**Introduction**

The Patient-centered Medical Home (PCMH) practice should continually strive to achieve interactions that center on patients and their concerns, and are consistent with their needs, preferences, and values. To do so, the effective PCMH care team needs to know more about patients than just their age, gender, signs and symptoms; team members need to know them as “whole persons.”

In the Patient-Centered Interactions Implementation Guide Part 1, we discussed tools and techniques to elicit information about the needs and concerns of patients and their families, and to learn about the experience of healthcare from their perspective. These are important strategies to begin to understand the “whole person.”

A truly patient-centered practice encourages patients to be more involved in decisions about their care, and in the management of their health. In Part 2 of Patient-Centered Interactions Series, we discuss how to build partnerships to help patients and their families understand the central role they plan in their health and wellness, and to actively engage them in their healthcare. The PCMH can also use those partnerships to identify ways to obtain feedback to make changes to the practice in order to improve quality of care. For people with chronic conditions, the patient-provider partnerships can provide them with the knowledge, skills, and confidence to manage their conditions well. The PCMH care team can use proven communication strategies and decision...
aids to empower patients and enhance their involvement in decision-making and self-management. Part 2 will provide an overview of these tools, and discuss how to use them to enhance patient-centered interactions.

**Managing Chronic Conditions**

Even the healthiest among us can benefit from eating healthy foods, being physically active, and regularly receiving recommended preventive healthcare services. For people with long-term health conditions, actively engaging in healthy activities and learning to manage chronic conditions is critical.

Yet, a recent review of 31 national surveys performed by the Center for Advancing Health (CFAH) showed that most people are not benefiting from healthy behaviors or the health care available to them. CFAH found that people engaged in behaviors such as exercise and consuming a healthy diet consistently about one-third of the time, inconsistently one-third of the time, and not at all one-third of the time. Low or marginal health literacy, lack of education, poverty, advanced age, and cultural disparity all make it more challenging for people to actively participate in their healthcare.²

Judith Hibbard, a health services researcher at Oregon Health Sciences University and developer of the Patient Activation Measure (PAM), found that about 60% of people feel passive about participating in their health and healthcare. Almost one quarter of those completing the PAM demonstrated a lack of ability to manage their care, and over a third faced significant barriers in both their knowledge and confidence in caring for themselves. Even the 40% who responded that they were able to actively participate in their own care were not confident about their ability to do so in stressful circumstances.

Giving patients tools to increase their confidence and overcome barriers to effective self-management of chronic conditions is critical to improving healthcare quality. Practitioners need guidance and advice on how to partner with and support patients in their self-management of their chronic condition. This implementation guide offers practical steps to help quality improvement coaches and practitioners develop these productive partnerships that can lead to better care.

We all self-manage. It’s how well we self-manage that makes the difference.

Managing conditions like asthma, diabetes, and depression day-to-day requires skills and confidence. Managing medical treatments and navigating a disjointed healthcare system are only part of the burden. Chronic conditions deeply alter people’s daily lives and challenge them to retain the relationships and activities that make life meaningful. How can clinical teams support patients with chronic conditions to make these changes? If they are fortunate, people diagnosed with these conditions recognize early that the success of their care depends as much on what they do as on the actions of their healthcare team. Chronic Disease Self-Management Program creator Kate Lorig, says, “We all self-manage. It’s how well we self-manage that makes the difference.”
Engaging Patients in their Health and Healthcare

Building collaborative relationships with patients and families is a core value of patient-centered care. In Patient-Centered Interactions Part 1, we discussed assessment of patients’ values and preferences as well as their experience of care as a key concept to consider in delivering safe and effective care. Understanding patient needs and preferences is an important first step. Later in this section, we’ll examine how to support patients and families to better manage their own chronic conditions and maintain their health. It is also important to consider how to collaborate with patients and families to bring their voice into the planning and delivery of healthcare, which has been shown to improve quality and safety as well as address their needs more effectively.

The Institute for Patient- and Family-Centered Care defines four core concepts to guide the development of patient-centered interactions:

- **Dignity and Respect.** Healthcare practitioners listen to and honor patient and family perspectives and choices. Patient and family knowledge, values, beliefs, and cultural backgrounds are incorporated into the planning and delivery of care.
- **Information Sharing.** Healthcare practitioners communicate and share complete and unbiased information with patients and families in ways that are affirming and useful. Patients and families receive timely, complete, and accurate information in order to effectively participate in care and decision-making.
- **Participation.** Patients and families are encouraged and supported in participating in care and decision-making at the level they choose.
- **Collaboration.** Patients, families, health care practitioners, and healthcare leaders collaborate in policy and program development, implementation, and evaluation; in facility design; in professional education; and in the delivery of care.

Involving patients and families in improving the quality of care for all patients takes time and commitment to move in small steps toward a more patient-centered culture. Safety net clinics have long mandated patients on boards and advisory panels. Inviting patients and families more directly into the planning and delivery of care at the team level requires courage and patience. In addition to the organization level steps outlined below, practice teams invite patients and their families to improve self-management support by giving feedback on patient interactions.
The following steps can help set a clinic or health system on its journey toward patient- and family-centered care:

1. Implement a process for all senior leaders to learn about patient- and family-centered care.
2. Appoint a patient- and family-centered steering committee comprised of patients and families and formal and informal leaders of the organization.
3. Assess the extent to which the concepts and principles of patient- and family-centered care are currently implemented within the clinic or health system.
4. On the basis of the assessment, set priorities and develop an action plan for establishing patient- and family-centered care at the organization.
5. Using the action plan as a guide, begin to incorporate patient-and family-centered concepts and strategies into the organization's strategic priorities. Make sure that these concepts are integrated into organizational mission, philosophy of care, and definition of quality.
6. Invite patients and families to serve as advisors in a variety of ways. Appoint some of these individuals to key committees and task forces.
7. Provide education and support to patients, families, and staff on patient- and family-centered care and on how to collaborate effectively in quality improvement and healthcare redesign.
8. Monitor changes made, evaluate processes, measure the impact, continue to advance practice, and celebrate and recognize success.


Primary resources for the above section:


Self-Management Support and the Cycle of Care

Patient-centered care includes supporting patients in making changes in their health behaviors, from preventive strategies such as eating healthier foods and exercising to support an active lifestyle, to taking medications appropriately and managing complex health conditions. Effective patient-centered medical homes train clinicians and staff to communicate with patients using techniques that acknowledge their positive health behaviors, involve them in decisions about care, and empower them to take better care of themselves day-to-day. They use collaborative goal setting, patient action plans and proactive follow up to motivate and sustain healthy lifestyles.

Although care teams might want to include these patient-centered interactions, the pressures of a busy practice may make them wonder how they can fit an intervention activity into a visit. To make time for patient-centered interactions, the key points are to prepare before the visit, to utilize effective, brief interventions to support self-care, and to connect patients with resources in the community so they have active help to manage their health day-to-day.
The Cycle of Self-Management Support below shows how repeated brief motivational interventions targeted at patient-identified goals can improve health behaviors and outcomes and lead to better collaboration and satisfaction for patients, their families, and the healthcare team.

**Collaborative Care: Cycle of Self-Management Support**

Patient-Centered Interactions From The Patient’s Perspective

For Mrs. M, who was diagnosed with diabetes six years ago, a visit to her doctor was something she needed to do periodically so that she could get her prescriptions renewed. She liked Dr. Lowry, who was pleasant and always asked after her family, but for the last few appointments, something in the office had changed. She felt Dr. Lowry was taking more of an interest in her. Several months ago, she received a call from Dr. Lowry’s assistant, Phyllis, to schedule a diabetes appointment. Phyllis asked her to come in to get her lab tests done before the appointment and sent her a form asking about her concerns and questions. Thanks to the form, Mrs. M had remembered to bring up the arthritis pain she was worried about. It was so bad lately, she was afraid to take the regular walks she enjoyed. Dr. Lowry reassured her that walking was good for her arthritis and helped keep her blood sugars under control, and that decreased exercise could help explain the higher blood glucose levels she was experiencing. He explained that her labs showed maximum benefit to the patient at each visit. Here, we address some specific strategies to support the patient and to enhance the patient-centered experience.

Before the Visit

Visit preparation creates time and space within a visit to build and maintain the relationships that are central to self-management. Health coaches, medical assistants, or front office staff can work from standing orders to assure that tests are completed and all necessary information is on hand ahead of the visit. Conversations about goals and activities for healthy behaviors flow more easily if patients are helped to prepare for the visit as well. Gather patient experiences and concerns in advance by distributing forms such as “Ask Me Three” by mail or in the waiting room to help patients focus their questions and bring needed information to the visit. “How’s Your Health” is a web-based tool that individuals can access at home at their convenience and print out to bring or email to their clinician. Collecting clinical information and patient experience information brings the world of medicine together with the patient’s life to form a foundation to collaboratively manage care.

Tips for Visit Preparation

- Give patients a heads up that you are changing care delivery and that they might find the visit somewhat different. Patients feel more comfortable when they know what to expect, and asking them to prepare in advance acknowledges that they have an important role to play.
- Use posters in the waiting room to tell the stories of patients who are on their way to successful self-management. Using patient and family advisors in your medical home implementation process may be a good place to begin.
- Consider administering a depression screening tool before the visit as standard care for patients with chronic conditions. Use the PHQ 2 and refer to the MacArthur Toolkit.
- Ask patients to bring medication lists or the medications themselves, as well as questions and results of any monitoring they’ve done on symptoms or glucose testing.
- Have medical assistants ask diabetes patients to “show us your feet” in readiness for a foot exam.

Primary resources for the above section:

Depression Management Toolkit. MacArthur Foundation Initiative on Depression in Primary Care. [click here](#).

How’s Your Health Survey [click here](#).

IMPACT: Evidence-based Depression Care [click here](#).


Take Charge—Setting a Goal [poster]. Cambridge Health Alliance, New Health Partnerships [click here](#).

Visit Preparation Form: Ask Me 3. National Patient Safety Foundation. [click here](#).

Visit Preparation Form: Dinner Plate Menus. New Health Partnerships. [click here](#).
During the Visit

Effective Communication Skills and Tools

Developing a trusting, collaborative relationship with the patient and family can be enhanced by the use of effective communication techniques. Then clinical teams can gradually, over a series of interactions, help patients build their skills and confidence in their ability to manage their condition day to day. These same tools and skills are effective in preventive care to help healthy patients stay healthy.

Communications strategies include:

- **Warm greeting:** Greet patients with a smile and a welcoming attitude.
- **Eye contact:** Make appropriate eye contact throughout the interaction.
- **Plain, non-medical language:** Use common words when speaking to patients. Take note of what words they use to describe their illness and use them in your conversation.
- **Slow down:** Speak clearly and at a moderate pace.
- **Limit content:** Prioritize what needs to be discussed and limit information to three to five key points.
- **Repeat key points:** Be specific and concrete in your conversation and repeat key points.
- **Graphics:** Draw pictures, use illustrations, or demonstrate with 3-D models.
- **Patient participation:** Encourage patients to ask questions and be involved in the conversation during visits and to be proactive in their health care. For guidance on how to encourage your patients to ask questions see the AHRQ Toolkit (page 61).
- **Teach-back:** Confirm patients understand what they need to know and do by asking them to teach back directions. The Teach-back methods, also known as the “show-me” or “closing the loop” method is a way to confirm that you have explained to the patient what they need to know in a manner that the patient understands. Their understanding is confirmed when they explain back to you the instructions you’ve given them. For tools and resources on learning and using this method, see the AHRQ Toolkit (page 28).

Training in communication techniques, Motivational Interviewing, or other brief motivational skills helps clinicians use open-ended questions to elicit patient experience, beliefs and attitudes. *Ask-Tell-Ask* and *Closing the Loop* techniques improve information sharing so that clinical advice is directed at issues of central importance to patients and that they understand and know how to use the information to manage their care when they get home. *Rolling with resistance* helps clinicians identify situations when patient and clinician are not on the same page, and change their interaction style to recreate an environment in which collaboration can occur.

Enhancing Patient Self-Management

The communications strategies outlined above are applicable to improving patient-centered interactions in all types of patient visits. Additionally, there are core competencies for enhancing self-management support. They are:

- Assessing patients’ needs, expectations and values;
- Sharing information;
- Collaborative goal setting;
- Action planning;
- Problem solving; and
- Ongoing follow-up.
The 5 A’s of behavior change – Assess, Advise, Agree, Assist, Arrange - is a helpful model to implementing the core activities.

**Assess: Experiences, Beliefs, Knowledge and Confidence**
If patients have completed a visit preparation or assessment form, it can pave the way to building a shared agenda for the visit. Reviewing the form opens the conversation with the patient’s concerns and experiences since the last visit. Patients are at differing levels of readiness for changing health behaviors, and may be more ready to take action on a healthier diet than on quitting smoking, for instance. This makes asking them about their needs and preferences regarding treatment especially important. It’s always more effective to focus on a patient-identified health goal, something they want to do, because it is their desire that brings the energy for change.

**Advise: Sharing Information**
As a clinician who has information and concerns about your patient’s health, you will want to offer information and provide advice about treatment. Offering information about your concerns and recommendations can be better understood by patients and family members if you use techniques such as “Ask-Tell-Ask” from the Motivational Interviewing methods and “Closing the Loop” to guide the conversation. Asking permission to offer information, giving information specific to that topic and then asking for understanding helps assure you have provided information in ways the patient can use when they try to apply it at home. Offering tailored information based on a patient’s own values or other clinical information makes the information more accessible, and shared decision making tools help present information in ways to facilitate collaborative decisions for some conditions. Good self-managers may keep data from self-monitoring of blood pressure, blood glucose, and oral anticoagulation agents. Conversations about self-management based on these records can help patients adapt regimens at home.

**Agree: Collaborative Goal Setting**
Studies of effective interventions to promote better self-care are mixed, but one clear finding is that providing information is necessary, but not sufficient. Collaborative goal setting is one way to connect the clinical concerns and treatment planning of the clinician to the priorities and preferences of the patient and their family. It is very useful for primary care providers to begin the conversation around goal setting, collaborating with the patient to arrive at some agreed upon areas to address. Carrying out complex treatment plans can be daunting, especially in complex and challenging lives. Encouraging the patient to identify their own goals and supporting their choices whenever possible will help to ensure the successes upon which further change is possible. Clinicians might offer a menu of options to consider in defining their goals. Tools to begin this process in the clinician visit are offered at the end of this section for clinicians who choose to do goal setting and action planning in the clinical visit.

Every practice has patients who are not ready for goal setting and action planning. If patients are not ready to take a more active role in their health, the best strategy is very often to acknowledge the difficulty of managing a chronic condition and what they have accomplished, even the fact that they have come in for the visit. This does not mean you are taking a passive role. You are expressing empathy and keeping the doors of communication open.

**Assist: Action Planning**
Goals provide something to aspire to, but cannot be achieved all at once. Providing patients with some help in thinking through how to achieve their goal can make a major contribution. Goals might be set for a period of three to six months, but action plans are most helpful for periods of one to two weeks. Action plans are a way to determine small steps toward a goal, specify more precisely what, how, when and where the actions will take place and anticipate any barriers to attaining the goal. Many of us don’t have or use these skills, but care team members can learn to use them in a coaching and support role, and transfer the skills to patients over time.
Action planning forms can provide a template for the health coach, MA, or other team member, outlining the steps to follow in the process. Consider talking the patient through the form as they do the planning. Make sure they take the form or a copy of it with them as a reminder and guide when they leave the visit, and document their goals and plans in the medical record so that the team can follow up on the plans in the future.

**Steps to an Effective Action Plan**

1. Base the plan on a patient-defined, collaboratively set goal: it should be something the patient WANTS to do.
2. Make it behavior specific, e.g., “walking,” not “increasing exercise.”
3. Define specific steps: what, where, when, and how much or how often.
4. Anticipate barriers.
5. Assess confidence in completing the plan and adjust if low.

Goal setting and action planning can be done very effectively in group medical appointments, also known as group visits, or in group educational settings. Done in groups, action planning allows patients to hear about others’ ideas and plans, to see the process through multiple times, and to offer mutual support. Assessing confidence about completing the plan and anticipating barriers in the group setting are activities that generate active and helpful conversations among group members.

**Primary resources for the above section:**


Coaching Patients for Effective Self-Management (video). California Healthcare Foundation. [click here](#)

Group Visit Starter Kit: A New Approach to Group Visits. Improving Chronic Illness Care. [click here](#)

Health Literacy Universal Precautions Toolkit. AHRQ. [click here](#)


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**Arrange: Follow Up and Links to Community Resources**

The best time to plan for follow up after a visit is during the visit. Setting up a follow up call as part of the action plan is a wise choice, setting the expectation with the patient and finding a workable time.

**Tips for Supporting Patients During the Visit**

- Acknowledge and document what patients are already doing to manage their health, help them understand the benefits of active management and provide the tools to do so.
- Provide guidelines for optimal care so that patients and families know what to expect.
- Patients benefit from interaction with other patients, so group medical appointments and group educational settings provide an excellent opportunity for learning from the experience of others.
- Involve family members and caregivers whenever possible; family members and loved ones can be powerful agents for and sometimes barriers to change. It helps when they are explicitly invited and involved in the visit.
- Involve every primary care team member in helping patients take charge. Hearing empowering messages consistently from team members increases the dose of self-management interventions.

Rebuilding Chronic Care Three Patients at a Time—Providence Health System. New Health Partnerships. [click here](#)


Self-Management Support Roles and Tasks in Team Care. New Health Partnerships. [click here](#)

Standing Order Form: St. Peter’s Family Medicine. New Health Partnerships. [click here](#)

Visit Preparation Form: Ask Me Three. National Patient Safety Foundation. [click here](#)
After the Visit

Follow-up on Action Plans
Even the best plans of action require adjustment to work effectively. Medications may produce side-effects or not produce the desired effect, requiring further support and explanation or alterations to make the plan workable, and barriers may arise. For all of these reasons, making regular contact with patients after a visit or change in treatment helps them sustain positive change. Studies on depression, in particular, document the need to follow-up with patients to assist them in succeeding with the action plan, particularly in adjustment to changes in medication.

Many teams suggest a brief call to review and problem-solve any issues arising for the patient in completing their action plan, as well as monitor any changes in treatment or medication regimen. The health coach, whether a medical assistant or nurse, frequently makes follow-up calls. Coverage of their time from other flow activities for one to three hours per week is often sufficient. Using a brief version of the 5 A’s and open ended questions, the coach can elicit problems and use problem solving techniques to help the patient adjust and revise their plan. Coaches offer support, normalizing what patients may consider failures, and acknowledging successes.

Making Effective Community Referrals
Community resources for self-management support provide convenient access, and also increase the likelihood of success since patients are learning about their condition with and from people like themselves. Holding culturally competent programs in community settings encourages participation and increases satisfaction, particularly among minority populations. Clinic/community partnerships that offer programs can promote self-management more comprehensively and seamlessly than any one organization could do alone. Partnerships that sponsor activities such as year-round walking programs and farmers’ markets also help individuals access these resources at the community level.

In addition to building referral resource guides for patients to identify help in the community, some healthcare systems are developing ongoing relationships with community agencies to fill gaps in services. Community-based promotoras and other community health workers do outreach and provide group self-management support. Partnerships with community agencies extend programs to meet the needs of specific populations.

Tips for Effective Community Referrals
- Resource guides for patients can be useful, but they should feature only trusted sources and must be regularly updated.
- Establish a person-to-person relationship with a representative from the community referral organization, and “extend” the relationship to the patient a warm handoff.
- Designate a community resource liaison within the practice to keep relationships healthy and active.
- Do in-service presentations to inform clinicians about quality community resources, and what specific populations will benefit from the referral.

Collaborating with Community Organizations to Address Patient Population Needs
Neil Korsen, a primary care physician in Maine, was concerned that his diabetes patients with depression needed support and encouragement. There was an active National Alliance on Mental Illness chapter nearby, but the group events they offered did not address some of the main concerns of his patients. Through a collaboration with that organization, groups to support self-management of depression, along with other chronic conditions were developed to fill that need.
Conclusion

True patient-centered interactions are integral to achieving PCMH transformation. Interactions teaching effective self-management for chronic illness empower the patient and improve outcomes. The PCMH care team should strive to engage patients in their healthcare, use proven tools such as Motivational Interviewing, Ask-Tell-Ask, and the 5A’s to improve patient communications and the patient-centered interaction.

Primary resources for the above section:

Chronic Disease Self-Management Program. Stanford School of Medicine. [click here]


Related Change Concepts

As previously mentioned, Patient-centered Interactions is considered a foundational Change Concept because it must be mastered before practices can tackle most of the others. For example, providing organized, evidence-based care requires that practices understand what patients want and need from their medical interactions. And, developing continuous relationships with patients relies on both patients and providers feeling respected and engaged in the care relationship. Specific Change Concepts that rely on patient-centered interactions include:

- Empanelment
- Continuous, Team-based Healing Relationships
- Enhanced Access
- Care Coordination
- Organized, Evidence-based Care

To effectively manage the ongoing demands of assessing and understanding patient experience in the context of the Change Concept Patient-centered Interactions, the following capabilities are needed: Engaged Leadership and Quality Improvement Strategy.

Additional Resources

Articles


Powers BJ, Trinh JV, Bosworth HB. Can this patient read and understand written health information? *JAMA.* 2010;304(1):76-84

**Websites**

**The Cross Cultural Health Care Program**
The Cross-Cultural Health Care Program’s primary goal is to improve the health care of communities that face linguistic and cultural barriers to receiving health services. The CCHCP develops training programs for health care providers and for medical interpreters, provides a central resource center, and works with underserved communities and institutions to change policies and procedures that create barriers to care.

**EthnoMed**
EthnoMed contains information about cultural beliefs, medical issues and related topics pertinent to the health care of immigrants to Seattle or the US, many of whom are refugees fleeing war-torn parts of the world.

**CDC Immigrant and Refugee Health**
This site provides information about medical examinations, health guidelines, laws and regulations.

**The Office of Minority Health**
OMH’s primary responsibility is to improve health and healthcare outcomes for racial and ethnic minority communities by developing or advancing policies, programs, and practices that address health, social, economic, environmental and other factors which impact health. OMH also houses the National Standard for Culturally and Linguistically Appropriate Services in Health Care (CLAS).

**Center for Population Health and Health Disparities – A RAND Health Center**
The RAND health center is one of the eight Centers for Population Health and Health Disparities. The RAND Center supports cutting-edge research to understand and reduce differences in health outcomes, access and care, particularly with respect to neighborhoods.

**National Center on Minority Health and Health Disparities, National Institutes of Health**
The NCMHD promotes minority health and leads, coordinates, supports, and assesses the NIH effort to reduce and ultimately eliminate health disparities. NCMHD conducts and supports basic, clinical, social, and behavioral research; promotes research infrastructure and training; fosters emerging programs; disseminates information; and reaches out to minority and other health disparity communities.

**National Center for Cultural Competence**
Part of the Georgetown University Center for Child and Human Development University Center for Excellence in Developmental Disabilities, this site provides provider and practice assessment tools, a resource database, and further links in the field of Cultural Competence.

**Center for Healthy Families and Cultural Diversity**
University of Medicine and Dentistry of New Jersey’s Center for Cultural Competency provides information for patients, health care providers, students, educators and researchers on the topic of cultural competency.

**Diversity Rx—Resources for Cross Cultural Health Care**
This site includes links to online training resources for providers and staff, including some CME eligible programs. They have a database of hundred of resources on cross cultural health care, resources to help benchmark current efforts, and a directory of organizations that work in the field.

**Useful Tools**

**Reducing Racial and Ethnic Disparities: Quality Improvement in Medicaid Managed Care Toolkit**
This toolkit details the experiences of a collaborative workgroup of Medicaid managed care organizations, Improving Health Care Quality for Racially and Ethnically Diverse Populations. The workgroup was directed by CHCS and funded by the Robert Wood Johnson Foundation and The Commonwealth Fund. This online toolkit provides information on how to collect data accurately and use it effectively. It provides case studies, self-assessment tools, and staff training information.

**Toward Culturally Competent Care: A Toolbox for Teaching Communication Strategies**
This curriculum teaches the skills and knowledge to help health professionals provide culturally competent care. At the end of training, participants will be more effective in eliciting accurate clinical information and providing appropriate care to
their patients, regardless of their cultural background. Clinicians also learn how to work with medical interpreters and acquire new approaches to addressing cultural differences.

**HRET—A Toolkit for Collecting Race, Ethnicity, and Primary Language Information**
This online toolkit provides information on how to collect data accurately and use it effectively. It provides case studies, self-assessment tools and staff training information.

**Resources For Translated Health Education Materials And Forms**

**Immunization Action Coalition (CDC)**
The Center for Disease Control and Prevention (CDC) provides translated health education materials/forms.

**Interpreter Services**

**California Academy of Family Physicians and CAFP Foundation**
“Addressing Language Access Issues in Your Practice: A Toolkit for Physicians and Their Staff Members”
This toolkit presents a systems approach to re-designing your office practice to provide the high quality care to patients who speak limited English.

**The Commonwealth Fund**
“Providing Language Services in Small Health Care Provider Settings: Examples from the Field”
The authors include an eight-step plan to help providers develop a strategy to meet the needs of their patients with limited English proficiency and the community.

**References**


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Safety Net Medical Home Initiative

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The objective of the Safety Net Medical Home Initiative is to develop and demonstrate a replicable and sustainable implementation model to transform primary care safety net practices into patient-centered medical homes with benchmark performance in quality, efficiency, and patient experience. The Initiative is administered by Qualis Health and conducted in partnership with the MacColl Center for Health Care Innovation at the Group Health Research Institute. Five regions were selected for participation (Colorado, Idaho, Massachusetts, Oregon and Pittsburgh), representing 65 safety net practices across the U.S. For more information about the Safety Net Medical Home Initiative, refer to www.safetynetmedicalhome.org.