

AHRQ Health Literacy Universal Precautions Toolkit

**Third
Edition**



AHRQ
Agency for Healthcare
Research and Quality

AHRQ Health Literacy Universal Precautions Toolkit, 3rd Edition

Editor of the 3rd Edition:

Cindy Brach, MPP

Authors of the 2nd Edition:

Angela G. Brega, PhD^{2,3}

Juliana Barnard, MA⁴

Natabhona M. Mabachi, PhD, MPH⁵

Barry D. Weiss, MD⁶

Darren A. DeWalt, MD, MPH⁷

Cindy Brach, MPP¹

Maribel Cifuentes, RN²

Karen Albright, PhD³

David R. West, PhD^{2,3}

Authors of the 1st Edition:

Darren A. DeWalt, MD, MPH⁷

Leigh F. Callahan, PhD⁷

Victoria H. Hawk, MPH, RD, CDE⁷

Kimberly A. Broucksou, MSW, MPA⁷

Ashley Hink, MPH⁷

Cindy Brach, MPP¹

Rima Rudd, ScD⁸

Author Affiliations:

1 Agency for Healthcare Research and Quality, Rockville, MD

2 Colorado School of Public Health, University of Colorado Anschutz Medical Campus, Aurora, Colorado

3 Department of Family Medicine, University of Colorado Anschutz Medical Campus, Aurora, Colorado

4 Colorado Health Outcomes Program, University of Colorado Anschutz Medical Campus, Aurora, Colorado

5 American Academy of Family Physicians, Kansas City, Kansas

6 Department of Family and Community Medicine, University of Arizona, Tucson, Arizona

7 The Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill, Chapel Hill, NC

8 Harvard School of Public Health, Harvard University, Cambridge, MA

Public Availability Notice. This product is made publicly available by AHRQ and may be used and reprinted without permission in the United States for noncommercial purposes, unless materials are clearly noted as copyrighted in the document. No one may reproduce copyrighted materials without the permission of the copyright holders. Users outside the United States must get permission from AHRQ to reprint or translate this product. Anyone wanting to reproduce this product for sale must contact AHRQ for permission.

Suggested Citation. Brach C, ed. AHRQ Health Literacy Universal Precautions Toolkit, 3rd Edition. Rockville, MD. Agency for Healthcare Research and Quality. AHRQ Publication No. 23-0075. March 2024.

AHRQ acknowledges the primary care practices and clinics that participated in testing of the first and second editions of the Toolkit. AHRQ also acknowledges the thoughtful feedback on revised and new tools for the 3rd edition by:

- | | |
|------------------------------------|---|
| ■ Mary Ann Abrams, MD, MPH | ■ Bhumi Khambholja, PharmD, MS |
| ■ Tom Bauer, MBA RT R | ■ Lyndee Knox, PhD |
| ■ Cynthia Baur, PhD | ■ Angela Kumar, MPH |
| ■ Melissa Bhatnagar, PharmD | ■ Lana Moriarty, MPH |
| ■ Cliff Coleman, MD, MPH | ■ Sunita Mutha, MD, FACP |
| ■ Carolyn Cutilli, PhD, RN, NPD-BC | ■ Greg O'Neill, MSN, APRN, AGCNS-BC, NPD-BC, NEA-BC |
| ■ Terry Davis, PhD | ■ Ruth Parker, MD, MACP |
| ■ Darren A. DeWalt, MD, MPH | ■ Michael Paasche-Orlow, MD, MA, MPH |
| ■ Stacie B. Dusetzina, PhD | ■ Farzana Samad, PharmD, FISMP, CPPS |
| ■ Neal Dickert, MD, PhD | ■ Matthew Simpson, MD, MPH |
| ■ Michele Erikson | ■ Jane Sims |
| ■ Kim Erwin, MDes | ■ Christopher Trudeau, JD |
| ■ Caroline Fichtenberg, PhD | ■ Meghan Wagner, PharmD, MBA |
| ■ Veronica Fitzpatrick, DrPH, MPH | ■ Barry D. Weiss, MD |
| ■ Alaina Fourier, PhD, MHCI | ■ Lois Wessel, DNP, FNP-BC |
| ■ Emily Ganos, PhD | ■ Mara Youdelman, JD |
| ■ Ashleigh Henrichs, MA | |

Table of Contents

Introduction	vii
--------------------	-----

Tools to Start on the Path to Improvement

Form a Team: Tool #1.....	1
Assess Organizational Health Literacy and Create an Improvement Plan: Tool #2	4
Raise Awareness: Tool #3.....	8

Tools to Improve Spoken Communication

Communicate Clearly: Tool #4.....	11
Use the Teach-Back Method: Tool #5.....	15
Follow Up with Patients: Tool #6.....	19
Be Easy to Reach: Tool #7.....	22
Conduct Brown Bag Medicine Reviews: Tool #8	26
Address Language Differences: Tool #9.....	31
Consider Culture: Tool #10.....	37

Tools to Improve Written Communication

Assess, Select, and Create Easy-to-Understand Materials: Tool #11	41
Use Health Education Material Effectively: Tool #12	46
Welcome Patients: Tool #13.....	50

Tools to Improve Self-Management and Empowerment

Encourage Questions: Tool #14.....	54
Make Action Plans: Tool #15	57
Help Patients Take Medicine Correctly: Tool #16.....	61
Get Patient Feedback: Tool #17	65

Tools to Improve Supportive Systems

Attend to Social Needs: Tool #18	72
Help Patients Pay Less for Medicine: Tool #19	78
Connect Patients with Literacy and Math Resources: Tool #20.....	81
Make Referrals Easy: Tool #21	84
Include Family and Friends: Tool #22	88
Talk About Costs: Tool #23	92

Appendices

Many of the [appendices](#) are available as Word documents on the AHRQ website.

Tools To Start on the Path to Improvement

Form a Team: Tool #1

- [No appendix](#)

Assess Organizational Health Literacy and Create an Improvement Plan: Tool #2

- [Primary Care Health Literacy Assessment](#)
- [PDSA Form](#)
- [Plan-Do-Study-Act \(PDSA\) Directions and Examples](#)

Raise Awareness: Tool #3

- [Health Literacy: Making it Easier for Patients To Find, Understand, and Use Health Information and Services.](#)
- [Health Literacy Video Questions for Discussion and Moderator's Guide](#)
- [Health Literacy Assessment Quiz](#)
- [Role Playing Ideas](#)

Tools To Improve Spoken Communication

Communicate Clearly: Tool #4

- [Key Strategies for Clear Communication Posters](#)
- [Communication Self-Assessment](#)
- [Communication Observation Form](#)
- [Plain Language Words](#)

Use the Teach-Back Method: Tool #5

- [Use Teach-Back Poster](#)
- [Teach-back Questions for Informed Consent](#)

Follow Up with Patients: Tool #6

- [Lab Results Letter](#)

Be Easy to Reach: Tool #7

- [Sample Automated Telephone System Menu](#)
- [Telephone Assessment Guide](#)

Conduct Brown Bag Medicine Reviews: Tool #8

- [Medicine Review Handout](#)
- [Medicine Review Form](#)

Address Language Differences: Tool #9

- [Language Access Resources](#)

Consider Culture: Tool #10

- No appendix

Tools to Improve Written Communication

Assess, Select, and Create Easy-to-Understand Materials: Tool #11

- [Permission to Bill Insurance](#)
- [Release of Medical Information](#)
- [Lab Results Letter](#)
- [Appointment Reminder](#)
- [Inclusive Language for Intake Forms](#)

Use Health Education Material Effectively: Tool #12

- No appendix

Welcome Patients: Tool #13

- [Simple Map](#)

Tools To Improve Self-Management and Empowerment

Encourage Questions: Tool #14

- No appendix

Make Action Plans: Tool #15

- [Action Plan Form](#)
- [My Action Plan](#)

Help Patients Take Medicine Correctly: Tool #16

- [Help with Medicines Poster](#)

Get Patient Feedback: Tool #17

- [Patient Portal Feedback Form](#)
- [Suggestion Box Poster](#)
- [Health Literacy Patient Feedback Questions](#)

- [Sample Cover Letter](#)

Tools To Improve Supportive Systems

Attend to Social Needs: Tool #18

- [Community Referral Form](#)
- [Additional Resources for Attending to Social Needs](#)

Help Patients Pay Less for Medicine: Tool #19

- [Resources for Financial Assistance for Medicine](#)

Connect Patients with Literacy and Math Resources: Tool #20

- [Community Referral Form](#)

Make Referrals Easy: Tool #21

- No appendix

Include Family and Friends: Tool #22

- No appendix

Talk About Costs: Tool #23

- [Staff Survey About Cost Conversations](#)

Introduction

This Toolkit offers evidence-based guidance to help healthcare providers make health information easier to understand and act on, make healthcare easier to navigate, and increase support for patients of all health literacy levels.

Most Americans face challenges in finding, understanding, and using health information and services. A [national survey](#) showed that 88% of U.S. adults do not have the health literacy skills needed to manage all the demands of the current healthcare system, and 36% have limited personal health literacy. It is our responsibility to change the system so patients do not face these hurdles.

Healthy People 2030, the Nation’s 10-year plan to improve the health of all Americans, recognized that [health literacy is foundational](#) to achieving all its other health goals. It expanded [the definition of health literacy](#) to include organizational health literacy, an explicit acknowledgement of the essential role played by organizations that provide health information and services.

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.

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.

What Are Health Literacy Universal Precautions?

This Toolkit promotes using health literacy universal precautions—the structuring of health information and services in ways that everyone can understand and use. Health literacy universal precautions call for—

- Simplifying communication and confirming understanding with everyone.
- Making the office environment and healthcare system easier to navigate.
- Supporting people’s efforts to improve their health.

Why Use Health Literacy Universal Precautions?

Like with blood safety, universal precautions should be taken to address health literacy because we do not know who is challenged by health information and tasks at any given moment. 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.

Everyone appreciates information that is clear and easy to act on and healthcare systems that are easy to navigate. Being a health literate organization helps people feel more involved in their care and increases the chances of their doing what is needed to take care of their health.

Implementing health literacy universal precautions can serve both your patients' needs and your practice's other goals. For example, being health literate is important to achieve patient safety goals, such as reducing misdiagnosis. Many of the action steps recommended in this Toolkit are consistent with and may help your practice qualify for Patient-Centered Medical Home (PCMH) or Health Equity Certification. Finally, improving interactions with and supporting patients can increase care team job satisfaction and reduce burnout.

What is in this Toolkit?

This Toolkit contains 23 tools designed for busy practices. Each tool describes concrete actions in one of these 5 areas:

- Start on the Path to Improvement
- Improve Spoken Communication
- Improve Written Communication
- Improve Self-Management and Empowerment
- Improve Supportive Systems

The Toolkit also includes 40 resources, such as sample forms, PowerPoint presentations, and assessment tools.

Who Should Use this Toolkit?

This Toolkit is designed to be used in any primary care setting, although earlier editions have been used in a wide variety of healthcare settings. The Toolkit can help practices with little or no experience addressing health literacy, as well as those that are already engaged in health literacy-related quality improvement.

Toolkit Testing

Earlier editions of this Toolkit were tested in primary care practices and community clinics. Participating facilities showed that they could make changes to improve the way they communicate with and support their patients. Just like these practices, your practice can benefit from this resource.

Where Should You Start?

We recommend that you start on the Path to Improvement with Tools 1 through 3.

- [Tool #1: Form a Team](#) provides guidance on developing a team to lead your health literacy efforts.
- [Tool #2: Assess Organizational Health Literacy and Create a Health Literacy Improvement Plan](#) will guide you in assessing your practice and identifying focus areas for your improvement efforts.
- [Tool #3: Raise Awareness](#) provides guidance and resources for educating your staff about health literacy.

These Tools will establish a foundation to successfully implement health literacy improvements in your practice. You can implement the remaining tools in any order.

Want to jump right in with another tool? Use the [Quick Start Guide](#) for suggestions on getting started.

Quick Start Guide

1	Watch a short video. This health literacy video (6 minutes) shows the challenges people with limited health literacy face, and 5 Things to Know About Health Literacy (2 minutes) describes how organizations can use health literacy strategies.	
2	Pick a tool and try it. Click on one of these tools and review it. Pick a day and try it out on a few patients.	
	I want to be confident that I know what medicines patients are taking and how they are taking them.	Conduct Brown Bag Medicine Reviews (Tool #8)
	I want to be confident that I am speaking to patients in a way that is easy for them to understand.	Communicate Clearly (Tool #4)
3	Assess your results. <ul style="list-style-type: none"> • How did it go? • Do you need to make some adjustments? • Do you want to address another statement from the list above and try another tool? Or, you may want to be more systematic and implement “Tools to Start on the Path to Improvement,” Tool #1 , Tool #2 , and Tool #3 .	

Form a Team: Tool #1

Overview

Implementing and sustaining health literacy universal precautions at an organizational level requires strong, effective leadership. You will need a dedicated team to plan and implement health literacy-related changes. This team should be led by someone who is vested with the authority to coordinate the team's efforts and implement practice changes. Because health literacy is important for patients' interactions with all members of the practice, the most effective teams include representatives of clinical, nonclinical, and administrative staff. Patients and caregivers can add critical insight, as well.

Actions

Identify team members.

- **Choose an energized and empowered Team Leader.** The Team Leader must have both enthusiasm for health literacy-related quality improvement and the clout to spearhead change. If the Health Literacy Team Leader is not part of senior leadership, senior leadership must make it clear that the Team Leader has the authority to act.
- **Include one motivated and respected representative from each area of your practice.** In small practices, it often works best to include most or all your clinical and administrative staff members. In large practices, it is important to include at least one representative from each area of your practice. Team members may include:
 - Physicians, physician assistants, and nurse practitioners.
 - Nurses.
 - Medical assistants.
 - Practice managers.
 - Front-office staff.
 - Billing and other back-office staff.
- **Keep the size of your team manageable.** Aim for 8 or fewer members. Limit yourself to no more than 12.
- **Incorporate patients, family, and/or caregivers into the team.** Having people you serve on the team can provide invaluable first-hand insight on what they experience and how systems and communication can be improved.

- Ask staff to identify and suggest patients, family, or caregivers who are typical of the people you serve.
- To show respect for their time, consider providing a meal, reimbursement for expenses, and/or a gift of appreciation. Most large organizations pay (e.g., stipend, honorarium) these team members.

TIP

If you have done quality improvement work before, you do not have to start a Health Literacy Team from scratch. Build on former or existing teams.


Bring team members together.

- Have an initial meeting, in-person if possible.
- Introduce health literacy by showing the [American College of Physician's health literacy video](#) (6 minutes) and [5 Things to Know About Health Literacy](#) (2 minutes).
- Go to [Tool #3: Raise Awareness](#) for additional methods of educating your team and others about health literacy.
- Introduce the Toolkit and its key components.
- Review the goals of implementing the Toolkit.
- Ask at least one or two team members to review the full Toolkit carefully to become familiar with its contents.

Have subsequent meetings and establish routine reporting.

- Schedule regular team meetings. Frequent meetings may be needed at the outset (e.g., weekly). Meetings can take place less frequently once your implementation activities are underway.
- Clarify each team member's role and responsibilities early on and throughout the process.
- Use [Tool #2: Assess Organizational Health Literacy and Create an Improvement Plan](#) to help you develop and implement your Health Literacy Improvement Plan.
- Report progress monthly, or at a minimum quarterly, to senior leadership to maintain accountability and team engagement.

Additional Resources

The Institute for Healthcare Improvement provides valuable information about the quality improvement process, including guidance on [Forming the Team](#) . The [AHRQ Practice Facilitation Curriculum](#) provides guidance on [Creating Quality Improvement Teams and QI Plans](#).

Assess Organizational Health Literacy and Create an Improvement Plan: Tool #2

Overview


The first step in creating a Health Literacy Improvement Plan is deciding which health literacy-related improvements to work on first. The [Primary Care Health Literacy Assessment](#) can help you examine your practice's strengths and weaknesses in five key areas:

1. Practice Change
2. Spoken Communication
3. Written Communication
4. Self-Management and Empowerment
5. Supportive Systems

After identifying priorities for improvement, your [Health Literacy Team](#) can develop a plan to implement selected tools.

Actions

Prepare the practice.

- **Engage practice leadership and prepare your staff for organizational change.** [Building Health Literate Organizations: A Guidebook to Achieving Organizational Change](#)  can provide some ideas for how to do this.
- **Educate staff** about health literacy. You can use resources provided in [Tool #3: Raise Awareness](#).

Review the Primary Care Health Literacy Assessment in a Health Literacy Team meeting.

- **Collect assessment data.** Ask each member of the Health Literacy Team to complete the [Primary Care Health Literacy Assessment](#). (It takes less than 30 minutes.) Make sure everyone has the same understanding of each question. Note that a few questions will require staff to walk through the practice and see it from a patient's point of view. You can also broaden the exercise by asking everyone in your practice to complete the assessment. Be sure to give them a deadline.
- **Discuss responses.** Have team members bring their completed assessments to a team meeting. If you had everyone complete the assessment, tally results before the meeting.
- **Congratulate yourselves on high performance areas,** where there is consensus that the practice is doing well.
- **Discuss opportunities for improvement.** You may want to begin by identifying questions commonly answered, "Needs Improvement" or "Not Doing," or those for which there is wide variation in responses.

Primary Care Health Literacy Assessment

Directions: Read each item carefully. Mark your response in the column that best describes your practice.

	Does not do it at all	Does it a little	Does it somewhat	Does it a lot	Does it perfectly
1. We have a written plan for how we will improve our health literacy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. We have a written plan for how we will improve our health literacy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. We have a written plan for how we will improve our health literacy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. We have a written plan for how we will improve our health literacy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. We have a written plan for how we will improve our health literacy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. We have a written plan for how we will improve our health literacy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. We have a written plan for how we will improve our health literacy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. We have a written plan for how we will improve our health literacy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. We have a written plan for how we will improve our health literacy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. We have a written plan for how we will improve our health literacy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Practice Experiences

Many practices have found the health literacy assessment to be beneficial. Here are some typical comments:

"The assessment increased our attention to areas not previously identified as concerns, like the signs in our practice. We just don't think of those things every day."

"Before doing the assessment, we had an idea about what tool we wanted to try. But after discussing our assessment questions, we completely changed our selection."


"We liked the assessment process, and when we looked at our answers, our priorities just lit up."

Develop a Health Literacy Improvement Plan.

- **Set your health literacy improvement goals.** In addition to the results of your assessment, think about your practice’s specific aims, practice improvement efforts already underway, and whether you want an “easy win” to jump-start the quality improvement process.
- **Use the Primary Care Health Literacy Assessment to identify which tools to use** for each area targeted for improvement. The [Health Literacy Team](#) should read the chosen tools carefully.
- **Develop a clear, written improvement plan.**
 - For each tool you implement, designate champions who can model changes for their peers.
 - Set SMART (Specific, Measurable, Attainable, Relevant, and Time-bound) objectives.
 - Establish measures to assess whether your objectives are being met. Consider using measures you already track (e.g., patient experiences of care, staff satisfaction), other [measures specific to health literacy](#), and the [Health Literacy Patient Feedback Questions](#). Specify when and how you will collect data for these measures, remembering that you may want to collect information before and after you begin tool implementation. Note that each tool in this Toolkit provides suggestions for tracking your progress.
 - Identify who will be responsible for implementing changes.
 - Include a plan for spreading successful changes throughout the practice. Improvements will not be adopted throughout your practice without a concerted effort to get everyone on board.

Prepare for implementation.

- **Brief the entire practice** on the results of the practice assessment and the Health Literacy Improvement Plan. This is an opportunity to get additional input and buy-in from others in the practice.
- **Get implementation tips** from [Implementing the AHRQ Health Literacy Universal Precautions Toolkit: Practical Ideas for Primary Care Practices](#).
- **Use the Plan-Do-Study-Act (PDSA) method to test and refine the changes you make.** Work out the kinks on a small scale before implementing changes practice-wide. In this Toolkit’s appendix is an [explanation and directions for conducting PDSA cycles, along with a PDSA worksheet](#) that can help you plan

your changes. Try changes that can reasonably be expected to achieve your goals. Keep trying new changes until you achieve the results you want. For more information about quality and process improvement strategies, go to [The Model For Improvement: Your Engine For Change](#).

Sustain your efforts.

- **Inform the whole practice** about health literacy improvement goals, activities, challenges, and accomplishments. This is critical to maintaining awareness of health literacy-related issues and enthusiasm for your quality improvement efforts. Consider posting updates in the lunchroom and making announcements at staff meetings.
- **Regularly brief practice leadership.** They may be able to help with challenges you are facing.
- **Celebrate successes, even small ones.** Start with celebrating what your practice did well before you started improving and continue with each achievement.

Track Your Progress

For each of the tools you implement, use the tool's suggestions for tracking progress. Even after goals are met, track some metrics for an extended period to monitor continued performance.

Use the [Primary Care Health Literacy Assessment](#) to re-assess your practice at regular intervals (e.g., twice a year). Doing so will help you confirm areas of improvement, find areas that need more work or a different approach, and identify new goals and objectives to update your Health Literacy Improvement Plan.

Raise Awareness: Tool #3


Overview

Implementing health literacy universal precautions in your practice requires that all staff members—from front office staff to the medical director—know about health literacy and consistently work to make healthcare clearer and easier.

Action

Educate all staff.

You can hold Lunch and Learn sessions and use staff meetings to educate staff about health literacy. Below are options for raising health literacy awareness.

- **Show and discuss a video.** Choose videos that help your practice understand that: 1) many patients struggle to understand health-related information and how to move through the healthcare system, and 2) practices can make it easier for patients to find, understand, and use health information and services. You can use the below videos.
 - [ACP Foundation's Health Literacy Video](#)  (6 minutes).
 - [5 Things to Know About Health Literacy](#) (2 minutes).
 - Refer to the [Questions for Discussion and Moderator's Guide](#) for guidance on running the session.
- **Conduct a presentation.**
 - [Health Literacy: Making it Easier for Patients To Find, Understand, and Use Health Information and Services](#). This PowerPoint presentation includes 33 slides with speaker's notes. You can get through the content in 30-45 minutes. Add time for discussion. The presentation can be divided into sessions. You can also distribute the presentation for self-study.
- **Share practice-specific examples** of health literacy improvement opportunities (e.g., a story about a patient's experience). Be careful to protect the identity of the patient and healthcare worker.
- **Consider using the [Health Literacy Assessment Quiz](#)** to gauge the knowledge of your staff. Ask staff to complete the quiz before and after your staff training. Feel free to adjust the items that reflect the key points you plan to cover.

Practice Experiences

“[During the session there were] a lot of good questions [and] a lot of good suggestions The staff came away feeling like this was [an] ongoing project in our office. So they seemed kind of energized by it ... we were very happy with the turnout and the general enthusiasm from everybody.”

– Residency practice

Teach specific tools.

- Focus an educational session on a tool your practice has decided to implement.
- Be practical; avoid conceptual and non-relevant information.
- Be interactive; draw on learners' experience and knowledge.
- Use visual aids that reinforce your message.
- Use experiential learning approaches, such as role playing. You can find [role playing ideas](#) in the appendix and in AHRQ's [Teach-Back Role Play Scenarios](#).
- Spell out the advantages of the change—why change is important and how it benefits clinicians, staff, patients, and the practice.
- Provide easy-to-understand handouts as reminders.

Encourage staff to take health literacy training.

- The Centers for Disease Control and Prevention (CDC) offers free continuing education credit for [online health literacy training](#) such as, “Effective Communication for Healthcare Teams: Addressing Health Literacy, Limited English Proficiency and Cultural Differences.”
- Share information about events, workshops, webinars, or conferences that teach health literacy skills, especially those that offer continuing education credit.

Maintain health literacy awareness.

- Plan to revisit the topic of health literacy periodically and train new staff. If you have students, residents, or fellows, be sure to emphasize during their training that they are learning communication skills that will be valuable regardless of their chosen specialty.

- Use existing opportunities (e.g., staff meetings, huddles) to provide booster training. Integrate health literacy strategies into other training (e.g., patient safety). Make it fun and memorable. Consider creating a very brief (and perhaps silly) video.
- Consider sending out "Health Literacy Weekly Reminders" to staff and clinicians with communication tips and plain language reminders to maintain interest in health literacy. Make it engaging, such as asking a True or False question, with the answer below.
- Post the [Strategies for Key Communication posters \(Tool #4: Communicate Clearly\)](#) to help staff remember the key tips for communicating effectively with patients.

Practice Experiences

"Our newsletter regularly included articles about our health literacy initiative and progress updates. We put stickers on staff members' computers to remind them to use health literacy strategies, and we instituted "Teach Back Tuesdays" to supplement the initial and formal training sessions. After nearly a year, 78 percent of clinical staff reported that it had changed the way they communicated with patients."

– Community health center

Track Your Progress

- Document the proportion of staff completing health literacy training, onsite, offsite, and virtual.
- Calculate the percentage of new hires, students, and residents that complete health literacy training in their first month.
- Ensure that health literacy education is offered to staff on an ongoing basis, including regular updates, as well as training for new employees and residents rotating into the practice.
- Compare [Health Literacy Assessment Quiz](#) answers before and after staff training to assess understanding and help you know where to focus your teaching.

Communicate Clearly: Tool #4

Overview

Communicating clearly helps your patients understand and act on health information. Using strategies to be clear in spoken communication also helps patients feel more involved in their healthcare and increases the likelihood of their following through on treatment plans. For guidance on improving written communication, go to [Assess, Select, and Create Easy-to-Understand Materials: Tool #11](#).

Research Findings

Up to 80% of the medical information patients are told during office visits is forgotten immediately. Nearly half of the information patients retain is incorrect.

– [Kessels 2003](#) 

Actions

Use strategies for communicating clearly.


- **Get a qualified interpreter** if a patient (or others participating in the visit) wants to use a language other than English. Do not try to “get by” with basic or intermediate foreign language skills or use unqualified interpreters such as family members or untrained staff. Go to [Tool #9: Address Language Differences](#) to learn more.
- **Engage with your patients.**
 - **Be respectful and caring.** Welcome everyone warmly. Use body language and a caring tone to communicate that you want to hear about their concerns. Sit at the same level as your patient and make appropriate eye contact instead of concentrating on your computer. Go to [Tool #10: Consider Culture](#) to learn about being respectful of patients from different cultures.
 - **Ask open-ended questions.** Encourage patients and companions to engage in the conversation with open-ended

questions. For example, say, “I’d like to hear—tell me, how are you doing?” Use nonverbal cues such as leaning in and nodding your head. Encourage them to voice their concerns.

- **Listen actively and with curiosity.** Give patients a chance to tell their story. Try not to interrupt. Pay attention, ask clarifying questions, and be responsive to the issues they raise and questions they ask. Use the [Toolkit for Engaging Patients to Improve Diagnostic Safety](#) to help clinicians to listen and patients to tell their story.
- **Encourage questions.** Refer to [Tool #14: Encourage Questions](#) for guidance on how to let your patients and their companions know you want to hear their questions.
- **Limit content and reinforce key points to avoid information overload.** Prioritize with the patient what needs to be discussed. Limit information to one to three “need-to-know” or “need-to-do” points, and emphasize them more than once.

TIP

Using jargon and terms your patients do not understand is an act of exclusion that can increase healthcare and health disparities.

- **Use plain, nonmedical language.** Do not use medical or difficult words.
 - Use the patient's words. Take note of what words the patient uses to describe their illness and use them in your conversation.
 - Use common words that you would use to explain health information to your friends or family who do not work in healthcare, such as tummy or belly instead of abdomen. Avoid acronyms. Find alternatives to medical terminology in the [Plain Language Medical Dictionary](#) .
 - Use simple words instead of difficult ones (e.g., “helpful” instead of “beneficial,” and “make worse” instead of “exacerbate”). Refer to the appendix [Plain Language Words](#) in for simple alternatives.
 - If you think it is important that a patient learn a medical term, ask whether the patient is familiar with it and if not, define it in a way that is easy to understand. For example, you can ask, “What do you know about a test called hemoglobin A1c?” and

if necessary, explain, “It is a way to measure how much sugar is in your blood over the past 3 months. It tells us whether your diabetes is under control.”

- **Slow down.** Speak at an unhurried pace and say the words clearly.
- **Be specific and concrete.** Do not use vague and subjective terms that can be interpreted in different ways. For example, say, “Two out of 10 people gain weight with this medicine,” instead of “Few people get side effects.”
- **Use pictures.** Draw pictures, use illustrations, or demonstrate with 3-D models. All pictures and models should be simple, designed to demonstrate only the important concepts, without overly detailed anatomy.
- **Show how it's done.** Whether doing exercises or taking medicine, a demonstration of how to do something is clearer than a verbal explanation.
- **Use teach-back.** Confirm patients understand what they need to know and do by asking them to teach back important information. Refer to [Tool #5: Use the Teach-Back Method](#) for guidance on how to use the teach-back method.
- **Practice.** Use staff meetings to conduct [role plays](#) so everyone can practice their clear communication skills.

TIP

Clinicians are often worried that they do not have time to use clear communication strategies. Invite skeptics to watch this [video](#) of Dr. Clifford Coleman using many of these strategies in a 15-minute visit.

Help staff remember these strategies.

- Review these strategies during staff meetings and huddles.
- Hang one of these [Key Strategies for Clear Communication posters](#) in non-patient areas (e.g., kitchen or conference room). Rotate posters regularly to keep reminders fresh.
- Ask clinicians and staff to use the [Communication Self-Assessment](#) with a few patients on a regular basis (e.g., every 4 to 6 months).

Track Your Progress

Before implementing this tool, ask all clinicians to complete the [Communication Self-Assessment](#) after a few patient encounters. Calculate the percentage who completed the self-assessment. One month after beginning implementation,

complete another round of self-assessments and look for increases in the number of completions and changes in responses.

Before implementing this tool and 2, 6, and 12 months later, ask a respected individual to conduct observations of clinical interactions with patients. Use the [Communication Observation Form](#) to assess communication quality. Provide feedback. Repeat this process routinely. Calculate the percentage of clinicians who have been observed once, and the percentage who have been observed more than once.

Before implementing this tool and 2, 6, and 12 months later, collect patient feedback on a selection of questions about this tool from the [Health Literacy Patient Feedback Questions](#).

Select [Tool #2: Assess Organizational Health Literacy and Create an Improvement Plan](#) to learn how to use data in the improvement process.

Use the Teach-Back Method: Tool #5

Overview

It is important to confirm that you have explained things in a manner your patients understand. The teach-back method is a way of checking understanding by asking patients to state in their own words what they need to know or do about their health. The related show-me method allows you to confirm that patients are able to follow specific instructions, such as how to use an inhaler. The teach-back and show-me methods are valuable tools for everyone in the practice to use with all patients. These methods can help you:

- Improve patient understanding and adherence.
- Decrease call backs and cancelled appointments.
- Improve patient satisfaction and outcomes.

Practice Experiences


“One of our residents decided to do her QI [quality improvement] project on using teach-back. Since people were worried that teach-back would take more time, she collected data that showed her average visit length decreased as she practiced teach-back, and was shorter than other residents who were not using teach-back. She also gathered data showing that patients who got teach-back were more satisfied than patients who did not. Then she spread teach-back to her colleagues.”

– Pediatric residency practice

Action

Learn the teach-back method.

- AHRQ’s Guide to Improving Patient Safety in Primary Care Settings by Engaging Patients and Families has [resources for learning and teaching the teach-back method](#), including Implementation Guidance and a Teach-Back Training Toolkit with a PowerPoint slide deck, role play scenarios, and a 10-minute interactive training module.

- The [Always Use Teach-Back! Toolkit](#)  describes principles of plain language, teach-back, coaching, and system changes necessary to promote consistent use of teach-back. Its Interactive Teach-Back Learning Module and supporting materials include key content and videos of clinicians and others using teach-back. The module can be used by clinicians and other staff members, in a group setting or as a self-directed tutorial, and by nonclinical health organizations like public health agencies.

Try the teach-back method.

- **Plan how you will ask non-shaming questions.** Remember, you are checking how well you explained something, not testing the patient. For example, you could say,
 - "We've gone over a lot of information, and I want to make sure I explained things clearly. So tell me, what do you think are the three most important things to know about diabetes?"
 - "When you get home, what will you tell your partner about this visit?"
 - "I want to make sure I've done my job well and explained things clearly. If you will tell me back the plan we've made, I'll type it up and send it home with you."

TIP

Clinicians are often worried that they do not have time to use clear communication strategies. Invite skeptics to watch this [video](#) of Dr. Clifford Coleman using many of these strategies in a 15-minute visit. Do not ask questions that can be answered with a "yes" or "no." "Do you understand?" and "Does that make sense?" are NOT teach-back questions. Patients are likely to answer "yes" whether they understand or not.

- **Use the show-me method.** When prescribing new medicines or changing a dose, research shows that even when patients correctly say when and how much medicine they will take, many will make mistakes when asked to demonstrate the dose. You could say, for example: "I've noticed that many people have trouble remembering how to take their blood thinner. Using these pills, can you show me how you are going to take them?"

- **Remember teach-back is not a test of patients' memory.** You can allow patients to refer to handouts when asking for a teach-back, but make sure they use their own words and are not reading the material back verbatim. Refer to [Tool #12: Use Health Education Material Effectively](#) for more information on reviewing written materials to reinforcing patients' understanding.
- **Clarify and check again.** If teach-back uncovers a misunderstanding, explain things using a different approach, and ask patients to teach-back again. Repeat the cycle of reteaching and asking for a teach-back until they are able to describe the information in their own words correctly. If they parrot your words back to you, they may not have understood.
- **"Chunk and Check."** Do not wait until the end of the visit to initiate teach-back. Chunk out information into small segments and have your patient teach it back. Then move on to the next segment and repeat as needed throughout the visit.
- **Start slowly and use consistently.** At first, you may want to try teach-back with the last patient of the day. Once you are comfortable with the technique, use teach-back with everyone, every time.
- **Practice.** It will take a little time, but once it is part of your routine, teach-back can be done without awkwardness and does not lengthen a visit.

Practice Experiences

"I decided to do teach-back on five patients. With one mother and her child, I concluded the visit by saying 'So tell me what you are going to do when you get home.' ...She could not tell me what instructions I had just given her. I explained the instructions again and then she was able to teach them back to me... I had no idea she did not understand.... I was so wrapped up in delivering the message that I did not realize it wasn't being received."

– Pediatric office


Promote the use of teach-back.


- **Train clinical and nonclinical staff.** All staff who interact with patients should use teach-back. For example, staff making appointments may use it to ensure that patients understand what is required of them at the next visit, such as

arrival time, insurance documentation, bringing medicines, fasting, and details about referrals to other clinicians.

- **Share teach-back stories.** Ask one person at each staff meeting to share a teach-back "Aha!" moment. This serves as a reminder of the importance of using teach-back consistently.
- **Post the [Teach-Back Poster](#)** from the appendix where clinicians and staff can see it.
- **Make teach-back a required part of obtaining informed consent.** The National Quality Forum, the Joint Commission, and the Leapfrog Group all recommend using teach-back during informed consent discussions as a safety practice. You can use the [teach-back questions](#) that were developed as part of [AHRQ's Making Informed Consent and Informed Choice: Training Module for Health Care Professionals](#).
- **Recruit teach-back champions.** Get people who use teach-back consistently to coach those who are not asking patients to teach back.

Track Your Progress

Ask staff to fill out anonymously the [Conviction and Confidence Scale](#) before you start using teach-back and then 1 and 3 months later. Track changes in the responses to see if people increasingly believe that teach-back is important and have confidence in using the method.

The [Teach-Back Observation Tool](#) should be used by a designated observer as clinicians build their skills and confidence with teach-back. There is also a teach-back question on the [Communication Observation Form](#). Use the findings to guide evaluation, coaching, and additional learning to establish consistent habits.

Before implementing this tool and 2, 6, and 12 months later, collect patient feedback on a selection of questions about this tool from the [Health Literacy Patient Feedback Questions](#).

Go to [Tool #2: Assess Organizational Health Literacy and Create an Improvement Plan](#) to learn how to use data in the improvement process.

Follow Up with Patients: Tool #6

Overview

Followup is the act of making contact with patients or their caregivers at a later, specified date to check on patients' progress since their last appointment. Appropriate followup can help you to identify misunderstandings and answer questions, as well as make further assessments and adjust treatments. In addition, followup helps to promote a trusting relationship between you and your patients.

Action

Decide on the reasons for followup and who will be responsible for followup.

Who follows up depends on the purpose of the communication.

Examples of Followup Tasks	Responsible Staff
<ul style="list-style-type: none">Follow up on complex or sensitive issues.	Primary Care Clinician
<ul style="list-style-type: none">Confirm medicine is being taken correctly.	Pharmacist Nurse
<ul style="list-style-type: none">Reinforce knowledge and check on action plans.Review health outcomes like blood pressure and blood sugar values.Discuss lab results.	Nurse Health Educator Medical Assistant
<ul style="list-style-type: none">Schedule appointments.Check on referrals.	Office Staff

Choose the ways your office will follow up.

- **Ask patients how they would like to be contacted.** Just because they have a mobile phone does not mean they want to be texted. Do not rely solely on electronic communication. Patients may not check their devices regularly.



- **Phone.** Talking on the phone allows patients to ask questions and callers to reinforce important points and check understanding. (Go to [Communicate Clearly: Tool #4](#) and [Use the Teach-Back Method: Tool #5.](#))
- **Secure email.** Secure email is part of many patient portals and can be an effective way to communicate with some patients. Make sure your emails are easy to understand (e.g., do not use medical terminology). Be sure to tell patients when and how often you check your email. Sensitive health and personal information should not be sent through unsecured email.
- **Texting.** For patients who use text messaging, this approach can be effective for sending patient reminders and answering quick questions. Be sure that patients are willing to be contacted in this manner, as they may be charged for receiving texts from your office.
- **Postal mail.** Postal mail can be used to share information, such as normal lab results and appointment reminders. This [Lab Results Letter](#) provides an example of an easy-to-understand letter explaining the need for followup.

Initiate and track followup.

- Identify the types of patients who would benefit from followup, such as patients:
 - On high-risk medicines.
 - With action plans to self-manage chronic conditions.
 - With missed appointments.
 - Recently discharged from the hospital.
- Decide who will be responsible for each step in the process for each type of followup.
- Identify an appropriate schedule for followup.
- Establish systems for tracking followup through the electronic health record (EHR) or by using a computer-based calendar.
- Identify the staff members who will update these tracking systems.

Incorporate followup into home monitoring programs.

- Ask your patients which system for tracking key clinical values (e.g., blood sugar, blood pressure, weight, pain) between visits they are most comfortable using. Reporting can be done with:
 - Simple forms.
 - Patient portals.

- Automated calling systems.
 - Apps such as the AHRQ Challenge winner [PRISM](#).
 - Devices that automatically communicate results to the practice.
- Train patients to take and report measures. Make use of resources such as these from Million Hearts® on [Self-Measured Blood Pressure \(SMBP\) Monitoring](#).
- Develop a system to review patient-reported outcomes and identify values that need followup.
 - If patients are using paper forms, instruct them to contact the practice when their clinical values are of concern (e.g., blood pressure above 140/90, weight gain of more than 2 to 3 pounds in a day for heart failure patients).
- Follow up with patients, thanking them for recording the information, highlighting how helpful it is, and providing clinical feedback, such as
 - "It looks like you are doing a good job of keeping your blood sugar under control."
 - "Your cholesterol is higher than we'd like it to be. Let's talk about what you are eating and whether we should adjust your medicine."

Track Your Progress

Select the records of a sample of patients who should have received followup after a recent visit (e.g., patients with heart failure).

- Count the number of patients who received followup actions that were scheduled in your tracking system.
- Count the number of followup actions (e.g., phone calls, emails, letters, automated calls) that were performed within the desired time frame.
- Note what was achieved by the followup contacts (e.g., medicine changes, referrals made, clarification of medicine regimens).
- Before implementing this tool and 2, 6, and 12 months later, collect patient feedback on a selection of questions about this tool from the [Health Literacy Patient Feedback Questions](#).
- Refer to [Tool #2: Assess Organizational Health Literacy and Create an Improvement Plan](#) to learn how to use data in the improvement process.

Be Easy to Reach: Tool #7

Overview

Patients get frustrated if they have trouble reaching their practice by phone or getting responses to secure email. Making your telephone and email systems patient-friendly is an important aspect of addressing health literacy. Some patients will hang up if the telephone system is confusing or it takes them too long to reach a person. Efficient and courteous call and email management may save your practice time and money and will benefit your patients as well.

Actions

Assess your telephone system.


- Use a “mystery shopper.” Have someone in your practice act as if they were a patient, both during and after business hours. Use the [Telephone Assessment Guide](#) to determine whether patients have difficulty.
- Ask patients about the phone system. Refer to suggestions in the [Track Your Progress](#) section below.

Improve your telephone system.

- If you have an automated system:
 - Offer choices in the languages commonly spoken by your patients.
 - Always have an option to speak to a person. Some patients are intimidated by automated systems or like talking to a person instead of a machine.
 - Create a menu with no more than five choices. Refer to [Sample Automated Telephone System Menu](#) for a set of options and a flow chart.
- **Set policies** for responding to phone calls:
 - How quickly phones should be answered (e.g., within three rings).
 - What to do when speakers of languages other than English call.
 - Checking back with people placed on hold after a set period (e.g., after 1 minute).

- Transferring calls (e.g., avoid asking patients to dial another number), including plans for what to do if the other party does not pick up the call.
- Always offering to transfer to voicemail or take a message.
- Have a schedule to ensure phones are covered throughout office hours. If your office closes for lunch, have a message stating the hours you are closed.
- Create an after-hours message or have a phone service cover the phones during non-business hours. After-hours messages should include instructions to call 911 in case of an emergency and a phone number to reach the clinician providing coverage. Say the phone number twice, slowly, so patients can write the number down.

Improve how well clinicians and staff communicate on the phone.

- **Instill a culture of friendliness and helpfulness.** Praise those who are calm, patient, respectful, and responsive. Make sure people know office procedures so they can be problem solvers who are willing to go the extra mile.
- **Develop and use written scripts** with responses to frequently asked questions to ensure that clear, consistent answers are given. For example, this [script](#)  is for appointment scheduling.
- **Use [Tool #4: Communicate Clearly](#)** to educate staff on best communication practices.
- **Encourage staff to [use the teach-back method](#)** to confirm instructions given over the phone were understood. In addition, phone calls should [encourage questions](#), such as asking, "What questions can I answer for you?"
- **Use telephone interpreter services** when you do not speak the caller's language. (Go to [Tool #9: Address Language Differences](#) for more information.)



Choose easy-to-use patient portals.

The [ONC Patient Engagement Playbook](#) recommends choosing a patient portal that is:

- [Easy to sign into](#). For example, does your portal include an option to see the password as it is typed?

- [Has features that patients need](#), such as secure messaging; appointment scheduling; and access to plain language clinical notes, lab results, and after-visit summaries.
- [Allows caregivers appropriate access](#).

Improve secure email exchanges.

- **Establish email procedures**, such as who will answer which types of messages and how quickly they need to respond.
 - Assigning messages that are not clinical to other staff can speed up responses and reduce clinician overload that can contribute to burnout. For more information on email management, refer to the American Medical Association's [EHR Inbox Management](#) tool .
- **Keep emails short and simple.** Use [plain, non-medical language](#) . Check that your email is responsive to the patient's request. Let patients know they can call with questions.
- If you are communicating instructions and need to make sure patients understand, call them and use [the teach-back method](#).

Educate patients about the phone and email systems.

- **Distribute a brochure** that explains when and how to contact the practice, both during and after office hours. Refer to [Welcome Patients: Tool #13](#) for guidance on developing an easy-to-understand brochure.
- **Tell patients how best to communicate with the practice.** If a patient needs to contact the practice for something specific—for example, to talk to a nurse—tell the patient exactly what they should do.

Track Your Progress

Regularly review the phone system. Do you see fewer problems over time? Measure expected outcomes of improvements before and after you institute changes (e.g., fewer missed appointments, increased job satisfaction of staff that cover phones).

Regularly monitor how quickly your practice responds to emails.

On a routine basis, ask a sample of patients to provide input on the phone and secure email systems. For example, during a specified week every quarter, have

staff ask patients at the end of each call or at check-out if they have had problems with the phone system or have any suggested changes. They could ask:

- "Have you had any trouble reaching the office on the phone lately?"
- "We have changed our phone system recently. Do you find it harder or easier to use than our old system?"
- "Have you used our secure messaging system on the patient portal? What suggestions do you have to improve our responses?"

Before implementing this tool and 2, 6, and 12 months later, collect patient feedback on a selection of questions about this tool from the [Health Literacy Patient Feedback Questions](#).

Refer to [Tool #2: Assess Organizational Health Literacy and Create an Improvement Plan](#) to learn how to use data in the improvement process.

Conduct Brown Bag Medicine Reviews: Tool #8

Overview

The "Brown Bag Medicine Review" is a common practice that involves 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 your list. Many practices conduct medicine reconciliation using information in the medical record or as reported by the patient. However, it is only by having patients bring in their medicine containers and discussing how they take those medicines that you can tell whether and why patients are not taking medicines correctly.

Practice Experiences

"Out of 10-15 brown bag reviews, only 2 were accurate."

"On the day of the brown bag review, we had a patient experiencing unexplained symptoms. It wasn't until we looked at his medicine bottles that we realized he was taking a double dose of beta blocker. Had we not had the medicine bottles to identify the problem, we would have sent him to the hospital."

Actions

Identify medicines patients should bring.

- All prescription medicines.
- All over-the-counter medicines.
- All vitamins, supplements, and herbal medicines.
- All topicals, liquids, injections, and inhalants.
- All pills—both the bottles they came in and pill box organizers.

Remind patients to bring all medicines.

Ask patients who have not had a medicine review in the past year, or who have changed their medicines recently, to bring in all their medicines. Use [Role Play 1](#) from the appendix to practice.

- Discuss medicine review during a visit and encourage patients to bring medicines to the next visit. Emphasize the potential benefits (e.g., possible reduction in number of medicines).
- Print a reminder on appointment cards.
- Mention it during appointment reminder calls.
- At checkout, provide the [Medicine Review Handout](#) and a carrier, such as a bag with your practice's name and "Bring All Your Medicines" printed on it, and ask them to bring all their medicines to their next appointment.

TIP

Every patient can benefit from a Brown Bag Medicine Review. Some patients may need a brown bag review several times a year, but every patient should have one once a year. Even patients for whom your clinicians have not written any prescriptions could be taking medicines or supplements clinicians do not know about.

Prepare for the review.

- Decide who will conduct the review—the primary care clinician, pharmacist, or nurse.
- Rooming staff can ask patients to set out all the medicines.

Perform the review.

- Thank patients for bringing in their medicines.
- When reviewing each medicine, ask questions like:
 - “When do you take this medicine?”
 - “Could you please show me how you take this medicine?”Have them:



- Remove pills from bottles and show how many they take for each time they take them or talk you through the pill box.
- Use syringes or pour liquid medicines to show the dose.
- Demonstrate how they use inhalants and injectables.
 - Have you had any difficulty buying or taking any of your medicines?
- Probe whether the patient takes other medicines or supplements that they did not bring in. Specifically ask about medicines that are in the medical record that the patient did not bring in, as well as any over-the-counter medicines and vitamins, supplements, and herbal medicines.
- Throughout the process, use the word "medicine," rather than "medication." Medicine is a common word that is easy for patients to understand.
- Clinicians should deprescribe medicines that patients do not need any more or are causing more harms than benefits. Turn on [CancelRx](#) in your electronic health system. Check [guidelines for deprescribing](#) to reduce doses or discontinue medicines safely.

TIP

Patients may have understood your instructions but decided not to take their medicine as directed. Patients will tell you what they think you want to hear unless you signal that you will not lecture them if they tell you what they are really taking.

Uncover problems and provide patients with support.

When you find that patients are taking medicines incorrectly, try to find out why.

- Patients may have gotten conflicting information or misunderstood. Clarify directions using common, everyday words and [precise instructions](#) (e.g., "Take 1 pill in the morning and 1 pill at bedtime.") Go to [Tool #4: Communicate Clearly](#) for tips for communicating in a way that will be easy to understand. [Use the Teach-Back Method](#) to confirm patient understanding.
- Find out if patients have difficulty paying for medicine. Use [Tool #19: Help Patients Pay Less for Medicine](#) to learn how to reduce medicine costs and get patients help.
- Patients may have difficulty reading labels or instructions. Check if they need glasses, but patients who claim they forgot their reading glasses may be

hiding a literacy problem. If reading or math is the problem, use [Tool #20: Connect Patients with Literacy and Math Resources](#).

- Patients may have difficulty remembering how to take their medicine. [Tool #16: Help Patients Take Medicine Correctly](#) has examples of easy-to-understand medicine lists and ways to help patients remember how to take their medicines correctly.

Document the review.

- Update the medicines in the patient's medical record.
- Document medicine inconsistencies and what the patient has been directed to take.
- Note in the record when medicine reviews are done.

Research Findings

After implementing this tool, practices saw marked **increases** in the number of:

Patients who brought all their medicines to visits: from 20% to 67% for prescription medicines and from 9% to 20% for non-prescription medicines.

Medicines brought to the visit from 1 to 6 medicines, on average.

Patients whose medicine regimen were changed as a result of the review from 18% to 42%.

–[Weiss et al. 2016](#) 

Track Your Progress

Calculate the below measures 2 months, 6 months, and 12 months after implementing this tool. See if the numbers change over time.

- Percentage of patients who brought in their medicine whose medicines were reviewed. For a week, ask patients at checkout if they brought in their medicines for a Brown Bag Medicine Review. If they have, ask if the review was performed.

- Percentage of patients with office visits who had a Brown Bag Medicine Review in the past 12 months. Use patient medical records to calculate.

Have clinicians complete the [Medicine Review Form](#) for a sample of patients who have brought medicines to review to calculate the following. **Note:** remove any questions from the Medicine Review Form relating to measures that you do not want to track.

- Percentage of patients who brought all their prescription medicines.
- Percentage of patients who brought all their over-the-counter medicines and supplements.
- Percentage of patients who were unable to show correctly how and when they took at least one medicine.
- Percentage of reviews that identified any kind of problem.
- Percentage of reviews that identified a problem that definitely or possibly posed a safety risk.
- Percentage of reviews that identified a problem that definitely or possibly explained negative symptoms the patient had been experiencing.
- Percentage of reviews resulting in a change to the medicine regimen.
- Percentage of reviews resulting in simplifying the medicine regimen.
- Percentage of reviews resulting in reducing the number of prescription medicines.

Before implementing this tool and 2, 6, and 12 months later, collect patient feedback on a selection of questions about this tool from the [Health Literacy Patient Feedback Questions](#).

Refer to [Tool #2: Assess Organizational Health Literacy and Create an Improvement Plan](#) to learn how to use data in the improvement process.


Address Language Differences: Tool #9

Overview

Patients who use a language other than English often do not get the health information and healthcare that others get. Addressing language differences is an essential health literacy strategy. Practices participating in Medicare or Medicaid are required to provide language access for patients who do not speak or understand English very well, as well as the parents and guardians of patients who are under 18 or are incapacitated. The Americans with Disabilities Act, which covers people who are deaf or have hearing loss, has additional requirements. Failing to use acceptable forms of language access services can expose a practice to liability.

Actions

Assess language preferences.

- Ask all patients what language they want to speak and read in.
 - For example, you could ask, “What language do you want us to speak to you in?” and “What language do you prefer for written materials?”
 - Record patients' language preferences in the medical record.
- For patients who do not speak enough English to respond to questions about language preference, use an ["I Speak"](#)  brochure to identify the language they speak.


Why ask what language patients want to speak instead of how well they speak English?

Everyone deserves to receive healthcare in the language they are most comfortable with.

People who normally speak English very well may lose their ability when they are sick, tired, or frightened.

People can be embarrassed to admit they have limited English proficiency.

Let patients know about language access services.

- List languages qualified bilingual clinicians speak in directories.
- Display [Interpretive Services Posters](#)  in your waiting and reception areas to make patients aware of the availability of free interpreter services.

Use only acceptable language access services.

- Provide language access services if patients or companions who are participating in the visit want to use a language other than English.
 - Consider all aspects of the practice that require language access services (e.g., appointment scheduling, signage, front desk, clinical visit, billing, followup communication, patient portals, secure messaging, obtaining patient feedback).
- Acceptable language access services include the following:
 - Bilingual clinicians and staff members whose proficiency in both English and the non-English language has been confirmed can communicate directly with patients in their preferred language.
 - Qualified healthcare interpreters. Many States have licensing and certification requirements, and qualifications and testing can vary. Qualified interpreters can include:
 - Staff who are trained as healthcare interpreters.
 - On-site dedicated healthcare interpreters.
 - Telephone or video healthcare interpreter services. Make sure you can access the necessary equipment (e.g., speaker or dual handset

phones, video conferencing equipment) everywhere you speak with patients.

- For people who are deaf or hard of hearing, tools such as real-time captioning and amplifiers can help you communicate effectively.

Qualified Interpreters:

Have demonstrated proficiency in speaking and understanding both English and at least one other language.

Interpret effectively, accurately, and impartially while preserving the tone, sentiment, and emotional level of the original.

Follow interpreter ethics principles, including client confidentiality.

Never use unacceptable language access services.

Unacceptable language access services include the following:


- Clinicians or staff who are **not** sufficiently proficient in both languages. Do not try to “get by” with basic or intermediate language skills.
- Clinicians or staff who are **not** trained and/or certified as healthcare interpreters. Research shows that people who not trained to be an interpreter make more clinically significant mistakes.
- The patient's family and friends, unless they are qualified interpreters. Using family or friends makes it impossible to have a private conversation with your patient, as recommended in [Include Family and Friends: Tool #22](#). Furthermore, family or friends may express their own views instead of the patient’s view. If a patient insists that a family member serve as interpreter, you should respect that request, but also get a qualified interpreter to assure that information is accurately relayed.
- Minor children should **never** be used as interpreters.

Plan for language access in advance.

- Use your patient assessment and community data to determine how best to meet language access needs (e.g., hiring bilingual staff, hiring professional

- interpreters, training staff as interpreters, contracting with a language agency, and telephone/video interpreter services).
- When making appointments, check what language patients want to use. Make arrangements for language access services for patients that use languages other than English.
 - Decide how to handle unanticipated language access needs, such as using on-demand telephone interpreters.
 - Train staff how to:
 - Follow the practice's language access policies, including documenting interpreter use.
 - Match patients with qualified bilingual clinicians.
 - Schedule interpreters in advance for in-person and telehealth visits.
 - Access interpreters when unexpected needs arise.
 - Use health literacy strategies to communicate clearly. (Refer to [Tool #4: Communicate Clearly](#)).
 - [Work effectively with interpreters](#).

Provide written materials and videos in patients' languages.

- Do not assume that non-English speakers, including sign language users, will understand notes or other materials written in English.
- Decide what to translate, such as signs, forms, instructions, appointment reminders, and patient surveys.
- Select qualified translators who use a [high-quality process](#). You can find best practices in this [Toolkit for Written Translation](#).
- Consider options for multilingual patient portals.
- Distribute multilingual health education materials, including videos in American Sign Language and other languages.
- When you cannot obtain materials in patients' languages, enlist the help of interpreters trained in sight translation. Sight translation is reading a written document aloud in a different language from the one in which it is written.

TIP

Interpreters and translators are different professionals with different skill sets.

Interpreters listen or watch in one language then speak or sign in another language.

Translators read text in one language and write what it meant in another.

Finance language access services.

- Investigate whether insurers will pay for or have negotiated discounts with interpreters. Medicaid reimbursement is available in a number of States.
- Consider:
 - Sharing language access services with local hospitals or among several practices.
 - Exploring language banks, which provide volunteers trained as healthcare interpreters.
 - Applying for grants to support interpreter and translation services.

Track Your Progress

Ask staff to record the number of patients they saw during a specified week who needed language access services and how these needs were met. Discuss instances when qualified interpreters or bilingual personnel were not used at the next [Health Literacy Team](#) meeting and brainstorm solutions. Repeat after 2, 6, and 12 months.

Routinely conduct a review of medical records of patients with recent visits to ensure that language preferences are being assessed and recorded. Compile a list of the most common languages spoken by your patients. Compare that list with the languages used in the written materials you distribute. Repeat after 2, 6, and 12 months to see whether more non-English materials are available.

Before implementing this tool and 2, 6, and 12 months later, collect patient feedback on a selection of questions about this tool from the [Health Literacy Patient Feedback Questions](#).

Refer to [Tool #2: Assess Organizational Health Literacy and Create an Improvement Plan](#) to learn how to use data in the improvement process.

Additional Resources

You can find resources for planning language access services, working with interpreters, and multilingual, easy-to-read materials in the appendix [Language Access Resources](#).

Consider Culture: Tool #10

Overview

Culture—including customs, beliefs, and values—can influence how people understand health concepts, how they take care of their health, and how they receive medical advice and make health decisions. People can be part of more than one culture, based on their racial, ethnic, religious, or political identity, as well as their age, family composition, what language they speak, where they were born, where they live, what their occupation is, and other factors. Clinicians can learn to develop treatment plans with patients that are consistent with and respectful of their cultures.

TIP

Here are some examples of how culture can influence how your patients interact with you.

Health beliefs: In some cultures, people believe that talking about a possible poor health outcome will cause that outcome to occur.

Family customs: In some cultures, family members play a large role in healthcare decision making.

Healing customs: Traditional healers and herbal or other remedies can augment or substitute for Western medicine in some cultures.

Religious beliefs: Religious, faith, or spiritual beliefs may affect healthcare-seeking behavior and people's willingness to accept specific treatments or behavior changes.

Dietary customs: Disease-related dietary advice will be difficult to follow if it does not conform to the foods or cooking methods used by the patient.

Interpersonal customs: Eye contact or physical touch will be expected in some cultures and inappropriate or offensive in others.

Actions

Learn from patients.

- Respectfully ask patients about their health beliefs and customs and note their responses in their medical records. Address patients' cultural values specifically in the context of their healthcare. For example:
 - "I would like to be respectful—what do you like to be called and what pronouns do you use?"
 - "Tell me about things that are important to you. What should I know that would help us work together on your health?"
 - "Lots of people visit providers outside the clinic. Who else do you visit about your health?"
 - "Tell me about the foods you eat at home so we can develop a plan together to help you reach your goal of losing weight."
 - "Your condition is very serious. Some people like to know everything that is going on with their illness, whereas others may want to know what is most important but not necessarily all the details. How much do you want to know? Is there anyone else you would like me to talk to about your condition?"
 - "What do you call your problem? What do you think caused it? How do you think it should be treated?"
- Do not stereotype. Understand that each person is an individual and may or may not adhere to certain cultural beliefs or practices common in his or her culture. Do not make assumptions based on group affiliations or how people look or sound. Asking patients themselves is the best way to be sure you know how their culture may impact their care.

Learn from other sources.

High-quality online resources provide education on how to provide culturally appropriate services.

- Courses and websites
 - Think Cultural Health offers several [courses](#) for free continuing education credit, as well as fact sheets on ways to improve care for diverse populations.
 - The Centers for Disease Control and Prevention (CDC) offers free continuing education credit for [Effective Communication](#)

[for Healthcare Teams: Addressing Health Literacy, Limited English Proficiency and Cultural Differences.](#)

- [EthnoMed](#) contains information about cultural beliefs, medical issues, and other related issues pertinent to the healthcare of recent immigrants.
-
- **Community organizations** such as religious institutions and cultural organizations often can provide information and support to help make your practice more "culture-friendly."
 - Invite a member of a relevant cultural group to attend a staff meeting and share observations about how their culture may impact healthcare.
 - Invite an expert to conduct an inservice training to educate staff on how to deliver culturally appropriate services.
 - Build ongoing relationships with leaders in the community who can serve as cultural brokers.
 - **Integrate cross-cultural skills into orientation and other trainings.** In addition to training dedicated to improving cross-cultural skills, you can weave those skills into all training activities.

TIP

Remember that culture is not limited to religious, racial, or ethnic groups.

Help staff learn from each other.

To increase understanding about cultural diversity:

- Hire clinical and other staff who reflect the demographics of your patient population. They can help contribute to creating a comfortable environment for patients and can share insights with others in the practice regarding the customs of their cultural groups.
- Have staff take cross-cultural skills trainings and set aside time for them to share what they learned.

Practice cultural humility.

- **Reflect** on your own values, beliefs, and cultural heritage; how that affects your personal health practices; and how you interact with the healthcare system.
- **Analyze** the ways the dominant and medical cultures shape how your practice delivers healthcare and consider changes to make it more inclusive of the patient populations you serve.
- **Do not make assumptions.** You cannot tell a person's race, ethnicity, or other cultural identities by looking at them. Treat everyone as an individual and ask people to tell you about themselves.
- **Reduce the power differential** between healthcare professionals and patients by:
 - Being humble and respectful.
 - Recognizing patients' expertise about themselves and what they want for their health.
 - Adopting a more open, less authoritarian style.
- **Commit to being a lifelong learner** who values diversity and seeks to make healthcare more equitable.

Track Your Progress

Before implementing this Tool, count the number of staff members who have completed a cultural competence training session. Repeat after 2, 6, and 12 months.

On a regular basis, randomly select some medical records and see what percentage have notes on the patient's culture, customs, or health beliefs.

Before implementing this tool and 2, 6, and 12 months later, collect patient feedback on a selection of questions about this tool from the [Health Literacy Patient Feedback Questions](#).

Refer to [Tool #2: Assess Organizational Health Literacy and Create an Improvement Plan](#) to learn how to use data in the improvement process.

Assess, Select, and Create Easy-to-Understand Materials: Tool #11

Overview

Practices often ask patients to fill out forms or provide them with written materials to read. Almost a quarter of U.S. adults have low literacy and a third have low numeracy. The average reading level for U.S. adults is 8th or 9th grade. Materials written for the “average” adult—and health education materials are frequently written way above the average reading level—means that **half of adults** will have difficulty understanding them. Assessing, selecting, and creating simple forms and easy-to-use educational materials can help your patient be successful with tasks that involve written information.

Action

Train a staff member to evaluate the quality of the materials you give to patients.

Have at least one person in your practice learn how to assess the materials you distribute. Focus first on important and frequently used materials, such as your lab results letter, after-visit-summary, appointment reminder, or fact sheets about managing chronic conditions. Be sure to review materials developed by your practice as well as those produced by outside sources to ensure they are appropriate for your patients.

TIP

Provide materials in languages your patients and their caregivers understand. Keep in mind that some patients who do not read English may have limited literacy in their native language. Find out more about meeting patients’ language needs in [Tool #9: Address Language Differences](#).

Assess whether materials are easy to read, understand, and act on.

There are many ways to assess patient materials. Combine approaches that examine a broad array of features that can make materials easy to understand and act on with those that measure how readable materials are.

- **Assess understandability and actionability.** AHRQ's [Patient Education Materials Assessment Tool \(PEMAT\)](#) provides separate measures of how easy materials are to understand and how easy they are to act on. You can also try the shorter [Health Education Materials Assessment Tool \(HEMAT\)](#), which has been adapted [for Spanish content](#). Both are validated ways to assess written and audiovisual education materials.
- **Get patient feedback.** Ask a diverse group of patients to evaluate your forms and other written materials that you hand out or are available on your patient portal. Go to [Tool #17: Get Patient Feedback](#) for guidance.
- **Use readability formulas.** Readability formulas focus on the length of the words and sentences, not on meaning. A high score signals that materials are difficult to read, but a low score does not necessarily mean they are easy to understand. Be aware of the [limitations](#) of readability formulas. Search the internet for "free readability formulas" to find online resources for commonly used formulas, such as the Fry, SMOG, and Flesch Reading Ease.

Choose materials that are easy to read, understand, and act on.

- **Identify poor-quality materials.** Identify materials that performed poorly on any of your assessments. Consider whether these materials can be improved or whether they will need to be replaced.
- **Select better materials.** When you identify unsatisfactory materials that cannot be revised, search for new ones. Make sure you assess the new materials using the tools mentioned above to see if they are really better.
- **Use the internet.** There are many free health education resources available on the web, such as the [MedlinePlus "easy to read"](#) collection, which contains interactive tutorials. Check out whether sites have simple navigation and are easy to read and understand. Before directing patients to a website, [check whether they have access to the internet](#).
- **Consider alternatives to written materials.** Even if your materials are written at the 4th or 6th grade level [as recommended](#), some adults will not be able to read them. Ask your patients how they like to get health information. For example, patients with sight loss may prefer large print or braille materials. Patients may prefer audio and video resources. Deaf and hard-of-hearing patients may prefer videos with closed captions or sign language. Videos are also useful for demonstrating self-care activities, such as injecting insulin, using an inhaler, or exercising. Make sure that a patient has the equipment, bandwidth, and know-how needed to view audiovisual materials before distributing them.

- **Do not eliminate paper-based materials.** Print and send information by regular mail if patients prefer it.

Create new materials to fill gaps and revise homegrown materials that need improvement.

Sometimes you just cannot find easy-to-understand instructions or other health information. Or you realize that the materials your office has created are not as easy to understand as you need.

- **Use guides.** The Department of Health and Human Services has several guides to help you design or revise materials and websites so they are easy to understand. Check out:
 - [Guidelines for effective writing](#)
 - [Health Literacy Online: A Guide for Simplifying the User Experience](#)
 - [Simply Put: A guide for creating easy-to-understand materials](#) (PDF, 1.9 MB)
 - [Plain Language Words](#)

TIP

If your clinical notes are shared with patients (“[open notes](#)”), use common, [everyday words](#), avoid [medical terminology](#), and follow guidance on making written information easy to understand and act on.

- **Involve patients.** Invite patients to contribute to the development of new materials. They're the experts on what information is important to them and what makes sense.
- **Design for readability.** Check that your materials follow [guidelines](#) to make materials easy to read, such as left justifying text, leaving white space, and avoiding all caps and italics.
- **Streamline forms.** Review all forms patients fill out.
 - Do they use [common, everyday words](#) and avoid [medical terminology](#)?
 - Is there adequate room to fill in the requested information?

- Do they ask only for the “need to know” information, and ask for it only once? Share information collected from patients with everyone who needs to know so patients are not repeatedly asked for the same information.
 - Use the appendix [Inclusive Language on Intake Form](#) and visit [Tool #13: Welcome Patients](#) for additional guidance on revising forms.
- **Watch out for numbers.** Ensure that your materials follow recommendations for improving communication of health-related numbers:
 - Provide **only** the information patients must have to make informed decisions or take care of their health.
 - Provide numbers along with verbal descriptors (e.g., “low risk”).
 - Use simple graphics to express numbers and provide a context for interpreting them.
 - Express risk/benefit in whole numbers, not fractions, decimals or percentages (e.g., “1 in 10,000” rather than “.01 %”).
 - Provide absolute risk (e.g., a decrease from 6 out of 100 people to 3 out of 100 people) rather than relative risk (e.g., a reduction of 50%), especially when the numbers are small.
 - Provide both the positive and the negative (e.g., “5 in 100 people will get the side effect, and 95 out of 100 will not get the side effect”).
 - Do the math for patients, rather than expecting them to perform calculations.
 - Stay consistent. Use the same denominator when making comparisons (e.g., “1 in 1,000 versus 20 in 1,000” instead of “1 in 1,000 versus 1 in 50”).
 - Present risk in terms of a time span that is meaningful for patients, such as a 10-year period rather than lifetime.
- **Assess the new materials during the development process.** Do not wait until the product is finished before you assess it. Assessment tools can remind you to follow health literacy principles.
- **Consult on legal issues.** When using a form for a legally binding purpose, consult a lawyer for legal advice. Remember—having patients sign something they do not understand is not legally binding, so be sure to advocate for plain language.

- **Get approvals.** Some practices may need administrative approval to revise or replace written materials. Changes to materials accessed through the electronic health record or patient portal may also require support of information technology staff. Consult with your administration for guidance on how to get approval and support for revised materials.

Develop a schedule for regularly assessing and updating written materials. Some organizations assess each written material every 2 or 3 years.

Track Your Progress

Every 4 months, tally the number of materials that have been assessed and the percentage of those that were rated as poor quality that have been replaced or revised.

Before you start using this tool, tally the percentage of questions that were not answered on forms filled out by patients in a given week. In 2, 6, and 12 months, do it again and see if the percentage of unanswered questions has gone down.

Before implementing this tool and 2, 6, and 12 months later, collect patient feedback on a selection of questions about this tool from the [Health Literacy Patient Feedback Questions](#).

Refer to [Tool #2: Assess Organizational Health Literacy and Create an Improvement Plan](#) to learn how to use data in the improvement process.

Additional Resources

The following are examples of easy-to-understand patient forms and letters. You can edit and share with legal advisors, as needed.

- [Permission to Bill Insurance](#)
- [Release of Medical Information](#)
- [Lab Results Letter](#)
- [Appointment Reminder](#)
- [Inclusive Language for Intake Forms](#)

Use Health Education Material Effectively: Tool #12

Overview

Health materials are effective only when used as part of an overall patient education strategy. Simply handing patients a pamphlet or referring them to a website is not enough to promote understanding or behavior change.

Action

Assess patients' learning style and readiness to learn.

- Ask patients how they like to learn and match educational materials to their learning style. For example, you could ask:
 - “What is the best way for you to learn new things? Do you learn better by reading, looking at diagrams, listening to someone talk, watching a video, or using an interactive program?”
 - “Would you prefer to read something first, or would you rather have me explain the information to you?”
- Make sure that patients are ready to learn. Right after getting a new diagnosis, for example, patients may not be ready for a lot of information. You could ask, “Are you interested in learning more about....”

TIP

Do not assume that your patients will read or view the materials you give them or direct them to. If the information is critical, make sure someone in the practice reviews the information with your patient and the patient's caregiver and checks their understanding.

Review handouts with patients.

- **Circle or highlight** the most important points as you talk about them.
- **Personalize** the material by adding the patient's name, medicines, and/or specific care instructions.
- **Use teach-back** to confirm understanding. Go to [Tool #5: Use the Teach-Back Method](#).
- **Emphasize the importance** of the material by referring to it during followup phone calls, emails, and office visits. You may need to give the material to the patient more than once.

Practice Experiences

An internal medicine practice developed and trained staff to review a one-page blood pressure educational tool with all patients with hypertension, chronic kidney disease, or diabetes. After using the tool for several weeks, the Health Literacy Team leader reported, "The staff seems to think it was pretty easy to use, easy to explain, and as far as I know, we've had a lot of patients say, 'Wow, thank you. I didn't even know what my BP should be or what a normal BP is.'"

Ensure patients know how to use audiovisual materials or access the internet.

- If you give patients videos or other audiovisual materials, make sure that they have the appropriate equipment and the know-how to listen to or view the materials. Before directing patients to websites or the patient portal, [check whether they have access to the internet](#).
- Always have a conversation with patients after they view audiovisual materials. Decision aids and tutorials can save time but are a supplement to, not a substitute for, a discussion and checking understanding.

Train patients to use the patient portal and to be discerning consumers of internet content.

- Even patients with excellent health literacy skills may have limited computer skills. To ensure that patients are able to access your patient portal, offer training sessions to show patients how to login and retrieve information from

the portal. Observe patients using your portal and use the [Patient Portal Feedback Form](#) to record how easy or hard it is. Go to [Tool #17: Get Patient Feedback](#) for more information about using the form.

- Patients often surf the internet for medical information on their own. You may want to educate them on how to find accurate health information. You can refer them to this [interactive tutorial](#) from the National Library of Medicine. You can also refer them to trusted health information websites like [MedlinePlus](#) and [MyHealthfinder](#).

Practice Experiences

In one family medicine practice, staff wore buttons saying, "Ask Me About our Patient Portal." This strategy increased the number of patients that used their patient portal.

Obtain patient feedback on materials.

- When following up with patients (Go to [Tool #6: Follow Up with Patients](#)), ask whether they found the materials helpful. This can allow you to emphasize the importance of the materials, review any questions patients may have, and obtain input from the patient about the materials provided. Go to [Tool #17: Get Patient Feedback](#) for more information about obtaining patient input.

Manage educational materials.

- Monitor and organize any materials you hand out regularly to ensure you know the type and amount of materials you have, can easily locate them, and know when you need to update or re-stock them.
- Assess materials available through your electronic health record (EHR) and patient portal. What is available may change rapidly. (Go to [Tool #11: Assess, Select, and Create Easy-to-Understand Materials](#) for information about assessing and selecting easy-to-understand materials). If materials are not easy to understand or act on, work with your vendor to develop strategies to access better materials. If materials are accessed via hyperlinks, check frequently to confirm that the hyperlinks still work.
- Create “information order sets” to make it easy to find the materials you want when needed. For example, you might create an order set of materials to give patients newly diagnosed with a chronic condition or who are starting

a new treatment. Information order sets can also be made available through the patient portal.

- Ensure staff know what education materials are available, where they are located (both physically and in the EHR or patient portal), and how to use them effectively. Remind staff on a quarterly basis.

Track Your Progress

Record each time you have run out of materials and each time someone in the office cannot find the materials they need. Every quarter, determine whether your system for managing your educational materials is performing better than in the prior quarter.

Periodically check in with staff and ask if they are using the materials and whether alternative materials are needed.

Have checkout staff look at materials that patients have been given. Record the percentage of materials that have been highlighted or personalized.

Some patient portals can report whether patients have viewed information provided through the portal. Track over time the percentage of patients that view educational materials on your portal and which materials they view.

If you use the [Patient Portal Feedback Form](#), check how patients answered questions #8 and #9.

Before implementing this tool and 2, 6, and 12 months later, collect patient feedback on a selection of questions about this tool from the [Health Literacy Patient Feedback Questions](#).

Refer to [Tool #2: Assess Organizational Health Literacy and Create an Improvement Plan](#) to learn how to use data in the improvement process.

Welcome Patients: Tool #13

Overview

Do your patients feel welcome when they enter your practice? Do people from all cultures feel comfortable? Will patients who have difficulty reading be able to find the restroom or the check-out desk? Do patients face a barrage of paperwork when they first come in?

Patients may feel anxious or intimidated in a healthcare setting. Creating a friendly and easy-to-navigate environment may help your patients feel welcome and relaxed.

Action

Assess your practice.

- **Shadow diverse patients or conduct a walk through.** [Navigating the Health Care System](#) describes how to walk in the shoes of your patients to assess how welcoming your practice is.
- **Review signs throughout your practice.** Check with your clinic administration to find out if an approval process is required to change signs in your practice. Look at all the signs in your practice, and make sure they:
 - Are visible and easy to read.
 - Provide clear direction. Use signs to direct patients to common locations, such as the practice entrance, the check-in and check-out areas, exam rooms, lab, and restrooms.
 - Are written in appropriate languages (i.e., written in the languages your patients read).
 - Use graphics when appropriate.
- **Consider other approaches to help patients find their way,** such as using color-coded lines paired with different shapes (to be color blind friendly) on the floors or walls.
- **Review forms.**

- Do they allow patients to indicate non-traditional family configurations (e.g., multiple parents, multigeneration household)?
- [Tool #11: Assess, Select, and Create Easy-to-Understand Materials](#) also has guidance on streamlining forms.

Train staff.

- **First impressions count.** The first person a patient talks to should be helpful, friendly, and respectful. Provide training to help staff be non-judgmental listeners with a customer service orientation.
- **Do not forget the back office.** Patients with billing questions often find it difficult to understand procedure codes and insurance practices. Teach your staff to provide easy-to-understand explanations of common billing and insurance concepts that avoid technical jargon.
- Go to [Tool #3: Raise Awareness](#), [Tool #4: Communicate Clearly](#), [Tool #5: Use the Teach-Back Method](#), [Tool #7: Be Easy to Reach](#), and [Tool #10: Consider Culture](#) for additional guidance on training.

Offer everyone help.

- **You can't tell by looking** which patients may need assistance, so offer all patients help. For example, you can offer help with:
 - Forms that they are asked to fill out or sign.
 - How to log in and use the patient portal.
 - How to use telehealth services.
 - How to get to a specialist or lab.
- Offer help in a friendly, non-stigmatizing way. For example:
 - "Here are some forms to complete. You can fill them out now or wait until you get to the room and the medical assistant will be happy to go over them with you."
 - "Many people find it hard to get started with a patient portal. Can I arrange for a class where someone can help you log on and use the portal?"
 - "It can be challenging the first time you have a telehealth visit. If anything is not clear, please call us at [phone number] and we will be happy to go over the instructions with you."

- "Patients sometimes tell us the lab is hard to find. [Let me draw you a map.](#)"


Assess language preferences.

- **Ask patients what language they want you to speak** and provide appropriate language access services. Go to [Tool #9: Address Language Differences](#) for further information.

Create a practice brochure.

- **Develop an easy-to-understand brochure** highlighting key elements of your practice, such as:
 - Contact information, including after-hours and emergency information.
 - Services provided.
 - [Address and directions to your office with a simple map.](#)
 - What to bring to appointments.

Make the waiting room inviting and informative.

- **Do not overwhelm patients** with too much material on walls or tables. Carefully curate materials, choosing only those that are most relevant to your patients. Consult [Tool #11: Assess, Select, and Create Easy-to-Understand Materials](#) for guidance on selecting easy to understand and act on materials.
- **Display colorful posters** to engage patients in their healthcare. Chose key concepts like:
 - Asking questions (e.g., [It's OK to Ask](#) .
 - Remembering to take medicines correctly. (e.g., [Help with Medicine Poster](#)).
- **Choose images and languages based on your patient population.** Make sure pictures look like the patients you serve. Consult [Language Access Resources](#) for sources of multilingual patient education materials.
- **Display photos of the care team**, including names, titles, and key responsibilities, to help patients better understand the roles different members play. Remember to use simple words (e.g., use "doctor" and "nurse" instead of "physician" and "RN").
- **Update materials regularly.** Assign staff to update materials on a regular basis.

- **Show easy-to-understand educational programming** if you have a television in your waiting room. Keep the volume down and use closed captions.

Track Your Progress

Conduct an initial assessment of your practice environment by asking a patient or staff member to walk through your practice and assess the points discussed in this tool. After making changes and training staff, conduct additional walkthroughs and compare the results.

Have a volunteer observe in the reception area. Record the percentage of patients who were greeted warmly, treated respectfully, and offered help with forms and other tasks. Track the percentage over time.

Before implementing this tool and 2, 6, and 12 months later, collect patient feedback on a selection of questions about this tool from the [Health Literacy Patient Feedback Questions](#).

Refer to [Tool #2: Assess Organizational Health Literacy and Create an Improvement Plan](#) to learn how to use data in the improvement process.

Encourage Questions: Tool #14

Overview

Patients sometimes do not ask questions because they are afraid of seeming ignorant or difficult. In some cultures, questioning the doctor is considered rude. The key to encouraging questions is letting patients know you expect and really want them to ask questions. Creating an environment that encourages patients to ask questions is an important way to engage patients as active partners in their healthcare and promotes patient safety, good health outcomes, and patient satisfaction.

Patient Experiences

“Some patients are reluctant to ask questions. I used to be like that myself. A doctor would tell me something and I’d say, ‘Okay, thanks.’... When I ask questions, I’m more likely to follow through with the advice from the doctor..... If I hadn’t started to ask my doctors questions, I honestly think I would be dead today.”

– [Bill Lee](#)

Action

Invite questions.

- **Ask "What questions do you have?"** This open-ended wording signals that you have time and are interested in their questions.
 - Ask several times during an office visit. Do not wait until the end.
 - Do **not** ask, "Do you have any questions?" Most patients will respond by saying "no," even if they have questions.
- **Create the expectation that they have questions.** For example, you could say:
 - "We covered a lot of information. What questions can I answer for you?"

- "This is the first time you're hearing about this condition, and I expect you have questions. What would you like to know more about?"
 - "Many people have questions. I'd like to hear what questions you have."
 - "Thanks for those question. What else would you like to know?"
- **Use body language to invite questions.**
 - Sit, don't stand: Sit at the same level as your patient.
 - Look and listen: Look at patients when talking and listening, not at the chart or computer.
 - Show that you have the time: Let them know you have time and want to listen to their questions. Do not interrupt or stand by the door.

Encourage all staff to make sure questions are asked and answered.

- **Check-in and rooming staff** can encourage patients to ask their clinicians any questions they have during the visit. Offer paper and pens to write down questions and take notes.
- **Check-out staff** can ask patients whether all their questions were answered. Make sure you have a plan for how to respond if a patient says "no."

Remind patients to bring questions with them.

- **Appointment reminders** can suggest patients bring a written list of questions with them or use the QuestionBuilder, available [online](#) and as an App, in English and Spanish, in the AppStore and Google Play.
- **Display posters** with encouraging messages like, "Ask more questions!" or "What do you want to know? Ask us!"

Encourage patients to ask questions in other health settings.

- For example, when giving a patient a new prescription, you might say, "Be sure to ask the pharmacist if you think of any additional questions about your medicine."

Track Your Progress

Ask clinicians to keep a log for 1 day of the number of patients they encouraged to ask questions using opened-ended phrases like, “What questions do you have?” Repeat after 2 months, 6 months, and 12 months.

Over the course of a week, record the percentage of patients who call or email the practice with questions within 48 hours after their office visit. Check before implementing this tool and again after 2 months, 6 months, and 12 months.

Before implementing this tool and 2, 6, and 12 months later, collect patient feedback on a selection of questions about this tool from the [Health Literacy Patient Feedback Questions](#).

Refer to [Tool #2: Assess Organizational Health Literacy and Create an Improvement Plan](#) to learn how to use data in the improvement process.

Make Action Plans: Tool #15

Overview

An action plan outlines one or more easy steps a patient can take to attain a health goal, such as losing weight or improving self-management of a chronic condition. Patients and health professionals create action plans together. This tool describes the process of creating and following up on action plans.

TIP

Use action plans to help patients:

Change their diet.

Cut down or stop smoking, drinking, or drugs.

Increase physical activity.

Manage stress or emotions.



Sleep better.

Take medicines correctly.

Action

Train clinicians and staff to work with patients on action planning.

Successful action planning requires working collaboratively with patients.

- **Decide who will be responsible for action planning and make sure they have the skills they need.** Many people can engage patients in action planning, including clinicians, nurses, medical assistants, diabetes educators, health coaches, and others.
 - The University of California at San Francisco [Center for Excellence in Primary Care](#)  has resources on health coaching and produced this [6-minute video](#)  that shows ineffective and effective ways to engage patients in action planning. A

longer version of the [video](#) explains the steps for creating action plans with patients.

- You can find short videos and action planning resources at the [Centre for Collaboration, Motivation, and Innovation](#).
- The resources in the AMA Steps Forward's [Health Coaching Module](#) can get your practice started with action planning.

Create action plans with patients.

- **Ask permission** to talk about health behaviors. For example,
 - “Would you like to talk about ways you could improve your health now?”
 - “Shall we discuss whether there is anything you would like to do for your health in the next week or two?”
- **Use an action plan form** to guide and record the conversation. This simple [Action Plan Form](#), with an example of a completed form, can be modified to fit your needs using this [Word template](#). This [Action Plan Form](#) is available in English and Spanish.
- **Find out what patients want to work on.** Ask patients, “What matters to you?” You may have a different opinion about what is most important, but always start with the topic the patient chooses.
- **Ask patients to choose a goal.** For the plan to be successful, the goal must be important to the patient.
- **Help patients break down goals into manageable steps.** Have patients pick one specific step they want to try. Steps should be small and realistic to do over a short time (e.g., 1 week). If they get stuck you could ask, “Would you like me to share some ideas that others have used?”
- **Assess confidence.** Assess the patient's confidence by asking, “On a scale of 1 to 10, with 1 being not sure at all and 10 being very sure, how sure are you that you can follow this action plan?” Research shows that a confidence level of 7 or above increases the likelihood that the patient will carry out the plan.
 - If they are below 7, explore what barriers might stand in their way and revise the plan so the patient feels more confident.
 - Ask patients who can help them succeed with their action plan. Support at home is key to success.
- **Ask when they'll start the action plan.** Set a concrete start date.

The image shows a sample 'Action Plan Form'. It includes fields for 'My doctor will write:' and 'Date:'. Below these is a section 'What I want to do for my health:' with checkboxes for 'I feel better', 'I manage my stress', 'I sleep better', 'Get down or stop smoking', 'drinking', 'drugs', and 'something else'. There are also checkboxes for 'No more action', 'Handle my feelings better', and 'Take my medicine'. A 'Goal' section asks 'One goal I want to achieve that will improve my health:' followed by 'My Action Plan - One specific step I can take to achieve this goal:' with fields for 'What:', 'Where:', 'How Much:', 'When and how often:', and 'I will start:'. A 'How sure are you that I can do this?' section features a scale from 1 to 10, with 1 labeled 'Not sure' and 10 labeled 'Very sure'.

- **Confirm the action plan with [teach-back](#).** For example, you could say, “Just to make sure we’re on the same page, what are you going to start next Monday?”
- **Set a time for followup.** Following up lets patients know that you are interested in helping them achieve behavior change. Ask patients when and how they’d like to check in and set a date and time. Go to [Tool #6: Follow Up with Patients](#) to learn about different ways to follow up.
- **Make a copy of the action plan.** Give a copy to the patient and document the plan in their medical record. If your electronic health record does not have dedicated action plan fields, determine how the practice will standardize documentation so everyone can find it easily.

Follow up after the visit.

- At the appointed date and time, contact the patient.
- When patients have not stuck to their action plan, reassure them that this is common and help them develop a plan that they can achieve.
- When patients have followed their action plan, congratulate them! Work with patients to plan the next step. Each small step gets patients closer to the ultimate goal of improving their health-related behaviors.
- Update the medical record to reflect the current plan the patient is working on.

TIP

It can be tempting to make suggestions, but action plans need to come from patients. Try having a menu of options (e.g., lists of exercises, foods to cut down on) that can give patients ideas for specific steps they can take. [MyHealthfinder.gov](#) has many suggestions for making healthy changes.

Track Your Progress

Randomly select the records of at least 20 patients slated to have action plans who were seen in the past week, and calculate the percentage who have an action plan. Check again in 2 months, 6 months, and 12 months to see if there has been an increase in that percentage.

Look at the records of at least 20 patients with action plans. See how many have notes on whether: 1) there was followup, 2) initial steps have been completed, 3) additional steps have been added, and 4) goals have been achieved. Repeat in 2 months, 6 months, and 12 months to see if there has been an increase in the percentages.

Before implementing this tool and 2, 6, and 12 months later, collect patient feedback on a selection of questions about this tool from the [Health Literacy Patient Feedback Questions](#).

Refer to [Tool #2: Assess Organizational Health Literacy and Create an Improvement Plan](#) to learn how to use data in the improvement process.

Help Patients Take Medicine Correctly: Tool #16

Overview

Research has shown that patients often have difficulty knowing how and when to take their medicines, especially if their regimens are complex. It is a safety issue if patients take their medicines incorrectly or not at all. Helping patients understand and remember their medicines increases the chances they will take the medicines they need to get and stay healthy and can reduce errors.

Actions

Prevent errors.

- Use [evidence-based instructions](#), which are available in English, Chinese, Korean, Russian, Spanish, and Vietnamese. Add these instructions to your electronic health record (EHR) for eprescribing.
 - These instructions are precise, minimizing confusion. For example, "Take 1 pill in the morning and 1 pill at bedtime" is unambiguous, whereas "Take twice daily" could lead to errors if patients do not know to spread out the doses.
 - These instructions simplify complex medicine regimens by using standard time periods (i.e., morning, noon, evening, and bedtime). They make it easier for patients to take their medicines correctly by clustering medicines and reducing the number of times a day patients take medicine.
 - Be explicit if any medicines should not be taken together, or if there is anything they should not eat or drink near the time they take the medicine.
- **Include in your prescription a plain language description of what the medicine is for** (e.g., "for high blood pressure").
- **Discuss and resolve patients' concerns.** Ask patients if anything makes it difficult or prevents them from taking their medicines.
 - Pay attention to reports of side effects; otherwise, patients may stop taking medicines without telling you.
 - If the difficulty is financial, use [Tool #19: Help Patients Pay Less for Medicine](#).

- If the difficulty is physical (e.g., cannot open containers) or cognitive (e.g., gets medicines confused), you can work with pharmacies that will presort medicines so patients have an easy-open packet of everything they need to take for each time of day. Also, see the strategies below to [help patients remember to take their medicines](#).
 - If the difficulty is logistical, use the strategies in the below section, [Make it easy to get medicines](#).
- **Consider prescribing options.**
- Blister packs can make it easier to take medicines that require tapering off.
 - Combination medicines or medicines requiring fewer doses (e.g., extended release) can mean fewer pills to take. However, these medicines can be more expensive. [Tool #19: Help Patients Pay Less for Medicine](#) may be helpful.
- **Suggest patients always check medicine labels.** Refills can come in different colors, shapes, and sizes. Tell patients that if the name of the medicine and the dose are the same as what they are used to taking, their medicine will work the same way and should be taken as directed. Encourage patients to talk with their pharmacist if they have questions or concerns about what they received.

Provide patients with a list of medicines.

- Include all prescription and over-the-counter medicines, as well as supplements.
- Figure out how your EHR can produce a medicine list that clearly shows when and how to take medicines. The list should be organized so it is easy to see when to take medicines over the course of a day.

- Alternatively, provide patients with one of these lists that clearly show what medicine to take at each time of day and how much to take:

- [My Medicines List](#).
- [Medicine Reminder Form](#).

You can fill in the list on paper or electronically with patients during [Brown Bag Medicine Reviews](#). Include blank sheets so patients can add to it.

My Medicines List

My Name: _____ My Allergies: _____ My Emergency Contact Information: _____

My medicines, vitamins, herbs, and supplements, as of _____ Date: _____

Include all prescription and non-prescription medicines. Non-prescription medicines may include vitamins, herbs, supplements, cold or cough medicines, aspirin, pain relievers, allergy relief medicines, antacids, laxatives, diet pills, and others that you do not need a prescription to buy.

Name (brand and generic)	Strength of medicine	I take this medicine for	I take these every day				
			Instructions	When, how, and how much I take	Morning	Noon	Evening

Make it easy to get medicines.

- **Simplify refills.**
 - Reduce how frequently patients need refills. Many prescriptions can be reasonably prescribed with a 90-day supply.
 - Prescribe refills for a year whenever it is reasonable. At a minimum, ensure that there are enough refills to last until they next need to check in with a clinician.
 - Synchronize the dates medicines need to be refilled whenever possible, so patients can make fewer trips to the pharmacy.
- **Find out if patients would like medicines mailed to them** instead of having to pick them up at the pharmacy.

Help patients remember to take their medicines.

- **Ask patients if they would like help remembering to take their medicines.** You might say, "Everyone forgets to take their medicine from time to time. Would you like to talk about ways to make it easier to remember to take your medicine?"
- **Suggest they create a routine** to take medicines with activities they do at the same time each day (e.g., meals, brushing teeth).
- **Provide pill organizers, and teach patients and caregivers how to fill them** using their medicine list as a guide.
- **Enlist help from family members.** Family members can play an important role in reminding patients to take medicines, filling pill boxes, or setting up electronic reminders.
- **Review options for electronic medicine reminders.** Offer help in choosing and setting up technologies that can remind patients to take medicines. These include:
 - Setting alarms on phones, watches, timers, tablets, voice assistants, or talking clocks.
 - Medicine reminder apps. Offer assistance in selecting an app and downloading or entering their medicine information into it. If your EHR has an easy-to-use medicine reminder app, using it will reduce the chance of errors being introduced when entering information.
 - Smart pill bottles and pill boxes that sound an alarm, flash lights, or send a message when it is time to take pills. These are available online and at some pharmacies.

- **Publicize ways you can help.** Hang the [Help with Medicine Poster](#) in your exam room or waiting rooms.
- **Document reminder strategies,** so everyone can reinforce them or suggest new strategies if needed. If you have an EHR, coordinate across the practice so everyone documents reminder strategies in the same location—one that you can query.

Track Progress

One month after implementing this tool, ask for volunteers at a staff meeting to use [Role Play 2](#) in the appendix. See how well they do and whether others can identify possible improvements.

Before implementing this tool, randomly select at least 20 medical records of patients who regularly take medicines and were seen in the last week. Identify the percentage of patients who take medicine and had a medicine reminder strategy documented in their medical record. Check again in 2, 6, and 12 months.

Before implementing this tool and 2, 6, and 12 months later, collect patient feedback on a selection of questions about this tool from the [Health Literacy Patient Feedback Questions](#).

Refer to [Tool #2: Assess Organizational Health Literacy and Create an Improvement Plan](#) to learn how to use data in the improvement process.

Get Patient Feedback: Tool #17

Overview

Frequently, practices are unaware of how hard patients find reading and completing forms, understanding health information, and navigating the healthcare system. Patients are in the best position to help you identify areas for health literacy improvement.

Action

Use multiple ways of gathering patient feedback.

Shadow patients.

- Have someone (like a nurse or patient educator) quietly observe a patient throughout a visit. Shadowing can provide valuable insight into how a patient experiences your practice. The presentation [Navigating the Health Care System](#) describes the kinds of information you can obtain by shadowing a patient.
- Decide how many patients to shadow and the timeframe within which you would like to complete the shadowing.
- Select diverse patients to shadow who represent the range of patients your practice sees. Consider age, race, ethnicity, language, and health issues. A mix of new patients and patients who have been with your practice for years is ideal.
- Before their appointments, tell selected patients about your goal of improving patients' experiences in the practice and ask if an observer can go along with them during the visit. Be aware that not all patients will want to be observed.
- When shadowing patients:
 - Stay with them from the time they arrive until they leave. Try to arrange to meet new patients outside your building to see how easy it is to find your practice's entrance and check-in desk.
 - At the end of the visit, ask the patient what went well and what was difficult about the visit.

- Complete a [Communication Observation Form](#) after each visit observed. This form focuses on the quality of communication with the patient. You can add questions to the form to address other topics your practice is interested in.

Conduct a walk through.


- Have a person unfamiliar with the practice walk through it with a staff member and give feedback on the signage and the physical environment.
 - Be sure that anyone who conducts a walk through will not observe any private or confidential interactions.
 - Consider recruiting a student from a local adult education program to conduct a walk through.

Observe patients using your patient portal.

- If you have a patient portal, ask several patients if you may observe while they use the portal. Try to include patients who are not very experienced using computers.
- Watch patients log in. Ask what they would do if they forgot their user id or password to make sure instructions on the home page are clear.
- After you let them explore the portal, ask them to complete a specific task (e.g., find information on a particular topic, look up their lab results, request a prescription refill), and ask them to describe what they are doing. Observing how patients use the portal will help you know where changes in appearance, wording, organization, or navigation of the portal may be needed.
- The [Patient Portal Feedback Form](#) contains a list of questions you can ask to gather feedback from patients about their experience using the portal.
- Discuss the feedback you collect with your patient portal vendor, and explore ways to address problems patients are experiencing.

Engage patient and family advisors.

- Having patient and family advisors (PFAs) provides opportunities to:
 - Learn from patients and families.
 - Get feedback on patient education materials.
 - Receive input on policies that affect patients and families.
 - Connect with the community you serve.

- Integrate patient and family perspectives into improvement teams.
- Larger practices may want to establish a standing patient and family advisory council (PFAC). Having virtual and hybrid meetings may help you recruit and retain diverse members.
- You can find information on recruiting and working with PFAs and forming a PFAC from the [Institute for Patient- and Family-Centered Care](#) .

TIPS: Getting feedback on materials

Find out what patients think of your materials by asking neutral, open-ended questions, such as:

“What do you think the key points are?”

"Which parts are easy to understand and which parts are hard to understand?"

“What questions do you have after reading/watching this?”

"What, if anything, would you do anything differently after reading/watching this?"

"What was helpful and what was not helpful?"

“Does it seem friendly and supportive?”

"Is there anything offensive?"

“Do you have any other reactions you would like to share?”

You can also get patient feedback using other methods, such as asking them to "think aloud" while reading or watching the material or asking them to demonstrate how to follow the instructions in the material.

Have a suggestion box.

- Let patients and family know you want to hear about any difficulties they have understanding information they have been given or getting the help they need. Use this [poster](#) to encourage patients to suggest ways your practice can improve.

Survey your patients.

- **Conduct quick, informal surveys** to help you assess your health literacy improvement efforts. Learn more about the Plan-Do-Study-Act (PDSA) method to refine the changes you make in [Tool #2: Assess Organizational Health Literacy and Create an Improvement Plan](#). You can also use data your practice already collects from formal patient experience surveys, such as the [CAHPS® Clinician & Group Survey](#).
- **Choose survey questions.** Choose a few questions that will supply feedback on the changes you are planning or have made. Keep surveys short. Sources of questions include the following.
 - The [Health Literacy Patient Feedback Questions](#) contains questions on spoken and written communication, self-management support, and other supportive systems. Note that these questions were designed to collect information informally for quality improvement work on tools in this Toolkit and are not validated.
 - The CAHPS [health literacy](#) and [interpreter services](#) questions were designed to be used with the CAHPS Clinician & Group Survey. Learn more about the [CAHPS Health Literacy Item Sets for Addressing Health](#).
- **Choose which patients to survey.** Your goal is to get feedback from diverse patients in terms of demographics and health conditions.
 - Make sure that the patients you ask to complete the survey are able to observe and report on changes you have made. For example, if you have implemented [action planning](#) only with patients with certain conditions, you will want to survey patients who have those conditions.
 - You can use a convenience sample of patients instead of choosing patients randomly. Be aware that a convenience sample will not be representative of your patient population. You can add a few demographic questions to your survey to

check that your sample is diverse. Pursue responses from patient populations that are not represented.

- **Choose how many patients to survey.** Small samples can give you quick feedback as you refine improvements. The larger the number of patients who respond to your survey, the more confident you can be in the results. If you want more reliable information, try to obtain 50 completed surveys.
- **Choose how to administer the survey.** Surveys can be conducted in-person, by phone, on the web, or by mail. There are pros and cons to each approach.
 - **In-person surveys** are convenient. Check-in staff can ask each patient if they would be interested in providing feedback to improve care. If they say yes, ask patients to complete the survey at the end of their visit, before they leave.
 - Be aware there will be bias in your sample. In addition to having more people who make frequent visits, your sample will probably include fewer patients with Medicaid or Medicare, patients who are Black, and patients with incomes below \$25,000, since [they are all more likely to use telehealth](#).
 - Having someone ask the questions rather than filling out a paper makes participating easier for patients with limited literacy skills. However, patients may be concerned about providing negative feedback to staff they know. Try to identify a volunteer from outside the practice who can collect survey data. Talking tablets is another option.
 - **Phone surveys** can reach a more representative sample of patients, but because few people respond to phone surveys there may be other biases. Phone surveys overcome literacy barriers and are sometimes used as a followup to a mail survey.
 - **Mail surveys** are less expensive than phone surveys but typically have lower response rates.
 - Use a [plain language cover letter](#) to introduce and explain the purpose of the survey.
 - **Web-based** surveys can make it easier to collect and analyze data but are less likely to get responses from people who do not use computers much.

- Consider providing an audio option to address literacy barriers.
- Using your patient portal to survey patients creates a bias, since [portal users](#) are more likely to be younger, white, privately insured, and have a higher income than patients who do not use portals.
- **Give patients a choice and assure confidentiality.** Regardless of how you collect data:
 - Make it clear that whether a patient provides feedback or not is their choice, and their care will not change if they say no.
 - Let patients know that their responses will remain private—their providers will not see their responses or even know that they completed the survey.

Act on your results.

- **Bring aggregated results back to the [Health Literacy Team](#).**
 - Devise a system for ensuring that patients' individual responses are not linked to them in an identifiable way, and only aggregate results are shared.
 - Identify areas for improvement.
 - Use [Tool #2: Assess Organizational Health Literacy and Create an Improvement Plan](#) to identify tools that can address areas identified for improvement. Plan, implement, and test changes to see if they addressed the concerns identified.
- **Collect patient feedback as a routine part of your quality improvement activities.** Obtaining patient feedback is not a one-time activity; it should be done on a routine basis. Consider obtaining feedback from a sample of patients every quarter.

Track Your Progress

The [Health Literacy Team](#) should examine efforts to obtain patient feedback. Ask yourselves:

- Have you carried out plans to obtain patient feedback? For example, were you able to shadow the number of patients you wanted to, and did you complete the process in your allotted time?

- Have you used multiple methods to obtain patient feedback?
- Have you obtained feedback from a sample of patients who are of varying ages, racial/ethnic/language groups, health conditions, and genders?
- Have you identified improvement goals based on feedback?
- Have you implemented improvement plans?

Attend to Social Needs: Tool #18

Overview

Unmet social needs can harm patients' health. Patients may need assistance with food, housing, transportation, employment, budgeting, and legal matters. Linking patients with available community resources helps reduce barriers to good health. To help patients navigate their way to assistance, practices can learn about the resources available in the community, be sensitive and caring when asking about social needs, direct patients to resources, and follow up to ensure that the connections are, in fact, made. In addition to helping your patients achieve better health, you may benefit financially if you receive payments based on measures of patient outcomes or incentives for screening for and attending to social needs. Having a way to link patients with community resources can also reduce care team stress and burnout.

TIP

Attending to patients' social needs is not simple. Patients may be hesitant to share information about their social needs. Find additional resources in the appendix to help you prepare: [Additional Resources for Attending to Social Needs](#).

Actions

Consider who in the practice will work on assisting patients with social needs.

- **Decide whether existing staff can take on new roles.** Are there people in the practice who can conduct assessments, identify and update community resource lists, establish relationships with community organizations, help with applications for assistance, refer and follow up with patients, and review aggregate data?
- **Explore options for augmenting staff.** For example, could you share a community resource specialist with other practices? Is there someone in the community who plays that role that you could partner with?

Decide which social needs to screen for and which screeners to use.

You can take an incremental approach and screen for one or two social needs, then add others as resources become available. Food, housing, and transportation are common priorities.

- Use community health assessments and talk with advisors from the community to find out which needs are most urgent in your area.
- Think about how you will use the information when deciding what information to collect. You might use the information for:
 - **Patient care.** Responses to positive screens include education and counseling, assistance, and referral. In addition, clinicians could use screening results to engage patients in [shared decision making](#) and help them choose treatments that are a good fit for them. Screening results could also trigger conversations about healthcare costs. Go to [Tool #23: Talk About Costs](#) to learn more.
 - **Population health.** Aggregate data on your patients' social needs will help you select the types of assistance and referral arrangements to put in place.
 - **Advocacy.** Documenting unmet needs can help with advocating for more resources for your community. It can also help with advocacy within your organization for attending to social needs.
- **Consider using standardized screening questions.** You can find links to tools and guides on screening for social needs in the appendix, [Additional Resources for Attending to Social Needs](#). Check if your electronic health record (EHR) has embedded social needs screeners.
- **Check requirements and recommendations for social needs screening.** More organizations such as State Medicaid agencies, Medicare, commercial health plans, and accreditors (e.g., The Joint Commission, NCQA) are promoting or requiring screening.





Decide whom to screen, how, and how often.

- **Decide which patients to screen.** While assessing the needs of all patients is ideal, you might want to start with certain populations. For example, patients with diabetes are often a priority due to the impact of food insecurity on their condition.
- **Choose how to administer the screener.** [Identifying and Addressing Social Needs in Primary Care Settings](#) discusses the tradeoffs between self-


administered and staff-administered screening, as well as between on-site and at-home screening.

- **If screeners are staff-administered, train staff** in skills to build trust with patients, such as using active listening, empathetic inquiry, cultural humility, and trauma-informed and asset-based approaches. People conducting social needs assessments should be aware of conditions in the community and their own potential biases about who they think needs help. Training can ensure that social needs are assessed in a way that is sensitive and does not stigmatize anyone.
- If the screening takes place on site, make sure it is done in a private space. Give patients the choice of excluding companions from the screening discussion.
 - **If screeners are self-administered**, make sure the screener is in plain language and available in the languages your patients read.
- If on site, offer to read the screener to all patients.
- If patients complete screeners at home, provide a phone number they can call to get help completing it.
- **Screen for social needs at least once a year.** Social needs can change quickly, so consider which patients you might want to screen more often.

Identify your community resources.

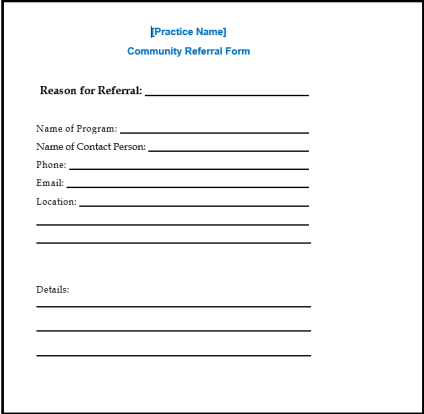
- **Work with community leaders** to find out about resources.
- **Use social health referral platforms**, such as [2-1-1– Information & Referral Search](#), [findhelp](#), and [one degree](#) to find resources near you. Find more resources in the appendix, [Additional Resources for Attending to Social Needs](#).
- **Partner with community organizations.** Establish referral agreements with community service providers so they accept your referrals and let you know when the referral is completed. This [Memorandum of Understanding](#) between a food bank and a health clinic is an example. Go to [Tool #21: Make Referrals Easy](#) for information on establishing referral agreements, and on supporting and following up on referrals.
- **Keep resources up to date.** Ask patients to let you know if they cannot reach a community resource or have a negative experience. Establish a schedule for verifying whether resource information is still accurate.

Assess patients' social needs and support systems.

- **Explain why you are asking questions about their social needs, who will see the information, and how you will use it.** This may overcome feelings of shame or fear that the information will be used against them (e.g., reporting their housing instability to child protective services).
- **Find out if any social needs are urgent.** If they screen positive for any social needs, it is important to know how quickly they need help.
- **Consider asking patients open-ended questions about things that may affect their ability to manage their health.** For example, you could ask, "Is there anything in your daily life that makes it hard to take care of your health?"
- **Ask about and involve the patient's current support systems,** such as family, friends, social workers, and care managers. Find out and note in the medical record the role each member of the support system plays in the patient's care. Never contact members of the support network or share information without the patient's explicit permission. Be aware that some information may be difficult for family members or friends to hear about.
- **Document patients' social needs and support system in your EHR.** Use [ICD-10-CM Z codes](#). Establish a place in the EHR to document other social needs and social support, and make sure everyone in the practice documents in the same way.

Connect patients with resources.

- **Ask patients if they want information, resources, or to be referred to community organizations.** Patients may not want or need help at that time or may distrust organizations they do not know. If patients screen positive for multiple social needs, help them prioritize.
- **Make a referral.** Two methods of referral are:
 - **Direct referrals.** You may be able to send an electronic referral from your EHR or other online platform. If not, you can call the agency, preferably in the presence of the patient. Give patients a [Community Referral Form](#) to record the details.




The form is titled "[Practice Name] Community Referral Form". It contains the following fields:

- Reason for Referral: _____
- Name of Program: _____
- Name of Contact Person: _____
- Phone: _____
- Email: _____
- Location: _____
- _____
- _____
- Details: _____
- _____
- _____

- **Self-referral.** Patients may choose to contact the organization later. Give them a [Community Referral Form](#) to provide essential information about available services.
- **Help patients apply for benefits or services.** If an application is required to receive benefits or services, offer help in completing it. Find out about community agencies, community health workers, and case workers that can help people with applications for public assistance, public housing or housing subsidies, food aid, or other services. Also check the appendix [Resources for Financial Assistance for Medicine](#) for services that assist with medicine costs.
- **Follow up.** Find out if the referral was completed by contacting the service provider. Document the outcome in the patient's record. Go to [Tool #6: Follow Up with Patients](#) for more information about different ways to follow up.

TIP

Certify a Notary Public. Select one person in the practice to become a Notary Public. This can help expedite completion of application forms and eliminate an additional step for patients. The following link provides access to a [Notary Public training course](#).

Track Your Progress

Periodically test whether your resource list is up to date. Call four randomly chosen service providers and verify their information.

Review 10 records of patients who are supposed to be screened for social needs. Check:

- Were patients screened at least once in the past year?
- Were patients' support systems recorded in the right place?
- Did patients who screened positive for at least 1 social need receive a response (e.g., education, counseling, assistance, or referral) within 30 days of the positive screen?
- Was the outcome of a referral made at least 1 month ago documented in the record?

Repeat in 2, 6, and 12 months.

Before implementing this tool and 2, 6, and 12 months later, collect patient feedback on a selection of questions about this tool from the [Health Literacy Patient Feedback Questions](#).

Refer to [Tool #2: Assess Organizational Health Literacy and Create an Improvement Plan](#) to learn how to use data in the improvement process.

Help Patients Pay Less for Medicine: Tool #19

Overview

Medicine is an important component of many patients' treatment regimens. Unfortunately, patients sometimes try to save money by reducing the amount of medicine they take or not taking their medicine at all. Helping patients reduce the cost of their medicine may make them more likely to take it and may help them afford other things important to their health.

Action

Consider whether patients can take fewer or less expensive medicines.

- **Deprescribe medicines** that patients no longer need or are causing more harms than benefits. Use [guidelines for deprescribing](#) to reduce doses or discontinue medicines safely.
- **Switch drugs to generics, over-the-counter medicines, or less expensive brands** when safe and effective.
- **Prescribe 90 days' worth of medicine** to reduce copays, if appropriate.
- **Prescribe medicines with low or no copays**, which will depend on the patient's insurance coverage.

Assess patients' ability to pay for their medicines.



- **Ask patients if they have difficulty getting their medicines.** Be sensitive to potential embarrassment. For example, you can ask one of these questions:
 - "Have you ever been unable to get medicine when you needed it?"
 - "Have you ever delayed taking medicine or taken less to make it last longer?"
 - "Is the cost of any of your medicines a burden for you?"
- **Document** patients' responses in a consistent place in the medical record.
- **Let patients know you want to help.** Emphasize how important it is for them to take their medicines. [Tool #23: Talk About Costs](#) provides more information about having these conversations. [Tool #16: Help Patients Take](#)

[Medicine Correctly](#) has suggestions on what to do if the barriers to getting medicine are not financial.

Fact

[According to the National Center for Health Statistics](#), 9.2 million adults (8.2%) between the ages of 18 and 64 report not taking medicines as prescribed due to cost. The rates for people with disabilities (18%), people in fair to poor health (20%), people with low income (14%), and people with no insurance (22%) were much higher.

Help patients find financial assistance or less expensive medicines.

- **Connect patients with medicine assistance programs.** [Resources for Financial Assistance for Medicine](#) provides links to services that help patients reduce their medicine expenses. Help patients find a program that fits their needs and help them apply.
- **Help patients shop around for the best price.** Prices for medicines can vary greatly. Mail-order pharmacies can sometimes provide chronic disease medicines at a lower cost, and they eliminate the need to pick up medicines from a pharmacy. Some pharmacies offer reduced prices for specific medicines for eligible people or general discount cards. Educate patients that they should give their medicine list to all the pharmacies they use, so pharmacies can identify harmful drug interactions and other safety problems.
- **Make sure Medicare patients have [Part D drug coverage](#).** People can get help enrolling in Part D from [State Health Insurance Assistance Program \(SHIP\)](#)  counselors or the [Medicare Rights Center](#) .
- **Document** what assistance you gave them, schedule a [followup](#) to see if they need further help, and document the results of the followup.

Track Your Progress

Track over time how many patients you identified as needing assistance paying for their medicines, and note the services the practice provided.

Before implementing this tool, randomly select at least 20 medical records of patients who regularly take medicines and were seen in the last week. Calculate the percentage of patients whose ability to pay for medicine was assessed and

the percentage of those in need who received assistance. Check again in 2, 6, and 12 months.

Choose a sample of patients whom you have referred to insurance or medicine assistance programs. Check whether there was [followup](#) within 1 month, and find out how many have obtained insurance or other help paying for medicine.

Before implementing this tool and then again 2, 6, and 12 months after implementation, collect patient feedback on a selection of questions about this tool from the [Health Literacy Patient Feedback Questions](#).

Refer to [Tool #2: Assess Organizational Health Literacy and Create an Improvement Plan](#) to learn how to use data in the improvement process.

Connect Patients with Literacy and Math Resources: Tool #20

Overview

According to a [national survey](#), almost one quarter of working-age adults in the United States have low literacy, and a third have trouble with basic math. The proportions are higher for older adults. For these patients, referral to an adult learning center for literacy and math classes can be a life-changing event. Patients are unlikely to mention limitations in their literacy or math skills unless you initiate a conversation.

Practice Experiences

"I was surprised that patients were overwhelmingly receptive to questions like, 'Are you interested in improving your reading skills?' Our eyes were really opened up by the literacy resources in our community and how easy it is to talk to people about them."

—Rural family medicine practice

Action

Identify community resources.

- The [National Literacy Directory](#) identifies local resources to provide help with reading, math, GED, and English for speakers of other languages.
- Contact resources in your community to verify their services and how to make referrals.
- Regularly update resource information.

Assess interest.

- **Ask everyone, "Are you interested in improving your reading or math skills?"** [Research](#) has shown that clinicians are not good at identifying which patients have limited literacy. Asking directly eliminates guesswork. Adding a question to intake forms is not enough, since patients with literacy challenges may leave forms incomplete.

- **Offer to assist.** For example: “I know of some resources in the community. Would you like more information?”
- **Document** patients’ responses in a consistent place in the medical record.

Connect patients to literacy and math resources.

- **Make a referral.** Two methods of referral are:
 - **Direct referrals.** You may be able to send an electronic referral from your electronic health record (EHR) or other online platform. If not, you can call the agency, preferably in the presence of the patient. Give patients a [Community Referral Form](#) to record the details.
 - **Self-referral.** Patients may not be ready to commit. Give them a [Community Referral Form](#) to provide essential information about available programs.
- **Document the referral.** Identify a place to document referrals to literacy and math programs in the medical record, and train staff to document referrals consistently.
- **Follow up.** Find out if the referral was completed by contacting the service provider. Document the outcome in the patient’s record. Go to [Tool #6: Follow Up with Patients](#) for more information about different ways to follow up.

[Practice Name]
Community Referral Form

Reason for Referral: _____

Name of Program: _____

Name of Contact Person: _____

Phone: _____


Email: _____

Location: _____

Details: _____

Research Findings

Depression symptoms lessened among patients with low literacy after a clinic referred them and they participated in adult basic literacy education.

—[Francis et al. 2007](#) 

Track Your Progress

Test whether your community resource list is up to date. Call four service providers and verify their contact information.

Before implementing this tool, choose at least 20 medical records at random of patients seen in the past week, and check whether they record information about literacy and math skills. Repeat in 2, 6, and 12 months to see if the medical records are more complete.

Track how many referrals are made in a month and then again 2, 6, and 12 months after implementing this tool. If you have an EHR, you can generate a tracking report from the system. Otherwise, collect copies of the Community Referral Forms to track referrals.

Note five literacy or math referrals you made. Check the medical record after 1 month to see if the outcome of the referral is documented. Repeat in 2, 6, and 12 months to see if the medical records are more complete.

Before implementing this tool and 2, 6, and 12 months later, collect patient feedback on a selection of questions about this tool from the [Health Literacy Patient Feedback Questions](#). Refer to [Tool #2: Assess Organizational Health Literacy and Create an Improvement Plan](#) to learn how to use data in the improvement process.


Make Referrals Easy: Tool #21

Overview

Primary care practices refer patients to specialists, ancillary healthcare clinicians, labs and screening facilities, and elsewhere. Making the referral process easy for patients increases the chances that they will follow through. Establishing referral agreements ensures that both you and the referral destination get all the information you need.

Action

Refer patients to clinicians who coordinate care with you.

- Identify, develop, and maintain relationships with places you refer patients to.
- Try to establish formal referral agreements with key specialist groups and other clinicians.
- Do not continue to refer patients to clinicians who do not send information back to you, do not provide timely appointments for your patients, or consistently get negative reports from patients.
- You can find more information in the guide [Referral Management](#).

Referral Agreements

Referral agreements spell out mutual expectations and responsibilities, such as:

Which patients are appropriate to refer.

Use of an e-referral system or other referral procedures.

What information is shared before and after a referral.

Setting aside appointments for urgent referrals.

Roles for both parties after the referral.

Do not rely on patients to relay information.

- **Provide a detailed referral to the other clinician** that contains all the information needed, such as the reason for the referral, pertinent medical history, medicines, and test results.
- **Get information sent directly back to you.** Make sure you get a full report back before your patient's next visit.
- **Explore making electronic referrals.** Check whether your electronic health record is able to make referrals directly to other clinicians. If not, self-standing referral management systems are commercially available for purchase.

Consider language differences.

- When making referrals for patients who use languages other than English, identify clinicians who speak those languages or confirm they use qualified interpreters. Go to [Tool #9: Address Language Differences](#) for more information on language access.
- Include information on your patient's language access needs when making the referral.

TIP

Consider whether you could avoid a referral by having a telephone or electronic consultation with a specialist. Advice and guidance may be enough to let you deliver the needed care.

Consider costs when making referrals.

Before making a referral, check whether the:

- Clinician or facility you are referring to participates in the patient's insurance plan.
- Patient has out-of-network benefits and wants to consider non-participating providers.
- Procedure or test you are referring the patient to requires prior approval with their insurer.

Make sure the patient understands the reason for the referral.

- Explain why the patient needs to be seen by someone else, and what might happen if they do not go.
- In the case of tests, explain how you and the patient will use the information to diagnose, manage, or decide on treatments for health conditions.
- In the case of screenings, give a clear explanation of the risks, harms, benefits, options. Ultimately, it is up to the patient as to whether or not to undergo any particular test or screening.
- Ask about and discuss any concerns or fears.
- Use the [teach-back method](#) to confirm you have been clear.

Offer help with the referral.

- Decide who in the practice will coordinate referrals.
- Ask patients if they would like help making the appointment.
 - If staff members are making appointments for patients, make sure they first find out when the patients are available.
 - If staff members are not making appointments for patients, ask patients to call the practice if they cannot get an appointment soon enough. You may be able to get an earlier appointment or refer to the patient to someone else who has more availability.
- Ask patients about transportation and other barriers to their completing the referral. Discuss how they could overcome these barriers. Use [Tool #18: Attend to Social Needs](#) to help them get services that could support their completion of the referral.

Provide clear instructions.

- For some referrals, patients will need to prepare in advance (e.g., fast, discontinue a medicine). Go over instructions with them and provide them in writing.
- Explain the referral process fully (e.g., how you and the other clinician will exchange information, when the patient should return to your office).
- Go over [clear written directions](#) on how to get to the referral location.
- Use the [teach-back method](#) to confirm patient understanding.

Follow up on referrals.

- Establish a process for tracking referrals, especially for high-risk or urgent referrals.
- Confirm and document whether the patient successfully completed the referral.
- Obtain information on the result of the referral and document in the medical record.
- [Follow up](#) with the patient on the results of any tests or screenings, even normal results. For more information, go to [Improving Your Laboratory Testing Process: A Step-by-Step Guide for Rapid-Cycle Patient Safety and Quality Improvement](#).
- Provide patients positive feedback for completing referrals. Let patients see how you use the information obtained from tests or specialist visits.
- If the patient has not completed the referral, find out why, review the reasons you think the patient could benefit, and discuss barriers.
- Determine whether the patient needs additional referrals.

Track Your Progress

Select at random the records of at least 20 patients who you referred to other clinicians a month ago. Calculate the percentage of patients whose referral results are in their medical records.

Select at random the records of at least 20 patients who were sent for lab tests a month ago. Calculate the percentage of patients who have completed the test and the percentage of those who have been notified of the test results.

Before implementing this tool and 2, 6, and 12 months later, ask a sample of patients who have not completed referrals why they did not follow through. Develop and implement improvement plans to address the reasons they give.

Before implementing this tool and 2, 6, and 12 months later, collect patient feedback on a selection of questions about this tool from the [Health Literacy Patient Feedback Questions](#).

Refer to [Tool #2: Assess Organizational Health Literacy and Create an Improvement Plan](#) to learn how to use data in the improvement process.

Include Family and Friends: Tool #22

Overview

According to [studies](#), patients report being more likely to understand and follow clinicians' advice, discuss difficult topics, ask questions, and be more satisfied when family members or friends participate in medical visits. Clinicians also report understanding patient concerns better when family members or friends participate in medical visits.

Benefits of Companions

Having a companion at a visit is valuable for everyone, not just older adults or people with cognitive impairments. Family members or friends can:

Help prepare for the visit (e.g., write down symptoms and questions).

Remind patients of what they wanted to tell or ask the clinician.

Engage the patient in decision making.

Alert the clinician if the patient seems not to understand or appears uncomfortable with what is being said.

Provide emotional support, encouragement, and reassurance to the patient.

Take notes, and help the patient remember instructions and followup tasks.

Action

Prepare staff and clinical teams.

- Define roles of staff in welcoming family and friends, and provide appropriate training.
- Prepare the clinical team to use conflict resolution techniques in case there are disagreements between the patient and their companion.

Let patients know that family and friends are welcome.

- Have staff who make appointments let all patients know they can bring a family member or friend. For example, staff might say, “Will anyone be joining you?” or “The doctor wants you to know that you are welcome to bring a family member or friend with you, if you like.”
- If you have an online appointment system, add a statement that encourages patients to bring family and friends. List the possible roles family and friends can play. For example, “A family member or friend can remind you about symptoms to report or questions to ask, provide you with support, and help you with followup tasks.”
- When sending appointment reminders, reinforce that family and friends are welcome.
- At the end of a visit, have clinical team members tell patients that they’re welcome to bring family and friends to the next visit.

Make family and friends feel comfortable.

- Greet family and friends warmly, introduce yourself, and ask them to introduce themselves.
- Confirm with patients that they want the family member or friend to participate.
- Let companions know that they are part of the care team while also requesting them to let the patient speak first.
- For in-person visits:
 - Have an extra chair near the patient so you can easily look at both of them.
 - Offer a [Note Sheet](#) (or [Note Sheet in Spanish](#)) and pens to take notes.

- For video visits, ask them to position the camera so you can see both the patient and the family member or friend.

Engage both the patient and their family member or friend in the discussion.

- Speak directly to the patient, while including family and friends in the conversation.
- Enlist the help of family or friends if you're having trouble making yourself understood. Family and friends may be able to identify the source of the difficulty or suggest other phrasing.
- Do not let family or friends dominate the conversation at the expense of patient participation. Family and friends often provide useful additions to what patients say, but the focus should remain on the patient. If a family member or friend is hijacking the agenda, gently return to the topic the patient wants to talk about.
- Do not rely on family or friends to interpret for patients who prefer a language other than English.
 - Untrained interpreters are more likely to make clinically significant mistakes. Use qualified interpreters. Refer to [Address Language Differences: Tool #9](#).
 - If patients prefer, they can have family or friends interpret for them. However, you should always have a qualified interpreter present to make sure no errors are made.

Ensure patients get private time.

- It is important to have private time to talk with patients confidentially about sensitive topics such as abuse, incontinence, sexual health, unhealthy substance use, mental health, or memory impairment.
 - You could say to the companion, "I like to spend the last 5 minutes of every appointment with just my patient. Please wait in the lobby."
 - If questioned, you can respond, "This is routine in my practice. I'm sure you understand. They'll be right out."
 - Be firm—don't make exceptions.

Track Your Progress

Monitor the impact of your effort using the following suggestions before implementing this tool and 2, 6, and 12 months later.

- Over the course of a week, have check-in staff keep track of the number patients who do and don't bring someone to the visit. Record the percentage of patients who brought someone with them.
- Over the course of a week, have check-out staff ask patients who did not bring a companion, "Did you know that you're welcome to bring a family member or friend to visits?" Record the percentage of patients who answered "No."

Before implementing this tool and 2, 6, and 12 months later, collect patient feedback on a selection of questions about this tool from the [Health Literacy Patient Feedback Questions](#).

Refer to [Tool #2: Assess Organizational Health Literacy and Create an Improvement Plan](#) to learn how to use data in the improvement process.

Talk About Costs: Tool #23

Overview


A majority of people want to receive cost information from their healthcare teams, but relatively few talk about costs with their providers. Nearly one in five people are unable to get or must delay healthcare because of cost. Having clear and understandable cost information helps people make decisions and plan accordingly. The [No Surprises Act of 2021](#) seeks to prevent unexpected charges. Your State may have additional requirements about providing cost estimates.


Patients may be embarrassed to ask about costs or worry that providers will not offer the full range of treatment options if they think cost is an issue. Practices should take the initiative of raising the topic and making sure they have resources to address concerns. Talking about costs lets people make informed healthcare decisions and budget so they have enough money to afford their healthcare.

Action

Create a culture that welcomes patients' questions and concerns about the costs of their care.

All patients should receive understandable, useful, accurate information about the expected costs of care in advance.


- **Teach everyone** about the importance of having cost conversations. The website [Cost of Care Conversations: Provider Tools](#) provides educational and implementation resources.
- **Involve the whole team** in making sure **all** patients have an opportunity to talk about costs. For example:
 - Check-in staff can say, “We encourage you to ask questions about costs so that you have all of the information you need.”
 - Medical assistants can ask patients after they see the clinician, “Would you like to meet with a member of our staff to talk about the costs of the treatment options you discussed?”
 - Have check-out staff ask, “Have you had all your questions about costs answered?”

- **Hang posters** in your patients' preferred languages that promote cost conversation. The brief [How To Welcome Cost-of-Care Conversations in Your Practice](#)  shows examples of posters. Possible messages include:
 - Ask your provider about costs.
 - Concerned about costs? Talk to us. We want to help!
 - Talk to our cost counselor about what your insurance covers.


Integrate cost into discussions about testing and treatment options.

- **Include cost as a normal part of the clinical conversation.**
 - Use available resources to find out about costs. For example, your electronic health record may tell you whether a medicine is covered by the patient's insurance.
 - If you do not know the exact costs, share relative costs (e.g., this option is typically twice as expensive).
- **Acknowledge non-healthcare costs** involved in treatment. Patients care not only about the money they have to spend on treatment, but also about indirect costs. They may lose income because they have to take time off work or have transportation or childcare costs. For example:
 - "I know getting to visits or taking time off work can be hard. For the physical therapy option, you would need to visit the therapist two times a week. Each visit lasts about an hour, and you'd need to go for 2 months. Would that be a problem for you?"
- **Help patients think about the cost-benefit tradeoffs.**
 - Use decision aids that can help patients clarify whether they think the benefits of an option are worth the costs.
 - Ask them if paying would pose a hardship for them. For example,
 - "If you had to pay [\$] for this treatment, would you have to skimp on other healthcare or make sacrifices in other areas of your life?"
 - "Is the cost of any of your medicines a burden for you?"
- **Ask patients if they would like to learn about how to get help paying for their healthcare.** For example, you could say, "Healthcare can be expensive. Would you like to talk to someone about options for getting help paying for your treatment?"

Designate someone in the practice to be a cost counselor who can provide accurate, understandable information about patients' share of cost.

- **Establish a workflow** that gets patients to the cost counselor.
- **Ensure privacy.**
 - Create spaces where you can have cost conversations without being overheard.
 - If the patient is a minor, talk to the responsible adult about costs out of the child's hearing.
 - Ask patients whether they want people accompanying them (e.g., a family member, friend, or caregiver) to participate in the cost conversation.
- **Help patients find out about their coverage.** Use online [insurance query systems](#). Make inquiries directly with insurers on behalf of patients when information is not available online.
- **Make it easy for patients to estimate and understand costs.**
 - Calculate total costs for patients. For example, if there are going to be multiple episodes (e.g., a series of injections) give them the cost for the entire course of treatment.
 - Print out the cost of options under discussion so patients can consider them at home.
 - Add a cost calculator to your website.
- **Encourage patients to alert the practice if they are not able to follow through on their treatment plan because of cost.** For example, you could include instructions on when to be in touch along with contact information for the cost counselor on After Visit Summaries. Cost counselors can connect patients with their clinician if treatment plans need to be adjusted.

Refer patients with financial needs to resources.

- **Help uninsured patients get insurance.**
 - Refer patients to your State's Marketplace, where they can apply for insurance, including Medicaid and subsidized private insurance. Use the [online directory](#) to find your State's Marketplace, which will have information about getting help with applications.
 - Patients who may be eligible for Medicare can help with the application from the [Medicare Rights Center](#) by calling their

hotline at 800-333-4114. Professionals can send questions on behalf of patients to profesional@medicarerights.org.

■ **Learn about programs that can provide financial assistance for healthcare.**

Options include:

- Programs that provide assistance for specific conditions, such as the [Patient Advocate Foundation Financial Aid Funds](#) and [Co-Pay Relief](#), [Accessia Health](#), and [Good Days](#).
- [Programs that help pay for medicines.](#)

Track Your Progress

Track the proportion of staff who have been taught about importance of cost conversations.

Before implementing this tool, and 2, 6, and 12 months later, conduct a survey of staff opinions on the importance of having cost conversations. Go to the [appendix for suggestions for survey questions](#).

Track the percentage of patients who met with the designated cost counselor and the number who were referred to financial assistance programs at 2, 6, and 12 months.

Before implementing this tool and 2, 6 and 12 months later, track the percentage of patients are late or have not paid their bills.

Before implementing this tool and 2, 6, and 12 months later, collect patient feedback on a selection of questions about this tool from the [Health Literacy Patient Feedback Questions](#).

Refer to [Tool #2: Assess Organizational Health Literacy and Create an Improvement Plan](#) to learn how to use data in the improvement process.

Appendices

Primary Care Health Literacy Assessment

Please select **one answer** that most accurately describes your practice:

Doing Well

Needs Improvement

Not Doing

Not Sure or N/A

Our practice is doing this well

Our practice is doing this, but could do it better

Our practice is not doing this

I don't know the answer to this question **OR**

This is not applicable to our practice

1. Prepare for Practice Change

	Doing Well	Needs Improvement	Not Doing	Not Sure or N/A	Tools to Help
1. Our health literacy team meets regularly.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1-Form Team
2. Our practice regularly reassesses our health literacy environment and updates our health literacy improvement goals.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2- Assess OHL & Create Plan 13-Welcome Patients 17- Patient Feedback
3. Our practice has a written Health Literacy Improvement Plan and collects data to see if objectives are being met.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2-Assess OHL & Create Plan
4. All staff members have received health literacy education.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3-Raise Awareness
5. All levels of practice staff have agreed to support changes to make it easier for patients to navigate, understand, and use health information and services.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3-Raise Awareness
6. All staff members appreciate that we have a responsibility to make sure that patients can understand and act on health information and services.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3-Raise Awareness

1. Prepare for Practice Change

	Doing Well	Needs Improvement	Not Doing	Not Sure or N/A	Tools to Help
7. Our Health Literacy Team understands how to implement and test changes designed to improve performance.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2- Assess OHL & Create Plan

2. Improve Spoken Communication

	Doing Well	Needs Improvement	Not Doing	Not Sure or N/A	Tools to Help
8. All staff members speak clearly (e.g., use plain, everyday words and speak at a moderate pace).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4-Commun. Clearly
9. All staff members listen carefully to patients without interrupting.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4-Commun. Clearly
10. All staff members limit themselves to 1-3 key points and reinforce those points.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4-Commun. Clearly
11. All staff members use simple pictures and models and audio/video materials to promote better understanding.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4-Commun. Clearly 12-Use Health Ed. Material Effectively
12. Our practice ensures patients have the equipment and know-how to use recommended audio-visual materials and internet resources.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	12-Use Health Ed. Material Effectively
13. All staff members review educational materials they hand out to patients and emphasize the important information.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	12-Use Health Ed. Material Effectively

2. Improve Spoken Communication

	Doing Well	Needs Improvement	Not Doing	Not Sure or N/A	Tools to Help
14. All staff members ask patients to state key points in their own words (i.e., use the teach-back method) to assess whether they have been clear enough.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	5-Teach-Back Method
15. Clinicians routinely review with patients all the medicines they take, including over-the-counter medicines and supplements, and ask patients to demonstrate how to take them.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	5-Teach-Back Method 8-Brown Bag Review
16. Our practice routinely provides patients with updated medicine lists that describe in easy-to-understand language what medicines the patient is to take and how to take them.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8-Brown Bag Review 16-Help Patients Take Medicine Correctly
17. Our practice trains patients to use our patient portal.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	12-Use Health Ed. Material Effectively
18. Our practice contacts patients between office visits to ensure understanding or to follow up on plans made during the visit.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6-Follow up
19. Our practice assess patients' language preferences and record them in the medical record.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	9-Language Differences 13-Welcome Patients
20. Our practice always uses acceptable language access services if patients, or companions who are participating in the visit, want to use a language other than English.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	9-Language Differences

2. Improve Spoken Communication

	Doing Well	Needs Improvement	Not Doing	Not Sure or N/A	Tools to Help
21. When staff members give directions for finding the office, they refer to familiar landmarks and public transportation routes as needed.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	7-Be Easy to Reach
22. If there is an automated phone system, one option is to speak with a person.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	7-Be Easy to Reach
23. Our practice can respond to phone calls in the main languages spoken by our patients.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	7-Be Easy to Reach
24. All staff members offer everyone help (e.g., filling out forms, using patient portal) regardless of appearance.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	12-Use Health Ed. Material Effectively 13-Welcome Patients
25. Our practice welcomes family and friends and includes them in visits as much as patients want.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	22-Include Family and Friends

3. Improve Written Communication

	Doing Well	Needs Improvement	Not Doing	Not Sure or N/A	Tools to Help
26. At least one staff member knows how to assess, select, and create written materials that are easy to understand and act on.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	11-Assess, Select, and Create Easy-to-Understand Materials
27. Our practice gets patient feedback on written materials.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	11-Assess, Select, and Create Easy-to-Understand Materials 17-Patient Feedback
28. Our practice assesses whether written materials are easy to understand.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	11-Assess, Select, and Create Easy-to-Understand Materials
29. Our practice's patient education materials are concise, use plain language, and are organized and formatted to make them easy to read and understand.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	11-Assess, Select, and Create Easy-to-Understand Materials
30. If appropriate, our written materials are available in languages other than English.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	9-Language Differences
31. Our practice's forms are easy to understand and fill out, collect only necessary information, and use inclusive language.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	11-Assess, Select, and Create Easy-to-Understand Materials

3. Improve Written Communication

	Doing Well	Needs Improvement	Not Doing	Not Sure or N/A	Tools to Help
32. Lab and test results letters are concise, use plain language, and are organized and formatted to make them easy to read and understand (e.g., avoid the use of “positive” or “negative” results).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	11-Assess, Select, and Create Easy-to-Understand Materials
33. The name of the practice is clearly displayed on the outside of the building, and signs are posted throughout the office to direct patients to appropriate locations (e.g., practice entrance, restrooms, check-in, check-out, lab, etc.).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	13-Welcome Patients
34. Our practice selects easy-to-understand and relevant materials for the waiting room and ensures that we do not to overwhelm patients.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	13-Welcome Patients
35. Office signs use large, clearly visible lettering and plain, everyday words such as “Walk-In” and “Health Center” rather than formal words such as “Ambulatory Care” or “Primary Care Practice.”	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	13-Welcome Patients
36. Office signs are written in English and in the preferred languages of our patients (e.g., if most of the patients read English or Spanish, signs are written in English and Spanish).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	13-Welcome Patients

4. Improve Self-Management and Empowerment

	Doing Well	Needs Improvement	Not Doing	Not Sure or N/A	Tools to Help
37. Our practice creates an environment that encourages patients to ask questions (e.g., asking, “What questions do you have?” instead of, “Do you have any questions?”) and get involved with their care.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	14-Encourage Questions
38. Our practice helps patients choose health goals and develop action plans to take manageable steps toward goals.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	15-Make Action Plans
39. Our practice follows up with patients to determine if their action plan goals have been met.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6-Follow up 15-Make Action Plans
40. All clinicians consider patients’ culture – including customs, beliefs, and values – when devising treatment options.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	10-Consider Culture
41. All clinicians write precise instructions for taking medicine that are easy-to-understand (e.g., “take 1 pill in the morning and 1 pill at bedtime” instead of “take twice daily”).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	16-Help Patients Take Medicine Correctly
42. Staff members discuss different methods for remembering to take medicines correctly and offer patients assistance setting up a system (e.g., pill organizers, electronic reminders).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	16- Help Patients Take Medicine Correctly
43. Our practice requests feedback from patients.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	11-Assess, Select, and Create Easy-to-Understand Materials 17-Patient Feedback

5. Improve Supportive Systems

	Doing Well	Needs Improvement	Not Doing	Not Sure or N/A	Tools to Help
44. Our practice assesses patients' social needs, including their ability to pay for medicines.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	18-Attend to Social Needs 19-Pay Less for Medicine
45. Our practice asks patients if they are interested in improving their reading or math skills.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	20-Literacy and Math Resources
46. Our practice maintains an up-to-date lists of community resources and assistance programs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	18- Attend to Social Needs 19-Pay Less for Medicine 20-Literacy and Math Resources 23-Talk About Costs
47. Our practice connects patients with community resources and assistance programs and gets patients help filling out applications, as needed.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	18- Attend to Social Needs 19-Pay Less for Medicine 20-Literacy and Math Resources 23-Talk About Costs
48. Our practice offers patients help with referrals, such as making appointments.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	18-Attend to Social Needs 19-Pay Less for Medicine 20-Literacy and Math Resources

5. Improve Supportive Systems

	Doing Well	Needs Improvement	Not Doing	Not Sure or N/A	Tools to Help
49. Our practice shares important referral information (e.g., reason for referral, pertinent medical history, test results) directly with the organization we are referring the patient to.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	18- Attend to Social Needs 19-Pay Less for Medicine 21- Referrals 23-Talk About Costs
50. Our practice follows up to confirms that a referral has been completed.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6-Follow up 18- Attend to Social Needs 19-Pay Less for Medicine 21- Referrals 23-Talk About Costs
51. Our practice welcome questions about healthcare costs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	23-Talk About Costs
52. Our practice gives patients accurate, understandable information about their share of costs before they make treatment decisions.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	23-Talk About Costs

Plan-Do-Study-Act Worksheet

Use Plan-Do-Study-Act to Help Create Action Plans

This plan-do-study-act (PDSA) worksheet helps create your action plan.

TOOL:

STEP:

CYCLE:

PLAN

I plan to:

I hope this produces

Steps to execute:

- 1.
- 2.

DO

What did you observe?

■

STUDY


What did you learn? Did you meet your measurement goal?

ACT

What did you conclude from this cycle?

Plan-Do-Study-Act Directions and Examples

The Plan-Do-Study-Act (PDSA) method is a way to test a change that is implemented. Going through the prescribed four steps guides the thinking process into breaking down the task into steps and then evaluating the outcome, improving on it, and testing again. Most of us go through some or all of these steps when we implement change in our lives, and we don't even think about it. Having them written down often helps people focus and learn more.

For more information on the PDSA, go to the [IHI \(Institute for Healthcare Improvement\) Web site](#) .

Keep the following in mind when using the PDSA cycles to implement the health literacy tools:

- **Single Step**—Each PDSA often contains only a segment or single step of the entire tool implementation.
- **Short Duration**—Each PDSA cycle should be as brief as possible for you to gain knowledge that it is working or not (some can be as short as 1 hour).
- **Small Sample Size**—A PDSA will likely involve only a portion of the practice (maybe 1 or 2 doctors). Once that feedback is obtained and the process refined, the implementation can be broadened to include the whole practice.

Filling Out The Worksheet

Tool: Fill in the tool name you are implementing.

Step: Fill in the smaller step within that tool you are trying to implement.

Cycle: Fill in the cycle number of this PDSA. As you work through a strategy for implementation, you will often go back and adjust something and want to test whether the change you made is better or not. Each time you make an adjustment and test it again, you will do another cycle.

Plan

I plan to: Here you will write a concise statement of what you plan to do in this testing. This will be much more focused and smaller than the implementation of the tool. It will be a small portion of the implementation of the tool.

I hope this produces: Here you can put a measurement or an outcome that you hope to achieve. You may have quantitative data like a certain number of

doctors performed teach-back, or qualitative data such as nurses noticed less congestion in the lobby.

Steps to execute: Here is where you will write the steps that you are going to take in this cycle. You will want to include the following:

- The population you are working with—are you going to study the doctors' behavior or the patients' or the nurses'?
- The time limit that you are going to do this study—remember, it does not have to be long, just long enough to get your results. And, you may set a time limit of 1 week but find out after 4 hours that it doesn't work. You can terminate the cycle at that point because you got your results.

Do

After you have your plan, you will execute it or set it in motion. During this implementation, you will be keen to watch what happens once you do this.

What did you observe? Here you will write down observations you have during your implementation. This may include how the patients react, how the doctors react, how the nurses react, how it fit in with your system or flow of the patient visit. You will ask, "Did everything go as planned?" "Did I have to modify the plan?"

Study

After implementation you will study the results.

What did you learn? Did you meet your measurement goal? Here you will record how well it worked, if you meet your goal.

Act

What did you conclude from this cycle? Here you will write what you came away with for this implementation, whether it worked or not. And if it did not work, what you can do differently in your next cycle to address that. If it did work, are you ready to spread it across your entire practice?

Examples

Below are 2 examples of how to fill out the PDSA worksheet for 2 different tools, [Tool #17: Get Patient Feedback](#) and [Tool #5: Use the Teach-Back Method](#). Each contain 3 PDSA cycles. Each one has short cycles and works through a different option on how to disseminate the survey to patient ([Tool #17: Patient](#)

[Feedback](#)) and how to introduce teach-back and have clinicians try it. ([Tool #5: Use the Teach-Back Method](#)).

PDSA (plan-do-study-act) worksheet

Tool: Patient Feedback

Step: Dissemination of surveys

Cycle: 1st Try

Plan

I plan to: test a process of giving out satisfaction surveys and getting them filled out and back to us.

I hope this produces: at least 25 completed surveys per week during this campaign.

Steps to execute:

1. We will display the surveys at the checkout desk.
2. The checkout attendant will encourage the patient to fill out a survey and put it in the box next to the surveys.
3. We will try this for 1 week.

Do

What did you observe?

- We noticed that patients often had other things to attend to at this time, like making an appointment or paying for services and did not feel they could take on another task at this time.
- The checkout area can get busy and backed up at times.
- The checkout attendant often remembered to ask the patient if they would like to fill out a survey.

Study

What did you learn? Did you meet your measurement goal?

We only had 8 surveys returned at the end of the week. This process did not work well.

Act

What did you conclude from this cycle?

Patients did not want to stay to fill out the survey once their visit was over. We need to give patients a way to fill out the survey when they have time.

We will encourage them to fill it out when they get home and offer a stamped envelope to mail the survey back to us.

Tool: Patient Feedback

Step: Dissemination of surveys

Cycle: 2nd Try

Plan

I plan to: test a process of giving out satisfaction surveys and getting them filled out and back to us.

I hope this produces: at least 25 completed surveys per week during this campaign.

Steps to execute:

1. We will display the surveys at the checkout desk.
2. The checkout attendant will encourage the patient to take a survey and an envelope. They will be asked to fill the survey out at home and mail it back to us.
3. We will try this for 2 weeks.

Do

What did you observe?

- The checkout attendant successfully worked the request of the survey into the checkout procedure.
- We noticed that the patient had other papers to manage at this time as well.
- Per Checkout attendant only about 30% actually took a survey and envelope.

Study

What did you learn? Did you meet your measurement goal?

We only had 3 surveys returned at the end of 2 weeks. This process did not work well.

Act

What did you conclude from this cycle?

Some patients did not want to be bothered at this point in the visit; they were more interested in getting checked out and on their way.

Once the patient steps out of the building, they will likely not remember to do the survey.

We need to approach them at a different point in their visit when they are still with us—maybe at a point where they are waiting for the doctor and have nothing to do.

Tool: Patient Feedback

Step: Dissemination of surveys

Cycle: 3rd Try

Plan

I plan to: test a process of giving out satisfaction surveys and getting them filled out and back to us.

I hope this produces: at least 25 completed surveys per week during this campaign.

Steps to execute:

1. We will leave the surveys in the exam room next to a survey box with pens/pencils.
2. We will ask the nurse to point the surveys out/hand them out after vitals and suggest that while they are waiting they could fill out our survey and put it in box.
3. We will see after 1 week how many surveys we collected.

Do

What did you observe?

- Upon self report, most nurses reported they were good with pointing out or handing the patient the survey.

- Some patients may need help reading survey, but nurses are too busy to help.
- On a few occasions, the doctor came in while patient filling out survey so survey was not complete.

Study

What did you learn? Did you meet your measurement goal?

We had 24 surveys in the boxes at the end of 1 week. This process worked better.

Act

What did you conclude from this cycle?

Approaching patients while they are still in the clinic was more successful.

Most patients had time while waiting for the doctor to fill out the survey.

We need to figure out how to help people who may need help reading the survey.

Tool: Teach-back

Step: MDs **initially** performing Teach-back

Cycle: 1st Try

Plan

I plan to: ask the physicians in Wednesday PM to perform teach-back with the last person they see that day.

I hope this produces: physicians performing teach-back and that they find that it was useful, did not take that much more time, and they will continue the practice.

Steps to execute:

1. We will ask the 5 physicians who hold clinic on Wednesday PM to perform teach-back with their last patient of the day.
2. We will show these physicians the teach-back video.
3. After their last patient checks out, we will ask the physicians if they felt:
 - a. It was useful?

- b. It was time consuming?
- c. They will do it again?

Do

What did you observe?

All physicians found the teach-back video informative and seemed eager to try this new tool.

Study

What did you learn? Did you meet your measurement goal?

4 out of 5 physicians performed teach-back on at least one patient in the afternoon. The 1 physician who did not indicated she did not quite know how to integrate it into her visit.

Act

What did you conclude from this cycle?

4 out of 5 felt comfortable with it and said they would continue using it.

For the 1 who was not sure how to integrate it, we will look for other teach-back resources to help address this.

Ready to introduce to entire clinical staff.

Tool: Teach-back

Step: MDs **continuing** to perform Teach-back

Cycle: modified 2nd try

Plan

I plan to: see if the physicians in Wednesday PM clinic are still performing teach-back by asking them after their last patient leaves. (3 weeks have gone by since initial introduction.)

I hope this produces: confirmation that each of the physicians will have performed teach-back on at least 3 of their afternoon patients.

Steps to execute:

1. We will approach the 5 physicians on Wednesday PM after their last patient leaves and ask them to count the number of patients they performed teach-back on this afternoon.

2. We will ask the physicians if they still feel:

- a. It was useful?
- b. It was time consuming?
- c. They will do it again?

Do

What did you observe?

Some physicians could not find appropriate situations for teach-back.

All still felt it was a worthy tool during their patient visits but feel they need to remember it and practice it more.

Study

What did you learn? Did you meet your measurement goal?

3 out of 5 physicians said they did perform teach-back on 3 of their patients.

1 performed it in one instance.

1 did not perform it at all (same one as before).

Act

What did you conclude from this cycle?

Teach-back is being used, maybe not as readily as I had anticipated.

Maybe the goals of '3 out of 6 patient encounters should contain teach-back' is unrealistic. We may put a sign in the clinic rooms, in view of the physicians, to remind them about teach-back.

Will measure again in 6 months.

Tool: Teach-back

Step: MDs **continuing** performing Teach-back

Cycle: 3rd Try

Plan

I plan to: see if the signs put up in the exam rooms help physicians remember to do teach-back and increased its utilization.

I hope this produces: physicians will perform teach-back 3 out of 6 times.

Steps to execute:

1. We will put signs reading "Teach it Back" taped on the exam room desk/work area to remind physicians to use the technique.
2. We will ask physicians if they notice the signs and if they reminded them to perform teach-back.
3. We will see if Wednesday PM clinic had increased use of teach-back.

Do**What did you observe?**

Nurses felt the sign will get in the way.

Study**What did you learn? Did you meet your measurement goal?**

4 out of 5 physicians did teach-back on 3 patients Wednesday afternoon. 1 did it on 1 patient.

4 out of 5 said they did see the sign and that it was a reminder to do teach-back.

Act**What did you conclude from this cycle?**

That a reminder is needed (especially initially) to help physicians use this tool in their visit.

No further intervention needed at this point.

Health Literacy: Making it Easier for Patients To Find, Understand, and Use Health Information and Services

This presentation includes 33 slides with speaker's notes. You can get through the content in 30-45 minutes. Add time for discussion. The presentation can be divided into sessions. You can also distribute the presentation for self-study.

Select to download the [PowerPoint slide deck](#).

Select for the [PDF](#) of the presentation (does not include speaker's notes).

Health Literacy Video: Questions for Discussion and Moderator's Guide

Questions for ACP Foundation Video

1. Now that you realize you can't tell someone's health literacy status just by looking, what have you noticed that would suggest your patients may have a difficult time understanding?
2. Consider the patients featured in this video. What surprised you about their attitudes, concerns, or questions?
3. What have you learned that you will use to improve your communication with patients?
4. What is the most important thing that our practice needs to change to promote better communication?
5. What ideas do you have for changes that would improve our patients' understanding?

Questions for 5 Things to Know About Health Literacy

1. Did the video change how you think of health literacy? How so?
2. Do you use any of the health literacy strategies mentioned in the video? Which ones, and why?
3. What are the benefits to using health literacy universal precautions?
4. What could our practice change to make it easier for patients to find, understand, and use health information and services?

Moderator's Guide

This guide is for the moderator of the discussion following the presentation of the health literacy video. To promote a productive discussion, please review the following information with the participants before you begin. Stress that there is work to do to move forward with implementing health literacy universal precautions in your practice and ideas and support from all staff is essential.

Remind participants that:

- Everyone is encouraged to speak.
- No one or two individuals should dominate the discussion.
- All ideas will be considered.
- Participants should listen to each other.

Other suggestions for the facilitator:

- Identify one person to take notes.
- Review each question.
- Summarize key ideas.
- Identify the next steps for your practice.
- Allow at least 30 minutes for discussion.

Health Literacy Assessment Quiz

We would like to get a sense of your knowledge and understanding about health literacy. Please complete this brief quiz that assesses some key facts about health literacy.

1. Which is an example of health literacy?
(Choose all that apply)
 - ☐ A. When people can read and understand health information.
 - ☐ B. When people can act on health information to make informed decisions.
 - ☐ C. When organizations make sure that people can find the health information they need.
 - ☐ D. When organizations ensure that people can equitably access and use health services.
2. More people have low numeracy (difficulty understanding and using numbers) than low literacy (difficulty reading and writing) True or False?
 - ☐ A. True
 - ☐ B. False
3. What can happen when health literacy is not addressed?
 - ☐ A. Medication errors.
 - ☐ B. Fewer preventive services.
 - ☐ C. More hospitalizations.
 - ☐ D. Bad health outcomes.
 - ☐ E. A and B.
 - ☐ F. All of the above.
4. You can tell how health literate a person is by knowing what grade they completed in school. True or False?
 - ☐ A. True
 - ☐ B. False

5. Which of the following skills are components of health literacy?
(Choose all that apply)
- ☐ A. Ability to understand and use numbers.
 - ☐ B. Reading skills.
 - ☐ C. Speaking skills.
 - ☐ D. Ability to understand what is said.
 - ☐ E. Writing skills.
 - ☐ F. All the above.
6. Being anxious affects a person's ability to absorb, recall, and use health information effectively. True or False?
- ☐ A. True
 - ☐ B. False
7. What is the average reading level of U.S. adults?
- ☐ A. 4th-5th grade
 - ☐ B. 6th-7th grade
 - ☐ C. 8th-9th grade
 - ☐ D. 10th-11th grade
 - ☐ E. 12th grade
8. To use good health literacy practices, staff and clinicians should use which of the following words/phrases when talking to or writing instructions for a patient or family member?

Circle the word/phrase in either Option 1 or 2 in each row

Option 1	OR	Option 2
a. Bad	OR	Adverse
b. Hypertension	OR	High Blood Pressure
c. Blood Glucose	OR	Blood Sugar
d. You have the flu.	OR	Your flu test was positive.
e. The cardiologist is Dr. Brown.	OR	The heart doctor is Dr. Brown.
f. Your appointment is at 11:00 AM. Check in 20 minutes early.	OR	Arrive at 10:40 AM to check in.

9. It is a good health literacy practice to assume that each patient you communicate with has limited health literacy. True or False?

- ☐ A. True
- ☐ B. False

10. How do you know when patients understand?

(Choose all that apply.)

- ☐ A. When they nod or say yes when you ask if they understand.
- ☐ B. When they ask questions.
- ☐ C. When they describe in their own words what they learned.
- ☐ D. When they can show you how they'll take their medicine.
- ☐ E. You can't know.

11. What strategies could all of us adopt to make sure that we are clear and minimize misunderstanding for patients?

Health Literacy Assessment Quiz

Answer Key

Question Number and Answers

1. A, B, C, and D
2. A – True
3. F
4. B – False
5. F
6. A – True
7. C
8.
 - a. Option 1 – Bad
 - b. Option 2 – High Blood Pressure
 - c. Option 2 – Blood Sugar
 - d. Option 1 – You have the flu.
 - e. Option 2 – The heart doctor is Dr. Brown.
 - f. Option 2 – Arrive at 10:40 AM to check in.
9. A – True
10. C and D
11. Answer Open-ended

Role Playing Ideas

Getting Started

Giving practice members a chance to try out new skills makes learning more fun and effective. Below are some ideas for role playing exercises. You can have people pair up to practice or play the patient with a volunteer.

You can also use AHRQ's [teach-back role play scenarios](#) to practice using the teach-back method.

Role Play 1.

Call a patient to remind them about an appointment the next day that will include a Brown Bag Medicine Review.

After the role play, discuss:

- Did they introduce themselves clearly and in a friendly manner?
- Did they use a respectful, caring tone of voice?
- Did they speak at a moderate pace.
- Did they ask them to bring in I.D., insurance information, and all prescription and over-the-counter medicines, vitamins, supplements, and herbals with them?
- Did they use teach-back to check understanding of the appointment time and what to bring?
- Did they offer to provide directions to the office?
- Were the directions clear, using landmarks to help the patient find their way?

Role Play 2.

You are prescribing antibiotics (10 days/500 mg/BID) for a child with streptococcal pharyngitis. You have samples of the pills. Explain to the child and parent how to take the medicine.

After the role play, discuss:

- Did they use a respectful, caring tone of voice?
- Did they speak at a moderate pace.
- Did they use [clear instructions](#) (e.g., “Take 1 pill in the morning and 1 pill at bedtime” instead of “Take 2 pills a day.”)?
- Did they ask the parent to show how they would give the medicine?
- Did they check the parent understood it was important to finish all the medicine, even if their child was feeling better?
- Did they suggest a routine for remembering to give the child medicine (e.g., set an alarm for half an hour before breakfast and dinner)?
- Did they ask the parent if they would have difficulty paying for the medicine?
- Did they encourage questions using an open-ended phrase (e.g., “What questions do you have?” or “Tell me about what concerns you have.”)?

Role Play 3.

You have just told a patient they have Type II diabetes. Tell them the “need to know” information using everyday words.

After the role play, discuss:

- Did they use a respectful, caring tone of voice?
- Did they use any medical terminology (e.g., blood glucose, diabetes mellitus, pancreas doesn’t produce enough insulin)?
- Did they limit themselves to 1 to 3 key points and repeat them?
- Did they speak at a moderate pace?
- Did they draw or use pictures?
- Did they use teach-back to check they were clear and the patient understood? Did they wait until the end to check, or chunk out the information and then check?
- Did they encourage questions using an open-ended phrase (e.g., “I just gave you a lot of information. What questions do you have?” or “What would you like to go over or hear more about?”)?

Key Strategies for Clear Communication

Key Strategies for Clear Communication

Use the template on the next page to make a poster reminding staff of key strategies for clear communication.

Key Strategies for Clear Communication

- Use qualified interpreters.
- Slow down.
- Limit content to 1 - 3 key points and reinforce them.
- Check you have been clear with teach-back.

Key Strategies for Clear Communication

Engage with your patients.

- Be respectful and caring.
- Listen actively without interrupting.
- Use open-ended questions to invite participation.
- Ask, “What questions do you have?”

Key Strategies for Clear Communication

- Show how it is done.
- Use simple pictures and models.
- Don't be vague. Put a number on it.

Communication Self-Assessment

Directions: After a patient encounter, rate whether you agree, are neutral, or disagree with the statements in the table. Your self-assessment is subjective, but it allows you to examine your communication with patients honestly. After completing the assessment, think about how you could improve.

	Agree	Neutral	Disagree
1. For patients or companions whose preferred language is not English: I used qualified interpreters or spoke to them in their preferred language fluently.			
2. I greeted the patient warmly and maintained a caring attitude.			
3. I was respectful and made appropriate eye contact.			
4. I used open-ended questions to encourage the patient and companions to participate in the conversation and voice their concerns throughout the visit.			
5. I listened without interrupting.			
6. I covered no more than 1 to 3 key points and reviewed them more than once.			
7. I used plain, nonmedical language.			
8. I spoke clearly and at a moderate pace.			
9. I gave specific, concrete explanations and instructions.			
10. I used graphics such as a picture, diagram, or model to help explain something (if applicable).			
11. I demonstrated how to do something (e.g., how to take medicine or exercise) (if applicable).			
12. I created the expectation that I wanted the patient and companions to ask questions (e.g., asking “What questions do you have?”).			
13. I checked that I was clear by asking the patient to describe what they need to know or do using their own words or by demonstrating.			

What areas can you improve on? What strategies can you use to improve them?

Communication Observation Form

Please observe the interaction between a patient and a clinician. After the encounter, rate whether you agree, are neutral, or disagree with the statements in the table. Feel free to write notes that can help the clinician improve their communication in the future.


	Agree	Neutral	Disagree
1. For patients or companions whose preferred language is not English: This clinician used qualified interpreters or spoke to them fluently in their preferred language.			
2. This clinician greeted the patient warmly and maintained a caring attitude.			
3. This clinician was respectful and made appropriate eye contact.			
4. This clinician used open-ended questions to encourage the patient and companions to participate in the conversation and voice their concerns throughout the visit.			
5. This clinician listened without interrupting.			
6. This clinician covered no more than 1 to 3 key points and reviewed them more than once.			
7. This clinician used plain, nonmedical language.			
8. This clinician spoke clearly and at a moderate pace.			
9. This clinician gave specific, concrete explanations and instructions.			
10. This clinician used graphics such as a picture, diagram, or model to help explain something (if applicable).			
11. This clinician demonstrated how to do something (e.g., how to take medicine or exercise) (if applicable).			
12. This clinician created the expectation that they wanted the patient and companions to ask questions (e.g., asking "What questions do you have?").			

	Agree	Neutral	Disagree
13. This clinician checked that they were clear by asking the patient to describe what they need to know or do using their own words or by demonstrating.			

Please provide other feedback about the encounter below:

Plain Language Words

Even if patients know difficult words, it takes them less effort to understand if you speak and write in plain language. This word list provides simple substitutes to complex words and phrases. It is adapted from a list developed by [Beccah Rothschild](#), MPA, Principal of Health Engagement Strategies, for Health Research for Action.

You can look up alternatives to medical terminology in the [Plain Language Medical Dictionary](#). Another resource is [Everyday Words for Public Health Communication](#), which gives you examples of how to rewrite public health jargon.

Instead of	Try
absence, absence of	no, none, not here, not present, without
accessible	open, ready, within reach, can be used by
accommodate	meet, agree to
accompany	go with, show up with, go along with
accomplish	carry out, do
accordance (with)	agree with, follows
accordingly	so
accurate	correct, exact, right
achieve	do, make
acknowledge	thank you for, accepted, recognized, approved
acquire	get, buy
activate	begin, start, turn on, act
active role	taking part in
activity	something you do (often)
actual	real
acute	sudden, happen without warning, sickness that lasts a short time and goes away
additional	more, added, extra, other
address	discuss, talk about
adhere and adherence:	sticks to
administer	run, handle, direct, manage, to give out
advanced (stages)	late stages, far along
advantageous	helpful, better, useful

Instead of	Try
adverse	bad
adverse event	injury or hurt
adversely affect/impact	hurt, set back, make worse
advise	recommend, tell
affix	stick, join, attach, add, fasten
afford an opportunity	allow, let
affordable	low cost, at a good price, at a price you can pay
aggregate	total
ailment	sickness, illness, problem with your health
alleviate your symptoms	help you feel better
allergen	something that causes an allergy
allocate	divide, give, share
alternative	choice, option, other
ameliorate	improve, make better
amend	change
analgesic	pain killer
anticipate	expect
apparent	clear, plain, easy to see
apparently	it seems, we think, it looks like
appreciable	many, much, large
appropriate	right, correct, useful
approximately	about
are requested to	please
are required to	must
as a consequence of	because
as a means of	to
ascertain	decide, find out, learn, tell, confirm
assist, assistance	aid, help
associated with	goes along with, is part of, linked to, related to, happens with
attain	meet a goal, get, reach, receive
attempt	try
at the present time	at present, now
authorization	permission, your written permission, your written approval
authorize	let, allow, approve, permit
authorizing disclosures	allowing us to share information
avoid	stay away from, do not use

Instead of	Try
be advised	know
before any costs are incurred	before we do anything that will cost you
be in the position to	can
beneficial	helpful
benign	is not cancer
burdensome	difficult, hard, tough
capable of, capability	able to, ability, can
caveat	warning
cease	end, stop
chronic	happens again and again, does not end, goes on for a long time
clinical	indicators signs or symptoms of your health problem
collaborate	work together, work with
collect and maintain	get and keep
communicate	tell, let you know
compensate	pay
competent	able to make choices, decisions
complications (flu-caused)	health problems caused by (the flu)
comply with	follow, obey
comprehensive	total, all, the whole, complete, full, major, large
comprise	make, form, include, made up of, gives, is
concept	idea
concerning	about, on
condition	health problem, how you feel
consent	accept, permit, let
consequently	so
consider	think about
constitutes	is, forms, makes up, gives
consult	ask, check with, refer to, look at, talk to, meet
contact	touch, get close to, be near, in the same area as, get in touch with
contagious disease	sickness that you can get from or give to another person
contains	has
contaminated	dirty, unsafe, not clean
contributes to	also causes

Instead of	Try
currently	now
deceased	dead, someone who died
deductible	the amount you pay before your insurance starts to pay
demographics	personal statistics, personal information
designate	choose, name, select, pick
desire	want, wish
detailed	complete, with all the facts, covers everything
detect	find
determine	decide, figure, find out
detrimental	bad, harmful
develop	make, write, form, create, learn
diagnosis	cause of your illness, what your illness is called
diet	what you eat, your meals
difficulties	problems
disclose	show, share, give, tell
discontinue	drop, stop, end, quit, cancel
disturbance	problem, change, something unusual
documents	records, papers, proof
dosage, dose	amount, how much medicine to take
due to the fact that	since, because
dysfunction	problem
economical	low cost
educate	teach, tell, show
effect, effectiveness	make, result, success, consequence, how something works
effective date	takes effect on, starts on
e.g.	for example
elect	choose, pick
eliminate	cut, drop, end, quit, stop
employ	use
enable	allow, make possible
enclosed	inside, with this ____, included
enlarge	get bigger, make bigger
ensure	make sure
equitable	fair
equivalent	equal, the same
establish	set up, prove, show, start

Instead of	Try
evaluate	test, check, rate, decide, think about, work out, study
evidence-based	shown to work, proven to work, tested
evident	clear, plain, easy to see
exacerbate	make worse
examination	exam, test
examine	look at, check, test
exceeds	out does, passes, tops, goes beyond, is above
excessive	too many
exclusions	services not covered by the plan, services your insurance does not pay for
exclusively	only
explain	tell, show
extensive	complete, full, goes on for a long time, large, long, major
facilitate	ease, make easier, help, move along, guide
facilities	clinics, offices, buildings
factor	other thing
failed to	did not
feasible	can be done, workable, will work, possible, can do, doable
febrile	feverish
finalize	complete, finish, end
for further instructions	to find out what to do next
formulary drugs	a list of the prescriptions covered by your insurance company
forward	send, give
frequently	often
function	act, role, work, do, serve
fundamental	basic
grant	give
grievance	complaint, problem, you do not agree
guidelines	rules, steps to follow, directions, recommendations
hazardous	not safe, dangerous, harmful, bad, risky
identical	same
identifiable information	personal information that can identify you
identify	find, name, show

Instead of	Try
i.e.	that is
immediately	at once, now, right now, right away, very soon
impact	affect, change, result
implement	start, put in place, get started, do, follow, carry out, set up
in accordance with	by, following, under
in addition	also, besides, too
incapable	unable, unfit, helpless, cannot do
inception	start, beginning
incomplete	lacking
incorporate	join, put together, combine, bring into
incorrect	wrong
increasingly	more often, more and more
indicate	show, tell, say, list, write down, mark, check off
inform	tell
indicate	show, write down
indication	sign
inflammation	redness, swelling
influenza	flu
inform	tell, share, show, give information
initial	first
initially	at first, first, to start with
initiate	start, begin
injections	shots
in lieu of	instead of, or, in place of
inquiries	questions
in regard to	about, concerning, on
insult	injury, harm
interfere	get in the way of, keep from, cause problems, prevent
intermittent	off and on
intervention	action, treatment, program
irregular	uneven, not usual, not normal
irreversible	cannot be changed, cannot be fixed
lesion	wound
localized	in a small area, in one place, spot
locate	find, put
lucid	clear

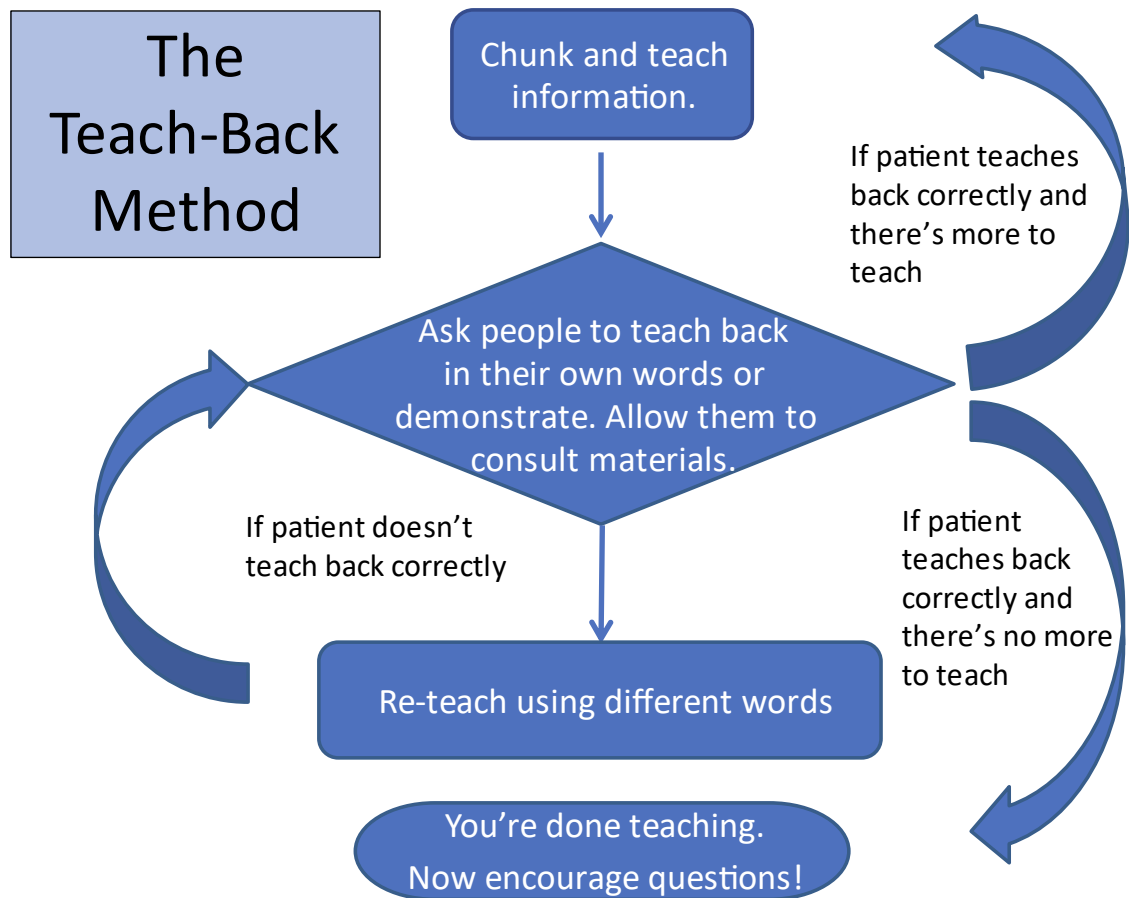
Instead of	Try
magnitude	size
maintain	keep, keep up, care for, look after, save, support, take care of
majority	most, greatest
manage	control, direct, be in charge of, take care of, watch, pay attention to
material change	significant change
maximum	greatest, largest, most
medications	medicines, drugs, pills, syrups
mentioned	told, said, listed
minimize	decrease, lessen, reduce
minimum	least, smallest
modify	change, fix
monitor	check on, watch, keep an eye on
morbidity	sick, sickness
necessitate	cause, make, have to, need to, must
negligible	very small, tiny
non-prescription	not ordered by a doctor, can be bought without a doctor's order, over the counter
notify	let us know, tell, call
numerous	many, [list a specific number]
observe	watch, see
obtain	get
optimal	best, greatest, most, ideal
optional	by choice
oral	by mouth, swallow
partially	partly
participate	take part in, join, go into, do
perform	do, carry out, end, finish, take
permit	let
permissible	allowed, you can
pertaining to	about, of, on
physician	doctor, provider
portion	part
possess	have, own
precaution	safety measure, care
preclude	prevent, stop, get in the way of
predominant	main

Instead of	Try
preference	choice, wish, desire, option
prevalent	common, happens often
previous	before, earlier, past, the time before
previously	before
primary	main, key, first
prioritize	rank, put in the right order, put first things first, put things in order of how important they are
prior to	before, earlier
proceed	do, go ahead, try
prohibit	forbid, ban, prevent, don't
prolonged	stays, lasts, carries on, goes on for a long time, continues
promptly	right away, soon
provide	give, offer, say, supply, list
proximity (to)	close to, near
receive	use, get
recognize	come to see, be aware of
recover	get well, get better, heal
recur	come back
reduce	cut, use less, lower
refer	send to
refrain	stop, stay away
regarding	about, of, on
regardless	no matter what
reject	turn down, deny, refuse
relating to	about, on
remain	stay
remainder	rest, left over
require	must, need, want, lack
requirement	need, rule
reside	live at, live with
resolve	decide, settle, agree, finish, go away, work out
responsible for	in charge of, handles
restriction	limit, rule against
resume	go back to, begin again, go on with, come back
retain	keep
review	check, go over, look at again
revised	new, changed

Instead of	Try
safeguard	protect, keep safe, save
settle your account	pay your bill
severe	strong, serious, harmful, dangerous, very bad
significant	important, major
similar to	like
solely	only
solicit	ask for, request
specialist	an expert in the field, a doctor who has special training
state	say, tell, write down
statement	bill, charge
state-of-the-art	latest
submit	give, send, mail, bring
subsequent	later, next, following
substantially	largely
sufficient	enough
supplement	add to
supplementary	extra, more
symptoms	problems, signs, or warnings of illness
tablet	pill, dose
thereafter	then, from the on, afterwards
therefore	so, then, for, since
this office	we
timely	prompt
time period	from ____ to ____
toxic	poisonous, unsafe
transmit	send, give to others, pass to others, spread
ultimately	in the end, finally
unforeseen	unplanned, not expected, sudden
urgent	cannot wait long, needs attention very soon
utilize, utilization	use, make use of
warrant	call for, permit
with regard to, with respect to	about
with the exception of	except for
withdraw	take away, remove, take out
witness	see

The Teach-Back Method Poster

Use the poster image below as a reminder to staff on how to use the teach-back method.



Teach-Back Questions for Informed Consent

These teach-back questions were developed as part of [AHRQ's Making Informed Consent and Informed Choice: Training Module for Health Care Professionals](#).

- “Just to make sure that I explained things well, can you tell me in your own words what will happen if you choose to have this procedure done?”
- “It’s my job to explain things clearly. To make sure I did, can you please tell me in your own words what good results you expect from this treatment? How likely do you think it is that you will get those results?”
- “Are there any downsides to this treatment?” To prompt the patient further about harms, you can say:
 - “What can’t you do while taking this medicine?” [e.g., eat certain food or beverages]
 - “Will you be limited in your activities? For how long?”
- “Every treatment has some risks. Can you tell me in your own words about the risks of this medicine?” To prompt the patient further about risks, you can say:
 - “What about the possible side effects we discussed?”
 - “Remember how we talked about allergic reactions?”
- “We have talked about some other treatments you could choose. Can you tell me what are some of the pros and cons of these alternative treatments?”
- “What if you choose not to get any treatment? Can you tell me in your own words what might happen?”

Lab Results Letter

Dear [Patient Name],

You had a blood test to measure your cholesterol on [date].

The **test results show that your cholesterol is high** and that we need to work together to lower it.

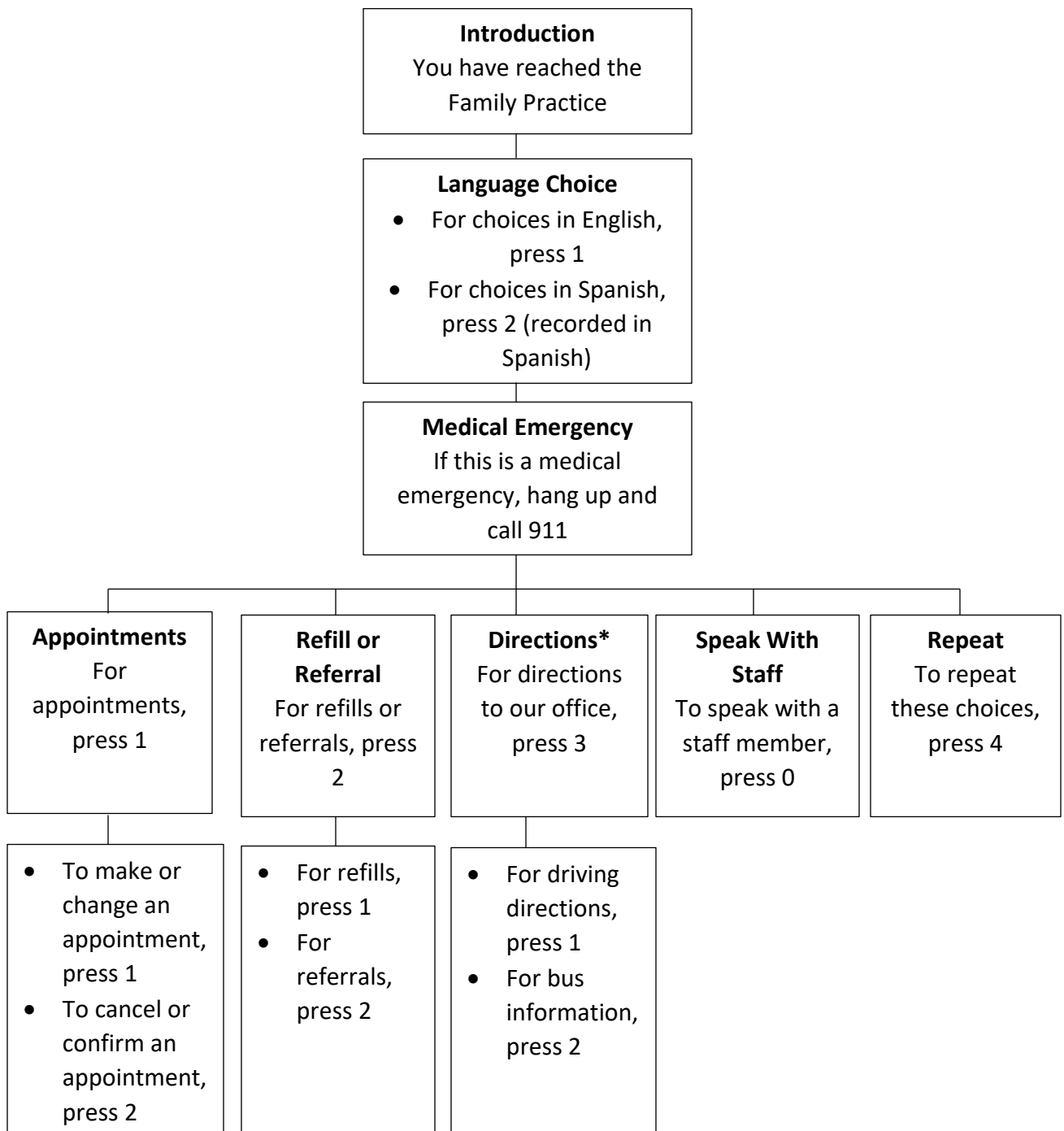
My office will call you to make an appointment so we can talk about this. If you have questions before your appointment, please call my assistant [name] at [phone number].

To see the exact test results before your appointment, log into the patient portal: [URL for patient portal]. If you do not have login information for the patient portal, please email [name and email address]. If you would like help logging into the patient portal, please call [name and phone number]

Thank you and talk to you soon,

Dr. [Name]

Sample Automated Telephone System Menu



* When giving directions, reference familiar landmarks and let callers know you have a map on your website.

Telephone Assessment Guide

Call your practice as if you were a patient, both during and after business hours.

- Did you get a busy signal?
- How long did you wait for staff to answer the phone?
- How long did it take to reach the staff member or obtain the information you wanted?
- If using an automated system, were the menus easy to understand? How many buttons did you need to press?
- Were you put on hold? For how long?
- Were you transferred to more than one other person?
- Were you instructed to call another number or told to use the patient portal?

Brown Bag Medicine Review

Bring ALL Your Medicines to Your Appointment!

This includes:

- Prescription medicines.
- Over-the-counter medicines.
- Herbal medicines.
- Vitamins and supplements.
- All creams, liquids, medicines you breathe in or give yourself with a needle (a shot).
- All pills—in the bottles they came in and any pill boxes you use to organize them.



Your provider will go over them with you to:

- Find out what you are taking.
- Make sure you are taking them safely.
- See if you can take fewer medicines.



Medicine Review Form

Patient Name/ Number: _____

Date: _____

Person Completing Review: _____

1. Did the patient say they brought in **all** of their prescription medicine containers?

- ☐ Yes, patient said they brought in **all** of their prescription medicine containers.
- ☐ No, patient said they brought in **some** of their prescription medicine containers, but not all of them.
- ☐ No, patient did not bring in any of their prescription medicines and supplements (skip to #3).
- ☐ The patient does not have any prescription medicines (skip to #4).
- ☐ I did not check whether the patient brought in all their prescription medicine containers.

2. How many prescription medicines did the patient bring in? _____

3. How many prescription medicines did you review with the patient? _____

4. Did the patient say they brought in **all** of their over-the-counter medicines and supplements?

- ☐ Yes, patient said they brought in **all** of their over-the-counter medicines and supplements.
- ☐ No, patient said they brought in **some** of their over-the-counter medicines and supplements, but not all of them.
- ☐ No, patient did not bring in any of their over-the-counter medicines and supplements. (Skip to #6)
- ☐ The patient does not have any over-the-counter medicines or supplements. (Skip to #6)
- ☐ I did not check whether the patient brought all over-the-counter medicines and supplements.

5. How many over-the-counter medicines and supplements did the patient bring in? _____
6. How many over-the-counter medicines and supplements did you review with the patient? _____
7. Was the patient able to show you correctly how and when they took each of the medicines you reviewed with the patient?
- ☐ Yes.
- ☐ No, patient was unable to show me correctly how and when they took at least one medicine.
- ☐ I did not ask.
8. What problems were found with the medicine regimen? Please mark all that apply.
- ☐ Duplicate medicines.
- ☐ Expired medicines.
- ☐ Patient had contraindications for one or more medicines.
- ☐ Possible drug-drug interaction.
- ☐ Patient is taking medicine incorrectly (e.g., wrong dose, wrong frequency).
- ☐ Patient is not taking any of a medicine that is in the medical record (e.g., failed to refill, too expensive, side effects, didn't know was supposed to take).
- ☐ Patient is taking a prescription medicine not in the medical record (e.g., prescribed by another doctor, prescription samples).
- ☐ Patient is taking an over-the-counter medicine or supplement that is not in the medical record.
- ☐ Other – Please specify: _____
-
- ☐ No problems. Thank you for completing this form. **You are now done.**
9. Did any of these problems represent a possible risk to patient safety?
- ☐ Yes.
- ☐ Possibly.
- ☐ No.

10. Would any of these problems explain negative symptoms the patient has been experiencing?

- ☐ Yes.
- ☐ Possibly.
- ☐ No.
- ☐ Patient was not experiencing negative symptoms.

11. Were changes were made to the medicine regimen? Please mark all that apply.


- ☐ Yes, the medicine regimen was simplified (e.g., fewer doses per day).
 - ☐ Yes, the total number of medicines was reduced.
 - ☐ Yes, other – Please specify: _____
-
- ☐ No changes were made.

Language Access Resources


Resources for Planning Language Access Services



The [Guide to Developing a Language Access Plan](#), from the Centers for Medicare & Medicaid Services, identifies ways that providers can assess their programs and develop language access plans.

The [Health Care Language Services Implementation Guide](#), from the U.S. Department of Health and Human Services Office of Minority Health, provides comprehensive guidance on providing language access in healthcare settings.

[Assessing Translation—A Manual for Requesters](#) provides a roadmap to help healthcare organizations improve the quality of their translated materials.

[LEP.gov](#) provides Federal guidance in providing language access.

The [American Translators Association](#) allows you to search for local translators (for written materials) and interpreters (for verbal communication).

The [Certification Commission for of Healthcare Interpreters](#) has a searchable registry of certified interpreters, as does the [National Board of Certification for Medical Interpreters](#).

Resources on Working With Interpreters




[Qualified Interpreting for Quality Health Care](#) (20-minute video)

[Working with Professional Interpreters](#) (19-minute video)

[Working Effectively With an Interpreter](#) (2-page fact sheet, link is at bottom of page)


[Introduction to Interpreting Services](#) (1-hour course on working with interpreters for deaf people)


[TeamSTEPPS Limited English Proficiency videos](#) include



- [Techniques](#)  to include interpreters as part of the team (<1 minute).
- [Opportunity video](#)  (6 minutes): when interpreters are not used.
- [Success video](#)  (6 minutes): when interpreters are used.


Resources for Multilingual, Easy-to-Read Materials

The National Institutes of Health's MedlinePlus provides multilingual materials by [language](#) and by [health topic](#).

[Health Information Translations](#)  provides materials in 15 different languages.

[Health Information Toolkit](#)  provides plain language health education videos and medicine instructions in 12 different languages.

National Center for Farmworker Health has [low literacy, one-page handouts in English and Spanish](#)  as well as other [health education resources](#) .

[Fast Facts](#)  videos provide information in American Sign Language on a variety of health topics.

Permission to Bill Insurance

1. I give permission to [name of clinic or doctor's office] to file for insurance benefits to pay for the care I receive.
2. I understand that:
 - [name of clinic or doctor's office] will send my medical information to my insurance company.
 - I must pay my share of the costs.
 - I must pay for the cost of the care I receive if my insurance company does not pay or I do not have insurance.
3. I understand:
 - I have the right to say no to any treatment or procedure.
 - I have the right to discuss all medical treatments with my provider.
 - I have the right to ask about costs before I am treated.

Patient's Signature

Date

Parent or Guardian Signature
(for children under 18)

Date

Print name

Release of Medical Information

Permission to share my medical records

I, _____ [patient's name], born on _____ [patient's date of birth], give my permission for my doctor/hospital _____ [name of doctor or hospital that has the records] to give the medical records (described on p. 2) to _____ [doctor who needs the records] so that they can better understand my condition and help me.

Permission to share sensitive information

You have my permission to share my records about topics below ONLY IF my initials are next to it.

- _____ My mental health.
_____ Any disease I may have that others could get from me, like HIV or hepatitis.
_____ My genes.
_____ My use of drugs or alcohol.
-

By signing below, I show that I understand:

- I do not have to share these records.
- The permission I am giving is good for only 3 months from the date I sign.
- If I want to stop sharing my medical records before then, I need to talk to the doctor's office or hospital that has the records and find out what I need to do to stop the sharing.

Patient's or Authorized Representative's Signature

Date

Relationship of Authorized Representative: _____

Consent for release of medical records for _____ [patient's name]

The doctor who needs the records will fill out this page.

Requesting records from:

Name of Practice: _____

Name of Physician: _____

Fax number/secure email address: _____

Address: _____

Types of records we are requesting:

☐ Any and all types of records you have for this patient

☐ Doctor visit notes

☐ Doctors orders

☐ Emergency room notes

☐ Nurses notes

☐ Urgent care notes

☐ Discharge summary

☐ History and physical

☐ Lab reports

☐ Hospital progress notes

☐ Radiology reports

☐ Operation or procedure notes

☐ Consultations

☐ Clinic notes

☐ Other _____

☐ Pathology reports

Records within the following dates:

☐ All dates

☐ Records dated between _____ and _____

Please send records to:

Attention: _____

At fax number: _____ or secure email: _____

Or mail to: _____

For any questions please call (phone number): _____

and ask for: _____

Lab Results Letter

Dear [Patient Name],

You had a blood test to measure your cholesterol on [date].

The **test results show that your cholesterol is high** and that we need to work together to lower it.

My office will call you to make an appointment so we can talk about this. If you have questions before your appointment, please call my assistant [name] at [phone number].

To see the exact test results before your appointment, log into the patient portal: [URL for patient portal]. If you do not have login information for the patient portal, please email [name and email address]. If you would like help logging into the patient portal, please call [name and phone number]

Thank you and talk to you soon,

Dr. [Name]

Appointment Reminder Letter

This is a reminder that:

[Patient name] has an appointment

For: [purpose]

With: [Clinician name]

Date: [Date]

Time: [Time]

Where: [Name of Practice or Clinic]

Address: [Address]

If you cannot come to this appointment:



Call [phone number]. When you hear the menu options, press [#] to talk to someone who will help you reschedule the appointment. Or you can reschedule your appointment on the patient portal at: [URL]

What to bring to your appointment:

- Bring your insurance information and a picture I.D.
- Bring a family member or friend if you want.
- Bring all prescription and over-the-counter medicines you take (such as pills, creams, liquids, inhalers, patches, and shots), as well as herbal medicines, vitamins, and supplements.
- Bring a list of the top 3 things you want to talk about.

Special Instructions [if appropriate]:

- We will be checking your blood. You can drink water, but do **not** eat or drink anything else for 12 hours before your visit.

Inclusive Language for Intake Forms

Below are examples of inclusive language you could use on your patient intake forms to ensure an inclusive and affirming patient experience. These questions align with United States Core Data for Interoperability Draft Version 5; however, depending on your electronic health record, you may need to make modifications to record patient information accurately.

What name would you like us to use?

Legal name (on insurance records or driver's license):

Current relationship status:

What is your preferred language?

Do you need a language interpreter?

For minors: Consider "Parent/Guardian 1," "Parent/Guardian 2," "Parent/Guardian 3," and "Parent/Guardian 4" to accommodate nontraditional family configurations.

For health history: Ask about "blood relatives" rather than "family."

Checkbox Alternatives

Checkboxes are commonly used in forms that are completed electronically. Even on paper forms, checkboxes make data entry easier.

Current relationship status (check all that apply):

- ☐ Not currently in a relationship
- ☐ In a relationship
- ☐ Never married
- ☐ Currently married
- ☐ Separated
- ☐ Divorced
- ☐ Widowed
- ☐ I use a different term: _____
- ☐ Prefer not to answer

What is your preferred language? _____

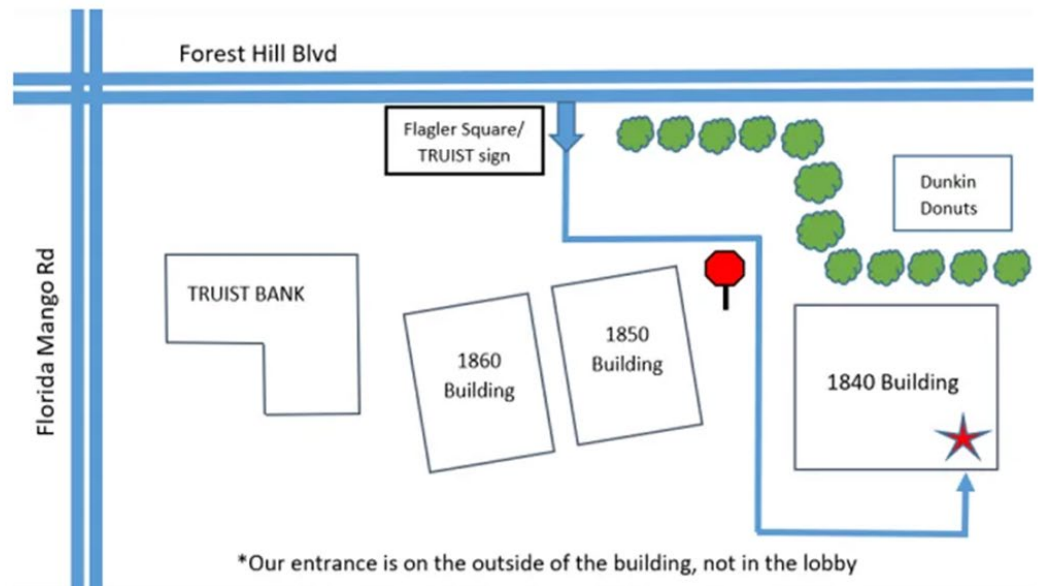
Do you need a language interpreter?

- ☐ Yes
- ☐ No

Sample of Simple Map

Make a map like this, creating shapes that look like buildings and landmarks around your practice, and using the names and numbers of streets and buildings.

Map and Directions



Action Plan Form

My visit with: _____ Date: _____

What I want to do for my health:

- | | |
|---|--|
| <input type="checkbox"/> Eat better | <input type="checkbox"/> Be more active |
| <input type="checkbox"/> Manage my stress | <input type="checkbox"/> Handle my feelings better |
| <input type="checkbox"/> Sleep better | <input type="checkbox"/> Take my medicine |
- Cut down or stop: ☐ smoking ☐ drinking ☐ drugs
- ☐ Something else: _____

Goal – One goal I want to achieve that will improve my health:

My Action Plan – One specific step I can take to achieve this goal:

What:

Where:

How Much:

When and how often:

I will start:

How sure am I that I can do this?

1	2	3	4	5	6	7	8	9	10	
Not sure										Very sure

What I want to do for my health:

-

[illegible]

Help With Medicines Poster

Help With Medicines

Use the template on the next page to make a poster that will help patients manage their medicines.

Do you have trouble remembering to take your medicines?

Ask us to help set up a system.

You can use:

1. My Medicines List

A list of your medicines, when to take them, and how much to take.

My Medicines List

My Name: _____ My Allergies: _____ My Emergency Contact Information: _____

My medicines, vitamins, herbs, and supplements, as of _____ Date: _____

Include all prescription and non-prescription medicines. Non-prescription medicines may include vitamins, herbs, supplements, cold or cough medicines, aspirin, pain relievers, allergy relief medicines, antacids, laxatives, diet pills, and others that you do not need a prescription to buy.

Name (brand and generic)	Strength of medicine	I take this medicine for	I take these every day					
			Instructions	When, how, and how much I take	Morning	Noon	Evening	Bedtime

2. Pill Box

A plastic box with sections to hold the pills you take at different times of the day for each day of the week.



3. An App

A reminder on your phone to take your medicine.



Patient Portal Feedback Form

Instructions: These questions are meant to guide your collection of feedback as you observe a patient using your portal. They are not intended for distribution directly to patients. Allow the patient to navigate the site. Ask if they could show you how to do something while on the practice's portal (e.g., request a prescription refill or make an appointment). After they are done, ask the following questions and use this form to record responses.

1. Is this the first time you have visited our patient portal? ☐Yes ☐No

If Yes: Why haven't you used the patient portal before? _____

2. How often do you use the Internet?

- ☐Every day
☐Several times per week
☐About once per week
☐Less than once per week
☐Never or hardly ever

3. Did anyone in the practice ask you if you'd like help signing into and using the patient portal?

☐Yes

If Yes, did you receive any training on the portal? ☐Yes ☐No

☐No

If No, would you have liked training on the portal? ☐Yes ☐No

4. Is it easy to sign into the patient portal?

☐Yes

☐No

If No, what would make it easier to sign in? _____

5. Is it clear how to get from the home page to the pages you want to use?

☐Yes

☐No

If No, what are you looking for that you cannot find from the home
page? _____

6. Is the site easy to read?

☐Yes

☐No

If No, what was hard to read and why?

7. Is the information you want on the site?

☐Yes

☐No

If No, what information would you like to have on the site?

8. Is it easy to find the information you want?

☐Yes

☐No

If No, what was hard to find and why?

9. Is the information on the site easy to understand?

☐Yes

☐No

If No, what was hard to understand and why?

10. Now that we have gone through the patient portal, would you use it again?

☐Yes

☐No

If No, why not? What would make it more likely that you would use the portal? _____

Ask the patient to perform a task on the portal (e.g., find information on a particular topic, look up recent lab results, request a prescription refill). Use this space to note how easy or hard it was for the patient to perform the task.

Suggestion Box Poster

Make a Suggestion Box

Make a suggestion box and use the template on the next page to make a poster.

Suggestion Box

Let us know how we are doing!

Please give us feedback.

- Are staff friendly and respectful?
- Are forms or written information clear or confusing?
- Are our explanations and instructions hard or easy to understand?
- Are you getting the help you need?
- How can we do better?

All comments are appreciated

Health Literacy Patient Feedback Questions

These feedback questions were developed specifically to monitor implementation of tools in the [AHRQ Health Literacy Universal Precautions Toolkit](#). These questions have **not** been validated.

Translate the questions you select into languages commonly read by your patients using a [high-quality translation process](#) and qualified translators.

Use these questions to conduct small tests of change as part of health literacy improvement activities. For example, you could **select a few questions** related to changes you plan to make and survey patients before you start your improvement work. Or you could select a single yes-or-no question and have patients put a poker chip into boxes marked “Yes” and “No” as they checkout.

Collect feedback again 2, 6, and 12 months later to determine if there has been an improvement. If you are not getting the results you hoped for, make adjustments and test again. Learn more about the Plan-Do-Study-Act method of quality improvement in [Tool #2: Assess Organizational Health Literacy and Create an Improvement Plan](#).

Some questions are screening questions to check whether a particular situation applies to the patient. If the patient answers “No,” the next question (or series of questions) does not apply. You will see the option “No → **go to question #**” for these questions, indicating that the patient should skip one or more questions. If there are no more questions, you can change the response to “No → You are done. Thank you.”

There are no survey questions for the first three tools of the Toolkit, because patients would not be able to observe directly whether they had been implemented or not.

If your practice submits [CAHPS® Clinician & Group Survey](#) data to the Centers for Medicare & Medicaid, you may wish to avoid the following questions that are based on ones in the CAHPS survey.

Questions for Communicate Clearly: Tool #4; Question #1. **Thinking about your most recent visit, did people in this practice explain things in a way that was easy to understand?**

Questions for Communicate Clearly: Tool #4; Question #5. **Thinking about your most recent visit, did people in this practice listen carefully to you?**

Questions for Communicate Clearly: Tool #4; Question #8. **Thinking about your most recent visit, did people in this practice spend enough time with you?**

Questions for Consider Culture: Tool #10; Question #1. **Thinking about your most recent visit, did people in this practice treat you with courtesy and respect?**

Questions for Welcome Patients: Tool #13; Question #1. **Thinking about your most recent visit, did people in this practice treat you with courtesy and respect?**

Questions for Communicate Clearly: Tool #4

Also see [Questions for Use the Teach-Back Method: Tool #5](#) and [Questions for Encourage Questions: Tool #14](#)

1. Thinking about your most recent visit, did people in this practice explain things in a way that was easy to understand?

- ☐ Yes, definitely
- ☐ Yes, somewhat
- ☐ No

2. Thinking about your most recent visit, did people in this practice use medical words that you did not understand?

- ☐ Yes, definitely
- ☐ Yes, somewhat
- ☐ No

3. Thinking about your most recent visit, did people in this practice talk too fast when talking with you?

- ☐ Yes, definitely
- ☐ Yes, somewhat
- ☐ No

4. Thinking about your most recent visit, did anyone in this practice use pictures, drawings, models, or videos to explain things to you?

- ☐ Yes, definitely
- ☐ Yes, somewhat
- ☐ No

5. Thinking about your most recent visit, did people in this practice listen carefully to you?

- ☐ Yes, definitely
- ☐ Yes, somewhat
- ☐ No

6. Thinking about your most recent visit, did people in this practice interrupt you when you were talking?

- ☐ Yes, definitely
- ☐ Yes, somewhat
- ☐ No

7. Thinking about your most recent visit, did people in this practice give you too much information at one time?

- ☐ Yes, definitely
- ☐ Yes, somewhat
- ☐ No

8. Thinking about your most recent visit, did people in this practice spend enough time with you?

- ☐ Yes, definitely
- ☐ Yes, somewhat
- ☐ No

Questions for Use the Teach-Back Method: Tool #5

1. Thinking about your most recent visit, did anyone in this practice tell you what to do to take care of an illness or health condition?

☐ Yes

☐ No → go to question #3

2. Were these instructions easy to understand?

☐ Yes, definitely

☐ Yes, somewhat

☐ No

3. Thinking about your most recent visit, did anyone in this practice ask you to describe or show them how you were going to follow these instructions?

☐ Yes

☐ No

Questions for Follow Up with Patients: Tool #6

1. Has anyone in this practice ever asked you how you would like to be contacted, such as by phone, text, or email?

☐ Yes

☐ No

2. During the past 6 months, did anyone in this practice order blood tests, an x-ray, or other tests or imaging for you?

☐ Yes

☐ No → go to question #5

3. Did someone from this practice follow up to give you those results?

☐ Yes

☐ No

4. Were the results easy to understand?

☐ Yes, definitely

☐ Yes, somewhat

☐ No

5. During the past 6 months, did anyone from this practice follow up after a visit to see how things were going?

☐ Yes

☐ No

Questions for Be Easy to Reach: Tool #7

1. In the last 2 months, did you try to contact this practice by telephone?

☐ Yes

☐ No → go to question #5

2. Did you have any trouble reaching the practice on the phone?

☐ Yes, definitely

☐ Yes, somewhat

☐ No

3. Did you speak to a person?

☐ Yes

☐ No → go to question #5

4. Was the person (or people) you spoke to friendly and helpful?

☐ Yes, definitely

☐ Yes, somewhat

☐ No

A patient portal is a website that you use with a password that has personal health information. You can use your patient portal to do things like check your health records, make appointments, ask for medicine refills, and send and get messages.

5. In the last 2 months, did you contact this practice through a patient portal or by secure email?

☐ Yes

☐ No → go to question #8

6. In the last 2 months, how often did you get a response by end of the next day?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

7. Was the response easy to understand?

- ☐ Yes, definitely
- ☐ Yes, somewhat
- ☐ No
- ☐ I didn't get a response

8. In the last 2 months, did you visit the patient portal to find information, such as health education materials or lab results?

- ☐ Yes
- ☐ No → You are done. Thank you.

9. In the last 2 months, was it easy to find the information you were looking for on the patient portal?

- ☐ Yes, definitely
- ☐ Yes, somewhat
- ☐ No

10. In the last 2 months, was the information you found on the patient portal easy to understand?

- ☐ Yes, definitely
- ☐ Yes, somewhat
- ☐ No

Questions for Conduct Brown Bag Medicine Reviews: Tool #8

1. Before your most recent visit, did anyone from this practice ask you to bring in all the prescription and over-the-counter medicines you were taking?

☐ Yes

☐ No

2. Thinking about your most recent visit, did you bring to this practice all the prescription and over-the-counter medicines you were taking?

☐ Yes, I brought all of them

☐ No, I brought only some of them

☐ No, I didn't bring any → **go to question #4**

3. Thinking about your most recent visit, did anyone in this practice look at your medicine bottles and talk with you about your medicines?

☐ Yes

☐ No → **You are done. Thank you.**

4. Thinking about your most recent visit, did anyone in this practice ask you to explain or show them how much medicine you take and when to take it?

☐ Yes

☐ No

Questions for Address Language Differences: Tool #9

1. Has anyone in this practice ever asked you what language you wanted people in the practice to speak to you in?

☐Yes

☐No

2. What language do you want people in the practice to speak to you in?

☐English→ go to question #3

☐Another language: _____

3. Thinking about your most recent visit, did your provider speak to you in the language you wanted or use an interpreter that the practice provided?

☐Yes

☐No

4. Thinking about your most recent visit, did other people in the practice speak to you in the language you wanted or use an interpreter that the practice provided?

☐Yes, definitely

☐Yes, somewhat

☐No

5. Thinking about your most recent visit, did anyone tell you that the practice could provide you an interpreter for free?

☐Yes

☐No

6. Thinking about your most recent visit, did anyone say anything that was hard to understand because there was no interpreter?

☐Yes, definitely

☐Yes, somewhat

☐No

7. Thinking about your most recent visit, did a family member or friend interpret for you?

☐Yes

☐No

8. Has anyone in this practice ever asked you what language you want your written materials in?

☐Yes

☐No

9. What language do you want your written materials in?

☐English→ go to question #10

☐Another

language:_____

10. Thinking about your most recent visit, did anyone give you written materials?

☐Yes

☐No→ You are done. Thank you.

11. Were the written materials in the language you want them in?

☐Yes, definitely

☐Yes, somewhat

☐No

Questions for Consider Culture: Tool #10

1. Thinking about your most recent visit, did people in this practice treat you with courtesy and respect?

- ☐ Yes, definitely
- ☐ Yes, somewhat
- ☐ No

2. Thinking about your most recent visit, did anyone in this practice judge you unfairly or treat you with disrespect for any reason?

- ☐ Yes, definitely
- ☐ Yes, somewhat
- ☐ No → **You are done. Thank you.**

3. Thinking about your most recent visit, did anyone in this practice judge you unfairly or treat you with disrespect because of your race, ethnicity, birthplace, skin color, or language you speak?

- ☐ Yes, definitely
- ☐ Yes, somewhat
- ☐ No

4. Thinking about your most recent visit, did anyone in this practice judge you unfairly or treat you with disrespect because of your religion, beliefs, or health practices?

- ☐ Yes, definitely
- ☐ Yes, somewhat
- ☐ No

5. Thinking about your most recent visit, did anyone in this practice judge you unfairly or treat you with disrespect because of your sex?

- ☐ Yes, definitely
- ☐ Yes, somewhat
- ☐ No

6. Thinking about your most recent visit, did anyone in this practice judge you unfairly or treat you with disrespect because of how you hear, see, or look, including your height or weight?

- ☐ Yes, definitely
- ☐ Yes, somewhat
- ☐ No

Questions for Assess, Select, and Create Easy-to-Understand Materials: Tool #11

1. Thinking about your most recent visit, did anyone in this practice give you written instructions or information about how to take care of your health?

☐ Yes

☐ No → go to question #3

2. Were the instructions or written information easy to understand?

☐ Yes, definitely

☐ Yes, somewhat

☐ No

3. Thinking about your most recent visit, did you have to sign any forms at this practice?

☐ Yes

☐ No → go to question #5

4. Were the forms you were asked to sign easy to understand?

☐ Yes, definitely

☐ Yes, somewhat

☐ No

5. Thinking about your most recent visit, did you fill out any forms at this practice?

☐ Yes

☐ No → You are done. Thank you.

6. Was unclear on how any part of the form should be filled out?

☐ Yes, definitely

☐ Yes, somewhat

☐ No

Questions for Use Health Education Material Effectively: Tool #12

1. Thinking about your most recent visit, did anyone in this practice give you written information about how to take care of your health?

☐ Yes

☐ No → You are done. Thank you.

2. Thinking about your most recent visit, did anyone in this practice explain or walk you through the written information that you were given?

☐ Yes, definitely

☐ Yes, somewhat

☐ No

Questions for Welcome Patients: Tool #13

Also consider [Questions for Consider Culture: Tool #10.](#)

1. Thinking about your most recent visit, did people in this practice treat you with courtesy and respect?

- ☐ Yes, definitely
- ☐ Yes, somewhat
- ☐ No

2. Were people in this practice as helpful as you thought they should be?

- ☐ Yes, definitely
- ☐ Yes, somewhat
- ☐ No

3. Thinking about your most recent visit, did you have to sign any forms at this practice?

- ☐ Yes
- ☐ No → go to question #5

4. Thinking about your most recent visit, did someone explain the purpose of a form or offer to read it to you before you signed it?

- ☐ Yes
- ☐ No

5. Thinking about your most recent visit, did you fill out any forms at this practice?

- ☐ Yes
- ☐ No → go to question #7

6. Thinking about your most recent visit, were you offered help in filling out a form at this practice?

- ☐ Yes
- ☐ No

7. Thinking about your most recent visit, did anyone in this practice judge you unfairly or treat you with disrespect because of how much education or money you have?

- ☐ Yes, definitely
- ☐ Yes, somewhat
- ☐ No

8. Thinking about your most recent visit, did anyone in this practice judge you unfairly or treat you with disrespect because of the type of health insurance you have or your ability to pay for care?

- ☐ Yes, definitely
- ☐ Yes, somewhat
- ☐ No

Questions for Encourage Questions: Tool #14

1. Thinking about your most recent visit, did people in this practice show interest in your questions?

- ☐ Yes, definitely
- ☐ Yes, somewhat
- ☐ No

2. Thinking about your most recent visit, did people in this practice encourage you to ask questions?

- ☐ Yes, definitely
- ☐ Yes, somewhat
- ☐ No

3. Thinking about your most recent visit, did you have a chance to ask all your questions?

- ☐ Yes, definitely
- ☐ Yes, somewhat
- ☐ No

4. Thinking about your most recent visit, did people in this practice answer all the questions you asked?

- ☐ Yes, definitely
- ☐ Yes, somewhat
- ☐ No

Questions for Make Action Plans: Tool #15

1. Thinking about your most recent visit, did someone from this practice talk with you about specific goals for your health?

☐ Yes

☐ No → You are done. Thank you.

2. Thinking about your most recent visit, did someone from this practice help you set up a plan to meet your health goals?

☐ Yes

☐ No → You are done. Thank you.

3. Thinking about your most recent visit, was the selection of a specific action to take for your health your choice?

☐ Yes, definitely

☐ Yes, somewhat

☐ No, it was not my choice

☐ No, I did not select a specific action to take

Questions for Help Patients Take Medicine Correctly: Tool #16

1. Do you take any medicine that was recommended by someone in this practice?

☐ Yes

☐ No → You are done. Thank you.

2. Thinking about your most recent visit, did anyone in this practice ask if anything that makes it difficult or prevents you from taking you medicine?

☐ Yes

☐ No

3. Thinking about your most recent visit, did anyone in this practice ask if you would like help remembering to take your medicines?

☐ Yes

☐ No

4. Thinking about your most recent visit, did anyone in this practice give you a list of all your medicines?

☐ Yes

☐ No → You are done. Thank you.

5. Was it easy to tell when and how to take your medicines from the list?

☐ Yes, definitely

☐ Yes, somewhat

☐ No

Questions for Get Patient Feedback: Tool #17

All questions in this document can be used to obtain patient feedback.

Questions for Attend to Social Needs: Tool #18

1. Thinking about your most recent visit, did anyone in this practice ask you if there is anything in your daily life that makes it hard to take care of your health?

☐ Yes

☐ No

2. Have you ever been asked by this practice if challenges like getting housing, jobs, transportation, or enough food?

☐ Yes

☐ No

Questions for Help Patients Pay Less for Medicine: Tool #19

1. Do you take any medicine that was recommended by someone in this practice?

☐ Yes

☐ No → **You are done. Thank you.**

2. Thinking about your most recent visit, did anyone in this practice ask if you ever have difficulty getting your medicines?

☐ Yes

☐ No

3. Thinking about your most recent visit, did anyone in this practice show you how to get help with paying for your medicines?

☐ Yes

☐ No

Questions for Connect Patients with Literacy and Math Resources: Tool #20

1. Thinking about your most recent visit, did anyone in this practice ask if you were interested in improving your reading or math skills?

☐ Yes

☐ No → You are done. Thank you.

2. Did you say you wanted to improve your reading or math skills?

☐ Yes

☐ No → You are done. Thank you.

3. Did anyone in this practice ask you if you would like information about community programs to improve your reading or math skills?

☐ Yes

☐ No

Questions for Make Referrals Easy: Tool #21

1. Thinking about your most recent visit, did someone in this practice tell you to go to another healthcare provider, lab, or other facility?

☐ Yes

☐ No → go to question #3

2. Thinking about your most recent visit, were you asked if you would like help making an appointment with the other healthcare provider, lab, or other facility?

☐ Yes

☐ No

Specialists are doctors like surgeons, heart doctors, allergy doctors, skin doctors, and other doctors who specialize in one area of health care.

3. In the last 6 months, did you see a specialist for a particular health problem?

☐ Yes

☐ No → You are done. Thank you.

4. In the last 6 months, did your provider seem informed and up to date about the care you got from specialists?

☐ Yes, definitely

☐ Yes, somewhat

☐ No

5. In the last 6 months, did the specialists you saw seem to know the important information about your medical history?

☐ Yes, definitely

☐ Yes, somewhat

☐ No

Questions for Include Family and Friends: Tool #22

1. Has anyone in this practice ever let you know that you are welcome to bring family or friends to your appointment?

☐ Yes

☐ No

2. Thinking about your most recent visit, did people in this practice make your family or friends who came with you feel comfortable?

☐ Yes, definitely

☐ Yes, somewhat

☐ No

☐ I did not bring anyone with me to my appointments→ **You are done. Thank you.**

3. Thinking about your most recent visit, did you have a private conversation with your provider without your family or friend?

☐ Yes

☐ No

Questions for Talk About Costs: Tool #23

1. Thinking about your most recent visit, did you discuss any options for treatment or medicine you might take?

☐ Yes

☐ No → go to question #4

2. Thinking about your most recent visit, did you want information about costs?

☐ Yes

☐ No → go to question #4

3. Thinking about your most recent visit, did you feel like you could ask about the cost of the treatments or medicines?

☐ Yes

☐ No → go to question #5

4. Thinking about your most recent visit, did you receive helpful information about costs?

☐ Yes, definitely

☐ Yes, somewhat

☐ No

5. Thinking about your most recent visit, did anyone in this practice ask if you would like to learn about how to get help paying for your healthcare?

☐ Yes

☐ No

Sample Cover Letter

FIRST AND LAST NAME
LINE ONE OF ADDRESS
LINE TWO OF ADDRESS (IF ANY)
CITY, STATE ZIP

Dear [FIRST AND LAST NAME],

We at [NAME OF PRACTICE] need your help. We want to improve the care we give you and other patients. We would like you to tell us your thoughts about the care you receive from our providers and staff.

The information that you give us will stay private. Your answers will never be seen by your provider or anyone else involved with your care. Your provider will not even know you helped us by answering these questions. You do not have to answer the questions. Your medical care will not change in any way if you say no.

If you are willing to help us, please answer these questions about the care you have received from our providers and staff in the last 6 months. This should take about [TIME] minutes or less of your time.

Please return the completed survey in the enclosed postage-paid envelope **by** [MONTH/DAY/YEAR].

If you have any questions, please call [CONTACT NAME] at [(XXX) XXX-XXXX]. All calls to this number are free. You can also email questions to [EMAIL]. Thank you for helping to make healthcare at [NAME OF PRACTICE] better for everyone!

Sincerely,

[NAME OF PERSON REPRESENTING PRACTICE]

Additional Resources for Attending to Social Needs

Screening and Implementation Tools

AHRQ's web page on [SDOH & Practice Improvement](#) links to social needs screening and other tools, including [Identifying and Addressing Social Needs in Primary Care Settings](#).

The Joint Commission's Health Equity Resource Center links to resources for [assessing health-related social needs](#).

The [Gravity Project](#) has assembled a collection of social risk [screening assessment instruments](#) considered to have face validity and other [implementation resources](#).

The Social Interventions Research and Evaluation Network (SIREN) links to:


- [Screening and implementation tools](#), such as the [Guide to Implementing Social Risk Screening and Referral-making](#)
- The [PRAPARE Implementation and Action Toolkit](#)
- [A Guide to Using the Accountable Health Communities Health-Related Social Needs Screening Tool: Promising Practices and Key Insights](#)

NCQA's [Social Determinants of Health Resource Guide](#) describes the strategies used by health plans and clinically integrated networks to address social determinants of health (SDOH), including decisions around screening, using the data, and metrics. Since publishing the guide, NCQA has issued a new [Social Needs Screening and Intervention measure](#).


The [Health Leads Screening Toolkit](#) includes language to foster meaningful and effective dialogue between providers and patients around social needs and a screening template in English and Spanish.

Tools for Linking to Resources

Social health referral platforms include [2-1-1– Information & Referral Search](#), [findhelp](#), and [one degree](#).


The [Medical-Legal Partnership Toolkit](#) provides guidance on addressing health-harming legal needs that disproportionately affect people living in poverty.

[Community Resource Referral Platforms: A Guide for Health Care Organizations](#)

 describes community resource referral platforms and shares lessons from organizations that use them.

[Benefits.gov](#) lets you search for Federal and State benefit programs.







Uninsured people can apply for insurance, including Medicaid and subsidized private insurance, at your State's Marketplace. To find your Marketplace website, which will have information about local navigator programs, go to <https://localhelp.healthcare.gov/>.

The [Affordable Connectivity Program \(ACP\)](#) and [Lifeline](#) are Federal Government programs that help eligible households pay for internet services and internet-connected devices.

The Patient Advocate Foundation's [National Financial Resource Directory](#) helps people quickly generate a list of national and regional resources that fit their situation.

Resources for Financial Assistance for Medicines

The assistance programs below help patients get medicine at a lower cost. Separate applications may be required for each medicine needed.

- Medicare lets you search for [State Pharmaceutical Assistance Programs](#), which are in most States and often serve people with low incomes and HIV/AIDS.
- Medicare beneficiaries with low incomes may be eligible for the [Medicare Part D Extra Help program](#), which helps pay deductibles and copays for medicine.
- Medicare has a [searchable list](#) of drug company programs that help people who do not have insurance or are enrolled in a Medicare Drug Plan (Part D) pay for prescriptions.
- [Medication Assistance Tool \(MAT\)](#), operated by Pharmaceutical Research and Manufacturers of America, which represents drug companies, lets you search for discount programs offered by drug companies.
- [NeedyMeds](#) is a non-profit that provides information about drug assistance programs. In some areas, people may be able to get help with completing the application.
- [RxAssist](#), a non-profit established with funding from The Robert Wood Johnson Foundation, offers a database of patient-assistance programs.
- [RxOutreach](#) is a non-profit, mail order pharmacy that offers prescription medicines to people who are uninsured or have limited prescription drug coverage.
- [Select Care Benefits Network \(SCBN\)](#) is a membership-based organization that helps people get expensive medicines at a reduced price if they do not have insurance that covers medicines. There is an application fee and monthly dues that depend on the number of medicines.
- [The Assistance Fund](#) an independent charitable patient assistance organization that helps pay for copayments, coinsurance, deductibles, and other health-related expenses for specific high-cost diseases.

Community Referral Form: [Practice Name]

Reason for Referral: _____

Name of Program: _____

Name of Person to Ask For: _____

Phone: _____

Email: _____

Location:

Details:

Example Community Referral Form

Community Referral Form: City Medical Care

Reason for Referral: Education Classes

Name of Program: Adult Reading Program

Name of Person to Ask For: Terry Baker

Phone: (555) 555-5555

Email: TBaker@CMC.CRF

Location: Spencer Adult Learning Center
560 Blake Lane
Fauxcity, FS 55555

Details: Call or email Terry, or stop by to sign up.

Staff Survey About Cost Conversations

We would like your honest feedback. Please answer these questions about the how our practice talks to patients about the cost of care.

1. Do you think it is important for patients to understand the cost of services when making healthcare decisions?

☐Yes ☐No

2. Do you think patients know that they can get their questions about costs answered?

☐Yes ☐No

3. Do you talk to patients about costs?

☐Yes ☐No

4. Does anyone in the practice routinely talk to patients about costs?

☐Yes ☐No If yes, who? _____

5. Does our practice have materials that explain costs in a way that is easy for patients to understand?

☐Yes ☐No

6. What (e.g., materials, tools, training) would help our practice explain costs in a way patients could easily understand?

Please note any comments you would like to share about talking about the costs of care.



Publication No. 23-0075

August 2023

www.ahrq.gov