Local Service Category:	**Linguistics Services**
Amount Available**:**	**To be determined**
Unit Cost**:**	
Budget Requirements or Restrictions **(TRG Only)**:	Maximum of 10% of budget for Administrative Cost.
DSHS Service Category Definition	Support for Linguistic Services includes interpretation (oral) and translation (written) services, provided by qualified individuals as a component of HIV service delivery between the provider and the people living with HIV (PLWH), when such services are necessary to facilitate communication between the provider and PLWH and/or support delivery of Ryan White-eligible services. Linguistic Services include interpretation/translation services provided by qualified interpreters to people living with HIV (including those who are deaf/hard of hearing and non-English speaking individuals) for the purpose of ensuring communication between PLWH and providers while accessing medical and Ryan White fundable support services that have a direct impact on primary medical care. These standards ensure that language is not barrier to any PLWH seeking HIV related medical care and support; and linguistic services are provided in a culturally appropriate manner. Services are intended to be inclusive of all cultures and sub-cultures and not limited to any particular population group or sets of groups. They are especially designed to ensure that the needs of racial, ethnic, and linguistic populations severely impacted by the HIV epidemic receive quality, unbiased services.
Local Service Category Definition:	To provide one hour of interpreter services including, but not limited to, sign language for deaf and /or hard of hearing and native language interpretation for monolingual people living with HIV.
Target Population (age, gender, geographic, race, ethnicity, etc.):	People living with HIV in the Houston HIV Service Delivery Area (HSDA).
Services to be Provided:	Services include language translation and signing for deaf and/or hearing-impaired HIV+ persons. ~~Services exclude Spanish Translation Services.~~
Service Unit Definition(s) **(TRG Only)**:	A unit of service is defined as one hour of interpreter services to an eligible PLWH.
Financial Eligibility:	Income at or below 500% Federal Poverty Guidelines.
Eligibility for Service:	People living with HIV in the Houston HSDA
Agency Requirements **(TRG Only)**:	Any qualified and interested agency may apply and subcontract actual interpretation services out to various other qualifying agencies.
Staff Requirements:	ASL interpreters must be certified. Language interpreters must have completed a forty (40) hour community interpreter training course approved by the DSHS.
Special Requirements **(TRG Only)**:	Must comply with the Houston HSDA **Linguistic Services Standards of Care**. The agency must comply with **the DSHS Linguistic Services Standards of Care**. The agency must have policies and procedures in place that comply with the standards ***prior*** to delivery of the service.

FY 2026 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/12/2025**
Recommendations:	Approved: Y:_____ No: ______ Approved With Changes:______	If approved with changes list changes below:
1.		
2.		
3.		
Step in Process: **Steering Committee**		Date: **06/05/2025**
Recommendations:	Approved: Y:_____ No: ______ Approved With Changes:______	If approved with changes list changes below:
1.		
2.		
3.		
Step in Process: **Quality Improvement Committee**		Date: **05/13/2025**
Recommendations:	Approved: Y:_____ No: ______ Approved With Changes:______	If approved with changes list changes below:
1.		
2.		
3.		
Step in Process: **HTBMTN Workgroup #3**		Date: **04/16/2025**
Recommendations:	Financial Eligibility:	
1.		
2.		
3.		

Ensuring the right to health for migrants and refugees

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See Series pages e861 and e873

Climate change, conflict, economic and political crises, and other events have led to markedly increased migration and forced displacement in the past decade. By 2020, 280·6 million people were considered international migrants, refugees, and asylum seekers (henceforth, migrants and refugees), with the majority in low-income and middle-income countries (LMICs).[1] Some migrants and refugees arrive in their destination country living with HIV, but stereotypes that they spread HIV are inaccurate and have led to harmful laws, regulations, and public health responses. Migrants and refugees are at risk of acquiring HIV and of experiencing treatment delays due to social vulnerabilities, insufficient protections, and exclusionary policies in transit and after arrival to their destinations.[2,3] The global community should urgently and collectively invest in strategies to mitigate these risks, not only as a moral obligation, but also as a pragmatic and proactive approach to public health in the face of continued displacement for the foreseeable future.

Two Series papers by Claudia P Cortes and colleagues[2] and Alena Kamenshchikova and colleagues[4] focus on access to HIV services among international migrants and refugees. The Series identifies key challenges for all populations on the move, regardless of the impetus for migration, and highlights social and structural issues that impede access to HIV diagnostics, prevention, and care.[2,4] The main recommendations from the Series broadly include ensuring access to confidential HIV testing and services without deportation or refoulement, providing health care regardless of migration status, and involving migrants and refugees in the planning and delivery of HIV services to ensure they are culturally and linguistically appropriate, affordable, and accessible.[2,4]

The right to health for migrants and refugees is protected by international humanitarian and human rights laws, which have been almost universally ratified (appendix). However, governments have often adopted a restrictive approach to migration under the pretext of preventing cross-border transmission and reducing potential health expenditures.[5] Despite insufficient public health justification, many of these discriminatory policies continue today.[5] Furthermore, in 2024, the HIV Policy Lab reported that most (114 of 194) countries had only partial policies or had not adopted national policies ensuring that migrants receive similar access to HIV services and primary care as citizens.[6] Countries with the largest numbers of migrants and refugees are least likely to have such policies. The discrepancy between commitments to the right to health and actual implementation reflects anti-migrant and anti-refugee sentiments, as well as insufficient funding, political will, and accountability for human rights and humanitarian law.

Universal health care that is inclusive of migrants and refugees is fundamental to addressing HIV. Very few countries, however, integrate migrants and refugees into government health programmes, including in terms of health insurance.[7] Short of universal health care, other strategies can be implemented to ensure the right to health for migrants and refugess. In Thailand, for example, where national health coverage is restricted to nationals, regular migrants are eligible for health coverage under the Social Security Scheme or Migrant Health Insurance Scheme.[8] In other countries, changes to migration policies have indirectly provided such access. At the height of a period of increased migration from Venezuela to Colombia, the Colombian government created a 10-year temporary protection status for approximately 1·8 million Venezuelans, ensuring access to health coverage through a contributory employment scheme or a subsidised scheme for those not formally employed.[9] The same occurred for Ukrainian refugees in the EU.[10] Although these models have limitations, they provide examples for settings where migrants and refugees are unable to access health care.

See Online for appendix

Acknowledging the challenges that increased migrant flows create in transit and destination countries, most of which occur in LMICs, is crucial.[1] However, integrating migrants and refugees into HIV prevention and care benefits both migrants and refugees and host communities by reducing HIV transmission, lowering health expenditures, and promoting a healthy workforce.[7] Although the inclusion of migrants and refugees into social insurance schemes requires early investment, it can lead to substantial economic growth. A 2022 analysis showed that early investment in integration of Venezuelan migrants and refugees costs countries (ie, Brazil, Chile, Colombia, Ecuador, and Peru) up to 0·5% of their GDP but is projected to increase in their GDP by as much as 4·5% by 2030.[11] Furthermore, integrating migrants and refugees into efforts to achieve universal health care might improve the quality of health services for both nationals and displaced people by streamlining national and international financing into a single health system.[12] Avoiding parallel health systems might also dispel the perception that migrants and refugees receive better or lower-cost services than do local populations.[12] Ultimately, integrating migrants and refugees into government-funded social services requires strong political leadership to address concerns from underserved host communities. All donors, including HIV-specific funders, should prioritise supporting the needs of all vulnerable people, not just migrants and refugees.

Migration and forced displacement will inevitably continue and probably increase, intensifying the need for substantial funding to achieve universal health care, particularly in LMICs. Achieving universal health care includes the provision of HIV services for all populations within their borders. The call for renewed adherence to human rights and humanitarian law,[2,4] increased funding from non-traditional sources, and innovative financing strategies has never been more pressing. Although the recommendations for addressing HIV among these populations might not all be new, the time to implement these solutions is now, before the opportunity is lost.

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Addressing HIV prevention and the PrEP gap among migrants

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See **Series** pages e861 and e873

Tremendous successes have been achieved in treating and caring for people living with HIV and in developing HIV prevention technologies such as pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP).[1] However, this progress has not been distributed evenly among key populations.[2] In fact, migrant populations have experienced great disparities despite their increased vulnerability to HIV acquisition.[3]

Existing research in migrants mostly focuses on access to the HIV continuum of care, whereas research on primary HIV prevention is comparatively scarce. Minoritised and racialised populations are easily labelled as hard-to-reach, but researchers might have insufficiently innovative strategies for sampling, identifying, recruiting, and interviewing them. As a result, minoritised and racialised populations are under-represented in HIV research. For instance, few studies have investigated peer-led and community-based outreach activities to promote HIV combination prevention, including HIV testing, despite the promising results of such approaches.

Improve patient outcomes by speaking their language

April 5, 2024
By Nic McMahon

Blog Article

Medical practices can choose from a wide array of tools to enable communication with patients from diverse backgrounds

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Patients with limited English proficiency (LEP) face poorer health outcomes due to low health literacy and language barriers.

In a recent systematic review, 75% of studies showed that LEP patients experienced better outcomes when they spoke the same language as their providers.Written translation also supports connection. In a recent study 91% of Spanish-speaking parents preferred to receive translated copies of their children's written discharge instructions to improve comprehension.

How can health care professionals build the trust they need to successfully treat culturally and linguistically diverse patients? A language access plan offers a roadmap to help practitioners build cultural competence to connect with patients. Planning ahead allows for efficient use of resources and effective communication.

Here's how to create an effective, patient-centered language access plan for your practice:

Assess community needs

The first step is to understand the population you serve. To determine which languages are spoken in your community, refer to the U.S. Census Bureau's language tables. For greater precision, artificial intelligence tools can fill in missing data based on the known demographics in your practice area. Once you understand your patients' needs and preferences, you can begin to meet those with communications that connect.

Keep in mind which points of contact these patients are likely to have with your practice team. Whether they're telephoning, using an online portal, or visiting the office for an appointment, ensure that your team is offering meaningful language access at each touchpoint.

Create your connection toolkit

Next, create a comprehensive language services toolkit. Consider the following questions when creating your plan:

Which types of interpreting will you offer? A review by the Wellesley Institute found that providing trained interpreters improved health outcomes and increased preventative care.

There are several ways to provide this service, and your practice will probably want to offer a mix of options. On-site interpreting and video remote interpreting (VRI) both offer face-to-face interaction for improved communication, allowing both the patient and interpreter to respond to important non-verbal cues like facial expressions and body language. VRI may provide a quicker, more cost-effective way to provide access to an interpreter in a patient's preferred language, allowing you to provide service to more communities.

Over-the-phone interpreting is the best fit for follow-ups or non-emergency situations when there isn't enough time to arrange for an on-site interpreter.

Remote simultaneous interpreting (RSI) is rapidly gaining popularity due to the recent increase in remote care. RSI is concurrent, which means the interpreter interprets while the other patient speaks, so there's no delay.

With RSI, the interpreter is in another location, so communication is handled through video and headsets. Although the interpreter is not in the room, patients often find the immediacy of RSI reassuring. Children's hospitals have used It to assess children in a global clinical trial. There's also evidence that RSI is the most effective interpreting method for reducing the rate of clinically significant medical errors.

How will you translate documents? Providing professionally translated documents helps ensure that patients fully understand their health care, insurance, and billing options. This is not only practical but also a matter of compliance: regulations like Section 1557 of the Affordable Care Act require specific documents to be available in the patient's preferred language.

But truly meaningful access requires not only making translated material available but going beyond minimum compliance mandates. A culturally competent approach to communication promotes equity and patient satisfaction by ensuring your patients understand their health status and treatment plan.

Machine translation technology can speed up the process, but only in tandem with specialist translators who understand the medical field and thus avoid translation errors that could harm patients or lead to frustration.

Some patients may have difficulty with written information, even when it's written in their home language or at or below the recommended fifth-grade reading level. A medical interpreter may be required to read the written documents to the patient and assist you with any follow-up questions.

Provide training

Train your staff so that everyone understands their specific role in implementing the plan. This includes training in both cultural competence and the technology used to provide language access to patients.

Cultural competence in health care goes beyond language to include skills such as fostering health literacy for diverse patient populations and navigating social and cultural differences in communication. To promote consistency in training and procedures, appoint one person on your team to the role of language access coordinator.

When everyone in your office can confidently handle requests for language access, patients will feel more confident in the care you provide.

Build community awareness

Now it’s time to let your community know that language isn't a barrier to getting care at your practice through an awareness campaign that includes the major marketing channels your patients use.

With growing diverse populations, your practice needs a plan that supports equal access to care. A language services provider has the expertise to assist with translation, language asset management and navigating regulations. This partnership increases accuracy, compliance and overall efficiencies.

The good news is that more language access tools than ever are at your team’s disposal. Using these tools to connect with patients can ensure everyone in your diverse community gets the care they need to improve their health in a culturally relevant way.

Nic McMahon is CEO of United Language Group*, a leading language solutions provider.*

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EDITORIAL

The value of communicating with patients in their first language

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1. Introduction

In today's era of globalization, clinicians have to deal with a diverse patient population, coming from a varied range of cultural, linguistic, and socio-economic backgrounds. Modern-day medicine emphasizes shared decision making that mandates active discussion between the clinician and patients. The clinician's choice of speaking his patients' language is of paramount importance in building a healthy clinician-patient relationship and overall better patient experience [1].

Communicating across linguistic barriers is a challenge for clinicians and healthcare workers all over the globe. Both clinicians and patients face problems because of language barriers. Sometimes, the patients are unable to understand the language of their clinicians and clinicians too find it difficult to gauge the extent to which their patients understood what was conveyed to them. Not just the use of different languages, but partial language barriers such as difficulty in finding words, problems with pronunciation or understanding of utterances, or just a different accent can make a clinician-patient conversation ineffective.

The barriers and challenges encountered in medical interactions are highly context-specific. Many clinicians, mainly the budding medical practitioners, tend to ignore the patient's level of understanding and their ability to process the information given to them. They often overlook that 'How' information is being communicated is as important as 'What' information is being communicated. The ground condition and challenges of medical practice and consultations are, in reality, quite different from communication models described in medical textbooks. As each patient is unique and has his/her way of expressing their health problem, they communicate essential information in different ways.

2. Components of effective communication: all are important

A clinician's conversation with his/her patient is not just about the choice of words or language. The attention with which the clinician listens to his/her patient, along with his/her non-verbal clues such as the body language, posture, gestures and para-verbal components such as tone, pitch and volume, all convey a strong message. Active listening is also a vital component of clinician-patient communication. It is essential for patients to feel that the clinician is actively attending to them and they should not be interrupted while explaining their problems. It is an excellent practice to ask the patient if he/she would like to add anything before closing the conversation/interview. Patients might not fully understand the nature, course or prognosis of the disease or the required treatment due to intellectual or linguistic barriers. Still, they sense the style of communication, which directly impacts their level of satisfaction, adherence to treatment and clinical outcomes [2].

3. Linguistic barriers in medical communication: impact and consequences

When patients and clinicians speak different languages, the whole process of treatment, including the signing of consent forms, reading disease-related printed material, understanding treatment-related expenses etc. becomes even more complicated for the patients. It has been seen that many clinicians often end up making crucial treatment-related decisions on their own without involving the patients due to language barriers. If a language barrier prevents doctors from ensuring that their patient understands the warnings or risks of a medication, those clinicians may be liable in tort for breaching the duty to warn [3]. Miscommunication due to linguistic barriers has been regarded as one of the common precursors for workplace violence in hospital settings [4]. A research study done in South India shows that one of the significant reasons behind patients filing lawsuits against clinicians is due to the inability to understand the nature of medical procedures to which they gave their consent. This is why so much emphasis is given to take informed consent from patients in understandable non-medical terms, preferably in the local language. The diagnosis, nature of the treatment, risks involved, prospects of success, prognosis if the procedure is not performed and alternate treatment options should all be well explained to the patient, in the language that he/she comprehends well [5].

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This article has been republished with minor changes. These changes do not impact the academic content of the article.

4. Benefits of talking in the patient's language

> "Patients do not remember the doctor's prescription; they remember the doctor's communication"
> - Prachi Keakar.

Talking to the patient in the language that he/she understands increases their confidence in the clinician. Not only does a common language facilitate comprehension of medical information, but it also allows for better assessment of patients' needs, perceptions, and expectations [6]. The patient feels comfortable in sharing his/her personal information about the disease without the fear of getting judged by the clinician. The two-way communication improves the diagnostic accuracy of the clinician, as they can extract crucial information from the patients. Not just the ease in diagnosis, even treatment compliance can be significantly improved through effective communication with the patients. Studies suggest that clinician-patient interactions if done in the patient's language enhances compliance with the treatment plan [7].

5. Strategies for learning skills to communicate in the patient's language

Medical aspirants in many parts of the world are selected based on national level entrance examinations which score them based on their subject-related knowledge. Soft skills like language, communication skills, attitude, etc., although important, are not an essential determinant for admission to medical schools in many parts of the world, especially in developing countries. Students from one region of the country take admissions in medical colleges in far off areas based on their ranks and choice. As a result, many clinicians end up working in areas where they are not familiar with the mother tongue of the local people. In situations like these, it becomes essential to train them at a young age, using questionnaire-based training modules to pick up the locally spoken language. At an individual level, such clinicians should make conscious efforts to involve themselves with friends and colleagues who belong to that area to be able to learn the key terms of the local language.

Not just learning the language, there are many patient-friendly communication strategies that clinicians should adopt to increase their efficiency in providing patient-centric care. It is always better to ask the patient what language he/she is comfortable with. A doctor should not assume that a multilingual patient can process his/her language well. Even while speaking the patient' language, the clinician must avoid the use of medical jargons. Instead, he/she should use simple terminologies/layman language that is well understood by the patient. For example, instead of using the term 'myocardial infarction' the clinician can use the word 'heart attack', similarly instead of 'hyperlipidemia', the term 'high cholesterol' can be used. A clinician can also use similes to make his/her patients understand complex information. It is also a good idea to ask the patient to repeat the given instructions. If the patient fails to do so, then the instructions should be provided in a simpler language.

Along with the delivery of information, it is equally important to master the art of active listening. This skill can help a clinician sail through the linguistic barriers to quite an extent. With experience and training, physicians are often able to understand the patient much better just by paying attention and listening to them carefully. To further enhance the communication process, a clinician should go beyond words. He should make use of drawings, pictures and illustrations which may help the patient in comprehending complicated health issues better. Visuals, models, videos can also be used to make patients understand about surgical procedures. A clinician must also acquire the knowledge, attitude and skills for meeting the cultural competency of the patient as this would help them resonate better with the values, beliefs and concerns of the patient. Hospitals and medical colleges must try to have time to time questionnaire-based assessments to evaluate the communication skills of their clinicians and healthcare staff to ascertain barriers to excellent communication and work on improving them [8].

6. Expert Opinion

Effective doctor-patient communication lays the foundation for a successful doctor- patient relationship. It is essential not only for correct medical diagnosis but also ensures adherence to treatment as well as patient satisfaction. Doctors all over the world face various hurdles while communicating in the patient's first language, which complicates the treatment process and sometimes may become precursor to violence in the hospitals. Learning the native language of the area where the doctor works, helps in facilitating doctor patient communication. Active listening is a strong pillar that supports communication across linguistic barriers. It is important that medical graduates appreciate the value of effective communication with the patients and invest time and energy in polishing their verbal and non verbal communication skills.

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White Paper

TALKING THE PATIENTS' LANGUAGE

The importance of effective, health literate, patient-centered engagement

JOHN PROCTER, Vice President, Patient Engagement & Medical Affairs, IQVIA
REBECCA GALBRAITH, Head of Medical and Patient Communications, IQVIA
CLARE MOLONEY, Program Insights and Design Lead, Medical and Patient Communications, IQVIA

TABLE OF CONTENTS

EXECUTIVE SUMMARY

FOSTERING POSITIVE HEALTH BEHAVIORS

This white paper explores evidence that improving patient engagement leads to positive outcomes for all healthcare system stakeholders. The clinical encounter is at the core of patient engagement, supporting and fostering positive health behaviors. This engagement can be amplified by patient support programs designed using the principles of behavior change, adult learning, health literacy and instructional design. Based on multimodal instructional design, such programs can enhance engagement of patients with different learning styles, using a range of modalities – print, video, digital, mobile, or face-to-face training. Behaviorally driven mobile health interventions are of particular interest, potentially offering an interactive channel to address pathways linked to sustained behavior change, although the benefits of face-to-face interaction should not be underestimated.

INTRODUCTION: USING PATIENT ENGAGEMENT TO OPTIMIZE HEALTHCARE OUTCOMES

Effective patient engagement and empowerment – driving patients' involvement in their own healthcare and decision making – has potential to improve treatment adherence, health outcomes and patient quality of life. However, while engagement is critical for better patient outcomes, as many as 56% of healthcare consumers in the United States show little or no engagement in their health.[1]

Over the past decades, clinical practice has gradually been increasing its focus from an "authoritative/paternal" model to a more "collaborative/consumer" model. This shift often calls on patients as consumers to become more active in their own healthcare decisions, and to move from "adherence" to "self-management" where they have a full understanding and belief in their treatment plan. As the number of chronic disease patients is growing significantly across the world, the healthcare industry has responded to the call for increased "patient engagement," with governments also supporting this trend.

PATIENT ENGAGEMENT IS DEFINED BY THE AGENCY FOR HEALTHCARE RESEARCH AND QUALITY (AHRQ) AS

"The involvement in their own care by individuals (and others they designate to engage on their behalf), with the goal that they make competent, well-informed decisions about their health and healthcare and take action to support those decisions."[2]

This response aligns with a growing body of evidence demonstrating that patient-reported and quality outcomes and patient experience are improved when patients become more actively involved in their own healthcare.

The rise in patient engagement activities represents a shift in approach within the current values and outcomes era. This increase in patient engagement accompanies the changes in long-term disease prevalence and therapies, an aging population, the presence in individuals of multiple chronic medical conditions (multimorbidity), simultaneous use of multiple drugs to treat a single ailment or condition (polypharmacy), and cancer increasingly becoming a long-term condition rather than a terminal disease.

Pharmaceutical company pipelines are also shifting, placing a new emphasis on patient identification, and patient education and training. The regulatory environment continues to evolve, with requirements to demonstrate that patient engagement activities meet a need, are non-promotional, and support patient autonomy. There is also increasing interest in use of eHealth (healthcare practice supported by electronic processes and communication) and mHealth (the use of mobile phones and other wireless technology in medical care).

An awareness of current policymaker agendas is essential. Of equal importance is the need to show value of a product if costs are increased, a push for greater citizen engagement, changes in the healthcare workforce, and availability of supporting technology.

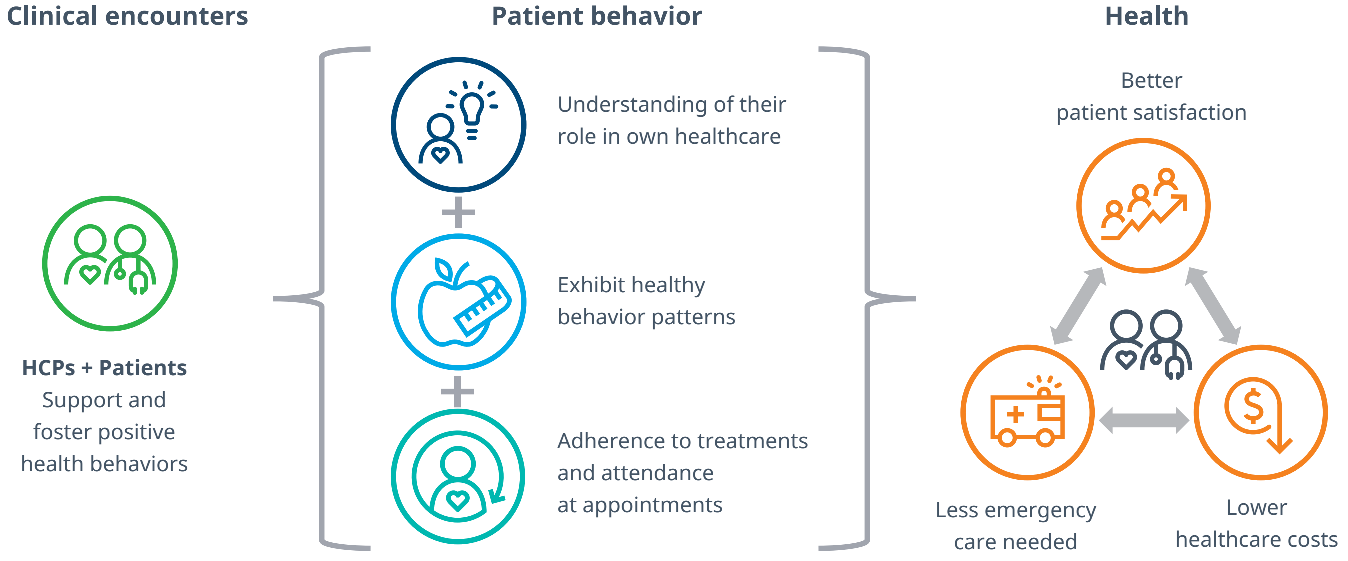
DRIVING PATIENT ENGAGEMENT, LEARNING AND RETENTION

The clinical encounter is at the heart of interactions between patients and the healthcare system, and this drives patient engagement, supporting and fostering positive health behaviors (Figure 1).

It is now widely recognized that increasing someone's level of involvement in the learning process is a key consideration when designing patient engagement services.[3] This moves us away from just providing passive content to considering ways in which people can engage and "be involved." In addition, multimodal programs incorporate multiple learning approaches to cater to the many learning styles that adults bring to training environments (Figure 2).

> ***Good patient engagement strategies using multimodal design can help enhance learning by building engagement through a variety of formats, which can benefit patients with many different learning styles.***

Figure 1: Patients actively participating in their own healthcare can achieve positive outcomes



Clinical encounters

HCPs + Patients
Support and
foster positive
health behaviors

Patient behavior

Understanding of their role in own healthcare

\+

Exhibit healthy behavior patterns

\+

Adherence to treatments and attendance at appointments

Health

Better patient satisfaction

Less emergency care needed

Lower healthcare costs

Figure 2: Considering different styles of learning

VISUAL LEARNERS

- Learn by seeing
- Best understand words that evoke images
- Respond well to demonstrations
- Enjoy visually pleasing presentations

KINESTHETIC LEARNERS

- Learn through trial-and-error
- Prefer hands-on approaches
- Use multiple senses to engage with material
- Enjoy solving real-life problems

AUDITORY LEARNERS

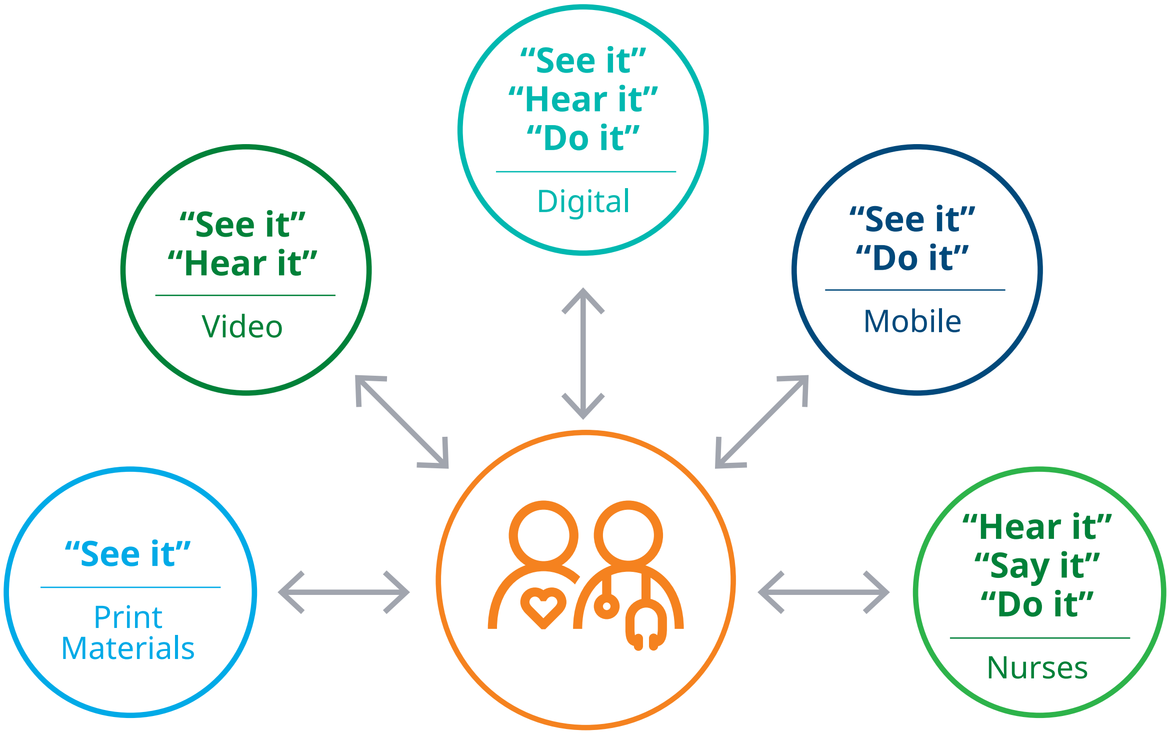
- Learn by listening and verbalizing
- Listen for keywords and phrases
- Respond well when things are explained aloud
- Think in a linear fashion

READ-WRITE LEARNERS

- Learn by reading and writing
- Best understand explanations on paper/screen
- Organize thoughts and make lists
- Translate lessons into words

Good patient engagement strategies using multimodal design can help enhance learning by building engagement through a variety of formats – print, video, digital, mobile and face-to-face training with healthcare providers (Figure 3). Varied formats can enable engagement of patients with many different learning styles. For example, informational content can be delivered via printed materials (“see it”). Patient stories and emotional engagement can be delivered via videos (“see it, hear it”). Action planning, goal setting and tools can be delivered to patients via digital channels, including the Internet and apps (“see it, hear it, do it”). Symptom trackers and text reminders are good examples of these channels, and allow patients to be prompted (“see it, do it”). Live discussions can take place through nurse educator or pharmacist contact, in person or through a call center (“hear it, say it, do it”).

Figure 3: Using multimodal design to enhance learning



“See it, hear it, say it, and do it”

DEVELOPING EFFECTIVE CONTENT FOR PATIENT ENGAGEMENT PROGRAMS

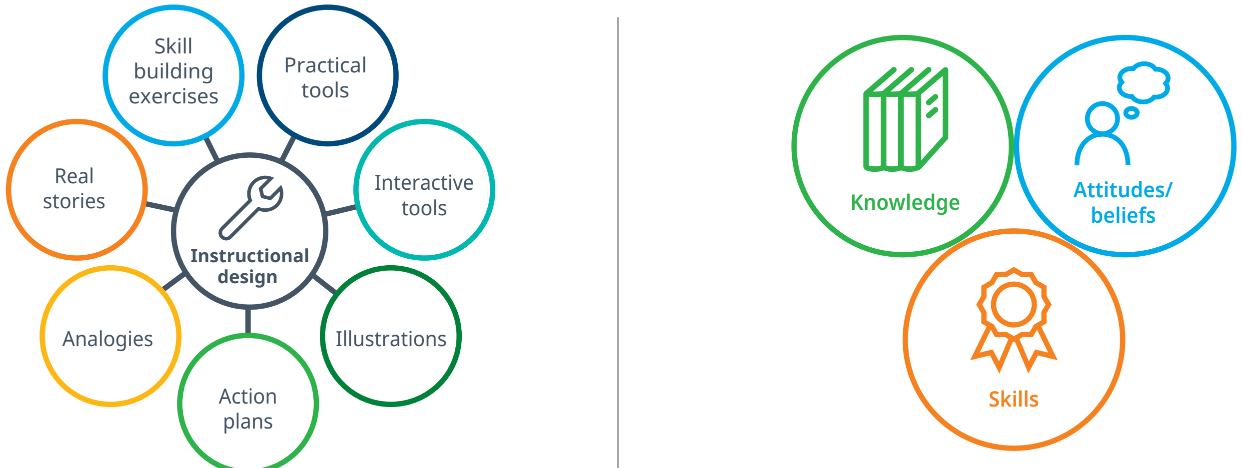
Effective content can be developed for patient engagement programs by using the principles of behavior change, adult learning and health literacy (Figure 4). Instructional design takes advantage of elements such as skill-building exercises, practical and interactive tools, illustrations, action plans, analogies and real stories. Behavior change models – taking account of patient knowledge, attitudes/beliefs and skills – have been applied to almost every disease state. In addition, incorporating evidence-based behavior change techniques into content, such as action planning and self-monitoring of behavior, increases the likelihood of effecting meaningful change.[4]

The 3 pillars of instructional design, behavior change and health literacy models can be a powerful combination to help engage patients, and should form the foundations of any patient support program. This combination provides:

- **Tools** to address values, beliefs, attitudes, emotions
- **Education** to address gaps and barriers, and justify the patient engagement program or product
- **Practical training** to increase self-efficacy, confidence and skill
- **Materials** that leverage the entire support network (HCPs, nurses, dieticians, physician assistants, pharmacists, advocacy, family)
- **Resources** to support access and overcome cost barriers
- **Action plans** that offer a linear path, showing the various steps the patient needs to follow (Figure 5)
- **Multimodal design** to accommodate multiple learning styles

Figure 4: Developing effective engagement content

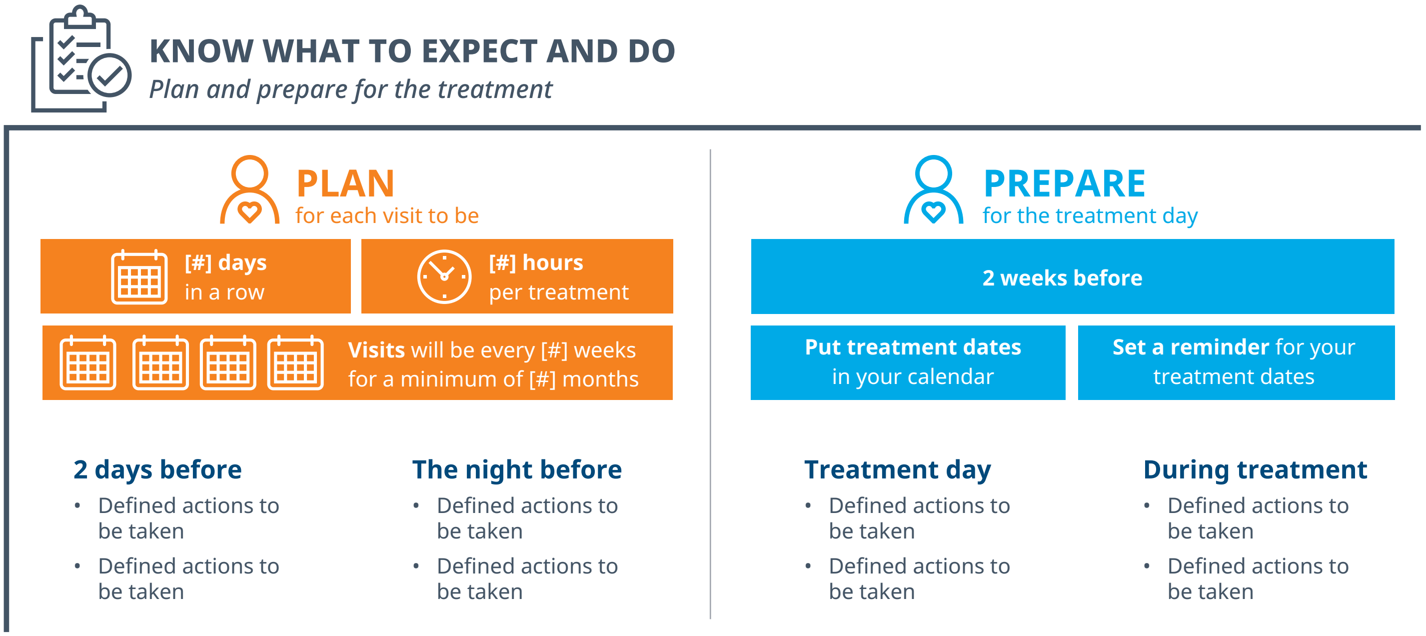
Using the principles of instructional design, behavior change and health literacy



Instructional design comprises practical tools and behavior change techniques for health communication

Behavior change models and techniques help us to understand, predict and change behavior

Figure 5: Action plans: Applying the theory to patient materials



KNOW WHAT TO EXPECT AND DO

Plan and prepare for the treatment

PLAN
for each visit to be

[#] days
in a row

[#] hours
per treatment

Visits will be every [#] weeks
for a minimum of [#] months

2 days before
- Defined actions to be taken
- Defined actions to be taken

The night before
- Defined actions to be taken
- Defined actions to be taken

PREPARE
for the treatment day

2 weeks before

Put treatment dates
in your calendar

Set a reminder for your
treatment dates

Treatment day
- Defined actions to be taken
- Defined actions to be taken

During treatment
- Defined actions to be taken
- Defined actions to be taken

THE IMPORTANCE OF HEALTH LITERACY

Health literacy is much more than being able to read. Patients need to be able to find information in print materials, online and through health and advocacy organizations. They can use this information to manage their health condition(s) by:

- **Understanding** treatment choices and recommendations, including risks and benefits
- **Interpreting information** – for example, risks for disease recurrence or progression – that may use numerical concepts such as percentages and probability
- **Asking questions** for clarification; and managing appointments and insurance-related tasks.

Health literacy is one of the strongest predictors of health status and outcomes, with low health literacy being associated with incorrect use of medicines, less knowledge of disease prevention and self-care strategies, more hospitalizations and emergency visits, and higher levels of illness.[5,6] Health literacy is a stronger predictor of health status than income, education, employment status, or racial or ethnic group.

HEALTH LITERACY IS DEFINED AS

"The ability to find, understand, and use basic health information and services needed to make appropriate health decisions."[7]

Despite its importance, health literacy remains a major problem around the world.[8,9] In Europe, fewer than 1 in 8 adults have excellent health literacy and one-half of adults have problematic or inadequate health literacy. In the United States, fewer than 1 in 10 adults have proficient health literacy, and more than one-third of adults have basic or below-basic health literacy.

PRINCIPLES FOR ENSURING CLEAR COMMUNICATION

To ensure clear communication, it is helpful to adopt proven principles for developing materials that are easy for patients to understand and use. Health literacy principles from the U.S. Centers for Disease Control and Prevention include:[10-12]

Providing content that solves problems, based on knowledge about the intended audience (Figure 6), by ensuring that the writer:

- Makes the purpose of the piece evident
- Validates patient/caregiver challenges
- Limits the number of concepts to what can reasonably be learned in the time allowed
- Focuses on behaviors, rather than medical facts
- For data/statistics, uses ratios with (or instead of) percentages
- Reviews key takeaways.

Figure 6: Characteristics of the intended audience

Values, emotions, beliefs and attitudes
- Barriers and motivators to behavior

Surrounding environment
- Socioeconomic factors
- Family/other personal experience with illness
- Access and coverage

Knowledge
- Disease and Rx
- Treatment experience
- Gaps and myths

Support network
- Family and friends
- Online discussions and resources
- Advocacy organizations
- HCP team

Self-efficacy
- Skills and self-confidence
- Practical skills

Writing and editing content for easy reading, including using an active voice, choosing common words that are a good fit, and being consistent with word use, are all essential approaches, which also facilitate the process of translating patient materials into other languages. New terms should be defined within the text, abbreviations spelled out at the first mention, and context provided when offering new information. Writing should be tailored to 6th to 8th grade reading level (U.S.) or 7th to 9th grade reading level (Europe), or lower, using the Fry readability assessment.[13] Subheads should be used, and information subdivided with bullet points, with no more than 7 items in a bulleted list.

Barriers to applying health literacy principles may exist, including Institutional Review Board (IRB) and Ethics Committee (EC) requirements, branding guidelines, the need for age-specific design (e.g. pediatrics), production specifications due to budgetary issues, and client preferences. Many companies and regulatory bodies, such as the FDA, are increasingly recognizing the importance of health literacy, and in some cases providing recommendations and requirements for material reading levels.

Designing for easy reading, using a general checklist:

- Provide adequate white space around the text and graphics. This helps keep the design simple and enables readers to focus on the main feature and message. White space helps readers feel less overwhelmed when trying to focus on content.
- Ensure that design is appropriate for the patient demographic (age, ethnicity, etc.), and provides consistency in layout from page-to-page, with an appropriate font style and size, left-justified body text, and limited use of italics and underlining.

Using color with purpose, providing contrast between text and background, and using blocks of color to highlight key messages in a “Tips” section or glossary. Dark text on a light background can be easier to read than white text on a dark background.

Using visuals for emphasis, to explain information, reinforce important content, and provide relief from large areas of text. Photos and illustrations can help demonstrate desired behaviors, with images chosen to represent the target audience. Tables, charts and diagrams should be used to explain information. Readers with low literacy levels might rely on pictures to help them understand information and what they need to do. Placing these images close to copy describing the desired behavior, as well as providing captions to the visuals, helps readers comprehend the information and, hopefully, moves them toward engaging in the positive action that is being depicted.

Involving the reader by validating the challenges that patients and caregivers face, and using a positive and friendly tone. Opportunities to interact with the material – via checklists, action plans, Q&A sections or notes pages – can help readers understand, absorb and apply the information.

AN EXAMPLE IN PRACTICE: THE BIOPSYCHOSOCIAL ASSESSMENT MODEL

When designing materials and methods to engage patients it is important to move beyond the medication and intentional non-compliance and consider psychosocial barriers. In many clinical situations, unintentional adherence barriers and treatment decisions are driven by psychosocial concerns. One example in practice, the Biopsychosocial Assessment Model,[14] provides a holistic view of patient and caregiver needs in 7 key areas (Figure 7).

> ***The IQVIA approach to digital innovation challenges the assumption that behavior change can be established through simple reminders, tracking and alerts, and supports the idea that behaviorally driven mobile health interventions can address multiple pathways associated with sustained behavior change.***

Figure 7: The Biopsychosocial Assessment Model

Ensures that we know the needs, drivers and barriers of the audience

Medical
- Disease: Impact/symptoms
- Treatment: Benefits/side effects
- Comorbidities

Confidence
- Skills and self-confidence
- Practical skills

Educational needs
- Disease and Rx
- Treatment experience
- Gaps and myths

Occupational
- Impact on work/school/volunteering
- General role changes
- Interests/hobbies

Support
- Family and friends
- Online discussions/resources
- Advocacy organizations
- HCP team

Emotions and beliefs
- Barriers and motivators to behavior
- Spiritual/cultural

Access/cost
- Socioeconomic factors
- Access and coverage

Figure 8: The Biopsychosocial Assessment Model applied to chronic pain

Medical
- Disease: Low quality of life
- Treatment: No cure/Temporary relief
- Comorbid with many conditions

Confidence
- Low self-efficacy/skill
- Low confidence in HCPs/Rx

Educational needs
- Coping strategies
- Treatment options
- Overcoming stigma
- Accessing services

Occupational
- Negatively impacts work/school/volunteering and valued roles/hobbies

Support
- Negative impact on relationships
- Active online seeking peer connection and validation
- Fragmented advocacy presence
- Many feel invalidated by healthcare system and government

Emotions and beliefs
- Feel invalidated/frustrated
- Depression
- Anxiety
- Helplessness
- Misunderstood/stigmatized

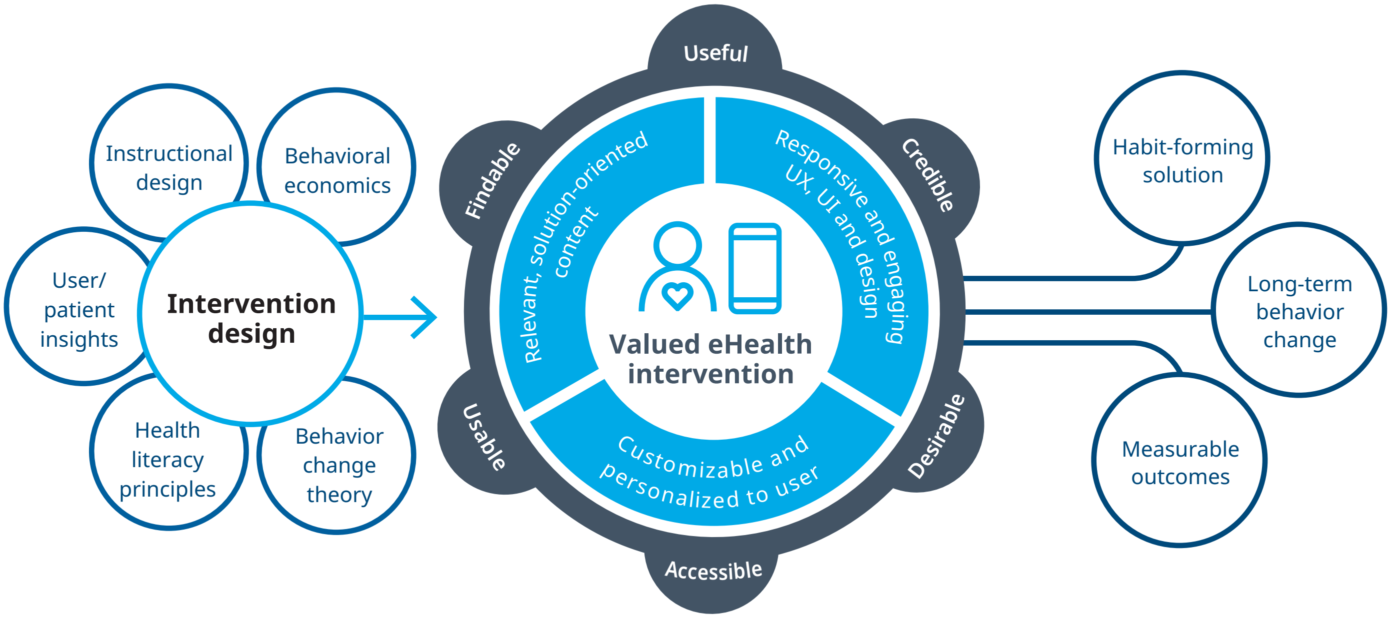
Access/cost
- Low socioeconomic status due to lost work/wages
- Access/coverage challenges

As an example, effective patient engagement material can be designed for the patient with chronic pain having first considered all relevant factors within this assessment model (Figure 8). This will include content, style and mode of delivery, which all need to be considered against the background of the assessment model results.

DIGITAL SOLUTIONS DRIVING ENGAGEMENT AND SUSTAINED BEHAVIOR CHANGE

Digital innovations may enable a nimble approach based on patient needs, helping to initiate and track behaviors, and encourage longer-lasting behavior changes and best practices. The IQVIA approach to digital innovation challenges the assumption that behavior change can be established through simple reminders, tracking and alerts, and supports the idea that behaviorally driven mobile health interventions can address multiple pathways associated with sustained behavior change (Figure 9).

Figure 9: Opportunities for digital innovation to drive engagement and efficiency



CONCLUSION: FACE-TO-FACE INTERACTIONS AND TECHNOLOGY CAN OPTIMIZE CARE AND OUTCOMES

Successful patient engagement programs depend on a tailored combination of face-to-face interactions and technology – including behaviorally driven mobile health approaches – with oversight from healthcare professionals. These programs need to respond to ongoing changes in disease prevalence, R&D pipelines, the regulatory environment and policymaker agendas. Based on best practices in supporting health literacy, such programs can prove their worth in enabling pharmaceutical and biotech companies to help optimize patient care and outcomes, while clearly demonstrating the benefits of their therapies. Continuing to talk the patients' language – through effective, patient-centered engagement – will build on this success in years to come.

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