Improving Health Literacy in DC:
Target populations and best practices.

Wesley Theological Seminary Heal the Sick Workgroup's

2019 DC Health Literacy Campaign Research and Findings

Health Literacy Research Workgroup

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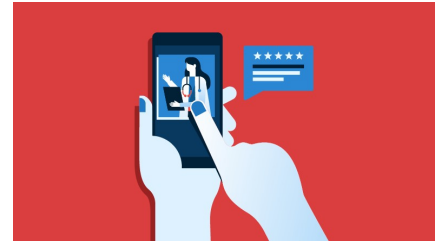Jessica Scudder, MPH Candidate, Community Oriented Primary Care (COPC)
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Introduction

Health Literacy and Public Health

Health literacy is defined as "the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions" (Rudd, 2016). Health literacy plays a significant role in determining how impactful medical information and services will be for an individual. One's ability to seek new information and services, articulate their treatment and care needs and preferences, comprehend the information they receive and make decisions based on an understanding of choice, consequence, and context of the information they are receiving are all impacted by a person's health literacy capacity (Rudd, 2016). Improving health literacy has the capacity to benefit every aspect of an individuals health and medical journey. When individuals are unaware of the warnings signs for poor health outcomes, the likelihood that they will seek primary care services is decreased. Simultaneously, when it is apparent that something is wrong with an individual's health but they are either unaware of how to evaluate the severity of the problem or they seek health care at the last minute, they may believe they have no other option than emergency services. utilize emergency room services. Health literacy products come in a variety of forms and can be tailored to suit specific populations. Popular forms of health literacy include, but are not limited to, multimedia programs which can include instructional videos or health information advertisements, poster and flyer campaigns, non-medical service partnerships such as health fairs in faith-placed locations, or a series of health classes and programs.

Improving Health Literacy & the Social Determinants of Health

Social determinants of health, as defined by the Health People 2020 campaign, are "conditions in the environments in which people are born, live, learn, work, play worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks" (Healthy People 2020, 2019). These determinants acknowledge the variety of institutional and structural influencers on health outcomes, and remove the blame of disease from the individual or population towards the external causes. Populations who experience increased individual and structural marginalization are more likely to experience the burden of disease due to social determinants of health (Healthy People 2020, 2019). Identifying the social determinants of health amongst a population experiencing a negative health trend, or an individual with a negative health experience, means that treatment can account for the specific circumstances. Furthermore, a thorough investigation into situational social determinants of health can uncover specific reasons for unequal health outcomes. Uncovering these influencers provides a basis for understanding that health literacy programs have a unique advantage as they can be applied to any level of intervention and address any aspect of health ranging from symptoms and individual experience to structural root cause.

https://conceptdraw.com/a1563c3/p1/preview/640/pict--circle-spoke-diagram-social-determinants-of-health.png--diagram-flowchart-example.png

Social determinants of health have the capacity to impact health literacy personally, socially, and institutionally. To understand the variety of ways that health literacy can be improved within all of these areas, it is beneficial to use the upstream/ downstream approach. This approach to public health is described within a story, adapted from Melli's description in Upstream: Talking Differently About Health (Meili, 2013). Picture three friends standing next to the end of a river near a waterfall when they suddenly notice that someone is being brought down the river with the current, and one friend has to jump in to save them from falling over the waterfall. People continue to come down the river for the friend who jumped in to save them. If the first friend cannot rescue someone in time, they are so close to the waterfall that they would fall over. So, the second friend runs halfway up the river to rescue the people when there is less risk. The third friend runs to the top of the river to see why everyone is falling into the river in the first place to stop them. All of the actors in this case scenario are crucial players in saving the lives of the people falling in the river. A health literacy program could be implemented downstream and address higher risk situations that need immediate action, mid-stream approaches can be implemented to support people who are at-risk of the situation, and an upstream approach can focus on long-term solutions that will prevent as many people from being at risk.

Emergency Room Utilization

In the United States there is an estimated $30.8 billion a year is used on ER services for preventable health conditions in typically low-income patients. This is alarming when you consider that emergency services are also constantly understaffed and overused, however a study by Dr. Shreya Kangovi discovered that the reasons ER's are being overused is not because patients are purposely trying to overuse it because they do not know how to use these services properly (Robert Wood Johnson Foundation 2013).

"Why is the ER being used as Primary Healthcare?"

Dr. Shreya Kangovi conducted a study asking this specific question, what she found was that this issue is not solely linked to insurance access. She conducted personal interviews through the community health care workers that the patients

trusted, they were 64 patients using ER services in Pennsylvania interviewed. The combination of people was 90% African-American and 30% of them lived below the poverty line, but more importantly they were a mix of people that were uninsured and insured by medicaid.

When asking these patients why they use the ER over Primary Health Care services they answered that there were too many barriers for them to access PHC. The barriers are situated primarily within convenience, cost, and quality:

Convenience: "You must call on the same day to set up a [primary] care appointment …" whenever they can fit you in." This resulted in patients taking days off work and still being unable to see a doctor, on top of that the Medicaid covered transportation required 72 hour advanced notice, often making it impossible for them to set up when they could get an appointment. Hospitals can be accessed at late hours, with multiple ways to access transport there, making it the far more convenient option.

Cost: Many participants had no co-pays when accessing the hospital ER, when a lot of the time when patients access their primary physician for a specific problem they will then be sent to several specialist that will require co-pays, with that they have to make those appointments, go to those appointments, and take even more time off work, effectively losing them more money than if they just used the ER.

Quality: When dealing with a chronic issue like high blood pressure, patients felt their primary care physician was not treating the condition aggressively enough, while the ER would get the blood pressure under control in a matter of days while the primary care physician had several years. While this does not necessarily say anything about the quality of care the ER or PHC gives, the fact that this was a common opinion amongst patients is a huge issue. Many conditions are complex and require long term treatments, however the faster more aggressive care given in an ER makes the quality of care "appear" more effective.

Reducing the number of unnecessary ER visits

To stop people from using the ER Dr. Kangovi and other researchers suggests that the best way is to change PHC so that there are not as many hurdles to navigate it, changing

the perception of it. This requires education on both sides of "Patient-Centered Care," meaning that patients need to understand what is being lost to the greater society by overusing the ER, and physicians need to be taught how to communicate what they are trying to do with each patient's case, while also understanding the background each patient has and what is actually feasible for them to do when considering, work, transportation, and finances, with or without insurance.

Ultimately if healthcare providers are taught how to be culturally competent to the demographic they are serving, then it will be more feasible to teach their patients health literacy. With an understanding of the struggle that patients go through just to access primary health care they can be better in providing information and services that will improve their understanding of the healthcare system and so that they do not overuse and abuse services like the ER.

However, it cannot be ignored that the state of health care right now is frankly not suited towards Patient-Centered Care amongst the low-income population that primarily uses these ER services. Real changes need to be made on how accessible PHC so that it can be comparable to the accessibility to the ER, alongside efforts to educate the population in health literacy so that there is a better understanding on how people should be using the ER and PHC (Kangovi et al 2013).

ER Utilization in DC

The use of Emergency Room services in DC is comparable to other cities like Philadelphia and New York City where the patient population is primarily low-income residents who either wait till they are sick enough to use the ER or they frequently use the ER due to the relatively easier access the ER has compared to PHC.

One alternative that we see in DC in terms of dealing with this issue can be found in Sibley Hospital urgent care unit, where people experiencing conditions that are serious but not necessarily life threatening can set up appointments to urgent care where they will be received quickly and effectively without having to drop in the ER. However, this presents the issue of making these services accessible and known, it also is not a service that is as convenient or uniform in DC.

Target Populations

An overarching recommendation is to stratify program goals, outcomes, and objectives around specific target populations that accommodate demographic needs categorized and distributed along age, sex, location, socioeconomic data, and other potential identifiers such as but not limited to English proficiency, level of education, and immigration status. This section will identify key populations that may bolster program goals within the context of the three recommended programs.

African-American Communities

Using visual and audio representations to educate about a specific topic can be useful especially to groups of people who require the treatment but are unaware of the implications if treatment is not done properly. Low health literacy especially to individuals with diabetes is the leading cause of hospitalization, in order to break this cycle a research design was implemented in Chicago public clinics by setting up computer kiosks in the waiting room. This computers were equipped with thorough multimedia instructions on how to manage diabetes individually for the intervention and for the control group formal survey questions were set up and at the end of the study it was revealed that those individuals who received the multimedia intervention showed an increased awareness on how to manage diabetes-related complications reducing the need for hospitalization (Khan et al 2011).

Sample Programs Exemplifying Recommended strategy:

Racial and Ethnic Approaches to Community Health (REACH)
Population: Minority Communities
Target: Alleviate obesity by increasing physical and nutritional activity

Practice: Community Based Outreach

REACH funds local, state departments, and community-based programs to develop health promotion programs. These programs have been able to transform communities and aspire hope for future generations using education, improving screening and other preventative measures.

In order to implement this program for the target population in DC, applying for funding would be the necessary first steps. For more information about REACH: https://www.cdc.gov/nccdphp/dnpao/state-local-programs/funding.html

Practice: Summer Training Workshop
Target population: African Americans 65 plus

This is a program that is specifically targeted to older African Americans, and the training workshops are a space where they can come and learn about the different medications, how to take them, what to do if feeling ill before going to the emergency room. This trainings will help with closing the gap of health disparities among aging African Americans

More information: https://ssw.umich.edu/offices/research/projects-grants/michigan-center-for-urban-african-american-aging/11992

Based on the information presented above, for a program to be effective it is important that a team is receiving federal funding to support with materials and staffing. For an intervention based on larger populations it is relevant to have the extra support from highly funded programs.

Faith-Placed Populations

Faith Communities and their role in the intertwining of spiritual and physical health has been well documented in history. As of recent, faith based organizations have

been utilized to serve as catalysis in health with disease prevention efforts and health literacy efforts. Faith communities and in particular religious congregations have been recognized for their potential in reach and in effectiveness to provide health programming, both mental and physical health. Their ability to reach underserved populations bearing the brunt of the worst health inequalities have led to opportunities and initiatives promoting their involvement in health programming. Different presidential administrations have noted the importance of Faith Communities and health, such as the "charitable choice" doctrine and the creation of the White House Office of Faith-Based and Neighborhood Partnerships. Health researchers and Public Health planners have also acknowledged the roles that Faith Communities can play in health programming.

Faith Communities are uniquely capable in that they can be utilized as a centered community location to connect target populations to resources while acting as an extended family unit where like minded individuals are dedicated to the well-being of one another. Reverend Joseph Heath-Mason and soon to be Rev. Laurel Capesius both comment that faith communities are dedicated to the needs of the whole person and community, believing that places of worship are natural centers for spiritual, emotional, and physical wellness and that the body is a gift from God to care for. Faith Communities aspire to deliver or enhance their ability to deliver health programming, reaching vulnerable population and recognizing that their physical and social capital capacities render them an appropriate community partner for health information and health care access.

Best Practices

Adopting User-Centered Design

Evidence supports involving members of the target audience, in this case by utilizing key members of the congregation, in the design and testing of health communication and health promotion design. By utilizing key members of the congregation, there was an increase in participation as an increase of community investment and accountability. This participatory design process results in improved outcomes, including those for people with limited health literacy.

Using a Universal Precautions Approach

As it is impossible to tell by looking who is affected by limited health literacy, many health professionals advocate using a universal precautions approach to health communication—that is, assume that most patients will have difficulty understanding health information. When 9 of 10 English-speaking adults have less than proficient health literacy skills, it is an issue that affects everyone. It is always best to use the clearest language possible. Several studies have shown that while interventions and materials that address health literacy barriers may have greater effects on individuals with limited health literacy, many of those at higher health literacy levels also prefer and benefit from them. By adopting universal precautions, health professionals use clear communication with everyone, regardless of their perceived health literacy skills.

Targeting Communication

Using targeted approaches to communication can improve self management and related health outcomes among patients with limited health literacy. Targeted approaches in faith based communities are adapted to meet the specific needs of congregations. Faith based interventions in clear language as delivered within the faith community targeted for those with limited literacy skills have resulted in strong ratings for acceptability and usefulness.

Homeless populations and health literacy

There are a variety of barriers that homeless individuals and families experience when accessing health care, and many of those same barriers impact health care providers ability to reach the same population. A lack of research has been conducted on the best practices to reach homeless populations, and this population is repeatedly responsible for seeking their own health care information and resources (Stennett, 2012). This should be kept in mind while planning the creation and implementation of a health literacy program for homeless populations, as preliminary studies, such as needs assessments, can address the necessity and expected success.

When implementing a needs assessment, resampling and generalizing the population are important considerations. To avoid resampling it is preferable to implement the needs assessment during one time period in multiple locations, rather than multiple time periods in one location (Stennett, 2012). To prevent generalization,

utilizing social services that focus on basic needs and appeal to a large variety of people, such as food and primary health care services, is crucial. This also account for the diversity of a homeless population within a specific city or region.

A needs assessment is essential to the programs success as the community is consulted on their genuine needs and desires from social services, rather than basing it off of well-intended assumptions. Housing security and access to other basic needs such as food, hygiene facilities, and schools/education are often a primary focus for individuals experiencing chronic or temporary homelessness (Colorado Coalition for the Homeless, 2013). Once basic needs are met, prioritizing health care and adherence to treatment become significantly easier for any population. A safe place to sleep and store personal belongings, eating, drinking, and maintaining hygiene in a reasonable and attainable way will encourage a balanced schedule that provides homeless populations with a greater capacity to focus on health care needs.

Best Practices

1. Focus on Basic Needs

Housing: As previously stated, there is a lack of research on the best practices for reaching and communicating with expansive groups of homeless populations, which can make supporting the health literacy of these populations a challenge. Directly addressing these non-medical barriers is a best practice for improving health literacy and health outcomes.

Increasing access to housing, either directly or through effective referrals and linkages, directly correlate to positive health outcomes. With a primary focus on improving housing accessibility, one program (please reference: *Colorado Coalition for the Homeless Report*) in Colorado saw a 72.9% decrease in emergency room service cots, hospital stays, and days incarcerated. Correlating basic needs and medical care has the capacity to encourage a healthier foundation for a new life transitioning into permanent housing, increasing the overall ability to apply health literacy to one's daily life.

Employment: Another example of a basic needs focus is employment security. A report published by the Homeless Services Planning and Coordinating Committee in Washington, DC addresses that in 2017 only 22% of homeless single adults were

employed in Washington, DC. Some of the barriers that prevented homeless single adults from maintaining employment included physical disabilities, and multiple behavioral and chronic health issues (Chapman, 2017). Employment assistance programs (please reference: *Repairers of the Breach*) provide clients with necessary skills to present themselves professionally during interviews and throughout the duration of their employment, increasing mobility within their career. Programs can also partner with community organizations that will let homeless clients use their resources to gain specialized skills.

2. Trauma-Informed Care

Due to the increased risk of physical and mental trauma for homeless populations, trauma-informed approaches are a best practice and necessity in creating adequate health literacy programs. There are disproportionately high rates of Adverse Childhood Experiences (ACEs) amongst many homeless populations, and if left unaddressed can contribute significantly to physical and mental illnesses (Colorado Coalition for the Homeless, 2013). Training case managers, social workers, medical providers, and other employees of health literacy programs on trauma-informed care is crucial.

3. Utilizing Basic Needs Services - Announcements During Meal Times

A survey study of homeless populations found that the best form of communication for advancing health literacy and advertising for health care programs is making announcements during meal times (Stennett, 2012). This is due to the diverse populations that basic needs services attract, and because meal times provide a place for community gathering. Due to the inconsistency of individuals utilizing meal services, to make the most significant impact there should be multiple announcements made throughout the week or weeks leading up to a more comprehensive verbal presentation. Verbal information can be accompanied by flyers or other visual aids, but not in place of.

Health Literacy Programs Around the US

Chicago

"Healthy CPS"

The Illinois Prevention and research Center funded Healthy CPS (Chicago Public Schools) as a way to encourage students families to engage with healthy behaviors including fitness and food. The program begun in 2016 with four specific goals which include; knowing how knowledgeable parents and family members are in regards to health literacy and physical activities, what other programs exist that encourage the community to live a healthy life, increase participation from parents from all corners of Chicago, and lastly encourage parents to continue engaging with wellness conference and discovering new ways to motivate their families. The program is standing strong and they continue to be engaged with the community through social media especially on Twitter. This program is specifically used to target families with school aged children which according to, *DC Health Matters*, 18.72% of Ward 8 population is between the ages of 5-17 and implementing the program in DCPS would allow for the parents and family members of these students to be reached.

Chicago Citywide Literacy Coalition (Empowerment-based Health Literacy Project)

This project was made possible by funding from local federally qualified health center and it has been aimed to increase health literacy knowledge and self-care awareness through adult education. Adult educators were offered training through CCLC and then they each had a group of adult students to lead through the awareness project. In 2015 the project had reached 775 adult learners. In order for this project to be reciprocated funding would have to be raised from the Health Literacy Team to train educators and purchase the necessary material.

Lawndale Christian Health Center

Founded in 1984, Lawndale Christian Health Center has been at the epicenter of offering affordable health care to Lawndale and the surrounding communities in Chicago. To this day the health centers are distributed throughout Chicago and they offer services from vision care to senior programs. LCHC has been able to reduce the number of emergency visits from the community because of the services they offer many feel comfortable coming to receive their treatment there. A program such as this would be amazing for Washington DC however, this is a project that has been developing for thirty plus years and it would require much coordination from the city to find space and to begin impacting the community here.

Detroit

DMC's Gateway to Health program

   To address the uninsured persons who come into the emergency room more than five times annually for non emergent or otherwise manageable or preventable conditions, Detroit established a 24/7 advice line as funded by a three-year, $10 million grant through the Patient Protection and Affordable Care Act of 2010.

   This initiative has put same day clinics next to the emergency rooms, and putting primary physicians in the ER and follow up care assigned to primary physician trying to better coordinate care for patients with diabetes, asthma, hypertension, heart failure, chronic lung disease, depression and HIV. By doing this, Detroit and its hospitals hope to deviate individuals to these non emergent, lower cost resources and ease the burden on emergency rooms in the city.

   This initiative can easily be adapted to Washington DC as long as there is funding and space to do build the clinics.

Vanguard Community Development Corp

            More than a dozen Detroit leaders and business partners have formed an alliance to develop housing, business, and educational options for a sustainable future for the residents of Detroit. They do this by sponsoring, adopting, or owning senior apartment complexes, charter schools. Churches like Little Rock Baptist Church have filled in the gaps addressing the needs of the community with projects like funding a

sliding scale neighborhood pharmacy where the cost of life saving drugs are dependent on the financial ability of an individual to pay. Churches are also noted sponsoring food pantries, water donations, diaper and early life ministries.

Houston

Houston Health Department actively uses their Facebook and Twitter pages to communicate new programs and relevant health information to the public. All participants of this program have to do is like the Facebook page or follow the Twitter page, and they will receive updates on upcoming events and tips on maintaining good health. The social media is utilized to advertise creative and new ideas that promote health literacy, such as the Houston Preparedness Icon music competition. This is a music competition for residents of Houston 18 and older to see who can write and perform the best song(s) encouraging other residents to prepare for emergencies. Using social media as a platform to increase health literacy can be done when using an effective social media strategy, as outlined later within this document.

It's Time Texas

"It's Time Texas" community challenge is supported by the Houston Department of Health (HDH). This is a competitive, state-wide, two-month challenge to see which communities can show their dedication to healthy living. Communities include neighborhoods, schools, companies and/or their branches, or any grouping of people and sub communities. People report exercise and other healthy activities to gain points in the competition. As this program includes any community grouping of people, it is accessible for a variety of diverse populations. The competitive aspect of the challenge creates a sense of teamwork amongst communities and promotes adhering to health lifestyle changes and behaviors for the duration of the program. Through the program, participants are educated on lifestyle choices that can make them healthier, and the nature of the program encourages participants to do their own research which increases their capacity for health literacy. To replicate this program, an online database would have to be created to keep track of and share the progress of each community. It would also be extremely beneficial to implement encouragement through social media and advertising to strengthen the incentive of winning the competition, in addition a final celebration or prize incentive for the winner. Washington, DC provides a variety of career opportunities and has a diverse collection of charter schools, and if this program were replicated it could strengthen the sense of community and emotional support within these institutions.
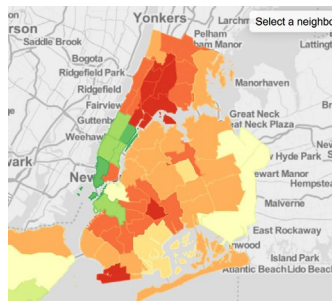
Charitable Feeding Programs

Houston Department of Health (HDH) provides food safety classes to any volunteer food provider free of charge. The program provides the incentive of a free training on adequate food preparation, a skill which is transferable to personal and professional settings. This program also provides benefits for the city of Houston, as it increases the population that is able to support charitable feeding programs through food preparation. In Washington, DC as there are a variety of food services that already have the necessary resources, such as large kitchens and trained staff. Strong community partnerships and trust will aid the utilization of these resources and guide the implementation of similar programs.

A Taste of African Heritage

This program is a six-week cooking course that teaches healthy eating using recipes with major foods of African heritage. A Taste of African Heritage addresses the increasing rates of heart disease and diabetes amongst African-American populations within the United States, and the complex social relationship between food and culture. Food as an aspect of culture can be a difficult area of health to address, and this program does so by introducing additional culturally relevant foods rather than advocating for restrictions. The incentive of the program is that participants have the opportunity to connect with their cultural heritage through healthy food. To implement this program in Washington, DC, demographic information should be accounted for to ensure the cultural information is relevant. Furthermore, a dietary-specific needs assessment can be implemented for the program implementers to understand the specific areas of nutrition that can be improved upon.

New York City

Housing, affordability, and income all have a role in shaping one's level of health literacy for it influences someone's connection to health insurance usage, health outcomes, and access inequities (Raby 2017). Per the map below (Raby 2017; red implying need), these inequities are concentrated in the Bronx and in parts of Brooklyn, where minority populations are also concentrated. Therefore, highlighted programs within the NYC area in this report will focus on said areas.

Bronx Community Health Network

Need HELP? BCHN provides families with one-on-one services, including connecting you with: • A doctor • Health insurance • SNAP and other public benefits • Housing and employment programs • Support services to ensure a healthy pregnancy, birth and father engagement. *For 20 years, BCHN has linked families and communities with quality, affordable healthcare. Let us help YOU now!* Call us today for more information! **(929) 220-8181** WWW. BCHNHEALTH.ORG/CHPEP **¿Necesita AYUDA?** BCHN provee familias con servicios individuales, incluyendo conectándole con: • Un doctor • Seguro médico • SNAP y otros beneficios públicos • Programas de vivienda y de empleo • Herramientas de apoyo para asegurar un embarazo y parto saludable, y el involucramiento paterno. *Por veinte años, BCHN ha conectado familias y comunidades con cuidado médico de calidad y accesible. Permítanos ayudarle ahora!* Llámenos hoy para más información! **(929) 220-8181** WWW. BCHNHEALTH.ORG/CHPEP	https://youtu.be/ 1HEEj516w6g UNDERSTANDING OPEN ENROLLMENT, *Open News* *News 12*	Health fairs

The BCHN funds a network of community and school based health centers to promote health services as a means of combating chronic illness in the Bronx. This program helps identify common diseases in the Bronx community and comments on social and economic causes of the negative health outcomes the Bronx experiences as a means to inform and alleviate the associated burden of disease.

With respect to health literacy and the promotion thereof, the BCHN is integrated in the community. While the website and their social media play a traditional role in marketing their services, the program goes above and beyond to appear on public local news channels and shows to discuss issues of health literacy and open spaces for communication (see video above). They also hold community events that educate the population about a range of topics such as childbirth education courses, community dinners, and coping with stress. This presence helps the BCHN connect with the community at large and provide in-person communications.

On a larger level, the BCHN has a number of community partners ranging from health clinics, churches, and local governments, which increases its presence in the community and strength of its programs.

Bronx Health REACH

The REACH program is an initiative to eliminate racial and ethnic disparities experienced among Latino and African American populations in the Bronx with respect to heart disease and diabetes. Among the many funding partners is the St. Edmunds Church, identified as a community partner.

REACH also follows number of theoretical papers and frameworks that makes their program more impactful. These materials were placed in churches across the Bronx and distributed and promoted by church leaders and role models.

Under the site's "Toolkits and Guides" tab, you can find documents that detail programs implemented in the community (within faith settings). This program called forth 11 community discussion sessions around topics such as healthy eating and nutrition, informational distributed, target population, advice on how to reach that target population, and more. The program relied on the faith setting to market and implement the program across the Bronx and establish continuity and sustainability within the church community.

DASH NYC

This document overviews the Bronx REACH program on a more official level. It identifies best practices such as "faith based not faith placed" (i.e. the need for faith communities to have materials made by the faith community). These best practices include how to maintain sustainable partnerships with community partners, having strong relationships with community leaders, and other basic community health initiative 101 practices.

#Not62

This article discusses an initiative called #Not62, a campaign dedicated to improving the Bronx's health outcomes after placing low on a national health ranking. It incorporates prominent flavors of faith-based programs and includes several churches in its 15 community partners.

Although I have yet to find its official website, its media coverage is extensive. If you search on bronxboropres.nyc.gov (linked above), and search "#Not62", you'll see that

there are numerous community events that reach varying levels of interest, promotes healthy eating, and intends on providing the community with opportunities to learn more about how to live healthier lives.

By the very nature of its programs coupled with the promotion coming from its diverse partner base, #Not62 seems to have a steady grip on marketing its events and showing the community that they are there to help--which lends to its overall success as a campaign.

Philadelphia

Pennsylvania Department of Health - Health Literacy Coalition
Department of Health in Pennsylvania has created a health literacy coalition consisting of healthcare organizations as well as community partners that can help provide resources, part of the Pennsylvania State Health Improvement Plan 2015-2020. Programs included in this action plan are; promoting additional residencies for primary healthcare in underserved areas, use community leaders to provide community based education on health literacy, and the advocacy to retrain health service providers to be competent in these measures. This strategy requires a lot of collaboration from healthcare organizations in the state, but ultimately not impossible to implement in DC. While this action plan may not have a direct avenue to tackle health literacy, the act of bringing these organizations together would be beneficial for a DC Health Literacy Campaign period.

The Free Library of Philadelphia's Health Literacy Month
October is Health Literacy Month in Philly, the Free Library of Philadelphia provides information and resources regarding health literacy/advocacy. Not just targeted towards kids, information about free screenings and materials and links targeted towards adults as well, funded by the Philadelphia department of education and regulated through the

Philadelphia public schools. This strategy is incredibly adaptable to the DC population, many of the systems such as public libraries and schools are already in place, the programming provided in Philadelphia is also public information that can be easily adapted to the DC population, the only thing that is required is to set up the relationship with the schools and libraries so the children from the schools can bring home information, so that their parents can take themselves and their children to programming in the libraries.

Penn Presbyterian Medical Center's Residency Community Initiative
This is a residency program where doctors are required to work in clinics, adult care facilities, shelters, and other locations that cater to vulnerable populations in the surrounding area in order to inform people on basic health literacy as well as provide medical services. This program requires doctors completing their residency to essentially fulfill community clinic hours in efforts to better the community's health literacy education, while also providing a friendlier space to meet physicians in your area

Future Recommendations

As your program grows and evolves, it will be easier to replicate for other DC communities. For future reference, please refer future inquiries about potential communities to the section below.

The Immigrant Community

When considering working with the immigrant community, one must consider two sets of barriers: the intrinsic and the extrinsic factors (Szczepura 2005). Intrinsic factors identify individual, subjective barriers at the interpersonal and individual level with respect to the socioecological model. These include differences such as but not limited to culture, religion and tradition, language differences, and unfamiliarity that limits the ability of an individual in pursuing healthcare services. Cultural differences depend on the immigrant populations, and vary between their nationality, level of income, reason for leaving their home country, and areas/societies that they grew up with. Often but not always, they may follow a different a set of social and medical values. When working with immigrants, it is important to consider current political implications as an influencer for treatment and willingness to pursue and health information rather than prioritizing cultural barriers (not inclusive of language) given the risk that "cultural competency" holds in further stereotyping non-white bodies. Finally, unfamiliarity means lack of understanding of the healthcare system, thus preventing individuals from utilizing it to its fullest extent.

Linguistic Barriers: Language barriers stand between consumers and services in that individuals whose language (in this case English, DC being English speaking) is not English will have a harder time booking appointments, communicating with the doctor, and finding clinics (finding good offices too). It will do a program well to produce communications, education, and diagnostic informational materials in various languages. Furthermore, due to this variety, programs must have a specific target audience to make the most impact in the community. Programs may be creative in addressing this barrier by carefully choosing partnerships with local organizations.

Cultural Difference: Explanatory models of disease must be considered as a component of cultural varieties. This is where immigrant communities may adhere to different models of biomedical disease conditions (Shaw et al 2008), thus potentially affecting their willingness to adopt other treatments. Programs may be creative in addressing this

barrier by carefully choosing partnerships with local organizations.

Extrinsic reasons are reasons that prevent a given organization/provider from extending access to the clients. Similar to cultural difference, providers may interact with clients in ways they are not used to. Staff may be poorly trained in cultural awareness and may harbour and/or subconsciously exhibit prejudiced behaviors. It is important to note that cultural competency may also further poses barriers as it implies the use of medical and social stereotypes in treatment settings (DVRP 2019). Generally, programs encompassing healthcare access--including health literacy, should ensure that non-profits and other functions of the health system keep providers accountable for being accessible (Shaw et al 2009).

Finally though not seemingly directly connected to promoting health literacy, programs must consider the trust many immigrants in the US might not have established with the local government regardless of immigration status. Individuals may fear that reporting need of services or accessing resources that better health and health literacy due to the danger disclosing any form of status might expose them to (Alper 2017). This positions churches, community organizations, and nonprofits with a close relationship to the community as prime sources of help.

BEST PRACTICES & RECOMMENDED STRATEGIES:

1. NEEDS ASSESSMENT RECOMMENDATIONS:

- *Identify target population:* **Be specific** when thinking about the target populations and social identifier overlap. Note: communications and program will sit differently per age group.

- *Identify partnerships:* Partner with organizations that provide linguistic services and resource connections such as AYUDA.

- *Evaluation strategy:* see sample focus group questions below:

Figure 1. Focus Group Questions

A. Think about the last time you were sick or needed care from a doctor. How did you decide how to get help? Prompts: Do you have a regular doctor? Who/where? Can you get help with health information over the telephone, from a friend or relative, or somewhere else? How do you feel about visiting the doctor? Do you feel respected? Understood?

B. When you visit a doctor, they ask you to fill out forms about yourself and your insurance. Do most clinics offer to help you fill out the forms, if you need it? Prompts: Have you ever had trouble filling out the forms? What did you do?

C. Sometimes, doctors use words that are hard to understand. It can be especially hard to remember what they are telling you if you are not feeling well or are upset. Can you think of a time when a doctor explained something to you which you later had a hard time remembering? Prompts: What was that like? How did you feel? Were you able to get the information you needed later?

D. Sometimes, doctors give you written directions or information about what to do at home to take care of your health. Is this helpful to you? Are the directions easy to understand? If you don't understand, is there someone who can help you (a friend/relative or phone number to call a nurse at the clinic)?

E. When a doctor tells you to take medicine, are you able to get the medicine that was prescribed? Does the drug store/pharmacy explain the directions clearly? If you have trouble with the directions, is there someone who can help you?

F. Can you think of any ways that would help you get better information about how to take care of your health? Where would you like/prefer to get information? Prompts: churches, doctor's offices, grocery stores, drug stores, schools, internet, videos, other… Would you attend health education classes? Where?

G. What could your doctor/clinic do to make it easier for you to understand directions for taking care of your health? Prompts: Do you prefer written directions, talking with a doctor or nurse, a telephone number to call with questions, all of these, something else …

H. Do you have any ideas for how to make it easier to take the medicines your doctor prescribes? Prompts: Color-coding, written directions, calendars, …

I. A lot of people have trouble following doctor's directions. Do you have any more ideas of how to help people take care of their health?

(Kimbrough 2007)

- *Set priorities:* In the immigrant community, hone in on language preferences and intrinsic/extrinsic barriers to accessing health information.

II. PLANNING RECOMMENDATIONS:
- *Goals and objectives:* Goals should measure types of accessible informationals and test results (if program is education specific).

IV. PROMOTIONAL RECOMMENDATIONS:
- Communications must be translated to fit the target audience.

- Post communications in culturally specific centers such as grocery stores, community centers, and/or schools. Emphasis on churches.

Methods to encompass immigrant population needs within the strategic planning method:

With regards to a health literacy campaign that aims to empower low-income immigrant communities in DC, these two tiers must be addressed through different campaign functions to sufficiently explore and address the issue at hand. Programs that perform these types of services include DVRP, an Asian/Pacific Islander specific organization that often serves immigrants. They provide direct services to immigrants and connect them to community resources, in addition to community outreach where trainings on how to help for other organizations and service providers are given. AYUDA is another DC based organization that has several components: social and legal service connections, in addition to language services. Additionally, given the root causes for low health literacy on a broader level--some of which being poor education opportunities, and the role poverty has in positioning medical care as financially inaccessible unless absolutely necessary, extrinsic reasons should be addressed on an environmental level with respect to the socioecological model.

Intrinsic program functions may include education workshops led by individuals with the ability to speak in the appropriate languages. These workshops should explore not only health basics such as nutrition, chronic disease, and biological systems overview, they should also teach individuals how to maneuver the healthcare system in the US with specifics towards DC--including community health clinics.

Educational opportunities come in varied forms and is not limited to classroom based interventions. It can happen at events in different community centers, through social marketing strategies, and church-based settings. No matter the setting, educators must be well-versed in the local, District-wide, and national resources that might be able to help individuals. These resources are not just health based, but community and

culturally based. Providing these resources will help immigrants build a sense of community in potentially unfamiliar, even intimidating settings.

This leads into designing branches of a potential program that address extrinsic barriers. Often, these programs provide organizational trainings for medical treatment facilities, workplaces, and/or community centers. This component is crucial because service providers have a responsibility to ensure that their service extends to minority populations. Adequate care may be achieved through the proper training of staff and debunking of internal and subconscious biases towards different immigrant populations, and even conceptions of racial stereotypes. This includes the specific avoidance of reductive language and the use of motivational interviewing (Panzera 2019). Racial biases and the overall othering of immigrant population often leads to a clinician conveying treatment information in a condescending manner, leading to less motivation, trust, and efficacy in the service provider. By providing training to clinicians and staff, service providers may better convey and treat their patients of the immigrant population.

Low-English Speaking Populations (LEP)

St. Paul Minnesota is perfect representation of the challenges and barriers that the low-English speaking population faces in terms of accessing healthcare and understanding health literacy. This is because of the demographic in Minnesota has a large population of Hmong and Somali immigrants with low English ability, as well as a large population of young adults (25+) that lack a high school degree, and the much older population (65+) that are suffering from low health literacy. Overall the majority of the people in these demographics make up the 200,000 population of people that need English as a second language services like ESOL (English for Speakers of Other Languages). A lot of the times however the lack of English speaking services is not the only barrier, but the cultural differences between healthcare providers and healthcare receivers and the like of cultural competency from the healthcare providers making it unlikely for many of these patients to seek out these health services.

This makes it incredibly hard for a needs assessment to be put in place for this population, since the majority are unable to communicate due to a lack of cultural understanding on both sides. That is the first obstacle in terms of providing health services to a population that is low English speaking and/or otherwise health illiterate. Cultural competency is the ability to understand and communicate effectively with

people across cultures, which requires one to be aware of their own world view, while also developing a positive attitude towards cultural differences, while putting effort into gaining more knowledge on other cultural practices and world views. Once cultural competency is achieved and a trusting relationship is built between the community and the healthcare providers servicing this community, teaching health literacy becomes possible and effective in these demographics.

Many of the needs of this demographic could be met when given an understanding of the US healthcare system, and given context on how patients should interact with this system. Many native English speakers take for granted the basic knowledge and skills that are needed for the low-English population to access their own healthcare. Many instances of improper healthcare usage in this population arises from not understanding the dosage and frequency one should take of a specific medication, what questions and concerns they should be bringing up to their primary healthcare providers, and how to do competent personal research on one's own health and healthcare access. These issues are present across all of the United States, not just one city in Minnesota, the USA is melting pot of diverse cultures and backgrounds and ultimately these problems with accessing healthcare ad understanding health literacy are present no matter what reason someone has low-English skills.

BEST PRACTICES

Cultural Competency

Measures in getting healthcare providers to be more culturally competent requires a few things. In requires a patient-centered approach, this means developing a rapport with patients and their families, making sure that any questions and concerns are explained. This also requires orienting the patient to the process by tailoring the care to the needs and preferences of the patient and the patient's context. Even something as simple as asking the patient to repeat back the medical process is effective in making sure patients and their families understand what will be required of them. Dismissing the misconception that these patients do not want to be treated properly needs to happen before any of these actions are performed, patients want to get better, but misunderstandings of medical practices and misconceptions of the healthcare system are preventing them, not a lack of motivation to get better.

Recruiting and maintaining a diverse workforce goes a long way in terms of creating a culturally competent healthcare practice. By increasing the number of ethnic and racial

minority health professionals, it creates greater opportunities for all patients to receive healthcare from someone who shares their ethnicity and diverse background. Patients from diverse backgrounds may have learned to distrust healthcare organizations that are run and staffed predominantly by white people, so having a workforce as well as leadership be more diverse opens the door for people that would otherwise be skeptical.

Providing training in culturally and linguistically appropriate service delivery can only benefit one's ability to be culturally competent. Lessons of this nature should be geared towards teaching each person to be self-aware of their own world view, while also acknowledging and appreciating cultural differences that do not necessarily apply to their own. Having this knowledge gives healthcare providers the ability to create cross-functional strategies to change the organizational practices that put barriers between healthcare providers and diverse patient-centered care.

Health Literacy Education Programs

Health Literacy for the low-English speaking population can be divided into 3 primary needs. The first is focused around teaching and motivating the participants to ask the right questions to their healthcare providers, these techniques include running mock practices of patients interacting with healthcare providers, as well as writing out the current concerns the participants have and workshopping how they should present these concerns to healthcare providers.

The second is focused on scheduling and preparing participants for their medical appointments. Explaining what at actions need to be taken depending on the kind of appointment or procedures, these strategies are for patients who lack an understanding on how they should be prepping for procedures and how they should be taking their medications.

The third is focused on teaching participants on how to use and navigate medically competent search engines such as Medline Plus medical search engine, so that when patients inevitably research their conditions themselves they are at least researching symptoms and health practices online t using a search engine maintained by organizations such as the National Library of Medicine and other National Institutes of Health, this decreases misconceptions involved with personal research amongst low-english speaking populations.

Social media best practices

Social media allows for people to be interconnected globally and for messages to be passed more adequately, but as much as it is an amazing platform social media can hinder communication if it is not used properly. For example, when it comes to health literacy social media is used for health promotion and campaigning for programs and there are certain guidelines that are necessary to follow in order to assure that the message is passed along to a larger and diverse crowd.

1) The message being passed has to be factual
   • Health misinformation circulates in many social networks daily and the health claims can be damaging to a community that is of low literacy. Taking time to make sure that the message is from a trusted source can save lives from running into a catastrophe
2) The message is engaging
   • Using visuals that are mentally stimulating yet not too flashy creates a space for the audience to learn more from the material
3) Message highlights diversity of the audience
   • Maintaining a professional yet engaging message for a diverse audience gives way for more substantive responses and efficient outcomes

Platform-specific best practices

Facebook: Facebook posts are most popular among 25+ populations, most popular between 30 - 50 (as of 2019). Thus, posts should use traditional language. Facebook can be used to promote events (promotional marketing funds should be written into grant applications to fund Facebook and Instagram advertising), distribute infographics that may be kept digitally, repost informational videos from community partners, amongst many other secondary information distribution methods. Organization and program logos/iconology should be unified and used as the Facebook profile picture to ensure the

promotion of this specific program. Facebook data is also readily available and extremely informative.

- Times best for posting: Morning and evening rush hours, 11 AM - 1 PM (weekdays); 10 AM, 3 PM, 6PM (Weekends)

Instagram: Instagram is an image based platform, therefore posts should be kept simple. See image below for sample layouts. Establish the Instagram account used for program promotion as a business account so that you can derive user data from the analytics tab. Primary age group: Gen. Z. through Millennials.

- Times best for posting: Morning and evening rush hours, 11 AM - 1 PM (weekdays); 10 AM, 3 PM, 6PM (Weekends)

Twitter: Given the text limit, prioritize the message you're trying to send and use concise wording that front loads this message. Can be used real-time to promote program activities. Can also be used to promote community partner content and redistribute articles.

Program List

Program Name	Program List
A Taste of African Heritage	http://www.houstontx.gov/health/Community/dawn/documents/cooking_taste_of_african_heritage.pdf
BCHN Health	http://www.bchnhealth.org/community-health-education.html
Bronx Health REACH	https://www.institute.org/bronx-health-reach/about/
Charitable Feeding Programs	https://www.houstontx.gov/health/Charitable/index.html
Children's National Parish Nursing Program	https://childrensnational.org/research-and-education/healthcare-education/continuing-education-and-conferences/continuing-nursing-education/parish-nursing-training
Colorado Coalition for the Homeless Report	https://www.coloradocoalition.org/sites/default/files/2017-01/CCH.SIM_.2013.pdf
Community based Outrach	https://www.cdc.gov/nccdphp/dnpao/state-local-programs/funding.html
DASH NYC	http://www.fphnyc.org/wp-content/uploads/2016/09/DASH-NYC-FBOI-Report.pdf
Department of Health in Pennsylvania Health Literacy Coalition	https://www.health.pa.gov/topics/Documents/SHIP/2015-2020_PA_SHIP_PCPS.pdf
Faith Community United Credit Union	http://www.faithcommcu.com/
Health Literacy for recent adolescent immigrants in NYC	http://www.iha4health.org/wp-content/uploads/2015/03/Health-Literacy-Program-for-recent-Immigrant-Adolescents-in-new-York-City.pdf
Houston Health Department Facebook Page	https://www.facebook.com/HoustonHealth/
Houston Health Department Twitter Page	https://twitter.com/HoustonHealth?ref_src=twsrc%5Egoogle%7Ctwcamp%5Eserp%7Ctwgr%5Eauthor
It's Time Texas	https://ittcommunitychallenge.com/en/home
Minnesota Culture Care Connection	http://www.culturecareconnection.org/index.html
Multimedia Education-Chicago	https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3173596/
Penn Presbyterian Medical Center's Residency Community Initiative	https://www.pennmedicine.org/departments-and-centers/family-medicine-and-community-health/community-initiatives/residency-community-initiatives

Program Name	Program List
Project Joy	https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1913665/pdf/pubhealthrep00206-0070.pdf
Project SHINE	http://www.livable.org/livability-resources/607-shine
Repairers of the Breach	http://www.repairers.org/
Summer Training Workshop-Michigan	https://ssw.umich.edu/offices/research/projects-grants/michigan-center-for-urban-african-american-aging/11992
Take Charge of Your Health Care: Asking Questions, Getting Answers	https://healthliteracymn.org/sites/default/files/images/files/Take%20Charge%20of%20Your%20Health%20report%20FINAL.pdf
The Free Library of Philadelphia Health Literacy Month	https://libwww.freelibrary.org/explore/topic/health-literacy-month

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