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Communicating with Patients and Families Around Difficult Topics in Cancer Care Using the COMFORT Communication Curriculum

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Abstract

Objectives: To examine nurse communication in cancer care and offer communication strategies for quality palliative care nursing.

Data Sources: Communication strategies offered are based on the COMFORT Communication curriculum, an evidence-based communication training program.

Conclusion: Whole-patient assessment, a major component of palliative care, involves communication that includes eliciting the patient's story, addressing health literacy needs, being mindful of burnout, and relating to the patient and family.

Implications for Nursing Practice: Quality communication skills are essential to oncology nursing, especially given their vital role in cancer care.

Keywords

communication; palliative care; oncology nursing; cancer communication; nursing education

Communication between nurse, patient, and family members involves more than just providing information. It includes discussing a range of topics, encouraging the sharing of feelings and fears about the illness, treatment, and prognosis, and helping patients and family members find a sense of control and a search for meaning and life purpose.¹ Nurses with strong communication skills have been shown to positively influence cancer patients' satisfaction, improve overall well-being, and influence patients' experiences.^{2–5} However, oncology nurses rarely receive formal instruction on communication as part of their clinical

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training.⁶ Nurse communication training is still relatively new and few training programs provide comprehensive skill training for palliative care. Existing programs have focused on discussions about fertility,⁷ self-efficacy in responding empathically,⁸ and discussing death, dying, and end-of-life goals of care,⁹ and have not included vital palliative care communication training skills such as ways to include family members, discussing social, psychological and spiritual care topics, and team-based delivery of care.¹ Overall, palliative care communication training tends to be physician-focused, with only a smaller amount of work devoted to nurses specifically.

However, the nurse's role is inherently different than the physician's role and involves talking with patients and families once they have received bad news, discussing spiritual and religious concerns, and talking with physicians and the oncology team about patients and family members.¹⁰ Often excluded when information is provided to the patient and family, nurses report discomfort, lack of role definition, a fear of taking away hope, and a lack of time for participating in discussions with cancer patients and their families.⁶ Communication barriers result in compromised psychosocial care for patient and family because nurses lack experience with screening tools and do not know how to approach sensitive topics.¹¹ Several barriers to effective communication for oncology nurses have been identified, including poor communication among the interprofessional team,¹¹ differing expectations among clinical staff, lack of skills for providing empathic care to patients and family members, the challenge of assessing patient expectations, how to initiate discussions about end of life, and explaining palliative care.¹²

By its nature, oncology nursing demands more attention to palliative care communication because it attends to both the patient and family and serves to coordinate many factions across a potential of multiple care settings. Patients and family members expect nurses to be honest when sharing information and answering inquiries, to ask about the patient's values and goals, take time to listen, and to collaborate with health care team members.¹³ Given the frequency of interaction between oncology nurses and patients and their families, it is crucial that oncology nurses possess strong palliative care communication skills to provide quality cancer care.¹⁴ This article will offer communication strategies based on the COMFORT Communication curriculum (Comfort Communication Project, Los Angeles, CA), program funded by the National Cancer Institute.¹⁵

COMFORT Communication Curriculum

COMFORT is an acronym that stands for the seven communication (C-Communication, O-Orientation and options, M-Mindful communication, F-Family, O-Openings, R-Relating, T-Team). Table 1 shows an overview of the curriculum and content of each module. Communication research based on clinical observations of terminal prognosis meetings with dying patients, hospice and palliative care team meetings, semi-structured interviews with palliative care team members, and extensive longitudinal research of patients and families from the point of diagnosis through death and bereavement¹ gave shape to the identification of the seven modules.¹⁶ By integrating communication theory into clinical research, the curriculum was detailed in a volume on communication in palliative nursing.¹⁷

With funding from the National Cancer Institute, the nurse communication curriculum was created for a 2-day training course for implementing evidence-based palliative care communication skills into practice. Clinical nursing faculty and communication researchers were brought together to teach the curriculum. To date, COMFORT communication training has been provided nationwide to 269 oncology nurses who have trained an additional 6863 other health care professionals at their home institutions. COMFORT has shown to improve clinician self-efficacy, attitudes toward communication, and reduce providers' apprehension about communication.^{18–20} Subsequent research with the curriculum has shown improvement in nurses' attitudes, comfort levels, and perceived self-efficacy regarding palliative care conversations²¹ and improvements in nurse-perceived confidence in initiating difficult communication topics with family caregivers.²² Highlighted below are summaries of the four most popular modules of the curriculum (modules C, O, M, R), derived from a culmination of a review of the literature, efficacy research, concepts grounded in communication theory, and feedback from nationwide nursing audiences and expert clinical faculty.

C-Communication (Clinical Narrative Practice)

Fundamental to the goal of palliative care in providing holistic, comprehensive care focused on the patient's quality of life, nurse communication should involve clinical narrative practice to capture an awareness of the patient/family life experience and incorporate that experience into communication about cancer. Clinical narrative practice is about narratives or the stories of our patients's lives. It is defined as being with and relating to others while honoring the patient's voice and lived experience. When gathering information about the patient/family, nurses should ask the patient/family to recall the cancer story. Storytelling is a natural form of human interaction and stories of illness reveal how health is defined, how symptoms and concerns are managed, and how care is evaluated. Stories also reveal understanding about the cause of cancer and personal risk of cancer,²³ help patients and families make meaning and manage identity, and reveal perceptions of reality.²⁴ The patient's story reveals his/her account of events and understanding, the circumstances of the illness in terms of heredity and life events, their living environment and occupation, and personality. Stories provide insight not gained through routine assessments.²⁵

Clinical narrative practice involves understanding the illness story²⁶ and tailoring communication to help the patient/family take control and find "alternative ways of being ill."²⁷ Frank²⁷ defines this as the quest narrative, when the story of illness is viewed as a journey from which something will be gained. As oncology nurses hear the patient's story, they should engage in relational communication by practicing active listening strategies. Each patient/family has a unique life story and a unique illness story.²⁸ Focus on gaps, ambiguities, and conflicting plots within the story. The patient's history can reveal common forms of self-blame (life decisions/actions that led up to the illness, feelings of guilt for poor decisions, and the desire to cure at all costs). Encourage reflection on loss and the changes cancer has brought to everyday living.²⁹ Table 2 provides example questions to ask patients that promote reflection on life and can aid in helping the patient identify values and goals for care.

By learning the patient's story, nurses can help families consider all dimensions of quality of life, create new solutions and plans, and explore alternative hopes for the future. Nurses can help the patient/family make meaning of what is happening, promote understanding and acceptance, and encourage reflection on how the illness has impacted daily life. To accomplish this, statements should explicitly recognize the patient's life, elaborate on how illness impacts the patient's life, and acknowledge the loss/change in life. In this manner, information is incorporated into important aspects of the patient's life to promote understanding, as in the following example:

A 74-year-old woman, Lois, with newly diagnosed non-small cell lung cancer was introduced to the palliative care team to discuss management of her dyspnea and goals of care. She had smoked 1 pack of cigarettes per day for 40 years but had recently quit; she has significant COPD and limited activity because of impaired pulmonary reserve. Her husband of 50 years has dementia and Lois cares for him in their home; he is verbal and capable of some self-care activities. One daughter lives nearby and assists with shopping and other errands, although she is employed full time and has a family. A son lives at a distance with his family and has limited financial means to visit frequently. The patient has approximately an 18-month prognosis and will undergo chemotherapy.

Explicit Recognition of the Patient's Life

"Fifty years of marriage is a very special life accomplishment, and so is quitting smoking. Congratulations on this achievement. You must have a lot on your mind with his care and your difficulty breathing."

Elaboration of the Illness in the Context of the Patient's Life

"Your cancer can be treated with chemotherapy, but it will be very hard on you, making it more difficult for you to care for Wendell, and it will not get rid of the cancer. Over time, it will not be possible for you to take care of Wendell. How are you feeling about all of this?"

Acknowledgement of the Loss/Change in Life

"After caring for him and being together for so long, we understand that your inability to care for Wendell will be a major loss. You will need a lot of support."

O-Orientation and Options

Oncology nurses bridge the divide between the language of medicine and the language of everyday life. They do this by helping patients and their families understand health within the context of daily living, translating medical words by using metaphors and adjectives, and conveying to the team what the patient and family understand and do not understand. When communicating about cancer, it is important that nurses provide orientation to the cancer stage by describing the big picture of a diagnosis (orientation) and summarizing the disease path (options). Nurses must explain options that have been provided to the patient and their family, and tailor the format and modality of information presentation.

For patient/family, the words used in everyday life make sense of health and illness. Body parts and functions are identified using plain language like-- puke, shaky, weak. Illness is understood by how it impacts work, family needs and expectations, and social relationships. On the other hand, providers, institutions, and online/printed material use the voice of medicine--nausea, malaise, activities of daily living. Medical terms, jargon, acronyms, and medical-speak identify parts of the body, procedures, and tests.³⁰ These are foreign and disorienting for a sick person and his/her family. Oncology nurses play a critical role during cancer care because they are often asked to translate medical terms, answer questions about the disease, diagnosis, and prognosis, and explain treatment and side effects.

Conversations about cancer need to match the health literacy of the patient family. Health literacy is different than 'literacy,' in that it requires more communication skills than reading. For example, collecting and selecting the best and most useful information and then acting on the information demands more than simply reading a set of instructions. Family and patient must be able to receive, acquire, understand, and use information to be health literate. Health literacy includes the language you use when communicating with patients/family (face-to-face or otherwise), the context of the interaction (are you in the ICU, ER, multiple patient room), culture (do you and the patient/family have the same cultural background), communication skill levels, and technology. Matching the health literacy abilities of a patient/family is central to delivering quality care.³¹ The case of Mr K demonstrates the many components of health literacy to consider when providing care:

The primary treating team and ICU team have arranged for a discussion about goals of care with first- and second-generation family members of Mr K, a 63-year-old gentleman of Asian descent who has been in the ICU for 7 days. He remains ventilated and unresponsive, without evidence of being able to be weaned from the ventilator. The need for tracheostomy placement versus revision to the plan of care is the focus for the meeting. A conference room has been reserved because the patient is intubated and unable to participate in the conversation. A pre-meeting is held among the health care providers, at which time the oncology nurse who has worked closely with the patient informs the other providers of the importance of this family's cultural background. In particular, he notes that if options are provided, the family will always choose whatever the doctor recommends, because doing otherwise would reflect disrespect, even if they know that the patient would disagree with the doctor's recommendation.

Health Literacy Components

Language—It will be important to provide a thorough introduction of each provider and his or her role. Family members will be confused by meeting three sets of providers (oncology treating team, ICU team, and palliative care team). The meeting should begin by orienting the family to the three services and how they work together. A pictorial chart or visual aid should be used to explain.

Context—The conference room should be large enough, so that all family members can sit down. Team members should be aware of where they sit; the team should not sit opposite the family. Team members should disperse and sit among the family to demonstrate partnership-

building and decrease authority and hierarchy. Family members and health care team members should silence pagers and cellular phones to reduce interruptions.

Culture—A translator may be needed. The pre-meeting huddle by the team should include a discussion of any language barriers for this family. A team member should be designated to ask the family about cultural needs regarding care.

Communication Skills—In a large family meeting, it is likely that communication skills among family members will vary. It is also likely that there is a member of the health care team that has already established a relationship with this family. The team should give careful consideration to who should lead the family meeting.

A patient and family's cultural and social background are also important aspects in orienting patient and family about cancer. Thirty-six percent of all Americans have basic or below-basic health literacy, with older Americans and women aged 50–79 from all ethnic groups having the most difficulty communicating with providers.³² There are several cultural and social factors that contribute to a patient's health literacy level, including their level of acculturation and language, limited English proficiency, the use of translators in explaining options, a lack of available educational materials in languages other than English, and their individual health beliefs.^{33–35} Cultural factors may affect a patient's treatment and result in a limited desire or ability to participate in care, a misunderstanding of cancer stage/stage awareness, less desire/need for cancer information, inaccurate assessments of risk and fewer questions asked to health care providers.

Oncology nurses should use plain language as a strategy to reduce the gap between provider and patient/family health literacy levels. Using plain language includes using an active voice (eg, "Use your inhaler") rather than a passive voice (eg, "After you have used your inhaler"). Plain language also involves speaking in the second person, limiting jargon, and defining new words (eg, everyday talk vs. health care talk). When using plain language, most sentences should have 15 words or less, limiting the information provided at one time. A list of tools for developing plain language materials can be found in Table 3 and includes a clear communication index for help translating medical terms as well as Web sites for evaluating the readability of written materials. Finally, the Plain Language Planner for Palliative Care (PLP) is a recommended resource for practicing plain language. The PLP is a tool for communicating about medications and symptoms in plain language at the 6th grade level. The PLP translates common medications and symptoms in palliative care and oncology treatment and side effects and includes English and Spanish translations. The PLP is part of the *Health Communication* iPhone smartphone app and is available for free download in the iTunes store.

M-Mindful Communication

Mindful communication in palliative care includes reducing self-talk, avoiding judgment about patient and family or how an interaction will proceed, and the ability to adapt to changes in the interaction. A nurse can be in the moment with patient and family by avoiding pre-determined scripts and engaging in mindful self-monitoring of the inner experience.³⁶ The inner experience of nursing also involves being mindful of the toll of care,

which can erode mindful communication practices overtime. Nurses often begin careers with motivation to practice effective communication with patients and families, yet may experience compassion fatigue from too little sleep and not enough time to meet demanding clinical tasks.³⁷ As a result, disconnection is communicated through interactions with patients and families. Repetition of ineffective communication experiences, such as the non-patient-centered delivery of bad news, can lead to diminished mindful communication.

There are specific communication stressors for nurses working in palliative care that can impact the ability to be mindful. For example, patients and families expect availability, access, competency, empathy, and patience from nurses. There are also specific factors that can affect the patient/family–nurse relationship. These factors include attachment, similarities, emotional balance, nurse mortality, and challenging spiritual beliefs.¹⁵ All of these factors may contribute to burnout, which can lead to severe negative consequences, such as early retirement, unprofessional behavior, and an increased risk of medical errors. Consider the following example of Sylvia:

After a decade of working as an oncology provider, Sylvia joined the palliative care team about 6 months ago. She is passionate about her work and is a strong team member. As usual, the team's case load remains high and the past month has included high-intensity s, consisting of two to three family meetings, often involving lawyers, caring for a patient who was an oncology provider that worked with Sylvia, and a newly diagnosed Alzheimer's patient who keeps referring to Sylvia as her daughter. Sylvia has been short-tempered and is neglecting her personal appearance. She has constant fatigue, feels overworked, and is questioning whether or not palliative care is the right clinical setting for her. She feels like her efforts go unnoticed by her colleagues. She is just 'going through the motions' at work, trying to find enthusiasm to return to work each day. She has witnessed so much suffering over the last 6 months and feels like she is 'failing' as a health care provider.

Sylvia may be experiencing burnout. Burnout can be described as an adverse psychological state characterized by emotional exhaustion, depersonalization, cynicism, and a low perception of personal accomplishment.^{38,39} Predictors of burnout among health care providers who work in palliative care include: working over 50 hours per week, working on weekends, less experience, isolation from peers, lack of confidence in regards to communication skills, time constraints that hamper successful communication, communicating bad news, addressing pain/suffering/death, working in smaller organizations, being under 50 years old, tensions between non-specialists and palliative care specialists, and regulatory issues.^{38–40} Burnout also has detrimental effects on personal physical and emotional health, as well as relationships.³⁹ It has been suggested that increased burnout among oncology providers is associated with feelings of not being trained properly in cancer communication skills and having a desire to change communication with patients.^{40,41} Table 4 summarizes indicators of stress at work that signify diminished ability to be mindful, which can result in poor quality of care, reduced patient trust and satisfaction, malpractice lawsuits, poor decision making, lower productivity, and emotional detachment from patients.

41–46

To prevent burnout, it is crucial for oncology nurses to create opportunities for self-care. For example, nurses should create ways to share difficult patient-family situations with colleagues. This can be done by seeking advice, confirming action, and sharing emotions. An activity that can be extremely helpful is journaling, which can aid in reflection. Journaling allows for the processing of emotions and feelings about events, and can aid in making meaning of situations.⁴⁷ Nurses can journal with other team members after the loss of a patient and share their writing with each other. They may also write a letter to a patient/family or to a colleague.¹⁵ Self-care is critical for nurses because neglecting self-care may not only have detrimental personal effects, but may also be detrimental for their patients/families and colleagues.

R-Relating

Relating involves being aware of the patient's/family member's understanding of the disease and its probable course and being willing to meet patients and families where they are in accepting the change brought by serious illness. In relating to patient and family, nurses should recognize that medical information such as prognosis and treatment option may need to be repeated numerous times to help patient and family reach awareness and understanding. Relating to the patient and family involves being aware of the multiple goals that can exist when talking about uncertainty and learning what hope means to the patient.

Multiple goals exist because task and relational communication impact how our words are received and interpreted. Simply, task communication imparts the content of the message, whereas relational communication includes the nonverbal components of the interaction. This communication approach is predicated upon the axiom that every message (verbal or nonverbal) conveys both content (verbal message) and relationship (nonverbal communication).⁴⁸ Multiple goals can exist through the direct (verbal) and indirect (nonverbal) actions of words. For example, the way a patient or family members says "I'm worried" can reveal multiple concerns depending upon how it is said alongside nonverbal cues. Nonverbal communication can convey why they are worried, what they are worried about, how relationships influence worry, and whether or not they feel comfortable expressing worry to provider. It is essential for oncology nurses to learn how multiple goals are present for patient and family.

Relating to patient/family involves building trust and establishing a relationship. Trust depends on the interpersonal and technical competence of the health care provider⁴⁹ and is gained by patient's perceived emotional support, ability to share personal feelings, whether or not multiple discussions have taken place, and collaboration with family.⁵⁰ It is established over time, not just in one visit,⁴⁹ and includes understanding patient/family preferences, values, and priorities. Encouraging patients to ask questions and actively participate in their care is one way to elicit preferences.⁵¹ Question prompt list is a communication tool that can facilitate difficult discussions and stimulate questions so that the clinician can understand the patient's most important concerns.^{51–54} A coaching intervention using the question prompt list in breast cancer survivors prompted questions regarding symptoms and recurrence and resulted in improved breast cancer self-efficacy.⁵³ An intervention with gynecologic cancer survivors included reflection and symptom sheets

to facilitate communication during the nurse telephone coaching sessions.⁵⁴ Sessions focused on assessing challenges, symptom education, and problem-solving strategies. The intervention group scored higher on quality-of-life and physical well-being subscales compared with the usual care group.⁵⁴

Relating to patient/family also involves exploring feelings of uncertainty that cause worry. Nurses can help patients manage uncertainty by framing information in terms of what is known and unknown and acknowledging that some uncertainty is unavoidable.³⁷ The ability to speak to nurses between follow-up visits can provide reassurance regarding the meaning of symptoms and may decrease anxiety.⁵⁵ Peer support groups and lay navigators are resources that can provide emotional and tangible support.⁵⁶ Cancer survivors who express ongoing anxiety, uncertainty, and fear of recurrence may benefit from cognitive-behavioral and cognitive-existential therapies, mindfulness-based strategies, and coaching and communication interventions.^{57,58}

Dean and Street⁵⁹ describe a three-stage model for clinicians to help patients navigate emotional distress and difficult feelings: a) recognition; b) exploration; and c) therapeutic action. Recognizing distress requires cognitive and communication strategies. Rapport building, listening, asking about patient concerns, and avoiding interruptions are strategies to help nurses recognize emotional concerns.⁵⁹ In the exploration phase, nurses can validate and normalize emotions using open-ended questions and empathic phrases. Even if the nurse is uncertain how to respond, listening and demonstrating caring behaviors can be therapeutic. In the therapeutic action phase, nurses can provide clear information about symptoms and follow-up care, and referrals to assist survivors in managing uncertainty.⁵⁹ Brief screening tools to assess distress and symptoms should be integrated with electronic medical records. For example, PROMIS instruments can be used to assess anxiety, depression, and quality of life and can help to identify psychosocial concerns.^{57,58} Consider the following case:

Mrs Rogers recently completed treatment for stage III ovarian cancer and returns for her initial follow-up visit. Nurse Carol J. sits next to Mrs Rogers and asks if she has any questions or concerns she'd like to discuss during the visit. Mrs Rogers responds "I'm really not sure about what symptoms I should report or be concerned about. I'm also feeling anxious waiting for my CA-125 test result." The nurse mentions that the transition to follow-up care can be stressful for many women and asked Mrs Rogers to tell her more about her concerns. Looking at the floor, Mrs Rogers explains: "I can't stop thinking about the possibility that my cancer may come back. My husband gets upset if I try to talk with him about it." The nurse responds "It must be difficult for you and your husband to deal with everything you have gone through in the past several months. Tell me about how he has helped you during your care and treatment. Do you think he is worried about the cancer returning?" The nurse quietly listens as Mrs Rogers shares about her relationship with her husband. The nurse provides education about common physical and emotional symptoms that survivors experience, suggesting that Mrs Rogers share these with her husband. The nurse reassures her that she will be available by phone if questions arise. She also mentions some support services that other women have

found helpful and asks Mrs Rogers her thoughts on these options. The nurse suggests that she invite her husband to participate in the discussion with the oncologist regarding surveillance and follow-up care.

In this case study, the nurse uses communication strategies based on principles from the Dean and Street⁵⁹ and COMFORT models. She asks about and actively listens to Mrs Rogers' concerns (Recognition). The nurse uses an open-ended clarifying question and acknowledges how difficult this must be. The nurse discusses options and seeks the patient's preference for possible support services (Exploration). The nurse provides education regarding symptoms to reduce uncertainty; reassurance that she will be available; and identifies possible resources (Therapeutic action). Using the COMFORT principle of Relating, the nurse encourages Mrs Rogers to discuss her concerns to further explore her feelings. She recognizes that Mrs Rogers' worry about her cancer returning is connected to a lack of communication about cancer with her husband. Moreover, Mrs Rogers is looking at the ground when she makes this statement (nonverbal cue), revealing that this is also a difficult topic for her to discuss with the nurse. To further explore how Mrs Rogers' relationship with her husband influences her anxiety, she asks Mrs Rogers to recall how her husband has participated in her care and to imagine how he must be feeling. Addressing the partners' uncertainty and concerns will promote well-being because the partner's and survivor's adjustment are interdependent.⁶⁰ Fostering healing relationships is a key communication task to help facilitate trust and relate to patient and family. Finally, the nurse builds trust by emphasizing that she is available by phone if questions arise.

Conclusion

A major component of palliative care is whole-patient assessment that includes the impact of the patient's illness on quality of life. Quality communication skills are essential to cancer nursing, enabling nurses to learn the patient's story, address patient and family health literacy needs, discuss patient uncertainty and emotional distress, and be mindful of the need for self-care. Engaging in difficult or sensitive conversations requires trust, compassion, and self-awareness.³⁷ Palliative care communication training for oncology nurses is needed, especially given their vital role in cancer care. The COMFORT Communication model offers a nursing curriculum for teaching palliative care communication.

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TABLE 1.

Overview of the COMFORT Communication Curriculum

Module	Communication processes
Communication	Understanding the patient's story Recognizing task and relationship practices
Orientation and Options	Gauging health-literacy levels Understanding cultural humility
Mindful communication	Engaging in active listening Understanding nonverbal communication Being aware of self-care needs
Family	Observing family communication patterns Recognizing caregiver communication patterns Responding to the varying needs of family caregivers
Openings	Identifying pivotal points in patient/family care Finding common ground with patients/families
Relating	Realizing the multiple goals for patients/families Linking care to quality-of-life domains
Team	Developing team processes Cultivating team structures Distinguishing successful collaboration from group cohesion

Source: The COMFORT Communication Project developed by Elaine Wittenberg, PhD and Joy Goldsmith, PhD (www.CommunicateComfort.com), revised 2016.¹⁵

TABLE 2.

Questions to Promote Reflection on Life

- “How has your illness (or his/her illness) affected your life and your relationships?”
- “How do you think ignoring this will affect your life?”
- “How does your illness (or his/her illness) reflect on you as a person?”
- “How do you see the future?”
- “How are you affected by others’ opinions?”
- “What do you think influences this experience?”

Source: The COMFORT Communication Project developed by Elaine Wittenberg, PhD and Joy Goldsmith, PhD (www.CommunicateComfort.com), revised 2016.¹⁵

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TABLE 3.**Tools for Developing Plain Language Materials**

- Health Literacy Measurement Tools (revised)
<http://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/literacy/index.html>
 - Check the Readability Level of writing
<https://readability-score.com/>
 - Health Literacy Toolkit for Providers
<http://www.ama-assn.org/ama/pub/about-ama/ama-foundation/our-programs/public-health/health-literacy-program/health-literacy-kit.page>
 - Training by CDC for Practicing and Teaching Health Literacy
<http://www.cdc.gov/healthliteracy/gettraining.html>
 - CDC Clear Communication Index
<http://www.cdc.gov/ccindex>
 - CDC Developing Materials Using Plain Language
<http://www.cdc.gov/healthliteracy/developmaterials/plainlanguage.html>
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Source: The COMFORT Communication Project developed by Elaine Wittenberg, PhD and Joy Goldsmith, PhD (www.CommunicateComfort.com), revised 2016.¹⁵

TABLE 4.

Indicators of Stress at Work

- Withdrawing from patients/colleagues
- Ignoring or delaying patient/family requests
- Quick emotional responses to others
- Overreactions to colleagues
- Calling in sick to avoid feelings
- Keeping busy with work, ignoring emotions

Source: The COMFORT Communication Project developed by Elaine Wittenberg, PhD and Joy Goldsmith, PhD (www.CommunicateComfort.com), revised 2016.¹⁵

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