Incorporating Health Literacy Into English as a Second Language Classes

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Adult learners attend English as a second language (ESL) classes to improve their skills in specific areas. They may desire to read and write better, learn to spell, communicate in English, or build their vocabulary. These goals have a multitude of purposes such as getting a better job, helping their children with their homework, dealing more effectively with their health and the health care system, or gaining ability to hold conversations (Bryson, 2013). Embedding health literacy content into adult learner classes helps promote understanding and application of health information to stay healthy and well. In addition, most adults learn best if the knowledge, skills, and strategies to be acquired are linked to real-life contexts that either mirror their own circumstances or illustrate a reality they would like to know (Bryson, 2013). In a study by Rowlands, Shaw, Jaswal, Smith, and Harpham (2017), adult learners recognized that their health and that of their families depends greatly on their level of health literacy. For this reason, learners are highly motivated to study health-related topics in the classroom.

Health literacy is the ability of the public to obtain, process, and act on health information to optimize and maintain health (Nielsen-Bohlman, Panzer, & Kindig, 2004; U.S. Department of Health and Human Services, 2000).

A growing body of research indicates that limited health literacy can lead to adverse health outcomes due to patients' inability to follow instructions on medications, labels, and health messages, especially in preventive care (Koh et al., 2012). Research estimates indicate that between one-third and one-half of all adults struggle with health literacy (Berkman, Sheridan, Donahue, Halpern, & Crotty, 2011). According to the Center for Health Care Strategies (2013), a disproportionate number of ethnic minorities and immigrants have health literacy problems. The Center for Health Care Strategies (2013) estimates that 50% of Hispanics, 40% of African Americans, and 33% of Asians have issues accessing and using credible health information. This may lead to limited overall health and wellness, increased and longer hospitalizations, difficulty managing chronic conditions, increased use of emergency care, and higher mortality rates (Berkman et al., 2011). Health literacy problems may cost the United States between $106 and $236 billion annually in unnecessary medical expenditures (U.S. Department of Health and Human Services, 2011).

Health literacy and limited English proficiency often are related. One study found 44.9% of a population with limited English proficiency (LEP) reported low health literacy compared with 13.8% of fluent English speakers

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(Sentell & Braun, 2012). The LEP population as a whole is more likely to be less educated and to live below the federal poverty line (Zong & Batalova, 2015). A recent community survey in California found that 41.1% to 45.1% of the LEP population reported poor health compared with 13.8% to 22.2% among the English-proficient population (Sentell, Braun, Davis, & Davis, 2013). In addition, another study reported only 57.4% of people with LEP had a consultation with any health professional in the last year compared with 81.8% of immigrants who were English proficient (Lebrun, 2012).

Specific health outcomes that have been observed to be poorer among LEP populations include low cancer screening rates (Lee & Vang, 2010; Sentell et al., 2013), low asthma self-management (Wisnivesky et al., 2012), and poor glycemic control among patients with diabetes (Fernandez et al., 2011; Levine et al., 2009). Poor health literacy also has been linked to higher all-cause mortality rates (Bostock & Steptoe, 2012). Researchers have found that adults with low health literacy have a hazard ratio of 1.26 for all-cause mortality compared to adults with high health literacy (Bostock & Steptoe, 2012). In addition, one study reported the average hospital length-of-stay for people with LEP was 6% longer than for English-speaking patients (John-Baptiste, 2004).

THE ISSUE

Given these examples, LEP populations clearly face health burdens that are different than their English-proficient counterparts. As such, the incorporation of health literacy components into ESL programs has shown promise (Chervin, Clift, Woods, Krause, & Lee, 2012; Duncan et al., 2013; Elder et al., 1998; Garcia-Lascurain, Kicklighter, Jonnalagadda, Boudolf, & Duchon, 2006; Soto Mas, Mein, Fuentes, Thatcher, & Balcazar, 2013; Taylor et al., 2008; Taylor et al., 2011). Chervin et al. (2012) evaluated the effectiveness of incorporating health literacy into adult education curricula. Despite only six classrooms being involved in the study, the researchers found participants' health literacy and self-efficacy improved significantly. Although this was a small sample size and the study took place in only one state, the findings suggest programs that incorporate a health literacy component can be successful and warrant further analysis.

A feasibility study of the Healthy Eating for Life program also has shown promise. The program was developed by Duncan et al. (2013) to incorporate health literacy into ESL classes. Unlike previous programs in which health literacy was simply added, the Healthy Eating for Life program was designed to teach participants English and health literacy together. The study, which included 227 participants, found significant increases in fruit intake, vegetable intake, nutrition knowledge, action planning, and coping planning. Furthermore, the researchers analyzed the results of English language testing and found that their program also increased participants' scores on testing. These results suggest this program was successful in furthering health education and literacy as well as understanding of the English language. Although continued testing is needed, the Healthy Eating for Life program could serve as a model for other programs that aim to improve health literacy among the LEP population.

Other research also has found support for the incorporation of health literacy into ESL programs (Elder et al., 1998; Garcia-Lascurain et al., 2006; Soto Mas et al., 2013; Taylor et al., 2008; Taylor et al., 2011). Based on this research, recommendations made for improvements have included incorporating flexibility in health literacy instruction and considering varying levels of knowledge, skills, level of English proficiency, and experiences among students. Center directors in one study also stated it was important not to make assumptions about students' understanding of health issues (Chervin et al., 2012). Larger sample sizes, investigation of self-reported needs of the targeted population, and ability to reinforce lessons were cited as ways to improve the program outcomes and ability to generalize the program to other populations (Chervin et al., 2012).

ADDRESSING THE ISSUE

As the Director of Health Literacy at The Literacy Coalition of Central Texas, a health literacy program that is no longer in existence, I embedded health literacy into ESL and LEP classes. The classes used adult learning theory foundations woven into lesson plans as a basis to impart health concepts through specific health curricula developed by my predecessor, Peter Morrison (Morrison & O'Bar, 2012).

For the most part, adults desire to approach tasks directly related to their reality. To thrive in most learning environments, they must be clear on how each lesson fits into their goals for self-advancement (Bryson, 2013). Questions and active learning exercises embedded into the curriculum facilitate application to real-life learning. Program instructors were educated to use these same techniques, empowering them to interactively engage their students in health topics (Morrison & O'Bar, 2012). As a

result, students gained knowledge and skills necessary to obtain, process, and act on health information they encountered in their community and health care setting.

The problem in continuing these programs stems from funding issues, especially in states with no health literacy legislation or organized health literacy effort. The program at the Literacy Coalition of Central Texas no longer exists due to these funding issues, which are often experienced by nonprofit organizations and community-based efforts. Without legislation or organized efforts, health literacy program directors also must be contract negotiators and salespersons in addition to completing the health literacy work. This makes the effort laborious with a low cost-to-benefit ratio, resulting in a low sustainability model. As a result of the demise of the program, my efforts turned to advocacy by assisting staffers in crafting a health literacy bill (HB 3682) using the existing legislation from other states as a model and also by testifying in the 2017 Texas Legislative Session.

When I had the opportunity to speak in front of the Texas state legislature, I came prepared with handouts referenced with facts and data visualization. The entire House Committee on Public Health was attentive and engaged, asking pointed questions without any discord observed with other testimony during the day. The committee members all embraced the importance of health literacy and passed HB 3682 to the next legislative round. Although the original health literacy bill was much more detailed, HB 3682 ended up suggesting health literacy be delegated to the State Health Committee. Unfortunately, HB 3682 died in chamber as the session ran out of time. However, the State Health Council had been tracking the bill and added health literacy to the State Health Plan (Texas State Health Plan, 2018). Having testified on the bill, I was asked to help inform the final State Health Plan Health Literacy section. Thus, I was able to add back the points desired from the original bill including K-12 education, provider education, and continuing education among other facets (Texas State Health Plan, 2018).

MOVING FORWARD

As the Senior Fellow for Health Literacy at SaferCare Texas (the state-funded Patient Safety Institute), I have carried forward the work of The Literacy Coalition of Central Texas with new resources and bandwidth to provide health literacy curriculum, tools, consulting, and training to health care providers, ESL educators, and other health agencies (SaferCare Texas, 2018). By having statewide reach and resources through SaferCare Texas as well as the ability to partner collaboratively on grant-funded research, my capabilities as a health literacy advocate have greatly increased. Currently, my grant (U54MD006882) through the Texas Center for Health Disparities by the National Institute on Minority Health and Health Disparities of the National Institutes of Health, as well as my grant (Innovative Teaching Grant) through The Association of Teachers of Maternal and Child Health, allows me to delve more deeply into the needs of the community and address systemic health care communication issues regarding maternal mortality. In doing so, both grants use community health workers (CHWs), a profession I consider to be the conduit of health literacy. CHWs help me to ensure that programs and materials developed under the grants educate the target population in a health literate and culturally appropriate manner. Ultimately, these efforts are targeted to improve postpartum education in Texas.

In addition, I serve as a community health worker instructor to prepare health literacy content for CHWs as a proxy to direct classroom education. CHWs serve as trusted health personnel from their communities and are able to bridge cultural and language barriers delivered in home or community-based settings for adult education that incorporates health literacy statewide (Lehmann & Sanders, 2007; Texas Department of State Health Services, 2018). CHWs implement targeted interventions, bringing together communities in an informal teaching setting; these communities often are at risk of limited social support and suitable health care providers (Centers for Disease Control and Prevention, 2014).

CHWs are particularly effective at increasing the understandability of health communications, improving access to health promotion services, and inspiring greater patient engagement among migrant and ethnic minority populations (Ochieng, 2013). It is important to note that CHW programs should not stand alone but rather allow more flexible approaches when integrated into overall health sector activities (Centers for Disease Control and Prevention, 2014). CHWs as part of the health care team provide support for health care providers in getting patients more engaged in their health and health care by filling the gap between patients and providers. Often, barriers to patient engagement have nothing to do with the health care system but rather social determinants of health embedded in communities that impede behavioral compliance (Centers for Disease Control and Prevention, 2014).

In a literature review conducted for the National Fund for Medical Education that analyzed funding streams for CHW programs, several studies demonstrated that CHWs can effectively deliver health interventions to improve both health-related behaviors and clinical measures among ethnic minority groups (Dower, Knox, Lindler, & O'Neil, 2006). The study concluded that CHWs can effectively deliver health care

education, promote healthy behaviors and compliance with disease management and prevention strategies, and even have an influence on clinical outcomes (although informal settings are harder to study) (Dower et al., 2006). Using an evidence-based community health champion model incorporating not only ESL and LEP instructors but also CHWs from a range of ethnic backgrounds maximizes educational venues while facilitating adult learners' health literacy and positive health outcomes (Texas Department of State Health Services, 2018). This model traditionally uses community volunteers who, with training and support, bring their ability to relate to people and their own life experience to transform health and well-being in their communities.

CALL TO ACTION

Everyone has a niche that can support the health literacy effort in general as well as in ESL classrooms. Researchers should continue to build evidence and apply for grant funding to support health literacy legislation and programs including both formal and informal CHW programs. Community activists should garner support for local and state legislation and community collaboratives to extend health literacy efforts with scant resources. Teachers of all types of adult education should serve as health champions and can play an important role by using their expertise to integrate health content into their curriculum with pre-existing resources or developing new content. Both formal classes and informal programs in which adults develop numeracy, language, and writing skills, regardless of their language, offer an important potential venue for health literacy education. However, we must keep these programs funded through community collaborative efforts, philanthropic donations or grants, and legislation earmarking local and state funding.

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