Increase belief the change will result in improvement.
- Minimize resistance to change.

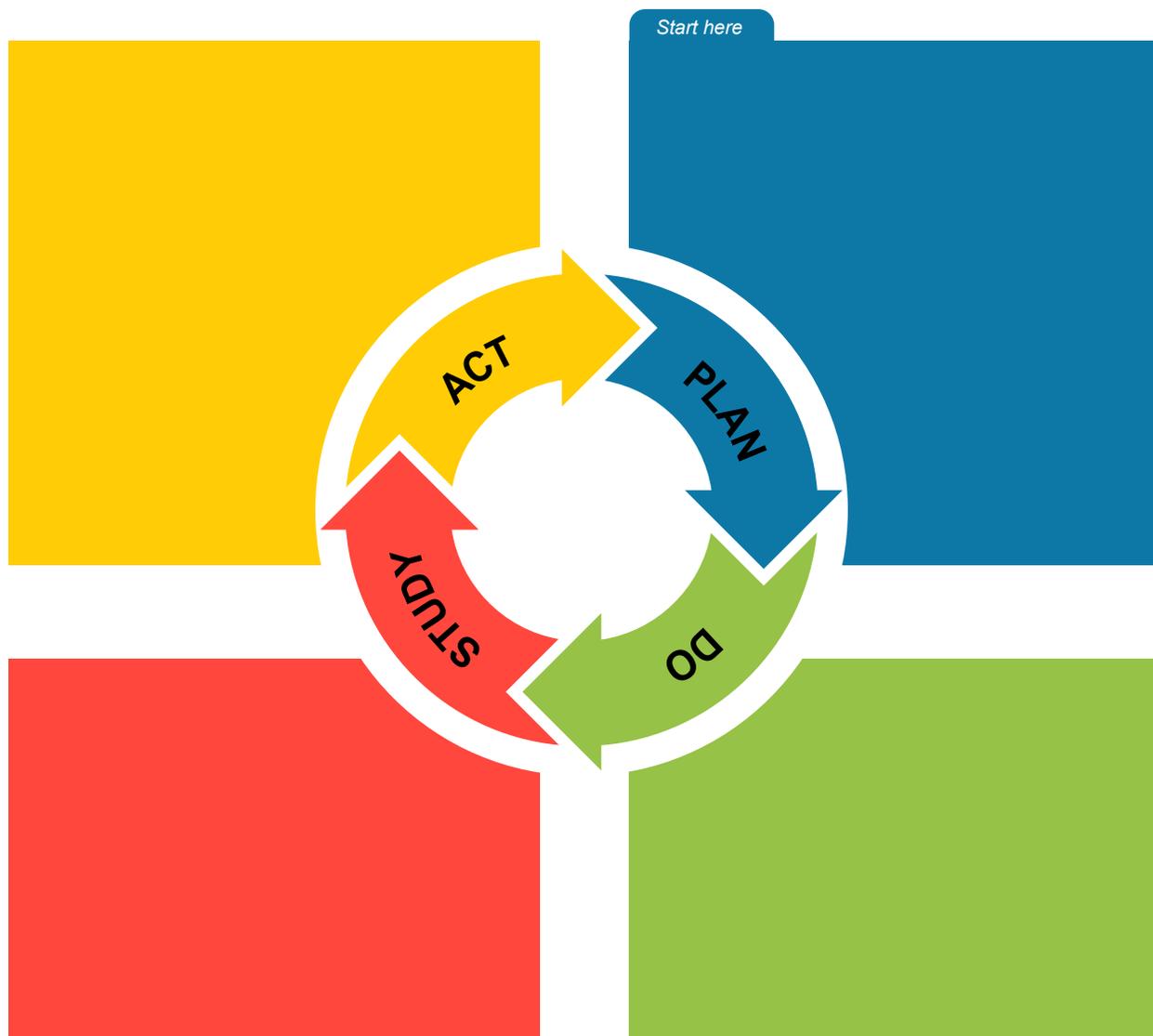
Other advantages include the chance to evaluate costs and side effects, refine the process before it becomes a done deal, and run multiple PDSA cycles in multiple areas at the same time.

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To be considered a complete PDSA test, the following must apply:

- The test or observation was planned (including a plan for collecting data).
- The plan was attempted (do the plan).
- Time was set aside to analyze the data and study the results.
- The next action was based on what was learned.

The figure shows how a PDSA cycle is designed. You will see illustrative examples throughout the Guidebook.



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The Model for Improvement is especially well-suited to addressing health literacy since it can create a *pull* as much as a *push*. This pull represents the fact that organizational change can begin on the front lines through people who work with patients, families, and clients, as well as a push from leadership.

Learning Collaboratives and the Model for Improvement

The Model for Improvement can be applied in any setting, from individual clinics, departments, or hospitals to public health. It can be used in learning collaboratives that focus on improvement using a philosophy of “all teach, all learn.” These are comprised of health organizational teams committed to making major, rapid changes and working together to identify improvement strategies and test changes.

Learning collaboratives involve learning sessions that bring participants together to share, teach, and learn. Between them are action periods for PDSA testing and sharing progress, problem-solving, and reporting lessons learned. Testing leads to implementation—making changes part of day-to-day operations of the organization, where support processes and resources become more important. Ultimately, testing leads to reliability and sustainability. This involves strategies like:

- Assigning ownership.
- Updating job descriptions.
- Formally including changes in orientation and training.
- Setting up standard processes and policies.
- Measuring, observing, and auditing.

As part of a county-wide initiative to advance organizational health literacy through capacity-building and infrastructure development, two 6-month Health Literacy Learning Collaboratives were conducted, with 19 teams participating in total over two years. Team members were from health care organizations, public health agencies, community-based organizations, health professions education, and a payor.

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During the first Collaborative:

- All teams conducted and used their Enliven Organizational Health Literacy Self-assessment Resource⁵⁶ findings and alignment with their organizations' missions, strategic plans, and priorities to develop and implement organization-wide or focused health literacy plans.⁵⁷
- Eight out of 10 teams advanced as health literate health organizations based on pre-/post self-assessments of organizational health literacy using the Enliven Organizational Health Literacy Self-assessment Resource.⁵⁶

What Team Leaders Said about Participating in the Health Literacy Learning Collaboratives

“The Health Literacy Learning Collaborative is an excellent way to network, engage in collective learning experiences, and share lessons learned and best practices.”

“Hearing from other organizations about how they address similar challenges; celebrating success; seeing that one small change can move the needle.”

“In three years' time, I see our organization expanding our team of health literacy champions, having all our resources translated into the five most common languages of those we serve, and an extensive recipe video database we can share with our community for free and with meal kit services.”

Hear from one team who participated in the Health Literacy Learning Collaborative:

<https://bit.ly/4c1A0g6>

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Summary of Key Points

- Health literacy is fundamental to health equity, safety, quality, and patient-, family-, and client-centered care.
- Organizational health literacy is the degree to which organizations equitably enable individuals to find, understand, and use information and services to inform health-related decisions and actions for themselves and others.¹⁰
- The prevalence of and impact related to limited health literacy are experienced throughout the world.
- A health literate organization recognizes that health literacy arises from individuals' capacities and the health literacy-related demands and complexities of the health care system.
- The demands of the U.S. health care system exceed the health literacy skills for nearly 90% of adults.
- Older adults, ethnic and racial minorities, and people living in poverty are among the groups at increased risk of low health literacy.
- Low health literacy is associated with poor health outcomes, health disparities, and increased costs.
- Any kind of health organization that provides health-related care, services, and/or education can work toward becoming a health literate organization.
- Improving organizational health literacy requires system changes and working toward attaining the 10 attributes of health literate organizations.
- The Model for Improvement and PDSA is a helpful improvement model that uses small tests of health literacy changes and then refines them to build reliable, sustainable organizational health literacy practices.

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Advance Health Literacy and Equity

3 | Advance Health Literacy and Health Equity

“Achieving health and well-being requires eliminating health disparities, achieving health equity, and attaining health literacy.”

— Healthy People 2030¹



To watch this video, click [HERE](#) or scan the QR code below.



Health equity is defined by the Healthy People 2030 Office of Disease Prevention and Health Promotion, U.S. Department of Health and Human Services (HHS), as “the attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities.”¹ By calling out historical and contemporary injustices, this definition emphasizes the role social factors and trauma can play in health outcomes. Prioritizing health equity for everyone may require different solutions for different groups of people.

Organizations often group diversity, equity, and inclusion efforts together, but these terms represent distinct concepts. Diversity refers to the representation or composition of various social identity groups in a workgroup, organization, or community. Inclusion refers to the behaviors that offer affirmation, celebration, and appreciation of different approaches, styles, perspectives,

Advance Health Literacy and Equity

and experiences.² While a diverse health workforce and inclusive behaviors can lead to more equitable patient outcomes, this chapter will focus specifically on health equity.

This chapter includes resources and best practices for advancing equitable health for all people and will increase your awareness of, knowledge about, and skills in:

- Understanding key terminology related to health equity.
- Understanding the link between health equity, social determinants of health, cultural competence, cultural humility, and health literacy.
- Recognizing the importance of health literacy in promoting health equity for all.
- Applying equitable and inclusive practices to health care and health promotion, information, and services at every point of contact.

A Health Literate Organization Provides Equitable Care

This Chapter addresses all Ten Attributes of Health Literate Health Care Organizations, especially Attributes 4, 5, 6, 7, and 8 and will help you provide equitable care to the populations you serve.³

Understanding Key Terms

Having a common understanding of key terms is essential for navigating the concepts laid out in this chapter.

Defining Health Equity

Health equity is the attainment of the highest level of health for all people. This requires everyone to have a fair and just opportunity to attain their highest level of health. Equity is not the same as equality.¹ **Equality** means giving the same access to resources for all, regardless of characteristics or outside influences. **Equity**, on the other hand, means providing resources for all and eliminating any disadvantages to ensure the same access is granted.

Advance Health Literacy and Equity

Cultural humility refers to the recognition of social, educational, and economic power imbalances among individuals, groups, or communities. Cultural humility requires being open, self-aware, ego-less, flexible, respectful, supportive, and self-reflective.⁷

Healthy People 2030 Defines Personal and Organizational Health Literacy

Personal health literacy is the degree to which individuals have the ability to find, understand, and use information and services to inform health-related decisions and actions for themselves and others.¹

Organizational health literacy is the degree to which organizations equitably enable individuals to find, understand, and use information and services to inform health-related decisions and actions for themselves and others.¹

Personal and organizational health literacy taken together constitute health literacy.

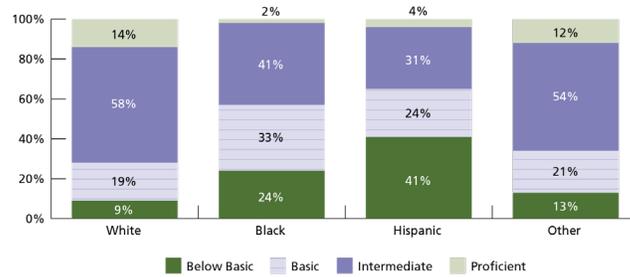
Why Are Both Health Equity and Health Literacy Necessary to Advancing Your Organization's Mission?

The demands of the U.S. health care system exceed the health literacy skills for almost 90% of adults.⁸ Racial and ethnic minorities are more likely to be at risk for lower health literacy and less likely to be in the proficient range. Additional populations at risk for lower health literacy include non-native English speakers, people with limited education, immigrants and refugees, people aged 65 years and older, those with lower incomes, and people with public or no health insurance.⁸

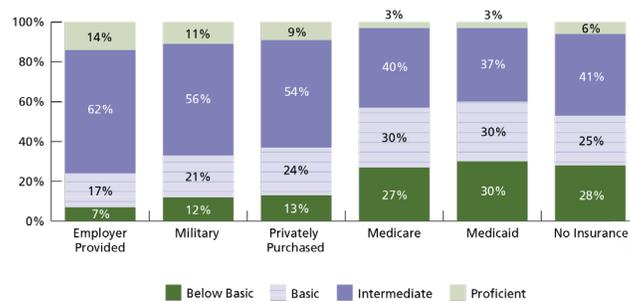
Advance Health Literacy and Equity

Percentage of U.S. Adults in Each Health Literacy Level

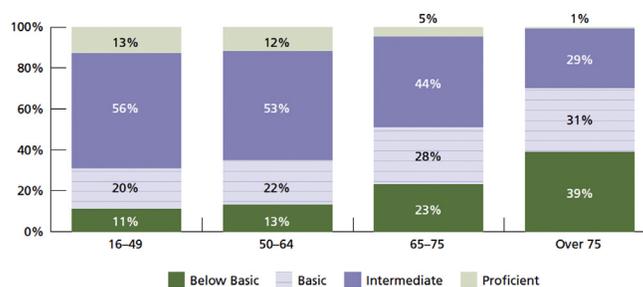
By Racial/Ethnic Group



By Type of Health Insurance



By Age



America's Health Literacy: Why We Need Accessible Health Information. An Issue Brief from the U.S. Department of Health and Human Services. 2008. Available at:

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Advance Health Literacy and Equity

Contributors to an increased risk for limited health literacy and poor health outcomes are complex. They are related to the effects of systemic racism, poverty, and other social determinants of health, along with less access to health care, community resources, and quality education.^{8,9,10} Low health literacy, in turn, mediates the relationship between socioeconomic status and health outcomes.¹¹ A person's health literacy impacts their health behaviors and choices, and ability to advocate for their health, housing, and education for themselves and their families.

Health Organizations' Roles

People have the right to understand what they need to care for their health and make choices. Health organizations have a duty to provide information in simple, clear and plain language, and to check that people have understood before ending the conversation.¹²

Healthy People 2030 recognized health organizations' responsibility to communicate clearly by defining organizational health literacy.¹ While personal health literacy refers to an individual's ability to understand health information, organizational health literacy represents an organization's ability to equitably communicate health information to all. Improved communication (i.e., giving information in simple, clear, and plain language and ensuring people understand) can reduce barriers and improve health equity.

Health organizations are also responsible for creating environments where all people feel welcome and safe. Mistreatment of people (both unconsciously and consciously) can lead to worse outcomes for those experiencing it. Racism, sexism, and ableism are a few examples of systematic mistreatment that can cement themselves within a culture and society and cause significant harm. Often, people may not realize how this mistreatment affects different groups. This lack of knowledge can lead to perpetuation of harmful stereotypes and biases about groups of people, adding to the barriers that make accessing quality health information and services harder for some people.

When people cannot get the information they need to understand their mental, physical, and emotional well-being, making informed decisions about their health is much harder. Research highlights how this leads to greater mistrust, less adherence and follow-up, and poorer health status.^{13,14} This is why improving health literacy is essential to achieving health equity.

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Health institutions, public health organizations, and health workers play a considerable role in how people form personal health literacy and in how principles of organizational health literacy are applied to ensure clear communication. It is critical to consider health literacy and health equity when attending to resources and steps in the health promotion and health care continuum. Examples include:

- Websites.
- Print materials.
- Language access services.
- Obtaining informed consent for procedures.
- Discharge teaching/instructions.

Health institutions also operate within the larger norms of society around who can access these resources. When racism, sexism, ableism, and other forms of mistreatment persist in a society, it disadvantages marginalized, historically excluded groups of people and makes them more vulnerable to low health literacy, health inequities, and poor health outcomes.

“It’s our collective responsibility to lower barriers to health.”

— CommunicateHealth¹⁵

Health Care Versus Health

Of all the factors affecting health outcomes, health care contributes only 10%.¹⁶ Studies have estimated the proportional contribution to health by other factors as follows: genetic predisposition (30%), social circumstances (15%), environmental exposure (5%), and behavioral patterns (40%). Historically, racial and ethnic disparities in health outcomes were falsely attributed to differences in genetic predisposition. While ancestry has a genetic basis, we now recognize race and ethnicity as social constructs, meaning they are not rooted in biology but instead are ideas created and accepted by the people in a society.¹⁷ Therefore, in scientific research, race and ethnicity should, in most cases, be considered proxies for other factors, including racism. The other contributors to life expectancy (social circumstances, environmental exposure, health care, and behavioral patterns) can all be affected by systemic racism. To eliminate disparities in health outcomes, we must interrupt the effects of racism in each of these realms.

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Equity Failures in Organizational Health Literacy

Black patients consistently experienced poorer communication quality, information-giving, patient participation, and participatory decision-making than white patients.

— Shen, et al. 2018¹⁸

Although health care contributes a small percentage to overall health, health care organizations must take responsibility for providing equitable care and for helping patients and families adopt healthy behaviors (e.g., manage chronic conditions, take preventive measures) when outside the health care setting. Health care and health behavior coaching require clear and culturally-attuned and -aligned communication to be effective. The complexity of health information and health system processes is a source of systemic disparities in accessing health information and navigating the health care system.

Systemic Racism in Health Communication

“Lack of organizational health literacy and clear communication policies are preventable, structural features of U.S. health care that contribute to systemic racism. Typical written and spoken health information is unnecessarily complex, is written at too high of a reading level, is presented using unfamiliar jargon terms, and requires too high of numeracy skills for the average patient. This creates systemic disadvantages for patients with lower health literacy, who are more likely to identify as American Indian or Alaska Native, Black, or Hispanic individuals. The issue of unequal access to high-quality, understandable, and usable health information, by virtue of population differences in educationally determined health literacy, has received little attention as a form of systemic racism.”

— Coleman, et al. 2023¹⁹

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What are Social Determinants of Health?

Social Determinants of Health



<https://health.gov/healthypeople/priority-areas/social-determinants-health>

Social determinants of health are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.²⁰ These social, economic, and environmental factors contribute to the overall health of individuals and communities. Understanding the relationship between how population groups experience “place,” and the impact of “place” on health is fundamental to the social determinants of health—both social and physical determinants.²¹ Not only do place-based environmental exposures directly affect health, but healthy behaviors may be more or less difficult based on place-based circumstances.

The Social Determinants of Health Shape Our Daily Lives

Watch this overview of how social determinants of health influence health outcomes and shape our daily lives.



To watch this video, click [HERE](#) or scan the QR code below.



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Examples of Social Determinants Include:

- Availability of resources to meet daily needs (e.g., safe housing and local food markets).
- Access to educational, economic, and job opportunities.
- Socioeconomic conditions (e.g., concentrated poverty and the stressful conditions that accompany it).
- Access to health care services.
- School quality and availability of language access services.
- Availability of community-based resources in support of community living and opportunities for recreational and leisure-time activities.
- Exposure to crime, violence, environmental hazards, and social disorder (e.g., presence of trash and lack of cooperation in a community).
- Transportation options.
- Public safety.
- Social norms and attitudes (e.g., discrimination, racism, and distrust of government).
- Segregated neighborhoods.
- Access to mass media and emerging technologies (e.g., cell phones, the internet, and social media).

Screening for social determinants of health can be useful in promoting health equity if it is accompanied by effective strategies to meet identified needs or mitigate the effects of social needs on health. As with other health interventions, health literacy should be considered in the development of screening processes and interventions.

Tools for Screening for Social Determinants of Health from the American Hospital Association (AHA)

The American Hospital Association (AHA) offers tools and resources for hospitals, health systems, and other community stakeholders to address the social determinants of health.

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Screening for Social Needs: Guiding Care Teams to Engage Patients

<https://www.aha.org/toolkitsmethodology/2019-06-05-screening-social-needs-guiding-care-teams-engage-patients>

Description: A tool to help hospitals and health systems facilitate sensitive conversations with patients about their nonmedical needs that may be a barrier to good health. The tool includes strategic considerations for implementing a screening program, tips for tailoring screenings to hospitals' unique communities, case examples, and national organizations that can help connect patients with local resources.

Addressing Social Determinants of Health Presentation

<https://www.aha.org/landing-page/addressing-social-determinants-health-presentation>

Description: This adaptable presentation deck gives you the tools and talking points to start discussing the social determinants of health.

ICD-10-CM Coding for Social Determinants

<https://www.aha.org/dataset/2018-04-10-resource-icd-10-cm-coding-social-determinants-health>

Description: ICD-10-CM Codes allow clinicians to code for social needs. This document reviews the codes and how hospitals can use them to record and track patients' social needs.

Social Determinants of Health Curriculum for Clinicians

<https://www.aha.org/physicians/SDOH>

Description: To help clinicians address social determinants, the AHA's Physician Alliance created a web-based virtual expedition to train and equip staff with how-to actions and companion resources.

Social Determinants of Health Guides

- Food Insecurity and the Role of Hospitals
<https://www.aha.org/ahahret-guides/2017-06-21-social-determinants-health-series-food-insecurity-and-role-hospitals>
- Housing and the Role of Hospitals
<https://www.aha.org/ahahret-guides/2017-08-22-social-determinants-health-series-housing-and-role-hospitals>
- Transportation and the Role of Hospitals
<https://www.aha.org/ahahret-guides/2017-11-15-social-determinants-health-series-transportation-and-role-hospitals>

Description: AHA is producing a series of guides on how hospitals can address various social determinants of health.

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Improving Value by Addressing the Social Determinants of Health

<https://soundcloud.com/ahahospitals/achi-tvi-podcast/s-EiUuB>

Description: This podcast features highlights from a presentation at the Association for Community Health Improvement's 2019 national conference about how hospitals drive value by screening for social needs.

What Does Success Look Like?

Health organizations that successfully implement health literacy and health equity practices ensure the following:

- The workforce is prepared to provide culturally-attuned care.
- Staffing reflects the diversity of populations served.
- Communities provide input on how the health organization can serve them best.
- An equitable approach is used for all patient, family, and client communication through using clear communication words and tools with everyone—the Universal Precautions approach.²²
- Quality metrics are analyzed for disparities and health literacy strategies are used to address the disparities.
- Race, ethnicity, and language data are used to improve information and care.
- Patients and clients are screened for social risks and needs, and assistance is offered in addressing these.
- Written and audio-visual materials are easy to read, understand, and use.
- Materials are reviewed by intended audiences to make sure they are culturally appropriate.
- Written and audio-visual materials are readily available in languages most commonly spoken by populations served, with the ability to access less common language materials when needed.
- All staff know how to access and work with qualified health interpreters for people who do not speak English as their preferred language.

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- Systems that are easy to navigate and/or support are available to help people with care transitions, scheduling appointments, wayfinding, and filling prescriptions.

Developing Cultural Competence and Cultural Humility in Health Organizations

Cultural competence and cultural humility are two distinct but related concepts created to address increasingly diverse populations, health disparities, and inequities. In this section, we'll take a look at each and follow with a perspective that uses both.

Cultural Competence

Cultural competence describes the ability to provide services to patients with diverse values, beliefs, and behaviors. This includes tailoring services to meet individuals' social, cultural, and linguistic needs⁶ and requires an iterative process.

Prioritize Cultural Competence as a Process for Health Equity

To provide the best care, organizations should systematically encourage staff to develop cultural competence. Here is a model describing a five-concept process for developing cultural competence, using the mnemonic 'ASKED.'²³

A - Cultural Awareness

- This involves **being aware of yourself first** (self-awareness and self-work), understanding your biases, prejudices, and assumptions of others, and working to eliminate them.
- Engage in cultural interactions to modify understanding of individuals and people from a certain culture and avoid stereotyping people.

S - Cultural Skill

- The ability to **collect relevant cultural data** and perform culturally-based assessments to determine how best to serve your patients and others.
- Demonstrate an ability to conduct thorough cultural assessments that pull from cultural data relevant to a patient's diagnoses.

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K - Cultural Knowledge

- Learning about others and seeking and understanding other world views.
- Develop a deep understanding of diverse groups using reliable sources that pinpoint health-related practices, cultural values, and disease incidence and prevalence.

E - Cultural Encounters

- Being intentional about **having face-to-face encounters** with others who you perceive as different from you.
- Demonstrate in practice a genuine interest in becoming culturally aware rather than a “check the box” action you perceive you have to take.

D - Cultural Desire

- This has to do with **your willingness to engage** in the process of learning about others. Listen and understand others’ perceptions, explain your own, and negotiate between the two.
- Practice introspection to analyze biases toward other cultures – are you aware of your biases and the presence of “isms”?

Benefits of Becoming a Culturally Competent Organization

Social Benefits	Health Benefits	Business Benefits
<ul style="list-style-type: none"> • Increases mutual respect and understanding between patient and organization. • Increases trust. • Promotes inclusion of all community members. • Increases community participation and involvement in health issues. • Assists patients and families in their care. • Promotes patient and family responsibilities for health. 	<ul style="list-style-type: none"> • Improves patient data collection. • Increases preventive care by patients. • Reduces care disparities in the patient population. • Increases cost savings from a reduction in medical errors, number of treatments, and legal costs. • Reduces the number of missed medical visits. 	<ul style="list-style-type: none"> • Incorporates different perspectives, ideas, and strategies into the decision-making process. • Decreases barriers that slow progress. • Moves toward meeting legal and regulatory guidelines. • Improves efficiency of care services. • Increases the market share of the organization.²⁴

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Cultural Competence and Cultural Humility

Cultural competence was the original framework used to address the needs of racial and ethnic minorities, immigrants, and economically disadvantaged populations.²⁵ There are multiple benefits to carrying out the actions listed above. And many organizations, institutions, and agencies use the cultural competence model effectively.

Cultural competence training often involves learning a specific body of knowledge about a community or population. This knowledge is intended to help employees engage knowledgeably with the community.

There are some limitations of the underlying assumptions of the cultural competency framework, including:

- Learning a finite body of knowledge about a group of people doesn't necessarily make someone competent in the group's culture and it can reinforce stereotypes.
- Learning about a group's culture does not consider the range of individual differences within the group.
- It is not possible to learn enough to be competent in the multiple cultures some health workers serve.
- There is an assumption that one can “learn enough” to be competent in a culture.

The concept of cultural humility was introduced as an alternative approach in 1998.^{26,27} Cultural humility refers to:

- Engaging in a lifelong process of learning and self-reflection.
- Challenging people to critique their cultural assumptions and biases.
- Encouraging a spirit of curiosity, flexibility, and openness.
- Challenging power imbalances in the patient-physician relationship, communities, and institutional structures—taking a social justice stance.^{7,26,27}

Bringing Competence and Humility Together

Understanding these two frameworks leads to a new perspective that encourages using features from each—a “both/and” as opposed to an “either/or” approach.²⁵ There are some areas of overlap and even synergy between these frameworks, e.g., cultural humility can be seen in the

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way cultural competence stresses “the need to question one’s assumptions, beliefs and biases.”²⁸ Cultural humility may complement, rather than replace cultural competence. If health care providers want to interact effectively with a culturally diverse population, they need both cultural humility and cultural competence.²⁹

A cultural competence mindset can remind us to keep learning as much as possible about the communities we interact with. A deep cultural humility mindset, listening with interest, and being aware of our own possible biases, keep us open to lifelong learning and reflection. Blending these two concepts gives people working in health organizations some of the most important tools for interacting with diverse individuals, groups, and communities.²⁵

Teaching and Learning Resources

<p>Culture, Language, and Health Literacy Health Resources & Services Administration (HRSA) https://www.hrsa.gov/about/organization/bureaus/ohe/health-literacy Description: Tools and resources for health literacy and cultural and linguistic competence are available.</p>
<p>Think Cultural Health U.S. Dept. of Health & Human Services Office of Minority Health https://thinkculturalhealth.hhs.gov/education Description: Free continuing education e-learning programs, each designed to help various health team members provide culturally and linguistically appropriate services (CLAS).</p>
<p>Cultural Humility: People, Principles and Practices https://www.youtube.com/watch?v=SaSHLbS1V4w&ab_channel=VivianChavez Description: A 30-minute video documentary by San Francisco State professor Vivian Chávez, mixes poetry with music, interviews, archival footage, and images of community, nature, and dance to explain what cultural humility is and why we need it.</p>
<p>CDC Webpage: Principle 1: Embrace cultural humility and community engagement. https://www.cdc.gov/global-health-equity/php/publications/cultural-humility.html Description: CDC’s Global Health Equity page on working with humility in communities. It also includes guidance on the work of building relationships with communities and prioritizing community engagement.</p>

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Implementing Culturally and Linguistically Appropriate Services Standards

The Culturally and Linguistically Appropriate Services (CLAS) Standards were developed by the Office of Minority Health in the HHS.³⁰ CLAS Standards offer a framework for services and organizational structure to provide equitable care. The Principal CLAS Standard explicitly recognizes the need to address health literacy, language, culture, and other communication needs to eliminate health disparities.

The Principal Standard

Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.³⁰

Blueprint for Advancing and Sustaining CLAS Policy and Practice

The Blueprint is an implementation guide to help you advance and sustain culturally and linguistically appropriate services within your organization.³¹ It offers concise, practical information on using the CLAS Standards in health and health care at your organization.

The Blueprint dedicates one chapter to each of the 15 Standards, presenting each Standard's:

- Purpose.
- Key components and concepts.
- Strategies for implementation.
- Additional resources for more information.

The Blueprint also offers:

- The case for the National CLAS Standards.
- Explanations of foundational concepts.
- Glossary of 75+ terms.
- 200+ Resources related to CLAS.

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Example: Once or Once? A Near Miss—What Almost Happened

A mother whose preferred language is Spanish had just picked up several medicines for their 6-year-old child, who had been sick for several weeks. The mother looked at the instructions on one of the medicine bottles and picked out the word “once.” In English, this word means one time; however, in Spanish, it means “eleven;” therefore, this mother assumed the child should receive the medicine 11 times per day. Fortunately, the mother was very attuned to how the child responded and recognized something was wrong by the third dose. She asked a neighbor to help her and then took her son to the emergency room.

Unfortunately, this and other scenarios happen far too often in care delivery. In this scenario, this parent did not speak or read English well and had only obtained a fifth-grade education, having been pulled out of school at 10 years of age to help care for her younger siblings while both her parents worked. Her daughters (aged 10 and 11 years) often accompanied her to doctor visits and acted as her interpreter since they had learned English at their elementary school.

Questions

- In what way could this scenario have gone differently?
- What was the responsibility of the health care team?
- Was there a “teach-back” moment so the parent(s) could demonstrate they understood and could effectively adhere to the treatment plan?
- Were interpretation and translation services available to provide culturally and linguistically appropriate care?
- What are some other ways to prevent these kinds of misunderstandings?

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Using Clear Communication and Inclusive Language

“Poor communication is a failing of the health system, not of patients.”
— Butler S & Sheriff N. 2021³²

Using universal precautions for clear communication reduces systematic inequities.²² Clear communication should be used with all patients, regardless of their education level or perceived personal health literacy abilities. Anyone can experience low health literacy at any time. Using clear communication makes information more accessible to all people and allows them to make more informed decisions.

Using inclusive language that reflects the populations you serve with diverse identities, abilities, and experiences allows people to feel seen, bolstering trust. The CDC’s Health Equity Guiding Principles for Inclusive Communication should be used when preparing written materials and speaking about patients and clients.³³ These principles include:

- Avoid using adjectives such as vulnerable, marginalized, and high-risk. Instead, focus on the systems that have affected some groups more than others (e.g., groups that have been economically marginalized).
- Use person-first language. For example, say “person with diabetes” instead of “a diabetic.”
- Be specific about the group to which you are referring. Instead of broadly referring to “minorities,” specify “people from” a specific racial or ethnic group.
- Avoid terms with violent connotations. For example, instead of referencing a “target population,” refer to the group as a “population of focus.”
- Avoid language that blames patients or clients. For example, rather than saying a patient is “non-compliant,” describe them as a person who “experiences challenges with accessing health services.”

The best way to know if the language you use in digital and written communication is clear and correct is to test the materials with the intended audience. Testing and gathering input allows

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the communities to give feedback, feel heard, and have a better finished product that reaches the intended audience. Inclusive communication also means the translation of written materials and the availability of interpreter services.

“Start by recognizing diversity of identity, perspective, and experience for what it is: a driver of better health communication.”

— CommunicateHealth¹⁵

Addressing Technology Barriers

Technology, including telehealth visits, asynchronous communication through electronic messaging, websites, and social media, can help to efficiently deliver health care and health information, but it can also lead to additional barriers.

Using technology requires more written communication, which can impact individuals with lower literacy, health literacy, and English proficiency skills. Many systems don't currently support other languages. It also requires individuals to have digital literacy skills, reliable broadband access, or a data plan. Electronic messaging can be asynchronous, and without tone of voice or visual cues, it can be more difficult for providers to assess understanding in real time with individual patients. When websites don't function well on mobile phones, individuals who don't own computers may have difficulty accessing the information.

On the other hand, there are opportunities to use technology to improve organizational health literacy practices. Technology can make it easier to standardize and translate patient instructions. Instructional and informational videos can be helpful tools with the ability to add voiceover and closed captions in multiple languages. Websites and social media can engage families and communities that historically have not had a voice in health care.³⁴ Electronic messaging platforms allow patients to communicate with health providers and ask non-urgent questions at times that are convenient for both.³⁵

Although technological solutions beg questions about equitable access to technology, programs may provide assistance for families who cannot afford internet access or internet-enabled devices.³⁶ Health care organizations can advocate for the expansion of such programs.

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Ensuring Accessibility for All

The CDC reports that 61 million (25%) adults in the U.S. live with some form of disability, with a higher prevalence (40%) among those aged 65 years and older.³⁷ This age group also faces an elevated risk of limited literacy skills, contributing to potential health disparities. Ensuring reader-friendly print materials and digital information are used is especially crucial for them.

Additionally, adults with disabilities often encounter difficulties accessing health care, experience disparities such as lacking a regular health care provider, and have unmet health care needs due to costs and absence of routine check-ups. People with disabilities may face obstacles in non-medical situations, such as emergency response information lacking sign language interpreters or evacuation route brochures being inaccessible to those with low vision.

Creating content accessible to people with disabilities is essential to address health disparities and achieve equity. Beyond readability, content must be understandable and actionable. However, meeting this standard isn't enough; further adaptations may be required for individuals with permanent, temporary, or situational disabilities. Content creators play a crucial role in removing barriers that might otherwise exclude people with disabilities.

Collecting Race, Ethnicity, and Language (REaL) Patient Demographic Data

Measurement is fundamental to system improvement. A critical barrier to eliminating racial and ethnic health disparities and improving the quality of patient care is the frequent lack of even the most basic data on race, ethnicity, and preferred language of patients and families. Federal and state data collection efforts vary, and many health plans, health systems, and hospitals do not collect data on patients' race, ethnicity, or preferred language. An individual's preferred language for spoken and written information may differ since some languages are not written, or people may ask someone who speaks a different language to read their health information on their behalf.

Health care organizations can use Race, Ethnicity, and Language (REaL) data to monitor health care delivery and quality of care by linking to clinical measures and examining the effects of interventions on specific groups. The Equity of Care: A Toolkit for Eliminating Health Care Disparities (<https://www.aha.org/hretdisparities/toolkit>), supported by HRET and the American Hospital Association, offers helpful resources.³⁸

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Many organizations use materials from the Robert Wood Johnson Foundation-funded “We Ask Because We Care” campaign. <http://forces4quality.org/node/4185.html>
Here is an example video.



To watch this video, click [HERE](#)
or scan the QR code below.



Guidance for Improving Demographic Data Collection

The Agency for Healthcare Research and Quality (AHRQ) provides guidelines as a starting point for improving data collection. The following are based on AHRQ’s Race and Ethnicity Data Improvement Toolkit.³⁹ https://hcup-us.ahrq.gov/datainnovations/raceethnicitytoolkit/home_race.jsp
You can adjust these to best fit your needs.

Why Health Organizations Collect Race, Ethnicity, and Language Data

- Improve quality and reduce disparities in health care processes and outcomes.
- Meet data reporting requirements.
- Understand the community served.
- Provide evidence of needs in grant applications and communication with potential donors.
- Match workforce to communities served.
- Identify areas in which quality initiatives are needed.
- Meet contractual compliance obligations.
- Quantify the need for interpreter services.

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How Health Organizations Use Race/Ethnicity/Language Data

- Ensure the availability of interpreter services and culturally and linguistically appropriate written and audio-visual materials
- Guide quality improvement/disease management programs.
- Design programs and benefits.
- Inform representation in marketing materials.

Why Every Patient Needs to Be Asked

- You cannot tell a person's race, ethnicity, or language from their appearance or accent.
- Self-reporting is the most accurate and consistent source of information.
- Self-reporting reflects how patients describe themselves.

Why It's Important to Standardize the Data Collection Technique

- To ensure that data collection is complete and accurate.
- Hospitals and policymakers understand and have confidence in the data.
- Explanatory scripts can prevent or address patients' and families' concerns about why you are asking these questions and how the information will be used.

When and Where to Ask

- Ideally, ask before an appointment or during phone registration.
- For patients who arrive and need to be seen right away, collect the information as soon as possible after treatment.
- Ask at the same time, in the same way as all other registration information.

Importance of the Introductory Statement

- Help patients and families understand why you are collecting the information and how it will (and will not) be used.
 - Example: “To help all patients receive the highest quality of care and the best services possible, we are asking all patients about their race, ethnicity, and language.”

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Help Staff Feel More Comfortable Asking Patients These Questions

- Be sure they:
 - Understand what disparities are and why they occur.
 - Are aware of their vital role in identifying and addressing disparities.
 - Are well-trained.
 - Are provided with responses to concerns and questions patients or families may raise.
 - Have participated in role-play in training so they can experience mock patients' reactions, concerns, and questions, and practice how to respond.

Help Patients Feel More Comfortable

- Explain that the questions come from a place of concern, and the data will serve a positive and valuable purpose.
- Patients should not feel forced to provide the information. Assure patients that their care will not be affected whether or not and how they answer and regardless of their response.
- Reassure patients that you respect their privacy and rights. Inform patients the data will only be reported in a group/aggregate form.
- Make sure data collection does not take too much time.

To Facilitate Data Collection

- Provide:
 - Justifications for hospital front-line staff and leadership/managers.
 - Scripts for hospital staff collecting patient information.
 - Staff- and patient-administered questionnaires.
 - FAQs for patients and hospital staff.

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Tools for Disparities Data

Health Disparities Calculator (HD*Calc)

National Institutes of Health (NIH) National Cancer Institute

<https://seer.cancer.gov/hdcalc/>

Description: A statistical software designed to generate multiple summary measures to evaluate and monitor health disparities (HD) in cancer care. HD*Calc was created as an extension of SEER*Stat that allows users to import population-based health data and calculate disparity measures in settings beyond cancer care.

Disparities Data

Health People 2030

<https://health.gov/healthypeople/objectives-and-data/about-disparities-data>

Description: Provides health disparities data by leading health indicators and disparity type.

SDOH Data and Analytics

Agency for Healthcare Research and Quality

<https://www.ahrq.gov/sdoh/data-analytics/sdoh-data.html>

Description: Datasets and analytic tools to power understanding of SDOH.

Health Equity Tools for Teaching and Training

Toolkits

Equity of Care: A Toolkit for Eliminating Health Care Disparities

Hospitals in Pursuit of Excellence (HPOE)

<https://ifdhe.aha.org/aha-disparities-toolkit>

Description: Highlights nine one-page case studies of health systems addressing equity of care.

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Improving Health Equity Through Data Collection AND Use: A Guide for Hospital Leaders

HRET Disparities Toolkit

<https://www.aha.org/ahahret-guides/2011-03-01-improving-health-equity-through-data-collection-and-use-guide-hospital>

Description: The Toolkit provides hospitals, health systems, clinics, and health plans information and

A Framework for Equity-Centered Health Communication

CommunicateHealth

<https://communicatehealth.com/insights/echc-framework/>

Description: Learn how to put health equity at the center of your health communication process—and create clear, inclusive, and accessible materials.

Inclusive Language Playbook: Writing for LGBTQ+ Communities

CommunicateHealth

<https://communicatehealth.com/insights/lgbtq-playbook/>

Description: Learn how to create respectful, inclusive materials for LGBTQ+ audiences.

AHE Toolkit

Advancing Health Equity

<https://advancinghealthequity.org/ahe-toolkit/>

Description: Roadmap, presentations, guides, worksheets, and publications to help create a stronger, more effective equity-focused intervention.

A Roadmap to Advance Health Equity

Advancing Health Equity

<https://advancinghealthequity.org/roadmap-to-ahe/>

Description: A series of activities to help an organization or multi-organization collaboratively create a sustainable approach to reducing or eliminating health and health care inequities.

CLEAR Collaboration Toolkit

McGill Department of Family Medicine

<https://www.mcgill.ca/clear/download>

Description: Clinical decision aid developed to help assess different aspects of patient vulnerability in a contextually appropriate and caring way and easily identify key referral resources. The toolkit has been translated into over 10 languages.

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Equity of Care: A Toolkit for Eliminating Health Care Disparities

American Hospital Association (AHA)

<http://www.hpoe.org/resources/ahahret-guides/1788>

Description: Helps to accelerate the elimination of health care disparities and ensure hospital leadership reflects the communities they serve.

AHA Disparities Toolkit

American Hospital Association (AHA)

<https://www.aha.org/hretdisparities/toolkit>

Description: Provides hospitals, health systems, clinics, and health plans information and resources for systematically collecting race, ethnicity, and primary language data from patients.

Resources for Advancing Health Equity

Resources

National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care

U.S. Dept. of Health & Human Services Office of Minority Health

<https://thinkculturalhealth.hhs.gov/assets/pdfs/EnhancedNationalCLASStandards.pdf>

Description: Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health and health care organizations.

National Institute on Minority Health and Health Disparities (NIMHD)

U.S. Dept. of Health & Human Services

<https://www.nimhd.nih.gov/>

Description: NIMHD works to expand the knowledge base of research on minority health and health disparities through research, education, training, and outreach initiatives.

Office of Health Equity (OHE)

Centers for Disease Control and Prevention (CDC)

<https://www.cdc.gov/minorityhealth/>

Description: Advances health equity and women's health issues across the nation through CDC's science and programs.

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Improving Access to Care for People with Disabilities

Centers for Medicare and Medicaid Services (CMS) Office of Minority Health

<https://www.cms.gov/priorities/health-equity/minority-health/resource-center/health-care-professionals-researchers/improving-access-care-people-disabilities>

Description: Tools and resources to help improve services and help patients understand their rights.

Advancing Health Equity in Chronic Disease Prevention and Management

National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP)

<https://www.cdc.gov/chronicdisease/healthequity/index.htm>

Description: Addresses health equity through its programs, research, tools and resources, and leadership.

Achieving Health Equity

Robert Johnson Foundation

<https://www.rwjf.org/en/library/features/achieving-health-equity.html>

Description: Why health equity matters and what you can do to help ensure we all have the basics to be as healthy as possible.

Finding Answers Disparities Research for Change

Advancing Health Equity

https://advancinghealthequity.org/wp-content/uploads/2023/02/FA_2015GranteePortfolio_FIN.pdf

Description: A collection of innovative Finding Answers partner projects across the country that designed and implemented interventions to reduce quality of care disparities.

Institute for Diversity and Health Equity (IFDHE)

American Hospital Association (AHA)

<https://ifdhe.aha.org/>

Description: Advances health equity, diversity, and inclusion by supporting hospitals, health care organizations, and the patients and communities they serve as trusted partners by disseminating evidence-informed practices, resources, and innovations that lead to sustainable transformation in health care.

National Center for Cultural Competence (NCCC)

Georgetown University Center for Child & Human Development

<https://nccc.georgetown.edu/>

Description: Resources to increase the capacity of health care and mental health care programs to design, implement, and evaluate culturally and linguistically competent service delivery systems to address growing diversity, persistent disparities, and to promote health and mental health equity.

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The Disparities Leadership Solutions Center

<https://www.mghdisparitiessolutions.org/>

Description: Focus on developing and implementing strategies that advance policy and practice to eliminate racial and ethnic disparities in health care.

National Quality Forum (NQF)

https://www.qualityforum.org/About_NQF/

Description: A not-for-profit, nonpartisan, membership-based organization that works to improve health care outcomes, safety, equity, and affordability. Affiliate of The Joint Commission.

American Essential Hospitals

<https://essentialhospitals.org/>

Description: A leading association and champion for hospitals dedicated to equitable, high-quality care for all, including those who face social and financial barriers to care.

Health Literacy Universal Precautions Toolkit, 3rd Edition

Agency for Healthcare Research and Quality

<https://www.ahrq.gov/health-literacy/improve/precautions/toolkit.html>

Description: Description: Tool 9, Language Access Resources; Language Access Resources; and Tool 10, Consider Culture.

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The Centers for Medicare & Medicaid Services (CMS) Framework for Health Equity (<https://www.cms.gov/files/document/cms-framework-health-equity-2022.pdf>), structured to align with HHS initiatives that seek to achieve health equity and reduce disparities among minority and underserved populations, offers an approach to advancing health equity and health literacy. The CMS Framework offers five priorities that serve as an integrated approach to build health equity into existing and new efforts by CMS and its stakeholders, including Priority 4: Advance Language Access, Health Literacy, and the Provision of Culturally Tailored Services.⁴⁰

CMS Framework for Health Equity 2022–2032



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Conclusion

“Achieving health and well-being requires eliminating health disparities, achieving health equity, and attaining health literacy.”¹ Unclear communication is a systemic driver of health disparities, but we have the tools to remedy it. This chapter can inform your work as you use the other chapters in this Guidebook to improve organizational health literacy and advance as a health literate health organization.

Summary of Key Points

- Health equity is the state in which everyone has a fair and just opportunity to attain their highest level of health.
- Health literacy is essential to health equity.
- Individuals from groups that have been economically and socially marginalized are at higher risk for experiencing limitations on attaining personal health literacy. Equitable access to education and health care can help individuals increase their personal health literacy.
- Organizational health literacy practices, such as clear communication, ensuring understanding, inclusive language, culturally competent care and services, cultural humility, considering the needs of all populations, and avoiding stigmatization, can help achieve health equity.

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Engage Leadership

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Health literacy has become common language in our organization. We think about it every time we post a sign, write a memo to staff, update our website, print materials, etc.

— Hospital CEO

One of Healthy People 2030’s overarching goals is to “Eliminate health disparities, achieve health equity, and attain health literacy to improve the health and well-being of all.”¹ Working with leaders is essential to advancing as health literate organizations because being a health literate organization means those in leadership roles and board rooms recognize the need to ensure clear communication.² They ensure their organizations meet the health literacy needs of the communities they serve and address health literacy to achieve organizational goals and financial expectations. Organizations more likely to attain the attributes of health literate organizations have champions within senior leadership who set health literacy-related expectations for service delivery, system operations, and customer service, and highlight opportunities to advance and sustain health literacy-informed practices.³ Leaders have the platform to support success by directing, expecting, and checking in on how health literacy and health equity are integrated throughout the organization.

Use your organization’s mission and identify key priorities, then illustrate how health literacy-informed practices help achieve those. This will also show how to integrate health literacy into planning, evaluation, patient safety, and quality improvement.³ For example, health literacy-related practices can help meet Culturally and Linguistically Appropriate Services (CLAS) standards⁴ to address the needs of communities served, improve satisfaction, meet accreditation requirements, and promote health equity. Another example—if reducing unplanned readmissions is a priority, adding teach-back as a standard component of discharge teaching supports that goal. Marking progress in achieving goals in these areas serves as guideposts and assessment points for achieving the organization’s mission and vision.

It is important to give leaders what they need to support advancing as a health literate organization.

Engage Leadership

The ideas and tools in this chapter are designed to help you:

- Prepare your leaders through engaging explanations and illustrations of the importance of organizational health literacy.
- Provide leaders with resources to support integrating health literacy practices into equity, quality, safety, and patient-, family-, and client-centered initiatives throughout your organization.
- Collaborate with your leaders to achieve success.

In a Health Literate Organization, Senior Leaders are Champions of Clear Communication

This chapter directly addresses Attributes 1 and 2 of the Ten Attributes of Health Literate Health Care Organizations³ and will help you provide senior leaders with resources and support to make health literacy integral to your organization's mission, structure, and operations and integrate it into planning, evaluation, safety, and quality improvement.

Leaders' roles vary by the kind and size of an organization. They may have formal or informal titles: chief executive officer; commissioner; chief medical officer; chief nurse executive; chief quality officer; executive, center, agency, or department director; manager; or clinical, practice, project, or unit lead. Senior leaders generally are the highest-ranking and respected people in your organization. They have both the authority and responsibility for:

- Quality and outcomes.
- Ethical and legal concerns.
- Meeting regulatory and accreditation requirements.
- Patient, client, and worker safety and satisfaction.
- Workforce development and accountability.
- Lowering costs and raising efficiency.
- Staying in business.
- Achieving the mission.

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Since it interfaces with all of these, addressing organizational health literacy is important to leaders' success.

Why Involve Senior Leaders?

Leadership Establishes an Organization's Culture

“Leadership establishes an organization’s culture through its language, expectations, behavior it models, and design of services and processes.”

— Brach C, et.al. 2012³

Engaging and involving your organization’s senior leaders in health literacy is one of the most important things you can do, because leaders can:⁵

- Take the status quo off the table.
- Remove barriers.
- Make sure you have the time and resources you need.
- Get your projects seen by others.
- Build will and support in your organization to help you succeed.

Give your senior leaders what they need to channel attention to supporting your organizational health literacy work.

The Currency of Leadership is Attention

“It has been said that the currency of leadership is *attention*. If that is true, then leaders who wish to transform their organizations should channel their attention to the key leverage points for the quality transformation, and use their chosen leverage points well.”

— Reinertsen J, et.al. 2007²

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Organizational Health Literacy Leverage Points for Leaders

Show your leaders how health literacy intersects with their roles and responsibilities in advancing your organization’s mission, vision, and values, and improving outcomes. They can:

- Shine light on the connections between organizational health literacy and your mission and goals, especially those related to equity, quality, safety, and patient- and client-centered care and services.
- Set, oversee, and share system goals to build capacity in clear health communication, and call for developing and measuring progress toward an executable strategy to achieve these goals.
- Focus attention on improving health—and all other—communication organization-wide through personal leadership, supporting systems, and openness about progress.
- Choose and support inclusive teams of health literacy, patient and client education, communication, and quality, safety, and equity leaders, in partnership with patients, families, and clients.
- Underscore health literacy as fundamental to quality, safety, and equity, and involve financial leadership to examine return on investment through improving communication between the health team and those they serve.
- Invite engagement of well-regarded community leaders, faculty, doctors, and others, and role-model and promote health literacy and clear communication.

What You Want Senior Leaders To Do

- Identify—explicitly—health literacy and clear health communication as vital to achieving your organization’s mission.
- Use their position and authority to underscore health literacy’s relationship to equity, quality, and safety.
- Convey the importance of health literacy to board members, other leaders, all staff and departments, and partners.
- Allocate time and resources to support related improvement efforts.
- Model plain language communication in their own speech and writing.

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- Make sure systems are in place to attain not only successful health literacy integration, but also to ensure sustained health literacy-informed culture, interventions, and operating procedures.

To make this a reality, you need to equip them with necessary information, resources, and tools.

What Does Success Look Like?

Here is how it might look when senior leaders invest attention and resources toward organizational health literacy.

- The Chief Executive Officer illustrates how health literacy is key to achieving the organization's mission, strategic goals, and objectives.
- The Chief Medical Officer advocates for and expects inclusion of health literacy in patient and worker safety, equity, and performance improvement work.
- Senior executives, clinical leaders, and top-level managers and directors understand the adverse impact and health disparities associated with limited health literacy.
- The Executive Team models plain language in everyday speaking with and writing for staff and the community.
- Top leaders in public health and community-based service organizations advocate for and expect inclusion of health literacy-informed practices in all community outreach and requests for and responses to grant proposals.
- The Board of Directors receives organizational health literacy scorecard updates, especially as they relate to equity, quality, and safety.
- Managers are accountable for setting and reaching department goals for staff training and use of health literacy practices.
- Clear verbal communication and plain language skills are valued parts of job descriptions and performance reviews.
- Performance improvement leaders include health literacy practices and patient or client health literacy skill development and support in disease management and self-management initiatives.
- Quality leaders ensure health literacy is incorporated upfront into quality improvement initiatives, and is not an afterthought.

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- Patient safety officers include clear health communication practices, especially teach-back to check for understanding, in medication safety initiatives.
- Health equity leaders convey how addressing health literacy is an actionable—and measurable—way to address health disparities and systemic racism.⁶
- Diversity, equity, and inclusion leaders apply clear health communication principles and skills to their initiatives.
- Language services leaders incorporate health literacy and cultural and linguistic competence and humility into all facets of care and services to address Cultural and Linguistically Appropriate Services (CLAS) Standards.⁴
- Risk managers know and demonstrate the importance of effective communication and ensuring patient understanding through plain language, teach-back, and language access in consent, adverse event analyses, and other discussions.
- Leaders set high goals (*very satisfied*) for communication-related measures on patient and client satisfaction and experience surveys.
- Organizational health literacy-related assessment data are part of organizational and department performance scorecards.
- Gathering patient, family, client, and adult learner input is part of organizational culture.
- Physician leaders, faculty, preceptors, and other teaching staff routinely model use of plain language, teach-back, and working with qualified health interpreters.
- Health literacy-related safety events are part of standard event reporting and review, leading to health literate communication performance standards and policies to mitigate errors.^{3,7}
- Marketing and communication leaders include health literacy in all types and formats of internal and external communication materials styles and in brand standards.

How Do You Involve Leaders?

How can you make the descriptions above a reality? Help leaders understand that failing to commit to health literacy goals may imperil strategic priorities such as patient quality and safety goals, employee morale and turnover goals, and equity goals. First, show leaders why it is important and beneficial to address organizational health literacy. Then help them champion and model health literacy practices in their organizational and community roles. And stay connected with them through frequent succinct communication.

Engage Leadership

Show Leaders the Importance and Benefit of Advancing as a Health Literate Health Organization

Build Leaders' Foundational Knowledge

Prepare talking points *and* institutional stories to convey key health literacy messages and data supporting the importance of and illustrating alignment between advancing as a health literate organization and your organization's mission. Share information from foundational health literacy source documents, references, and publicly available online resources to provide supporting evidence. Use various opportunities—one-on-one meetings, hallway encounters, or group settings—to connect the dots between settings, circumstances, and opportunities in your organization and health literacy. Familiarize your leaders with the points below and show how they relate to your organization's mission.

Ensure Leaders Understand Organizational Health Literacy

- *Individual and Organizational Health Literacy*
 - Health literacy is the product of individuals' capacities and the health literacy-related demands and complexities of the health care system.⁸
 - Together, the following constitute health literacy:^{1,9}
 - *Personal health literacy*: the degree to which *individuals* have the ability to find, understand, and use information and services to inform health-related decisions and actions for themselves and others.
 - *Organizational health literacy*: the degree to which *organizations* equitably enable individuals to find, understand, and use information and services to inform health-related decisions and actions for themselves and others.
 - Addressing health literacy means improving the skills of the *system* in communicating with individuals such as patients, clients, family members, employees, staff, and communities.
 - The health system has the responsibility to provide clear, understandable information and to make sure it is understood by those who need that information.¹⁰
- Highlight the Ten Attributes of Health Literate Health Care Organizations³ and how they can guide advancing as a health literate organization, using assessment, measurement, and evaluation to inform continuous improvement for the whole organization or focusing on a specific area.

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Underscore for Leaders the Associations of Lower Health Literacy with Poorer Health Outcomes

- Less healthy behaviors.
- Less preventive care.
- Less personal health knowledge.
- Less understanding of treatment options.
- More medication mistakes; difficulty understanding medication labels and messages.
- Greater use of emergency care.
- Excess hospitalizations.
- Increased mortality and poor health outcomes.
- Higher health care costs.¹¹⁻¹⁴

Help Leaders Recognize the Prevalence of Limited Health Literacy

- Nearly 90% of U.S. adults lack the health literacy skills to navigate our health system.¹⁵
 - *Anyone* can have trouble understanding health information, especially if they are sick or worried.¹⁶
 - Between 1980 and 2019, the number of Americans who spoke a language other than English at home grew from 23.1 million to 67.8 million (a 194% increase).¹⁷
 - Over 1,000 studies show most health information is written at or over 10th grade level. The average reading level of U.S. adults is 8th grade.
 - The health literacy demands of the U.S. health system dramatically exceed the health literacy skills of the public.¹¹

Illustrate for Leaders the Intersection of Health Literacy with Health Equity

- Groups at increased risk for lower health literacy include:¹⁵
 - Some racial and ethnic minorities.
 - People aged 65 years and older.

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- People with public or no insurance.
- Non-native English-speakers.
- Those with limited education.
- Those with low income.
- Those with physical, mental, or chronic health problems.

Contributors to increased risk include the effects of systemic racism, poverty, and other social determinants of health, and less access to health care, community resources, and quality education.

- Achieving health and well-being requires eliminating health disparities, achieving health equity, and attaining health literacy.¹⁸
- In *Health Literacy and Systemic Racism—Using Clear Communication to Address Systemic Racism*, Coleman, et al⁶ state:
 - “Failure to communicate health information in its simplest and easiest-to-understand form unjustly favors people who have more education and higher health literacy.
 - Lack of organizational health literacy and clear communication policies are preventable, structural features of U.S. health care that contribute to systemic racism.
 - A robust set of consensus-based clear communication educational competencies and best practices has been identified.”

**Since anyone can experience low health literacy, we need to use
clear communication words and tools for everyone.**

— AHRQ Health Literacy Universal Precautions Toolkit¹⁶

Engage Leadership

Personalize Your Organization's Data and Stories to Show Impact

In addition to providing evidence and data, shed light on your local picture and put human faces on it. Use data and stories from your setting, organization, or community, and involve your own patients, clients, and workers. Show and reinforce that health communication challenges exist throughout health organizations; that these adversely impact patients, families, clients, and the organizations themselves; and that improving communication helps everyone.¹⁶

Gather Data from Your Setting

Show communication challenges using data already being collected by your organization, such as:

- Low communication-related satisfaction and patient experience survey scores.
- Frequency and causes of unplanned 30-day readmissions.
- Language access challenges for those who do not have English as their preferred language.
- Disparities in services, care, or outcomes when examined by race, ethnicity, or language.
- Risk management issues.
- Frequency or severity of communication-related safety events specifically for communication between health team members and patients, families, or clients.^{3,7}

Build Your Story Library

There are numerous examples of people not understanding important health information, with individual consequences ranging from slight misunderstanding to life-threatening outcomes, and also negative impacts on an organization or community. There are also stories describing how using good health literacy practices mattered to improving a situation.

Regularly communicating stories that illustrate the value of health literacy to leaders will nurture their growth and understanding of the importance of health literacy as an organizational priority.

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Sources for Health Literacy Stories

- Health Literacy: A Prescription to End Confusion | The National Academies Press
<https://nap.nationalacademies.org/catalog/10883/health-literacy-a-prescription-to-end-confusion>
- “We Shouldn’t Be Surprised by What People Don’t Know” – Unnecessary worry for a child’s caregiver who has diabetes.
<http://bit.ly/3ZoLYdo>
- “Back to the Hospital” – Story of my grandmother with limited literacy leading to harm in a hospital setting.
<http://bit.ly/3mbFe4r>
- “Successful Learning to Manage Insulin” – Story of my grandmother with limited literacy successfully learning to manage insulin with support from the health team.
<http://bit.ly/3Z8EknQ>
- “Fear of Returning to the Hospital” – Story of a woman experiencing adverse effects but afraid to call her doctor or return to the hospital.
<http://bit.ly/3SyIMK6>
- “Patient-centered Communication around Language Preference” – Miscommunication related to language preference.
<http://bit.ly/3ZJ3dpZ>
- “Asking ‘Why’ Can Reveal a Lot” – Story of a mother making repeated, but unnecessary, emergency department visits for her infant with fever.
<http://bit.ly/3EJ9aLk>
- Children’s Wisconsin videos describing how difficult it can be for people to understand, navigate, and use health information and services.
<https://childrenswi.org/medical-professionals/patient-referral-toolkit/health-literacy>

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But it is important to gather stories from *your* setting. Be sure there is no identifying information before sharing them with others.

- People may reveal stories from a health setting where they experienced or observed a family member, friend, client, or patient struggle with understanding spoken or written communication.
- You and your health literacy team may observe or experience such situations. Think ahead about how you can collect and share these.
- Patients, clients, and family members who participate in your organization's health literacy work, e.g., through a Patient/Family Advisory Committee, a health literacy or quality committee, a focus group, or by providing feedback and suggestions, responding to surveys, or asking questions at public health events, may describe experiences where communication should be improved.

All of the above are valuable sources to personalize the data. They can be used to:

- Improve recognition of the many ways communication can be unclear – a sign, a form, a process, verbal or written communication, and others.
- Demonstrate the impact of unclear communication on:
 - An individual, e.g., annoyance, dissatisfaction, non-adherence, medical error, liability, serious safety event, poor outcome.
 - The organization, e.g., same-day surgery cancellations, clinic no-shows, unnecessary repeat visits, unplanned readmissions, safety events, dissatisfaction, wasted human and financial resources, inefficiency, potential liability, reputational damage, or decreased reimbursement.
- Illustrate the frequency of such occurrences in your setting. This can be eye-opening since these may not have been previously identified and recognized as health literacy-related events:
 - They may be used to estimate potential return on investment by incorporating health literacy-informed practices as part of a comprehensive approach to reviewing, analyzing, and mitigating such occurrences.

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Examine the Business Case

Since this is important to operations, acknowledge the need for research to demonstrate a return on investment by addressing health literacy. But, since we know from many studies that limited health literacy and poor health communication are associated with adverse health outcomes, this should not prevent implementing evidence-based health literacy practices that promote health, mitigate harm, enhance adherence, reduce liability, and address health disparities.

Employing health literacy-informed practices is within the scope and responsibility of the health system for safety, quality, and to help reduce racial and ethnic inequity in health care.⁶ Health care organizations have described financial losses resulting from same-day procedure cancellations because people did not understand preparation instructions, know how to get questions answered beforehand, or were unaware of support to address challenges like transportation barriers.

There are other financial implications for organizations related to limited health literacy, including costs related to waste, inefficiency, no-shows, and what has long been labeled as non-compliance or non-adherence, which allots blame to patients rather than acknowledging a failure of the health system to communicate clearly and ensure understanding.¹⁹ Reducing avoidable acute care utilization and duplicative services are related priorities that may be addressed through clearer communication.

Financial incentives exist through public and private payers and the Affordable Care Act by aligning health literacy approaches with priorities like reducing lengths of stay, unplanned readmission rates, and safety events, and improving patient experience and satisfaction.¹⁹ Applying health literacy strategies may help health organizations meet guidelines and standards and demonstrate excellence outlined by accreditation, quality, and recognition entities like The Joint Commission (<https://www.jointcommission.org/who-we-are/>), The Leapfrog Group (<https://www.leapfroggroup.org/>), and Magnet Recognition Program (<https://www.nursingworld.org/organizational-programs/magnet/>).

Balance discussions by recognizing that no single health literacy intervention will transform health outcomes, but, if reliably integrated into system-based equity, quality, and safety strategies, health literacy practices can contribute to achieving health organizations' missions, improving outcomes and reducing health disparities.¹⁹

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Consider convening a group of chief financial officers (CFOs) to not only educate them about these matters, but, importantly, to seek their counsel on how such a business case should be strengthened.

Engage Your Leaders

Senior leadership support to voice the importance of organizational health literacy throughout the institution and to address barriers will accelerate success. Regular conversations in brief monthly meetings with an identified sponsor or senior leader can go a long way.

Keep it Short

Senior leaders have a lot on their minds and many competing concerns, so help them view health literacy as an asset for achieving their priorities. Early on, describe an incident from your setting where poor communication between the health team and a patient, client, or family or lack of a patient's, client's, or family member's understanding could have or did end in harm to a patient or a poor outcome for a client. This harm may have been short- or long-term, physical, emotional, mental, or financial. Invite the leader to reflect on their own or their family's experience, or to think of a time when it was hard for them to understand health information, or something outside their area of expertise. Use illustrative excerpts, graphics, or brief materials—especially from your setting.

Have a Plan Ready

Be ready if your leader asks, “So what do we need to do?” Focus your response on creating lasting improvements in how your organization communicates verbally and in writing that shows respect for patients, families, or clients, and how clear communication helps people navigate through the overall health system (e.g., referrals), use a website or portal, or find their way to or within a building. Your goals are to inspire interactions that optimize outcomes, create a positive lasting impression, and improve satisfaction. Being a health literate organization is more than initiating a few projects. It should reflect a culture focused on ensuring everyone you serve understands the information you give them. It means that health literacy is an organizational value.³ This cannot be done by education alone, although that is a vital component. It also means changing behavior.

Engage Leadership

Give Your Leader a Role

Tell your leader where they can help through their unique influence. They can:

- Assure resources—time, staff, budget.
- Channel attention by asking key groups, like safety and quality committees, and diversity, equity, and inclusion, to identify how ensuring clear communication aligns with their goals and to prioritize training and use of system-based health literacy practices with patients/clients and families and workers.
- Model clear communication practices like plain language in their verbal and written communication, and participate in health literacy-related activities, like a navigation exercise to see how well people can find their way in your buildings, clinics, offices, and service locations.
- Meet regularly for updates and to advise on accelerating progress or overcoming barriers.
- Recognize staff who contribute to ensuring clear communication practices address equity, safety, and quality.
- Highlight and share the importance of this work with and provide updates for boards and external partners.

Get on the Schedule and Check in Often

Setting timelines will help you clarify what you need to get the job done by a certain date. Be realistic and flexible. Put it in writing and review it periodically with them. Make good use of leaders' time.

Meet together regularly and report on progress, barriers, lessons learned, and resources needed. Leaders can't help if they don't know what problems you are facing. They can't recognize progress if they don't know how things are going. During these regular updates and reports, your leader can help solve problems, remove barriers, raise visibility, and promote spread throughout the organization.

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Get Started Getting Started to Make Progress

Think ahead about what you will do when you have leaders' support. The Centers for Disease Control and Prevention's *Developing a Plan in Your Organization* offers helpful planning resources for changing organizational and professional health literacy practices on this website:

<https://www.cdc.gov/healthliteracy/planact/develop/index.html>

Form a team and start with the Ten Attributes of Health Literate Health Care Organizations;³ and use assessment, measurement, and evaluation to guide ongoing improvement. There are various tools to establish a baseline, help assess strengths and improvement opportunities for attributes that resonate most with your setting, and track progress. Assessments can be conducted for the whole organization or to focus on a specific area. Findings help identify alignment, where you are likely to make an impact, determine starting points, and follow progress in advancing as a health literate organization. Give thought to who you want to participate in these assessments to obtain informed responses and determine the frequency for repeating them.

After completing and studying an initial assessment, set an aim aligned with your organization's mission. Consider:

- Linking health literacy practices with and incorporating them into existing and emerging priorities.
- Using your organization's quality, safety, and equity framework to integrate clear health communication into your culture and standard operations.
- Developing and tracking regular education and training for new and current staff on health literacy practices.
- Using small tests of change and coaching to build clear communication skills into routine practice.
- Working toward and tracking measurable goals and objectives.
- Following up with policies, standard operating procedures, job aids, and technology-based and other supports to ensure reliability and sustainability.

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Health Literacy Assessments for Organizations

- Enliven Organizational Health Literacy Self-assessment Resource
<https://cbrhl.org.au/wp-content/uploads/2020/11/YES-Enliven-health-literacy-auditresource-Mar-2015.pdf>
- Primary Care Health Literacy Assessment – Tool 2 in AHRQ Health Literacy Universal Precautions Toolkit: <https://www.ahrq.gov/health-literacy/improve/precautions/tool2.html>
- The Health Literacy Environment of Hospitals and Health Centers. 2006. Navigation: Walking Interview Activity (Pg. 99): <https://files.eric.ed.gov/fulltext/ED508596.pdf>
- HLE2 The Health Literacy Environment of Hospitals and Health Centers. 2019
<https://files.eric.ed.gov/fulltext/ED606503.pdf>
- Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Literacy Item Sets: <https://www.ahrq.gov/cahps/surveys-guidance/item-sets/literacy/index.html>
- Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS):
<https://www.ahrq.gov/cahps/surveys-guidance/hospital/index.html>.
- International Self-Assessment Tool Organizational Health Literacy (Responsiveness) for Hospitals (updated 2022). International Working Group Health Promoting Hospitals and Health Literate Healthcare Organizations
https://www.hphnet.org/wp-content/uploads/2023/12/SAT-OHL-Hos-v1.3-EN-international_update-20230717.pdf
Or access the tool through this webpage: <https://m-pohl.net/OHLDesignandMethods>
- Organizational Health Literacy, M-POHL: <https://m-pohl.net/OHL>
- Is Our Pharmacy Meeting Patients’ Needs? A Pharmacy Health Literacy Assessment Tool User’s Guide: <https://www.ahrq.gov/sites/default/files/publications/files/pharmlit.pdf>

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Start with one unit, department, condition, or initiative. Starting small is important so you can work out the bugs, build support, and embed changes over time before spreading. It may be helpful to join a project already underway, providing a health literacy perspective and ideas for improvement. Build the skills of managers to coach staff as they adopt new communication habits. This has the added benefit of gaining new champions to help you.

If you start a new health literacy-related project, focus on building skills and culture, as well as implementing health literacy practices, so that everyone in your organization understands their role and values the importance of health literacy to achieving your mission.

Measures

Since Attribute 2³ involves integrating health literacy into planning, evaluation measures, patient safety, and quality improvement, it provides a clear framework for both weaving health literacy-informed practices into existing priorities and projects and originating new health literacy-focused initiatives. As you collaborate with colleagues and your health literacy team, explain how the Ten Attributes and the overarching aims for improvement for health relate to your aims and measures.⁹

Here are example measures:

- Outcome Measures: How is the system performing? What are the results?
 - Examples:
 - Number of unplanned hospital readmissions.
 - Number of hospitalizations for heart failure.
 - Frequency of asthma-related urgent care visits.
 - Number of school absences for Boys Club members.
- Process Measures: Are the parts/steps in the system performing as planned?
 - Examples:
 - Teach-back and show-back use by asthma clinic staff.
 - Average PEMAT scores for post-operative care hand-outs.

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- Balancing Measures: Are changes improving one part of the system but causing new problems in another?
 - Examples:
 - Length of clinic visits after *full* implementation of a teach-back initiative.
 - Budget for increased use of interpreters.

Integrating Health Literacy With Health Care Performance Measurement (<https://nam.edu/wp-content/uploads/2015/06/BPH-IntegratingHealthLiteracy.pdf>) is a useful starting point for linking health literacy to quality measures and integrating health literacy performance measurement into all aspects of the patient experience.²⁰

Have a Communication Plan

Developing relationships and sustaining improvement require many conversations. A communication plan helps you and your team engage leaders and others and create awareness across the organization. Think about everyone who needs to know or do something to promote a successful initiative, including those already involved and those you wish to engage. Stakeholders include those you serve—patients, clients, families—and those who serve them, both inside and outside your organization. For each group, identify the right individual to communicate with. Think about why you are reaching out; what you want them to know; and the best way to reach them and how often. Specify the best person to communicate with each target audience, and the when and where for each message. Remember, people are busy, so being succinct is important. Example: “Our team leader will meet in person monthly with our senior sponsor.”

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The picture below, from the Always Use Teach-back! Toolkit, shows a Communication Plan example.²¹ <http://teachbacktraining.org/>



Communication Planning

Communication Plan Template*

Always Use Teach-back!

Team Name: _____ Updated: _____

Target Audience	Type/Purpose of Communication	Message(s) Customized to values of group or individuals	Method	Frequency	Who, By When, Where
Sr Leaders Partners Frontline staff Stakeholders Influencers Project team Others	Awareness Information Take action Gain consensus Review/Comment Other	Progress Proposed drafts Lessons learned Scripted responses to frequent or expected questions Other	Existing meetings Newsletters Email Personal contact Unit meetings Other	Planned/ongoing As needed Other	Name of person or group Date

*See Communication Planning for the value of planning communication and an experienced team's story. Download Communication Plan Example for sample plan.

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Communication Plan Example*

Always Use Teach-back!

Team Name: _____ Updated: _____

Target Audience	Type/Purpose of Communication	Message(s) Customized to values of group or individuals	Method	Frequency	Who, By When, Where
Sr Leaders Partners Frontline staff Stakeholders Influencers Project team Others	Awareness Information Take action Gain consensus Review/Comment Other	Progress Proposed drafts Lessons learned Scripted responses to frequent or expected questions Other	Existing meetings Newsletters Email Personal contact Unit meetings Other	Planned/ongoing As needed Other	Name of person or group Date
Senior Leader Sponsor	Keep informed of progress and barriers Gain clarity on key messages for moving forward Provide stories for sponsor to share about value & benefits of teach-back	How teach-back fits our mission and vision What is to move forward across our facility with teach-back and connect it with our existing equity initiative How we are developing and carry messages throughout the organization	Face-to-face meetings Email progress	Monthly as weekly	By end of month Adrienne Weiss By Initiative Lead
First Recruited Unit	Teach-back's importance to our organization Their needs and determining their readiness Initiative awareness and timeline	How teach-back fits our mission and vision Their needs and interests are important to the success of this program What is a flow to teach-back training Using PDAs in small units	Face-to-face meeting Value and when of updates will be developed to meet their needs Updates in regular staff meetings	1st meeting with Manager 2nd meeting with Unit then weekly	1st meeting this week Unit meetings with Initiative Lead Then Manager with Lead as needed

*See Communication Planning for the value of planning communication and an experienced team's story. Download Communication Plan Example for sample plan.

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Example*

Always Use Teach-back!

Team Name: _____ Updated: _____

Target Audience	Type/Purpose of Communication	Message(s) Customized to values of group or individuals	Method	Frequency	Who, By When, Where
Program	Progress Proposed drafts Lessons learned Scripted responses to frequent or expected questions Other	Existing meetings Newsletters Email Personal contact Unit meetings Other	Existing meetings Newsletters Email Personal contact Unit meetings Other	Planned/ongoing As needed Other	Name of person or group Date
our help us use	Helps our patients and clients understand what they need to know and do to stay safe Their needs and interests are important to the success of the program What and when of updates will be developed to meet their needs	Face-to-face meeting Value and when of updates will be developed to meet their needs Updates in regular staff meetings	Awareness sharing Ready to be initiated	Determined by Division Director	Division Director and Initiative Lead
QI Department	Our initiative plan for teach-back Needs for their support Challenging measures, data Get our data abstracts and reports	Their participation will be important Contrast up collaboration Who can help us? What can they do? Roles & expectations?	Face-to-face meeting What and when of updates will be developed to meet their needs	Clarify who and when set a schedule as needed	During planning of the initiative by the Initiative Lead
IT	Current data, metrics Keep in the loop assessments	Their participation will be important There is potential for requesting changes to EHR or other IT systems	Initial meeting this month	Set a schedule as needed	Initiative Lead and Senior Sponsor

*See Communication Planning for the value of planning communication and an experienced team's story. Download Communication Plan Example for sample plan.

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Key Health Literacy References and Resources Organizational Health Literacy

Healthy People 2030 personal and organizational health literacy	https://health.gov/healthypeople/priority-areas/health-literacy-healthy-people-2030
Healthy People 2030 foundational principles and overarching goals	https://health.gov/healthypeople/about/healthy-people-2030-framework
Article: Ten Attributes of Health Literate Health Care Organizations ³	https://www.ahrq.gov/health-literacy/publications/ten-attributes.html
Agency for Healthcare Research and Quality - Health Literacy	https://www.ahrq.gov/health-literacy/index.html
Centers for Disease Control and Prevention – Health Literacy	https://www.cdc.gov/healthliteracy/index.html
Centers for Disease Control and Prevention’s Developing a Plan in Your Organization	https://www.cdc.gov/healthliteracy/planact/develop/index.html
Attributes of a Health Literate Organization, Health Literacy	https://www.cdc.gov/healthliteracy/planact/steps/index.html

Health Equity and Health Literacy

Article: Health Literacy and Systematic Racism-Using Clear Communication to Reduce Health Care Inequities ⁶	https://pubmed.ncbi.nlm.nih.gov/37358860/
Centers for Disease Control and Prevention - Health Equity Guiding Principles for Inclusive Communication	https://www.cdc.gov/healthcommunication/Health_Equity.html

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Universal Precautions, Plain Language, and Teach-back

AHRQ Health Literacy Universal Precautions Toolkit 3rd Edition	https://www.ahrq.gov/health-literacy/improve/precautions/index.html
Always Use Teach-back! Toolkit	http://www.teachbacktraining.org/
Video: American Medical Association Foundation. (2010). Health Literacy and Patient Safety: Help Patients Understand.	https://www.youtube.com/watch?v=cGtTZ_vxjyA

Culture and Language Access

CLAS Standards Think Cultural Health	https://thinkculturalhealth.hhs.gov/clas/standards
CLAS Standards Resources	https://thinkculturalhealth.hhs.gov/resources
CLAS Standards Education	https://thinkculturalhealth.hhs.gov/education
TeamSTEPPs Agency for Healthcare Research and Quality (ahrq.gov)	https://www.ahrq.gov/teamstepps-program/index.html
TeamSTEPPS LEP Safety Agency for Healthcare Research and Quality	https://tinyurl.com/ypvaxezx
National Council on Interpreting in Health Care	https://www.ncihc.org/
National Council on Interpreting in Health Care Guide for Partnering with an Interpreter	https://www.ncihc.org/assets/documents/publications/NCIHC%20Partnering%20with%20an%20Interpreter%2C%20with%20graphics.pdf

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Reader-friendly Materials

Plainlanguage.gov	https://plainlanguage.gov/
Plain Language National Institutes of Health (NIH)	https://www.nih.gov/institutes-nih/nih-office-director/office-communications-public-liaison/clear-communication/plain-language

Accessibility

The Americans with Disabilities Act ADA.gov	https://www.ada.gov/
Usability – Digital.gov	https://digital.gov/topics/usability

Documenting the Challenge

Kutner M, Greenberg E, Jin Y, Paulsen C. The Health Literacy of America’s Adults: Results from the 2003 National Assessment of Adult Literacy. 2006, National Center for Education ¹⁵	https://nces.ed.gov/naal/health.asp
Program for International Assessment of Adult Competencies (PIAAC) 2012-2017	https://nces.ed.gov/surveys/piaac/national_results.asp
National Assessment of Adult Literacy State & County Estimates of Low Literacy (2003)	http://nces.ed.gov/naal/estimates/StateEstimates.aspx

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Documenting the Challenge (continued)

<p>Health Literacy Data Map (Use Firefox Browser)</p>	<p>http://healthliteracymap.unc.edu/</p>
<p>Institute of Medicine Committee on Health Literacy, Nielsen-Bohlman; et al., <i>Health Literacy: A Prescription to End Confusion</i>. 2004, National Academies Press (US)¹¹</p>	<p>https://nap.nationalacademies.org/catalog/10883/healthliteracy-a-prescription-to-end-confusion</p>
<p>The Joint Commission: <i>Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care: A Roadmap for Hospitals</i>. Oakbrook Terrace, IL: The Joint Commission, 2010</p>	<p>https://www.jointcommission.org/-/media/tjc/documents/resources/patient-safety-topics/health-equity/roadmapforhospitalsfinalversion727pdf.pdf</p>
<p>The Joint Commission (2007). What Did the Doctor Say?: Improving Health Literacy to Protect Patient Safety</p>	<p>https://www.imiaweb.org/uploads/pages/215.pdf</p>
<p>America’s Health Literacy: Why We Need Accessible Health Information. An Issue Brief From the U.S. Department of Health and Human Services. 2008</p>	<p>https://www.ahrq.gov/sites/default/files/wysiwyg/health-literacy/dhhs-2008-issue-brief.pdf</p>
<p>Berkman; et al., Low Health Literacy and Health Outcomes: An Updated Systematic Review. 2011, <i>Annals of Internal Medicine</i>¹³</p>	<p>https://pubmed.ncbi.nlm.nih.gov/23126607/</p>

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Documenting the Challenge (continued)

Vernon et al. Low health literacy: implications for national health policy. 2007 ¹⁴	https://hsrc.himmelfarb.gwu.edu/sphhs_policy_facpubs/172/
U.S. Department of Health and Human Services, (2010). National Action Plan to Improve Health Literacy	https://health.gov/our-work/national-health-initiatives/health-literacy/national-action-plan-improve-health-literacy
IOM (2003). <i>Priority Areas for National Action: Transforming Health Care Quality</i>	https://nap.nationalacademies.org/read/10593/chapter/1#i

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Summary of Key Points

- Organizational health literacy principles can be applied to all types of health organizations to promote high quality health care and services, safety, and health equity.
- Give leaders the tools and resources they need to channel attention to organizational health literacy and ensure clear communication with those you serve.
- Provide leaders with foundational knowledge, data, and stories—ideally from your setting—and examples of how health literacy-informed practices intersect with your organization’s mission.
- Use tools that fit your leader’s available time and working style.
- Check in with your senior leader regularly.
- Have a plan that includes a specific role for your senior leader.
- Involve your leader in communicating how health literacy and clear communication are fundamental to achieving your organization’s mission.
- Highlight opportunities for your leader to recognize and model ideal health literacy practices.
- Demonstrate ways to integrate health literacy and clear communication into equity, quality, and safety initiatives.
- Integrating health literacy into planning, evaluation measures, patient safety, and quality improvement provides a framework for both weaving health literacy practices into existing priorities and projects and originating new health literacy-focused initiatives.
- Set aims, identify measures, and use small tests to start putting health literacy interventions into practice, build support, and spread successful efforts. Then put policies and procedures in place to sustain the improvements. Ask your leader to recognize these successes.
- Use periodic assessments to establish a baseline of your organization’s status as a health literate health organization, set aims and measurable goals, and track improvement over time.

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Prepare the Workforce

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“Learning about health literacy has really made a difference in how I work in my clinic setting every day. It has made me more aware of my interactions with my patients and their families. I find myself taking the time to ask questions differently and listening to answers differently. I ask more clear questions and listen to the answers and take that into consideration when I am writing up my after-visit summaries and discharge instructions and making sure that as I am discharging my patients, I make sure they truly understand the care they are supposed to be providing for their child after they leave my care.”

— Susan H., Pediatric Nurse Practitioner



To watch this video, click [HERE](#)
or scan the QR code below.



To be a health literate organization, everyone needs to be aware of and trained in clear health communication skills. The importance of effective communication with clients, patients, and families cannot be understated since it is central to carrying out the mission of most health organizations. Fostering skill-building and long-term adoption of clear communication practices is vital.

Knowing is not the same as doing. That is, education and training do not automatically translate into behavior change. Still, both are needed to become a health literate organization. Health professionals and staff must see the connection between what they have learned and what happens in their setting and put that into action.

Prepare the Workforce

The ideas and tools in this chapter are designed to help you:

- Make the case for all health professionals and staff to understand health literacy and use clear health communication.
- Identify and use client, patient, and family experiences as teaching tools and recruit health literacy champions.
- Build capacity for clear, effective health communication among all members of your team.

A Health Literate Organization Prepares Its Workforce

This chapter directly addresses Attribute 3 of the Ten Attributes of Health Literate Health Care Organizations¹ and will help you prepare all team members to be health literate and to monitor progress.

Clear Communication Is Everyone's Job

Clear health communication is not just one person's or one profession's responsibility. It is the responsibility of all members of the team. Everyone must understand:

- What low health literacy is.
- That anyone can experience low health literacy.
- The adverse impact of limited health literacy on health behaviors, outcomes, and costs.
- How limited health literacy plays out in their own setting.
- That low health literacy may play a role in people not carrying out instructions for taking care of their own health.
- That health literacy is related to both individual skills and system complexity.

Note that clients, patients, and families may ask questions of staff who do not give direct care or services. These staff may seem more approachable and talk with patients and clients informally. They include workers in administration, reception, language services, housekeeping,

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transportation, food services, maintenance, and others. All staff need to be able to do the following for any patient or client:

- Give clear answers.
- Assess their own ability to answer a question and recognize when to go to someone else.
- Convey important questions to the right person for answers.
- Recognize signs that the questioner needs more help.
- Pass what they observe along the continuum of care.
- Go the extra mile to help out.

It's also important for all staff to recognize that when a patient or client is confused or does not understand, it may reflect an opportunity to make system changes that could help everyone.

Health Literacy Training Has Many Benefits

Training to improve health communication can help your organization meet continuing education needs; comply with guidelines, recommendations, requirements, and regulations; and improve care and outcomes. The U.S. health care system also includes financial incentives where better communication can have a positive impact.

Examples include:

- Reducing unplanned readmissions and cancellations.
- Improving patient and client transitions to needed services within and outside of your organization.
- Enhancing client, patient, and family experience and satisfaction.
- Establishing medical and dental homes.
- Managing chronic disease.

Newly trained health professionals are entering the workforce knowing more about education and health communication. Health organizations can and should build on and support that foundation.

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Your Own Workers May Need Help, Too

Increasing awareness about low literacy and low health literacy can help your organization in unexpected ways. Some of your own workers may struggle with reading. This may interfere with their ability to perform their jobs well and live their lives fully. They may need to read manuals, difficult-to-read directions on hazardous products and equipment, and steps to follow in an emergency like a tornado or fire.

Your workers use health services and benefits, too. Improved understanding of how to care for themselves and their families may help them use these resources better. It may lead to better job performance and reduce time away from work related to health problems. The same may hold true for workers and their families whose first language is not English. Only 12% of people in the U.S. have what is considered proficient health literacy skills.² Add to this the fact that many U.S. adults struggle with numeracy—the ability to understand and apply numbers.³ Chances are that some of these are your patients and clients, and some are your staff and co-workers.

What Does Success Look Like?

What successful health literacy and clear health communication skills training for all health professionals and staff looks like:

- An action plan for training with goals and aims is in place.
- Health literacy and the need for clear health communication are part of orientation at all levels: organization, department, unit, and volunteer.
- Policies and practices are in place to ensure all health professionals and staff periodically complete streamlined training in health literacy and clear communication.
- Health professionals and staff earn continuing education credit for education and training in health literacy, health communication, and patient teaching.
- Competencies are set for key health literacy skills, like using plain language and checking understanding using the teach-back method.
- Storytelling, personal observation, and reflection are part of all health literacy and health communication talks, training, and workshops.
- Community representatives are given ways to provide their important perspectives on health literacy and clear communication talks, training, and workshops.

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- All health literacy and clear communication talks, training, and workshops lead to action steps.
- Engaging learning modes (e.g., video, interactive modules, case studies)⁴ are used for training about health literacy and health communication skills.
- Direct observation and coaching are used to help staff move from long-standing habits toward new health communication practices.

What success looks like when training leads to all health professionals and staff understanding the importance of health literacy and applying clear health communication skills:

- All health professionals and staff use plain language and confirm client, patient, and family understanding of key information.
- Plain language principles are used in all communication, including marketing, public relations, billing, and volunteer services.
- Employee handbooks are written using plain language principles. Supervisors are trained on how to talk workers through the handbooks.
- Plain language principles are used in developing computer-based and other learning modalities to be user-friendly for intended learners.
- All health professionals and staff can readily describe how clear communication and effective teaching relate to quality, safety, and equitable health outcomes.
- Standard order sets and electronic health records call for the use of teach-back or other means of checking for and ensuring understanding during patient education.
- Managers and supervisors are equipped to coach and empower staff to always use plain language, teach-back, and other health literacy skills.
- Job descriptions and performance reviews include responsibilities related to clear health communication.
- All departments and units set goals for improving health communication, and managers are responsible and accountable.
- A process is in place to share communication-related stories and lessons learned from health professionals and staff as well as from clients, patients, and family members.
- Incidents involving poor communication are considered markers for possible harm;⁵ the organization reviews and addresses such communication-related adverse events.
- Leaders publicly recognize staff and teams leading health literacy improvement.

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The Power of Personal Stories

Raising awareness about health literacy should combine teaching and training with health professionals' own experiences. Health professionals need to move from abstract knowledge to personal insight, and recognize signs of limited health literacy within their own settings. Overlaying data with stories of patient experiences can be a powerful way to achieve this. This is especially true when stories come from your team's own setting. It can be easy to dismiss data as not reflecting your own patients and clients. Finding just one or two stories demonstrating a patient or client not understanding critical information can move the health team toward action. Health professionals' personal experiences as patients or family members can underscore the fact that anyone can have low health literacy at times. This holds true even for those on the team who are highly educated, and shows the importance of better health communication for all patients.⁶ When these *a-ha* moments happen, they become tipping points for change. Your staff begin to:

- Communicate differently with patients and clients.
- Open up to partnering with patients, families, and clients.
- Evolve into being health literacy champions.

What if No One Speaks up When You Ask Them To Share a Story or Personal Experience?

This seldom happens if you wait long enough. But in case it does, tell your own stories or use the ones you'll find in this Guidebook. These stories should show the harm—actual or potential—that can come from poor health communication. Prepare two or three questions to ask after they hear each story. Better yet, ask someone in your audience to read the story aloud and ask the first question. Don't be afraid of silence. Someone will step forward to fill it. Your job is to make it comfortable for them to start talking.

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Raising Awareness and Changing Behavior

Keep in mind that principles of changing behavior show that increasing a person's conviction that making a change is important, and their confidence in being able to make a change, make it more likely they will be successful.⁷ You can give your staff tools to assess their conviction and confidence in using health literacy-related techniques (like teach-back). Their conviction and confidence levels can guide you in focusing training and coaching. If learners are not convinced of the adverse impact of low health literacy and its widespread nature, they are less likely to adopt a new way of communicating with patients and clients. So, you want to be sure they understand the impact of limited health literacy. On the other hand, if they are not confident in how to use a technique like plain language, you want to build their comfort and skill in this area.

Here are three approaches to raising awareness and changing behavior among all members of your team:

- Teaching and training.
- Marketing and outreach strategies.
- Coaching to a new habit.

Teaching and Training

Traditional ways of conveying knowledge to health professionals and staff may be most useful when you are introducing health literacy the first time. They need to come away with an understanding of health literacy, how common low health literacy is, its relationship to poor health outcomes, and what can be done to improve it and move your organization toward becoming more health literate. Here are tips for how to plan your approach and some tools to help you move forward.

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Identify Your Audience

Think about who you want to influence—senior organizational leaders, doctors, department managers, front-line staff, informal leaders, community health workers—and seek them out.

Find Ways to Reach Them

Look for opportunities to connect with your audience whenever you can. Take advantage of formal and informal ways to talk with them. You may have a one-time opportunity to speak to 100 doctors at a staff meeting, or a 5-minute conversation with one social worker.

Take Advantage of These Pre-existing Educational Activities and Opportunities and Build on What's Already in Place.

Continuing Education

- Grand rounds
- Conferences
- Lunch and Learns
- Special events (e.g., Health Literacy month activities [October])

Meetings

- Department meetings
- Quality and safety meetings
- Board meetings
- Community meetings
- Planning meetings

Employee Training

- Orientation
- Credentialing
- Skills fairs
- Recertification
- Competency assessment
- Computer-based learning modules
- Performance reviews

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Decide on and Prepare Your Message

Think ahead about the most important information you want to convey. There are many ideas in this Guidebook to help you identify important topics and supporting information to help you feel prepared to deliver your message.

Get to know national data and key health literacy information. Then collect stories about communication-related troubles of patients and clients who struggle with reading and those with strong literacy skills who didn't understand.

Choose what information and which stories will mean the most to your audience. If you can, invite a patient or client to share their story. Make sure they feel alright sharing their experience in a group setting with health professionals. Many people find this daunting, not just those who struggle with reading.

My Grandmother's Story: Back to the Hospital

“My grandma had a lot of health issues including diabetes and heart disease as well as a learning disability. She was very talkative as well as a gifted conversation partner. But she was unable to read most things. She could manage on her own until she got a little older and her memory started to worsen.

One evening she was hospitalized. Her blood sugar was dangerously high, so she was kept for observation to be released the following day. She had developed recent allergies to medications when she was hospitalized earlier that year, so we were careful to go over everything with the nurse assigned to her at the time.

The next day she was released but then she had an allergic reaction to the diabetes medicine administered after the shift change and had to return to the hospital. We asked how that could have happened. It turns out some of her newer allergies weren't updated on her chart and were overlooked with the shift change. Flustered by the different care team and speed of questions when asked about the medication she had taken during her last hospital stay, she had only been able to say yes or no. By the time the staff had finished that long list, my grandma had forgotten to bring up the new allergies she had developed to some of those very medicines.”

— Meagan J., Language Services Coordinator

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To watch this video, click [HERE](#) or scan the QR code below.



Questions

- What are some things the nurse could do to help this patient and her granddaughter?
- What can you do when you are in a situation where there is time pressure and opportunity for confusion?

Have Tools Ready

It's good to give your audience something to look at or use later. This can illustrate a point, reinforce your message, and give you a reason to check back later. It's often useful to ask your audience, "What would you like to learn more about?" and provide them with resources for learning more.

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Health Literacy Tools for Teaching and Training

Teaching Tools

Health Literacy Universal Precautions Toolkit, 3rd edition

Agency for Healthcare Research and Quality (AHRQ)

<https://www.ahrq.gov/health-literacy/improve/precautions/index.html>

Description: Describes and links to an assortment of health literacy interventions and tools.

Always Use Teach-back! Toolkit

<http://www.teachbacktraining.org/>

Description: Online toolkit includes resources, tools, and an interactive learning module for learning about teach-back and putting it into practice.

Health Literacy and Patient Safety: Help Patient Understand

AMA Foundation

https://www.youtube.com/watch?v=cGtTZ_vxjyA

Description: 22-minute video with patient and provider testimonials describing and demonstrating health literacy-related challenges and solutions.

Health Literacy Video

American College of Physicians Foundation

<http://www.acponline.org/multimedia/?bclid=782539368001&bctid=790962260001>

Description: 6-minute video features physicians interacting with patients challenged by low health literacy.

Health Equity Guiding Principles for Inclusive Communication

Centers for Disease Control and Prevention (CDC)

https://www.cdc.gov/healthcommunication/Health_Equity.html

Description: Guide to using a health equity lens and specific suggestions for first person language and preferred terms.

Health Literacy Online

Office of Disease Prevention and Health Promotion

<https://health.gov/healthliteracyonline/>

Description: Guide to writing and designing websites for all health literacy levels.

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Curricula for Trainers

Making Informed Consent an Informed Choice:

Training Modules for Health Care Leadership and Professionals

Agency for Healthcare Research and Quality (AHRQ)

<https://www.ahrq.gov/health-literacy/professional-training/informed-choice.html>

Description: Two, 1.5-hour modules and implementation guide on principles of informed consent and strategies for clear communication.

Strategies to Improve Communication Between Pharmacy Staff and Patient Training Program for Pharmacy Staff

Agency for Healthcare Research and Quality (AHRQ)

<https://www.ahrq.gov/health-literacy/improve/pharmacy/guide/train.html>

Description: Training program to introduce pharmacists to problem of low health literacy. Includes agenda (2-hours), slides, and handouts.

TeamSTEPPS Enhancing Safety for Patient with Limited English Proficiency Module

Agency for Healthcare Research and Quality (AHRQ)

<https://www.ahrq.gov/teamstepps/lep/index.html>

Description: Training to promote teamwork for working with patient with limited English. Includes all training and train-the-trainer materials.

Innovate to Communicate

Health Literacy Texas

<https://www.healthliteracytx.org/health-literacy-toolkit-certificate>

Description: Resources for health literacy workforce development and training. Includes lesson plan, slide presentation, videos, and role play scenarios.

Clinical Conversations Training Program

National Network of Libraries of Medicine

<https://www.nlm.gov/guides/clinical-conversations-training-program>

Description: Micro-trainings on health literacy, cultural humility, LGBTQ + care, social determinants, motivational interviewing, and other with speaker notes, slides, and handouts.

Rural Health Literacy Toolkit

Rural Health Information Hub

<https://www.ruralhealthinfo.org/toolkits/health-literacy/2/community/school-based>

Description: Toolkit for improving health literacy at the community, patient, digital, and organizational levels including school-based curricula, models, examples, and approaches.

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Online Trainings and Tutorials

Health Literacy Training for Public Health Professionals

Centers for Disease Control and Prevention (CDC)

<https://www.train.org/cdctrain/course/1105934/details>

Description: Free web-based, self-study trainings. Offered as part of the CDC TRAIN Learning Network, providing quality training for health professionals working to improve public health. Courses offer continuing education credits.

Fundamentals of Communicating Health Risks

Centers for Disease Control and Prevention (CDC)

<https://www.train.org/cdctrain/course/1066960/>

Description: Free web-based, self-study trainings. Offered as part of the CDC TRAIN Learning Network, providing quality training for health professionals working to improve public health. Courses offer continuing education credits.

Effective Communication For Healthcare Teams: Addressing Health Literacy, Limited English Proficiency, and Cultural Differences

Centers for Disease Control and Prevention (CDC)

https://www.train.org/main/training_plan/3985

Description: Free web-based, self-study trainings. Offered as part of the CDC TRAIN Learning Network, providing quality training for health professionals working to improve public health. Courses offer continuing education credits.

Health Literacy Distance Education Program

Ohio State University College of Medicine

<http://healthliteracy.osu.edu/modules>

Description: Up to 12 online modules providing instruction on health literacy for practitioners providing direct and indirect patient care. Each module is approximately one hour long. Receive continuing education certificate; continuing education credits available.

Physician's Practice Guide to Culturally Competent Care

ThinkCulturalHealth, Office of Minority Health, US, Department of Health and Human Services

<https://cccm.thinkculturalhealth.hhs.gov/>

Description: Self-directed, online courses for health care providers, public health professionals, and health professions students on how to provide culturally and linguistically appropriate services. Courses offer continuing education and continuing medical education credits.

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Cultural Competency Program of Oral Health Professionals

ThinkCulturalHealth, Office of Minority Health, US, Department of Health and Human Services

<https://oralhealth.thinkculturalhealth.hhs.gov>

Description: Self-directed, online courses for health care providers, public health professionals, and health professions students on how to provide culturally and linguistically appropriate services. Courses offer continuing education and continuing medical education credits.

Culturally Competent Nursing Care

ThinkCulturalHealth, Office of Minority Health, US, Department of Health and Human Services

<https://ccnm.thinkculturalhealth.hhs.gov/>

Description: Self-directed, online courses for health care providers, public health professionals, and health professions students on how to provide culturally and linguistically appropriate services. Courses offer continuing education and continuing medical education credits.

Culturally and Linguistically Appropriate Services in Maternal Health Care

ThinkCulturalHealth, Office of Minority Health, US, Department of Health and Human Services

<https://thinkculturalhealth.hhs.gov/maternal-health-care/>

Description: Self-directed, online courses for health care providers, public health professionals, and health professions students on how to provide culturally and linguistically appropriate services. Courses offer continuing education and continuing medical education credits.

Improving Cultural Competency for Behavioral Health Professionals

ThinkCulturalHealth, Office of Minority Health, US, Department of Health and Human Services

<https://thinkculturalhealth.hhs.gov/education/behavioral-health>

Description: Self-directed, online courses for health care providers, public health professionals, and health professions students on how to provide culturally and linguistically appropriate services. Courses offer continuing education and continuing medical education credits.

Health Literacy and Public Health

University of Albany

<https://phtc-online.org/learning/?courseId=16>

Description: Two 1-hour online trainings to enhance knowledge and competence in health literacy addressing literacy issues in spoken and written communication.

Strategies for Addressing Low Health Literacy

University of Albany

<https://phtc-online.org/learning/?courseId=17>

Description: Two 1-hour online trainings to enhance knowledge and competence in health literacy addressing literacy issues in spoken and written communication.

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Deliver Your Message

- Briefly present data and evidence about health literacy. Put it in the context of a complex health system that is hard for most people to navigate.
- Follow with local literacy data. You can get estimates from the National Assessment of Adult Literacy data using this tool: <http://healthliteracymap.unc.edu/>. (Please note, you need a Firefox web browser to access this map.)
- Explain the stigma and shame of low literacy. Build empathy using a backward reading exercise, and invite them to share how it made them feel.
- Share one or more stories about poor communication from your own setting. Then, invite your audience to share their own stories.
- If you have patients or clients willing to do so, ask them to share their experiences in-person or virtually, or they can share a short video as another good way to show different points of view.
- Emphasize that even people with strong literacy and health literacy skills can struggle to understand health information in certain circumstances.

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Backward Reading Exercise

This training exercise simulates what readers with low literacy experience with the printed page. Ask participants to read the paragraph out loud and together. Hint: The words are written backward. For example, the word “gninaelc” is read “cleaning.” As you discuss the questions, point out that the frustration they may feel is similar to how patients with limited literacy may feel.

Ot erussa hgih ecnamrofrep, yllacidoirep naelc eht epat sdaeh dna natspac revenehw uoy eciton na noitalumucca fo tsud dna nword-red edixo selcitrapp. Esu a nottoc baws denetsiom htiw lyporposi lohocla. Eb erus on lohocla sehcuot eht rebbur strap, sa ti sdnep ot yrd dna yllautneve kcarc eht rebbur. Esu a pmad tholc ro egnops ot naelc eht tenibac. A dlim paos, ekil gnih sawhsid tnegreted, lliw pleh evomer esaerg ro lio.

Questions

- How did you feel trying to read the passage?
- What did you remember from reading the passage?
- How much reading would you do if it was this hard?

Help Your Audience Connect the Dots

Your audience will care most about things that hold meaning for them. To carry your message home, help them answer “What’s In It For Me (WIFM)?” Help your audience see the relationship between health literacy and what they are focusing on. Talk about how health literacy affects their specific area of practice, like health care, public health, chronic disease, housing, food insecurity, health equity, research, or how it can help them by decreasing cancellations and no-show appointments, increasing specific improvement outcomes or processes, improving the informed consent process, or preventing mistakes or misinformation. Get them to ask, “What is the health literacy impact on my work?”—whatever it is they are working on.

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Something Is Wrong With My Sinuses

“A family member who has an accounting degree was discharged from the hospital. Because he said he didn’t understand any of the discharge instructions that were given, we were reviewing the after-discharge summary together. While going over the medicines, he continued to ask where the medicine for his nose was. I had no idea what he was talking about because there wasn’t anything related to his nose on the medicine list. Finally, he pointed to the words “sinus tachycardia”^{*} and said, ‘It says right here I have something wrong with my sinuses so where is the medicine for that?’”

— Stephanie S., Physical Therapist



To watch this video, click [HERE](#) or scan the QR code below.



Questions

- What could providers have done to be sure this patient understood his discharge instructions?
- How could they have prevented the patient’s confusion about his diagnosis?

^{*}Sinus tachycardia means a normal heartbeat that is faster than usual. Often, it is caused by things like exercise, fever, stress, worry, pain, or caffeine.

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My Son's Story: Inadvertent Anti-Convulsant Drug Overdose

“My son had a brain concussion. He was going in and out of convulsions. I called the doctor. I was giving him, I think, three teaspoons three times a day and the doctor told me to give him one more teaspoon. Well, I was confused. So, I was giving him four teaspoons, three times a day. The poor little thing was walking into doors and into walls. And here was a chair, and he'd sit down over there. I couldn't figure out what was wrong with him, so I brought him in to see the doctor. He wasn't having any more convulsions. So, the doctor asked me how much medicine I gave him. I told him, and he said, 'No, no. Just one more extra teaspoon.' Well, I didn't understand, and I should have asked questions. But I didn't. It's a wonder I didn't harm him worse than I did; but he's fine now.”

— New Reader



To watch this video, click [HERE](#) or scan the QR code below.



Questions

- What do you think about the conversations that took place between the doctor and the mother? What do you think about her feelings about what happened?
- What can be done to prevent this or similar situations?
- How does the increase in telehealth impact the importance of and approach to ensuring understanding?

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Show Them What They Can Do

Describe how using health literacy approaches with all clients, patients, and families can help them obtain and understand the information they need to care for themselves or loved ones. Emphasize how important it is to create a shame-free environment that makes it comfortable for clients, patients, and family members to ask questions; fosters dialogue; and supports the use of plain language for verbal and written communication and teach-back to assess whether key information was understood. Highlight the special importance of using these techniques, tools, and strategies during critical times, like a new diagnosis or new eligibility for services; change in treatment or benefits; referrals; or hospital discharge or other care transition. Show how these help people feel more comfortable asking questions, and help the health team identify areas of misunderstanding.

Call to Action

Close by asking your audience to commit to doing something specific. Here are some questions you can ask to get them started:

- What can you do by Tuesday to improve one aspect of health communication in your setting?
- Do you think you could try using this plain language handout during education with one patient or client?
- Would you be willing to try teach-back with your last patient or client tomorrow?
- How do you see using teach-back and chunk and check in your next naloxone training?
- Could you ask a client, patient, or family member for feedback to help you improve your check-in process?
- Can I call or email you next week to find out how it went?

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Engaging Doctors

Doctors are a key audience for advancing health literacy. They are leaders of health care teams and influence what other people think, say, and do. There are tremendous demands on their time, and you are asking them to change their behavior, which is hard. Remember, change happens best when perceived benefit outweighs perceived discomfort. Make sure you address: “What’s in it for me—how will this help me provide better care for my patients?”

Marketing and Outreach Strategies

Seeking out busy health professionals may mean taking a somewhat different approach. Try these lessons learned from the marketing field on how to develop a successful sales pitch to promote the use of health literacy-based interventions and tools. (F. Burns, personal communication, 2012)

Pre-call Planning

- Set a specific goal or goals.
- Think ahead to objections the person may make.
- Prepare and practice.

The Pitch

Opening

Get their attention and guide the conversation toward what you want to talk about. State the problem and offer your solution.

Explain Benefits

Give the *benefits* of your health literacy solution:

- Use short, convincing sentences. Don’t talk fast; talk briefly.
- Limit yourself to three key points. That’s all most people can absorb at one time.
- Use visual aids like a brief handout or video to open a conversation, illustrate a point, handle an objection, or as a reminder of your conversation.

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Ask Questions

What does the listener think, feel, or need? Try to find out what their objections are. Then wait for their answers and listen. Silence can be powerful.

- How do you feel when patients or clients don't keep their follow-up appointments?
- Where do you see using teach-back as being most helpful?
- Is there something you don't like about using plain language handouts?
- How do you see yourself using this reader-friendly vaccination handout?

Handle Objections

- Don't be defensive or take objections personally.
- Objections mean they are interested enough to listen and think about what you said.
- Believe body language and tone of voice over words.
- Restate the objection to ensure you understand each other. Clarify your own points if needed.
- Address their issues and concerns.
- Provide guidelines or research to support your point.

Handling Possible Objections

Objection	Response
There isn't enough time.	Ask for a few minutes to show them how: <ul style="list-style-type: none">• Plain language and teach-back may save time in the long run by making sure patients or clients understand.• Health professionals find that once they get the hang of it, they use teach-back throughout the visit, and it doesn't take longer.• Plain language and teach-back may also improve equity, quality, safety, and patient and client satisfaction.

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<p>That isn't my job.</p>	<p>Acknowledge they are busy, with many demands on their time.</p> <ul style="list-style-type: none"> • Underscore how making sure patients, families, and clients understand is the responsibility of everyone on the health team. • Suggest approaches that invite other team members to help with plain language explanations and teach-back. • Offer to help train the health team in these techniques.
<p>This isn't a problem in my practice.</p>	<p>Emphasize that health literacy can be a problem for any client, patient, or family member.</p> <ul style="list-style-type: none"> • Note it can be hard to recognize when someone doesn't understand—you can't tell by looking. • Even highly educated people can experience low health literacy, especially if they are sick, worried, sleep-deprived, or in a lot of pain. • Invite them to consider a time when they did not understand what they were being told by an engineer, attorney, or a physician in another specialty. • Research shows that people often do not admit that they don't understand.⁸
<p>No one can really do anything about it anyway.</p>	<p>Highlight that while addressing health literacy is a challenge, the rewards are great.</p> <ul style="list-style-type: none"> • Plain language and asking people to review what you said in their own words can go a long way in helping them understand, remember, and use the information you gave them to care for themselves and their families. • Research shows using teach-back among hospitalized adults with asthma or chronic obstructive pulmonary disease (COPD) was associated with fewer acute care events within 30 days of discharge.⁹ • Research shows a pediatric health literacy discharge medication communication bundle reduced home liquid medication errors and improved caregiver knowledge. (Carroll, et.al. 2024)

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<p>No one can really do anything about it anyway (from previous page).</p>	<ul style="list-style-type: none">• Research shows using teach-back among patients with diabetes is associated with improved outcomes.¹⁰• Teach-back serves as a valuable tool to support quality and safety, shared decision-making, and improved health literacy and other outcomes.^{11,12}
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Closing

Always close with a call to action. Consider leaving a handout or tool for them to look at later. Try to gain a specific commitment. For example, you might say:

- Would you be willing to use this plain language handout tomorrow when you talk with a parent or client about fever and safe use of over-the-counter medicines?
- Would you be willing to talk to your colleagues about the problem of low health literacy and how poor communication affects patients or clients?
- Can I follow up with you on this in _____ days/weeks?

Post-call Notes

- Did you meet your goals for this conversation?
- What is your plan for following up?
- Be sure to follow up on objections.
- Continue to build your case with other supporting concepts or documents. If you tell them you will give them more information or resources, note when you will deliver what you promised. Be specific.

Follow Up

When you follow up, check on the action plan you discussed—what was done and how it went. If things went well, encourage another step. If things didn't go well, help figure out how to make it go better, and encourage them to try again.

- Don't expect too much at first. It can take eight calls to create buy-in.
- Remember WIFM. (What's In It For Me?)

Prepare the Workforce

- Show how your health literacy solution is a win-win.
- Use the power of brand recognition; reinforce key words and techniques, like plain language and teach-back.
- Watch body language to see how they are reacting to what you say.
- Paint a picture. Give real-life examples that reflect their setting.
- Confidence and enthusiasm make a lot of sales. The way you convey your message can create success.
- Remember, you are the health literacy expert!

Early Adopters and Champions

One way to speed improvement and adoption of evidence-based or best practices is to work with early adopters (those willing to try new ideas early on). Often, we spend a lot of energy trying to convince those most resistant to change or most invested in traditional patterns. Trying to make change happen this way can be frustrating.

Instead, focus your energy on early adopters—those open to new ideas and willing to try them.

- Give them the data and stories.
- Elicit their experiences or observations that show the importance of understanding.
- Tell them about and invite them to try a new health communication skill with just one patient or client. From one, they can build to a few more on a few more days with a few more conditions. Eventually, the skill is built into their practice patterns.
- Then invite and encourage them to share their experience with colleagues, thus evolving into champions.

Strive to identify and engage early adopters—those willing to try using improved communication techniques, who may become champions and help advance your work.

Prepare the Workforce

Coaching to a New Habit

Giving staff knowledge of health literacy interventions is important. But, to change from long-standing communication and education habits to routinely using plain language principles and checking for understanding by using teach-back benefits from coaching. Coaching can help staff be successful by enhancing their skills in moving away from long-standing habits and integrating new ones by providing support and overcoming challenges over time. Here are tips to help you coach staff to new health communication habits like teach-back.^{13,14,15}

Build Motivation

- Encourage the use of the new habit by focusing on ideal care.

Honor the Current Work Through Acceptance

- Establish relationships by observing those seeking to build the new habit (teach-back).

Understand that Change Is Hard and Uncomfortable

- Use active and reflective listening.
- Use open-ended *what* and *how* questions to determine individual barriers:
 - What worries you about using teach-back?
 - How did using teach-back with your patient make you feel?
 - Tell me more about...

Resistance to Change Is Natural

- Resistance comes from fear of change.
- Confront the problem, not the person.
- Resistance is a signal to change the response and approach.

Prepare the Workforce

Promote New Skill Development

- Promote each individual's belief in their ability to change.
- Focus on previous successes.
- Focus on skill development.
 - Set goals: I will use teach-back with each patient starting a new medicine, or client starting a new program.
 - Develop a change plan. Habit change happens with conscious planning.
 - Mentally rehearse:
 - What is the most important thing I want to be sure the patient or client understands?
 - How would I ask this question?
 - Embed reminders to use teach-back in established habits:
 - After each interaction, I will ask open-ended questions to elicit understanding.
 - Use job aids to remind and support the use of the new skill.

Build Confidence to Integrate the New Habit into Work Patterns

- Rate your confidence in using teach-back on a scale of 1 to 5.
- What might help you increase your confidence from a 3 to a 4?

Prepare the Workforce

Build Reliability

- Even when people reach goals, they often need reminders and support to continue to be successful.
 - Create standard work: content, sequence, timing, and outcome.
 - Build in job aids and reminders.
 - Take advantage of pre-existing work and habits.
 - Make the desired action the default rather than the exception.
 - Create back-ups when appropriate to reduce risk or enhance safety.
 - Group related tasks.

Manage Relapses

- Make a plan for follow-up coaching and observation to reinforce the new habit.
- Share questions and problems. Develop process improvements.
- Recognize, reward, and celebrate successes!

Use Coaching Tools

The Always Use Teach-back! Toolkit provides additional guidance to help staff be successful in helping patients and clients understand what they need to know and do.¹³

The first page of a Coaching resource from the Toolkit is illustrated on the next page. The entire Toolkit is available at: <http://www.teachbacktraining.org/>.

Prepare the Workforce

Coaching for Always Using Teach-back



Providing *knowledge* about teach-back and its effectiveness is important but not sufficient to make teach-back an [Always Event](#). It takes coaching to help people change from long-standing habits of explaining and then asking “Do you have any questions?” which can be answered with yes or no, to using teach-back to take responsibility for being clear and to confirm understanding via the patient’s own words.

Changing behavior and building new habits takes time and adds value. After [Starting a Teach-back Initiative](#), coaching helps staff be successful by enhancing their skills in helping patients and clients understand what they need to know and do.

Build motivation and confidence.

- Encourage use of the new habit by focusing on improving equity, safety, outcomes, and everyone’s desire for service excellence.
- Ask staff to consider what they would want for their own family members or friends. Example organizational mantra: “We deliver the care we wish our loved ones to receive.”
- Provide patient or client testimonials about teach-back’s usefulness to make sure they understand. See [Patient Sharing Appreciation for Teach-back at Hospital Discharge](#).

Address resistance to change.

- Resistance is natural, comes from skepticism about change, and is a signal to change the response and approach. Accept that change is hard and uncomfortable.
- Connect the new habit to a vision of better care or services to build the will to always do it well. Example team mantra: “Using teach-back will help our patients understand what it is important to know or do to stay safe at home.”
- Develop mutually agreed upon SMART¹ (Specific, Measurable, Actionable, Achievable, Relevant, and Time-bound) goals and objectives. See [Aims, Goals, and Objectives](#).
- Relate the need for understanding information to life experiences like needing technical support for computers or phones when people are not tech literate, or helping children with remembering where to be at a certain time.

Prepare the Workforce

Move From Awareness to Action

All the education and training in the world can't bring about sustained behavior change. Get people started by challenging everyone in your health literacy training to find one small change they can make in one aspect of their work by next Tuesday to improve health communication. This shifts their thinking toward action. It also decreases the perceived risk of making a change and builds confidence to try it again.

Repeated small tests by one person, followed by more testing by others, spread experience and acceptance of new ways of communicating with patients. This process can also lead to creative problem-solving as people work to figure out what might have been done differently to make the test go better. It helps you work out the bugs, build support, and figure out how to make improvements last and spread.

Work with staff to set short- and long-term goals to drive and assess progress toward improving health communication. A long-term vision gives guidance and motivation. Starting with one or two key areas provides focus and allows people to see progress, for example, using teach-back for people who have diabetes, making paperwork simpler, or offering help with forms.

Then, use small tests of change to help adapt interventions and tools quickly and easily for their settings. This works better than trying to introduce blanket policies all at once because improving health communication practices calls for:

- A cultural shift and continuous improvement.
- Making sure improvements last by hard-wiring changes into normal operating procedures and systems.
- Spreading change throughout the system.

Combining small tests with short- and long-term measures and goals moves people toward action, with timelines and measures to gauge success. This leads to reliable, sustainable use of health literacy practices. It underscores the importance of working together across disciplines and with clients, patients, and families. And it builds confidence among team members that they can succeed.

Prepare the Workforce

Develop Health Literacy Leadership

Health literacy as a field of study and practice continues to develop and grow. The focus of health literacy publications has expanded to include well over 1,000 research articles and expanded to look at the effectiveness of interventional solutions.¹⁶ Today, health literacy leaders in research and practice are working together to develop, study, and share approaches to improve health literacy for all.

Establish Health Literacy Professionalism

Professional associations are critical to promoting professionalism and for sharing research and best practices.¹⁷ In 2016, the International Health Literacy Association (IHLA) was established for just this purpose. IHLA is a member-based organization dedicated to development of its members and the health literacy field of research and practice. One way to build your health literacy skills is to join or start an interest group within the professional associations you are already involved with or join IHLA. Visit the IHLA website (www.i-hla.org) to see a list of interest groups and learn from others doing similar work.

HLRP: Health Literacy Research and Practice

<https://journals.healio.com/journal/hlrp>

An independent and international open-access publication dedicated to promoting excellence in research and practice to advance the field of health literacy. It is the official journal of the Institute for Healthcare Advancement and is a forum for dissemination of high-quality original research to bridge research with best practices.

Achieve Health Literacy Competencies

There is a growing focus on teaching health literacy to health professionals in training as well as health professionals already in practice. A growing body of research looks at clear communication competency for health professionals, and how best to teach those competencies.^{18,19,20} To identify health literacy competencies you want to establish and teach, consider best practices and competencies established by consensus among health literacy professionals and health professions educators, such as apply teach-back, avoid jargon, and work with interpreters.

Prepare the Workforce

There are a number of virtual or in-person conferences and training programs for advanced health literacy professional development. This list does not include all the health conferences, trainings, initiatives, programs, and networks that provide opportunities for health literacy leadership but these are well regarded places to start or continue your journey.

Advance Health Literacy Professional Development

Conferences and Training Programs

Health Literacy Annual Research Conference (HARC)

<https://harconf.org/>

Description: Interdisciplinary meeting for investigators dedicated to health literacy research designed to advance the health literacy field, raise the quality of health literacy research, and provide a venue for professional development. Attracts a wide range of investigators engaged in health literacy research, including a broad array of public health, health services, epidemiology, translational, and interventional research activities. Offers continuing education credits.

Health Literacy Collaborative Summit

<https://www.healthliteracycollaborative.org/>

Description: Wisconsin Health Literacy expands its traditional Health Literacy Summit by partnering with other organizations to host this event. Attended by professionals from health care, community-based organizations, libraries, health insurance, health information technology, adult literacy, and public health. This Summit emphasizes practical approaches participants can use right away. Offers continuing education credits.

Health Literacy Specialist Certificate Program

<https://www.healthliteracysolutions.org/learning-lab/certificate-program-faq>

Description: An assessment-based certificate program offered fully online. After completing lessons, passing exams, and earning micro-credentials in seven domains, learners receive a Health Literacy Specialist Certificate and Digital Badge. Created by the Institute for Healthcare Advancement (IHA) in collaboration with subject matter experts, instructional designers, credentialing specialists, psychometricians, and others. Offers continuing education credits.

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Institute for Healthcare Advancement (IHA) Annual Health Literacy Conference

<https://hlc.iha4health.org/>

Description: IHA's Annual Health Literacy Conference offers participants opportunities to learn about practical and effective solutions to health literacy challenges. Attracts health educators, physicians, nurses, hospital representatives, academics, writers, researchers, and public health workers among others with interest in the field. Offers continuing education credits.

International Health Literacy Association (IHLA) Global Health Literacy Summit

<https://www.i-hla.org>

Description: IHLA's Global Health Literacy Summit brings together people from all over the world who are passionate about health literacy. IHLA is a member-based organization dedicated to health literacy professional development and growing the field. The organization supports research and practice, encourages high standards, and fosters collaboration. The Summit is held every three years in a different country. Attend in person or virtually. Receive a certificate of participation.

Plain Language for Health (PL4H)

Health Literacy Leadership Institute (HLLI)

<https://go.tufts.edu/healthliteracyleadership>

Description: Tufts University School of Medicine and Tufts Medical Center offer professional development programs, including Plain Language for Health (PL4H) and the Health Literacy Leadership Institute (HLLI). While in-person and online instructional design vary, all include large group discussion, small group work, networking, and practice. Receive a certificate of completion and continuing education credits.

Other Possibilities

There are also independent health literacy experts who offer training, consulting, coaching, and mentoring for individuals and groups, online, or in person. Search the internet using terms like organizational health literacy, health literacy initiatives, plain language, health literacy and health equity, or health literacy and patient engagement to see what is relevant to you.

Or look for local and regional meetings, coalitions, and collaborations offering other learning opportunities. You may want to look at what your local academic and medical institutions are offering in terms of health literacy teaching, training, initiatives, and programs.

Prepare the Workforce

Make It Stick

For permanent change, embed improvements in standard operating procedures, and use systems to support reliable use of and sustain those improvements.

Set Up Policies and Procedures

Use operating guidelines like these to make sure your improvements last.

- Add clear communication responsibilities to all job descriptions and performance reviews.
- Address health literacy during orientation and be sure staff understand they will be responsible for effective communication.
- Build in policies that ensure new staff and those changing jobs or roles are trained in health literacy activities they are responsible for in their new situation.
- Include health literacy practices as part of continuing education (CE) and continuing medical education (CME) programming.

Take Advantage of Systems

- Create or use computer-based or online learning modules to meet continuing education, certification, and credentialing requirements. Assign these and make sure they are completed.
- Be sure everyone gets periodic review and reinforcement. Use opportunities like recertification and skills fairs. Use observation, feedback, and coaching to keep skills and techniques from eroding. This provides an opportunity for improvement and a chance to celebrate progress and success.⁴
- Don't miss chances to build plain language skills and teach-back into all guidance and processes. For example:
 - A script for follow-up phone calls that uses plain language and includes teach-back as part of a public health campaign or research project.
 - A home health nursing competency for a dressing change includes plain language teaching and teach-back.
- Use incentive and bonus strategies. Some organizations include health literacy as an area in which managers and staff can apply for a quality improvement bonus.

Prepare the Workforce

Keep It in Front of Everyone

Here are ways to keep health literacy as a guiding principle for your organization:

- Include health literacy-related performance as a standing agenda item for quality and board meetings.
- Include health communication in organizational performance scorecards. This can help direct more attention and resources to sustain improvements in patient or client communication.
- Develop ways to identify, examine, and address communication-related mistakes and adverse events.
- Include end-user input and community review as a standard part of developing written materials.
- Faculty for health professions students should teach, model, and evaluate the use of clear communication skills (especially teach-back) for their learners.
- Include teach-back in evaluations for all health care professional training rotations.
- Recognize those who show leadership and demonstrate successes in health literacy and health communication. Highlight their work.
- Use opportunities like Health Literacy Month (October) (<https://healthliteracymonth.org/hlm/hlm-home>) to feature projects and successes. Invite the community to join you by addressing health literacy in events like health fairs and talks to community groups.

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Involve Patients, Families, and Community Members

Create ways to involve patients, families, and community members in your work. It may be simplest to set up or draw upon a patient and family advisory council or community advisory group. These work with members of your organization to provide valuable feedback and personal insight.

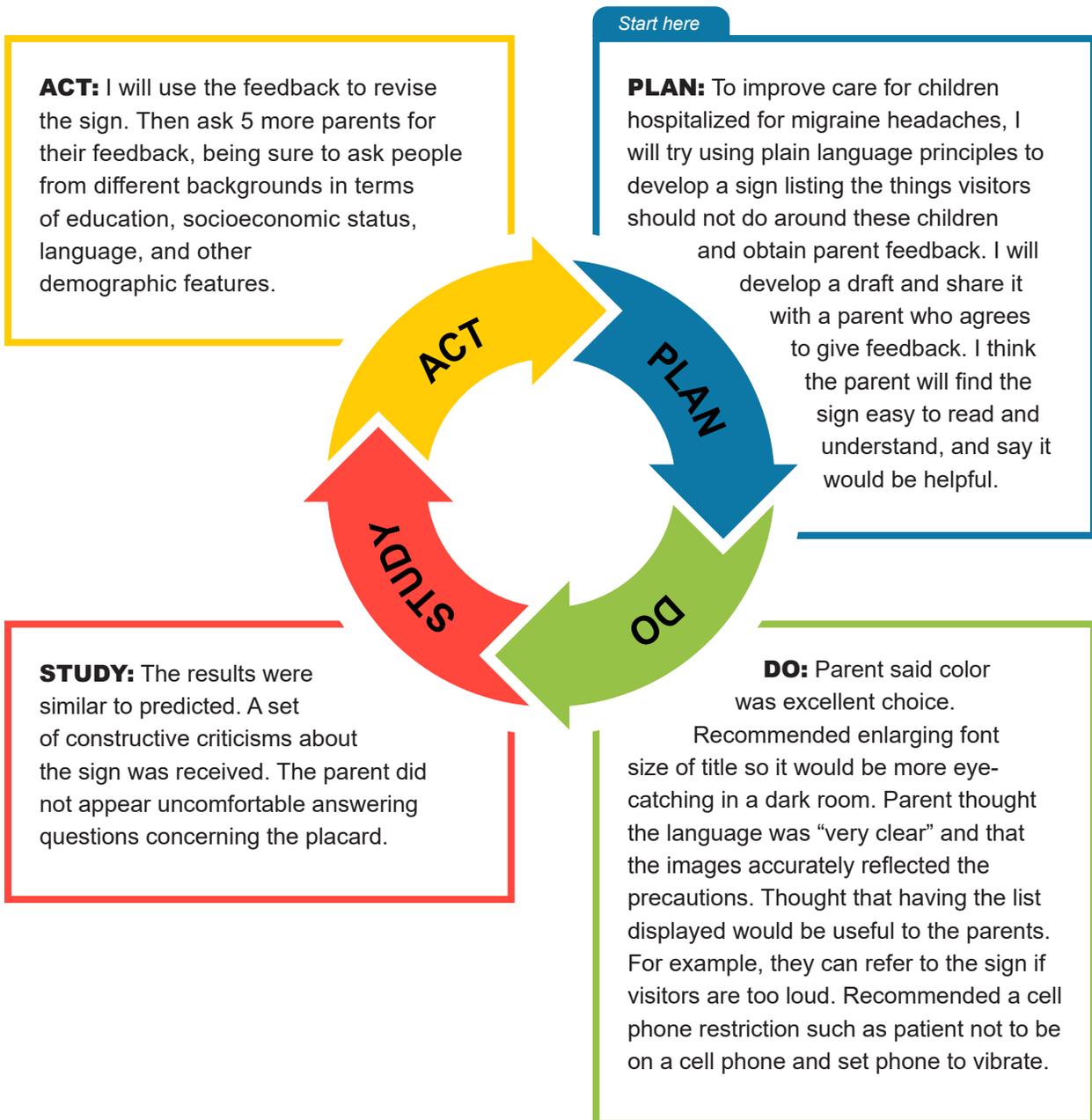
If your setting is already involving patients and community members, find how to involve them on health literacy teams and invite their feedback in more ways. These could include navigation interviews, written materials reviews, and presentations to health professionals and other staff.

Base your efforts in patient- or client-centered care principles. Patient- and family-centered care is an approach to planning, delivery, and evaluation of health services that is based on mutually beneficial partnerships among health professionals, patients, families, and community members. The core concepts of patient- and family-centered care are dignity and respect, information sharing, participation, and collaboration.²¹

Prepare the Workforce

PDSA Cycle: Preparing the Workforce

After participating in health literacy training, a team wanted to do a PDSA related to plain language and family involvement. A nurse, S.J., planned, carried out, and led a discussion of this PDSA.



Prepare the Workforce

Summary of Key Points

- Anyone can experience limited health literacy.
- Health professionals and staff need to understand the role of health literacy in general, and in their settings in particular.
- It's easy to think that communication is not a problem in your setting. The statistics say otherwise.
- Learning effective communication and education skills is ongoing. It needs to be reinforced, repeated, recognized, and rewarded.
- Awareness, education, training, and personal connection are needed to change behavior. But they won't bring about behavior change on their own. You need to prompt members of your team to action.
- Use small tests and cultivate coaching skills to support lasting changes in the use of health literacy interventions.
- To make long-term changes, build clear health communication into organizational priorities, policies, procedures, job descriptions, and daily routines.
- Advance health literacy knowledge and skills by attending training programs, workshops, and conferences to learn about the latest areas of inquiry and best practices.

Prepare the Workforce

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Create a Shame-free Environment

6 | Create a Shame-free Environment

“The night after my neighbor returned home from the hospital, she experienced some bad side effects. But did not call the doctor right away. When asked why, she said she was scared because she felt like she never knew what was going on when she talked with her doctors. She ultimately decided to go to the emergency room, but her poor experience with health communication could have had a massive impact on her well-being at that time and in the future.”

— Chase B., Clinical Research Associate



To watch this video, click [HERE](#)
or scan the QR code below.



The first interaction with your organization’s health information or services sets the stage for all the following interactions and outcomes. Whether it is a website, telephone call, or in-person visit, the ease and comfort with which people are able to find and use information to meet their needs can go a long way toward creating a welcoming health literate culture within an organization.

It can also help decrease shame and stigma that often accompany low literacy.¹ But while especially true for those with limited reading and math skills, confusion and embarrassment can affect anyone in the health setting. Sometimes the most educated people feel the most embarrassed asking for help.

Create a Shame-free Environment

The ideas and tools in this chapter are designed to help you:

- Understand what a shame-free care environment is and why it is needed.
- Make your health setting more welcoming, safe, and patient- or client-friendly to foster dialogue and questions.
- Make it easier for people to find, understand, and use your information and services to manage their health.

A Health Literate Organization Offers a Shame-free and Supportive Care Environment

This chapter directly addresses Attributes 5 and 7 of the Ten Attributes of Health Literate Health Care Organizations, and will help you “provide easy access to health information and services and navigation assistance” to “meet the needs of populations with a range of health literacy skills while avoiding stigmatization.”²

Why Do We Need to Change?

People Hide Their Reading Problems

Patients with limited literacy skills may feel “less of a person” or that “something is wrong with me.” This can make them anxious, fearful, angry, or suspicious.³ Many people with limited skills hide their reading problems because they have had bad experiences in school or in the health care setting.

Nearly 20% of those with limited literacy skills have never told anyone.³ That’s one in five. People may not reveal their reading troubles, not even in a long-term trusting doctor-patient relationship. Even if they are asked about it in a caring way, they may not share their problems with reading, understanding, and learning.

Create a Shame-free Environment

Many patients who struggle with reading never ask for help.

— Parikh NS, et. al. 1996

The Ways People Cope

People who struggle with reading learn to cope in clinical and public health settings. To avoid appearing uneducated or stupid, they may act in ways that adversely affect their health. For example, they may:

- Wait to seek health care until they absolutely have to, such as when their illness has worsened.
- Act difficult by walking out of a social service agency before being seen, making excuses, becoming angry or demanding, or clowning around.
- Answer questions or talk about things in ways that sidestep the health or service provider’s intent, so the real concern isn’t addressed.
- Be quiet and passive, not bringing up a concern if it wasn’t asked about directly.
- Not ask any questions at all so they can leave more quickly.⁴

These actions lead the health team to assume people understand. Or, depending on the behavior, they may mistakenly label the person as “difficult” or “non-compliant.” Rather than emphasizing the health system’s responsibility for clear communication, these assumptions and labels focus blame on patients, families, or clients. Similarly, health team members may be relieved when people don’t ask questions, not recognizing they left without truly understanding what they needed to know or do.

Screening for Low Health Literacy

“A doctor’s office is no place for a reading test.”

— New Readers of Iowa, 2004

Create a Shame-free Environment

Several tools to assess literacy in health settings are available. They have changed over time. Early assessments were more like actual reading tests, with lists of words and fill-in-the-blank paragraphs. More recent assessments related to health literacy are reflective of how people apply health information. It's important to understand how these tools have evolved so decisions are made thoughtfully about which tool to use for which purpose and whether or not to screen for limited literacy or health literacy.

In health, screening is used to identify a health problem early, so there is time to prevent more severe illness. Screening for limited health literacy can be viewed similarly. In other words, is there value to finding or knowing about limited literacy among those coming for health-related services? Should we test patients' literacy in clinical or health service settings? Some think it might aid in finding those who need extra help. We could then tailor information to meet the literacy and learning needs of individual patients or clients and refer people to adult literacy programs and other community services to support their understanding and action.

But we also know there is the possibility of shame and embarrassment when people feel like they are being tested. Adult learners say they have spent much of their lives being tested. They do not want to be tested when they come for help and are sick or in pain. Some say they won't return if tested when they seek services. You may alienate the people you most need to serve by testing them, and alienated people may not return until their health problems are much worse.

Think about what you will or can do differently if you know someone who needs your services and has trouble reading. Does your organization have a library of easy-to-read handouts along with the usual materials? Will you teach and check for understanding differently than with other people? If not, then it may not make sense to routinely measure health literacy or screen for low health literacy. If yes, then screening may make sense for your organization. Either way, testing alone won't improve understanding.

Tools to measure an individual's health literacy were originally developed and used in research settings where people being tested gave informed consent. Health literacy measurement tools like the Rapid Estimate of Adult Literacy in Medicine (REALM)⁵ and the Test of Functional Health Literacy in Adults (TOFHLA)⁶ helped build an evidence base documenting the prevalence of and problems associated with limited literacy. The REALM is a list of 66 medical terms in English and Spanish that a person is asked to read aloud in two to three minutes. It checks word recognition and reading but not understanding of numbers. The TOFHLA is available in long (10-22 minutes) and short (5-12 minutes) forms and in English and Spanish. It includes multiple choice and fill-in-the-blank questions on a page of medical instructions to check reading and understanding.

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A variety of other tools are now available to measure health literacy among different audiences and contexts, and for clinical and research purposes. Since you will hear and read about these tools for assessing personal health literacy in your work, it's good to know more about them.

Tools to Measure Personal Health Literacy

Newest Vital Sign

The Newest Vital Sign^{7,8} is one of the most widely used health literacy screening instruments. The person reads an ice cream nutrition label and is asked to answer six questions. It is available in English and Spanish. It assesses document and number literacy.

<https://www.pfizer.com/products/medicine-safety/health-literacy/nvs-toolkit>

Parental Health Literacy Activities Test (PHLAT)

The PHLAT^{9,10} is an assessment of parent health literacy, specific to infant care. It is an English tool containing 20 items. The Spanish version contains 8 items. It tests prose, comprehension, and numeracy. <https://healthliteracy.tuftsmedicine.org/phlat>

Short Assessment of Health Literacy – Spanish and English (SAHL S&E)

In the SAHL S&E¹¹, the person reads aloud 18 test terms, one at a time, and chooses a word close to the meaning of each word from two choices. It tests comprehension and pronunciation.

<https://www.ahrq.gov/health-literacy/research/tools/index.html#rapid>

Single Item Literacy Screener (SILS)

Of three questions found to be effective at screening for inadequate health literacy by Chew, et al.,¹² “How confident are you filling out medical forms by yourself?” is considered the strongest single question and just as useful as asking all three questions.¹³ This single item health literacy screening question can be incorporated into other screening activities in clinical settings.

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2324160/>

There is an evolving discussion around the role of carefully incorporating health literacy screening into clinical settings.¹⁴ For example, electronic health records may enable system-wide screening and documentation using less stigmatizing tools. Results can be used to support focused interventions to address specific health conditions and social determinants of health and

Create a Shame-free Environment

to promote safety. Thoughtful screening implementation with attention to training and integration into routine workflow and processes may identify opportunities to devote extra resources to address challenges related to limited health literacy.

Visit the NEW Health Literacy Tool Shed at Tufts Medicine Center for Health Literacy Research & Practice to learn more about and find health literacy measures

<https://healthliteracy.tuftsmedicine.org>



Estimate the Prevalence of Low Literacy

You may find it helpful to estimate the prevalence of low literacy in your community to help raise awareness and stimulate action to address health literacy. The Health Literacy Data Map (Use Firefox browser: <http://healthliteracymap.unc.edu>) shows estimates of the average health literacy levels of people living in various areas. You can't use this to tell whether an individual has limited health literacy skills, but it can give you an idea of what percentage of your patients or clients might have trouble understanding health information. This can help you demonstrate the importance of addressing health literacy to leaders and motivate staff to improve the care environment, as well as to start using ways to communicate more clearly.

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To find the percentage of people in your community who may have limited health literacy skills, try using the Health Literacy Data Map. (Use Firefox browser.)

<http://healthliteracymap.unc.edu/>

Taking a Universal Precautions Approach

Health Systems are too Complex for Everyone

Reading problems aren't the only reason people have trouble understanding or remembering all the information they get. Here are some other reasons:

- The health system is more and more complex.
- There is a growing need for self-care related to more people having chronic health conditions and living longer.
- Health care professionals often rely on print materials to teach patients about their condition. Yet, they often lack simple handouts to give out with spoken instructions.
- Pain or illness, worry, some medicines, lack of sleep, preoccupation, and other concerns can make it hard for anyone to understand and remember health information.

Interventions for people with low literacy can also help those with higher literacy skills.¹⁵ Even good readers prefer information that is concise and easy-to-read.^{16,17} This is why we need to use a universal (meaning it applies to everyone) approach to improving health communication. The term “universal precautions” is used to describe how we handle blood and other body fluids in the same way for everyone, because we can't tell who might have an infection. In the same way, we use the term “universal precautions” to describe how we should use communication principles that are clear to everyone.¹⁵ Remember, we can't easily tell who may struggle with reading or remembering.

There are several basic principles for this universal precautions approach to health literacy:

- Everyone benefits from clear information.
- Many people are at risk of misunderstanding, but it's hard to identify them.
- Screening for literacy difficulties alone does not ensure understanding.¹⁸
- Interventions for people with low literacy also help people with higher literacy.¹⁵

Create a Shame-free Environment

Acting on these principles leads to a more equitable and safer health environment where people:

- Understand their health status.
- Make informed health decisions.
- Know what they need to do.
- Do not experience a sense of shame or embarrassment.

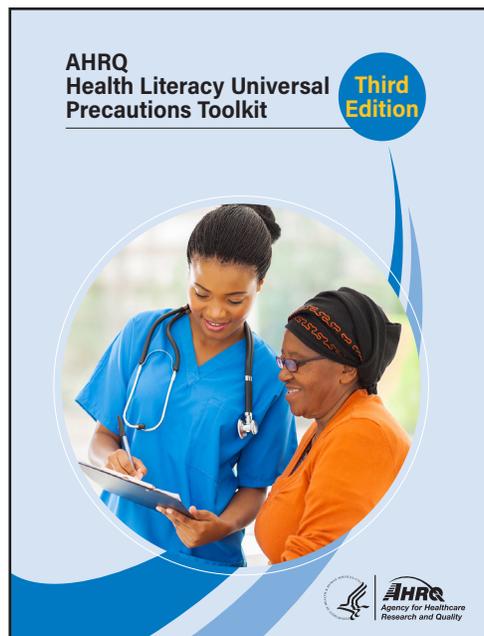
By creating a safer, shame-free environment, we address our duty to recognize, anticipate, and act on potential harm or risk and mitigate or avoid risk through system change.¹⁸

AHRQ Health Literacy Universal Precautions Toolkit – 3rd Edition

This toolkit will help you improve your organization’s health communication for everyone.

The cover of the Toolkit is illustrated below. The entire Toolkit is available at:

<https://www.ahrq.gov/health-literacy/improve/precautions/index.html>



Create a Shame-free Environment

Tools to Assess Organizational Health Literacy

The Ten Attributes² provides guidance for setting change expectations at the systems level. Systems change requires clear expectations and accountability. There are tools to assess organizational health literacy that can be used to measure improvement over time. For example, with input from a panel of patients and health literacy experts, the Agency for Healthcare Research and Quality (AHRQ) identified 22 measures to assess organizational health literacy improvement.¹⁹

Some tools rely on patient satisfaction reports, while others look at measurable objectives associated with different system areas, like the percentage of staff with formal health literacy training. Still other tools use staff assessments and observations for measurement.

Enliven Organisational Health Literacy Self-Assessment Resource

The Enliven Organisational Health Literacy Self-Assessment Resource²⁰ aims to provide health and social service organizations with a self-assessment tool that can be used to guide and inform their development as health literate organizations. Each of the Ten Attributes² is operationalized within the Resource as a set of evidence-grounded processes, outputs, or outcomes that together constitute an appropriate response to health literacy at the organizational level.

<https://www.enlivenvictoria.org/resources>

HLE2

This is the Health Literacy Environment of Hospitals and Health Centers: An Updated Assessment Tool for Identifying Facilitating Factors and Barriers to Information, Care, and Services (HLE2).²¹ There are five areas of review, each with a rating scale, including policies; practices; navigation; culture and language; and communication (print, website, and patient portal). <https://eric.ed.gov/?id=ED606503>

International Self-Assessment Tool for Organizational Health Literacy of Hospitals

The International Self-Assessment Tool for Organizational Health Literacy of Hospitals²² can be used to conduct a comprehensive assessment or an assessment of select aspects of organizational health literacy. It is designed for initiating and monitoring organizational change.

https://m-pohl.net/sites/m-pohl.net/files/inline-files/SAT-OHL-Hos-v1%200-EN-international_update1.1_1.pdf

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Pharmacy Health Literacy Assessment Tool & User's Guide

The Pharmacy Health Literacy Assessment Tool & User's Guide²³ is designed to help pharmacies assess how well they are serving patients with limited literacy. It includes an assessment tour of the pharmacy, staff survey, patient focus group guide, and a section on how to interpret the results. <https://www.ahrq.gov/health-literacy/improve/pharmacy/guide/index.html>

You can use the results from these tools to give your organization a baseline and periodic feedback on progress in advancing as a health literate organization.

Take a Look Around Your Setting

One of the most accessible approaches to organizational health literacy assessment is the navigational interview.²⁴ It helps bring fresh eyes to your setting. To do this, ask a patient or client, adult learner, or English language learner to walk through and find three specific places in your setting. Have them talk aloud about what they are seeing and experiencing. Ask them to tell you what guides them as they find their way.

This type of exercise can tell you a great deal. It can give a starting point for your work to improve your care environment. It can alert staff to problems with signs, directions, and instructions. It may bring to light communication problems that usually go unspoken, like a sign that is hard to read because of color, size, location, language, or wording.

You can also assess your printed materials, telephone systems, common office practices, and how providers and staff talk to patients. *The Health Literacy and Patient Safety: Help Patients Understand A Manual for Clinicians*⁴ offers tools like a Checklist for Patient-Friendly Office Procedures (Table 9). Getting patients' and families' input can also help you. Findings from such assessments can serve as a baseline and then be revisited periodically to follow progress in addressing problems and testing interventions.

You can also raise awareness and brainstorm responses with your staff by asking them to think about times when they or a family member:

- Were not greeted when they came to a registration desk.
- Were put on hold or got lost in an automated telephone answering system.
- Lost their way trying to find the right department.
- Wanted to ask a question but felt like they couldn't because staff were too busy.

Create a Shame-free Environment

Then, get started making improvements. Creating a patient-, family-, and client-friendly care environment doesn't take a lot of money. Take a look at the hospitality industry. Hotel and restaurant workers are trained to greet people with a smile and eye contact, to say hello, and ask if they can help. These are easy things to do. Smiles and eye contact are free, and they can change the entire atmosphere.

Guidance on How to Involve the People You Serve in a Navigational Interview as Part of Your Organizational Assessment

The Health Literacy Environment of Hospitals and Health Centers Partners for Action: Making Your Healthcare Facility Literacy-Friendly²⁴

https://publications.worlded.org/WEIInternet/inc/common/_download_pub.cfm?id=16716&lid=3

The Health Literacy Environment Activity Packet: First Impressions & Walking Interview²⁵

<https://healthliteracy.nswlhd.health.nsw.gov.au/wp-content/uploads/2023/09/activitypacket.pdf>

What Does Success Look Like?

Here is what it could look like when a health organization creates a shame-free environment that welcomes people from all cultures and backgrounds, fosters effective dialogue in all languages commonly spoken in the community, and offers navigation assistance.

In-Person Experiences

- All patients and clients are greeted with appropriate eye contact and a smile.
- Everyone knows how to access qualified health interpreters to assist with communication.
- All patients, caregivers, and clients are offered help with paperwork in a friendly way.
- Clients, patients, and family members know that questions are welcome and expected.

Create a Shame-free Environment

- People get easy-to-understand directions when they move from one department or location to another or are referred to a specialist.
- Qualified health interpreters are readily available for people who do not speak English as their primary language.

Print and Digital Information

- Information on paper and websites is easy to read, understand, and use.
- Information on paper and websites is available in languages most commonly spoken in the community.
- Websites include audio, video, and interactive learning tools.
- Signs and wayfinding tools are easy to understand and use, no matter what language people speak.
- Facilities and materials, including websites, are easy to access, navigate, and understand for those with disabilities.²⁶
- Facilities and materials, including websites, are easy to access, navigate, and understand for people who do not speak or read English.

Stakeholder Feedback

- Patients, clients, family members, staff, volunteers, and others participate in planning and evaluating interventions to improve the care environment.
- Patients, clients, family members, staff, volunteers, and others routinely provide input about print and web materials intended for the public.
- Patient and client surveys show very high scores for questions about experience and satisfaction with communication.

Training and Representation

- Written training and education policies ensure all workers recognize signs that suggest patients and clients do not understand, and know what to do to help.
- Staffing reflects the diversity of populations served.
- Pictures, artwork, and reading materials reflect the diversity and culture of communities served.

Create a Shame-free Environment

Making Your Environment Shame-Free

A shame-free care environment is welcoming. Everyone is greeted with a smile and a “hello” in their preferred language; help is offered proactively and sensitively; the availability of interpreter services is clearly noted; questions are encouraged; and signs, directions, and electronic information are easy to read and available in English and other languages spoken by people in your community. This kind of setting allows patients and clients to feel comfortable:

- Saying they don’t understand.
- Asking questions.
- Talking openly about their health and concerns.

Resources to Encourage and Support Questions

Ask Me 3®

<https://www.ihl.org/resources/tools/ask-me-3-good-questions-your-good-health>

This resource is available in seven languages through the Institute for Healthcare Improvement. It promotes the use of three questions to help encourage clear health communication. They are:

- What is my main problem?
- What do I need to do?
- Why is it important for me to do this?

Create a Shame-free Environment

Resources to Encourage and Support Questions

Questions are the Answer

<https://www.ahrq.gov/questions/index.html>

This initiative of the Agency for Healthcare Research and Quality (AHRQ) encourages and supports patients and families to be engaged in their health care with various tools.

- The 10 Questions You Should Know
<https://www.ahrq.gov/questions/10questions.html>
- Be More Engaged in Your Healthcare tips and publications
<https://www.ahrq.gov/questions/be-engaged/index.html>
- QuestionBuilder App, to help you prepare for medical visits
<https://www.ahrq.gov/questions/question-builder/index.html>
- Videos and public service announcement
<https://www.ahrq.gov/questions/videos/index.html>

Create a Welcoming Setting

AIDET (Acknowledge, Introduce, Duration, Explanation, Thank you)²⁷ is a tool intended to reduce anxiety, inform people of what is about to happen, make them feel comfortable and cared for, answer basic questions, provide people with opportunities to ask questions, and confirm understanding before tests and treatments or services are provided.

Create a Shame-free Environment

Using AIDET in a Health Literate Care Environment

Here is an example of how using AIDET²⁷ as a health literacy tool helps create a welcoming and shame-free care environment.

A – Acknowledge. Welcome the patient or client by name. This helps them feel confident that you know and care about them and understand why they are here.

I – Introduce. Introduce yourself by position or role in terms people understand. This creates confidence you are the right person for the job. Also, they will know who to follow up with, if needed. For example, “My name is Nicole. I am here to draw some blood. I’ve had 7 years of experience so this should be quick and easy.”

D – Duration. Tell the patient or client how long the interaction will take. For example, “Registration takes about 5 minutes and then I will take you to X-ray.” People want to know how long they will be here or how long it will be until they get answers. When you respect a person’s time, they become less anxious and can concentrate on what you are saying.

E – Explanation. In plain language, explain the need-to-know information about what is going to happen. For example, “I will put warm gel on your shoulder and move the ultrasound wand over the sore area in small circles. It should not hurt at all. And it will help lessen your pain and swelling. What questions do you have before we start?” Phrasing the question this way helps people know that questions are expected and welcomed. It allows for questions before things progress. Using plain language allows the person to understand what is about to happen, how it will feel, and what it is for. This is also a time to use teach-back, if needed.

T – Thank you. Thank the patient or client for allowing you to care for them. Include an open-ended question regarding follow-up or other issues. Use teach-back one last time, if needed. It is common for people to think of a question at the end, especially if they are anxious or distressed. People have choices. Let them know you appreciate their confidence and trust.

Create a Shame-free Environment

Make Sure Signs are Understandable

Make clear signs and maps available whenever people need to find their way. A health literate organization will be sure signs are in the languages of the community served. Signs may be needed in multiple languages.

Consider using wayfinding symbols that are widely understood and have been shown to be helpful in many settings.²⁸ When you have wayfinding tools, like arrows or color-coded hallways, point them out so people can recognize and use them.

Follow the Green Arrows

A client came out of a meeting with a case worker and couldn't find checkout. The receptionist noticed, showed him the way, and nicely told him this happens a lot. While the employee did make the man feel better about being lost, why wait for him to be confused? There were green arrows on the floor to help people find their way out. Pointing those out upfront could prevent the client from feeling confused and embarrassed and the reception staff from being interrupted.

Give People Help with Paperwork

Staff should offer *everyone* help with paperwork. Make it clear that it's no trouble by saying something like, "These forms are complicated. A lot of people need a little help filling them out. I'm happy to help you. We do it all the time." And be sure you have readily available forms in the languages most used by your patients or clients. You might ask all patients, "Would you like to complete the forms in English or another language? We also have these in Spanish and Portuguese." Bilingual staff can ask if people need help filling out the forms.

When you offer assistance, point to the parts of forms you are talking about and give simple explanations. For example: "This is a form that talks about the laws that keep your health information private." Be sure to:

- Always point to exactly where people should sign a form.
- Ensure forms and processes ask for the same information only once.
- Give patients the chance to fill out paperwork before they come to see you.

Create a Shame-free Environment

Example of an Unwelcoming versus Welcoming Care Environment

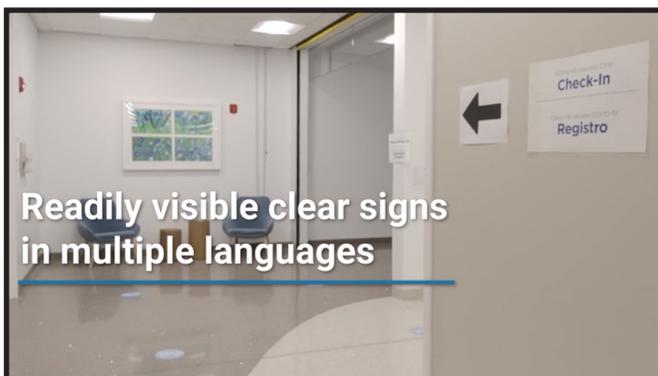
Unwelcoming Environment: A person with limited English proficiency goes to a public health department to be vaccinated. They are unsure where to go. There are unclear, hard-to-read signs and only in English. No greeting is given at registration. No interpreter services are offered. No assistance is offered after hours, and the person leaves without being vaccinated.



To watch this video, click [HERE](#) or scan the QR code below.



Welcoming Environment: A couple with limited English proficiency goes to a public health department to be vaccinated. There are readily visible easy-to-read signs and navigation guides in multiple languages. They receive a warm greeting at registration with a smile. A language identification guide is offered, and a qualified health interpreter is quickly made available at no cost. The couple is vaccinated.



To watch this video, click [HERE](#) or scan the QR code below.



Create a Shame-free Environment

Watch for Cues that Someone May Need Help

All staff should be able to spot cues that a person is struggling with reading or understanding. These may include taking a long time to fill out forms, incomplete or inaccurate answers, or asking if it's okay to take paperwork home to complete. These tell staff to:

- Offer extra help filling out forms.
- Use pictures and videos to supplement verbal instruction learning.
- Ask if they would prefer information in another language.
- Pass along the person's need for extra help to others.

Make sure staff know how to convey concerns about lack of understanding or low literacy to other members of the team. Also, investigate adult literacy, Adult Basic Education (ABE), and English Language Learner (ELL) programs in your area, so you can make referrals when appropriate.

Cues that May Indicate Limited Literacy

Health Literacy and Patient Safety: Help Patients Understand A Manual for Clinicians⁴ offers some cues that may indicate limited literacy.

Signs

- Incomplete or inaccurately completed forms.
- Frequently missed appointments.
- Not taking medicines or taking them incorrectly.
- Lack of follow-through with tests or referrals.
- Reports taking medicine but no change in condition.

Behaviors

- Becoming angry and walking out.
- Clowning around and using humor.
- Being quiet and passive.
- Having difficulty explaining health concerns.

Create a Shame-free Environment

- Detouring—letting others miss the concerns.
- Having no questions.

Responses to receiving written information

- “I forgot my glasses. I’ll read this when I get home.”
- “I forgot my glasses. Can you read this to me?”
- “Let me bring this home so I can discuss it with my children.”

Responses to questions about medicines

- Unable to name medicines.
- Unable to explain what medicines are for.
- Unable to explain how or when they take their medicines.

Give People Help with Portals and Telemedicine

Although health care portals are meant to provide people with more of their own health information and improve communication between providers and patients, they are challenging for many people. This is especially true for anyone who is not tech-savvy. Telemedicine also has pros and cons. It provides a great opportunity for those who have difficulty getting out or who need to travel long distances for health appointments. Still, its impact on people with limited communication skills must be considered, especially because there may be a lack of non-verbal communication cues. The need for additional skills to navigate a digital platform can create barriers for older adults, those with less education, those with less experience using the internet or other online environments, and those without internet access.

Create a Shame-free Environment

Suggested Practices When Using Telemedicine

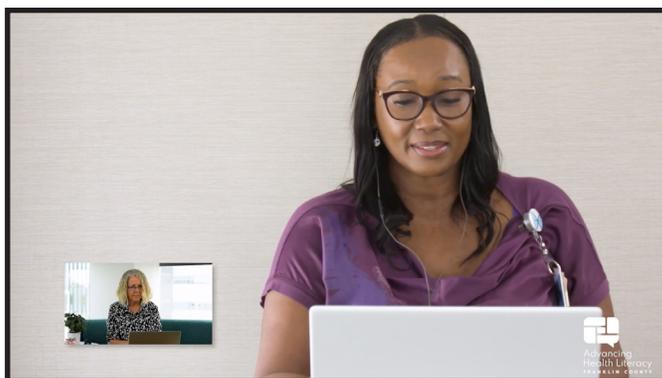
From a recent article in the *Health Literacy Research and Practice Journal*²⁹

- **Follow universal communication precautions.** These assume everyone is at risk for miscommunication. Whether communicating via telemedicine or in-person, avoid jargon and define unfamiliar terms to improve understanding for all clients.
- **Use trained interpreters.** Working with a trained interpreter reduces the risk of communication errors and omissions. Telephonic and video conferencing interpreters can establish three-way connections between the client, health professional, and interpreter to provide language access services.
- **Establish an agenda.** Setting an agenda upfront outlines what will be covered and is an opportunity to find out what is most important to discuss. It helps avoid the last-minute question “Before you hang up...” that may actually be the client’s most pressing concern.
- **Use plain language.** In oral communication, plain language means using language that is familiar to your patient or client and defining new words and concepts. What is plain language to one may not be plain language to another. Don’t make assumptions. People appreciate when you review information rather than assume they know or remember.
- **Avoid information overload.** People have a hard time remembering a lot of information and struggle to identify what is most important. Ask yourself what you would emphasize if your patient or client only remembered one to three key points. Focus on this “need-to-know” information and summarize it near the end.
- **Encourage questions.** Instead of asking, “Do you have any questions?” ask an open-ended question like “What questions do you have?” Asking open-ended questions elicits more than a yes or no answer and is best practice for encouraging questions.
- **Use teach-back.** Near the end of the telemedicine visit, use the teach-back method to ask a patient or client to explain what they understood. Checking for understanding is the best way to determine if your communication was clear.

Create a Shame-free Environment

Example of a Telemedicine Visit

Clinical social worker and grandparent telemedicine visit. This video demonstrates suggested practices for communication when using telemedicine such as using plain language, avoiding information overload, and encouraging questions. Time stamp :36 to 2:04.



To watch this video, click [HERE](#) or scan the QR code below.



Literacy, Language, and Culture

The United States population is increasingly diverse. This diversity includes great variety in culture, languages, and in people's oral and written language skills. Many U.S. adults understand, speak, read, and write English very well. Others may understand, speak, read, and write well in several languages. Still, others may understand and speak both English and another language very well but read and write only in a language other than English. There are those who cannot read or write in their own language. And some languages are oral only, having no written form.

Note these trends:

- By 2060, 57% of the people in the U.S. will belong to a racial or ethnic minority.³⁰
- Between 1980 and 2019, the number of Americans who spoke a language other than English at home grew from 23.1 million to 67.8 million (a 194% increase).³¹
- In 2019, 22% of U.S. residents spoke a language other than English at home.³¹
- Of the population that spoke a language other than English, 48% reported their English-speaking ability as being less than “very well.”³¹

Create a Shame-free Environment

The risk for lower health literacy skill levels tends to be higher among people who are aged 65 years and older, have less education, are poor, belong to minority groups, or have limited English.³² Literacy, language, and culture add communication barriers that may stand in the way of providing equitable health information and care.³³ When cultural differences and language barriers are not addressed, the results can be the inability to communicate, misunderstandings, harm, or poor outcomes.³⁴

The intersection between culture, language, and health literacy and its impact on the content and outcome of health communication are recognized by the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in health and health care.³⁵

Provide Language Access Services

Developed by the Office of Minority Health in the U.S. Department of Health and Human Services, the Culturally and Linguistically Appropriate Services (CLAS) Standards³⁵ offer a framework for services and organizational structure to provide equitable care. Derived from an analysis of practices and policies on cultural competence, the original 14 national standards issued in 2001 can be grouped into three areas: 1) leadership and workforce development, 2) communication and language assistance (primarily through interpreting and translation), and 3) community engagement and accountability. Enhanced in 2013, the CLAS Standards now include a principal standard that explicitly recognizes the need to address health literacy, language, culture, and other communication needs to eliminate health disparities.

Culturally and Linguistically Appropriate Services (CLAS) Standards

Principal Standard (Standard 1): Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse **cultural** health beliefs and practices, preferred **languages, health literacy**, and other communication needs.³⁵

Create a Shame-free Environment

CLAS applies to any health organization receiving federal funding and is a mandate under Title VI of the Civil Rights Act, which prohibits discrimination on the basis of race or ethnicity, and requires language access services (interpreting and translation) to ensure meaningful access to health information for everyone.³⁶

Following in the footsteps of the CLAS Standards, the Ten Attributes of Health Literate Health Care Organizations² also calls for an organizational approach to addressing barriers to health information and services. Like the CLAS Standards, the Ten Attributes call for leadership and workforce training, effective written and oral communication, and engaging communities by involving populations served. Both the CLAS Standards and the Ten Attributes focus on the need for health organizations and systems to reduce literacy, language, and other communication barriers to eliminate health disparities and achieve health equity.

Providing Culturally and Linguistically Responsive Care

To provide culturally and linguistically responsive services, an organization must have the policies, resources, and commitment to meeting the needs of diverse patient populations. For example:

- Have trained bilingual and bicultural staff and health interpreters available.
- Train service providers to communicate effectively in ways that can be easily understood by different audiences.
- Provide equitable access to information services for all groups.
- Be respectful of traditional beliefs and practices and integrate them where possible.
- Create an environment where people feel comfortable talking about their beliefs and practices and how they relate to treatment or services.
- Promote cultural humility and the recognition of cultural values and structural forces that shape people's experiences (including health care experiences) and opportunities.
- Provide print and electronic information and materials in languages other than English.
- Weave knowledge of a patient's culture and community into policy and practice.
- Involve the community in developing and evaluating the quality of services.

Create a Shame-free Environment

Make Your Environment Accessible, Usable, and Inclusive to All

Meeting the needs of people with all kinds of differences is part of providing optimal care and services. Your physical space must be accessible to people who use a wheelchair and other mobility devices. It must also be accessible and inclusive to people who are deaf or hard of hearing, blind or have low vision, and those with intellectual and developmental disabilities.

A health literate organization's services, information, and communication must meet the needs of all the individuals it strives to serve. Technology and the internet offer many ways to use audio, video, and interactive content to make health information and services easier for all to understand and use. To learn more about how to meet the needs of all people, review the following accessible, usable, and inclusive design resources and strategies.

Resources for Accessible, Usable, and Inclusive Design

- <https://www.ada.gov/>: Start here to learn about the Americans with Disabilities Act (ADA) law, regulations, and design standards.
 - Communicating Effectively with People with Disabilities: <https://www.ada.gov/topics/effective-communication/>
 - Access to Medical Care for Individuals with Mobility Disabilities: <https://www.ada.gov/resources/medical-care-mobility/>
 - Telehealth: <https://www.ada.gov/topics/telehealth/>
- <https://www.annasarol.com/>: Anna is a disabilities advocate and blogger normalizing the conversation about accessibility and youth leadership.
- <https://digital.gov/topics/usability/>: Focus on the user experience (UX) to improve access, efficiency, and ease of use.

Create a Shame-free Environment

What To Do When You See a Problem

Any member of the health team who sees signs that someone may be struggling with reading or understanding should pass their concerns along. A standardized patient safety communication tool—SBAR (Situation, Background, Assessment, Recommendation)³⁷— can be useful for front office and other non-clinical staff to pass communication concerns to those who can look into it further and take steps to ensure understanding and offer help.

SBAR Example - Front Office Staff to Medical Assistant

Situation: Mrs. Reston seems to have something bothering her.

Background: She is here for a diabetes check, and when I gave her the paperwork to update her forms, I noticed she kept it a lot longer than most people. When she gave it back to me, it was only half filled-out.

Assessment: I think she may have trouble reading or, at least, she is not able to see the forms very well.

Recommendation: Can you be sure everyone goes over all her health concerns and medicines very clearly, and makes sure she really understands when to come back? Maybe someone should ask if she wants to bring somebody with her to her appointments.

Talk with people about their reading when the time is right. Understanding is vital to caring for one's health, and literacy is key to understanding. It's important to raise the question of reading comfort in a non-threatening way, and to explore it in the context of a trusting patient-provider relationship. Providers can use the social history to open the door to talk about literacy issues by asking questions like:

- How comfortable are you with reading?
- How confident are you filling out medical forms by yourself?³⁸
- Have you ever had trouble reading the materials you get from your health care provider?
- Would you be interested in a program to help you read better?³⁹

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The DIRECT Approach

If you choose to ask patients about their reading comfort, this DIRECT Approach³⁹ can be used to find out if patients have problems with reading and then refer them for help.

- D** – Ask about **difficulty reading**: “Have you ever had a problem with reading?”
- I** – Ask if they have an **interest in improving**: “Would you be interested in a program to help you improve your reading?”
- R** – Have **referral information** for adult and family literacy programs ready to give to patients identified with reading difficulty.
- E** – Ask **everyone** about their literacy skills. Let patients know it is your policy to ask everyone.
- C** – Emphasize that low literacy is a **common problem** and they are not alone: “Half of Americans have some difficulty with reading!”
- T** – **Take down barriers** to joining literacy classes (e.g., help with the initial phone call, make follow-up contact to see if they find the right class, etc.).

Know Your Community’s Adult Basic Education Resources

Search National Literacy Directory (NLD) <https://www.nld.org/> to find out about adult literacy and English language learner programs in your area. They provide information about what programs are available, contact information, hours, and directions. When you make a referral to an adult literacy or English language program, do it in the context of a caring relationship and do it with sensitivity.

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Preventing Low Literacy through Reach Out and Read

Programs like *Reach Out and Read* (<http://www.reachoutandread.org>) can be used to incorporate literacy promotion into pediatric well child care.

This national research-based intervention partners with trained providers to prescribe reading and foster a multi-generational nurturing and language-rich home environment. Caregivers learn how to support their children’s literacy development by receiving books and increasing shared reading time. Developing early literacy skills through *Reach Out and Read* encourages early relationship-building and healthy brain development, preparing children for lifelong learning.

At every well-child visit from 6 months through 5 years, providers:

- Share expected growth and development related to language.
- Advise parents or caregivers about reading aloud to their children.
- Give a new book tailored to the child’s age, development, and family’s preferred language.

The Joint Commission report “What Did the Doctor Say?” Improving Health Literacy to Protect Patient Safety,⁴⁰ describes *Reach Out and Read* as a precedent for addressing literacy in health care. Prescribing books can help prevent and address low literacy and low health literacy among children and their adult caregivers. Providers can use *Reach Out and Read* to explore parents’ reading comfort and respond to needs appropriately (e.g., access to language services, improved communication, referral to adult reading programs). *Reach Out and Read* can be an access point for culturally, linguistically, and economically diverse patient populations.

Use Survey Data to Help You Improve

Health systems use various tools to assess how well they provide services. These include satisfaction and Consumer Assessment of Healthcare Providers and Systems surveys (CAHPS),⁴¹ Hospital Consumer Assessment of Healthcare Providers and Systems surveys (HCAHPS),⁴² and the CAHPS Item Set for Addressing Health Literacy Supplement⁴³ to track care experiences. The CAHPS surveys include questions about communication with nurses and doctors, new

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medications, and discharge processes. Since reimbursement is influenced by HCAHPS scores, this is an ideal way to link staff use of health literacy skills and patient involvement with efforts to address equity, improve quality, and promote a business case. You can use the results of these surveys to establish baselines and set improvement goals. Start by targeting low-performing items with interventions to raise those scores and review progress frequently.

Sample HCAHPS Domains and Items Related to Health Literacy

Consider using HCAHPS⁴² health literacy-related domains and items to guide your improvement work.

Communication with Doctors

- How often did doctors use medical words you did not understand?
- How often did doctors talk too fast when talking with you?
- How often did doctors answer all your questions to your satisfaction?

Communication with Nurses

- How often did nurses use medical words you did not understand?
- How often did nurses talk too fast when talking with you?
- How often did nurses answer all your questions to your satisfaction?

Communication about Medicines

- Did hospital staff ask you to describe how you were going to take your medications when you were at home?
- Did hospital staff tell you who to call if you had questions about your medications?

Filling Out Forms

- How often did hospital staff offer you help to fill out forms?
- How often were the forms easy to fill out?
- How often were the forms you had to fill out or sign available in your language?

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Sample Health Literacy, Language, and Culture Survey Items Related to the Care Environment

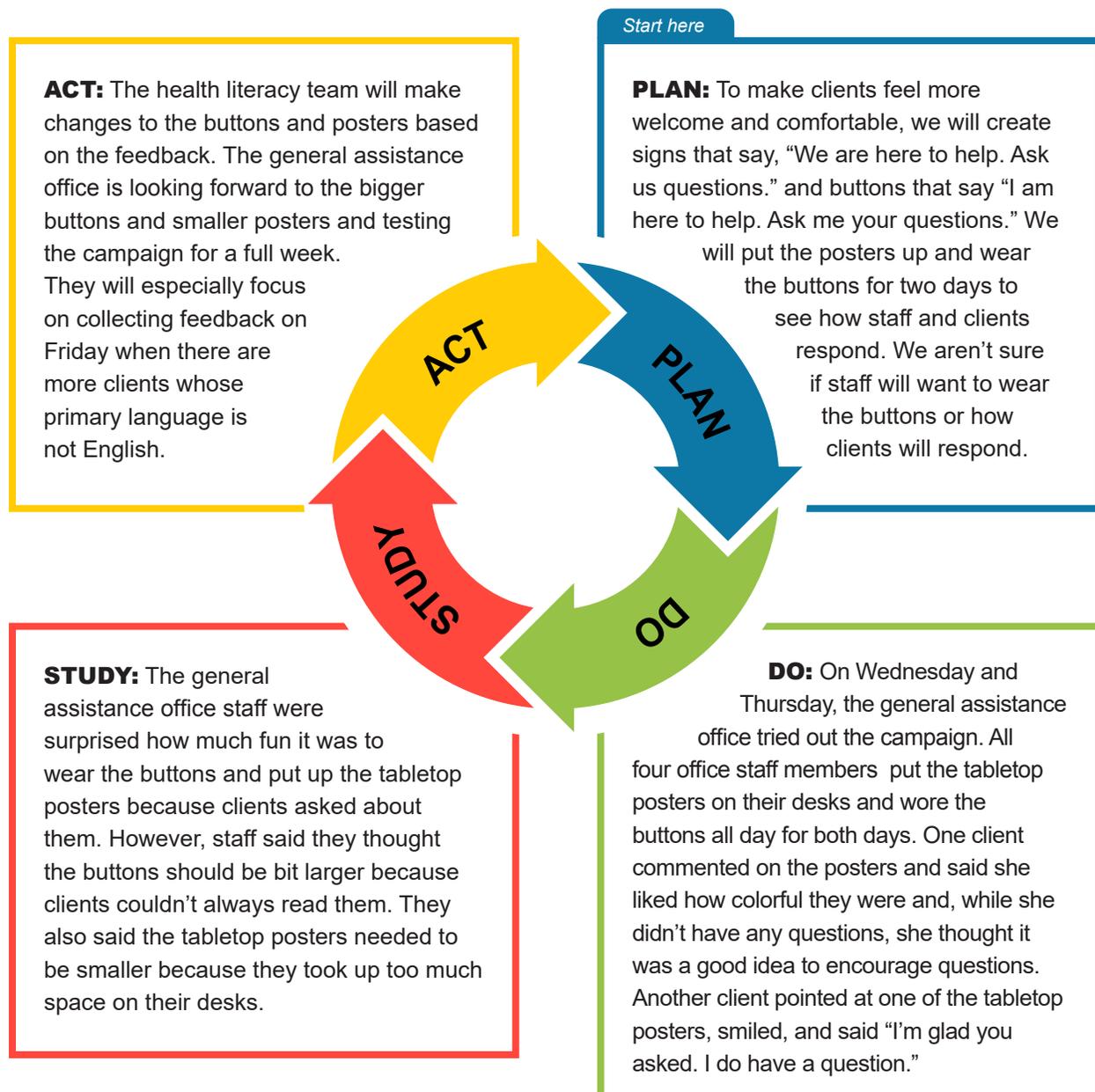
Consider using HLE2²¹ items to guide your improvement work.

- Are language services available or can they be called upon with short notice?
- Are forms offered in languages other than English?
- Do training sessions for staff include information about the patient population (culture, language, literacy, and other demographics)?
- Does orientation for staff include information on how to access, use, and document interpretation services?
- Does the organization offer staff opportunities for Adult Basic Education (ABE) or English Language Learner (ELL) classes to build literacy skills?

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PDSA Cycle: Creating a Shame-free Environment

After gathering feedback from clients, the health literacy team at Empowerment Health Social Services (EHSS) decided to initiate a campaign to make clients feel more welcome and comfortable asking questions. The campaign included posters and buttons. They did a series of PDSAs with two departments to try out their idea before encouraging the whole organization to join. The general assistance office carried out the first PDSA and shared their experience.



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Summary of Key Points

- Even people with strong literacy skills can have trouble understanding and remembering.
- Approach all patient, family, client, and community communications using health literacy universal precautions.
- Shame and stigma can be barriers to addressing health literacy. Any health literacy screening should be planned and carried out thoughtfully.
- People who have trouble understanding health information often hide the problem. So, it's important to use clear communication principles and check for understanding with everyone, using the universal precautions approach.
- The language and culture of public health and health care are not familiar to most people and contribute to communication problems.
- A shame-free care environment allows patients, families, and clients to feel comfortable saying they don't understand, asking questions, and talking about their health.
- Be sure your organization, materials, and websites are accessible to all by being proactive and responsive to cultural health beliefs, preferred languages, health literacy, and other communication needs.
- Use guidelines and tools to make sure your facilities and materials are accessible for those with communication needs beyond literacy and language, like hearing, vision, or mobility limitations.
- Health organizations can learn from businesses like hotels and restaurants that work hard to make people feel welcome.
- Learn about resources in your community that offer help with literacy, as well as English language learning programs.
- Use tools to help people find their way around your care setting, feel comfortable asking questions, and get the information they need.
- Create a welcoming environment through staffing, artwork, and reading materials that reflect the diversity and culture of the community served.
- Use results from organizational health literacy assessments and satisfaction and experience surveys to identify opportunities for improvement, set goals, and monitor progress.

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Involve Populations Served

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“It is neither just, nor fair, to expect a patient to make appropriate health decisions and safely manage his or her care without first understanding the information needed to do so.”

— Health Literacy and Patient Safety: Help Patients Understand, 2007¹

Involving members of the community you serve in planning and evaluating your programs and services is an important way to “meet the needs of populations with a range of health literacy skills.² Not only can it help make your health communications and materials more relevant and clear, it will improve and enrich your work and your organization’s effectiveness. It may seem challenging at first, but learning to do this well, and making it part of your standard way of operating, is integral to providing patient- and client-centered care and services.

The ideas and tools in this chapter are designed to help you:

- Understand the importance of patient, family, client, and community member involvement, and benefit from the feedback you get.
- Recognize the significant contribution that partnering with adult basic education and English language programs in your community can make.
- Find ways to involve the people you serve and other community-based organizations in your health literacy work.

In a Health Literate Organization, Populations Served Inform How Health Information and Services are Provided

This chapter directly addresses Attributes 4 and 5 of the Ten Attributes of Health Literate Health Care Organizations,² and will help you achieve a health literate organization that includes populations served in program design, implementation, and evaluation to best meet the needs of people with a wide range of skills.

Involve Populations Served

Why Involve Populations Your Organization Serves?

Patients, family members, and clients are the experts in what they need to know to care for their own health. They can tell you what they do and don't understand. They also can tell you what helps or hinders them in understanding and remembering health information. Involving the community you serve in the process of designing and evaluating information and services will help you recognize and address health disparities and inequities. If you are not communicating in ways people can understand, you are not providing equal access to quality information and services.

Patient Involvement Is Basic to Patient-Centered Care

Involving patients and their families is basic to patient-centered care, one of the six elements of quality health care for all. The core concepts of patient- and family-centered care are:

- **Dignity and Respect.** Health care providers listen to and honor patient and family ideas and choices. Patient and family knowledge, values, beliefs, and cultural backgrounds are included in the planning of care.
- **Sharing Information.** Health care providers communicate and share information that is complete, accurate, and timely, so patients and families can effectively participate in care and decision-making.
- **Participation.** Patients and families are encouraged and supported in participating in care and decision-making at the level they choose.
- **Collaboration.** Health care leaders collaborate with patients and families in policy and program development, implementation, and evaluation; in facilities design; in professional education; and the delivery of care.³

Health literacy is central to carrying out the components of patient-centered care, and more health organizations are realizing this. It is also central to offering relevant and acceptable services your community wants, understand, and uses. Patients and families can participate in Patient and Family Advisory Councils. Community members can have formal roles on advisory councils and committees. They can also be partners in specific health literacy-related efforts within your organization.

Involve Populations Served

These partnerships can include several types of activities and apply to all kinds of health-related organizations, including:

- Informal review of written materials and your organization’s website.
- Navigational interviews.⁴
- Serving on health literacy teams and committees.
- Acting as faculty and spokespersons about health literacy.
- Contributing to design and evaluation of efforts to improve quality and health outcomes.

Adult Learners Offer Important Insights

“Doctors who can read and write well assume other people are at the same level.”

— New Reader of Iowa

One aspect of community involvement is partnering with adult learners—those who struggle with reading and are learning to read as adults, those who are learning new job skills, and learners who are new to the country and learning English. Including adult learners’ voices puts a face on data. For staff, it transforms working on health literacy “from a project to a passion” (Vonda W, personal communication, 2005). It shows health professionals and staff that people they see, interact with, and care for every day may have hidden literacy problems. Furthermore, the embarrassment, coping strategies, and consequences associated with low literacy and low health literacy become real when expressed by those seeking care or services. This kind of testimonial can engage leadership, promote staff buy-in, lead to provider *a-ha* moments, and generate solutions to communication problems.

Who are Adult Learners?

In this Guidebook, we use the term adult learner for someone who is taking action to improve their literacy, math, or English language skills. Some work with tutors in an adult literacy program. Others enroll in adult basic education (ABE) or English language learner (ELL) classes. Adult learners bring an important perspective, so be sure to involve them in your health literacy discussions.

Involve Populations Served

New Readers

A term often used in the literacy community is new readers. This refers specifically to adults who are learning to read. In the early 1990s, two national adult literacy organizations sponsored a gathering in Washington, DC. Adult literacy and English language learners from every state gathered to learn about government, visit their legislators, and request continued funding for adult education. It was the first of its kind. The group found it an ideal forum in which to tell literacy providers and others how they felt. They created a formal statement asking literacy practitioners to refer to them as new readers instead of illiterates, a demeaning term.

What Does Success Look Like?

Here is what it could look like when patients, families, clients, and adult learners are fully involved in health literacy efforts:

- Health literacy is a key operating principle for Patient and Family Advisory Councils and is also reflected in community engagement work.
- Patients, families, clients, and adult learners serve on advisory committees, quality improvement teams, and other key teams, such as safety or community-based chronic disease management.
- People with limited literacy or limited English proficiency are well-prepared and supported to participate as advisors and in team meetings.
- When members of the organization discuss health communication issues, they include stories and recommendations from the community they serve.
- Patients, families, clients, and adult learners participate in or contribute to educational presentations related to health literacy by sharing their stories.
- The organization conducts periodic navigational audits with patient, family, client, and adult learner participation to improve navigation and wayfinding.
- Patients, families, clients, and adult learners are called on as resources in development and revision of written materials and communication processes.

Involve Populations Served

- All health professionals and staff know how to appropriately address or pass along concerns about patients' or clients' reading ability and comfort when it affects delivery of care or services.
- Staff know how to make referrals to adult literacy, adult basic education (ABE), and English language learner (ELL) programs in their area.
- There is two-way, mutually beneficial communication between adult literacy programs in the community and your organization.
- Adult learners' stories and experiences serve as a bellwether for recognizing and addressing the importance of employee literacy and English language skills in the workplace.
- Consumer Assessment of Healthcare Providers and Systems (CAHPS),⁵ Hospital CAHPS (HCAHPS),⁶ and patient and client satisfaction data are monitored regularly and serve as guides to improve health communication.
- Clients, patients, and family members managing health conditions that impact communities at risk for disparities serve as members of advisory teams to develop and evaluate educational programs and other interventions.
- Members of communities experiencing health disparities partner with health researchers to inform what gets studied, research approaches, and how to communicate with participants, e.g., Patient-Centered Outcomes Research Institute (PCORI).⁷⁻⁹

Involve Populations Served

How Do You Involve Patients, Families, and Clients?

Begin by seeking communication-related stories in your setting. Once attuned to health literacy issues, most staff can identify examples from their own experience. Look for stories where communication problems resulted, or could have resulted, in a quality or safety problem or contributed to health disparities, for example, inaccessible public health education programs for conditions like sickle cell disease that largely affect populations at risk for health disparities.⁹ Identifying and sharing such stories raises awareness and builds will to take action. It also starts the process of finding patients, families, and clients who may be willing to take a more formal role in this work.

About Culture and Trust

“...if providers do not understand patients’ culture, patients may have a hard time trusting the diagnosis and following through on the instructions given to them.”

— Somali Doctor, personal communication, 2021

Find People Willing to Help

Institute for Patient- and Family-Centered Care (IPFCC)¹⁰ resources can be useful as you seek members for your team. The IPFCC recommends asking staff and doctors to identify people they believe would function well on a team such as a Patient and Family Advisory Council. It also recommends reviewing surveys and other sources of feedback to identify those who have offered constructive input. Your staff may have talked with a patient, family member, or client who shared a personal story and expressed willingness to take that to the next level. Keep in mind that clients and patients who are already active in your system may not provide the feedback you need to reach people with low literacy skills or who don’t speak English as their first language. You may need to partner with community organizations and provide additional support to engage those with less access to health information and services. Remember to respect confidentiality and legal requirements for protected health information.

Involve Populations Served

The Patient and Family Advisory Council

Patient and Family Advisory Councils work with members of the hospital staff to provide valuable feedback and personal insights on the patient care experience. Members of a Patient and Family Advisory Council can:

- Provide input, feedback, and approval on projects and initiatives presented at regular meetings.
- Participate as full members on institutional committees and projects, consistently infusing the patient/family perspective into discussions and decision-making.
- Participate with staff on executive search and interview committees.
- Help create and edit patient and family education and communication materials and processes.
- Help design and plan patient care areas and new programs.
- Generate new program ideas to benefit patients, family members, and caregivers.

Ask Patients, Family Members, and Clients What They Think

An easy way to begin is by asking a patient, family member, or client for feedback on written materials you are creating or revising. But remember, people who don't read well may not immediately accept an invitation to look at written materials. Be sure to say that you are working to make these easy to read and ask for their impressions and suggestions. Tell them what you are working on and your purpose. For example, your purpose may be:

- Making forms easier for people to fill out.
- Making health education handouts simpler.
- Making consent forms and processes better.
- Getting better at providing guidelines for care.
- Finding better ways to share information.

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Ask a few specific questions to let them know what you are looking for, and get comfortable providing feedback and suggestions. This also shows them you really want their input. Try several of these questions:

- Does this look like something you want to read?
- Is this easy to read?
- What parts are hard to understand?
- How would you make this better?
- What words are hard to understand?
- What is a better way to say this?
- Is there a better way to share this information with you?

In addition to giving you useful feedback on your materials, this helps staff:

- Get comfortable seeking people's input.
- Recognize the value of the input.
- See how easy it can be to get the input.

Invite Patients, Family Members, or Clients to Join Your Team

Now you're ready for the next step. Let's say you have identified a few patients, family members, or clients to approach, either from contact suggestions or outreach efforts. Tell them you are working on improving services by improving communication. Invite them to help you do that by expressing their unique point of view as a patient, family member, or client. Tell them you have a team working on this that meets regularly. Ask if they would be willing to come to the meetings—in-person or virtually—to get to know the team, and to help find ways to work together to improve communication.

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Creating a Volunteer Health Literacy Work Group

At one hospital, a 5-member team—the Volunteer Health Literacy Work Group—met with the head of their HL Team every month for two hours to review patient education materials and teaching brochures.

To establish this committee, the Volunteer Coordinator suggested candidates who might be interested in participating in a workgroup. She selected them from current volunteers who helped elsewhere in the hospital. An initial meeting was used to introduce the potential team members to health literacy using training and education presentations. The group then discussed the goals of this committee, when they would meet, and desired outcomes. Of the initial volunteers, five chose to participate.

The committee looked at materials that were currently in use or being revised or developed by hospital staff and could benefit from review by end-users. The group used plain language guidelines and the Checklist for Reader-Friendly Print Materials to make recommendations. They provided feedback to the Health Literacy Leader, who jotted down their suggestions and sent this back to the materials developer. After being reworked by the developer, materials were returned to the group for another look. It was important and motivating for them to see the results of their efforts in the final product.

This approach was very successful. Patient and staff feedback of revised materials was positive. In addition, the hospital believed the process of end-user review of written materials, at least in part, played a role in improving patient satisfaction scores related to patient understanding.

Involve Adult Learners

Adults with low literacy skills are not likely to volunteer their opinions on written materials. So, as you collect feedback, keep in mind that you are probably hearing from more literate members of your patient or client community. You may want to make a special effort to get feedback from less-skilled readers at some point.

Involve Populations Served

How to Recruit Adult Learners

Involving adults with low literacy skills or those who are learning English-as-another language is one of the best ways to learn how to meet their needs. Including them as team members helps make the team even more attuned to literacy and navigation issues. But it can be hard to find and recruit adults with low English literacy skills for two reasons:

- Low literacy carries with it a great deal of shame and stigma.¹¹
- People need English language and literacy skills to take part in team activities.

If you haven't been able to recruit team members with this background from your patient or client community, try searching out adult learners in your community.

The best place to find adult learners is in adult basic education or English language programs. These programs may be linked to your local community college or public school system. Or there may be a community-based organization that serves new immigrants. In some areas, social service groups and nonprofit organizations offer adult basic education in their programs.

Find an Adult Literacy Program

Health is a topic of interest to adult learners, and adult basic education and English language teachers often incorporate health into their lessons. These programs and teachers will be most receptive to collaborating and advancing your health literacy goals.

Health literacy is immediately applicable to most adult learners whether they are concerned about their children's, their older parents', or their own health. English language learners especially may be unfamiliar with the U.S. health system, and they may not have the skills to communicate effectively with their health care providers.

New immigrants and refugees, in particular, may be unfamiliar with the U.S. health care system and less willing and comfortable seeking health care for a variety of reasons—including misinformation, distrust, previous experiences, and other factors. Literacy, language, and culture are intersectional barriers, meaning it's not enough to simply translate information from English into another language. Recognize that some languages are primarily spoken, not written, and that many health words in English cannot be directly translated into other languages. You must also pay attention to people's literacy in their first language, and to cultural references, to achieve equitable access to information and services.

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You can find local adult literacy programs through these websites:

- National Literacy Directory (NLD): <https://www.nld.org/>
- ProLiteracy Find an Adult Literacy Program:
<https://www.nld.org/volunteers/find-a-volunteer-opportunity>

Or try reaching out to your local refugee resettlement programs that provide legal assistance, language services, case management, and English language classes.

Health Literacy and Language

“I learned that Afghani women do not have a word for prenatal care.”

— Obstetrician, personal communication, 2022

When you have a list of local programs, find out which are teaching health or offer health literacy lessons. These programs may be especially open to working with you.

For example, the Teaching the Skills That Matter (TSTM)¹² in Adult Education project trains and provides resources to adult education teachers across the United States to integrate the nine skills that matter, including adaptability and willingness to learn, communication, critical thinking, interpersonal skills, navigating systems, problem-solving, processing and analyzing information, respecting difference and diversity, and self-awareness. There are three approaches that work (integrated and contextualized learning, problem-based learning, and project-based learning) in five topics, including civics education, digital literacy, financial literacy, workforce preparation, and of course, health literacy.

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Offer Adult Literacy Programs Something in Return

It's important to understand a few basics about these programs and their learners before making contact. Funding for adult literacy, adult basic education, and English language programs is limited. Programs are often understaffed, and, in some places, volunteers are the primary tutoring and teaching workforce. They have few resources and many demands. Working with local health organizations is usually not part of their mission. This may be true even if they see the connection and want to partner with you. It's best to find creative ways of helping them as they help you. Your organization might consider providing a financial donation, new books for their classroom or library, or organizing a health fair and offering free screenings.

Working With Adult Literacy Programs

Communication between adult literacy programs and health organizations fosters collaborative health literacy work, such as:

- Health professionals making presentations or offering question-and-answer sessions on health-related topics.
- Health representatives volunteering in adult literacy programs as tutors or board members.
- Adult learners taking part in the organization's health literacy improvement efforts.

Adult Learners May Need Mentoring

Learners in adult literacy, adult basic education, and English language programs face many challenges, but they have conquered the first one—coming forward, admitting they need help, and enrolling in a program. Overcoming the shame associated with not reading well can be a huge stumbling block. And because of literacy or language barriers, some adult learners may have low-paying jobs, work two jobs, struggle to make ends meet, and have transportation problems. The complex interaction of such social determinants of health with health literacy can contribute to health disparities.¹³

Just getting to classes and doing homework are big achievements. Adult learners' lives may leave little time for gaining experience as speakers or committee members. They may be intimidated by the thought of being on a team with educated, highly literate people. Given these facts, you

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can't simply call an adult literacy program, tell them what you're looking for, and expect several adult learners to attend your next meeting.

A few local or state literacy organizations across the country have leadership training programs for learners who want to help adult literacy programs by:

- Speaking in the community to raise awareness and recruit new learners.
- Serving on the board or committees.
- Serving as staff in the program.

It's important to know if the adult learner program in your area has done any formal leadership training. If not, you may need to work with the program to find and prepare learners for the roles you wish them to fill. If you're lucky, the coordinator may know of two or three adult learners they think may be willing to take part and offer to check with those people.

Generally, you should expect to spend time orienting, training, and supporting the adult learners you recruit. Remember that standard meeting items like agendas, slides, and minutes often require high-level literacy and language skills. Remember, too, that email or printed materials may be less helpful. Be sure to contact adult learners by phone or text, based on their preference, to confirm dates, times, and locations.

Valuing Community Involvement

The following suggestions will help ensure that people from the community feel welcome and are active members of your teams:

- Always include at least two patients, family members, clients, or adult learners on the team, so they feel comfortable.
- Assign someone to meet, greet, and mentor them in initial and subsequent meetings, especially if English is not their first language.
- Provide clear directions for getting to the building and the meeting room. Meet, escort, and orient them. Provide parking vouchers.
- If the meeting is virtual, contact them beforehand to be sure they know how to join the meeting and participate.
- Provide appropriate language access support, as needed.

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- Consider some form of compensation for participation. For example, you might reimburse mileage, pay a stipend, or offer other compensation, depending on how much time is involved. You can also work with your volunteer department so they can go through the usual process for helping in your organization. This accrues volunteer hours for their time.
- Respect their time and constraints.

In meetings and presentations, involve patients, family members, clients, and adult learners from the community you serve from the beginning. Don't be afraid to respectfully turn to them for input and comments during the meeting, being careful not to put them on the spot. This can be helpful when you reach a stumbling block about wording or how to resolve a communication or navigation challenge. They have a fresh, external, non-clinical perspective that health professionals can't provide regardless of good intentions. By making sure they are involved in discussions, you can help prevent and offset objections like "This isn't possible." or "It won't work." or "There isn't enough time to do this."

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Case Study: UnityPoint Health and New Readers of Iowa

Here's an example of adult learners and health care providers coming together to improve health literacy.

An important and valuable partnership developed between the New Readers of Iowa and UnityPoint Health Literacy Teams. Outcomes of note include a series of three Iowa New Readers Conferences that were all devoted to health literacy. These conferences supported the health literacy efforts of the more than 100 adult learners and health professionals present. Events included:

- A panel of health care professionals (doctor, nurse, pharmacist, respiratory therapist, medical technologist, and radiology technologist) gave tips to New Readers members about how to talk with health care providers. They also responded to members' questions and concerns.
- Small groups of adult learners critiqued UnityPoint Health written materials and gave valuable feedback about wording and layout.
- Adult learners developed several health literacy statements in guided workshops.
- State, national, and international leaders in health literacy presented on different areas of literacy and health. Speakers came from the American Medical Association, Harvard School of Public Health, and the United Kingdom.
- Pharmacists conducted one-on-one medication reviews with adult learners.
- Adult learners took part in a panel discussion about their experiences asking questions in the health setting.
- Health screenings were provided for New Readers members.
- New Readers members participated in a hospital navigational interview to help improve wayfinding.

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Case Study: UnityPoint Health and New Readers of Iowa (continued)

These conferences got national attention. They were groundbreaking platforms where health professionals and adult learners came together on equal footing to address health literacy. This partnership resulted in several members of the New Readers playing roles at the regional and national levels:

- Adult learners participated in workgroups and on committees of other health professional organizations, including the American Medical Association and American Academy of Pediatrics.
- New Readers members presented and co-presented with health professionals to discuss and provide training about health literacy and patient safety at local, regional, and national conferences.

UnityPoint Health also supported the New Readers in a leadership development grant to build leadership capacity among adult learners. New Readers members learned about mentoring other adult learners through educating, empowering, communicating, and advocating. They also built their skills in raising awareness of and educating health professionals about health literacy. They learned how to use various individual and group venues for this purpose, like patient encounters, professional health conferences and meetings, and media coverage. A New Readers of Iowa member served as co-chair for the UnityPoint Health Patient Safety Implementation Team, which led patient safety improvement work across the system.¹⁴

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Adult Learners Reviewing Written Materials

Here is how one adult learner helped improve written materials at a hospital. The adult learner read through print materials the Health Literacy Team wanted to simplify, marked out all unfamiliar words, and returned it to them to review; much of the meaningful content was missing. This technique provided insight into how challenging it is to read information when you don't understand significant parts of it. It gave guidance for changing words that are hard to read or understand because they are too complex, technical terms, or jargon. The Health Literacy Team then made revisions to the document to improve readability.

Let People Choose How They Will Help

Bear in mind that patients, family members, clients, and adult learners may take on specific roles or choose those they can do on an as-needed basis. They may prefer to review written materials when needed. They may choose to take part in periodic health literacy walkthroughs of your setting. This is when you ask a layperson to find a location or go through a process in your setting without help and have them describe how they are making decisions and what they are thinking as they go.⁴ It raises staff awareness and helps identify areas for improvement. Depending on their comfort level, patients, family members, clients, and adult learners may be willing to share their own experiences—in person or in videos. With guidance and support, virtual communication options provide more ways people can be involved and more flexibility.

You can offer a menu of ways they can help, such as:

- Sharing their stories and perspectives about health concerns.
- Brainstorming with the team to identify areas to work on.
- Giving feedback on ideas and care experiences.
- Providing input on improving communication processes.
- Reviewing written materials.
- Taking part in navigational interviews and other wayfinding activities.⁴
- Sharing in presentations to represent and convey patients' perspectives.

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Depending on their comfort level, these roles can expand or shift over time. It may be particularly helpful to assign a small concrete task early on, to build confidence and rapport. For example, you could ask for input on a short document or a sign, or ideas to make waiting more pleasant.

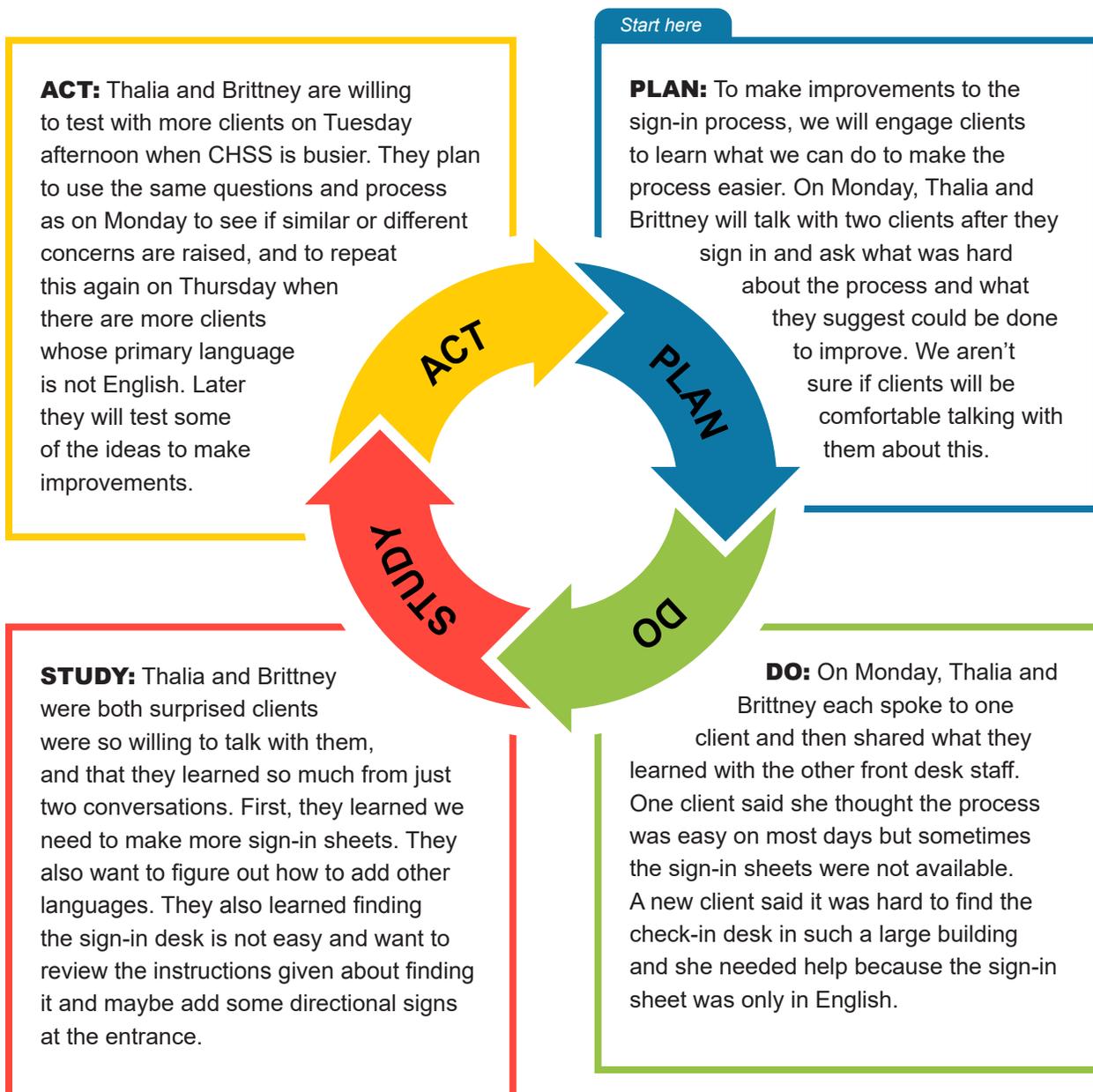
Next Steps

As you and your organization become more familiar and comfortable with patient, family, adult learner, and community member involvement in your health literacy work, spread it to other areas. Explore opportunities to include people from the community on other teams where clear communication is critical, like working to increase the use of preventive services or reduce the number of missed appointments or unplanned readmissions. As your colleagues see the benefits of this approach, they may seek out and request such input proactively. Use patient and client experience and survey data to guide your progress. Use small tests of change to get all staff involved.

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PDSA Cycle: Involving Populations Served

A health literacy team at Community Health Social Services (CHSS) chose to focus on fostering a welcoming environment and partnering with those who use their services. As a starting point, they designed a series of PDSAs to gather input to help improve the sign-in process. The front desk staff planned, carried out, and led a discussion of this initial PDSA.



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Summary of Key Points

- Involving populations served in health literacy improvement work is central to addressing health disparities and working toward health equity.
- To get patient, family, client, and community members' points of view and benefit from their feedback, talk to the people from the community you serve and involve them in your health literacy work.
- Patients, family members, and clients can play various roles on your team.
- To get started finding community-based people for your team, ask colleagues to share stories of problems they have had with communication challenges. Ask if they know of patients, families, or clients who might be willing to share their stories and opinions.
- Many people willing to review documents, practices, and procedures have high literacy. That is, they represent the more educated members of your community. Their input is valuable because it's patient- and client-focused.
- You will also want to gain insights into the experience of people with less formal education or English language proficiency. For this, you may need to seek out adult basic education and English language learners in the community.
- To recruit adult literacy, adult basic education, and English language learners to your team, contact local adult education programs or literacy groups. Adult learner volunteers will need varying amounts of mentoring to fulfill advisory roles. Those who have gone through leadership training in their adult basic education or English language programs can be especially helpful.
- Barriers related to literacy, language, and culture mean you must pay attention to literacy levels in other languages and cultural contexts to achieve equitable access to information and services. It's not enough to simply translate information from English into another language.
- All team members need to be respected and valued. This is especially true for people who may feel like outsiders or non-experts.
- Track your success through HCAHPS or patient and client satisfaction data.

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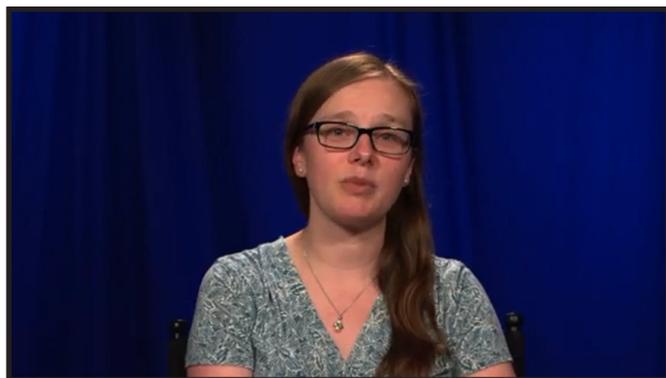
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Communicate Effectively

8 | Use Clear Interpersonal Communication and Confirm Understanding

“With a little teach-back, we could have saved this mom—and the health care system—a lot of time and energy. That’s basically what my “why?” question was—a chance for the patient’s mother to explain in her own words what the plan was. When we find ways to let the patient explain the next steps in their own words, we improve the quality and safety of our care. That’s why teach-back is so important.”

— Laura H, primary care physician



To watch this video, click [HERE](#) or scan the QR code below.



Clear verbal communication is key to ensuring people have actionable information needed to manage their health. Using health literacy approaches, including confirming understanding throughout the clinical and public health continuum, is among the most important attributes of a health literate organization. Care transitions—within or between health care settings or on return home—carry added risk. Ensuring people understand how to sign up for public or private health insurance or benefits that address social determinants of health is also vital to provide stability and help families thrive. Assessing and ensuring understanding in these and other situations improves safety and quality and promotes health equity.

Communicate Effectively

The ideas and tools in this chapter are designed to help you:

- Use, explain, and demonstrate health literacy approaches like plain language, teach-back, and language access services.
- Show how *all* staff can use clear interpersonal communication skills.
- Get everyone started building health literacy communication habits into their routines.
- Set up systems that make checking for understanding standard practice.

A Health Literate Health Organization Confirms Understanding

This chapter addresses Attributes 6 and 9 of the Ten Attributes of Health Literate Health Care Organizations. These attributes call for using “health literacy strategies in interpersonal communications and confirm[ing] understanding at all points of contact,” especially in “high-risk situations, including care transitions and communications about medicines.”¹

Why Is Clear Interpersonal Communication So Important?

Research clearly links limited health literacy to poor health outcomes.^{2,3} Communication impacts quality, safety, health equity, and patient-/client-centered care and experiences. Anyone can experience limited health literacy, depending on the circumstances.⁴ Health organizations have a responsibility to equitably enable people to find, understand, and use information and services so they know how to care for their health.⁵ Health care, public health, health-focused community-based, and similar organizations should incorporate health literacy into education, prevention, care delivery, service provision, funding streams, research agendas, and quality, safety, and health equity initiatives.

Communicate Effectively

Communication Is at the Heart of Care

“Patients have the right to understand health care information that is necessary for them to safely care for themselves, and the right to choose among available alternatives.”⁶ In *Reducing the Risk by Designing a Safer, Shame-free Health Care Environment*,⁷ the AMA and AMA Foundation underscore that:

- Patient understanding is the first patient right.
- A lack of understanding limits the patient’s ability to exercise all other rights.
- This isn’t a right that doctors confer, but one they help their patients to exercise freely.
- It isn’t just or fair to expect a patient to make good health decisions without being able to understand the information needed to do so.

This applies to all those in the health continuum—nurses, dentists, physicians, public health professionals, social workers, community health workers, and more.

“Health care providers have a duty to provide information in simple, clear, and plain language and to check that patients have understood the information before ending the conversation.”⁶

This leads to a shift from talking *to* people toward talking *with* them, keeping in mind that *everyone* appreciates clear communication.

We Need to Make Complex Health Information Clear

Health providers work hard to master complex technical language and concepts. These terms are needed to convey accurate information among members of the health team. It’s also important to convey clear information to patients, families, and clients. Care is directed by health professionals for a relatively small amount of time while people and their families routinely make health decisions and carry out daily health regimens. People with chronic conditions may interact with the health system for several hours every few months. The rest of the time, they’re on their own or with family or other caregivers. To stay as healthy as possible, they need to know how and what to do to care for themselves and have appropriate resources and support. They also need to understand options and trade-offs so they can make informed health decisions. To make sure of this, the health team needs to practice and master clear communication techniques, including:

Communicate Effectively

- Translating technical health terms and jargon into everyday living room—or kitchen table—language.
- Using smaller common words and analogies from people’s lives rather than medical culture.
- Prioritizing and limiting the amount of information conveyed.
- Checking for understanding, and re-teaching and checking again, as needed, through teach-back.
- Supplementing teaching with reader-friendly plain language materials and tools like pill boxes and tracking calendars.
- Using culturally- and linguistically-appropriate communication practices and working with qualified health interpreters.
- Making sure information is accessible for those with disabilities.

All members of the health team play a role in expanding on, supplementing, or reinforcing important health information, or finding the right person to do so.

What Does Success Look Like?

Here’s what it could look like in any health setting designed as if everyone is at risk of miscommunication.

- The Universal Precautions⁴ approach—using clear communication words and tools with everyone—is used for all patient, family, and client communication.
- All staff are trained in using plain language and teach-back.
- Plain language is used for all education and communication with clients, patients, and families.
- Health team members use teach-back reliably—every time it is indicated—to support patients, families, and clients in all health-related settings.
- Everyone is prepared to respond to questions using plain language or by finding someone who can provide a response.

Communicate Effectively

- Tools like Ask Me 3^{®8} are used to help identify key teaching points to help people ask questions and make sure they understand the information.
- Agencies and health care organizations adhere to the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care⁹ to guide culturally- and linguistically-appropriate services and care.
- All team members know when and how to access and work with qualified health interpreters.
- Plain language videos (in languages commonly spoken by community members) are used to help people understand all kinds of health information, for example, how to prepare healthy food, when mobile vaccination clinics will be available, how to administer naloxone in an emergency, or what will happen before and during a surgical procedure.
- Leaders use and model plain language in their speech and writing.

In health care settings:

- When people move through the health care continuum, extra attention and support are used to ensure understanding, especially in high-risk situations like care transitions, medication management, and informed consent discussions.
- People are encouraged to include a family member or friend during visits to help them ask questions and remember information.
- Teach-back is built into patient care competencies and job aids help staff remember how to use the essential elements of teach-back.
- Order sets include using teach-back during patient/family education.
- Documentation systems include prompts to use and places for interdisciplinary recording of teach-back and patients' responses.
- Policies are in place so clinical and non-clinical members of the health team can use SBAR¹⁰ if they sense someone doesn't understand, or is confused by what they're told and to pass along the need for extra communication support.
- Tools like Ask Me 3^{®8} and AHRQ's Questions Are the Answer¹¹ are used to help people ask questions and prepare for encounters.
- Health professions students learn to use plain language and teach-back through effective curricula, role-modeling, practice, and evaluation.

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- Faculty model effective use of teach-back.

In public health and community settings:

- Extra attention and added support are used when needed to ensure understanding, especially in high-importance situations like explaining benefit eligibility criteria, renewal processes, and deadlines; steps to prevent or manage communicable diseases like COVID, measles, or other vaccine-preventable diseases; or how to access quit lines and helplines.
- People are encouraged to include a family member or friend during encounters to help them ask questions and remember information.
- Teach-back is built into staff training and competencies.
- Standard operating procedures include using teach-back during client education, instruction, or other interactions.
- Documentation systems include prompts for and places to record the use of and response to teach-back.
- Policies are in place so any staff member can stop the line if they sense someone doesn't understand or is confused by what they're told, and pass along the need for extra communication support.
- Tools like Ask Me 3[®] are used to help people ask questions and make sure they understand key information for health services, benefits, or resources.
- Interns and students learn to use plain language and teach-back through effective curricula, role-modeling, practice, and evaluation.
- Faculty model effective use of teach-back.

How Do You Move Toward Clear Communication in Your Setting?

Start by showing how people are vulnerable when they come to health settings. They may be ill, worried, distracted, or in pain. They may be suffering from medication effects or lack of sleep. They may be distressed due to worries about loss of benefits or services, missing work or school, medical costs, or language or cultural barriers. Or perhaps they don't understand or can't follow and remember technical health information and jargon.

Communicate Effectively

Underscore that the health team is responsible for making sure people have and understand the information they need to care for themselves or someone else. This Universal Precautions approach assumes all patients, families, or clients may have difficulty comprehending health information and that the health team should communicate in ways anyone can understand. Everyone benefits when health literacy universal precautions are used. Research shows interventions designed for people with limited health literacy also benefit those with stronger health literacy skills. Communicating clearly helps people feel more involved in their health care and increases the chances of following through on treatment plans. And everyone appreciates receiving information that is clear and easy to act on.⁴

Show what can happen when clients, patients, or family members, especially from your setting, don't understand.

Example of What Can Happen When People Don't Understand

We Shouldn't Be Surprised by What People Don't Know

“He spent a long time worrying because I (and many other health care professionals) figured he knew something that he didn't. The reason we talk about “universal precautions” for health literacy is to prevent these kinds of situations. When we assume that people “get it already,” we risk skipping important information that they weren't aware of. Even when a patient seems “educated” or “knowledgeable,” we have a responsibility to communicate completely and clearly.”

— Laura H, primary care physician



To watch this video, click [HERE](#) or scan the QR code below.



Communicate Effectively

Example of What Can Happen When People Don't Understand

Back to the Hospital – Medication Confusion

Listen to Meagan describe how changes in care team members, rapid questioning about her medicines, and not assessing understanding contributed to her grandmother having an allergic reaction to her medicine.

— Meagan J., Language Services Coordinator



To watch this video, click [HERE](#) or scan the QR code below.



Communicate Effectively

A Close Call: What Nearly Happened Due to a Misunderstanding

The Importance of Clarifying Therapy Expectations to Optimize Outcomes

At a care conference during week three of rehabilitation in a skilled care facility, the occupational therapist reported a 76-year-old man was no longer making good progress and appeared to not want to participate in self-care or other activities. She suggested he may need to be discharged sooner than planned. The highly-motivated patient said he was working hard. He had asked to delay some therapy sessions because he wanted to be sure there was enough time for him to be ready to go to his follow-up doctor's appointment. During the ensuing discussion, it became clear that his understanding of therapy was confined to the specific sessions, and he did not realize that his daily activities were also part of overall therapy. Within 24 hours of this clarification, he took on several self-care tasks with assistance, walked to and from meals, and attended a group activity.

By not checking for and ensuring understanding, the staff misinterpreted this patient's motivation, abilities, and functional potential. This might have led to premature discharge, curtailment of rehabilitation, inability to return home where he had previously lived independently, and financial repercussions.

Use and Model Plain Language

Plain language—in speaking or writing—means using clear language that conveys exactly what the audience needs to know “without unnecessary words or expression.” Key elements include using everyday words, active voice, logical organization, and easy-to-read design features. “It is not ‘unprofessional writing’ or ‘dumbing down’ or ‘talking down’ to a person.”¹²

Plain language helps everyone, not just those with limited literacy skills. Few people who are not health professionals understand technical health terms, just like a surgeon might not understand the language of an engineer or lawyer. Plain language can help bridge communication gaps between people and health professionals and staff by presenting information in ways that make it easier for everyone to understand.¹³

Communicate Effectively

The following plain language principles can help improve understanding in verbal and written communication.⁷

- Focus on *need-to-know* rather than *nice-to-know* information. Nice-to-know can get in the way of need-to-know.
- Use examples and analogies to explain uncommon words. For example, saying “Your heart is like a pump, moving blood all through your body,” helps people create a mental image.
- Limit the amount of information given at one time. Research shows people don’t remember much of what clinicians tell them^{14,15} Focus on the three to five most important things you want them to remember.
- Use non-medical language and avoid jargon. Conversational language—living room or kitchen table language that anyone in your family would understand—helps people understand and invites them to engage in conversation with you. When you must use a technical term, explain it.
- Chunk your information and review important points. “Chunk and Check”⁴ refers to separating multiple concepts into separate topics; identifying the two to three most important points; and clearly explaining those and confirming understanding before moving on to the next topic.
- Encourage questions and interaction. Ask “What questions do you have?” rather than “Do you have any questions?” This shows learners that questions are welcome and expected, and that you are genuinely interested. Let people know who they can contact for answers to questions that come up later.

Communicate Effectively

Plain Language

Writers of plain English let their audience concentrate on the message instead of being distracted by complicated language. They make sure their audience understands the message easily.¹³

Why Plain Language?

Listen to these two stories from a physical therapist conveying why the universal precautions approach to communication and plain language principles is so important.

Why Universal Precautions?



To watch this video, click [HERE](#) or scan the QR code below.



Technical Terms - Sinus Tachycardia



To watch this video, click [HERE](#) or scan the QR code below.



Communicate Effectively

Plain Language in Oral Health Settings

Watch the following examples contrasting complex technical and plain language in the dental setting. Think about which communication style fosters patient comfort and openness to asking questions.

Dentist Using Complex Oral Health Language



To watch this video, click [HERE](#) or scan the QR code below.



Dentist Using Plain Oral Health Language



To watch this video, click [HERE](#) or scan the QR code below.



Communicate Effectively

Use Teach-back

Teach-back is a way to make sure the health team explains information clearly; it is not a test or quiz of clients, patients, family members, or caregivers.

- It involves showing you are taking responsibility for making sure you are clear by asking a person, in a caring way, to explain— using their own words—what they need to know or do.
- It is a way to check for understanding and, if needed, re-explain differently, and check again.
- It is an evidence-based health literacy intervention that promotes patient understanding, quality, safety, shared decision-making, and health equity.¹⁴⁻²⁰
- It can help identify those who may need more support with understanding and remembering.

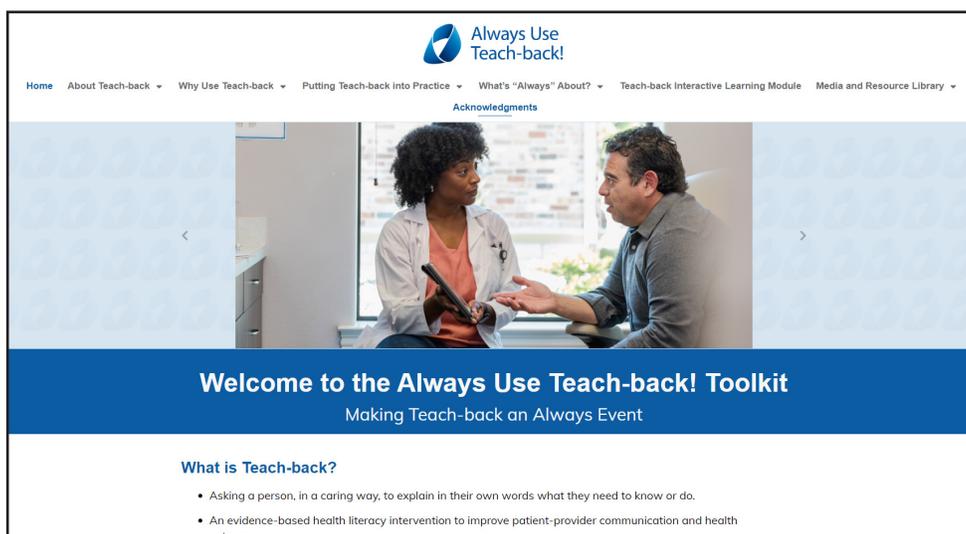
Teach-back creates the opportunity for dialogue in which the speaker gives information and then asks the person to respond and confirm understanding in their own words before adding new content. It should be used by anyone sharing important information with patients, families, and clients in clinical and non-clinical settings.

The Always Use Teach-back Toolkit

The Always Use Teach-back! Toolkit²¹ (<http://teachbacktraining.org/home>) offers resources, tools, a learning module, and videos to guide training, assess skills, and support implementation for reliable and sustainable use of teach-back for individuals and organizations.

Communicate Effectively

Always Use Teach-back! Toolkit



The Always Use Teach-back! Toolkit²¹ (<http://teachbacktraining.org/>) is an online resource to help every member of the health team learn to use teach-back—every time it is indicated—to support patients, families, and clients throughout the health continuum.

It provides individuals and health organizations of any size with teach-back and improvement content, resources, and tools—including an online learning module, teach-back observation tool, and video library—to start or improve teach-back use in clinical and non-clinical settings.

- About Teach-back.
- Why Use Teach-back?
- What’s “Always” About?
- Putting Teach-back into Practice.

The Toolkit’s 10 Elements for Using Teach-back Effectively²¹ can be a good starting point.

Communicate Effectively

10 Elements for Using Teach-back Effectively



Set-up

- Identify key “need-to-know” concepts and “need-to-do” tasks for teach-back.
- Include family members/caregivers or other support persons when present and appropriate.

Teach-back

- Be respectful and address cultural and communication needs.
- Use plain language.
- Use words that show you are taking responsibility for being clear.
- Ask the person, in a caring way, to explain back (or show back), using their own words. Do this after each “need-to-know” concept or “need-to-do” task (Chunk and Check).
- If the person is not able to teach back accurately, explain in a different way and re-check.
- Use non-shaming open-ended questions.

Support

- Use reader-friendly plain language materials to support learning, sharing, and finding information.
- Document use of and the person’s response to teach-back.

For more about each of the 10 Elements, see [10 Elements for Using Teach-back Effectively – Detail](#).

Communicate Effectively

Set-up

Identify key “need-to-know” concepts and “need-to-do” tasks for teach-back. Focus on what is most important for the person to know or do.

Include family members, caregivers, or other support persons when they are present or needed and as appropriate. Determine which people to include in the discussion and teach-back, depending on the circumstances.

Teach-back

When using teach-back, be respectful and address cultural and communication needs. Use a caring tone, attitude, and body language, and make appropriate eye contact. Speak clearly and not too fast. Use the person’s preferred name. Show interest in them by focusing on the person, not on a computer, chart, or paperwork. Address neurosensory (e.g., hearing, vision, cognitive) needs.

Demonstrate cultural humility. This means not making assumptions. Ask about health beliefs and practices. Use qualified interpreters when speaking with people whose preferred language is not English.⁴

Use plain language for teaching and explaining information, then use teach-back to check that the key “need-to-know” or “need-to-do” concepts or tasks are understood.

Essential teach-back components include:

- Using words to *show you are taking responsibility for being clear* so the person does not feel like they are being quizzed or put on the spot. Emphasizing your own communication effectiveness may also reduce concerns about making people feel uncomfortable.
- Asking the person to explain or demonstrate back *using their own words*, not just repeating what was said. Using their own words helps reveal what they understand or remember.
- When needed, *rephrasing* and *re-explaining* the information and asking them to teach back again, until you are comfortable they understand or you have a different plan.

When questions are needed during the teach-back discussion, use non-shaming open-ended questions like “What questions do you have?” rather than those that can be answered with yes or no, like “Do you have any questions?” or “Do you understand?”

Communicate Effectively

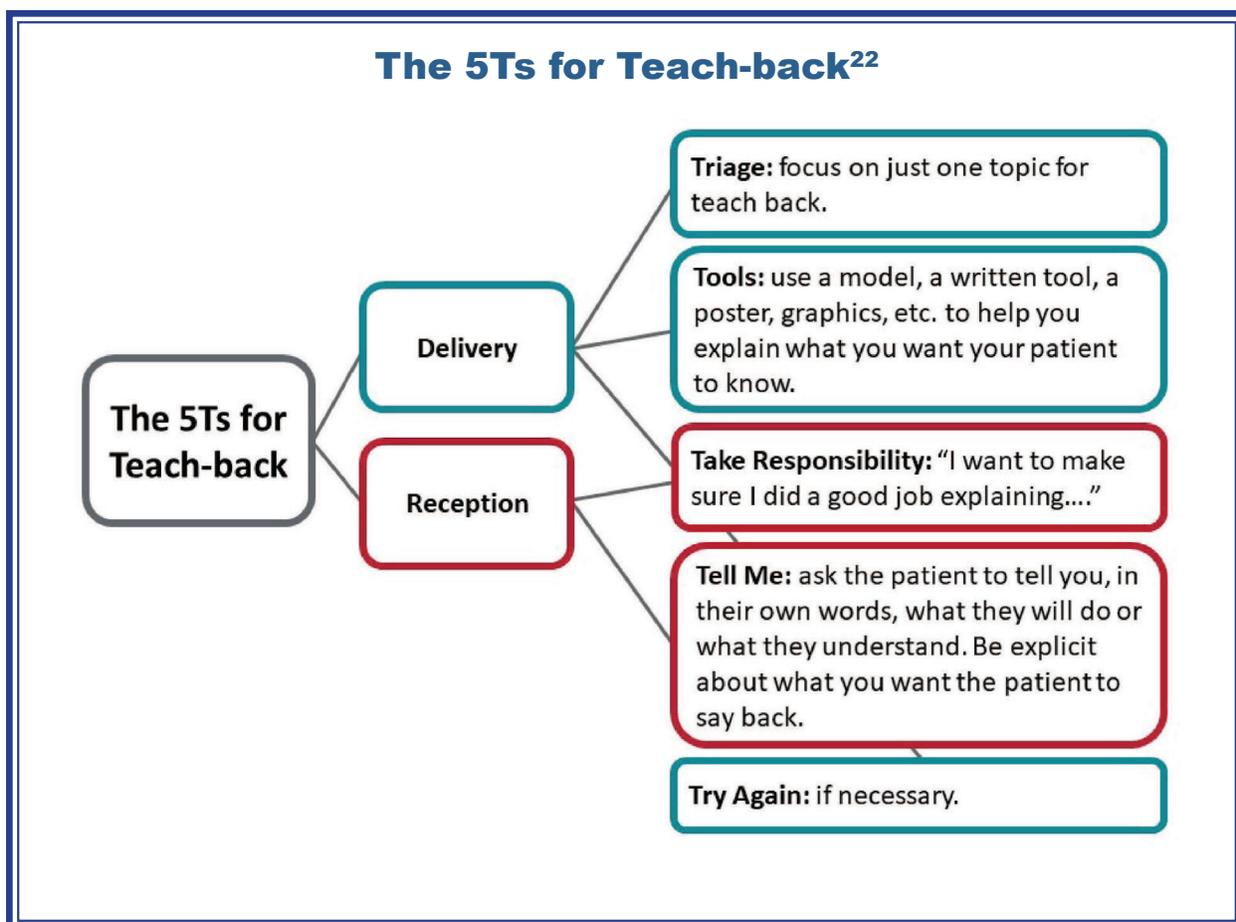
When multiple topics are being covered, use Chunk and Check.⁴ This means teaching, explaining, and using teach-back after each “need-to-know” concept or “need-to-do” task before moving on.

Support

Use reader-friendly plain language handouts, pictures, models, videos, demonstrations, and other teaching tools and strategies to reinforce the information. Personalize materials for the learner by pointing to, underlining, marking, circling, and filling in key information; this helps them find information later. Supplemental approaches, like pictures, models, audiovisuals, or drawings can help overcome communication barriers. Tools help reinforce information after the discussion, serve as reminders, and can be shared with others.

Include prompts for using teach-back in electronic health record systems and order sets. Build teach-back into electronic medical records and care documentation systems, and document its use and patients’, families’, or clients’ responses to teach-back. Noting concepts the person found difficult to teach back can guide future education or care. Documentation can be used for follow-up education, continuity of care, care coordination, interprofessional collaboration, quality indicators, and performance improvement. These systems can also be used to track the percentage of people with whom teach-back was used and their ability to teach back. Use these measures to drive improvement in use of teach-back over time.

Communicate Effectively



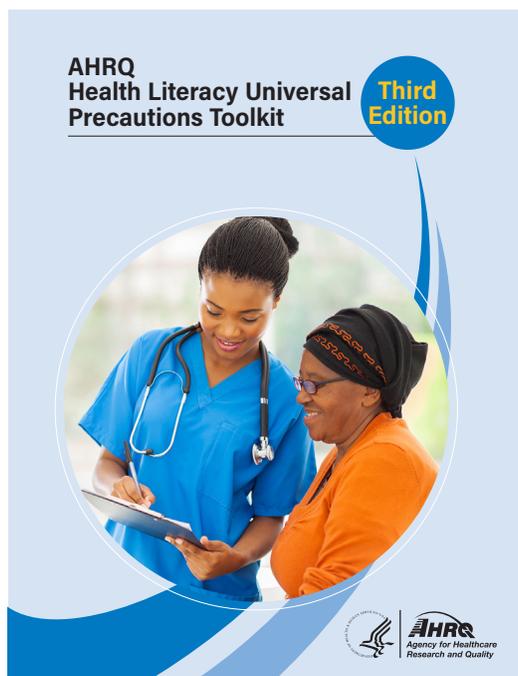
The AHRQ Health Literacy Universal Precautions Toolkit

The AHRQ Health Literacy Universal Precautions Toolkit⁴ provides additional teach-back resources for: training and promoting the use of teach-back among staff; tips to support its use and getting started; and ways to track progress and guide evaluation, coaching, and additional learning to establish consistent habits.

Communicate Effectively

AHRQ Health Literacy Universal Precautions Toolkit

The 3rd edition of the AHRQ Health Literacy Universal Precautions Toolkit⁴ (<https://www.ahrq.gov/health-literacy/improve/precautions/index.html>) helps health care organizations make health information easier to understand and act on and health care easier to navigate. The Toolkit contains 23 tools for busy primary care practices that describe concrete actions to improve spoken and written communication, self-management and empowerment, and supportive systems. The 3rd edition includes tools relevant to this chapter, i.e. Communicate Clearly: Tool 4 (<https://www.ahrq.gov/health-literacy/improve/precautions/tool4.html>), Use the Teach-Back Method: Tool 5 (<https://www.ahrq.gov/health-literacy/improve/precautions/tool5.html>) and Encourage Questions: Tool 14 (<https://www.ahrq.gov/health-literacy/improve/precautions/tool14.html>). Many of its tools can be adapted for use in a variety of clinical and public health settings.



Use the Toolkit to learn about using health literacy universal precautions—the structuring of health information and services in ways that everyone can understand and use.

Communicate Effectively

Ways to Ask for Teach-back

There are various ways to demonstrate taking responsibility for being clear or helping the learner feel comfortable by stating up front that the information they are being taught is complicated and a lot to take in.

Here are examples of how to ask people to demonstrate understanding, using their own words:

General

- “I want to be sure I explained everything clearly. To be sure I did, can you please explain it back to me in your own words?”
- “Can you tell me in your own words how often and when you will use each of these inhalers? And show me how you will use them. This will help me be sure I explained it clearly.”
- “To make sure I was clear, can you please tell me when you will use your controller medicine?”
- “Please tell me when your appointment for your next HPV vaccine dose is.”
- “A lot of people find these directions for preparing for your procedure confusing. To make sure I was clear, can you go over what you’re going to do to get ready for your surgery?”
- “What I just went over is a lot to remember. Let’s make sure your application paperwork gets handled right. Can you tell me what you will do with these forms and the deadline for turning them in?”
- “It can be hard to find the vaccination clinic from here. I don’t want you to get lost, so, to make sure I was clear, can you tell me what signs you will watch for as you go?”
- “We want to be sure you understand what your insurance will and will not cover. Can you go over it for me using your own words? This will help me know if I explained it well.”
- For a child (beginning about age 8 years): “To make sure I’ve done a good job teaching you how to use the medicine that helps keep you from wheezing, can you show me how you will use it...say if you are staying overnight with your cousins?”

Communicate Effectively

What will you tell someone else?

- “I want to make sure we were clear in explaining how and when to call the emergency hotline. Can you please go over what you will tell someone about how and when they can use the hotline?”
- “What will you tell your mother about what her insurance will and will not cover? Can you go over it in your own words? This will help me know if I explained it well.”
- “What will you tell your partner about how to give Juanita her medicine?”
- For a parent or caregiver: “To make sure everyone who watches Aditi knows how to help her with her controller medicine—the one that helps keep her asthma from acting up—could you please show me what you will teach them, using your own words?
 - And, to make sure I did a good job being clear, can you tell me when she should use it?
 - Could you tell me how you will explain her asthma action plan to her dad?”

Behavior change

- “We’ve talked a lot about how you can increase your physical activity. Please go over what we talked about in your own words. How will you make it work for you at home?”

Telling the learner beforehand

- “We’re going to go over a lot of information about naloxone. To make sure I do a good job explaining it all, I will ask you to go over key points in your own words for each thing we talk about.”
 - Q1: “Where will you store your naloxone kit?”
 - Q2: “How do you know if somebody is overdosing?”
 - Q3: “What should you do before you give the naloxone?”
 - Q4: “How do you give naloxone?”
 - Q5: “What should you do after you give the naloxone?”

Communicate Across Settings

Clear communication should be used in the hospital, home health, and primary care settings, where it is especially important to ensure knowledgeable self-care practices after going home. Patients may be dealing with a new diagnosis, have undergone a procedure, or have had changes in their health management regimen that make it hard to understand and remember key information.

Communicate Effectively

High-risk Situations

Hospital-to-home transitions, medicine changes, and informed consent discussions carry extra risk if people do not understand. When people leave the hospital, they must care for themselves or be cared for by family members. This means bringing new medicines, routines, and behaviors into their lives. And all this has to be done while recovering from whatever led to their hospital stay. Discharges are busy, full of distractions, and associated with multiple exchanges of information and materials. They can be anxiety-provoking since patients and families are being asked to assume or resume care after one or more significant health events that led to hospitalization. Confusion, declines in health status, and changes to medicines and care regimens can result in misunderstanding that leads to non-adherence and errors.

Not understanding what is recommended, the associated benefits and risks, and the alternatives prevents someone from providing true informed consent. AHRQ's Making Informed Consent and Informed Choice: Training Module for Health Care Professionals offers teach-back questions to enhance the informed consent process (<https://www.ahrq.gov/health-literacy/professional-training/informed-choice.html>). In public health settings, it is vital for people to understand what they are eligible for, what to do to participate in public health and community-based programs, and how to follow up. Not understanding can have serious repercussions like loss of benefits or delay in receiving vaccine doses.

Be Sure People Understand Before Leaving

Begin discharge education at admission, not waiting until the day of discharge. Starting right away makes it possible to cover multiple topics, reinforce critical information, identify challenges to learning or alternative ways to teach topics that remain unclear, and gather supporting resources. Confusing areas may need different teaching techniques, approaches, or extra follow-up. Teach-back should be used especially to go over self-care regimens; signs or symptoms to look for; when to call the doctor; and when, where, and how to follow up.

The research-based Re-Engineered Discharge (RED) Toolkit²³ (<https://www.ahrq.gov/patient-safety/settings/hospital/red/toolkit/index.html>) is a good resource for improving the discharge process. It includes actions the health team can take during and after the hospital stay to ensure a smooth and effective transition at discharge.

Communicate Effectively

Confusion After Discharge

“When I was in the hospital all I was focused on was getting home. And then I got home and realized I didn’t know what I needed to do.”

“I wasn’t clear on what medicines I needed to stop taking.”

“There are some symptoms that I’ve been having, but I wasn’t sure if I should just wait for my appointment in three weeks.”

— Patients with heart failure following hospital discharge.

Use Teach-back for Safety with Medicines

Use Teach-back in Brown Bag Medicine Reviews

The AHRQ Health Literacy Universal Precautions Toolkit⁴ describes the rationale for and how to conduct and track progress for Brown Bag Medicine Reviews (<https://www.ahrq.gov/health-literacy/improve/precautions/tool8.html>). These involve encouraging patients to bring all their medicines and supplements to their visit and reviewing them. The goal is to determine what medicines patients are taking and how they are taking them. The process can uncover medicine errors and medicines missing from health records. It is only by having patients bring their medicine containers and discussing how they take those medicines that you can tell whether and why people may not be taking medicines correctly. Teach-back is a valuable tool during Brown Bag Medicine Reviews.

Communicate Effectively

Teach-back in Action: Brown Bag Medicine Reviews

Listen to a health literacy researcher talk about the importance of teach-back during Brown Bag Medicine Reviews.



To watch this video, click [HERE](#)
or scan the QR code below.



Communicate Effectively

Use Teach-back for Medicine Safety

Teach-back should be used to ensure patient and family understanding when there are new, or changes to, medicines. People need to know what each medicine is for, when and how to take it, and what response or side effects to watch for.

Teach-back in Action: Pharmacist with Granddaughter Picking Up Grandfather's Prescription

Watch the pharmacist use teach-back to make sure the family member understands and can tell her grandfather about how to take his medicine.



To watch this video, click [HERE](#) or scan the QR code below.



Use Teach-back for Telehealth and Telephone Encounters

The expansion of telemedicine during and after the COVID pandemic reveals another important area in which to ensure clear communication. While the ability to use phone and video technology for health services improves access, it also creates an imperative to use plain language and ensure understanding through teach-back since some usual cues to understanding may be absent in a virtual environment.

Communicate Effectively

Teach-back in Action: Clinical Social Worker and Grandmother During Telehealth Encounter

Listen as the clinical social worker uses health literacy practices to ensure this grandmother understands what she needs to do for her granddaughter's diabetes care services during a telehealth appointment. Time stamp 3:33 to the end.



To watch this video, click [HERE](#)
or scan the QR code below.



Pre-procedure and Follow-up Calls

Include plain language and teach-back training and expectations for staff who schedule appointments and conduct phone calls that remind people about how to prepare for and attend upcoming procedures. This can help make sure people understand important information like when to stop eating; what medicines to take or not take; and when and where to arrive. It is inefficient and wasteful for all those involved when someone does not come to a scheduled procedure, or a procedure has to be cancelled because they ate recently or did not prepare appropriately. Such occurrences impact quality since unused operating time is very expensive; other patients could use that time, and people may have taken off work, driven a long distance, hired childcare for siblings, or missed school. Telephone protocols that ensure people can teach back key information can help prevent or reduce such situations.

Communicate Effectively

Follow-up phone calls are helpful since questions often arise after people return home. Information volume and complexity can be overwhelming, so timely follow-up calls to review key information and ensure understanding can help prevent adverse outcomes. Use plain language and teach-back during these calls to be sure people really do understand.

Comparison of Follow-up Calls Using Yes/No Versus Teach-back Questions

Yes/No Questions	Teach-back Questions
Do you have your follow-up doctor appointment scheduled?	Please tell me when your next appointment with your doctor is.
Do you understand your medications and how you are to take them?	Sometimes medicines can be confusing. Let's start with the key medicines you are taking. Please tell me what you know about what medicine A is for and when you take it.
Do you have any pain?	How are you handling your pain?
Do you have any further questions or concerns or need for further health information?	What questions do you have about what you need to do to take care of yourself over the next week or two? What questions do you have about what we went over today?
Do you know where you can get your flu shot?	Sometimes it's hard to know where and when you can get a flu shot. Can you please tell me where you plan to get your flu shot and how you will get there?

Communicate Effectively

Revealing Other Issues

“Using teach-back during follow-up phone calls reveals other issues that impact patient care and have not come up in the past when we were asking the yes/no questions. For example, we have discovered several patients with issues related to buying groceries and having access to healthy food. With the open-ended format the approach is more conversational, which allows the patient to share more information and not be held to a quick yes/no answer. This has resulted in other issues being identified that need to be addressed. I think this is a positive outcome of changing the approach to the questions and has allowed us to take a holistic approach to the patient.”

— Director of Population Management

Public Health Virtual Education

Virtual public health education can help address important issues, including those largely affecting populations at risk for health disparities. Features of one such program incorporated health literacy practices, including core knowledge objectives for parents; a plain language talking points guide; health literacy strategies to engage and foster learning; reader-friendly visuals; a narrated version for after the virtual session; and standardized educator training.²⁴

Teach-back in Action

Here are excerpts from a telehealth education program script for parents of newborns with sickle cell trait:²⁴

“So, we’ve talked about the ways sickle cell trait and sickle cell disease are different from each other.”

“All this can be complicated and is a lot to remember. And you’ll probably get questions from your family and friends.”

“To make sure I explained everything clearly, can you tell me in your own words what you would tell people about the differences between sickle cell trait and sickle cell disease?”

Communicate Effectively

Use Teach-back at Home Health Visits

Use home health referrals, even if only for a few visits. The stress of being in the hospital or having a new diagnosis or health set-back can make learning difficult. Questions may not arise until people are at home dealing with self-management in their usual setting and discovering needs for additional resources. Using teach-back at home health visits can:

- Identify and clarify areas of uncertainty or confusion.
- Answer questions.
- Review and reinforce key information.
- Assess for ongoing risk.
- Reveal information that should be relayed to doctors by the home health team or patients themselves.
- Identify needs and eligibility for additional supporting resources, like home meal delivery, fall alert systems, or internet access programs.

Teach-back in Action: Physical Therapist During a Home Health Visit

Watch how the home health physical therapist explains, asks for teach-back, re-explains, uses handouts, and re-asks for teach-back. Time stamp 1:42 to the end.



To watch this video, click [HERE](#)
or scan the QR code below.



Communicate Effectively

Use SBAR

SBAR (Situation-Background-Assessment-Recommendation)¹⁰ is a standard, objective format that streamlines communication and ensures no crucial information is left out. Staff members, clinical and nonclinical, can use SBAR to *stop the line* if they think a client, patient, or family member has not understood what they were told by someone on the health team. A helpful tool for stopping the line is the CUS (Concern, Uncomfortable, Safety) Tool, found on <https://www.ahrq.gov/teamstepps-program/curriculum/mutual/tools/cus.html>.

This is especially important in settings where it might otherwise be awkward to raise a concern. For example, if a staff member sees a problem arising from how a nurse gave information to a patient or family member, SBAR gives that person a way to ask the nurse to clarify when there are concerns about understanding. Clarifying could take the form of talking with the family member, giving additional discharge education, delaying a procedure until a patient shows their questions have been answered, or using teach-back to confirm understanding before a test or procedure. Similarly, if a community health worker recognizes that a family does not understand what a public health worker told them about when and where to go for a service, they can use SBAR to request clarification from a manager or supervisor.

SBAR can be used to pull in everyone on a care team. For example, a housekeeper may hear a family member say they didn't understand anything the doctor told them. With SBAR as a standard tool for all staff, the housekeeper could tell a nurse that based on what she heard, it sounds like the patient and family have questions. The nurse can follow up appropriately.

Communicate Effectively

Examples of SBAR in Action

These examples show how using SBAR to address communication challenges can contribute to safety, quality, equity, and patient- and client-centered care.

Housekeeper to Nurse

Situation: I think Mrs. Juarez's family has a lot of questions.

Background: She's the patient in Room 3237 who just got back from surgery.

Assessment: I heard her family talking after Dr. Kunan left. They sounded very confused and they thought they were getting mixed messages.

Recommendation: Can you make sure someone goes in to answer all their questions? Her daughter is the main person everybody talks to but she's not always there. You should make sure to have an interpreter too.

Dietitian to Nurse, Social Worker, or Respiratory Therapist

Situation: I'm concerned that Mr. Jones isn't ready for discharge.

Background: He's a 65-year old man with COPD and is supposed to go home with oxygen for the first time.

Assessment: When I went in to see him, he seemed very upset. I think he may be worried about how his home oxygen is going to work. Or there may be something else upsetting him.

Recommendation: I recommend you talk with him about his concerns and go over what will happen with his oxygen when he gets home.

Continued on the next page

Communicate Effectively

Resident to Resident Hand-over

Situation: Mr. Sutter’s scan isn’t back yet, and his wife wants to be with him when he gets the results. She can only be here in the evening, so you’ll need to talk with them about the results then.

Background: The scan will determine what we do next and he might need surgery. They just arrived here and are trying to find a place to live, start jobs, and get their kids in school. They are pretty stressed.

Assessment: I’m worried they aren’t going to be able to take everything in and will be overwhelmed.

Recommendation: Be sure to use teach-back to make sure they really understand—not only about the results but possible next steps. Let them know Dr. Powell and I will be here tomorrow to go over everything again. And remind them the social worker will be able to help them too.

Outreach Worker to Supervisor

Situation: A family who doesn’t speak English is here for the vaccination clinic.

Background: They want to get their children’s vaccines up-to-date and they look very worried and confused. I think it’s because all the signs and information are only in English.

Assessment: I’m concerned they will leave since they can’t get their questions answered, and their children won’t be vaccinated.

Recommendation: We need to call for a qualified health interpreter and go over how to use the clinic with them. Then make it a priority to get signs and materials in other languages.

Communicate Effectively

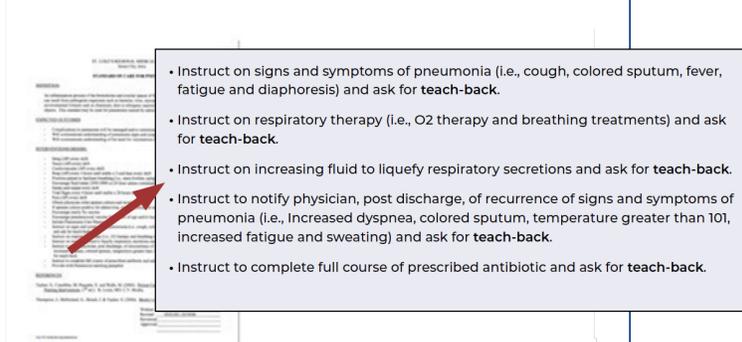
Building New Habits and Making Them Last

To change from long-standing patient education habits to reliably—every patient/client every time—using plain language and teach-back to confirm understanding via people’s own words takes time.

First, be sure health literacy skills like plain language and teach-back are included in orientation for all staff. This is because anyone may interact with patients, families, clients, and community members, even if not in the clinical setting, e.g., telephone schedulers and billing representatives, and even if it is not part of their official job description.

Ensure opportunities to establish and maintain competency in using teach-back, like skills fairs and competency assessments.

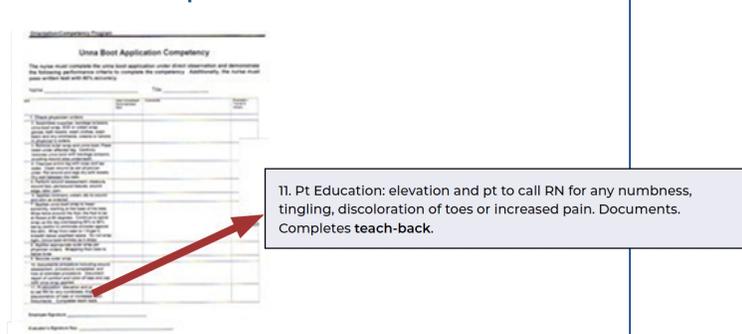
Example: Teach-back is part of standards of care: Pneumonia



The image shows a screenshot of a clinical care plan for pneumonia. A red arrow points from a callout box to the 'Patient Education' section of the care plan. The callout box contains the following instructions:

- Instruct on signs and symptoms of pneumonia (i.e., cough, colored sputum, fever, fatigue and diaphoresis) and ask for **teach-back**.
- Instruct on respiratory therapy (i.e., O2 therapy and breathing treatments) and ask for **teach-back**.
- Instruct on increasing fluid to liquefy respiratory secretions and ask for **teach-back**.
- Instruct to notify physician, post discharge, of recurrence of signs and symptoms of pneumonia (i.e., increased dyspnea, colored sputum, temperature greater than 101, increased fatigue and sweating) and ask for **teach-back**.
- Instruct to complete full course of prescribed antibiotic and ask for **teach-back**.

Example: Teach-back is included in clinical competencies: Unna Boot



The image shows a screenshot of a clinical competency checklist for 'Unna Boot Application Competency'. A red arrow points from a callout box to a specific item on the checklist. The callout box contains the following text:

11. Pt Education: elevation and pt to call RN for any numbness, tingling, discoloration of toes or increased pain. Documents. Completes **teach-back**.

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Small Tests of Change

Use small tests of change to help the health team change how they communicate and sustain those improvements over time (<https://www.ahrq.gov/ncepcr/tools/transform-qi/deliver-facilitation/modules/index.html>). Small tests can help health team members gradually adopt plain language and build teach-back into their routines.

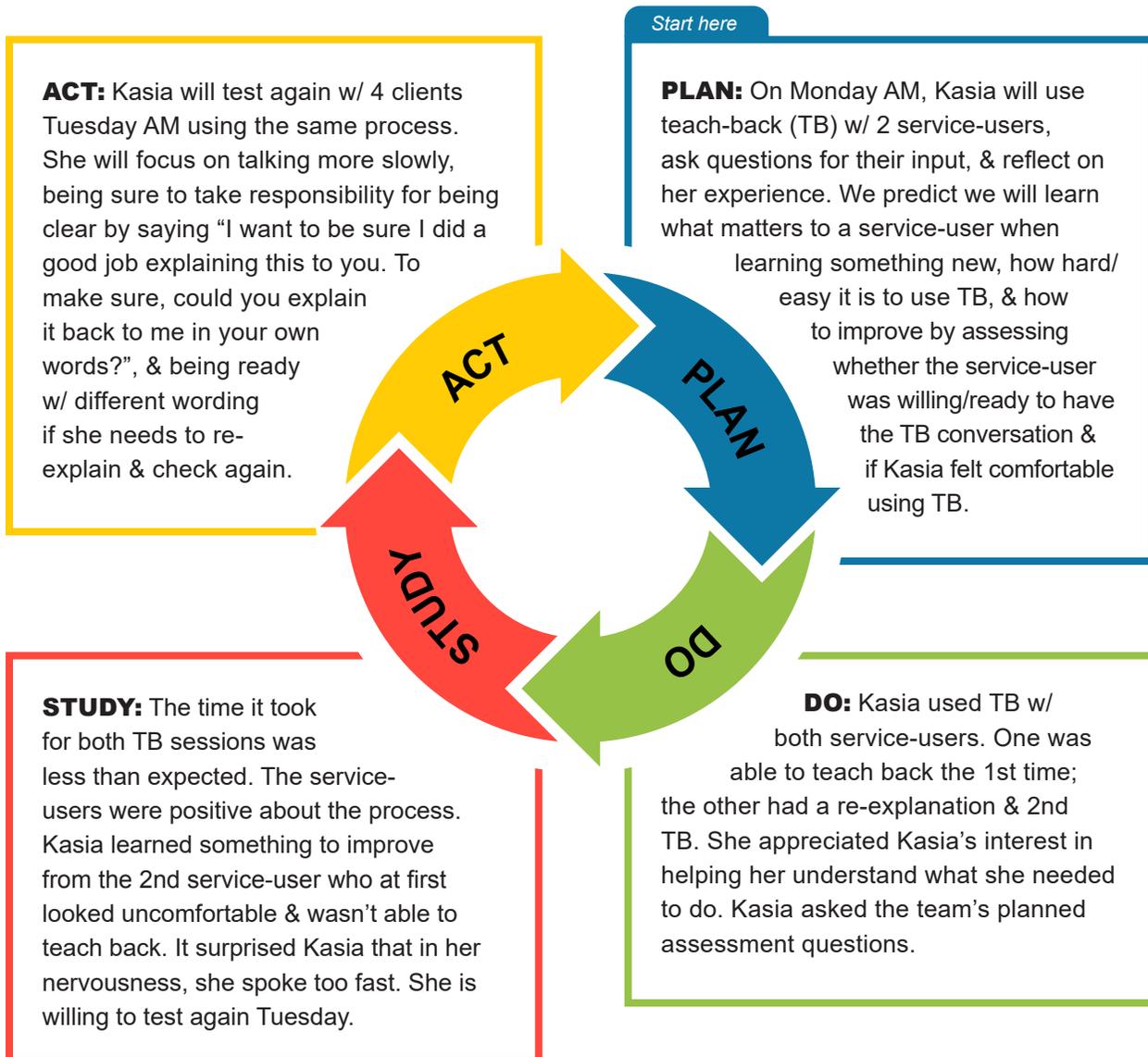
It's useful to start with one patient or client; the last person on the schedule is good, to minimize real or perceived time pressure. Use Plan-Do-Study-Act (PDSA) cycles²¹ to build comfort with using wording to show you are taking responsibility for being clear, asking the person to explain back using their own words, and, if the person is unable to explain back, re-explaining differently and checking again. As you learn from a series of small tests and build experience, expand to more patients or clients, other groups, or other settings. As you discover patterns where people struggle to explain back, you will find better ways to explain things with plain language upfront. As you become more proficient, share your observations and experiences with colleagues and other health team members, and encourage them to use teach-back too.

For example, a community health worker or provider can begin with the last client or patient of the session, day, or rounds to lessen concern about getting behind schedule. If this small test goes well, they can expand to three to five people, or all people with a certain condition. They can share successes with colleagues. If the small test does not go well, they can study the test, figure out why it didn't go well, modify the plan, and try it again. This way, they can build their experience and confidence, work out the bugs, and then, over time, expand use of teach-back into routine practices.

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PDSA Cycle: Using Teach-back in a Social Service Setting

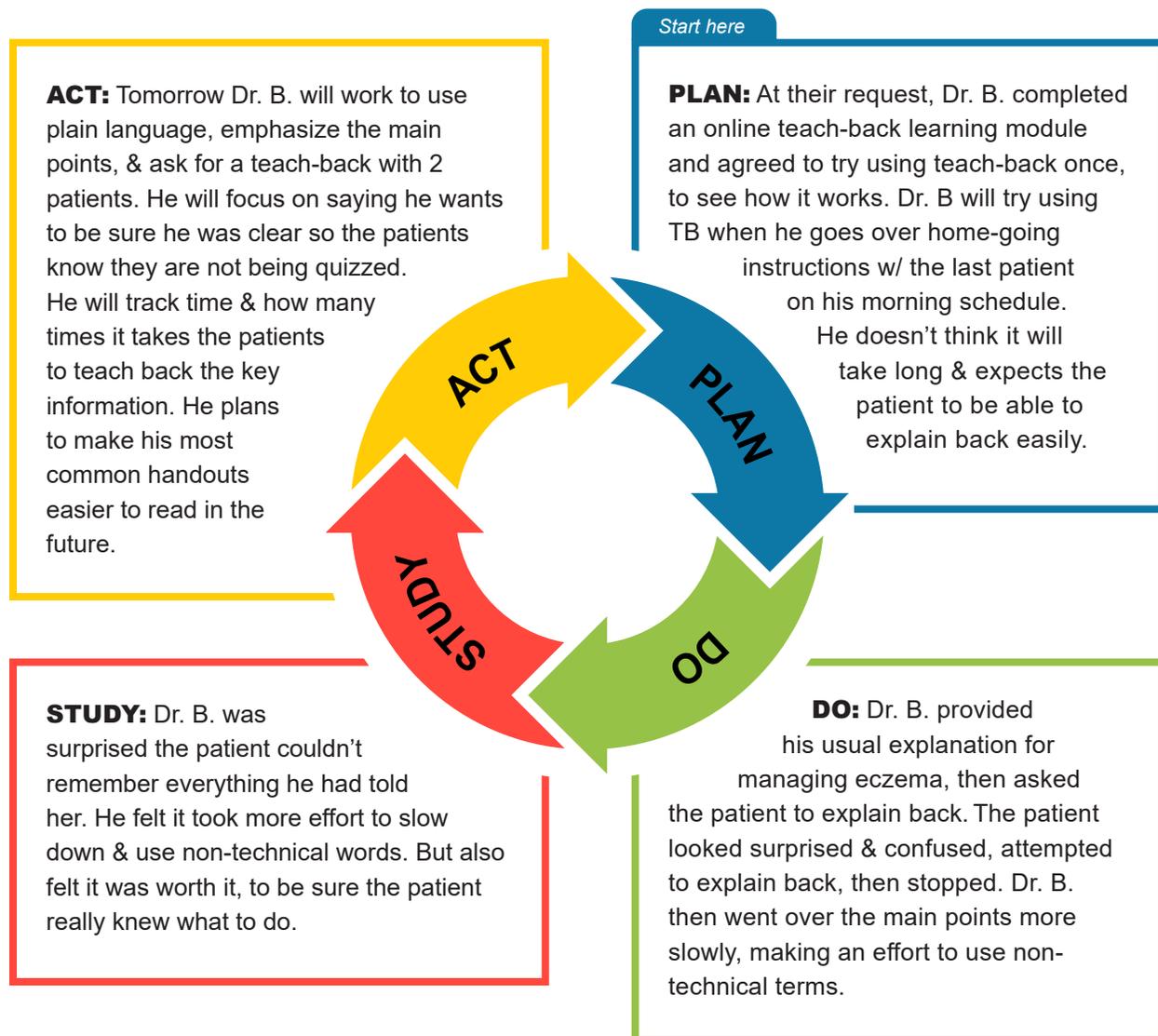
Here is a PDSA from a team who wants to include using teach-back as they work to increase client engagement. They will test the use of teach-back by one newly trained staff member.



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PDSA Cycle: Using Plain Language and Teach-back in Outpatient Dermatology

Dr. B. tries hard to explain things clearly, completely, and in a friendly way to patients, but talks quickly. His staff learned about teach-back at a conference and told him about it.



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A job aid, like that in the Always Use Teach-back! Toolkit,²¹ can help people remember the essentials and the hows and whys of teach-back.

Teach-back Job Aid			
Important Steps – “Know What”	Key Points – “Know How”	Reasons – “Know Why”	
<ul style="list-style-type: none"> Logical segments of a process when something happens to advance the work 	<ul style="list-style-type: none"> Make or break the job Make the work easier to do Avoid injury to team member 	<ul style="list-style-type: none"> Reasons for the Key Points 	
1. Greet the person.	<ul style="list-style-type: none"> Use a caring tone, respectful attitude, body language, & appropriate eye contact. Sit down if possible. Address cultural, language, & other communication needs. Include family members/caregivers or other support persons when present & appropriate. 	<ul style="list-style-type: none"> Hurried, worried, & distracted attitudes can be barriers to a person’s ability to listen & remember information. Trained health interpreters help ensure quality & safety. Family & caregivers can support remembering. 	
2. Teach the person.	<ul style="list-style-type: none"> Identify the “must know” concepts or “must do” tasks to teach. Use reader-friendly teaching material people can keep & refer to later or share with others. Use plain language. Do not use technical terms or jargon. Segment topics when there are multiple things to teach or demonstrate; teach & then check understanding for each. (Chunk and Check) 	<ul style="list-style-type: none"> Easy-to-understand materials are good reminders after the conversation & at home to support learning, sharing, & finding information. Technical terms & jargon are barriers to understanding in all settings. Explaining using everyday language, analogies, & visuals is helpful. Checking understanding after each “must know” concept or task helps keep things clear. 	
3. Ask “Please tell me in your own words....(what you just taught).”	<ul style="list-style-type: none"> Take responsibility for being clear. Preface with a message that doesn’t sound like a test of the person, e.g., “I want to be sure I did a good job of explaining all of this to you.” or “We talked about a lot of things today...” Ask the person, in a caring way, to explain or show back, using their own words. If a person is not able to teach back, explain in a different way & re-check. Clarify with non-shaming open-ended questions that cannot be answered with only “yes” or “no.” Never ask, “Do you understand?” 	<ul style="list-style-type: none"> It is our responsibility to make sure we are clear and to not make the person feel they are being tested. Purpose is to make sure you explained it well enough for this person to take important action & stay healthy & safe. Being able to say it in their own words helps reveal what they understand or remember, and internalize learning. Most people will say they understand whether or not they do. 	
4. If person is unable to teach back correctly, teach again in a different way, & recheck.	<ul style="list-style-type: none"> Be sure they have hearing aids, glasses, or other needed supports. Repeat the process 2-3 times if the person is not frustrated; it may be necessary to try again later. If the person or family is unable to teach back after multiple tries, alternative approaches may be needed. 	<ul style="list-style-type: none"> Multiple opportunities to hear the teaching, with different words, may enable them to teach back. Alternative approaches are critical when the person’s safety is at risk. 	
5. Document.	<ul style="list-style-type: none"> Document use of & the person’s response to teach-back. 	<ul style="list-style-type: none"> Other team members need to know what people have been taught & what they may need more help with. 	

Page 1 of 1



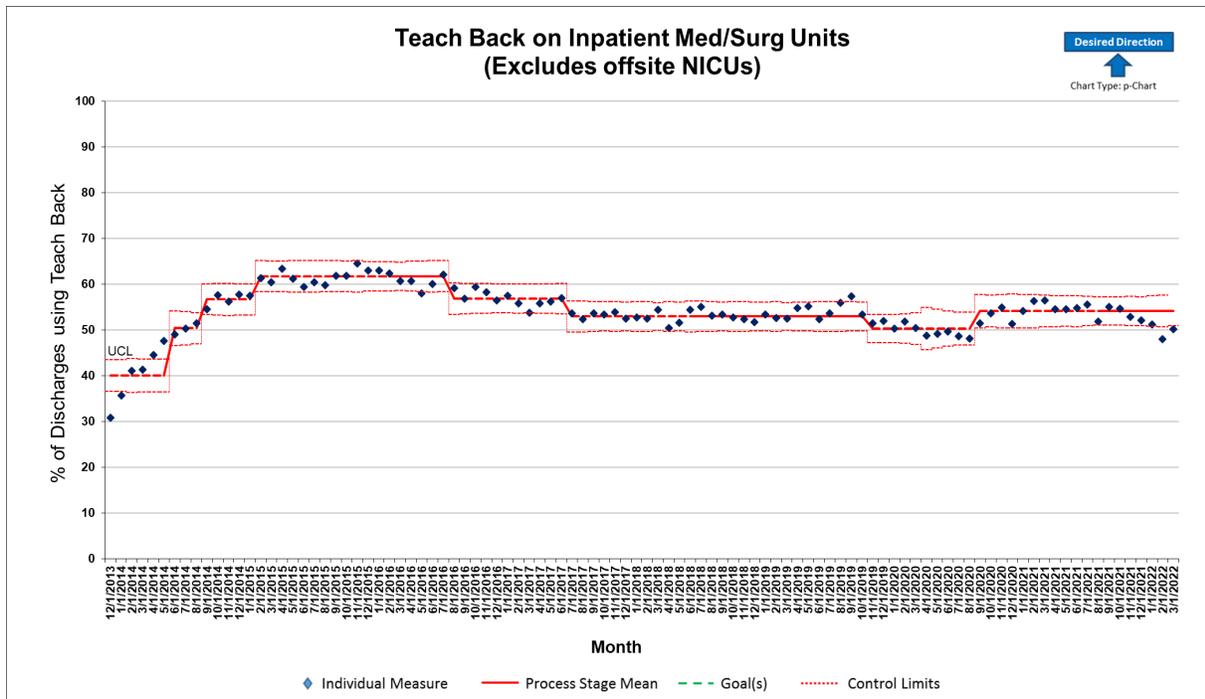
Quality Improvement Approaches

Use quality improvement approaches to begin or increase teach-back use. Consider starting with one area, providing training and identifying a few early adopters willing to test teach-back. As staff build comfort, consistency, and experience, expand to more people. Another approach is to start by focusing on people with a certain health issue.

You can use quality improvement projects to directly increase teach-back use or fold it into a multi-pronged QI project aimed at improving outcomes, for example, reducing unplanned readmissions, where teach-back can help ensure people understand how to manage heart failure after leaving the hospital. Setting a goal and using quality improvement strategies can lead to increased use of teach-back.

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Here is an example of a QI project training hospital inpatient unit nurse leaders on using teach-back. They then trained and coached nurses on their units. The control chart shows how use of teach-back increased over time, but how ongoing attention and effort are needed to continue to improve. Electronic health records can be used to help track this.



In another quality improvement project, respiratory therapists, with a standard asthma teaching protocol, used teach-back to explain patients' asthma action plans and check for understanding.²⁵ Their use of teach-back during asthma clinic visits improved from 43% to 80%. There was also a 10% decline in emergency department visits among the same population over the same time period. This is an example of how multidisciplinary members of the health team can contribute to improving outcomes with teach-back.

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When People Struggle to Teach Back

Sometimes, a person will not be able to teach back, despite several attempts. If that happens, consider these ideas:

- Be sure they are using hearing aids, eyeglasses, or other assistive devices, if needed.
- Ask if they would like to include a family member or friend.
- Ask another person on the health team to help with teaching and explaining.
- Schedule another visit or call.
- Check for language, literacy, or cultural barriers. Be sure you are working with a qualified health interpreter, including for American Sign Language, when needed.
- Think about other ways to share the information, like a video.
- Pass along the need for extra help to other staff and providers so they can provide ongoing support.

Handling Objections and Concerns About Time

People often have concerns about using teach-back. The Always Use Teach-back! Toolkit²¹ offers possible responses to and insights on common objections.

- “It’s not a problem for people we serve” - Emphasize that anyone can experience limited health literacy, depending on the circumstances.
- “There’s nothing we can do about it” - Highlight how using health literacy strategies has been shown to contribute to improved outcomes.
- “It’s not my job/role” - Everyone on the health team has a role in making sure people understand what they need to know or do.
- “There’s not enough time” - Acknowledge they are busy and provide positive counterpoints, and offer ideas for making time for teach-back.

Providers and staff often worry about how much time teach-back will take. A study in a public outpatient clinic showed using teach-back did not significantly increase the length of an encounter, while its use was associated with improved glycemic control among adults with

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diabetes. On average, it took 1.8 minutes more.¹⁶ This adds up over the course of a day, but providers can *lose* time looking for missing information; trying to figure out why a patient is not responding to therapy even though they answer yes when asked if they are taking their medicines; and responding to interruptions to answer questions and give clarifications for staff on behalf of patients who didn't understand or remember. The same is true for nurses and others who handle telephone calls and answer client or patient questions.

Other studies showed increases in length of 2.6 minutes for implementation of repeat-back within an electronic informed consent system that improved patient comprehension; 4.3 minutes for hospital teach-to-goal education that led to improved metered dose inhaler use; and 7-8 minutes for respiratory therapists using teach-back in pediatric outpatient asthma clinics.²⁵⁻²⁷ These are good examples where taking some additional time, involving multidisciplinary health team members, and adding teach-back to important discussions, especially in higher-risk situations, can enhance care.

Compare the investments of time, purpose, or staff to the potential benefits. Investing in organizational teach-back initiatives may impact factors that contribute to determining/assessing return on investment, such as:

- Improved outcomes, especially for chronic conditions that impact reimbursement.
- Accountable care organization requirements to optimize the health of populations.
- Patient experience data that contribute to determining reimbursement.
- Reduced liability/improved risk management.
- Addressing accreditation and regulatory guidelines.
- Promoting health equity, reducing health disparities, addressing systemic racism.
- Promoting patient safety and reducing adverse medication events.
- Promoting patient-/family-centered care.
- Alignment with mission, vision, and values.
- Improved efficiency through fewer interruptions, call-backs, and missed appointments, and better adherence.

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Additional time is often less than believed or experienced at the outset of using teach-back, as skills are gained and embedded into practice patterns and habits. Doctors have reported that once they get the hang of it, teach-back doesn't lengthen visits because they didn't add it on at the end. Instead, they changed how the visit flowed, building in little teach-backs throughout. They also came to recognize when they were using confusing wording, so were able to change how they explained things upfront, enabling people to teach back successfully. And, time saved by limiting information to three need-to-know concepts can be used for teach-back.

As understanding increases, there may be fewer call backs and cancellations, better adherence, smoother transitions in care, and improved rapport and satisfaction. Then, the health team can focus more on ensuring the information they convey is understood and gives people what they need to care for themselves later.

Observations of a Family Physician Who Introduced Teach-back into His Practice

“There were surprising misconceptions of patients’ understanding of instructions [before using teach-back]. Nonverbal cues do not seem reliable. In [the] absence of teach-back, the only indicator of misunderstanding may be [a] medication mistake or patient error, which could be harmful.”

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Selected References Demonstrating Effectiveness of Teach-back

- Carroll, et al., 2024, *JAMA Network Open* - In a pediatric tertiary care hospital, a health literacy discharge medication communication bundle reduced home liquid medication administration errors and enhanced caregiver medication knowledge. <https://doi.org/10.1001/jamanetworkopen.2023.50969>
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- Press, et al., 2016, *Ann Am Thorac Soc* - Among hospitalized adults with asthma or COPD, use of teach-back (teach to goal [TTG]) was associated with fewer acute care events within 30 days of discharge, especially among those with low health literacy, and lower metered dose inhaler misuse immediately after education; the effect waned, suggesting need for reinforcement. <https://doi.org/10.1513/AnnalsATS.201509-603OC>
- Schillinger, et al., 2003, *Archives of Internal Medicine* - In a public outpatient clinic, physician use of teach-back was associated with improved glycemic control among adults with diabetes. <https://doi.org/10.1001/archinte.163.1.83>
- Ulrich, et al., 2022, *Journal of Asthma* - Through a quality improvement project, respiratory therapists, with a standard asthma teaching protocol, used teach-back to explain pediatric asthma patients' asthma action plans and check for understanding. Use of teach-back during outpatient pediatric pulmonary asthma clinic visits improved from 43% to 82%; there was a 10% decline in emergency department visits among the same population over the same time. <https://doi.org/10.1080/02770903.2020.1870131>

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Teach-back in Action: Successfully Learning to Manage Insulin

Listen to this story about Meagan’s grandmother, who struggles with reading. When Meagan and her grandmother’s primary care doctor worked with her to teach her how to use her insulin and then used teach-back and return demonstration to assess and confirm understanding, her grandmother had a positive learning experience.



To watch this video, click [HERE](#)
or scan the QR code below.



Help People Initiate Teach-back with the Health Team

It’s helpful to encourage people to elicit teach-back to empower them as active participants in their care since not every member of the health team will use teach-back. There is usually at least some information they may not understand or remember well enough to share with others. Although you may not call it teach-back, introduce teach-back with individuals and also in community presentations, classes, and health fairs. Help people practice how to ask for teach-back using phrases like these:

- “Let me be sure I understand. This is what I heard you say...”
- “I want to go over this again because it’s complicated...”
- “I want to be sure I can tell my grandfather what he needs to do. Can you explain that again?”
- “Can you write that down for me...?”

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Explain this in the context of their role as partners in their care:

- “You are checking to be sure you understand the information you need.”
- “You are making sure you get the highest quality care.”

Teach-back in Action: Initiating Teach-back in Various Settings

Adult Patient Asking for Clarification with Primary Care Nurse Practitioner



To watch this video, click [HERE](#)
or scan the QR code below.



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Grandmother Asking for Clarification with Nurse in a Neonatal Intensive Care Unit



To watch this video, click [HERE](#) or scan the QR code below.



Shopper Initiating Use of Teach-back by Vendor at a Mobile Produce Market



To watch this video, click [HERE](#) or scan the QR code below.



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Anytime Anywhere – Meeting Attendee Asking for Clarification



To watch this video, click [HERE](#) or scan the QR code below.



Tools to Encourage Questions Help Identify Key Messages

Ask Me 3[®] can be used to encourage clients, patients, and families to ask questions. It can also guide the health team in identifying key messages and using plain language to ensure people know the answers to these three questions—the need-to-know information—before concluding a health encounter. The following examples show how thinking about and preparing to share the answers to the questions can streamline and clarify the most important message.

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Patient: Ramon, 4-Year-Old Boy With Cavities

Ask Me 3[®] Questions	What the Parent Should Understand At the End of the Visit
What is my child's main problem?	<ul style="list-style-type: none">• Ramon has cavities, or holes in his teeth.
What do I need to do?	<ul style="list-style-type: none">• I should stop his bottle.• I should brush his teeth two times every day.• I should stop giving him sugary drinks, including juice.• I should get him a dentist appointment as soon as possible.
Why is it important for me to do this?	<ul style="list-style-type: none">• If Ramon's cavities get worse, he will have pain and might even need a big operation to fix them. They might even hurt his health later in his life.

Reprinted with permission from *Plain Language Pediatrics: Health Literacy Strategies and Communication Resources for Common Pediatric Topics*, copyright 2009 by the American Academy of Pediatrics

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Client: Trina, 24-Year-Old Woman With Type 2 Diabetes

Ask Me 3[®] Questions	What the Person Should Understand At the End of the Visit
What is my main problem?	<ul style="list-style-type: none">• I need to re-enroll in Medicaid before the end of this month.
What do I need to do?	<ul style="list-style-type: none">• I need to _____.• Then I have to _____.• I have to do this before _____.• If I don't hear back by _____, I need to check with them by _____.
Why is it important for me to do this?	<ul style="list-style-type: none">• If I don't re-enroll by the end of this month, I will not have health insurance for my doctor's appointments and medicines, and it will take another _____ months to get signed up again.

Changing the Way I Talk with Parents

One pediatric resident noted, "Using Ask Me 3[®] changed the way I talk with parents." It helped her highlight what parents needed to know to care for their child. She said, "The three questions helped me make sure I gave them the answers to these important questions in a way they could understand."

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Work with Qualified Health Interpreters and Communicate across Cultures

Everyone on the health team should know how to access and work with a trained health interpreter who follows a Code of Ethics. People whose primary language is not English are more likely to experience errors in the health care setting.²⁸ Asking a family member or using staff who speak the language but are not skilled in health interpreting to serve in that role for medical information can result in omissions, additions, opinions, and errors. Asking a child to interpret for a parent is especially problematic due to embarrassment, confidentiality concerns, and stress related to upsetting roles and responsibilities within families. The AHRQ Universal Precautions Health Literacy Toolkit⁴ (<https://www.ahrq.gov/health-literacy/improve/precautions/tool9.html>) provides valuable tools for addressing language access.

Language services are generally provided through translation of written materials and direct interpreting of verbal language. Interpreter services can be provided in several ways, including staff interpreters, contract interpreters, language banks, and video interpreters. In health care, interpreting is usually consecutive. The provider speaks, then pauses for the interpreter to interpret. The client, patient, or family member speaks, and again, there is a pause so the interpreter can interpret. When working with an interpreter, here are key practices to know:

- The health team member faces and speaks directly to the client, patient, or family member.
- The client, patient, or family member should face the health team member and interact directly with them.
- The interpreter uses first-person speech and interprets everything that is said. Transparency is critical.
- Sometimes, the interpreter may intervene to clarify or to explain a cultural practice. If so, the interpreter is playing a cultural broker role. It is important that everyone knows what role the interpreter is playing, whether it be direct message converter, message clarifier, or cultural broker. Also, be sure your interpreter colleagues know how teach-back works.
- Health teams should call for an interpreter whenever there may be miscommunication. For example, for family members even if a patient says they speak English or when they want to use a family member or friend to interpret. Explain that this will help make sure everyone understands.

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Language Access Video Resources

Information about the importance of language access to safety, equity, and patient- and client-centered care can be found in these resources:

- TeamSTEPPS® Enhancing Safety for Patients with Limited English Proficiency Module (6:20). This is a good resource for staff to help them work as a team with interpreters to improve safety.
<https://tinyurl.com/ypvaxezx>
- MPATHI: Making Professionals Able Through Immersion (19:38). This enables you to walk in others' shoes by experiencing and identifying with language barrier challenges immigrant families face in obtaining care for their child in another country.
<https://tinyurl.com/bdecnuc4>

Here are resources when working with interpreters:

- Working Effectively with Professional Interpreters, Stanford University Medical Center (18:50 minutes): <https://tinyurl.com/bdy cru26>
- Qualified Interpreting for Quality Health Care (19:27 minutes)
<https://tinyurl.com/4vt sm65k>

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Addressing Language Barriers in Action

These videos focus on language access in an unwelcoming and welcoming health environment—one that does not address language access and one that does.

Unwelcoming Environment: A person with limited English proficiency goes to a public health department to be vaccinated. There are unclear signs and only in English. There is no greeting at registration. No interpreter services are offered. The person leaves without being vaccinated.



To watch this video, click [HERE](#) or scan the QR code below.



Welcoming Environment: A couple with limited English proficiency goes to a public health department to be vaccinated. Readily visible, easy-to-read signs and navigation guides are available in multiple languages. There is a warm greeting at registration with a smile. A language identification guide is offered, and a qualified health interpreter is quickly made available at no cost. The couple is vaccinated.



To watch this video, click [HERE](#) or scan the QR code below.



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Be sure everyone on the health team is trained in how to work effectively with an interpreter, including ASL interpreters.

The National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS Standards)

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National CLAS Standards

National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care

View the Standards (PDF - 48 KB)

The enhanced National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS Standards)⁹ (<https://thinkculturalhealth.hhs.gov>) give guidance for responding to diversity in health and health care. The Principal Standard recognizes the issue of health literacy and calls on health professionals to be “responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs.” The Standards are designed to provide a common understanding and structure for advancing health equity, improving quality, and eliminating health disparities by specifically addressing three areas:

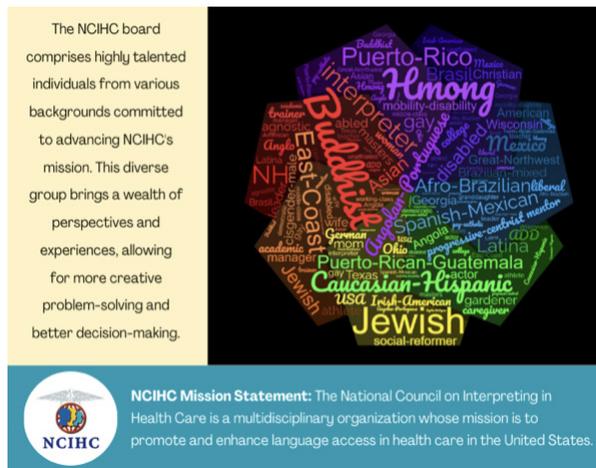
- Governance, Leadership, and Workforce
- Communication and Language Access
- Engagement, Continuous Improvement, and Accountability

There is an Implementation Checklist with examples of successful CLAS-related organizational activities and an action worksheet to plan CLAS activities. The CLAS website has information in multiple languages. <https://thinkculturalhealth.hhs.gov/assets/pdfs/AnImplementationChecklistfortheNationalCLASStandards.pdf>

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National Council on Interpreting in Healthcare

The National Council on Interpreting in Healthcare (NCIHC) (<https://www.ncihc.org/>) is a multidisciplinary organization whose mission is to promote and enhance language access in health care in the United States.



NCIHC advocates for policies and practices that support language access in health care, including the use of qualified interpreters and the provision of language assistance services. Their website is a good resource for users of the Language Access guidebook. Most of the resources and webinars are available to the public. Members have access to additional resources such as a Listserv and can attend continuing education at no cost.

As part of a collaboration with the Accreditation Council for Graduate Medical Education (ACGME), the NCIHC created a short guide to partnering effectively with an interpreter in health care settings.

Guide for Partnering with an Interpreter from the National Council on Interpreting in Health Care:

<https://www.ncihc.org/assets/documents/publications/NCIHC%20Partnering%20with%20an%20Interpreter%2C%20no%20graphics.pdf>



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Countering Misinformation

Think about using health literacy approaches to counter misinformation. Explaining in clear, everyday language and checking for understanding can promote trust. Demonstrating genuine interest in people’s concerns and listening and responding thoughtfully can help diminish emotional and sensational overtones and clarify key messages. Providing credible, understandable, and easy-to-navigate information sources can support people who want to find answers to their questions. Partnering with trusted community leaders can foster trust and convey messages with cultural humility.

MedlinePlus is a reliable online consumer health information resource in English, Spanish, and other languages. It has accurate, up-to-date information, and features that make it easier to use, like various reading levels, multiple languages, and interactive tools.

Reducing Parent Uncertainty

“My grandson was diagnosed with strep throat which then got worse. His doctor referred him to a specialist who described his diagnosis in language that left his parents in total terror by the time they left the office. They called me, and I decided to do a little research on my own.

A friend had been using a medical website she was very comfortable with and shared it with me –MedlinePlus.gov (<https://medlineplus.gov/>). I went into this site very skeptical. I found the medical term was very easy to pull up and the language level was easy to understand. This site explained the symptoms, diagnosis, and treatment, answering many of my questions and concerns.

I would recommend this website to anyone who has questions on health-related topics and concerns. I shared it and my findings with my daughter and she was very impressed with the simplicity and information you could get your hands on right away. The best diagnosis to this story is that my grandson is a very healthy 5-year-old again.”

—Patient Caregiver

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Sources to Learn About Countering Misinformation

Confronting Health Misinformation: The U.S. Surgeon General’s Advisory on Building a Healthy Information Environment

<https://www.hhs.gov/sites/default/files/surgeon-general-misinformation-advisory.pdf>

How to Address COVID-19 Vaccine Misinformation

<https://www.cdc.gov/vaccines/covid-19/health-departments/addressing-vaccine-misinformation.html>

Evaluating Internet Health Information: A Tutorial from the National Library of Medicine

<https://medlineplus.gov/webeval/webeval.html>

Trusted Health Information Websites

MedlinePlus: https://medlineplus.gov/all_easytoread.html

<https://medlineplus.gov/languages/languages.html>

MyHealthfinder: <https://health.gov/myhealthfinder>

Community Health Workers as Trusted Community Partners

Community health workers who serve as trusted community partners can share accurate, culturally- and linguistically-appropriate, and health literacy-informed health information with their community. They can use plain language and teach-back to make sure complex information and terms are conveyed and understood by those they are helping navigate both public health and clinical settings.

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Insights from a Community Leader on Building Community Health Literacy to Achieve Health Equity

“Similarly, community health workers serve as educators and trusted community liaisons serve as a bridge across cultures that interprets language and culture. Cultural interpretation is more complex than language interpretation or translation. The cultural liaison deeply knows the community norms, social life, structure, religion, art, culture, and language and interpretation of those terms in the contexts of their own community. The cultural liaison also knows the other culture by training and lived experience, so they can become a liaison in messaging for both cultures in a meaningful way.”

— Bhutanese Nepali Community Engagement and Career Coordinator²⁹

Teach-back in Action: Community Health Worker at a Public Health Vaccination Clinic

Watch a community health worker use teach-back practices with a community member at a vaccination clinic.



To watch this video, click [HERE](#)
or scan the QR code below.



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Summary of Key Points

- Communication is at the heart of health care and public health. Without understanding, people can't be partners in their care.
- The health team has a responsibility to make sure people have, understand, and can use the needed information.
- Ensuring clear communication and understanding contributes to health equity, safety, quality, and patient-, family-, and client-centered care.
- *All* members of the health team should use plain language.
- *All* members of the health team should use teach-back for key information.
- Team members should pass along concerns about understanding, or get someone to help, to be sure people understand what they need to do to care for their own or others' health.
- Teach-back should always be used to support patients and families, especially during higher-risk situations like transitions between health care settings, medication discussions, and the informed consent process.
- Teach-back should always be used to support clients and community members when there are complex and/or important health issues to address.
- Without teach-back, you may only learn that someone didn't understand when a bad outcome happens.
- Everyone on the health team should know how to access and work effectively with qualified health interpreters.
- Tools like Ask Me 3^{®8} can help promote use of plain language and identify key actionable messages among health team members.
- Small tests of change and quality improvement approaches can help health teams build teach-back and other effective communication strategies into their routines.
- Using plain language and teach-back may take extra time at the beginning but can become second nature with practice.
- Investing time to communicate clearly up-front may lead to better outcomes and save time and resources by preventing interruptions, cancellations, and having to problem-solve later.
- Using clear interpersonal communication practices can build trust and help overcome misinformation.

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9 | Use Reader-friendly Plain Language Print Materials and Digital Content

“With the help of an interpreter, I did my best to explain what a recall was. ... The scary thing is that if she had not given me that letter, her child could have been at serious risk. The recall said the seat the child sits in had a risk of detaching from the base, thereby putting her at risk for injury. While this situation was indeed complicated by a language barrier, I had a similar situation with an English-speaking family who also disregarded the letter and recall because they didn’t understand its importance.”

— Stephanie S., Physical Therapist



To watch this video, click [HERE](#) or scan the QR code below.



To be a health literate organization, print materials and digital content given to clients, patients, and families should be:

- Written in plain language and at a reading level that is effective for the widest range of people possible.
- Current and accurate.
- Engaging, relevant, and effective.
- In the language spoken (and maybe read) by the intended audience.

Reader-friendly Print and Digital Content

Ideally, organizations will have all the print materials and digital content needed to communicate effectively with the full range of people they serve, as well as their employees and stakeholders. Also, senior leaders, directors, and managers should understand that easy-to-read, culturally- and linguistically-appropriate information supports goals for health quality, patient/client safety, equity, health disparities, and improved health outcomes.

The ideas and tools in this chapter are designed to help you:

- Create reader-friendly plain language information that is easy to understand and act on for the people who come to your organization for services and information.
- Assess information from inside the organization as well as outside sources, including vendors, websites, and publishers, for its fit for your patients and clients.
- Ensure the communication needs of people with learning differences, disabilities, and language and cultural barriers are met to the fullest extent possible.

A Health Literate Organization Provides Print Materials and Digital Content that Are Easy to Understand and Act On

This chapter directly addresses Attribute 8 in the Ten Attributes of Health Literate Health Care Organizations — “Designs and distributes print, audiovisual, and social media content that is easy to understand and act on.” This chapter will also help your organization address Attributes 4, 5 and 7. These Attributes call for “involving populations served” in creating health information, “meeting the needs of populations with a range of health literacy skills,” and “providing easy access to health information.” Skills you will learn in this chapter will also help with Attribute 10, which calls for “communicates clearly what health plans cover” and what the costs are.¹

This chapter is a great start for people in your organization to learn how to create effective print and digital information. While it is not possible to be comprehensive in a chapter, we cover foundational principles and key guidelines for creating information for as many people as possible. If you want to dive deeper, take a look at the resources listed throughout. You can also explore classes and workshops (in-person or live online) and self-paced online modules. Find something that works for you.

Reader-friendly Print and Digital Content

What are Print Materials and Digital Content?

In this chapter, we use the terms above to refer to two categories of information—print and digital. The information may differ in how it is produced and in how it is disseminated.

We use *print materials* to refer to paper documents like handouts, flyers, forms, brochures, magazines, or books. These are usually produced digitally and disseminated in print format.

We use *digital content* to refer to information that is electronic or digital and is produced and disseminated via websites, mobile phone apps, social media, videos, digital broadcasts, streaming, or other platforms.

Note that some information may be online and downloadable to be printed. The digital and print versions both must follow reader-friendly guidelines.

Why Do Print Materials and Digital Content Need to be in Plain Language?

First, what is the plain language approach? And why should you use it? Here is a definition: “A communication is in plain language if its wording, structure, and design are so clear that the intended readers can easily find what they need, understand what they find, and use that information.”² Notice the definition focuses on *finding*, *understanding*, and *using* information.

You might notice, too, that the definition refers to structure and design in addition to wording (language). “Plain language” is an *approach* to clear communication. You will learn more about creating plain language communication later in this chapter. For now, we discuss reasons to use the approach and some of its benefits.

Everyone has a right to forthright, understandable communications from all segments of society, e.g., health-related organizations, schools, lawyers, law enforcement, businesses, and more. If health information is intended for the public, we need to think about reaching people with all levels of reading skill.

It’s generally easier to create content for people with higher literacy skills because most highly educated people are used to reading and writing at a higher level. Writing in plain language can be more challenging. As they craft content, writers need skills beyond finding simpler wording.

Reader-friendly Print and Digital Content

They must also keep in mind other principles of plain language writing, organization of the content, and information design. It can surprise people to find that this can be a more difficult assignment than writing as usual.

We cannot ignore people who have lower literacy skills. They may struggle with text in any format. And yet, in today's society, text is the form of almost all health-related information. We know that people with low or limited literacy skills read differently from those with well-developed skills. Research shows the reading behavior of higher-skilled readers is very different from that of lower-skilled readers. Higher skilled readers can skim text to find what they need or want, but readers with lower literacy skills usually dig in and plow through text word by word. They need to sound out unfamiliar words and usually lack fluency even with words they know. Their reading process is more difficult and much slower.

Therein lies the challenge. Readers need fluency and speed to comprehend what they are reading. Words need to flow in the reader's mind—more like conversation—to be easily understood. So, when we take time to use plain language writing and to apply other guidelines that help struggling readers, we show we care about them. To get a sense for how struggling readers feel, try reading this:

The purpose of the Consumer Nokeefrap Grixto is to help all consumers understand key grixto about their ipsher nokeefrap, including how to sapt it, how to vish it, and other general grixto. It also gives grixto on bogstraps and eeksters.

Did you zip through the two sentences above? Probably not! Chances are you struggled. Maybe you tried to figure out how you might pronounce the strange words, what they could mean, and why they were there. Or perhaps you gave up and jumped to this paragraph. The words you couldn't make sense of are fake words. Did you figure out "grixto" meant "information?" The mystery paragraph above is an edited version of text from a Consumer Medication Information document.

Either way, you experienced how it feels to struggle with reading words you don't recognize and to try to make meaning from text. This is what it's like for many people when they try to read print or digital information commonly used in medical, public health, and other health-related organizations.

Think about how long you would be willing to hang in there with a document you couldn't easily read. Most of us give up quickly and tell ourselves we'll read it later. We put it down and seldom return to the "To Read" pile—the Document Graveyard!

Reader-friendly Print and Digital Content

In some cases, it's not too much of a loss to put a document down and never get back to it. But in other cases, health and even life can be at stake.

The Plain Language Approach

The plain language approach demonstrates the organization or entity cares about, respects, and understands its audience and has taken the time to communicate what the audience or clients need to know or do. Plain language allows people to focus on the message itself instead of the complexity of the message. An organization that shows transparency by using plain language in its communications can build trust and loyalty among its employees and customers.

The video below explains more about plain language, what it is and isn't, and its benefit.



To watch this video, click [HERE](#)
or scan the QR code below.



There are other reasons to use the plain language approach. Anyone can struggle to understand (and act on) health and medical information, regardless of their literacy skills. Many factors can influence a person's ability to comprehend and remember what they hear in medical or public health settings as well as in the media. Examples are:

- Lack of familiarity with a new environment.
- Lack of knowledge in a topic area.
- Unfamiliar vocabulary, e.g., technical terminology.
- Lack of familiarity with, or lack of trust in, the organization providing the information.

Reader-friendly Print and Digital Content

- Fear.
- Anxiety.
- Worry.
- Fatigue.
- Illness.
- Distractions.
- Time pressure.

We cannot control the factors above but we can address the literacy and language challenges. It's critical to understand the gap between the literacy demands of most health information and the literacy abilities of most adults in the U.S. As many as 2,000-3,000 studies have shown the reading level of information in various health-related fields is at or above 10th “grade” level.³ The median reading level of adults (who are able to read English) in the U.S. is about 8th “grade” level and 1 in 5 U.S. adults reads at 5th “grade” level.⁴ (We use quotation marks around “grade” because the scores do not match what is currently taught in those grades in schools. Instead, think of the scores as numbers on a continuum.) As far back as 2004, the gap had been identified.⁵ This gap creates the need for more carefully-crafted reader-friendly, plain language information.

Many adults struggle with reading, writing, and math for a variety of reasons—from lack of education to language barriers to learning and other types of disabilities. Much of the public's contact with health information is through the written word, whether on paper, computers, phone apps, or other sources. The written word can be a useful tool for a person with well-developed general literacy skills but it can be an obstacle for a person who has limited general literacy skills and/or doesn't speak or read English well.

Lastly, even skilled readers prefer information that is easy to read. No one complains that information is too easy, especially if it contains new words like the name of a test or their newly-diagnosed condition. Most of us are just grateful the information is a “quick read” so we can process what it means and what we need to do and then get on with our day.

Reader-friendly Print and Digital Content

Literacy vs. Health Literacy

How are general literacy skills different from health literacy skills? An individual's *health* literacy is their ability to “find, understand, and use health information and services”⁶ to inform decisions and actions about their own health and, possibly, others. Low health literacy can affect anyone, from those with limited to excellent general literacy.

People may have low health literacy because of:

- Lack of knowledge about the human body, causes of illness, taking and giving medications, and how their health care system works.
- Being in an unfamiliar environment.
- Illness or side effects of medicines.
- Fear, anxiety, worry, distractions, and more.

Regardless of general literacy skills, limited health literacy can be a barrier in understanding health information and managing the tasks related to getting care for our own health and helping others with their health.

Effective Print and Digital Information Supports People in Clinical Settings

Patients, families, and caregivers need plain language print and web information to manage their health. Many people who struggle with reading say they don't go to the doctor because they are intimidated by the forms. Think about all the other tasks in health care that would also be barriers for them.

Reader-friendly Print and Digital Content

Frustration and Fear at the Doctor's Office: A Patient's Experience

The story below illustrates where opportunities for better communication exist in many health care settings.

“When a person does not have strong reading skills, you go into a doctor’s office, a clinic or a hospital, there’s always paperwork they automatically hand to you...and say, ‘Fill these things out.’ A lot of frustration starts to build up inside of a person. It just keeps building and building as you look at the form... You actually have fear of, ‘How am I going to spell this word? Am I going to be able to write?’ When you have questions you wanted to ask, by the time you get to the doctor or other professionals, you’ve lost your train of thought. You get lost in the shuffle... Sometimes you feel like you got shortchanged on your medical experience.”

Osborne, H, host. “Archie Willard talks about struggling to read”. *Health Literacy Out Loud* #3 October 20, 2008. <https://www.healthliteracyoutloud.com/2008/10/20/archie-willard-what-its-like-to-be-a-struggling-reader/>

This story illustrates the frustrations and fears many patients have as they enter health care settings. Another challenge many patients face is forgetting information because of the stress they experience in the health care setting—an unfamiliar and scary place to many. No matter how well a health care provider answers questions about an illness, treatment, or next steps in a process, patients may not remember what was said after they leave the exam room or hospital.

Research shows most people forget 40-80% of the information covered, or they remember it inaccurately.⁷⁻¹³ This can be true in any health care encounter, be it an exam room, hospital, pharmacy, home health visit, or telemedicine appointment. It is also likely that public health information, delivered via media or in person, may be remembered incorrectly or not at all. For this reason, health literate organizations make sure to supplement verbal communication with effective, plain language print materials, and/or digital information, that can be referenced later. Patients need to use print and digital information in these settings.

Reader-friendly Print and Digital Content

Potential Uses of Text-based Information in Clinical Settings

Patients and families in medical or dental settings need to use print or digital information when they are:

- Finding a doctor's office, lab, or urgent care clinic.
- Filling out health history forms at a dental clinic.
- Using a patient portal.
- Reading prescription and over-the-counter drug labels.
- Using their insurance, filing insurance forms, and paying medical bills.
- Creating an advance directive to share with their doctors.
- Writing questions before, and noting answers during, appointments with health care providers.
- Searching for reliable health information.

How Reader-friendly Information Can Help

People often need time to process what they have heard in their doctor's office. Effective handouts can guide, reinforce, and supplement providers' explanations after the patient leaves the health care setting. This is true especially if providers write directly on the handout while telling the patient what marks they are putting near specific content. Some people will remember what content is near each mark, e.g., a star by the instructions for wound care or a circle around how to take a new medication. This can help readers refer back to the information later, and is especially helpful for people who are not confident readers.

Plain language documents can also help providers by furnishing simpler versions of wording for their spoken explanations. Providers should be able to switch from medical language to plain language in verbal communication. While they learn and practice this skill, handouts with plain language terms can be helpful.

Patients are only with their health care providers a fraction of the time they are dealing with their health conditions. Most self-management of health conditions is carried out by patients and families or caregivers at home, work, or school.

Reader-friendly Print and Digital Content

Family members and other caregivers rely on printed information to help them support loved ones. They will find reader-friendly plain language information useful, if not essential, to understand how to care for themselves or their loved one.

Effective Print and Digital Information Also Supports People in Non-clinical Health Settings

In public health and other health-related organizations, plain language information supports communicating critical news or guidance with people they need to reach.

There are many health-related tasks needed or carried out in non-clinical settings like public health programs, managing health insurance paperwork, or working in a hospital role with no direct patient contact. In each of these cases and many more, people working in non-clinical settings need to interact with print and digital information on the job or in their own lives.

Potential Uses of Text-based Information in Non-clinical Settings

In public health and other health-related organizations, employees, clients, and community members use print materials and digital information when they are:

- Reading flyers and brochures about vaccination clinics, public health fairs, or community clinics.
- Understanding and using text messages from a public health agency on parenting tips or notifications of exposure to a contagious disease.
- Reading and understanding their health insurance member handbook.
- Understanding the services offered at a tribal public health clinic.
- Reading food labels to check for sodium or sugar content to make healthy choices.
- Reading instructions on using equipment at a gym.
- Completing health surveys.
- Distinguishing between disinformation, misinformation, and information from credible sources.

Reader-friendly Print and Digital Content

How Reader-friendly Information Can Help

The volume of information from multiple sources can be difficult to navigate, regardless of literacy skills. For people who have low or limited literacy skills, it can be very tough. Reader-friendly documents and digital information can help them obtain and understand the information they need.

In non-clinical settings, people may be on their own to find, understand, and use print or web health information. They may not have access to someone to talk with about the information they seek or what they find. Reader-friendly, plain language information can give them the opportunity to understand, judge, and decide on their next action by being better informed. One example: recognizing misinformation or disinformation may be difficult for many people. Reader-friendly information can be helpful because it is generally easier to understand. And when people understand what they read, they are able to think it through, and more easily judge its validity.

Many people find themselves trying to compare and choose the right health insurance plan. They may struggle to understand the jargon and technical terms used in the insurance industry. It can also be hard to compare features because they are often not described in comparable terms. Easy-to-read information could help them learn the insurance vocabulary. When you know how insurance works, and you understand the concepts for things like deductible (needing to pay for some things at the beginning of the year) and the vocabulary used for those concepts, choosing insurance is easier. It's less likely people will end up with a policy that doesn't provide the coverage they or their family needs or one that costs more than it needed to.

Effective Print and Digital Information Promotes Safety and Quality

Plain language print and web information is essential for safety and quality in health organizations. What can happen without it?

On a health history form, patients and consumers may skip questions they don't understand. Some people have described marking "no" to every condition so they are not asked questions about health issues they don't understand. Important responses may be missing, like not listing a family member with a genetic condition, leaving doctors without information needed to diagnose and manage health problems.

Reader-friendly Print and Digital Content

Similarly, in research settings, participants may be asked to sign consent forms, many of which are written at college level, making them extremely difficult for most of the public. If people don't fully understand their choices, the risks and benefits, or possible health outcomes related to their research participation, they may have unexpected adverse results.

When people don't understand instructions, they can't follow them. If patients and families don't understand how to care for themselves or their loved one after a hospitalization, it could lead to poor outcomes, unreimbursed readmissions, and repeated hospital stays. For example, directions on a prescription medication bottle may show one interval for dosing but directions on the discharge papers may show another. Conflicting information like this can lead to confusion and potential medication errors.¹⁴

For clients or patients who need language assistance, their safety and their trust in the organization is at stake. If a trained interpreter is not called to interpret verbal instructions, and printed information is not translated, misunderstandings or adverse safety events may occur. For example, a person who doesn't receive a translated handout of instructions for a colonoscopy may not properly prepare for the procedure. This can lead to undiagnosed polyps or tumors that are not addressed.

Effective Print and Digital Information Can Help Lessen Health Disparities

Plain language information can help overcome communication and learning barriers that contribute to health disparities. In addition, information that addresses cultural and linguistic factors can help overcome these barriers. This can be done by ensuring all information is: 1) appealing, sensitive to, and relevant to the audiences' cultural beliefs, various identities, and practices, and 2) is in the audiences' preferred language.

Communication and Learning Differences

People with different communication or learning needs can be helped with clear, plain language information. Here are some examples.

People with a *visual impairment* or a *learning disability* can benefit from documents and digital information that follow many of the guidelines for plain language information. These include using language that is easy to read and understand. They also include these formatting and type

Reader-friendly Print and Digital Content

specifications: about half of the total space on each page should be white space (this means open space or images—just not text), text that is 12 point or larger, use of clear headings and bullets that help the reader (or user) navigate through the document, and clear, relevant illustrations.

These same people may need easy-to-navigate digital information designed to work with assistive devices like screen readers. Print information may need to be enlarged. Documents, websites, and other digital media that meet accessibility standards are also helpful for information exchange and can address health disparities. Without these supports, people with visual impairments or learning disabilities may experience health disparities that negatively affect their health.

Both *Deaf and hard of hearing* people can face barriers in understanding health-related information in print or digital formats. The barriers create health disparities for these populations.¹⁵ Deaf and hard of hearing people may not read, write, or understand English well enough to comprehend medical information. Many Deaf people will have learned American Sign Language (ASL) as their first language, particularly if they have a Deaf parent. ASL is a distinct language not related to English so without explicit instruction, Deaf people may not have learned English.

Hard of hearing people may miss a significant amount of the English spoken around them. If they were hard of hearing as children, they may have struggled to learn a clear model of English. For these reasons, Deaf and hard of hearing people are often considered English language learners. They may be learning English for years, or even their whole lifetime. They will likely benefit from plain English in print and digital information. Being able to access easier to understand English can address health disparities in these two populations.

If you're interested in understanding the reason for the capital D in "Deaf" above, we recommend you search the internet for "big D and little d deaf" for an explanation. The distinction is very important to deaf identity and the deaf community.

Cultural and Linguistic Differences

Cultural and linguistic differences between clients or patients and those who serve them can create communication barriers that contribute to health disparities. Print and digital information that reflects your audiences' language and culture is very important. For example, a patient and family may be from a cultural group that has different beliefs about causes, prevention, and cures for illness than the health care system where they receive care. Culturally-relevant messages, delivered in plain language, can help members of the intended audience recognize the information

Reader-friendly Print and Digital Content

is applicable to them and feel better equipped to decide a path forward that makes sense to them.

In addition to cultural challenges, speaking and reading only a language other than English is a barrier for many people in our largely English-speaking health care system. High quality, plain language translations are needed for all populations who read a language other than English.

What Does Success Look Like?

Here is what a health literate organization with easy-to-find, easy-to-understand, and easy-to-act on print materials and digital content may have in place.¹

Print Materials and Digital Information

- Print and digital information is appealing to look at, relevant, and easy for the intended audiences to read, understand, and act on.
- All information—from consent forms to your website to signage in your facilities—adheres to guidelines for plain language, cultural relevance, and accessibility.
- When creating plain language information, the organization engages members of the intended audience(s) to help determine what and how much they want to know, how the information can be communicated, and what will make it engaging and relevant.
- Print and digital information is written at 8th grade reading level or below (measured with the SMOG—Scientific Measure of Gobbledegook—readability formula).
- Information starts with the most important content for the reader to know and to do.
- The purpose and audience for the information are obvious at first glance.
- Print and digital information is not assumed to replace verbal communication, and doesn't conflict with what providers and staff say.
- Reader-friendly print and digital information is available in the primary languages spoken by the communities you serve.
 - Translators are provided plain language versions of documents in the source language (usually English) to work from.
 - Translators are trained to create a plain language adaptation in the target language (the language into which the new document is translated), keeping the text at a similar reading level as in the English text.

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- Translators are also from a similar background and culture as those for whom they are translating information so they can provide a cultural adaptation. A cultural adaptation is a process of keeping the meaning but adapting it so it makes sense to people from other cultures.
- Some print materials are created directly in the needed language with collaboration among members of the intended audience, subject matter experts, and plain language materials developers.

An Organization's Health Care Providers and Staff

- Health care providers understand the importance of using effective plain language print and digital information and choose the most reader-friendly information available.
- Staff are trained to make sure they get the right materials into the right hands at the right time.
- A core group of employees is formally trained in plain language and has experience in developing new, and revising existing, print materials and digital information. This core group works closely with members of the intended audiences in developing new materials and information.
- Health care providers and staff who are not fully trained to develop new materials have learned some strategies for revising existing materials to better meet the needs of patients, families, consumers, and the public. They also have access to a team of people who are fully trained and have experience in developing reader-friendly, plain language information to advise them.
- Health care providers learn and use strategies to mark up print materials as they go over them with patients, families, or clients. This helps people with all but the most basic levels of literacy find, understand, and use the information on their own later.
- Health care providers always check for patient, family, and client understanding when using print and digital content by using teach-back, a specific strategy for assessing and confirming comprehension.^{16,17}

The Organization

- Your organization has policies that call for use of plain language print and digital information and include plain language guidance and comprehensive assessment criteria.

Reader-friendly Print and Digital Content

- Your patients, families, clients, staff, and community have easy access to relevant effective materials on many common topics.
- Your organization’s leaders devote resources to health literacy. For example, they allocate funding and employee time for:
 - Revising existing and developing new print materials and digital content.
 - Creating quality translations.
 - Training for health care providers and staff.
 - Establishing an electronic system for cataloging and creating documents and digital content that is simple to maintain and widely available when needed, and
 - Time and staff to update digital information on a regular basis.
- Navigation interviews (or walk-throughs) are used to identify opportunities to improve signage and wayfinding.¹⁸
- Adult learners and Patient and Family Advisory Committee members are recruited and trained to provide input on improving print materials and digital content.
- Paperwork and forms are minimized. Paperwork is sent or downloadable ahead of time so people can fill it out at home. In the clinical setting, help is offered to everyone in a friendly, pro-active, non-shaming way. There is dedicated, private space for staff to help patients and clients with paperwork.
- Letters and correspondence from your organization, like lab and x-ray results or billing notices, use plain language writing and design principles.¹⁸
- In health care organizations, content for patients for after visit summaries and within the patient portal is in plain language.
- Print and digital information is accessible for people with disabilities and different communication or learning needs.

Ensuring Print Materials and Digital Content Are Reader-friendly

There are several ways to ensure your organization’s content matches the literacy and health literacy needs of your various audiences.

Reader-friendly Print and Digital Content

Find Reader-friendly Print Materials

There is a variety of reader-friendly health information available from federal agencies, consumer websites, health publishers, health systems, and others. However, there is no single repository for plain language health content. You will need to explore a variety of sources.

You will also need to learn to evaluate whether information meets reader-friendly guidelines and whether it will be effective with your audiences. Evaluating is imperative because information is often incorrectly labeled. For example, on some health-related websites there are print materials and digital content labeled “easy-to-read,” “reader-friendly,” or “plain language” that are not any of those! They *don't meet* recommended guidelines. Some vendors label their content with these terms without measuring them against known guidelines or testing them with the intended audience.

In addition, some information that is easy-to-read may not be labeled as such. For example, you can find some excellent easy-to-read materials for seniors on the National Institute on Aging website at <https://www.nia.nih.gov>, but they are not identified as “reader-friendly” or “plain language” in their descriptions. You and your health literacy team will need to be vigilant in evaluating information before recommending or using it. (The next section covers tools for evaluating information.)

Below are some commonly-used, credible health-related websites that can be good places to start searching. Most include at least some reader-friendly content in plain language that is easy to read but you may have to dig for it. And keep the cautionary notes that follow in mind.

- <https://medlineplus.gov/>
- <https://www.cdc.gov/health-topics.html>
- <https://www.mayoclinic.org/patient-care-and-health-information>
- <https://familydoctor.org/>
- <https://www.healthline.com/>
- <https://www.medicare.gov>
- <https://www.mlanet.org/page/top-health-websites>

Reader-friendly Print and Digital Content

Note these issues before sending clients or patients to the above sites.

- The reading levels of information, ostensibly for the public, ranged from level 8 (approximately middle school) to level 15 (approximately high college level). They were sometimes inconsistent on the same page or site. Think carefully before sending people to sites where the difficulty of the text is inconsistent or is at a level far above the average reading level of English-speaking adults—“grade” level 8.
- Some sites were appropriate for lay persons but it was very easy to click on a link, leave the plain language site, and not be able to get back. Getting lost in that way can be quite frustrating for less skilled readers. Try making your way through any digital content yourself before you recommend it to others.
- Several sites had separate information for health care providers and the public. That’s great in principle. However, on some sites, it was difficult to keep track of what information was for which group because the content was not different enough in appearance, reading level, or content.

Your organization’s employees should, when possible, evaluate information according to plain language guidelines rather than assuming it is easy to read, understand, and use. Or at the very least, be on the lookout for information that doesn’t look or sound easy, and avoid using it.

Evaluate Information Before Using It

Three respected assessment tools for evaluating documents are described below. They assess a variety of features of print information like appeal, type size, images, use of color or whether it includes a recommendation for action. They do not include checking reading level of text. A readability analysis is another key part of an assessment. There is a section on using readability formulas later in this chapter.

Patient Education Materials Assessment Tool (PEMAT)

Created by the Agency for Healthcare Research and Quality (<http://www.ahrq.gov/pemat>), the PEMAT is a tool to assess and score how well patients can understand and act on print or audiovisual patient education information.¹⁹ It includes a guide for assessing print materials and a separate guide for assessing audiovisual information. The PEMAT should be paired with a readability analysis to round out the overall assessment and provide more information on the difficulty of text. See the section on readability in this chapter for guidance.

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CDC Clear Communication Index (CCI)

This evidence-based tool created by the Centers for Disease Control and Prevention (<https://www.cdc.gov/ccindex/>) helps develop and assess public communication messages in any format.²⁰ The items in the CCI assessment represent the most important characteristics that support people’s understanding of information. They are drawn from scientific literature in communication and other related fields. There is a modified score sheet to use with social media, podcast scripts, and more. The CDC-CCI does not include a readability analysis. We recommend doing a readability analysis with this tool, too, to round out the overall assessment and provide more information on the difficulty of text. See the section on readability in this chapter for guidance.

The Suitability Assessment of Materials (SAM)

The SAM guides the user through the process of assessing a document on each of 22 key factors including content, literacy demand, graphics, layout and typography, and cultural appropriateness. It also includes items on “Learning Stimulation & Motivation” which is not included in the other tools. The instructions for the SAM are in the book *Teaching Patients with Low Literacy Skills* by Doak, Doak, and Root beginning on page 49.⁴ The book is out of print but might be found online or in public libraries. Those working in health literacy or a related field may have a copy to lend. Many consider it to be one of the most important and influential sources on the topic.

Checklist for Reader-friendly Documents/Content

Below is a checklist which covers most of the features of plain language and reader-friendly documents and digital information. The checklist can be used alone, or with the PEMAT or CDC-CCI. When used with a readability analysis, it can inform decisions about using the document as it is or working to create a more effective version. Check the boxes if the item is true. The more boxes are checked, the more the document aligns with reader-friendly principles.

Content is Well Planned

- Does content have only three to five main points?
- Does content tell people only what they need to know to do the recommended action?
- Are the key points in the order readers expect to find and use them?
- Is the content appropriate for the audience’s gender, age, and culture?

Reader-friendly Print and Digital Content

Writing is Conversational and in Plain Language

- Does the writing use mostly one- and two-syllable words?
- Are sentences short and clear (averaging 15-20 words)?
- Are technical terms and confusing jargon avoided or explained?
- Are acronyms used sparingly and spelled out on the first use?
- Is writing in active voice?
- Is the text written at or below 8th grade level using the SMOG readability formula?

Typefaces and Fonts Follow Guidelines for Reading Ease

- Is the body of the text written in at least 12-point font?
- Does the document use three or fewer different type styles?
- Is the format consistent throughout?
- Is the text in upper and lower case instead of ALL CAPITALS?

Layout is Easy to Navigate and Read

- Is the format clean and simple?
- Does the text cover no more than half of the total space on the page?
- Are headings and subheadings used?
- Are bulleted or numbered lists used?
- Are illustrations easy to recognize? Do they relate to the text? Do they make sense?
- Are illustrations appropriate to the audience's age, race, ethnicity, and culture?
- Is the document accessible to people with disabilities of all kinds?

The Content is “Actionable”

- Does it list at least one action readers can or should take?
- Are tools, like a list of steps, blanks to write in, a chart, a planner, or a checklist of things readers will do, provided to help them take action?

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Content and Design are Culturally Relevant

- Is the content culturally relevant to the intended audience?
- Are pictures, illustrations, photos, and design elements culturally relevant and meaningful?
- Is the document written in the first language (or home language) of the readers?
- If information is translated from English, was the translation adapted for culture?
- Was the translation created by someone from the same community as those who will read the document?

Evaluating Health Websites, Social Media, and Other Digital Content

Beyond print materials like handouts, forms, and booklets, multiple types of digital media are used to convey health information. Many clinical and public health organizations produce digital content for websites, patient portals, phone apps, YouTube videos, and social media. Content can be found on a wide variety of topics including finding vaccination clinics, preparing for procedures, stopping smoking, and managing insurance coverage.

Evaluating Websites for Design and Usability

Organizations can't know who will arrive at their site seeking information. Therefore, they must anticipate the information needs of users as well as their abilities to use the organization's site. Some users will easily read and navigate the site. But remember that about half of adults living in the U.S. have limited literacy skills.²¹ In addition, nearly 9 in 10 U.S. adults struggle to navigate the health system and complete health-related tasks.²²

An excellent resource for developing and evaluating health websites and digital tools is Health Literacy Online: A Guide for Simplifying the User Experience, 2nd Edition (<https://health.gov/healthliteracyonline/>).²³ This research-based, updated website provides guidelines for design and usability of websites as well as mobile devices. It includes updated findings on the cognitive processing of adults with limited literacy skills and how they use websites. To evaluate a website or a digital health tool, use the checklist provided at the website here: <https://health.gov/healthliteracyonline/checklist/>.

Much of the information also applies to all steps of creating print materials. It's a great resource for those as well.

Reader-friendly Print and Digital Content

Tips for Evaluating Other Digital Content

Digital content can be engaging, inviting, and fun. That's great if its message is also relevant, easy to read and understand, and useful in helping readers decide on a course of action. However, digital content, like traditional content, is fraught with opportunities for miscommunication.

Creating content that meets guidelines for reader-friendly, actionable information is just as important for digital documents as for traditional documents like handouts. In creating or recommending digital content to members of the intended audience, carefully consider whether it meets reader-friendly guidelines. (Of course, it also needs to be credible, timely, etc.)

Here are some reader-friendly guidelines often overlooked in social media, and some tips to keep in mind when creating or recommending their content:

- Text is written in plain language rather than jargon or technical terms.
- The text speaks directly to the reader with words like “you” and “your” and the organization is referred to as “we” and “us.”
- Only one or two fonts are used in each screen.
- Upper- and lower-case type is used rather than all capitals.
- Red, orange, pink, green, and yellow text is avoided. Colorblind people will struggle to read some of these colors.
- Reverse text (light text on a dark background) is avoided for more than a few words at a time.
- Text is left-justified and ragged on the right margin.
- Images help clarify the topic, are easy to understand, and show the right way to do the action you are encouraging readers to do.

Guidelines to Ensure Accessibility for All

Access to print materials, the web, and other digital content is critical for people with disabilities. Recommended guidelines and adaptations for people with disabilities can also benefit people without disabilities, broadening the range of people who can use information.²⁴

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Using guidelines for accessibility is “essential for some, and useful for all.”
— Inclusive Docs²⁴

For People with Disabilities

According to CDC, 1 in 4 (61 million) U.S. adults is living with some type of disability.²⁵ Disability is especially common (2 in 5 adults) among people aged 65 years and older²⁵ who are also at higher-than-average risk for limited literacy skills, thus putting them at increased risk for health disparities.. Reader-friendly materials are essential for them.

Many adults with a disability also have challenges accessing health care. Common health disparities for people with disabilities include not having a regular health care provider, having an unmet health care need because of cost, and not having a routine check-up in the past year.²⁵

In non-medical health situations, like finding out about an on-going emergency response, people with disabilities may encounter barriers as well. For example, what if the information is available on TV but there is no sign language interpreter? How could a deaf person learn about it? What if a brochure about evacuation routes is only available in paper but a person with low vision can't find her hand-held magnifier?

Content that is accessible to people with disabilities is needed to lessen health disparities and achieve equity. One of the first requirements for accessible content, whether in print or digital format, is being reader-friendly, understandable, and actionable. This standard is necessary, but not sufficient. People with permanent or situational disabilities may need further adaptations to make content accessible to them. Content creators need to remove barriers that could exclude people with disabilities.

There are several ways to make documents more accessible. Most word processing programs have built-in accessibility checkers. Find the accessibility checker in the word processing program you use. If you can't find it on your own, use a search engine to find the checker in the program and version you're using. The checkers won't find everything but they're a great first pass. Examples of document features the checker will alert you to are use of:

- Alt text, a function used to describe what is in an image.
- Missing style codes for the levels of headings that show the structure of the document.
- Appropriate color elements.

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Ensure Documents and Digital Information Are Accessible to People with Disabilities

Plain language can be part of making information more accessible to everyone. In particular, it can make information more accessible (readable, usable, etc.) for people with:

- Intellectual and developmental disabilities.
- Learning disabilities that affect their ability to read text, comprehend what they read, and/or remember the content of the text they read.

Of course, there is another meaning for “accessible”—making a document, webpage, or device more useable and useful for people with vision, hearing, mobility or dexterity needs.²⁶

Use “Alt” Text

Alt text, or alternative text, is descriptive text used to identify what is in images. An example might be, “Man with companion dog walking alone in a park.” If the images are decorative only, they should be labeled “decorative.” But a principle of reader-friendly design is to use only images that are meaningful to the message.

Use Clear Headings

Use different levels of headings to show the structure of the information. For example, a page might have a large, bold, centered heading at the top to announce the overall topic. Under that heading there will likely be some smaller headings to announce subtopics. These may be left-justified, also bold, but a smaller size and perhaps a different color. There may also be a third level of heading which is even smaller to identify further distinctions in the subtopics. Those headings might also be left-justified, bold, an even smaller size, and a different color.

For accessibility, having the styles defined and labeled enables them to be tagged for screen readers. Each level’s style can be created in a word processing program like Word or Pages. In Word, using the Style dropdown menu, it’s possible to define a specific style for each level of heading like an outline.

Use Color Carefully

Choose colors that provide adequate contrast. Choosing black text instead of gray on a white background is a good example. Black against a light background provides more contrast. Avoid using

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light text on a light background and dark text on a dark background. The accessibility checker should alert you to problems with contrast.

In addition, don't use color as the only way to convey meaning. Notice in the heading descriptions above, there are several features that identify the heading level: justification, size, font, and color. So even if a person can't see the color, they can still easily discern the level of the heading. Since about 1 in 12 men are color blind (only 1 in 200 women are color blind), this is more important than many realize. Using multiple features, not just color, is key.

See these blogs for tips by a designer on achieving accessibility. The first link below is the original article. The second link is an updated article. Both have great information, including good examples of the principles for contrast and avoiding using color alone to convey meaning.

- <https://www.viget.com/articles/a-designers-guide-to-accessibility-and-508-compliance/>
- <https://www.viget.com/articles/designing-for-accessibility-what-to-watch-for/>

Evaluate Digital Content for People with Disabilities

Resources for ensuring and evaluating accessibility of websites, apps, and other digital content for people with disabilities can be found at these sites:

- <https://www.w3.org/wai>
 - The site provides international standards from the Web Accessibility Initiative that develops guidelines for making websites more accessible. It offers an excellent free introductory course, Digital Accessibility Foundations, as well as other more detailed courses on various aspects of accessibility. This is a good place to start investigating courses on a variety of topics: <https://www.w3.org/WAI/fundamentals/>. The courses teach principles that are, as the website points out, “essential for some, and useful for all.”
- <https://webaim.org/>
 - Includes a 508 Checklist at <https://webaim.org/standards/508/checklist>
- https://www.youtube.com/watch?v=hE83Qn-PTGA&ab_channel=NNgroup
 - This video differentiates accessible design and inclusive design.
 - It also includes a great section on perspective getting vs. perspective taking.

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After you have evaluated the content with the tools above, take time to test it with at least three to five potential users to get feedback on the accessibility of your information.²⁷ Their feedback upon using the information is the best, most instructive guidance you can get.

Principles for Creating and Revising Materials

Once you learn basic principles about reader-friendliness, it's time to begin creating or revising some written materials. You may never feel like you know enough, but this is an area where the more you work on it—and the more you seek feedback from people who will use your content—the better you get. You will no doubt go through multiple drafts as you work through a document, and you will likely see things you missed and continue to make changes over time. Use the following guidelines to get started. The guidelines come from various authors, organizations, and government agencies.^{20,28–30}

Involve Stakeholders

Start by making sure you know who the stakeholders are. Medical and legal professionals, administrators, policy specialists, marketing professionals, and others in your organization may want or need to approve the materials. Perhaps the materials were funded by an agency or foundation whose staff or members also have a stake in how they turn out. Think about these people early in the process, inform them about your work, and get their involvement and support. Help them understand that reader-friendly plain language communication is appreciated by people of all reading abilities.³¹

Members of the intended audiences are equally important stakeholders. Ultimately, they are the people who will benefit, or not, depending on how the content was created. Ask for their input and ongoing help. To learn about what they need and want to know, ask them. To find them, you may need to contact public health agencies, community groups, senior centers, advocacy groups, adult literacy and English language learner programs, religious groups, tenant organizations, hospitals, clinics, or other places you can approach them or gatekeepers.

Learn About All the People Who Could Be in Your Audiences

Learn about the people in the communities your organization serves or hopes to serve. Research their demographics: socioeconomic status, race, ethnicity, age, educational level, gender identities, languages they speak, whether they are new to your area or the U.S., cultural groups

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with which they identify, their health beliefs, and their preferences and expectations about how health care is delivered.

How Do You Learn All This?

- Research government databases about the communities your organization serves.
- Build relationships with representatives of those communities.
- Ask the audiences your organization serves to help you understand their perspectives and to help you involve them in creating materials. They can identify:
 - The topics they need and want information about.
 - What key messages are appropriate and compelling.
 - How they perceive proposed illustrations or photographs.
 - How they perceive graphic elements like color and design.
 - How cultural beliefs and norms need to be addressed.
 - Who might be the most trusted and recognizable spokesperson to include in the materials.

If the information is for people who have a diagnosis, treatment, or recommended behavior change, find people who have experienced the same journey and ask for their help understanding what they wish they had known.

Create Your Key Messages

Individual Level Health Behavior Theories

As you begin, we recommend exploring individual level health behavior theories, if you don't already have a background in this area. They can be very helpful in thinking about how you frame the topic to help your readers take action. Three of the most useful and accessible theories are:

- Health Belief Model.
- Theory of Planned Behavior.
- The Stages of Change (Transtheoretical) Model.

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One of the best places to learn about these is from Theory at a Glance (<https://cancercontrol.cancer.gov/sites/default/files/2020-06/theory.pdf>), a concise summary of health behavior theories produced by the National Cancer Institute. It is primarily designed for public health and health promotion practitioners but is also helpful for materials developers in medical and other health-related organizations.

Planning the Approach and Content

Limit your document to three to five key points or messages most readers will want to know at the time they are reading the text. Put the most important information first. Include only what readers must know to carry out the recommended action—the need-to-know versus the nice-to-know. Because we tend to include much more than patients or consumers need or want to know, a good guideline is “If in doubt, leave it out.” Avoid including information that answers questions the audience would not likely ask, unless they are unlikely to ask because they don’t understand its importance.

Think from the readers’ perspective. Think about what they will want and need to know, how they may feel about the information, and what you can do to make things easier for them. Make sure the three to five key points are in the order readers will expect to find them and will need to use them. For example, what if you’re developing a brochure for parents on what to feed their babies and toddlers? You might think of the foods in categories and be tempted to list them that way. But how will parents look for the information? By the age of their child. If you list the information by age groups, parents can quickly find and read just the information that matters to them at the time. If you list it by food groups, they will have to read each section looking for the content that applies to their child’s age.

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The Reader's Perspective

Creating effective key messages requires knowing the intended audience well. It requires understanding the perspective the readers may have as they arrive at the reading process. Understanding the reader's perspective is what can set you up for success as a materials developer. It's important to learn about the perspective of the people you're writing for before you start writing. Getting that information will be learned by asking audience members directly.

In the story below, ask yourself what the patient might have been thinking, feeling, and worrying about. See if you can take her perspective and understand her response.

A 76-year-old woman who had experienced chest pain was told by her doctor she needed to start taking nitroglycerin for angina. She told her husband and daughter she didn't want to take it. They read the handout on how to use it with her. Her family was surprised when she resisted further. In asking about her reticence, they discovered she was afraid it would explode in her body.

She had only heard of nitroglycerin being an explosive. She had never heard of it as a medicine. Neither the handout nor the doctor mentioned that it was understandable for a patient to be concerned but that it was safe and effective. After she talked to her cardiologist, she understood it was safe and important for her to take when she had pain. She was then willing to do as her doctor recommended. Her perspective explained her valid concerns. If the handout had mentioned that point, she might have been more comfortable using the medicine.

Not all patients or clients will be on the same page as the people who write the information they will receive. Ask for more information and hear their insights, then start writing.

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Basic Plain Language Writing Principles

When switching from spoken to written language there is a tendency to become more formal. This occurs in many languages and the difference can be quite noticeable. In English, words and sentences usually become longer in text, and, in general, tend to feel more official or academic. Avoid that shift when writing in plain language. Write as though you are talking to your neighbor, aunt, or grandfather, unless, of course, your aunt is a surgeon or a subject matter expert in a different topic. If that is true, think of a different person. Start with a focus on the audience you are writing for.

Sometimes people are concerned that plain language will offend their readers with writing that is “too easy.” This concern often arises when writing for skilled readers with subject matter expertise in the topic. The truth is, a skilled reader can read complex text, especially in their area of study. But they may still prefer a “quick read.” Remember, “no one curls up with a Medicare brochure. Readers just want to get the message, without travail.”²⁹

The video below explains more on why offending people by being too easy is not likely to be a problem. The video was created by Nielsen Norman Group, a highly-respected usability firm that usually works in digital media but the examples all apply to print information, as well.



To watch this video, click [HERE](#) or scan the QR code below.



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What about less skilled readers? Plain language writing is not only helpful, it is crucial for people who struggle to read. People for whom reading is an effort definitely prefer easier text. No one enjoys laboring over challenging text, least of all readers with limited literacy skills. Help them get the key information they need and get on with their day, too. Using plain language writing principles is supportive, kind, and respectful to everyone, but especially those with reading challenges.

Use Shorter, Conversational Words

Use wording that sounds more like something you would say at home than something an expert on the topic would say. These kinds of words are often called “kitchen table” or “living room” language. Shorter words and phrases tend to be more familiar and they require less work to read and understand. Therefore, people who find reading difficult have a better chance of understanding if words are shorter.

In general, use one- or two-syllable words where they have the same meaning as longer words.

Original Word or Phrase	Shorter, More Conversational
Demonstrate	Show
Eliminate	Get rid of
Consequently	So
She requires assistance	She needs help
For more information	To learn more

If you struggle to write in “kitchen table” language, try recording yourself explaining aloud what you want to say. You can talk to a friend, family member, or even a pet or a doll. Then listen to the recording and see how you explained the topic aloud. Most people speak in plainer language than they write, so you will most likely find a new way to write using shorter words. If not, you may need to get someone else to help reword your writing for you. Writing about their topic in plain language can be especially difficult for subject matter experts.

Avoid Technical Words and Jargon

Technical words and jargon usually refer to vocabulary used in a particular field, by a specific group of people, or in a particular activity. Medicine and public health fields are well-known

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for their specialized terms of art. It's easy for everyone who has an area of special training and knowledge to forget what words and concepts were foreign to them early on. When writing for the general public, avoid these types of words.

Many people will not know words that are common in a health or a public health organization. In a brochure explaining an upcoming surgery, a person with no medical background will likely be confused by the term *intubated*. A better choice might be, "We will put a small tube into your airway to help you breathe during surgery." Similarly, in public health contexts terms such as *exposure*, *tobacco control*, and *health promotion* may be used. But most members of the general public will not know what those terms mean either. An explanation works here, too. An alternative to *exposure* might be *been around*. "Within 5-7 days of exposure to..." could become, "Within 5-7 days of being around someone with..."

Explain New Words and Concepts in Context

Often when we think of introducing or teaching new words or concepts, we think of defining them. To many of us, it's natural to grab a dictionary. But that's not necessarily the way to approach it. Instead of thinking "define," we need to think "explain" and "describe."

We can explain what the new term means in conversational language without ever using a dictionary definition. For example, let's say you need to make sure your readers understand what "melanoma" is. You could start with a *definition* like this, "A malignant tumor that arises from a melanocyte, the cells that make melanin, and occurs most commonly on the skin." Or you could *explain* it like this, "Melanoma is a kind of cancer usually found on the skin. It starts in the cells that make the coloring in skin." Conversational language (writing like you speak to a friend) usually works much better, especially with a frightening topic like cancer.

Avoid Abstract Concepts

Giving concrete, specific information is more helpful than abstractions. For example, when warning about post-operative bleeding, instead of the abstract concept "excessive bleeding" try "blood that soaks your bandage all the way through." In this example, you might even give a time frame, like "in 2 hours or less" for even better specificity. Readers will now know exactly what to do and when.

Another example is "Get adequate sleep every night." What is adequate? That could be interpreted in different ways. We need to give specific recommended amounts that are considered adequate. You could say, "Get 7-8 hours of sleep every night."

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In public health settings, there might be discussion of “health equity initiatives,” an abstract concept to many. But if a client hears there is health information available in different languages so everyone has access to relevant information, the abstract becomes more concrete.

Avoid Acronyms or Make Sure You Explain Them First

Acronyms are used extensively in health-related organizations (and in many other settings). It’s easy to forget that the acronyms you and your colleagues use with mutual understanding may be completely foreign to those you serve. For example, you might use “BMI” all the time. But remember that your clients and patients may need to be specifically taught: 1) what BMI stands for, 2) what body mass index means, 3) why it matters, and 4) what theirs should be. The first time you use an acronym in a text-based document or a conversation with a client, patient or family member, explain it clearly.

Use Short, Direct Sentences

Don’t let the urge to be formal make your sentences longer than necessary. The average sentence length should be 15-20 words. That means some sentences can be more than 20 words if most are shorter. If all sentences are less than 15 words, the writing may sound awkward and unnatural, which can impair understanding. Also, make sure sentences are simple, clear, and straightforward. See examples below. (Note: BBTD stands for baby bottle tooth decay.)

Original	Revised
When you consider the potential cost of treating the problems associated with BBTD, it is best to prevent this condition from developing in the first place. (26 words)	It can cost a lot to treat Baby Bottle Tooth Decay. So start taking care of your baby’s teeth before the first tooth comes in. (11 and 14 word sentences)
Most people with COVID-19 will experience mild illness that does not require hospitalization, but some people who are at higher risk for serious illness can develop further medical complications. (29 words)	Most people who get COVID-19 will have a mild case. They won’t have to go to the hospital. But some people are more likely to get very sick. They can have serious medical problems from COVID-19. (8-10 word sentences)

Reader-friendly Print and Digital Content

Use Active Instead of Passive Voice

Active sentences put the person or thing doing the action before the action word. Passive voice often uses the sentence structure, “X was done by Y.” Here are some examples of how to fix passive voice.

Passive	Active
Members have been confused by some of the new regulations.	Some of the new regulations have confused members.
Patient satisfaction was evaluated by the hospital last year.	The hospital evaluated patient satisfaction last year.
Blood sugar levels can be evaluated often with these strips.	You can check your blood sugar often with these strips.

Write Directly to Readers in a Friendly Tone

Personalize the message by writing *to* your readers rather than *about* them. You might use “you” or just address your readers with an “understood you” as in “Check your blood sugar after each meal.” It works well to use “you” for the reader/consumer and “we” for the organization. If the document comes from your organization, it’s obvious who “we” stands for. Being friendly and inviting is important, too. Sometimes it’s even more important if you’re using the direct approach. Focus on people rather than things. See examples below.

Original	Revised
This medicine may cause drowsiness.	This medicine may make you sleepy.
Vaccines are important for protecting children’s health.	Protect your child’s health. Get the right vaccines on time.
The client must arrive for the first appointment	Please come 20 minutes early for your first visit.

Guidelines for Using Readability Formulas

Background

Mathematical formulas can be used to predict reading difficulty by analyzing two specific characteristics of text. The characteristics that have been shown to best predict difficulty are word length and sentence length. Long words and long sentences require more mental effort and short-term memory to read and understand. Therefore, the longer they are, the more difficult the text is. In general, the mathematical formulas count the average number of syllables per word and average number of words per sentence (or some variation of those). Readability formulas give writers very important information, but they don't tell the whole story.

It is important to recognize that there are many aspects of printed materials that formulas do not measure. These other aspects influence understandability, appeal, relevance, and more. It is the job of the creator of the document or digital information to take into account these additional factors which include:

- Organization and density of information.
- Familiarity of vocabulary or concepts.
- Influence of format, design, or visuals.
- Cultural appeal, sensitivity, and relevance.
- Credibility or believability.
- Readers' readiness to learn.

Understanding Common Objections to Assessing Readability

Some people think we should not use readability formulas because they don't measure the features above. But they were never meant to. It's like saying you should never use a hammer because it doesn't drill holes. Indeed, it won't do the job of a drill. It was never meant to. It will, however, be great at pounding in nails—just what it was designed to do.

Some people also say readability formulas “don't work” because you can get different scores on various formulas for the same text. Yes, you can. But it's not that the formulas don't work. It's that the formulas vary in how they measure the features of text. That's why it's important to know which formula(s) to use. Learn to use readability formulas correctly and use them only for the things they're designed to do. That will be a fair, appropriate, and ethical way to use them.

Reader-friendly Print and Digital Content

“Grade” Level versus a Continuum

Readability results give an estimated reading “grade” level to the text. Readability experts sometimes use quotation marks around “grade” to show that it’s not necessarily equivalent to the texts in any given grade in today’s schools. The formulas were developed in the 1920s and one (the SMOG) was updated in the 1960s. What students were reading in those earlier decades was likely different from what students in schools in the 2020s and later are reading. School curricula have changed in those years, too.

In addition, people’s reading habits have changed. Consider how many of us prefer to watch videos, streaming services, or TV rather than use our reading skills. As we read less, our skills can degrade. The landscape of reading is very different now. We take that into account by thinking of the “grade” level scores as indicators of difficulty on a continuum like this:



Choosing the Right Formula

There are many different formulas to choose from. The main difference between them is their requirements for comprehension. Before you choose, think about the purpose of the document. Is it for entertainment or for vital health information, or something in between? When reading text for entertainment, 50% - 75% comprehension is probably enough to get the gist of the story. However, for health-related texts, writers usually want their audiences to be able to read and understand most or all of the content.

The SMOG formula requires 100% comprehension.^{32,33} If you want readers to understand most or all of your content, use the SMOG formula. The SMOG will usually score two “grade” levels higher than most of the other formulas and sometimes three “grades” higher than the Flesch-Kincaid. Don’t feel concerned about that. Trust the SMOG. Try to write at the 8th “grade” level or lower using the SMOG formula to enable your readers to understand your important information.

Reader-friendly Print and Digital Content

Using the Formulas Electronically

Most people prefer to assess text electronically because it's quicker than doing them by hand (or “manually”). There are many electronic readability tools that calculate the scores for you. They include:

- Free websites.
- Commercial software programs.
- A feature in some word processing programs.

Big caveat here: be careful when using electronic readability functions in any of the applications above. They might be handy, but there can be problems with the programming assumptions that underlie their functions. And you must know which of these tools are valid and reliable, how to select the text, how large a sample to use, and how to prepare the document. There is more help on this below.

Since readability formulas were created to be done by hand (long before computers were around), the gold standard is applying the formulas to text just as they were designed to be used—by hand. Before using or recommending any of the increasingly more common websites, software, or word processing programs for readability, this author wanted to check their validity by analyzing text and comparing scores on every readability website, software program, and word processing function found and accessible at the time.

As of 2024, after comparing the scores on a text sample done by hand to the electronic results, there was only one tool—a website—whose electronic scores consistently matched the manual scores. It was developed by Alain Trottier, innovation and technology leader, with input from G. Harry McLaughlin, the creator of the SMOG formula. Having a readability expert contribute in the development of the website helped ensure it applied the guidelines for the formula correctly.

It can be found at: https://www.online-utility.org/english/readability_test_and_improve.jsp.

We trust and recommend the website for English documents.

Your organization might also consider purchasing software to analyze reading level. Some readability software also provides suggestions to make the text more readable. These programs speed up readability analysis and save time by offering a variety of plain language edits. Be aware the edits are not always appropriate. Be sure to check each one before you accept it.

Reader-friendly Print and Digital Content

Analyzing Text Electronically

You need to know a few things before you analyze anything electronically. There are specific steps to take to achieve accurate results. The information below may look a bit intimidating but it's not as hard as it looks. In the beginning, you will want to go slowly and carefully. Everything you need to know and do is right here. You just need to work your way through it three to four times. Then it begins to make more sense and you will see the benefit.

Get a Large Enough Sample

In science, you need a large enough sample of whatever you are researching to get good results. With readability, it's the same. Small samples of text may not give an accurate score. To check reading level, you need at least 10 sentences or 300 words. Ideally, 30 sentences is best. The less text you use, the less accurate your results will be.

Choose the Text

- Use only complete sentences. Choose samples of connected, flowing text.
- If the text is long, take a sample from near the beginning, the middle, and the end.
- Cut and paste the text you'll analyze into a new document. Prepare it as described below.

Prepare the Text

This is critical! Your scores can be way off if you don't "clean up" or prepare your text first.

- Delete all headings and sentence fragments.
- Delete periods that don't mark the end of a sentence. This includes periods in a numbered list (1. or 2.); abbreviations (Jill Sanchez, M.D. or Q. & A.); periods in e.g., or i.e., decimals (98.6 degrees or 12.9%); and periods in times (9 a.m.). If you don't remove extra periods, the program may count letter or word strings that are not really sentences. This can artificially lower the reading score by four to five grades!
- Replace website URLs with the word "website." E.g., www.cdc.gov/flu/ becomes "website."
- With bulleted lists, you need to create sentences for the formula to work. See these tips on doing that:

Reader-friendly Print and Digital Content

- Use the opening clause (stem) if it is a full sentence. But be sure to remove the colon and insert a period.
- “You may have some of these symptoms or none at all:” (bulleted list follows) becomes “You may have some of these symptoms or none at all.” Now it can go into your sample.
- If a line of bulleted text is a full sentence (with subject, verb, and object), put a period at the end. If the bullets say, “Your waist is bigger than 35 inches” and “Your HDL is less than 50 mg/DL,” you can simply add a period to each line and use them in your readability sample.
- If a bullet is not a full sentence, put the stem in front to recreate a sentence.

For example:

Call your health care provider if you have:

- trouble breathing
- severe diarrhea
- ketones in your urine

Revised into a Sentence

Call your health care provider if you have trouble breathing, severe diarrhea, or ketones in your urine.

Analyze the Prepared/Cleaned Text On-Line

- Go to: http://www.online-utility.org/english/readability_test_and_improve.jsp. This site is quick, free, and the *only* one we use. Be sure to prepare your text first, as described above.
- Paste your prepared text into the blank box on the first screen and click “Process text.”
- Next, a screen of scores will come up. It will look like the screen shot below (without the highlighting). 
- Look at the SMOG score first. Aim for a **SMOG score of 8 or lower**, rounded to the nearest whole number. Note that with some topics, it may be difficult to reach that level because of certain vocabulary you may need to use.

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- Also look at the average syllables per word which should be less than 1.5. Check the average words per sentence, too. It should be 15-20.

Reading the Results

Number of characters (without spaces) :	781.00
Number of words :	159.00
Number of sentences :	8.00
Average number of characters per word :	4.91
Average number of syllables per word :	1.67
Average number of words per sentence :	19.88
<i>Indication of the number of years of formal education that a person requires in order to easily understand the text on the first reading</i>	
Gunning Fog index :	13.48
<i>Approximate representation of the U.S. grade level needed to comprehend the text :</i>	
Coleman Liau index :	11.62
Flesch Kincaid Grade level :	11.90
ARI (Automated Readability Index) :	11.64
SMOG :	13.25
Flesch Reading Ease :	45.13
List of sentences which we suggest you should consider to rewrite to improve readability of the text :	

These are helpful numbers, but look at the SMOG Grade Level score below first.

The SMOG score is the most informative. See "What Good Scores Look Like" below.

Here you will find a list of sentences you could revise for easier reading.

Measure	Scores	Fixing the Problem
SMOG Score	Aim for 8 or lower (rounded to the nearest whole number)	Use both tips below.
Average Syllables per Word	Aim for less than 1.5	If it's higher, you are using too many long words. Try to use shorter words and conversational, "living room" language.
Average Words per Sentence	Aim for less than 20 words. Remember, this is an average. You can use some longer sentences but avoid more than 30 words.	If it's edging toward 18 words per sentence or higher, look for sentences that can be shortened. Also, check for sentences that can be broken into two without losing flow and meaning.

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ar@healthliteracyconnections.com. May be duplicated for dissemination if copyright is included.

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Understanding Results

Most formulas are only accurate to within 1 or 1.5 grade levels. Always round your score to the nearest whole number, so 9.3 becomes 9th “grade” level and 9.7 becomes 10th “grade” level.

If the score is higher than your target level, go through the guidelines above and apply them more stringently. Cut out jargon. Shorten sentences that are longer than 20 or 25 words. Hunt down the three- or four-syllable words you can change to more commonly-spoken words.

In summary, readability formulas are just one of many tools for creating and assuring reading ease. They should not be the sole determinant but they are a critical part of creating or assessing text-based information.

Artificial Intelligence, Plain Language Writing, and Readability

Artificial Intelligence (AI) can do many things, but it’s critical not to assume it can do everything. Organizational leaders should ensure AI tools are thoroughly evaluated before being adopted for use in plain language and readability. Organizations that use plain language writers may be wondering if they still need humans or if AI can replace them. The answer is...you still need humans!

AI can be useful to:

- Research a topic.
- Create a proposed outline.
- Write a first draft.

However, as of mid-2024, AI cannot:

- Ensure a document meets the ISO Plain Language Standards.
- Analyze reading level accurately.
- Write or revise text to a specified reading level.
- Confirm content is accurate and truthful.
- Compose for maximum clarity.
- Assess the structure of a document.

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- Add useful and consistent headings.
- Recommend or apply graphic design, layout, or typesetting guidelines.

What's the bottom line? There is nothing like the human touch for accessible, plain language document writing and design.

Graphic Design, Type, Layout, and Visual Elements

Good design elements are just as important to readability and usability as the words. Few readers want to spend time wading through unnecessary information. We all want to find what we need quickly and easily. Good design can make that much easier. When possible, use a professional graphic designer with specific training in typesetting for legibility. If your organization doesn't have the resources to work with a professional graphic designer, be sure people who create documents use the guidelines below.

Typeface Does Not Influence Legibility

There has been an ongoing debate among document designers, graphic designers, typographers, and researchers for at least 100 years. The primary question was whether serif or sans serif typefaces were better for text legibility. Over the years, a good deal of research on the question has been done. An extensive literature review in 2022 concluded, "...the overwhelming thrust of the available evidence is that there is no difference in the legibility of serif typefaces and sans serif typefaces either when reading from paper or when reading from screens."³⁴

A common convention has been to use a serif typeface like Times Roman for the body copy (the main text of the document) and sans serif like Calibri (this is Calibri) for headings. This is an effective combination for paper documents. For on-screen documents, sans serif typefaces are recommended for all text.

Different "Treatments" of Type Do Influence Legibility

Treatments, or formats, of type can affect legibility and readability. Examples of text treatments or formats are italics, bold, underlined, and color. Whether serif or sans serif, avoid condensed, script, unusual, or artistic typefaces. These may not be easy to see or read. Stay with type that is

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used fairly regularly. Choose conventional over unusual treatments so the treatment and the type don't become distractions to the message.

White Space Gives Readers a Visual Break

When you're creating easy-to-read materials, give readers a visual break by surrounding content with white or open space. How much is enough? In general, half the page. White space generally means an open area free of text. It can be colored as well as white and can include non-text elements like illustrations, photos, or easy diagrams. You can create white space with:

- At least one-inch margins on the top, bottom, and sides in letters and flyers —with anything on 8½" by 11" paper.
- Adequate space above and below headings and subheadings that introduce information.
- Short paragraphs with space between them.
- At least half an inch between columns of text.
- Bulleted text with one quarter inch between the bullet and its text.

Use dark type on a white or light background for good contrast between the text and background. Light or white text on a dark background is called reverse type and should be avoided in both print and digital information other than for three to five words in titles, for example. It can be hard to read.

Emphasize What You Want Readers to Remember

Use one or two of these methods to highlight the most important messages:

- Write short paragraphs with one or two key points.
- Put information in a text box, also known as a “call-out box.”
- **Bold** a term or phrase. But don't overdo it. Too much bold can be hard to read.
- *Italicize* a term or phrase. Like bold, however, be aware that too much text in italics can be hard to read and may slow readers down.
- Use bullets for lists. Limit lists to five to seven items.
- Use numbers if there are steps in a process that should be done in a specific order.

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Good Headings Do More than Announce a Topic

Headings and subheadings are great for helping readers find a topic and directing their attention to specific information. They can instruct, inform, and invite introspection. They can also:

- Catch and guide the reader’s eye.
- Encourage the reader to think about the message.
- Drive your message home.
- Make it more memorable.

Carefully written text can also help your headings and subheadings do double duty by accomplishing more than simply announcing a topic. Here are examples of four types of headings to consider.

Topic: “How Diabetes Develops”

This type of heading introduces, or announces, the topic well but doesn’t provide any information. It is probably the weakest type of heading but is also commonly used, maybe because it’s the easiest to write.

Statement: “You May be on the Path to Diabetes!”

This type of heading makes a statement that can get attention and invite readers to go further since they can see how the information may apply to them. This is a bit stronger type of heading but still not very compelling.

Question: “Are You on the Path to Diabetes?”

This type of heading invites readers to answer an important question for themselves. Questions can make compelling headings by bringing information closer to home and getting readers’ attention. This is a very strong heading type.

Instruction or Call to Action: “Get Checked for Diabetes!”

This type of heading gives an instruction or urges the reader to take action. A Call to Action is a key feature of most health-related information, whether it concerns a health issue like diabetes or choosing a new Medicare plan by the deadline. This is also a very strong heading type.

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Write Headings That Give Information

Use headings to deliver new information instead of simply announcing a new topic. This technique can be especially helpful for reluctant readers who may read only the headings. Don't miss this opportunity to reach your readers.

Visuals Encourage Understanding

Visual features can be great teaching tools—if they make sense. Visuals can include photos, images, illustrations, infographics, pictograms, clip art, charts, graphs, tables, emojis, and others. Visuals have many advantages. They provide less text-heavy pages, add interest, and show the right way to do something. They can depict people, environments, activities and more, in culturally-appropriate and inclusive ways. (See this site for guidance: https://www.cdc.gov/healthcommunication/Inclusive_Images.html). They can help people who struggle to read get the message. They can also help confident readers get the message more quickly and easily. Moreover, they make information more memorable.

Visuals should be used to complement and help explain information. Look at any visual elements you are considering and ask:

- Do they help explain the main message?
- Do they make understanding the message easier for the reader?
- Do they reinforce the message?
- Will the meaning be clear if the person looking at it cannot read the accompanying text because of a literacy, language, or vision challenge?

If you answer yes to the above questions, then use the visuals. If not, search for others. If they are pictures or other visuals used only to fill space on the page, to add some interest, or to break up a page with mostly text, don't use them. Instead, add interest by making the message more compelling, and breaking up the page with headings, white space, and relevant visuals.

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The image below is a great example because it shows clearly what to do and how the air flow should move. It can be effective even for those who don't read. In a document on indoor air quality, it would meet most of the above criteria. However, the only way to know if it's effective is to test it with people in your intended audience(s).



Source: https://www.cdc.gov/coronavirus/2019-ncov/images/prevent-getting-sick/2_Fresh-Air.png?_=69906

More Tips on Visuals

- Illustrations and photos should resonate with your intended audience. Test them with your intended audiences to be sure.
- If your material is intended for a specific culture, your photos and images should be of people from that culture.
- Consider how color images, illustrations, and graphic features will look if printed in black and white.
- Depict the right way to take the recommended action. For example, if a document is about changing a bandage on a wound, images should show the steps for the right way to do it.

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A note: Showing the right way can sometimes be enhanced by contrasting it with the wrong way. This can help the reader compare and draw attention to details that are not immediately noticeable. For example, when showing how to wear a bicycle helmet the correct way, it's best to show an image of the correct use and one of someone wearing it wrong. Then, be sure to use arrows pointing to the overly loose straps or the improper tilt of the helmet to emphasize the wrong way, thus, helping readers understand the right way.

Sometimes, though, the whole point of a document is to show what **should not** be done. For example, a person who has just received a thyroid radiation treatment may be given a long list of things they should **not** do in the next few days.

They may be told **not** to:

- Kiss anyone.
- Cook or share meals with anyone.
- Travel by bus, plane, or train.
- Go to work.
- Be near pregnant women and children.

In this scenario, it would be best to add pictures of activities the person should **not** do with a large red X over them. See the image here for an example.



Reader-friendly Print and Digital Content

Use this Style to Show “DON’T” or “Not” Images



Avoid this Style for “DON’T” and “Not”

Interestingly, the symbol of the red circle with the line diagonally across it is not understood as universally as many people believe. It’s best to use the red X above to show what should **not** be done.



Tips for Videos

Videos can help inform people with low literacy skills and/or low health literacy skills. They can help patients understand recommendations and feel more prepared for procedures and surgery. Videos can help patients understand and retain health information.³⁵ They can help people understand public health recommendations and more.

There are, however, a few practical recommendations that are often forgotten when using or creating videos. Watch for these.

- The script, and any text on the screen, should be written in plain language. If text on the screen is as difficult as text in a handout, the benefit of a video is diminished.
- Jargon or technical terms used in the video should be explained in plain language.

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- On-screen text meant to be read should move at a pace that can be easily read, even by slower readers.
- If instructional videos contain side-by-side text instructions and video instructions, viewers should not have to quickly move back and forth from text to a video showing the recommended actions. The video should stand alone in communicating the information.

Remember that simply watching a video, listening to the audio, or being handed a printed handout does not mean people will understand, remember, and act on new concepts. They may need further in-person teaching and support.

Reader-friendly Print and Digital Content

This parent handout shows plain language writing and design principles in action

Living room language

Colds

Most children get 8 to 10 colds before they are 2 years old. Most colds come and go without any big problems.

There is *no* cure for the common cold since colds are caused by viruses. Antibiotics don't kill viruses so they will not make your child's cold better. But you can help your child *feel* better until the cold goes away.

Signs of a Cold

A child with a cold may show these signs:

- Stuffy, runny nose
- Sneezing
- Coughing
- Watery eyes
- Eating more slowly, not feeling hungry
- Sore throat

There may also be a mild fever (under 102°F or 38.9°C) or headache. All this can make your child fussy too.

Colds usually last about a week but can even last for 10 days. If there is fever, it should come at the start of the cold and then go away. Mucus (MYOO-kus) in your child's nose may turn yellow or green after 3 or 4 days. Children can get one cold right after another. So it may seem like your child is sick for a long time.

Call the Doctor If...

...your child has any of these signs:

- Fever lasting more than 2 or 3 days
- Cold symptoms that get worse, instead of better, after a week.
- Trouble breathing or drinking
- Ear pain
- Acting very sleepy or fussy
- Coughing more than 10 days



Clear headings and sub-headings

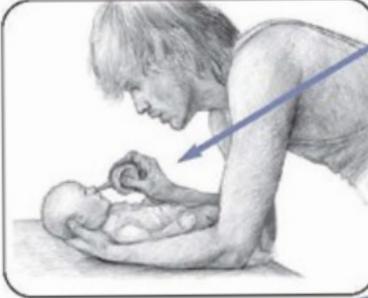
What to Do for a Cold

To Help a Stuffy Nose

Put a cool-mist humidifier in your child's room. A humidifier (hyoo-MID-uh-fye-ur) puts water into the air to help clear your child's stuffy nose. Be sure to clean the humidifier often.

Thin the mucus. Use saline (saltwater) nose drops. Never use any other kind of nose drops unless your child's doctor prescribes them.

Clear your baby's nose with a suction bulb. (This is also called an ear bulb.) Squeeze the bulb first and hold it in. Gently put the rubber tip into one nostril*, and slowly release the bulb. This will suck the clogged mucus out of the nose. It works best for babies younger than 6 months.



Actionable content

Showing how to do the action

Need-to-know information

Bullet lists

Plenty of white space

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Tables, Charts, Graphs, Pictograms, and Infographics

These and other tools can be a great way to visually explain information if done simply. However, they can also confuse readers. Before using any of these formats, test them with your intended audiences to be sure they are understandable and effective.

Tables, Charts, and Graphs

Using a table or chart should require no more than a simple strategy like:

- Reading the column headings across.
- Going back to the first column.
- Reading down the first column to the correct row.
- Then going across the row to the right column to find the needed information.

A simple table might be two to three columns with a few rows like the examples that follow. Notice the helpful brief introduction and the simple label that tells readers exactly what they will find in the table. This is a great tip for making tables or charts more useful.

Here are a few good examples:

<i>Daily Calcium Needs</i>	
Age	You Need This Much Calcium (mg per day)
4–8 years	800 mg
9–18 years	1,300 mg
19–50 years	1,000 mg

Calcium is measured in milligrams.
The short way to write milligrams is *mg*.

Source: National Academy of Sciences

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Reader-friendly Print and Digital Content

Get Extra Help paying your Medicare drug costs

If you have limited income and resources, you may qualify for **Extra Help**, a program to help pay for some drug costs.

You may qualify for Extra Help if your yearly income and resources are below these limits in 2023:

	Yearly income	Resources
Single person	less than \$21,870	less than \$16,600
Married person living with a spouse and no other dependents	less than \$29,580	less than \$33,240

Source: *Medicare and You 2024*, pg. 92, SSA.gov, U.S. Department of Health & Human Services. Centers for Medicare & Medicaid Services, CMS Product No. 10050, September 2023.

Parts of Medicare

Medicare helps with the cost of health care, but it may not cover all medical expenses and does not cover the cost of long-term care when it's the only care you need. This section explains the different parts of Medicare and the services they cover.

Original Medicare (Parts A and B)

Original Medicare Includes:

- Part A
- Part B

You can add:

- Part D
- Supplemental Coverage

Medicare Advantage (Part C)

Medicare Advantage includes:

- Part A
- Part B

Most plans also include:

- Part D
- Extra Benefits

Source: Security Administration, Publication No. 05-10701, June 2022

Another Example—Vaccine Chart for Parents

The chart on the next page was identified as a “parent-friendly, easy-to-read” version on the CDC website (<https://www.cdc.gov/vaccines/schedules/easy-to-read/adolescent-easyread.html>) several years ago. In 2024, it was updated, with more reader-friendly features. But this earlier example offers an opportunity to highlight features that make such tools easier or harder to use.

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Key

 <p>Indicates when the vaccine is recommended for all children unless your doctor tells you that your child cannot safely receive the vaccine.</p>	 <p>Indicates the vaccine series can begin at this age.</p>	 <p>Indicates the vaccine should be given if a child is catching up on missed vaccines. A vaccine series does not need to be restarted, regardless of the time that has elapsed between doses.</p>	 <p>Indicates children not at increased risk may get the vaccine if they wish after speaking to a provider.</p>
-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	----------------------------------------------------------------------------------------------------------------------------------------------	--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

Recommended Vaccines												
Vaccine	7 Years	8 Years	9 Years	10 Years	11 Years	12 Years	13 Years	14 Years	15 Years	16 Years	17 Years	18 Years
COVID-19* Coronavirus disease 2019	COVID-19*											
Flu** Influenza	Flu (One or Two Doses Yearly)**		Flu (One Dose Yearly)									
Tdap Tetanus, Diphtheria, & Pertussis					Tdap							
HPV† Human papillomavirus				HPV†								
MenACWY Meningococcal disease					MenACWY				MenACWY			
MenB Meningococcal disease											MenB	

Source: **Recommended Vaccinations for Children 7 to 18 Years Old, Parent-Friendly Version.** <https://www.cdc.gov/vaccines/schedules/easy-to-read/adolescent-easyread.html>. Last Reviewed: February 10, 2023. Accessed 9-1-23.³⁶

For many health care and public health workers, this chart probably includes familiar information in a format they had seen before. For them, it was likely relatively easy to use.

But how might it work for many parents? Would they be able to understand it? Let's look at it through their eyes. The chart covers a great deal of complex information in a single visual. Parents first need to familiarize themselves with the Key to know what they will be seeing in the chart. However, many less experienced readers would likely start with the chart and not even look at the Key. The overlapping color circles may seem complicated and be intimidating. Parents may also skip the Key because they aren't familiar with its function. If they skip the Key, they won't be able to understand the information.

Reader-friendly Print and Digital Content

Parents also need to understand two other common features of charts in this vaccination schedule. They need to know the large colored bars going across several columns were meant to show that the information applies to corresponding ages in navy blue circles below the black bar and above the COVID line. In addition, parents need to know what the different colors and patterns in the bars mean. Without the key, they won't know any of this. The chart would be meaningless for them.

It is likely to be especially difficult for parents with:

- Low to intermediate literacy skills.
- Little experience reading charts.
- Limited knowledge of childhood vaccines.

In fact, even educated, confident readers who are not familiar with the topic may find it confusing when they first encounter it.

We recommend using much simpler charts with a lower literacy and knowledge demand for the general public/parents. This chart could be made easier by separating information into three different age groups, perhaps elementary school, middle school, and high school ages. It could also be easier if only the colored circles that were used in any given chart were shown.

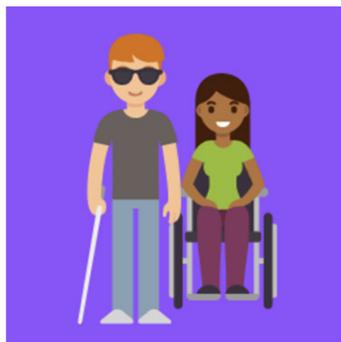
Pictograms and Infographics

Research in psychology shows the human brain prefers information that is picture-based over text-based.³⁷ Picture-based aids have been shown to improve patient comprehension, understanding, and recall as well as medication adherence and health outcomes.³⁷ They may also help with language and cultural barriers.

Visual information is usually easier to understand than text so it can be a good tool for both skilled and less skilled readers. However, it's important to carefully consider who it is for and what you want the result of reading it to be.

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A **pictogram** is a picture or image that represents an idea, an object, or simple data, like these examples from Venngage.com.



An **infographic** is a document that “combines visuals and text to communicate an idea, insight or information like the example below.”³⁸



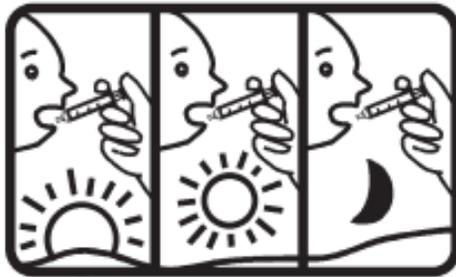
Reader-friendly Print and Digital Content

Pictograms

Figure 2. Universal Medication Schedule (UMS)

Take	1 pill in the morning	
Take	1 pill in the morning 1 pill in the evening	 Morning: 6-8 am
Take	1 pill in the morning 1 pill at noon 1 pill in the evening	 Noon: 11-1 pm
Take	1 pill in the morning 1 pill at noon 1 pill in the evening 1 pill at bedtime	 Evening: 4-6 pm  Bedtime: 9-11 pm

The pictogram example here uses the Universal Medication Schedule (UMS) wording in a simple table format without accompanying images.³⁹ The UMS wording is standard language for giving medication instructions. The wording is recommended by the National Council for Prescription Drug Programs. The UMS language, e.g., 1 pill in the morning, is in the table to the left in the middle column.



Take 3 times a day by mouth
Tome 3 veces al día por la boca

The pictogram on the left uses illustrations to indicate the time of day for each dose. Notice, though, the standard UMS wording is not used.

Reprinted with permission from *Plain Language Pediatrics: Health Literacy Strategies and Communication Resources for Common Pediatric Topics*, ©2009, American Academy of Pediatrics.

Using the simple explicit language of the UMS, numerals instead of words, and images that show the specific times of day in a visual format is considered best practice.³⁹ See the example below. It combines the UMS wording with images for time of day—the best approach.

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We asked our graphic designer to create the table and images below as an example for this book. Your organization may have a graphic designer who can create images that your audience(s) would find culturally appropriate and recognizable. If not, you too can hire one. This style of depicting when to take medicine is so helpful. It's a great example of a pictogram that works well.

	Morning 6 am-9 am	Noon 11 am-1 pm	Evening 4 pm-8 pm	Bedtime 9 pm-11 pm
Medication Name and Strength				
Metoprolol 50 mg	Take 1 pill in the morning.	Take 1 pill at noon.	Take 1 pill in the evening.	Take 1 pill at bedtime.
Calcium 500 mg	Chew 1 pill in the morning.			

Infographics

The features to check when choosing (or creating) an infographic are similar to features used in a printed or digital document. See the Checklist for Reader-friendly Documents/Content above on pages 305-307. Consult the Design and Layout section, then assess the infographics below. Jot down notes on each one. What could be changed to be more effective and what is already in line with our guidelines?

Reader-friendly Print and Digital Content



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What You Should Have Noticed

Don't Read Further if You Didn't Do the Suggested Activity Yet

We use the + sign for things that are working well and the Δ (delta) symbol for things that could be changed to improve.

In the BMI Body Fat Infographic:

- + Images are colorful and eye-catching.
- + Adequate open space without text or images.
- Δ An all dark background is hard to look at and navigate.
- Δ Lots of hard-to-read reverse text (light on dark).
- Δ Small font is hard to read.
- Δ All capitals in some lines instead of upper and lower case.
- Δ Unconventional reading direction—not easy to tell where to start.

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In the 4 Tips to Help Your Loved Ones infographic

- + Only a small number of words in reverse text (light on dark).
- + Most text set in lightly colored boxes instead of on the dark background.
- + Conventional reading flow—start at upper left, go across, then down and back to the left.
- △ **“Be a Mental Health Supporter”** needs to be larger or bold to be more visible
- + General guidelines in numbered text boxes.
- + Specific “how to” tips (actionable) in larger text boxes.
- + Adequate open space without text or images.
- △ Images on either side of the person, as well as the arm coming down, are unclear and potentially confusing.
- △ A better image might be two people sitting together and one is reaching out a hand to the other one.

Helpful Points for Creating Infographics

- Do your research and ensure you know if the information is factual or AI-generated, Check the source to determine if you can trust it. Can you ethically share the information?
- Make sure your data are presented in ways that make it clear and factual.
- Use a format or layout that matches the type of data. For example, what will work best—a list, a flowchart, a timeline, comparisons, maps, how-to images, a case study, etc.?
- Use data storytelling (see How to Tell a Story with Data—<https://venngage.com/blog/data-storytelling/>) for a great description of this technique).
- Make sure the visuals illustrate a point related to the topic and are not included simply because they are cute or entertaining.
- Notice if the overall look of the infographic is clean, balanced, and approachable vs. crammed with too much information and too many graphics that are distracting.

On the next page you will see an example of a good infographic. It was 8½” by 11” but was reduced here.

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“The Ideal Bedtime Routine” is a template from a commercial website for creating infographics. We edited the font size and type on this single-sided version. We thought the original text was too small and too light to be easily readable. The color in the text works well with the images. Notice, too, there are only five main points, scant text that is easy to read, and lots of white space—great, effective features!

Notice the images make sense only when the text is read. Be aware of this when choosing your images. If you can find images that need no explanation, that’s the best.



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Culturally and Linguistically-appropriate Materials

The intersection of health and culture is fascinating and challenging. This field of study is related to many others. There are many courses, books, and degree programs on this topic. In this section, we focus on culture relative to developing reader-friendly, plain language health information. We want to raise awareness and remind readers what should be considered in communicating in text-based media with people from cultures, communities, and countries other than their own.

A good place to start is to think of every health-related encounter as a cross-cultural exchange. The people health-related organizations serve have their own varied cultures. Similarly, the people who comprise health-related organizations and their workforces have customs, values, beliefs, rituals, roles, specialized vocabulary, prescribed clothing, tools, and more within their organizations—all elements of culture, too. Even just booking an appointment and going to a doctor requires patients to enter into the culture of health care.

To communicate effectively with the intended audience(s) whether in person, in print, or in digital media, it is ideal to know about their cultural beliefs around health. Thinking and learning about some of the health beliefs and behaviors that are influenced by culture can help content developers create caring and effective communications.

However, we can only know as much as the people from another culture want us to know and are willing to explain to us. Remember, wanting to understand a cultural belief does not obligate someone from the other culture to *explain* it to us.

If we practice being open-minded and open-hearted, and we listen with compassion and care, there is a good chance we will learn much of what we need to know. Ask people from the community you serve, and people who work with that community, to share with you some of the following information, if they are comfortable doing so. Ask about the beliefs of the community or individuals, relative to:

- Prevention, causes, and cures of illness.
- Western medicine like medications, radiation, and surgery versus Eastern medicine like acupuncture, cupping, and Chinese herbal medicine.
- The client's or patient's prioritization of their needs in relation to the needs of the family.

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- The client's or patient's sense of control over their health decisions and outcomes.
- The roles of the client or patient and their family members regarding decisions such as the course of treatment or whether to be vaccinated.
- Whether patients should discuss options with their doctor or trust in their doctor's recommendations without question.
- The role of religious or spiritual beliefs and practices about health.

Even learning about some of the above can help people in health-related settings create more relevant, appealing, and effective information. When we are not familiar with an individual's or community's belief systems or traditions, we cannot create content that is as effective as we would like. Here is an example from a health care provider who was not familiar with her patient's religious practices.

A Missed Opportunity for Medication Success

A hurried doctor prescribed an antibiotic to a Muslim man. The doctor didn't mention that the medication had to be taken four times a day even though the patient mentioned that he was observing Ramadan. When the patient picked up the prescription, he learned he needed to take it four times a day with food. This would be impossible since, as a Muslim, he would be fasting from food and water from sunrise to sunset for the month of Ramadan. If the doctor had been familiar with Ramadan, she could have prescribed something that he could take once a day after sunset. The man had to call to ask for a different medication. He felt frustrated that his doctor didn't know about Ramadan and that he had to go to the trouble of getting a new prescription when he was already not feeling well.

Ensuring Quality Translations for Greater Equity

Translating information may sound like an easy and straightforward process. However, if we look at translation from an equity standpoint, it is not so simple. First, let's get some background on a set of standards and guidelines called the enhanced National Standards for Culturally and Linguistically Appropriate Services (CLAS) (<https://thinkculturalhealth.hhs.gov/clas/standards>). The CLAS Standards are intended to improve equity and quality in health care and to help eliminate health care disparities.

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The standard that applies to this chapter requires health organizations to “Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.”⁴⁰ Let’s ensure a few key points are familiar:

- Translating means going from one language to another in *written* form. Interpreting means going from one language to another in *spoken or signed* form. It’s important not to confuse the two.
- Translators should ideally be bilingual and bicultural.
- Use translators from the same country or area as the people for whom they are translating. Native language speakers make the best translators.
- The translator should be a member of the intended community and should have worked with people who have low or limited literacy skills.

The usual translation process may seem to meet the standard but there are challenges that can get in the way. These challenges only began to be described in the mid-2000s. And processes to address them are not yet common practice.⁴¹ One major challenge is that a translation of an English document at 7th “grade” level is often not at the same “grade” level in the other language. It is difficult to translate into plain language if the translator is not trained in plain language principles. The other main challenge is being able to identify the cultural nuances of meaning in the source language (usually English) and translate those into the target language.

In 2015, a commentary on translation was published by the National Academy of Medicine, *Beyond Translation: Promoting a New National Standard for Equity in Health Materials Translated From English*.⁴¹

The commentary’s 7-step process in the next paragraph outlines the need for a new quality assurance process that informs our thinking.

Before diving into the proposed national standard, however, it must be recognized that many health organizations may have limited translation budgets, a lack of qualified translators, and pressing time frames. The proposed standard could serve as an aspirational equity goal for all organizations. Along the path to equity, do what you can to get this process in place in your organization.

Here is the recommended 7-step process to address the challenges and potential unintended bias of translations:⁴¹

1. Revise and reformat the document or digital resource so it is easy to read and understand in English before translation (reading level 6-8).

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2. Translation by a trained professional. Then a second trained professional reviews the translation for quality assurance. The two then come to consensus on final translation.
3. Plain language adaptation to adjust for comprehension, reading grade level, terms, and flow of language.
4. Cultural adaptation to adjust for cultural differences. This step also addresses cultural appeal, text, and images, and culturally-appropriate motivators.
5. Back translation into English by a different trained professional to check for plain language and cultural adaptations. Back translation is taking a translated document to a different translator and having it translated back into the original (source) language. The back translation is then compared to the source document.
6. Field testing (also called audience testing) with members of the intended audience.
7. Conduct a quality assurance translation check to ensure an accurate translation and that the translated version is written at the easiest reading level possible. Best practice is to have two independent translators, from different cultural backgrounds, translate the document and reconcile any differences. Then have a third translator conduct the final review.

Regardless of the translation process used, the next best step would be testing the document with the intended audience. Ask questions about the content and illustrations/photos. Be sure to ask questions that will result in useful feedback. (See field testing questions below.) Revise the document based on the community feedback.

What Does this Mean for Creating Content in Print or Digital Formats?

One of the main cultural implications for print materials or digital content is that it is best to develop a separate document or digital application for any group that is distinctly different from others in:

- Preferences about food, dress, who they see as a spokesperson, or religious beliefs.
- Beliefs about health, disease, and healing.
- Language and vocabulary on the topic of the document or digital application, i.e., if a food eaten by a group from one country is considered to be only for animals in another country, it would be best to customize for each group.

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Best Practice: Create print materials that consider the country of origin or ancestry of the intended audience rather than their language. This means you should create separate documents for Spanish-speakers from Mexico and Spanish-speakers from Argentina. Creating one Spanish document or digital content for all people who speak Spanish won't work as well as creating custom documents and digital content for people from various backgrounds.

What we discussed in the last few pages means we have the opportunity to craft messages and information that take culture into account. When we think about culture, we can ask ourselves:

- Is there a need for this information? Or do I think there is because of my cultural background?
- What messaging approach and message frame (e.g., gain/loss) would work best?⁴²
- What words, expressions, and tone will work best?
- Are the actions I want to recommend possible in the audience's cultural context?
- What visuals or images will be helpful, clear, and engaging?
- Whom will readers believe as the authority on the topic?

Collaborate with Your Intended Audience

Collaborate early on with the people for whom you are developing information in planning and developing materials. Take what they tell you to heart. Otherwise, your materials are unlikely to be used.

This phase is called formative research. You can develop materials without it. But if you can talk with two or three people before you develop materials, it may save you trouble further into the process.

- Talk with a few community members about the content you plan to discuss and determine if it is culturally appropriate. Avoid offending your audience or presenting information that is simply not relevant. Use an approach and examples that fit with their views.

The best way to know what those are is to ask. Conducting individual interviews before developing your materials is a great step. Field testing your materials when they are in draft form is also an effective step. Both are strategies you can use to learn about the culture, traditions, and language of your audiences.

- Use words, concepts, and idioms from the population's everyday language. Ask members of the community what is meaningful to them. They'll help you decide what to say and how to say it.

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- Make sure you use photos and illustrations that will resonate with your audience(s). Think hard about what your illustrations represent and run them past members of the community. You want your audience to personally identify with the photos, illustrations, and other images in your piece. (See the section below on field testing your information.)

Field Test Materials

What could be more important than knowing if our information is relevant, understandable, findable, and compelling enough to move people to act? Asking potential readers/users for their feedback about the information, or watching them use it, are two ways to find out if it is effective. The process of getting user feedback is known by several names, e.g., field testing, audience testing, user testing, and usability testing (which usually refers to watching someone use a website or other digital resource). This section provides an overview and might whet your appetite for conducting feedback sessions.

Obtaining feedback can be done with focus groups or individual interviews. Generally, focus groups are more difficult to do than individual interviews. For a focus group, it may be hard to find: 1) participants with the reading skills or health literacy levels you want, 2) a time most people can attend, and 3) a facilitator who can manage a lively group. Getting feedback from three to five individual interviews is logistically easier and will provide you with information on the most important problem areas.⁴³

For a quality improvement project, the process can be *less formal*. You can find three to five people in waiting rooms or the organization's cafeteria. Tell them you're working to make a form or flyer, etc. easier for everyone to use and you would like their thoughts, if they don't mind. If you can find members of the intended audience—probably patients or clients—that is great. For additional perspectives, it can also be helpful to interview family members or caregivers who may need to use the print materials or the digital content being tested, if you can find and recruit them but this usually is not easy with an informal, drop-in kind of field test.

Formal field testing with individual interviews requires more effort, is carefully planned in advance, may involve compensation, and takes longer. But it provides more in-depth information. There are several steps in preparing for formal audience testing. One of the first steps is deciding:

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- Whom to recruit.
- Where or how they will meet with an interviewer.
- Who the interviewers will be.
- Whether there will be compensation for the people who serve as consultants in giving their feedback.

Another step in preparing is to develop an interview guide. The guide will serve as a map for you to inform the volunteer about the process and ask the right questions to uncover opportunities for improvement. With a carefully constructed interview guide, it's possible to learn where readers struggle, what they understand or misunderstand, whether they can see themselves doing the recommended action, and much more. These findings will guide the last step, decisions about what to revise. There may be only a few small changes needed. Or the feedback may lead to reconsidering the entire approach of the document or website. Or you may land somewhere in between.

Conducting audience testing can be intimidating at first. After a few interviews, initial nervousness usually lessens. Many people who conduct field testing report finding the process fascinating, humbling, instructive, fun, and worth the effort.

Writing field testing questions is tricky. Don't ask yes or no questions because all you will get are yes and no answers, which doesn't tell you much. Instead, ask open-ended questions. Use phrases like:

- "How well did...?", "How much does..?" or "What does..?"
- "Can you tell me more about that? Is there anything else?"

Design questions to learn about their self-efficacy (do they believe they can do the suggested action), the information's usefulness (does the action make sense for them), and persuasion (were they persuaded by the message).

Sample Questions for Field Testing

- Would you say this booklet is easy to read and understand or hard to read and understand? Please tell me why you say that.
- What would you say are two or three of the main points the people who made this want to get across in this booklet?

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- Who do you think this booklet is written for?
- Would you give this booklet to a family member or friend? If yes, why? If no, why not?
- Please flip through the booklet and look at all the pictures. Do the people in them look like people you know? Are there any you would change?
- Now let's open up to the first two pages. What do you think about the way these pages look? For example, what do you think about the size of the letters and how many words are on the pages? The colors, like green words on the headings?
- Are there any words or ideas that people you know might not understand?
- Are there any words or pictures or illustrations you think might offend people you know?
- On this page, what seem to be the most important things to remember?
- What do you think people are supposed to do with this?
- What might make it hard for people you know to do (recommended action)?
- I'm not sure I understand. Could you please say that again?

Learn more about conducting effective field testing by understanding user testing with paper documents, digital content, mobile applications, and web pages. Usability testing is usually done with digital products but many of the principles also apply to field or audience testing. Check out this easy-to-use, thorough kit for people with no to little experience in usability testing at <https://www.dhs.gov/cx/dhs-usability-testing-kit>. You can also watch a series of YouTube videos that introduce the kit at <https://rb.gy/lb4n69>.

Learning the Skills to Create or Revise Print Materials and Digital Content

Your goal could be that everyone in your organization who uses print and digital content understands the importance of reader-friendly information. They need to know basic characteristics of reader-friendly print and digital information. For example, think of a disease prevention worker in a public health department who has not been trained to create a handout for clients from scratch. But they should at least know how to revise existing materials by making a few changes that will fix the biggest barriers for readers. Over time, and with practice and coaching, you can develop a core group of go-to plain language writer/editors.

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Hands-on Workshops

The best way to learn the process (from conceptualizing your message to designing to field testing) is an in-person, or on-line, hands-on workshop conducted by a qualified experienced materials developer. In a live training, you can see many examples of what works and what doesn't, and learn why. You learn the basics, practice what you learned, and get feedback from the workshop facilitator and fellow participants. Consider inviting a plain language expert to lead a tailored on-site training for a group from your organization. In addition to helping build expertise and capacity within your organization, this will establish a critical mass of trained, excited people who can, in turn, build momentum and commitment.

Books and On-line Resources

Learning from health literacy and plain language books, articles, guides, toolkits, and on-line resources is a way to get started and an option if resources are limited. However, learning from a book or web-based guide is usually not enough guidance to learn to create reader-friendly materials or websites from scratch. If you want your organization to have a group of go-to experts, they should have in-depth, live training with an expert in the field. That said, in the table below, we list the most up-to-date and well-respected resources.

Health Literacy Tools for Developing Print Materials

Resource	Description
ISO International Standard: Plain language—PART1: Governing principles and guidelines (Iso 24495-1:2023). Published online 2023. https://www.iso.org/standard/78907.html	The first international standards for plain language information. Also, the most recent set of guidelines. Citing ISO International Standards can give you more authority.
The U.S. Government's website on plain language, created to help government workers comply with the Plain Writing Act of 2010. https://www.plainlanguage.gov	Includes background information on the plain language law and plain language writing guidelines. A very helpful starting place to understand plain language and how the federal government uses and promotes it.

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Resource	Description
Centers for Disease Control and Prevention (2013). Clear Communication Index https://www.cdc.gov/ccindex/index.html	Evidence-based tool used for developing and assessing public health messages.
Agency for Healthcare Research and Quality (2014). Patient Education Materials Assessment Tool http://www.ahrq.gov/pemat/	A tool to assess the understandability and actionability of print and audiovisual patient education materials. Helpful in creating or assessing print materials.
<i>Oxford Guide to Plain English</i> . 5th ed., Cutts, M. Oxford University Press; 2020.	A complete, detailed, and very usable guide. Outlines 30 key guidelines.
Plain Language Thesaurus of Health Care Terms by United Health https://www.justplainclear.com/en	A great tool when you can't think of a simpler word on your own. Just don't get lazy and rely on this. Make your brain practice to get better!
<i>The Non-Designers Design Book: Design and Typographic Principles for the Visual Novice</i> , 4th Edition. (2015) Williams, R.	An award-winning book about design. It covers all aspects of design, from using color to combining typefaces. A solid classic in its 4th edition.

Health Literacy Tools for Developing Usable Websites

Resource	Description
Department of Health and Human Services (2010). Health Literacy Online: A Guide to Writing and Designing Easy-To-Use Health Web Sites https://health.gov/healthliteracyonline/	Comprehensive and excellent online guide geared toward web designers, web content specialists, and health communication professionals.

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Resource	Description
<p>Redish, Janice (Ginny). <i>Letting Go of the Words: Writing Web Content that Works</i>. 2nd Edition. (2014)</p>	<p>The 2nd Edition of this book offers excellent guidance for creating or revising content for websites and apps. Readers at all levels of experience will learn something new. The book is older but is as relevant now as ever.</p>
<p>Krug, Steve. <i>Don't Make Me Think: A Common Sense Approach to Web Usability</i> (2014). http://www.sensible.com/dmmt.html</p> <p>Krug, Steve. <i>Rocket Surgery Made Easy: The Do-It-Yourself Guide to Finding and Fixing Usability Problems</i>. (2010). https://sensible.com/rocket-surgery-made-easy/</p> <p>The link below is a video of a usability test Mr. Krug conducted to show people how easy it is: https://www.youtube.com/watch?v=1UCDUOB_aS8&ab_channel=SteveKrug</p>	<p>Krug's books are older but still great classics on usability. If you're a newbie, start here. Don't Make Me Think proposes a simple approach to usability testing appropriate for anyone involved in development of a website. See especially Chapter 9.</p> <p>His 2nd book is a companion to Don't Make Me Think and teaches how to do usability testing and apply the results. See especially Chapter 5.</p> <p>There is even a video of him conducting a usability test.</p>
<p>Nielsen Norman Group. Website Forms Usability: Top 10 Recommendations. (2016) https://www.nngroup.com/articles/web-form-design/</p>	<p>Includes strategies, guidelines, and resources Describes the barriers users with limited literacy skills may experience when searching websites for information. This is an older reference but still as relevant as ever.</p>
<p>Jorgensen, E. <i>Strategic Content Design: Tools and Research Techniques for Better UX</i>. (2023) https://rosenfeldmedia.com/books/strategic-content-design/</p>	<p>A recent addition on improving the user experience. This guide offers useful, evidence-based methods to make content effective. It also tells you what to do if you learn through testing that your content is not effective.</p>
<p>Web Accessibility Initiative https://www.w3.org/WAI/fundamentals/accessibility-intro/</p>	<p>Includes strategies, guidelines, and resources to make the web accessible to people with disabilities.</p>

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Resource	Description
Jarrett, C, & Gaffney, G (2009). <i>Forms that work: Designing Web forms for usability</i> (Interactive Technologies). San Francisco: Morgan Kaufmann/Elsevier.	Offers proven, practical guidance on how to create great forms that people can easily complete.

Making Handouts and Discharge Instructions More Useful to Patients and Clients

Now that you've read this far, you should have a much better idea of what makes a good patient handout and what doesn't. From now on, you'll probably look at all patient materials with a more discerning eye. If you need to find or create better alternatives, you can make those you do have work in the meantime.

Here are a few tips for getting the most out of handouts you already have:

- **Highlight the key points.** Circle or mark the most relevant and important information for the client or patient. Say out loud what marks you're using for what points. Doing so can help the person remember and have guideposts to find information later. This is especially helpful for people who are not confident readers or are not yet skilled in the English language.

For example, say, "Another thing to watch for is a fever. If your temperature goes over 101° F, call us. I'm putting a star by this to help you remember." Use a star, or underline, or highlight other information. Be sure to say out loud what you're doing.

- **Use handouts as a springboard for discussion.** Don't be surprised if patients say they have no questions when glancing at the materials. Most need time to digest the information especially if they can't easily read it. If you have to leave the room for five or ten minutes, that can be enough time for the person to look over a brief handout and decide if there's something they don't understand. When you return, remember they may not tell you they don't understand unless you ask, especially if they do not read well. They may say they understand if you just ask a yes or no question. For important information, use teach-back to assess and ensure understanding.

Reader-friendly Print and Digital Content

- **Write notes on the handout.** Print clearly rather than using cursive.
- **Offer to go over or read the key points in materials with the client or patient.** This can help them remember what you told them, especially if you rephrase what you're reading, using simple language.
- **Realize the limitations of handouts.** They don't work for people who can't read well enough to get meaning from print (about 1 in 5 adults). Also, if they're not visually appealing, and they don't look easy to read, people are not likely to read them.

What's Next? A Process to See if Changes in your Print or Digital Content Are Leading to Improvement

When creating new or revised print materials or digital content, we don't know if the changes are an improvement until we ask the people for whom we are creating them. One model for learning about the effect of your changes is the Model for Improvement and the Plan-Do-Study-Act Cycle (<https://www.ihi.org/resources/tools/plan-do-study-act-pdsa-worksheet>) used in the Model to make small tests of change.⁴⁴

Here is the PDSA model:

- **Plan:** Describe the change you want to test and the question you want to have answered. You also predict what you will find.
- **Do:** Do the test to see what happens. Describe the findings, what you noticed, etc.
- **Study:** Compare what you thought would happen to what did happen. Identify what you learned.
- **Act:** Decide what to do next, 1) keep the change, 2) adjust something for another small test of change (a PDSA cycle), or 3) throw out the change.

Reader-friendly Print and Digital Content

PDSA Cycle: Use Reader-friendly Plain Language Digital Information

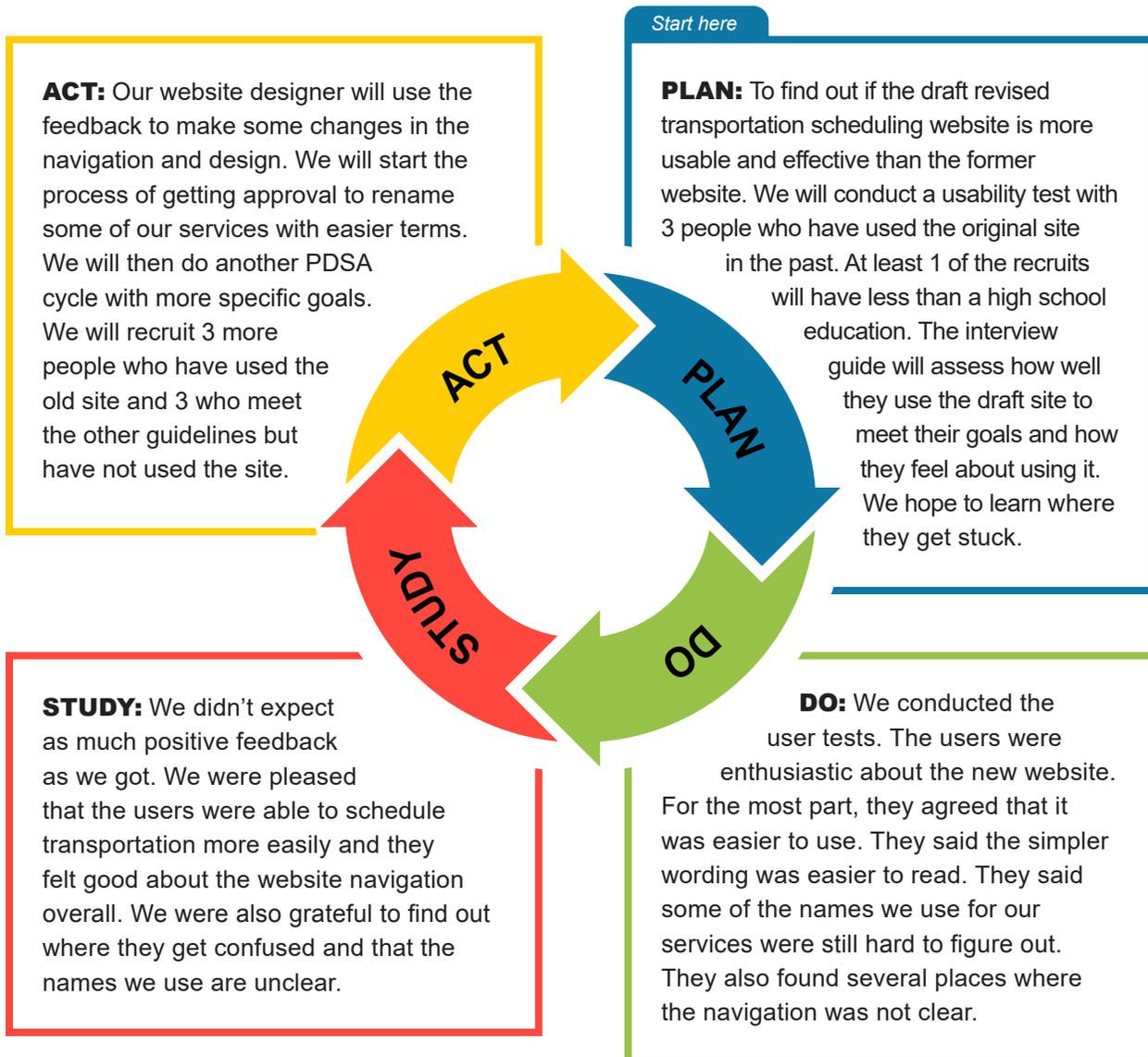
For years, a state agency that manages a transportation scheduling website has received complaints about the confusing language, definitions, and special names for different kinds of transportation. Users have also complained of the difficulty of navigating the original website.

The agency's mission is to ensure that everyone, but especially older adults, people with mobility challenges and other disabilities, and those with low incomes, can find accessible and affordable transportation within their service area. They want to see where they can improve their transportation scheduling website.

The agency decides to revise and rewrite the website to make it easier to navigate. Then they want to find out if their changes will work. They want to know if the wording is easier to read, if the new navigation elements make it easier to find the way, and ultimately, if clients are able to find and book their transportation options with less or no frustration. Here is a PDSA cycle to see if their changes are leading to improvement.

Reader-friendly Print and Digital Content

PDSA Cycle: Use Reader-friendly Plain Language Digital Information



Reader-friendly Print and Digital Content

Summary of Key Points

- Everyone benefits from reader-friendly plain language information. Much communication between patients and health care systems, or clients and other health-related organizations, is through the written word. Effective print materials and digital content are a key element of good health communication.
- Reader-friendly print and digital materials promote safe, high-quality care and services in any health organization. They can also help lessen health disparities.
- People may not remember much of what is said to them in a health-related setting, so they need clear information in print to take with them and refer to later.
- Your organization can provide effective, reader-friendly information by: 1) finding existing materials and websites outside the organization; 2) revising materials already used in the organization; or 3) creating new materials.
- Staff responsible for choosing, revising, or creating print or web-based information should have training in plain language and clear design principles.
- Checking the reading “grade” level at which information is written is necessary but not sufficient to assess understandability and usability. Information also needs to be assessed for a wide range of other qualities.
- Design, layout, and visuals are key ways to enhance reader-friendliness. Even if you do not have graphic design skills, you can ensure plain language guidelines for type are followed.
- To address health disparities and inequities, both print and digital information should be relevant and accessible to people with diverse cultural backgrounds, disabilities, and learning differences. Be sure to consider the needs of all people as you evaluate, develop, and deliver health information.
- Ideally, materials in languages other than English should be produced directly in the language and culture of the audience. If translation is needed, use qualified translators, get plain language and cultural adaptations, and field test the translation with members of the intended audience.
- Field testing your materials is the only way to know if your materials are effective. Even a few interviews will give you great information about how well your materials are working. Don’t skip this step!

Reader-friendly Print and Digital Content

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Case Studies

10 | Case Studies

“Health care organizations that embody these [ten] attributes [of health literate health care organizations] create an environment that enables people to access and benefit optimally from the range of health care services.”¹

This chapter contains case studies describing how six different health organizations addressed the discussion paper, *Ten Attributes of Health Literate Health Care Organizations*¹ to advance organizational health literacy. The cases represent several organization types and vary in approaches and focus. They illustrate how to use strategies discussed in this Guidebook to implement health literacy principles and practices.

The case studies include:

- Children’s Wisconsin – Building Leadership Buy-in and Staff Education in Health Literacy by Focusing on Safety and Quality
- ChristianaCare – Creating a Strategic Plan to Becoming a Health Literate Health Care Organization
- Columbus Public Health – Addressing Organizational Health Literacy and the CLAS Standards in Public Health
- Franklin County Public Health – Building a Health Literate County Health Department
- St. Vincent Charity Hospital – Institutionalizing Health Literacy Across a Health Care Organization’s Continuum of Care.
- UnityPoint Health – Developing a Reader-Friendly Consent Process to Improve Health Literacy, Health Care Quality, and Safety

“A health literate health care organization makes it easier for people to navigate, understand, and use information and services to take care of their health.”

— Brach, et. al. 2012¹

Case Studies

The ideas and information in this chapter are designed to help you:

- Identify strategies to begin implementing organizational health literacy improvements in your setting.
- Describe how health literacy initiatives can help an organization become more health literate.
- Visualize success and apply the Ten Attributes of Health Literate Health Care Organizations¹ to help advance your organization as a health literate organization.

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Case Study: Children’s Wisconsin – Building Leadership Buy-in and Staff Education in Health Literacy by Focusing on Safety and Quality

This case study describes the journey of a pediatric hospital to become a health literate health care organization. It illustrates how the strategies implemented align with those in the discussion paper, Ten Attributes of Health Literate Health Care Organizations.¹

The Beginning as an Interest Group

Children’s Wisconsin is a regional Midwest quaternary pediatric health system that began work with a health literacy interest group around 2005. Members of the Education Services Department organized and led this multidisciplinary group. Individuals with an interest in health literacy gathered monthly to discuss and share ongoing work. In 2009, we hosted a Pfizer Visiting Professor in Health Literacy. After that visit, the interest group developed and began an organized program to educate clinical providers throughout the health system on health literacy principles. The interest group continued this work for many years, reaching various nurse groups, physicians, and advanced practice providers, but without any outcome measurement on performance other than tracking which groups received education.

Patient Education Foundation

The health system has always had a robust patient education department and focus on writing education materials using health literacy principles. As a pediatric quaternary specialty system, our situation is unique. Our system will likely always require “homegrown” materials because prominent vendors focus on adult materials and do not cover the pediatric specialty materials we need. Teaching sheets used system-wide must be approved through a review process that includes the Patient Family Information and Education Committee, including education specialists, nurses, respiratory therapists, physicians, and parents. This team has been in place for over 20 years. With the expansion of digital information, the review process has changed somewhat, but is still required for materials used system-wide.

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The Transition

As the interest group grew, leadership transitioned. Leaders had traditionally been from our Education Services Department. The new leaders were a safety specialist (and nurse by background) and a physician. They reaffirmed the relationship and sponsorship by the hospital's Chief Medical and Safety Officer, who was apprised of the ongoing work of the interest group through quarterly meetings and approved of the work and the interest group.

While reaffirming sponsorship, the sponsor directed leadership to form a group charter. At this point, we were setting a new direction and decided to rebrand ourselves as the Health Literacy Task Force (HLTF) to draft the charter. The plan was to evolve the direction of the group from providing staff education to moving forward with organizational initiatives and strategic planning.

Staff education continued to be part of the HLTF role. Rather than trying to do individual clinical departments, we are included briefly in all medical staff orientations and offer an online and 30-minute in-person session for all new nurse orientees.

An Ask to Expand Our Staff Education (Attribute 3)

Our HLTF was asked to establish a training program in our primary care clinics. Being asked to provide expertise is an ideal improvement opportunity. The primary care clinic improvement network was prepared to deploy an intervention to become a patient-centered medical home. Our role was to develop the materials and program. All staff were asked to participate, including front desk staff, administrators, nurses, physician assistants, nurse practitioners, and physicians. A total of 475 people participated. The training included:

- Surveys to measure our impact: pre-survey, post-survey, and one-year post-survey.
- Online content module to allow for participation on their own time.
- Boost email within two days of completing the online module asking them to think of one thing they learned.
- In-person session within two months using a quiz format as teams and including discussion of answers.
- Continued reminder content throughout the year.

Case Studies

This method showed improved health literacy knowledge, behavior, and confidence in using health literate teaching techniques.² We now have a practical approach within our health system that we can translate into other health literacy topics.

Turning Point (Attributes 1, 3, and 4)

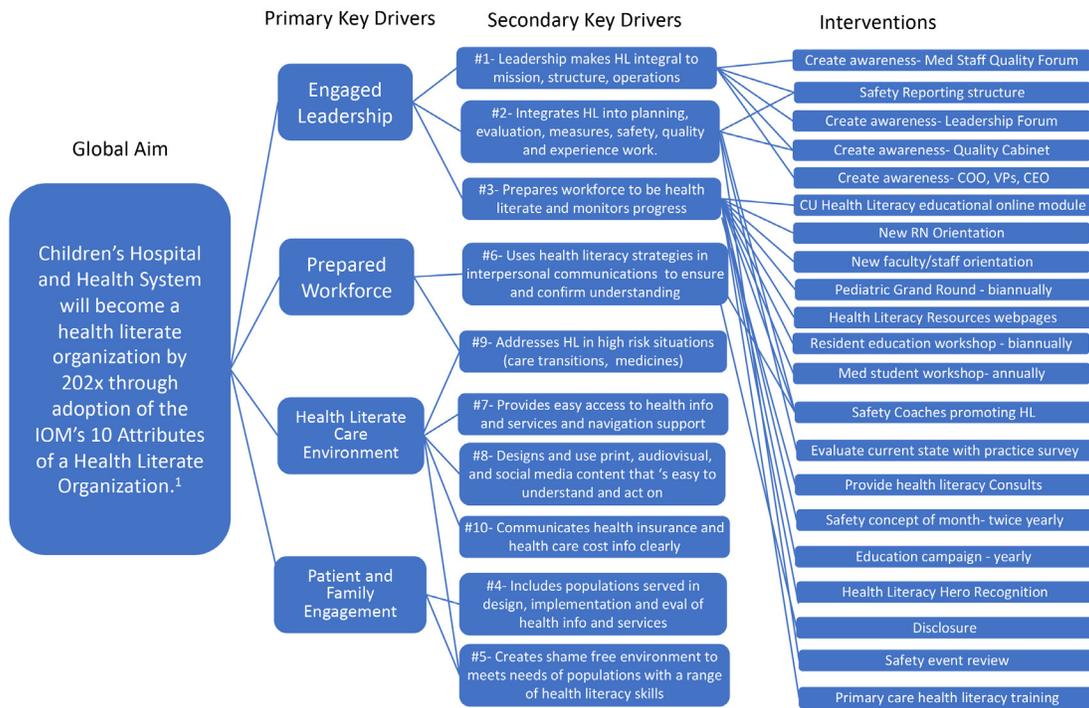
In evaluating the HLTF work and developing the charter, we invited a national speaker to help learn about building a health literate organization. During that visiting professorship, the speaker delivered Grand Rounds, spoke to individual divisions, and met with our Chief Medical Officer, a new Chief Quality and Safety Officer, and Chief Experience Officer. She helped the HLTF understand direction and think through what a key driver diagram would look like using each of the Ten Attributes¹ as Secondary Key Drivers.

In taking a closer look at the interventions we had already undertaken (Figure 1), we understood that we had worked intensely on involving leadership, getting leadership buy-in, and preparing the workforce. Our institution has always done an outstanding job including populations served in materials design.

We could now visualize our gap. Our future focus (Figure 2) should be on integrating health literacy into planning, evaluation, measures, patient safety, and quality improvement. We also saw the need to address health literacy in high-risk situations. These insights helped us plan our future work and focus.

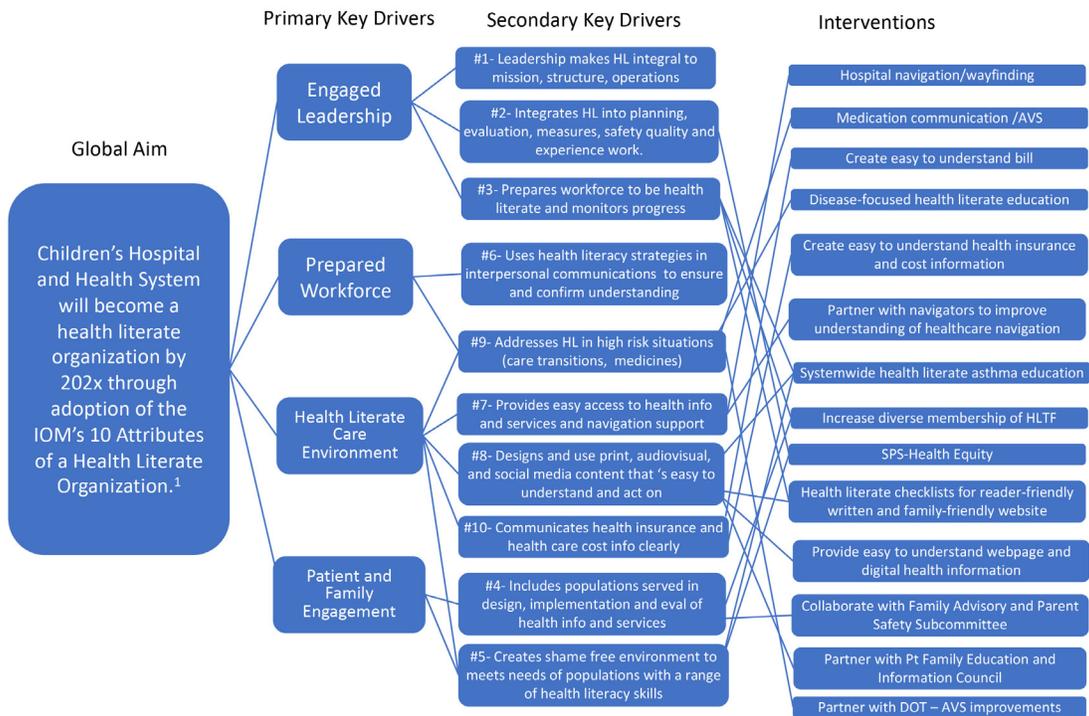
Case Studies

Figure 1. Health Literacy Task Force Key Driver Diagram - Current State



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Figure 2. Health Literacy Task Force Key Driver Diagram - Future State



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The Need for the Local Case (Attribute 1)

To build the case and understand the need to address health literacy in high-risk situations, we needed to help our institution value its importance. Discussing literature was not enough; we needed local data to convince leaders. We undertook a qualitative evaluation of safety events at our hospital.³ We learned the following:

- Health literacy-related safety events occur at least four times a week.
- Over half of the safety events occurred with misunderstandings and miscommunications related to medications.
- Another quarter of the events occurred with miscommunications around discharge or transition situations. When leaving the hospital or clinic, families misunderstood the next steps, plan, equipment, etc.
- Another quarter of the events were miscommunications about health system navigation.

The safety event review served two purposes:

- Created urgency with our leadership to understand the importance of health literacy in communication issues related to safety.
- Prioritized health literacy efforts in key areas of patient safety needs.

After presenting these findings at national conferences for health literacy and safety, our leaders became more engaged in our work. This type of data is not unique to hospitals. Almost any organization has a kind of prioritized data (e.g., experience, customer service complaints, program outcomes). Finding a systematic way to review data from a health literacy perspective can provide understanding about how to engage leadership and prioritize efforts. At this point, we were able to have our physician leader sponsored as a medical director of health literacy, allowing us to expand our quality program.

Addressing High-Risk Situations (Attributes 2 and 9)

Now that we identified improving medication-related communication as a priority, we began to work with our system-wide medication reconciliation group to address discharge medication communication. We developed a plan for implementation across the hospital system.

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- We use a process similar to our primary care training program with online and in-person boost content. The education has taught nurses, pharmacists, advanced practice providers, and physicians about clear medication communication.
- We have also included an added application to the electronic health record that will improve how medications display to families on the printed after visit summary.

An emergency department pilot has shown improvement in patient/family rated experience of medication teaching at discharge and in observation of medication teaching at discharge. Through this work to address discharge medication safety, we now have measures on our health system balanced scorecard quality measures and have advanced health literacy measurement. We hope this continues to build the integration of health literacy into quality and safety improvement.

Lessons Learned

Two additional important lessons stand out.

1. We chose to focus our local case for change on safety and quality. This could easily have been a case focused on equity or experience.
 - At our institution, this is where we felt we could partner best with ongoing initiatives.
 - Go with the flow. Use the ongoing initiatives at your institution to partner. Using health literacy strategies will improve outcomes in all these areas.
 - Your personal “why” for improving health literacy is not necessarily the message to which your institution will respond best. My “why” does not match the main initiatives of my institution.
2. It may seem like Children’s Wisconsin has come much farther than your institution.
 - We have been in your seat. You may feel like you only have a spoon to dig a hole the size of the Grand Canyon, and other institutions may have a backhoe.
 - Most of this work was done with intention and persistence, and within roles lacking funded time specifically for health literacy by a passionate group of individuals. Currently, our only funded role is a percentage of our Medical Director’s time. We hope to increase this as our work and impact progress.

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- We found we got farther once we acted with intention. Using a Key Driver Diagram to map out our past work in reference to the Ten Attributes¹ helped us understand where we had gaps. This helped focus future work on individual attributes we were not addressing and look for institutional partners. We did not work on the attributes in order, rather focused where alignment and intention presented opportunities.
- Never underestimate yourself and your team. A committed team with a strong “why” can accomplish great things.

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Case Studies

Case Study: ChristianaCare – Creating a Strategic Plan to Becoming a Health Literate Health Care Organization

An overview of how one health system created and implemented a new health literacy strategic plan, inspired by the discussion paper Ten Attributes of Health Literate Health Care Organizations,¹ demonstrates how these attributes can be used as a driving force for change.

The ideas in this case study will help you:

- Determine who should own and champion health literacy work in your organization.
- Formulate a health literacy-related strategic plan for your organization.
- Apply the attributes in a deliberate way to support your journey to becoming a health literate organization.

A health literate organization will have a plan and make a commitment!

As a leader in the community, ChristianaCare, a large dynamic health care organization based in Delaware, has committed to becoming a health literate organization as we “serve our neighbors with excellence and love.” Using the tenets of the Ten Attributes,¹ ChristianaCare embarked on this journey in 2017 by creating a strategic plan for health literacy and implementing it over five years. This case study describes the evolution of this strategy and work to-date to see it through.

Case Studies

Where to Start: Who Owns and Drives Health Literacy?

Historically, the patient education leader role was assigned to a single system-wide nurse educator within the Nursing Professional Development Department. This was not an adequate support for all the role entailed so, as part of a broader system reorganization, the case was made to promote the role to manager level and to hire another educator. As leadership support and awareness for the vision of creating a more health literate organization began to grow, more staff were added to support the efforts. Masters-prepared nurse educators from diverse backgrounds were hired, and the Patient & Family Health Education Team was formed.

This team of five Nursing Professional Development Specialists (NPDS) works together to support health literacy best practices throughout the system with the following focused roles.

Patient & Family Health Education (PFHE) Director

This position leads the strategic plan for patient education and health literacy initiatives.

Content Curator

This nurse educator manages custom patient education content, patient education vendor implementation and operations, technology integration, print asset utilization, and marketing/language services collaboration.

Acute Care Specialist

In this role, two nurse educators focus on supporting the patient education needs for the acute care population. This includes regular rounds throughout both hospitals to answer questions and educate caregivers regarding health literacy best practices and patient education resources.

Ambulatory Care Specialist

This nurse educator supports the patient education needs throughout the ambulatory practices. This includes regular presentations and visits to clinical sites to answer questions and educate caregivers regarding health literacy best practices and patient education resources.

All team members provide general nursing education system support and additional project work, including major initiatives and partnerships such as the Teach-Back Initiative, a consumer-facing health literacy campaign, and health literacy review services.

Case Studies

Attribute 1: Has Leadership That Makes Health Literacy Integral to its Mission, Structure, and Operations

The immediate changes described above would not have been possible without a clear articulation of the need to improve the organizational approach to teaching and communicating with patients. A few key leaders in the position to support the work were willing to listen. This meant first addressing the direct leadership where the work was being done. Fortunately, both the Director of Nursing Professional Development and the Chief Learning Officer for ChristianaCare understood the benefits and rallied behind the new strategy. Additionally, the case was made in any venue possible over the course of the next year, including nursing councils, leadership meetings, accreditation workgroups, and provider/service line leader meetings.

At this point, regional site visits were conducted to learn what other health systems were doing to address health literacy, from internal infrastructure and process to vendor strategy. These visits were insightful, highlighting opportunity areas such as implementing centralized management and curating custom education content, consolidating vendors utilized throughout the system, establishing a governance process, and creating a team of specialists to focus on the work. From this, a detailed five-year strategic plan was developed, approved, and shared with leaders. Soon, other leaders within the organization began to buy in to the health literacy strategic plan and became allies to the work from areas like equity and language services, marketing and communications, accreditation, information technology, provider leadership, nursing leadership, and pharmacy/respiratory/therapy services.

In a great partnership between nursing and physicians, a Medical Director of Patient & Family Health Education was designated to strengthen the mission within the organization and provide additional perspective in leadership engagement. Nurses continue to be strong advocates for patient, family, and community teaching and have incorporated health literacy best practices into the fundamental goals within the Nursing Professional Governance framework.

Case Studies

Attribute 2: Integrates Health Literacy into Planning, Evaluation Measures, Patient Safety, and Quality Improvement

Establishing a strategic plan and a team to operationalize the work has enabled continued inclusion of health literacy considerations in various projects and initiatives throughout the organization. This ranges from large efforts, like consolidating all system-wide patient education content vendors under the PFHE team, to smaller efforts, like performing a health literacy review of a single patient-facing letter. The variety of ways a health system reaches communities can be influenced through a health literacy lens. Health literacy advocacy with design teams can improve web content, patient portals, text messaging, form-based applications, telephone hold messages, social media, and traditional media. The team frequently collaborates with IT, marketing, working committees, and other content generators around the system to act as an advisor for plain language messaging.

In addition to various utilization reports for content or communication modalities, it is beneficial to build health literacy directly into system processes. Documentation of patient education in the electronic medical record is a great example. Changes were made to reduce the burden of documentation and focus on key content areas that are regulatory requirements and critical to delivery of safe, high-quality care. Primary sections in the record for documenting patient education were narrowed to include a simplified learning needs assessment and priority content like diagnosis, safety topic, specialty topic, hospital stay topics, and medications. These sections include the ability to document the effectiveness of teach-back and the type of assets used for teaching.

An excellent example of collaboration and planning is the system-wide Teach-Back Initiative. To evaluate the effectiveness of introducing new teach-back training, in partnership with the patient experience team, a question was added to the patient survey to measure use of teach-back throughout the system. All patients are asked to participate after every health care encounter with the question: “After giving you information about your care, were you asked to demonstrate or explain things back in your own words?” From this, data are collected and evaluated on performance of the teach-back best practice for health literacy. Since implementation (April 2020 – October 2022), over 480,000 responses have been collected. For the first time, data of this sort can be used to directly influence the performance of health literacy best practices within the organization. Ongoing work to train observers for each clinical area will enhance the professional development of caregivers to ensure effective use of teach-back to improve patient outcomes.

Case Studies

Attribute 3: Prepares the Workforce to be Health Literate and Monitors Progress

Over the course of several years, the resources, training, and services provided by the PFHE team have evolved into a wide array of interdisciplinary onboarding classes, e-learning modules, promotional materials, health literacy month events, research projects, technical integration work, recognition programs, awareness presentations, job aids, and video boosters, and statewide collaborative efforts to bring health literacy interventions to all interested stakeholders. Some details of the efforts are:

- Health literacy presentations are incorporated into orientation classes for new providers, nurses, and unlicensed assistive personnel.
- When teach-back was introduced in 2019, web-based learning was designed internally and assigned to caregivers throughout the organization. Leaders attended classes in the simulation lab to learn how to complete staff observations and to evaluate their use of teach-back with patients. Additionally, special role-playing workshops are conducted with nurse residents six months after hire to reinforce the practice.
- Over 70 teach-back presentations have been completed for staff in ambulatory practices from January 2021 to July 2022.
- A new teach-back toolkit and curriculum were added to the PFHE website providing continuing education credits for nursing and medical providers, and a special iPad-based rounding tool was added for leaders performing observations.
- Acute care and ambulatory care specialists from the PFHE team round in the inpatient and outpatient areas to reinforce health literacy best practices in real time.
- A ticketing system similar to one used for IT requests was set up for the PFHE team. More than 600 health literacy support or review tickets have been processed in three years. Turn-around-time on requests is usually one or two weeks, with some larger projects stretching to months. To date, request volume has been steady but manageable. Consideration to expand the team will be needed should requests increase sharply.

Case Studies

Attribute 4: Includes Populations Served in the Design, Implementation, and Evaluation of Health Information and Services

This important component of health literacy best practices has been integrated into multiple health literacy initiatives. During the initial phases of integration of health literacy strategies across the system, a Patient & Family Health Education Governance group, including patients from the Patient and Family Advisory Council (PFAC), was created to gain an understanding of priorities from various perspectives and to ensure broad leadership support.

The PFHE team received a grant from the Junior Board of ChristianaCare to promote health literacy throughout the community. The team held focus groups to find plain language options for the campaign and to help design a research survey. Focus groups were comprised of both English- and Spanish-speaking patients and families.

When it was decided that a new patient education vendor was needed to support the patient education needs of the organization, the PFAC was asked to provide guidance on this decision, even participating in the vendor demonstrations.

Attribute 5: Meets the Needs of Populations with a Range of Health Literacy Skills While Avoiding Stigmatization

As mentioned above, the new strategic plan called for evaluating content vendors and contracts. After a lengthy evaluation process, a new patient education vendor was selected to meet the content, access, and modality needs of the patients, families, and communities served. The vendor was vetted and chosen based on their incorporation of health literacy best practices and their focus on meeting the needs of a diverse population. Some of the health literacy best practices utilized by this vendor include using plain language, videos, 15 language options for many text-based pieces, and diversity and inclusion in text, video, and image content, with a targeted focus on race and gender inclusivity.

Case Studies

While our vendor supplies most of our patient education materials, there are some custom documents created to meet specific needs of a department. The content curator coordinates and organizes all custom content and consults with the departments to create health literate resources.

Clinical leaders schedule consults through a ticketing system with the PFHE team when materials need review or when a new idea is suggested. This content consists mostly of patient instructions or communications. All members of the PFHE team help with completion of health literacy reviews of patient-facing materials. Requests for patient-facing material may include how-to guides, short videos, patient letters mailed to the home, or leaflets about programs and services.

The PFHE team works closely with the Health Equity and Cultural Competence team. These groups stay in frequent contact to understand the needs of patients and to ensure alignment of interventions.

Attribute 6: Uses Health Literacy Strategies in Interpersonal Communications and Confirms Understanding at All Points of Contact

A teach-back initiative was implemented throughout the organization to improve the experience and effectiveness of care. Web-based learning was assigned to caregivers throughout the organization. Leaders learned how to complete teach-back observations with staff to provide feedback and improve skills. Teach-back was added as one of the six core behaviors of the nursing bundle to improve patient experience.

A specific goal to improve education, knowledge, and delivery of health literacy principles throughout nursing was added to the fundamental goals of the Nursing Professional Governance bylaws.

Patient feedback comments from post-encounter surveys are published on the hospital's intranet platform for staff to encourage use of teach-back.

Case Studies

Attribute 7: Provides Easy Access to Health Information and Services, and Navigation Assistance

The selection of a new patient education content vendor allowed the delivery of consistent, reliable health information in all care areas of the organization. Access to this information was improved with vendor-provided publishing software, making it easy to incorporate the same vendor material in marketing assets, the public-facing website, and the patient portal. With this multi-modal approach, more people have access to consistent information, and staff have more ways to connect patients and families via a preferred method. The PFHE team also contributed to production of videos and leaflets that provide plain language instruction on using a resource like the patient portal.

Attribute 8: Designs and Distributes Print, Audiovisual, and Social Media Content that Is Easy to Understand and Act On

One of the challenges with a large health care system is consistency. The combination of separate IT platforms, variation in workflows and populations, and differing priorities can be a recipe for a disconnected experience for patients and families, making it even more difficult to understand health information. In this case, many different vendor solutions were in use without any real coordination or consideration to health literacy.

Through the creation of a centralized resource for health literacy advocacy, work was done to re-design the discharge process, improve cost and process inefficiency by consolidating vendor solutions, improve alignment with regulatory requirements, and coordinate digital content to, at minimum, match print content, but preferably to offer multilingual video as well. Vendor selection was influenced heavily by functionality that made it easier for marketing teams to access and use the same content given out at the end of an encounter or discovered online in the health library.

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Attribute 9: Addresses Health Literacy in High-risk Situations, Including Care Transitions and Communications About Medicine

During the COVID pandemic, a special team was created across the system to specifically address communicating with high-risk populations. The PFHE team participated in this group and was critical to creation of plain language communication and interventions related to COVID.

Recently, a new transition of care team was developed. Through advocacy and awareness, the nurse manager of this team consulted with the PFHE team's ambulatory care specialist to discuss patient education resources and best practices. Health literacy support services are made available to any specialist group of clinicians or caregivers addressing high-risk populations.

Attribute 10: Communicates Clearly What Health Plans Cover and What Individuals Will Have to Pay For Services

One of the examples of utilizing these new health literacy resources was the review of insurance coverage messaging for Medicare outpatient observation patients. Another is the review of multiple email communication campaigns via care management describing preventive screenings available to patients through insurance to reduce cost as a barrier. Forms like these are reviewed frequently for plain language as a member of the PFHE team is embedded within system-wide form committees.

Findings and Feedback

Maintaining Senior Leadership Commitment and Advocacy

This important element of health literacy takes ongoing effort due to the ever-changing health care and social landscape.

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Empowering Nurses and Nurse Leaders Early Is Essential

However, true adoption of best practices should be interdisciplinary, and ongoing efforts to ensure all health care team members are proficient is an opportunity for future efforts.

Ongoing Investment in Staff Resources

This will be necessary as the organizational commitment to health literacy best practice grows. Requests for help can quickly outsize the health literacy team.

Monitoring Performance Standards

This has been very informative. Creative ways to assess performance, including real-time observations and patient surveys, should be continued.

Time Is Always a Concern

Nurse leaders have expressed time challenges associated with completing teach-back observations on staff. Exploration into streamlining observations, utilization of simulation, and asking additional nurses in professional governance to help are being explored.

Vendor Consolidation

This finding has yielded more focused support for staff, large increases in asset utilization, cost savings, and strategic partnerships for co-evolution of products and services.

Gain Momentum When Possible

As awareness builds, so does leadership buy-in. One service line convened a work group to evaluate all communication and education resources for a comprehensive overview of improving efficiency and health literacy best practice. This should provide a template for other service lines to follow.

Nursing Professional Development (NPD) Specialists

Driving health literacy practices in the organization provides an excellent balance of clinical, education, and leadership skills necessary to create change. In this case, the only difficulty is balancing other NPD demands in a role that is growing in responsibility and influence in the health literacy sphere.

Case Studies

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Case Studies

Case Study: Columbus Public Health – Addressing Organizational Health Literacy and the CLAS Standards in Public Health

This case study describes how a public health agency deployed the Ten Attributes of Health Literate Health Care Organizations¹ and the National Cultural and Linguistically Appropriate Services (CLAS) Standards² to address cultural and linguistic competency and organizational health literacy with a focus on specific attributes and CLAS Standards.

Columbus Public Health’s Mission

Columbus Public Health (CPH) is the local health department for the cities of Columbus and Worthington in Ohio. CPH identifies and addresses public health threats, enforces laws that protect health, and provides services to prevent and control disease. Over 40 distinct programs – focusing on environmental health, maternal and child health, infectious disease, community health, disease surveillance, linkage to care, planning, and emergency preparedness – are supported by over 500 full- and part-time employees. The department’s mission of protecting health and improving lives is achieved through policies and programs that assess community health status and assure that needed health services are delivered to the community.

Populations in Columbus and Worthington and the Need for Health Literacy

Columbus is the capital of Ohio. It is the 14th most populous city in the United States and is increasingly diverse. Worthington is a smaller, suburban city adjacent to Columbus. Columbus’ population is 909,686 with a growth rate of 13.8% (6.9% higher than the national average).³ The city’s population is approximately 8% foreign-born with more than 155,000 residents from nations including Bhutan, Somalia, Democratic Republic of Congo, India, and Mexico. As a local government agency, we are the access point for many services throughout the city, including our health clinics. As we move to improve the quality of services for all community members, we seek to become a more health literate organization and to implement CLAS Standards² throughout our organization.

Case Studies

Advancing as a Health Literate Health Organization

As CPH moves toward becoming a health literate health organization, we work with various divisions and staff to gain insight. We started by getting others involved in completing an initial organizational health literacy self-assessment, using the Enliven Organisational Health Literacy Self-assessment Resource⁴ to obtain a baseline and identify where there were gaps in the Ten Attributes¹ affecting programming and services we provide to the community.

Aligning the CLAS Plan to Our Organizational Health Literacy Efforts

Both the annual update of CPH's CLAS plan and the Enliven assessment came about around the same time, with staff members working on both initiatives. We identified multiple points where we could unify efforts through implementing CLAS plan policies and activities to help us to become a more health literate organization. The process started with a dialogue to leverage work in multiple programs throughout CPH. Aligning CLAS and health literacy efforts led to coordinating funding to launch specific initiatives such as wayfinding improvement and review of policies with respect to the CLAS Standards and the Ten Attributes.¹

Through a series of staff conversations, multiple smaller teams were formed to carry out initiatives. One of these was to change wayfinding to improve the accessibility of our clinics. By improving accessibility, we will be able to provide better services to our diverse communities and priority populations. There is a clear connection between CLAS Standards 1 and 8 with sub-items in Enliven Attributes 5 and 7. See table on the following page.

Case Studies

Connection between CLAS Standards and Enliven Attributes in Wayfinding for CPH

CLAS Standard	Enliven Ten Attributes & Sub-items
<p>Standard #1: Principal Standard Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.</p>	<p>Attribute #7: Provides easy access to health information and services and navigation assistance. Sub-item A: Have facilities with features to help people find their way.</p>
<p>Standard #8: Communication and Language Assistance Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.</p>	<p>Attribute #5: Meets the needs of populations with a range of health literacy skills while avoiding stigmatization. Sub-item B: Create a physical environment that is welcoming and does not require a high level of health literacy to understand and navigate.</p>
	<p>Attribute #7: Provides easy access to health information and services and navigation assistance. Sub-item B: Use easily understood language and symbols on all signage.</p>

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In parallel and anecdotally, the need for internal and external wayfinding was raised by staff who were regularly assisting community members locate the main entrance, as well as helping them find services once inside. To support the need for change, an assessment was needed. Key staff were convened from clinical services, outreach, quality improvement, and the front desk to participate. Data were compiled on navigation, signage, and customer feedback. Next, it was determined that an external organization should also conduct an assessment. A scope of work was created to identify a vendor with the expertise to conduct the assessment and design an internal and external wayfinding program. This wayfinding project is ongoing. We expect this work to improve access to our services, including clinics, for our diverse clientele and community members.

Continuing the Process

Improving wayfinding expands access and navigation to services using health literacy practices. Health-literate wayfinding increases awareness of these services, makes the process of finding them easier, and makes the information more digestible to comprehend and retain.

As we continue to move through the wayfinding improvement process, we will undertake improvements to the physical structure. These include, but are not limited to, directional and service location signage translated into multiple languages based on program interpretation services usage. Once in place, customer and staff feedback and surveys will be used to monitor navigation ease and upkeep. We will also check in with staff through formal and informal conversations, using qualitative data methods.

CPH will use both the Enliven assessment and CLAS Standards to continually improve efforts to meet the needs of the communities we serve and address organizational health literacy. The wayfinding project has helped to align efforts within CPH as we strive to become a more health literate organization.

Case Studies

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Case Studies

Case Study: Franklin County Public Health – Building a Health Literate County Health Department

This case study is an overview of how a public health agency in Franklin County in central Ohio is working toward becoming a health literate health care organization based on the discussion paper, Ten Attributes of Health Literate Health Care Organizations.¹ Franklin County, Ohio's most populous county, has a population of 1.3 million people. Franklin County Public Health (FCPH) provides comprehensive public health services to 17 townships, nine villages, and 14 cities with a focus on the health of communities or groups. FCPH has five divisions with approximately 146 employees. Staff include plumbers, food inspectors, harm reduction specialists, tobacco prevention specialists, nurses, community health workers, and many others. Health literacy is essential to all these roles.

Through Building a Health Literate Community: Toward an Equitable Response to COVID, a 2021 federal Office of Minority Health and Health and Human Services-funded grant, FCPH, Columbus Public Health (CPH), and Nationwide Children's Hospital (NCH) launched Advancing Health Literacy Franklin County (AHLFC), a collaborative effort to build long-term institutional organizational health literacy knowledge and capacity and to promote health equity.

Healthy People 2030² defines personal and organizational health literacy and provides guidance on health literacy interventions and best practices. It underscores that both personal and organizational health literacy are necessary to attain health equity. The Enliven Organisational Health Literacy Self-assessment,³ based on the Ten Attributes,¹ offers a starting point for discussion and action among organizations toward advancing as health literate organizations. At FCPH, baseline assessments began in April 2022, repeating every four months to determine progress. Based on the results and leveraging key participants, we focused on Attributes 1 (Leadership) and 3 (Preparing the Workforce). Without collective work on both, we would not be able to work toward all attributes. We addressed the following key questions:

- 1) Who is responsible for health literacy at FCPH?
- 2) How do we continue to engage leaders and promote visibility of health literacy efforts?
- 3) How do we keep up our collective momentum?

Case Studies

Key Participants

Partner Team

For the greater AHLFC grant, critical partnerships within Franklin County were created and developed to carry out the work, including Ethiopian Tewahedo Social Services. Each had a unique complementary role, working with the core teams from NCH, CPH, and FCPH.

FCPH Internal Team

The FCPH internal health literacy team is comprised of a small group promoting and working on health literacy, including a Principal Investigator, Program Coordinator, Data Analyst and Evaluation Coordinator, and Communication Specialist. Over time, the core group evolved and brought on other members, including an epidemiologist and a health educator.

Through AHLFC, Health Literacy Champions were identified and trained. FCPH had a Health Literacy Champion who provided internal health literacy trainings and joined document assessments. Although this Champion recently left their position, multiple individuals across our agency are joining an upcoming Champion training cohort.

The six-month NCH-led Health Literacy Learning Collaborative (HLLC) is a cohort of public health, health care, and community-based organization teams committed to improving organizational health literacy. Six FCPH team members, representing Human Resources; Diversity, Equity, and Inclusion; and Prevention and Wellness, contributed unique experiences and viewpoints to discussions on how our organization planned to work toward becoming a health literate organization, focusing on the prioritized attributes.

Enliven Team

For each Enliven³ assessment, FCPH formed a group of cross-divisional employees and leadership. This group changed over each iteration due to staff turnover and schedule conflicts.

Case Studies

Attribute 1: Has Leadership That Makes Health Literacy Integral to its Mission, Structure, and Operations

At FCPH, leadership involvement in health literacy has been crucial to making changes. The grant Principal Investigator is the Assistant Health Commissioner and Director of Prevention and Wellness. She was highly involved in all grant planning and efforts and a member of our HLLC team. The Associate Director of Equity and Inclusion also participated in the HLLC. She brought an understanding of the intersection of health literacy and equity and inclusion and how they complement each other. In addition to these two leaders, there has been increased visibility of health literacy with our Health Commissioner and the FCPH Board of Health.

FCPH leaders host an Equity Advisory Council (EAC), periodically bringing together members and leaders from within the health department and the community. The EAC has been supportive, integrated, and engaged throughout the grant health literacy initiatives. At regular EAC meetings, health literacy staff present findings and training opportunities to help sustain ongoing support and visibility. EAC leaders continuously encourage members to keep health literacy as a standing priority.

Using Enliven³ assessments, we collect comments and feedback to understand why individuals feel an Attribute is or is not present. Many comments about Attribute 1 discussed the need for new or improved health literacy-related procedures and increased training availability. As a result, leaders across FCPH now participate in various health literacy trainings, creating increased visibility.

Attribute 3: Prepares the Workforce to be Health Literate and Monitors Progress

To become a health literate organization, we must develop our workforce's skills in cultural competence and the National Cultural and Linguistically Appropriate Services (CLAS) Standards.⁴ This will strengthen FCPH when providing direct service and population-based public health practice and is key to serving our community equitably. During the grant period, we provided a wide variety of evidence-based health literacy training opportunities. In addition, we found ways to create and develop institutional knowledge from the wealth of training information.

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AHLFC has offered a variety of health literacy trainings, including CLAS and Cultural Competency, National CLAS Standards Implementation Workshops, Digital Health Literacy, Reader-friendly Plain Language Materials, and more. To date, 93 trainings have been offered, with nearly 2,000 participants.

FCPH hosted National CLAS Standards Implementation Workshop trainings. These were conducted in partnership with our Associate Director of Equity and Inclusion, who worked with a trusted community leader and subject matter expert to lead 14 three-hour CLAS Implementation training sessions. FCPH staff attendance was required and 131 (90%) attended; pre-/post-surveys were used to assess knowledge gained. We are now trying to find a process to continue training new staff, potentially through recordings. Trainings instilled both workforce development and institutional knowledge and sparked further conversations about cross-divisional participation in health equity and health literacy.

Another way we are working to impart institutional knowledge is through Standard Operating Procedures (SOPs). We began working cross-divisionally on SOPs that would make incorporating health literacy easier for everyone throughout FCPH. The first SOP created was how to conduct an Enliven³ assessment. This SOP gives step-by-step instructions on how to identify a representative group of FCPH employees to ensure completion of a comprehensive assessment, with a follow-up consensus meeting. Additionally, we worked with our epidemiologists and Data Committee to craft an SOP about numeracy best practices. This SOP describes how to incorporate numeracy guidelines into daily work and public-facing materials. Our next goal is to create an additional SOP focused on document materials assessment.

To develop a sustainable approach to preparing our workforce for the long term, FCPH and AHLFC created a website (<https://advancinghl.org/>) to house health literacy resources. The website is accessible not only to our workforce but to anyone looking for information about health literacy. Many of the trainings conducted were recorded to create a video training catalog. For example, CLAS and Digital Health Literacy trainings will be available on demand. We are curating this library and plan to launch a dedicated training page on our website. A guide called *This, Not That* was created by our communications team and added to the website as a resource for those working on enhancing document reading ease. It offers reader-friendly alternatives for words like epidemic, risk, and other public health terms. Additional health literacy resources and contact information are available on the site.

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Throughout this process, FCPH has learned the importance of internal and external partners within and outside the public health realm to maximize impact in the community and promote organizational health literacy.

Future Directions

1. Who is Responsible for Health Literacy?

FCPH is working to identify who is primarily responsible for health literacy. We all have a part in optimizing reading ease, numeracy, and health literacy practices. Still, we want to identify a person or group to whom employees can go for answers and resources. To do this, we are focusing on these strategies:

- We are looking for new ways to increase leadership buy-in and to engage new leaders within FCPH.
- Health literacy principles are important to all divisions within our agency. To best communicate our expectations, we are working on creating and improving additional SOPs.
- We have many foundational committees that allow for cross-divisional partnerships. We are deciding whether to create a new committee with a focus on health literacy or a sub-committee within the Equity Committee to focus on health literacy.

2. Dissemination of Health Literacy Work

Over the last year, we discovered that dissemination of information was not happening as we thought it was within our agency. Through many assessment comments, we noticed different perceptions of whether an Attribute sub-item was present or not within a division or team. We need to make sure that lead individuals or groups can disseminate the work to engage all staff and leadership. To do this, we are focusing on these strategies:

- We are exploring new ways to get the word out. For example, we are creating a new committee or sub-committee with cross-divisional participants.
- There has been increased visibility within one of our Advisory Councils, where internal and external partners can hear more about our progress.

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3. How to Keep the Momentum

We want to identify ways to keep momentum and progress moving forward. This brings the owners of health literacy and the need for dissemination together. Creation of a sub-committee or committee will allow us to have a place in the organization for health literacy to live and flourish. A diverse group of employees will also increase visibility throughout the agency and allow continued engagement with leadership. This committee would continue periodic Enliven³ organizational self-assessments, document materials assessment, create and oversee new SOPs, and disseminate results and resources.

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Case Studies

Case Study: St. Vincent Charity Hospital – Institutionalizing Health Literacy Across a Health Care Organization’s Continuum of Care

This case study describes one hospital’s journey toward becoming a health literate organization. It illustrates how the strategies implemented align with those in the discussion paper, Ten Attributes of Health Literate Health Care Organizations.¹

Background

In 2007, St. Vincent Charity Medical Center, a faith-based, urban not-for-profit teaching hospital in downtown Cleveland, Ohio and one of the Sisters of Charity Health System ministries, was awarded a grant from the Sisters of Charity Foundation in collaboration with Project Learn, a Cleveland adult learning center. The goal was to institutionalize health literacy across the continuum of care. The Foundation recognized that health literacy lies at the intersection of many socio-economic conditions, from gaps in education to the complexity of the health care system.

The director of staff and patient education was appointed to lead the project on behalf of the hospital and was initially trained on health literacy principles with other grantees through several community learning circles facilitated by the Foundation.

Leadership Support (Attribute 1)

One of the project’s first initiatives was to provide awareness training to senior and mid-level leadership of the organization. The project lead delivered the training, using the American Medical Association Foundation’s training manual² as a guide. The response was overwhelmingly positive and internal fiscal and human resources were provided. Support continued through three changes in senior leadership over 15 years and included:

- Formation of a health literacy team. Department directors identified staff to participate in monthly committee meetings as well as associated projects. Team members met monthly for 15 years and served as health literacy champions throughout the organization. An average of 12 members represented different disciplines in the hospital.
- Establishment of the Health Literacy Institute in 2009. It was recognized as a separate accounting unit with its own operating budget and designated as a Center of Excellence by the Sisters of Charity Health System. The director of staff and patient education was appointed a second role as director of the Institute.

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- Creation of a dedicated health literacy section on the hospital’s website.
- Development of a patient and family education policy requiring all staff use health literacy universal precautions in verbal and written communication (Attributes 2, 5, 6). This includes use of plain language, chunk and check, and teach-back techniques.

Awareness Building and Training (Attribute 3)

Once the health literacy team was identified, members required training on health literacy principles. This was accomplished through workshops provided by the Institute’s director as well as the founder of Project Learn. The training included evidence-based health literacy practices delivered through lecture, videos, role play, and in-depth hands-on revision of written materials. Following team training, members were equipped to educate other hospital staff, including:

- Health literacy training for all clinical departments during staff meetings.
- Mandatory one-hour training for all nurses during annual in-person clinical competencies.
- Initially three, one-hour workshops for medical residents followed by annual mandatory training.
- Health Literacy 101 training for all newly hired hospital staff on the first day of orientation.
- Additional one-hour health literacy training for newly hired nurses during centralized nursing orientation, including interactive role-playing activities focusing on use of plain language and teach-back (Attribute 6).
- Mandatory annual online competency for all hospital staff.
- Numerous Health Literacy Month events for hospital staff and the community.

Audiovisual and Print Materials (Attribute 8)

The health literacy team also worked toward achieving the eighth attribute—designing and distributing print, audiovisual, and social media content that is easy to understand and act on. One of the first objectives was to assess current patient education materials. A random sampling of hospital-developed patient education materials revealed an average 12th grade reading level. An assessment of patient education materials provided by the current vendor for patient education revealed those materials were at an even higher level. The following strategies were implemented to address these issues:

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- Revision of all hospital-developed patient education materials by the health literacy team to 8th grade reading level or below.
- Per policy, vetted all patient-facing written materials for the hospital through the health literacy team before distribution.
- To include populations served, a patient representative was added to the health literacy team to assist with revisions (Attribute 4).
- A market analysis of patient education vendors was completed, and a new vendor was chosen based on their commitment to health literacy practices. Their plain language patient education materials are provided in English and other languages.
- Materials were made easily accessible by including them in the electronic health record.
- The health literacy team partnered with the patient experience committee to develop patient information folders that include documents written in plain language. In the folders, separate tabs house general welcome and hospital information, information about medicines, disease-specific education forms, and a discharge summary including information for follow-up care.

The hospital also worked to improve interpreter services by investing in a new vendor for video remote interpreting. The hospital also purchased health education videos for every inpatient room.

Navigation (Attribute 7)

Another significant effort involved adult learner students from Project Learn in different projects and focus groups (Attribute 4). In 2012, students were asked to complete navigation tracers to assess hospital signage based on the Health Literacy Environment tool.³ On three different occasions, adult learners were brought to the lobby of the hospital and asked to find a particular location, such as CT (computed tomography) scan or radiology. The results showed that although caregivers were happy to help when asked for directions, hospital signage was not clear. With support of senior leadership, the health literacy team held further focus groups. In these groups, students were given a list of all the hospital departments and asked for input on the terminology used. Based on those results, many hospital signs were changed. For example, instead of “Radiology,” the new sign will read “X-ray.” New signage was also created in Spanish as well as English. We found that sometimes language can seem straightforward but still prove to be a barrier. For example, the department where patients check in for tests was called “Admitting,” even though patients were not being admitted to the hospital. The name was changed to “Patient Check-In.”

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A post-revision navigation tracer was completed in 2014, with collected data and adult learner students reporting a much-improved experience and greater ease with wayfinding (Attribute 2).

High-risk Populations and Procedures (Attribute 9)

The health literacy team was also interested in addressing high-risk populations and high-risk procedures. One target area for improvement was informed consent. The health literacy team developed an informed consent document with input from the hospital's legal counsel. The form was written in plain language while still maintaining legal requirements.

The interdisciplinary team also developed new plain language print materials on diabetes self-management and created plain language pre- and post-test knowledge surveys to determine the patient's utilization and comprehension.

In addition, extensive training was completed around the medication reconciliation process. All nurses and medical residents were trained in best practices to obtain accurate information, including the requirement for family involvement, whenever possible.

Evaluation (Attribute 2)

The health literacy team conducted three health literacy organizational assessments since 2011 to determine performance and progress in promoting health literacy. These assessments used an adaptation of the Ten Attributes¹ and the Enliven Health Literacy Assessment tool.⁴ In revisiting the assessments, the team addressed attributes and interventions that had only been partially implemented or not implemented. For example, the team noted there was a gap in aligning health literacy with hospital safety plans. In response, the team requested that communication-related safety events be included as an agenda item for the Patient Safety Committee. The team also noted that although hospital signage was more health literate, there was still work to do on improving access and navigation strategies.

Additional assessments included:

- Ongoing random audits of patient education materials pre- and post-revision to assess improvement in readability.

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- Ongoing random audits of electronic health record patient education screens to assess documentation of use of teach-back. Results showed consistent documentation of teach-back use, but actual use in practice remained unclear.
- Conducted a performance improvement project in 2018 to assess staff use of teach-back. Implemented in three parts, the project sought to determine the teach-back utilization rate.
 - The first part assessed staff knowledge and use of teach-back, to include quantifying providers' self-reported use of and confidence in using this method.
 - Secondly, the project assessed and addressed perceived barriers to the use of teach-back.
 - Finally, the project aimed to assess whether patients recalled their providers' use of teach-back.

The study revealed that 49% of patients surveyed acknowledged being asked to explain back in their own words what they had been taught. Factors that may have influenced these results included patient demographics and timing of the survey. Patients were chosen at random times during their stays and, therefore, may have been surveyed shortly after admission and before receiving patient teaching. Further study was needed to assess use of teach-back with patients before they are discharged, as well as after discharge.

Collaboration and Partnerships

St. Vincent remained committed to collaboration and partnerships and reached out to other institutions to broaden its work. Members of the Institute were invited to provide presentations, workshops, and guest lectures to other hospitals, community-based organizations, health care associations, and universities. It contributed to local, state, and national efforts to improve organizational responses to health literacy. The director of the Institute served as chair of the Cleveland area health literacy committee. The director also co-founded and is immediate past president of Ohio Health Literacy Partners, a state-wide non-profit health literacy collaborative, and chaired the National Council to Improve Patient Safety through Health Literacy. St. Vincent also hosted three state-wide health literacy conferences.

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Lessons Learned

The team learned the journey is long, and obstacles are to be expected along the way. Becoming a health literate organization will never be completely attained but should be continually strived for, knowing further improvement can always be made. Some of the most notable lessons include:

- Ensure consistent engagement with and buy-in from senior leadership. There were changes in senior leadership three times since 2007, and each time the team had to build the case for health literacy again. Maintaining documented action plans and evaluations, along with an overall strategic plan proved very beneficial.
- Identify champions to join the workgroup or health literacy team. The team was down to three to four members at times. It was helpful to recruit from different disciplines during awareness trainings.
- Obtaining buy-in from marketing and communications staff is also critical. The first director of marketing we worked with was a true champion of health literacy, a member of our team, and consistently followed health literacy strategies in hospital-wide messaging. Push-back on health literacy initiatives occurred with subsequent marketing teams because they were not brought on board at the outset.
- Persistence and patience pay off. It took seven years for a plain language procedure consent form to be approved and put into distribution.

Finally, to illustrate a model of its work, the health literacy team devised a graphic incorporating five steps to better health literacy. This was laminated and posted in every department and in all the organization's health care clinics as a daily reminder for health care providers to incorporate these principles in all their communications.

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St. Vincent Charity Medical Center Health Literacy Model



Health Literacy 101

Your role as a healthcare provider



SPEAK SLOWLY

Take time to understand the patient's concerns. Limit the amount of information provided at each encounter.

TEACH BACK

Use this method to make sure patients truly understand what you are teaching them. Ask, "How will you describe this to your family?" Do not ask, "Do you understand?"

ENCOURAGE QUESTIONS

Empower patients to ask questions about their health care.

PLAIN LANGUAGE

Use language that is easy to understand. All patients appreciate information that is clear and concise.

SHOW EXAMPLES

Draw or show a picture to patients to help convey a complex concept or a body part.

HEALTH LITERACY INSTITUTE
ST. VINCENT CHARITY MEDICAL

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Case Study: UnityPoint Health – Developing a Reader-Friendly Consent Process to Improve Health Literacy, Health Care Quality, and Safety

“Health care organizations that embody these [ten] attributes [of health literate health care organizations] create an environment that enables people to access and benefit optimally from the range of health care services.”

— Brach, et. al. 2012¹

This case study demonstrates how UnityPoint Health used a health literacy initiative—developing a reader-friendly consent process by addressing multiple attributes of a health literate organization—to improve quality, safety, and equity.

The ideas and information in this case study are designed to help you:

- Describe how one health literacy initiative can help an organization become more health literate.
- Visualize success and apply the Ten Attributes¹ to improve organizational health literacy in your setting.

A Health Literate Health Care Organization Values True Informed Decision-Making

This chapter addresses virtually all the Ten Attributes¹ and demonstrates how health literacy is critical to patient understanding and delivery of high quality health care.

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To support their overarching health literacy goals of improving interpersonal and written communication and patient-centered care, UnityPoint Health, a large Iowa-based integrated health system, decided to focus on enhancing its process for obtaining and documenting informed consent for surgery from patients. Each affiliate hospital's health literacy team was invited to identify and implement goals to optimize a patient-centered care environment and improve patients' understanding and the informed consent process through improving interpersonal and written communication.

The objectives of the consent project were to:

- Educate staff about health literacy concepts.
- Develop an understanding that consent is a process not a form.
- Develop a reader-friendly consent form.
- Improve patient understanding through use of plain language.
- Incorporate teach-back to evaluate patient understanding.
- Facilitate a general culture optimizing peri-operative consent communication.

The process, formal evaluation, and reader-friendly consent form have been described elsewhere.²⁻⁴

Developing a New Approach

The informed consent process for surgery and invasive procedures can fail to fully engage the patient in informed decision-making for various reasons, including time constraints for providers, consent forms that can be difficult to understand, and lack of attention to the consent process. This may be especially challenging for patients with low health literacy or general literacy, or limited English proficiency.⁵⁻⁷ As a result, patients may undergo surgery without fully understanding the procedure, its potential risks and benefits, and possible alternative treatments.

Planning and development of a health literate approach to informed consent should incorporate several attributes of a health literate health care organization. At UnityPoint Health, the health literate informed consent initiative included the following steps:

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- Obtain support of health system leaders. Health literacy representatives met with system leaders and representatives of the Law Department to present the idea of designing a reader-friendly consent form to be used across the system, with the decision to adopt this form and process voluntary for each affiliate hospital.
- Obtain plain language expert training. Affiliate health literacy teams attended a UnityPoint Health-sponsored training workshop on developing reader-friendly print materials. This was pivotal to teams' understanding and skill-building for development of reader-friendly materials, including the new consent form. The health literacy trainer provided a sample template of a reader-friendly form to use as a starting point.
- Revise the current consent form. Affiliate health literacy team representatives revised the initial consent form in collaboration with adult learners, affiliate risk managers, health care providers, and the UnityPoint Health Law Department.
- Obtain feedback and revise the form. Input from the New Readers of Iowa was critical. The team revised the consent form through an iterative process that involved multiple reviews to clarify terms and improve reader-friendliness. The final consent form was translated into Spanish.
- Incorporate teach-back. Since informed consent is not just a form, but a process of communication, the consent document was designed to facilitate and prompt use of plain language in the consent discussion and use of teach-back to assess and confirm understanding.
- Pilot test in one setting. The final draft of the consent form was piloted through a small test-of-change process with documented steps to facilitate implementation at other system hospitals.
- Expand system-wide and to other procedures. After pilot testing and additional revisions, the first hospital adopted the new consent form and process for all surgical procedures. Additional UnityPoint Health affiliates subsequently adopted the new consent form and process, following the implementation steps.

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The entire initiative involved a foundation of education and understanding focusing on health literacy principles, distinguishing the informed consent process and the consent form, and utilizing the new consent and teach-back process to ensure patient understanding. The reader-friendly surgery and procedure consent form was subsequently used to develop additional consent forms using similar reader-friendly principles, including consents for non-physician and radiology procedures, and blood transfusion.

While health literacy teams devoted significant effort to upfront development, staff education, and implementation, the program did not require additional financial resources other than a small grant for a formal research evaluation. Existing staff incorporated it into their daily routines. Having an active health literacy team to test and implement health literacy interventions and spread understanding of health literacy principles was instrumental to system-wide success.

The Health Literate Consent Process

Following an initial discussion with the surgeon, the patient is guided through an interactive process using a simple, reader-friendly, health literacy-based consent form designed to increase the likelihood that the patient reads and understands the consent form, understands the procedure, and feels comfortable asking questions prior to giving consent. The purpose of this enhanced process is to promote patient understanding through use of plain language principles and teach-back. Key elements include:

- **Surgeon-patient discussion:** The project encouraged the surgeon to use plain language verbal communication principles (e.g., speaking clearly and slowly; avoiding use of acronyms and unexplained complex medical language) to discuss with the patient the need for the surgery, the nature of the procedure, the risks and benefits associated with it, and alternative treatments. This discussion may occur in the surgeon's clinic or at the patient's bedside (if surgery is scheduled during hospitalization). The surgeon documents the discussion in the patient's medical record.
- **Reader-friendly, health literacy-based consent form:** The surgeon or nurse uses the reader-friendly, health literacy-based consent form to reinforce and confirm the patient's understanding of the surgical procedure. The new form replaced the standard consent form that had been at the college reading level. Features of the new form include:

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- Reader-friendly wording and format: Written at 7th to 8th grade reading level, the new consent form includes simple words, short sentences and paragraphs, and minimal use of medical terminology. It is designed to be reader-friendly with large (12 to 14 point) serif font, clear headings, bullets and numbering, ample white space, key use of bold text, and 1.5-line spacing.
- Space for patient description of procedure: The consent form includes the traditional section for description of the procedure in medical terms, as well as a section for writing the patient’s description of the procedure in their own words. This additional element incorporates use of teach-back, a research-based strategy for assessing patient understanding.
- Key elements of informed consent: The consent form outlines six elements of informed consent in bulleted form. By signing the form, the patient gives permission for the procedure and confirms the following: “I understand, and my doctor has told me:
 1. What I am having done and why I need it.
 2. The possible risks to me of having this done.
 3. What might happen to me if I don’t have it done.
 4. What other choices I can make instead of having this done.
 5. What can happen to me if I choose to do something else.
 6. What can happen to me if I choose no treatment.”²
- Plain language description of additional components of surgery: The consent form outlines, in plain language, additional components of a surgical procedure, including use of anesthesia, possible unexpected conditions encountered during surgery, removal of tissue or body parts, creation of pictures or video if needed for a medical reason, presence of observers (such as medical students), and potential need for blood products.
- Reminder to ask questions: To further encourage communication, the form includes a prompt to the patient to be sure all of their questions have been asked and answered before signing it.

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- Obtaining consent: After reviewing the form with the patient and making sure they have no more questions, the surgeon or nurse obtains the patient's signature on the consent form. If the nurse deems the patient's understanding to be inadequate or the patient has questions, the nurse will alert the surgeon of the need for additional discussion with the patient prior to obtaining the patient's signature on the consent form.

Findings and Feedback

The new form and consent process increased the proportion of patients observed to be reading the form and who were able to describe their surgery in their own words, and enhanced patients' comfort level with asking questions.^{3,4} Anecdotal reports also suggested that patients, families, and nurses were satisfied with the enhanced process and form.

- More patients were able to describe their surgery: Approximately 71% of patients undergoing total hip or knee replacement (elective procedures) or gall bladder surgery (a more time-sensitive emergent procedure) who used the new consent form and process strongly agreed with the following statement, "I was asked to tell the nurse what surgery I was having done, using my own words," significantly higher than the 59% of patients using the original form and consent process. This finding suggests that health literacy principles can be used to refine the consent process to promote patient understanding through use of plain language and teach-back.
- Greater comfort asking questions: Patients with whom the new form and consent process were used were also more likely to strongly agree with the statement, "I felt comfortable asking questions about my surgery," consistent with facilitating a culture of communication.
- Satisfaction with form and process change: Anecdotal feedback suggested that patients and families, as well as nurses, were satisfied with the process change and the new reader-friendly consent form. Nurses reported more patients reading the new consent form compared to the original form.

Lessons Learned

- Articulate health literacy as a system goal. Would-be adopters can obtain support for the program from administrators and providers by emphasizing alignment with the organization's mission and the industry's increasing focus on health literacy, patients'

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right to understand health care information, organizational health literacy, and health equity. This is facilitated by presenting informed consent in a way that is simple, clear, and in plain language.

- Emphasize that the form alone does not ensure informed consent. The consent form is a tool to document that the informed consent discussion took place and help drive use of plain language and teach-back in the consent process continuum.
- Get feedback from consumers. Input from patients or families (particularly those with low literacy) can be very valuable to improving the readability and user-friendliness of print materials, and thus to ensuring they contribute to patient understanding and the ability to make informed choices about health care options.
- Emphasize the value of teach-back. Listening to patients describe what they have heard in their own words allows providers to be sure patients or caregivers understand relevant health information, and to provide additional clarifying teaching and re-check for understanding, if necessary.
- Monitor and report on impact. Tracking and reporting key metrics related to the impact of the new process (such as the proportion of patients who have read the consent form and are able to describe their surgical procedure) can help gain and sustain the support of administrators and providers. Over time, as providers use the new form and process and patients react positively to them, the revised health literacy-based reader-friendly consent form and process can become part of standard operating procedures. Other potential benefits to the organization relate to increasing patient satisfaction, and improving safety, equity, and risk management.

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Relationship between Elements of a Health Literacy-based Consent Process and the Attributes of a Health Literate Health Care Organization

Attributes of Health Literate Health Care Organizations	Elements of Health Literacy-based Consent Process
1. Has leadership that makes health literacy integral to its mission, structure, and operations.	Health literacy representatives met with system leaders and representatives of the Law Department to present the idea of designing a reader-friendly consent form to be used across the system.
2. Integrates health literacy into planning, evaluation measures, patient safety, and quality improvement.	Obtained support from administrators and providers by emphasizing the industry’s increasing focus on health literacy and patients’ right to understand health care information, including presenting informed consent in a way that is simple, clear, and in plain language.
3. Prepares the workforce to be health literate and monitors progress.	Affiliate health literacy teams attended a UnityPoint Health-sponsored training workshop on developing reader-friendly print materials that was pivotal to teams’ understanding and skill-building for development of reader-friendly print materials, including the new consent form.

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<p>4. Includes populations served in the design, implementation, and evaluation of health information and services.</p>	<p>Input from the New Readers of Iowa, a group of individuals who learned to read later in life, was critical. Health literacy teams revised the consent form through multiple versions, each reviewed by the New Readers of Iowa and/or UnityPoint Health health literacy teams, to clarify terms and improve reader-friendliness.</p>
<p>5. Meets the needs of populations with a range of health literacy skills while avoiding stigmatization.</p>	
<p>6. Uses health literacy strategies in interpersonal communications and confirms understanding at all points of contact.</p>	<p>Consent form includes a traditional section for description of the procedure in medical terms and a section for writing the patient’s description of the procedure in his or her own words, incorporating teach-back. Purpose of this process was to promote patient understanding through use of plain language principles and teach-back.</p>
<p>7. Provides easy access to health information and services and navigation assistance.</p>	<p>To further encourage communication, the new form includes a prompt to the patient to be sure all of their questions have been asked and answered before signing the consent form.</p>
<p>8. Designs and distributes print, audiovisual, and social media content that is easy to understand and act on.</p>	<p>Written at 7th-8th grade reading level, including simple words, short sentences and paragraphs, and minimal use of medical terminology. Reader-friendly features include large (12 to 14 point) serif font, clear headings, liberal use of bullets and numbering, ample white space, key use of bold text, and 1.5-line spacing.</p>
<p>9. Addresses health literacy in high- risk situations, including care transitions and communications about medicines.</p>	<p>The enhanced process addresses risks associated with the informed consent process by engaging patients in this important decision, so they fully understand the procedure, its potential risks and benefits, and possible alternative treatments.</p>

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