Putting the Spotlight on Health Literacy to Improve Quality Care

Sharon Allison-Otteny, MD, chair of the Health Literacy Task Force of the National Medical Association (NMA), recalls an example to which many colleagues could relate: She recently prescribed pills for a diabetic patient who was to take two a day: one in the morning and one in the afternoon. However, when the patient (a college graduate) returned for a follow-up visit, her blood glucose was surprisingly very high—because she had been taking both pills in the morning.

For Allison-Otteny, the situation is not that unusual. “Every single day, I see problems associated with poor health literacy,” she says. However, what makes her most concerned is the question of what may be happening among the broader senior population in the United States and among the growing number of individuals who have difficulty speaking or understanding English if this can occur to an American college graduate?

This issue has caught the attention of the American Medical Association Foundation, which presented a Washington, DC, briefing in May on the state of health literacy in the U.S. In 1998, the AMA was the first national medical organization to identify the impact of limited patient literacy on medical diagnoses and treatments.

According to Joseph Riggs, MD, president of the foundation’s board of directors, 90 million Americans, almost half of all adults, face challenges in understanding basic, common instructions given to them by their physicians.

This can range from understanding prescription bottle labels to comprehending test results to knowing how to complete simple medical insurance and consent forms. “We used to think in the past that maybe these people were disinterested or maybe they were lazy. But we know now that’s not very true,” Riggs says.

“We know that they do not have the proper skills to understand, and therefore, they can’t receive proper care,” he says. For individuals with poor health literacy skills, this has resulted, according to recent studies, in higher rates of improper medication use, higher rates of hospitalization, and poorer health outcomes—at an additional annual cost estimated at $54 billion to $73 billion.
A recent survey from the foundation found that the issue still is a small blip on many physicians’ radar screens: Two-thirds of the physicians questioned said they had not heard of health literacy. Of those who had heard of it, 87% agreed that it was “very important” and “very necessary” for proper healthcare, and 67% said they wanted to make changes in their offices to address health literacy.

The issue is beginning to receive greater oversight in other sectors. For instance, “self-management/health literacy” was one of 20 categories chosen by the Institute of Medicine (IOM) Committee on Identifying Priority Areas for Quality Improvement. (See The Quality Letter, 2/2003.) The IOM also convened a board last year to “assess the problem of health literacy” and provide direction on developing a “public health/public education framework.” Its report is due early next year.

This issue of The Quality Letter for Healthcare Leaders highlights findings from the AMA Foundation briefing on the prevalence of poor health literacy and the strategies that are needed to optimize communication between providers and patients. It also interviews individuals who are taking new approaches to address health literacy issues in their organizations and communities as a way of improving quality of care and empowering patients to take an active role in their own care.

Defining Health Literacy

To understand what health literacy is, it is important to understand what it is not. “A lot of people, especially a while ago, often confused the terms ‘health literacy’ and ‘literacy.’ They are not the same,” says Helen Osborne, MEJ Dist. OTR/L, who is president of Health Literacy Consulting, a Natick, MA-based firm she founded that works with healthcare organizations to improve their understanding of health literacy issues.

“You certainly need adequate literacy skills in order to be able to understand health information. But that alone doesn’t mean you can understand health information,” Osborne tells The Quality Letter. “What I often say is that given the right set of circumstances, we can all have trouble understanding.”

In working with her clients, says Osborne, the founder of Health Literacy Month (see box at right), she tries to stress the different variables that impact learning and communication. They include not only literacy but also age, language, culture, disability, and emotional state.

“I think that there are many reasons that we have trouble understanding, so personally,

“You certainly need adequate literacy skills in order to be able to understand health information. But that alone doesn’t mean you can understand health information. What I often say is that given the right set of circumstances, we can all have trouble understanding.”

Helen Osborne
Health Literacy Consulting

Health Literacy Month

To promote health literacy and the need for understandable health information, Helen Osborne, president of Health Literacy Consulting, founded “Health Literacy Month” in 1999. Information about the month—every October—is available at www.healthliteracymonth.com.

Started as a “web-only event,” the idea has been attracting increasing attention, Osborne says. Last year, organizations from 30 states and 10 countries became involved by promoting local activities addressing health literacy, and Osborne says the numbers are expected to be higher this year.

However, the concept is shifting toward “complementary online and offline components” where “we really encourage organizations—alone or in partnership with others—to raise awareness or increase our capacity to make a difference at the local level in whatever way makes sense,” Osborne says. “I don’t think there’s just one size that fits all.”

In the past, organizations have participated by: organizing national and regional health literacy conferences and symposia; running workshops and making presentations about health literacy; distributing Health Literacy Month postcards at conferences and association meetings; and displaying Health Literacy Month posters.

Whether in the United States or elsewhere in the world, “many of us are dealing with comparable issues no matter where we are or what kind of setting—inpatient or outpatient, urban or rural, rich or poor,” Osborne says. “We are all struggling with how do we communicate effectively.”
"I think from a system standpoint, we have to realize that one of the reasons we don’t know [the extent of the literacy problem] has to do with how we are. So, it’s going to involve a cultural shift on the part of providers."

Ruth Parker
Emory University School of Medicine

I don’t focus on any specific population,” Osborne says. “I try to sensitize professionals or those doing the writing or communicating that there can be a lot of reasons” why patients or other consumers may have difficulty understanding what is being said.

“I think when we call it health literacy, we stumble because we think it’s just about those people who can’t read,” says Robert Friedland, PhD, the founding director of the Center on an Aging Society at Georgetown University in Washington, DC.

“I think that’s a mistake,” according to Friedland, who spoke at the AMA Foundation briefing, “because there are people who can read. But they have the inability to put that information together because it requires a [variety] of skills—not just reading but also [understanding] instructions and visual cues and having empowerment to just ask questions.”

Ruth Parker, MD, an associate professor of medicine at the Emory University School of Medicine in Atlanta, said in an interview that hospitals, health systems, and other health organizations first need to “recognize that it is a problem, and embrace it as a real problem.”

Second, she says, they need to recognize that the problem is “very likely experienced” by people “that they’re providing services for and are involved with on a daily basis at every level—from the access to care process to outcomes.”

This means that organizations need to find ways “to begin to partner with people who have the problem—to figure out where their intervention points are,” says Parker, who has been examining the issue for more than a decade. Partnerships and cooperative efforts can be used to “bridge the enormous gap that is being created by the fact that those that are providing [healthcare] and those who are in need of service very commonly do not share a common language and understanding.”

Often, healthcare organizations underestimate the extent of low health literacy among their patients. It is somewhat like the “elephant in the room,” where the problem is there but no one wants to talk about it—even though it can have such a major impact on patient outcomes, says Parker, who is a member of IOM’s Committee on Health Literacy.

Not surprisingly, one reason the problem is underestimated is that many people are very good at concealing their lack of comprehension. “I think people hide it because it’s so embarrassing not to know, and it’s so embarrassing to have to admit you don’t know,” she says. “I think from a system standpoint, we have to realize that one of the reasons we don’t know [the extent of the literacy problem] has to do with how we are. So it’s going to involve a cultural shift on the part of providers.”

Low Health Literacy: A Quality Problem?

A decade ago, the congressionally sponsored National Adult Literacy Study released a landmark report estimating that 40 million American adults were functionally illiterate and could not perform basic reading tasks required to function in society; another 50 million were found to have only marginal literacy skills. Although the study did not specifically look at issues related to health, “we knew that this had tremendous
implications,” says David Baker, MD, who is chief of general medicine at Northwestern University’s Feinberg School of Medicine in Chicago.

“This was really a wakeup call for many of us in medicine,” adds Baker, who also spoke at the AMA briefing. “The question that we all had to ask ourselves is can patients read and understand materials that we expect them to be able to read?”

It’s a question he has been studying for years. In the mid-1990s, Baker—working with Parker and colleagues at Emory—developed a test to measure patients’ literacy skills, called the Test of Functional Health Literacy in Adults (TOFHLA). “We were not talking about if [patients] can read different texts,” he says. “We were talking about basic things that we expect patients to be able to do.”

The test consisted of 50 reading comprehension items that included questions about instructions for preparing for an upper gastrointestinal series, the patients’ rights and responsibilities section of a Medicaid application form, and a standard hospital informed consent form. A 17-item oral numerical ability test included directions for taking medicines, monitoring blood glucose, keeping clinic appointments, and obtaining financial assistance.

The test (in English and Spanish versions) was administered to nearly 400 outpatients. In compiling the results, the researchers found that many of them had difficulty understanding health-related instructions: 15% could not read and interpret a prescription bottle label with directions to take one pill by mouth four times a day; 37% did not understand instructions to take a medication on an empty stomach; and 48% could not determine if they were eligible for free healthcare (J Gen Intern Med 1995;10(10):537–541).

Similar results were noted in subsequent years by Baker and his fellow researchers. In 1997, in studies of patients using the emergency departments at Grady Memorial Hospital in Atlanta and Harbor-UCLA Medical Center in Torrance, CA, low literacy was “strongly associated” with self-reported poor health; however, the number of years of school completed was not strongly linked with self-reported health status. In Atlanta, patients with inadequate health literacy were more likely to report hospitalization in the previous year (Am J Public Health 1997;87(6):1027–1030).

And the issue of health literacy was found to be prominent among the highest users of healthcare: the elderly. In a 1999 study that interviewed more than 3,200 Medicare enrollees in four Prudential HealthCare plans in Cleveland, Houston, Miami, and Tampa, 34% of English-speaking and 54% of Spanish-speaking respondents were found to have inadequate or marginal health literacy (JAMA 1999;281(6):545–551). Low health literacy ranged from 16% of those 65–69 to 58% of those 85 or older.

Low or inadequate health literacy meant the individuals struggled with understanding the most primary healthcare information, and marginal health literacy meant, for instance, that they could do basic tasks such as reading a prescription bottle label but grappled with more-difficult prescription instructions.
Overall, the studies point to the fact that low health literacy is a large and growing issue in the U.S. “As the population ages—and as we have a higher prevalence of chronic diseases—we’re going to have more people who will have difficulty understanding the medical information central to [monitoring and maintaining their health],” Baker says.

This “discordance” of reading abilities “is likely to grow as we develop more-effective therapies as well,” Baker says. “This is a problem that we can’t ignore.”

**Low Literacy and Chronic Disease**

When internist Dean Schillinger, MD, joined the staff at San Francisco General Hospital in 1994, he was bothered by a pattern he observed among his patients with chronic conditions. “I’m an outpatient primary care physician [at a public hospital],” he says, “so I obviously see patients with chronic conditions in an ongoing fashion. But I was seeing people deteriorate at rates that I thought were unacceptably high for reasons that I couldn’t entirely explain.”

Even keeping in mind other factors that his patients faced—such as lack of money for medications, competing family demands, or housing problems—he was convinced that something else was impacting the poor health and outcomes of these patients.

After seeing published studies quantifying low literacy in public health settings (see previous section), Schillinger, who also is an associate professor of clinical medicine at the University of California-San Francisco (UCSF) and a fellow of the Soros Open Society Institute, which funds physicians’ work on social issues, took a new perspective on the issue. “The connection was very obvious to me that there are some things related to socioeconomic status that are beyond our control in the healthcare system,” he said in an interview. “But there are some things clearly under our control: That is how we communicate to patients both at the office-based setting as well as at the system level.”

Thus began Schillinger’s research into the area of communication—at both the provider-patient level and the health system-patient level—by working with and observing patients with type 2 diabetes.

As illustrated in research findings published last year in *JAMA*, he suggests that inadequate health literacy may be linked to poorer glycemic control and higher rates of retinopathy. In the study, 408 English- and Spanish-speaking type 2 diabetes patients, all older than 30, were enrolled. Their health literacy was assessed with a short form of the TOFHLA in English or Spanish (*JAMA* 2002;288(4):475–482).

Earlier studies have shown that maintaining optimal hemoglobin A1c (HbA1c), or blood sugar control, can prevent retinopathy. However, only 20% of patients with inadequate health literacy had optimum control, compared with 33% of those with adequate health literacy. In the study, 36% of the patients with inadequate health literacy, compared with 19% of those with adequate health literacy, had diabetic retinopathy. (The study found similar patterns for other outcomes related to diabetes, but it was not powered to detect those differences.)

But physicians and other providers may be able to make an impact in the literacy area now by eliminating the clinical and technical jargon they
use when speaking to patients, Schillinger says. Sometimes the jargon is technical, such as telling a diabetic patient about checking HbA1c levels; instead, the patient might understand the term “blood sugar levels” better.

Sometimes terms have different meanings in lay life and in medical life. For instance, a physician may say that a patient’s blood sugar is “stable.” However, “patients were all over the map when we asked them what it meant,” Schillinger says. Some thought it was a bad level, some thought it was good, some thought it was going up, and others thought it was going down.

Another area of misunderstanding is qualitative jargon, such as the phrase “call me if you’re having excessive bleeding.” “What is excessive?” Schillinger asks. “How much is too much? We need to be very, very clear with patients about what we’re asking them to do and not use jargon.”

Another area Schillinger and his colleagues at UCSF’s Primary Care Research Center have examined with diabetic patients is what he calls “closing the loop”: the interactive “teach-back” method in which a physician discusses treatment instructions or information about a medical condition and asks the patient to repeat back his or her understanding of what was said. This method, which was discussed in a study published this year, can be used by providers to assess patient’s recall or comprehension of a new concept or idea.

In the study, audiotapes were made of visits to 36 physicians by 74 English-speaking patients with diabetes and low health literacy. With regard to the frequency with which the teach-back method was used, the physicians assessed recall and comprehension of a new concept in 12 (20%) of 61 visits and for 15 (12%) of 124 new concepts.

Not surprisingly, Schillinger says, when the teach-back method was used, patients and physicians disagreed about half the time, allowing for subsequent clarification. “But what we found interesting was that those patients whose physicians used this method—a very simple method—had better blood sugar control,” he says. According to the study, patients whose doctors used teach-back were more likely to have HbA1c levels below the mean (just less than 8.6%) than those whose physicians did not use the method (Arch Intern Med 2003;163(1):83–90).

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**Optimizing Patient-Physician Communications**

Studies have shown that patients generally recall only about half of what providers tell them during a medical visit; for patients with low health literacy, that rate of recall could be less, says Darren DeWalt, MD, a fellow with the Robert Wood Johnson Clinical Scholars Program at the University of North Carolina at Chapel Hill. To optimize communications with all patients, he suggested at the AMA Health Literacy Forum that providers need to keep in mind what can jeopardize good communication between themselves and their patients—and what can improve it and improve outcomes:

- **High levels of patient anxiety.** When this occurs, information can be hard to retain. Patients with low literacy levels may have higher anxiety levels—due in part to feelings of powerlessness or a “sense of embarrassment about the ability to understand,” DeWalt says. **Solution:** Talk to patients more slowly, and simplify instructions. “Patients learn best when we translate medical information into their normal life experiences,” he says.

- **Too many recommendations.** When physicians try to explain too many recommendations, patients often are unable to remember all of them. **Solution:** Prioritize the most important points. “Patients remember one or two things that we tell them. Make sure they’re the most important things,” DeWalt says.

- **Severe illness impact.** When patients are ill, it is difficult for them to concentrate on, retain, and recall what a provider is saying. **Solution:** Have the patient bring along a family member or friend to help her or him remember.

- **Powerful emotions.** Powerful emotions—which can occur, for instance, with the delivery of bad news or a new diagnosis—can impair communication. **Solution:** The physician should recognize this and arrange for a close follow-up visit.

In addition, DeWalt notes that repetition can be a useful communications tool. “Most of us need to hear things one, two, or three times before we can really ever remember using it,” he says.

He also recommends the “teach-back” method, which encourages the patient to repeat instructions. “Research shows patients retaining medical information better when their physicians ask them to restate the main concepts at the end of the encounter,” DeWalt says. “This also helps the patients take more active roles in the conversations.”
Next, Schillinger is looking at the health system level, where the “barriers are perhaps more profound,” he says, for patients with low health literacy. To “focus less on barriers and more on solutions,” the San Francisco hospital has started a 2-year, randomized, controlled project to determine whether “a disease-management [DM] strategy—if done right—can reduce some of the disparities that we’ve observed” among the diabetic population with low health literacy.

Many hospitals and health systems across the country have made limited use of DM strategies in addressing chronic illnesses, Schillinger says. And among those that employ DM, most “have not tailored their strategies to meet the needs of people with limited health literacy,” he adds.

To test how DM can help diabetic patients “in a way that is appropriate to the health literacy level,” the hospital is comparing two DM techniques. One is a “low-tech” automated phone program that calls the patient in her or his primary language once a week to monitor the patient’s diabetes symptoms. When the symptoms appear to be outside a specific range, a nurse manager contacts the patient to provide further assistance.

A tailored education option also is made available to the patient by phone: For instance, instead of just being told to check his or her feet every 7 days, the patient can push a button to hear a “testimonial,” for instance, of “how Mrs. Jimenez did it,” Schillinger says. “We very much worked with low literacy folks to have them shape the messaging—both the content and the tone—in which we deliver this.”

The phone method is being compared with a “more interpersonal approach,” a monthly group visit, Schillinger says. At the meetings, patients set the agenda and talk about what they want to in relation to their diabetes. Direct care also is provided during the group visits (such as checking feet, changing medications, or reviewing HbA1c levels). The project is supported by the San Francisco Community Health Network, the Commonwealth Fund, the California Endowment, and the Agency for Healthcare Research and Quality.

As for which option patients prefer, only time will tell: Results are expected in about 2 years. “What I do know is patients have clearly said that the one-size-fits-all approach is not great—that right now, you basically get your doctor and good luck to you,” Schillinger says. “That’s no way to meet patients’ learning styles and preferences in the healthcare system.”

**Institution-Wide Change**

To make changes addressing health literacy issues, one system has found that it generally helps to make sure everyone is on the same page. Last year, the Cambridge (MA) Health Alliance—comprising four hospitals, the Cambridge Public Health Department, more than 20 primary care practices, and a statewide managed Medicaid health plan—took a big step in that direction: It adopted a proposal by the chief nursing officer that the system make it a policy—not just a suggestion—that all patient education materials be written in English at the sixth grade level or less before being translated. (Also see sidebar on following page.)

“We had sort of unofficial support before then,” says the alliance’s coordinator of patient education Linda McIntosh, EDM, APN. But to adopt a policy instead of just having an option “really moved things along at a quantum leap.”
This is a significant move for the alliance, which McIntosh says has a “huge population” that doesn’t speak English as a primary language and which has materials routinely prepared as well in Spanish, Portuguese, and Haitian Creole. In addition, translations in Italian, Russian, Vietnamese, and other southeast Asian languages sometimes are needed.

The alliance, one of seven grantees of the Institute for Healthcare Improvement’s Pursuing Perfection initiative, also has been looking at other ways to reach out to members with health literacy difficulties. One is the trial development of authorware—software designed for multimedia functions to be used with a computer touchscreen—that will give newly diagnosed patients at the tuberculosis clinic printed and spoken information about TB.

The information will address differences between TB infection and TB disease, how TB disease is spread, and why an individual needs to make an appointment for a doctor visit. “The provider will go over it with a patient,” McIntosh says. “Hopefully, by reinforcing it—but not a spending a lot of time teaching basic material—[the providers] will have a lot more time for the patient’s questions.”

**Improve Care to Improve Literacy**

One of the more culturally diverse cities in the country is Long Beach, CA. About 6 years ago, Long Beach Memorial Medical Center/Miller Children’s Hospital, recognizing that the number of Hispanic and Asian patients in the community was increasing, looked at needed changes in the way it provided care.

“We needed to improve the ability of these patients to get healthcare … and to be culturally [and] linguistically sensitive to the community,” says Guadalupe Padilla, MD, chief of staff at Miller Children’s Hospital, and the chair of the Medical Center’s Hispanic Task Force. To make this happen, a performance improvement project was begun.

One goal was to attract more Hispanic mothers-to-be to the medical center—to make it a place where they would want to deliver their babies. But much had to be done. “We needed to have the appropriate cultural and appropriate language infrastructures,” Padilla, a neonatologist, said in an interview. But to improve health literacy, the hospital had to improve the way it delivered healthcare.

One area it approached was determining how many employees were bilingual, and how they could communicate better with patients—whether to tell them how to get to a restaurant or if they should breathe or not push when delivering a baby. For the approximately 200 non-Spanish-speaking

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**Creating Easy-to-Read Materials**

Linda McIntosh of the Cambridge Health Alliance has compiled tips to make written material easier for patients to understand, which appear in a recent article at [www.nursingspectrum.com](http://www.nursingspectrum.com). She suggests using materials (often labeled “easy to read” or “plain language”) that have most of the following characteristics:

- Lots of white space on a page;
- Pictures that explain the content and reflect the intended audience;
- Short paragraphs, short sentences, easy words;
- Personal words (“you,” not “the patient”);
- Active verbs;
- “Need-to-know” information—not everything about a topic; and
- Content in a logical order.

When only hard-to-read material is available, she suggests that providers can:

- Review handouts with patients;
- Identify the most important parts of the material (highlighting them in yellow);
- Draw a small image next to text as a memory-jogger; and
- Make a brief audiotape with critical information for patients.

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9
Making Healthcare Words Understandable for All

“Ask Me 3,” an educational program from the Partnership for Clear Health Communication, notes that most people have difficulty understanding words used in healthcare. This sometimes occurs even with words that are familiar if the individual does understand it in the healthcare context.

To promote better understanding, the group has developed four categories of healthcare words that can cause misunderstandings: medical words, concept words, category words, and value judgment words. Healthcare providers can use alternative words or phrases to make the meanings clearer to patients. For more information, see www.AskMc3.com.

Medical Word Examples
(words often used by physicians and in healthcare instructions):

<table>
<thead>
<tr>
<th>Problem Word</th>
<th>Consider Using</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ailment</td>
<td>Sickness, illness, problem with your health</td>
</tr>
<tr>
<td>Benign</td>
<td>Will not cause harm; is not cancer</td>
</tr>
<tr>
<td>Condition</td>
<td>How you feel; health problem</td>
</tr>
<tr>
<td>Dysfunction</td>
<td>Problem</td>
</tr>
<tr>
<td>Inhibitor</td>
<td>Drug that stops something that is bad for you</td>
</tr>
<tr>
<td>Intermittent</td>
<td>Off and on</td>
</tr>
<tr>
<td>Lesion</td>
<td>Wound; sore; infected patch of skin</td>
</tr>
<tr>
<td>Oral</td>
<td>By mouth</td>
</tr>
<tr>
<td>Procedure</td>
<td>Something done to treat your problem; operation</td>
</tr>
<tr>
<td>Vertigo</td>
<td>Dizziness</td>
</tr>
</tbody>
</table>

Concept Word Examples
(words used to describe an idea or notion):

<table>
<thead>
<tr>
<th>Problem Word</th>
<th>Consider Using</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active role</td>
<td>Taking part in</td>
</tr>
<tr>
<td>Avoid</td>
<td>Stay away from; do not use (or eat)</td>
</tr>
<tr>
<td>Collaborate</td>
<td>Work together</td>
</tr>
<tr>
<td>Factor</td>
<td>Other thing</td>
</tr>
<tr>
<td>Gauge</td>
<td>Measure; get a better idea of; test (depending on context)</td>
</tr>
<tr>
<td>Intake</td>
<td>What you eat or drink; what goes in your body</td>
</tr>
<tr>
<td>Landmark</td>
<td>Very important (as adjective); important event or turning point (as noun)</td>
</tr>
<tr>
<td>Option</td>
<td>Choice</td>
</tr>
<tr>
<td>Referral</td>
<td>Ask you to see another doctor; get a second opinion</td>
</tr>
<tr>
<td>Wellness</td>
<td>Good health; feeling good</td>
</tr>
</tbody>
</table>

(continued on page 11)

healthcare workers, 12 beginning and advanced 1-hour Spanish classes were provided. Likewise, managers were offered training in cultural diversity.

Keeping in mind its community outreach, the organization began offering Lamaze classes in Spanish for Hispanic mothers-to-be, along with a “stork club” where expectant women could talk with their peers. A hospital representative attended to try to “demystify” old wives’ tales, if necessary. And the women received language-appropriate material on pregnancy written up to the sixth grade level.

“They got a chance to truly say what they were thinking. It was a very good atmosphere for information exchange,” Padilla says. While many of the women got information from their physicians, of course, “you sometimes find that people learn from each other better than they learned from their doctors.”

The next challenge was getting the mothers to return with their newborn children for appropriate care. To achieve this, a number of barriers needed to be overcome, Padilla says. “If you can’t come out to each and every one of them, how do you get them here [for health education]?”

In 2000, the organization located a Women, Infants, and Children center near the campus obstetrics clinic where mothers could get food stamps and nutritional counseling from staff members who spoke Spanish or Cambodian, in addition to English. If necessary, they also could receive appropriate OB care and counseling while visiting the center. More than 2,200 women use the facility each month.

At the children’s hospital, a number of changes have taken place. Everyone working at the hospital’s “entry points,” such as receptionists, is bilingual. More bilingual nurses and lab techs have been hired, and every medication given to a baby in the intensive care unit has instructions in both English and Spanish. Parents are taught CPR in English and Spanish. And employees’ name badges tell what languages they
“It just suddenly has a life of its own,” Padilla says.

“It’s hard to say you’ve just improved [health] literacy. No, you have to say you’ve improved care along with literacy,” she says. But it doesn’t stop there. A new Cambodian task force is looking at the needs of the area’s Cambodian population.

**Ask 3 Questions**

Keeping in mind the challenges of low health literacy, the Partnership for Clear Health Communication, an advocacy group founded last year by national organizations and individuals interested in this issue, has unveiled a new patient education campaign.

Called “Ask Me 3,” the campaign promotes an “aspirin-free solution” for “clear health communication” between providers and patients, says Barbara DeBuena, MD, PhD, who is senior medical director of public health with Pfizer Pharmaceuticals, one of the founding organizations. The three “simple but essential questions for everyday healthcare” that patients are urged to ask are:

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

It is hoped that use of the questions will help “destigmatize” the shame and embarrassment surrounding low health literacy, says DeBuena, who spoke at a media briefing for the Ask Me 3 campaign. In addition, the program is intended to give providers a cue to “distill complex health information into three concise clearly delivered messages.” (See suggestions on pages 10–11.)

Allison-Otter, an internist and geriatrician, who also spoke at the briefing, says that awareness needs to be raised about the scope and impact of poor health literacy since anyone can be affected by the problem. “You can’t tell by looking,” she quips.

“Medicine should be a partnership with fluid communications between all healthcare providers and the patient,” she adds.

### Making Healthcare Words Understandable for All (cont.)

<table>
<thead>
<tr>
<th>Category Word Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>(words describing a group or subset that may be unfamiliar)</td>
</tr>
<tr>
<td><strong>Problem Word</strong></td>
</tr>
<tr>
<td>Activity</td>
</tr>
<tr>
<td>Adverse (reaction)</td>
</tr>
<tr>
<td>Cognitive</td>
</tr>
<tr>
<td>Hazardous</td>
</tr>
<tr>
<td>High-intensity exercise</td>
</tr>
<tr>
<td>Generic</td>
</tr>
<tr>
<td>Noncancerous</td>
</tr>
<tr>
<td>Poultry</td>
</tr>
<tr>
<td>Prosthesis</td>
</tr>
<tr>
<td>Support</td>
</tr>
</tbody>
</table>

### Value Judgment Word Examples

(words that may need a visual or other example to convey their meaning clearly)

<table>
<thead>
<tr>
<th><strong>Problem Word</strong></th>
<th><strong>Consider Using</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Adequate</td>
<td>Enough</td>
</tr>
<tr>
<td>Example: “adequate water”—6 to 9 glasses a day</td>
<td></td>
</tr>
<tr>
<td>Adjust</td>
<td>Fine tune; change</td>
</tr>
<tr>
<td>Cautiously</td>
<td>With care; slowly</td>
</tr>
<tr>
<td>Excessive</td>
<td>Too much</td>
</tr>
<tr>
<td>Example: “bleeding”—if blood soaks through the bandage</td>
<td></td>
</tr>
<tr>
<td>Increase gradually</td>
<td>Add to</td>
</tr>
<tr>
<td>Example: “exercise”—add 5 minutes per week</td>
<td></td>
</tr>
<tr>
<td>Moderately</td>
<td>Not too much</td>
</tr>
<tr>
<td>Example: “exercise”—so you don’t get out of breath</td>
<td></td>
</tr>
<tr>
<td>Progressive</td>
<td>Gets worse or better</td>
</tr>
<tr>
<td>Routinely</td>
<td>Often</td>
</tr>
<tr>
<td>Example: every week, every other day</td>
<td></td>
</tr>
<tr>
<td>Significantly</td>
<td>Enough to make a difference</td>
</tr>
<tr>
<td>Temporary</td>
<td>For a limited time</td>
</tr>
<tr>
<td>Example: for less than a week, for less than a day</td>
<td></td>
</tr>
</tbody>
</table>