**U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES**
**Office of Minority Health Division of Program Operations**
**Advancing Health Literacy to Enhance Equitable Community Responses to COVID-19Final Progress Report**

**GRANT PROGRAM**
Office of Minority Health Division of Program Operations

**GRANT PROJECT NAME**
Advancing Health Literacy to Enhance Equitable Community Responses to COVID-19

**GRANT NUMBER**
1 CPIMP211271-01-00

**GRANTEE ORGANIZATION**
City of Albuquerque

**PROJECT TITLE**
City of Albuquerque Health Literacy Project to Enhance Equitable Community Response to COVID-19

**CONTACT PERSON, TITLE, TELEPHONE NUMBER, AND EMAIL ADDRESS**
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**LOCATION**
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Albuquerque, NM 87102

**PERIOD OF PERFORMANCE**
July 1, 2021 – June 30, 2023

**AWARD AMOUNT RECEIVED**
(2-Year Total) $ 3.9 million

**PERIOD OF PERFORMANCE NARRATIVE**

**SECTION I: INTRODUCTION/PURPOSE**

**Purpose**.
The Albuquerque Health Literacy Project to Enhance Equitable Community Response to COVID-19 was designed to address the disproportionate impact of COVID-19 on Black, Indigenous and other People of Color (BIPOC) communities in Albuquerque, New Mexico by co-creating a network of culturally and linguistically competent community care providers that would reduce health disparities among the most socially vulnerable and be more connected, adaptive, responsive, and ready for existing and future public health emergencies.

Specifically:

- To address the disproportionate impact of COVID-19 on BIPOC communities in ABQ
- To implement an innovative, culturally and linguistically appropriate, CHW-led Health Literacy (HL) model to reduce COVID-related health disparities in ABQ
- To partner with Community Health Centers, Community Based Organizations, the NM Department of Health, and the University of New Mexico (UNM) to use local data to identify racial and ethnic minority populations who are at highest risk for health disparities, low HL, and not being engaged or reached through existing public health messages and approaches for promoting COVID public health recommendations.
- To conduct the work in accordance with Culturally and Linguistically Appropriate Services standards
- To use a multidimensional quality improvement (QI) approach that will allow us to promote dissemination, adoption, and sustainability of the model
- To promote COVID-19 HL among the target population in a way that will have a positive impact on COVID-19 knowledge, prevention practices, vaccination uptake, and infection rates

**Approach**.
The City of Albuquerque (CABQ) implemented an innovative, culturally and linguistically appropriate, community health worker (CHW)-led HL model to reduce COVID-19-related health disparities in Albuquerque, New Mexico. We partnered with community health centers (CHCs), community-based organizations (CBOs), the New Mexico Department of Health (NMDOH), and the University of New Mexico (UNM), a Minority-Serving Institution, to promote COVID public health recommendations by leveraging existing infrastructure and relationships and using local data to identify racial and ethnic minority populations at highest risk for health disparities, low HL, and not being engaged or reached through existing public health messages and approaches.
This project addressed the urgent need for CABQ to have an evidence-based, culturally and linguistically appropriate health literacy (HL) public health response system – one that is creative, agile, and sensitive to community needs while enhancing prevention, education, and outreach strategies to reduce COVID health disparities among racial and ethnic minorities and other socially vulnerable populations that have been demonstrated to be at high risk for negative COVID-related health outcomes. We had found that among these groups, low COVID HL, driven by lack of information, disinformation, and myths disseminated via social networks and social media were

having a damaging effect on our ability to implement coherent, effective public health practices to prevent or mitigate COVID.

**Partnerships.**
To reach the populations of interest for the project, the City of Albuquerque has partnered with 15 community clinics and community-based organizations. Each of these organizations was chosen because of their history of success with engaging clients from vulnerable populations through peer educators and community health workers who speak the languages of the populations they serve and involve the community in the design, implementation and evaluation of programs. These partners have cultural and community-specific expertise that complemented and informed the data, allowing us to reach beneath the surface of racial and ethnic identities to engage sub-populations who for various reasons, were less likely to have received and acted upon public health advice and resources.

These partners provide services ranging from health education in community-based settings, co-located with services such as food distribution, clothing and school supply pantries – to full-service primary care clinics that provide comprehensive access to medical, dental, behavioral health and mental health care. The partners integrated the co-designed health literacy intervention into their existing patient/client flows, conducting screenings, health education, vaccine registration assistance and myth busting during the course of their work to meet their patients/clients other needs, for which they sought assistance.

**Population of interest.**
The Albuquerque Health Literacy Project to Enhance Equitable Community Response to COVID-19 was designed to address the disproportionate impact of COVID-19 on BIPOC communities in Albuquerque, New Mexico.

**Disparate Populations**.
The disparate populations are American Indian, Black, and Hispanic, as well as smaller sub-groups of refugees and immigrants living in Albuquerque, particularly those with Limited English Proficiency.

**Comparison Group**.
Total County Population

**Rationale**.
Compared to the total county population, BIPOC:

- Experience higher rates of COVID-19 cases and hospitalizations
- Participate in vaccination at lower rates
- Are more likely to lack access to affordable health care
- Have higher rates of limited English proficiency

| | COUNT | PERCENT |
|---|---|---|
| **COVID-19 TEST** | 55,257 | 5.9% |

| | | |
|---|---|---|
| **POSITIVITY, CUMULATIVE (AS OF 4/8/2021)** | | |

*Data source: New Mexico Electronic Disease Surveillance System (NM-EDSS), Infectious Disease Epidemiology Bureau, Epidemiology and Response Division, New Mexico Department of Health.*

| RACE / ETHNICITY | COVID-19 CASE COUNTS | COVID-19 CASE RATE PER 100,000 |
|---|---|---|
| **American Indian / Alaska Native** | 3,825 | 12,533.9 |
| **Asian or Pacific Islander** | 1,122 | 5,589.6 |
| **Black or African American** | 1,105 | 5,263.1 |
| **Hispanic** | 28,381 | 8,297.5 |
| **White** | 10,589 | 3,981.4 |
| **Other** | 1,952 | |
| **TOTAL** | **46,974** | **6,912.1** |

Census tracts in the southern half of Bernalillo County have the highest Social Vulnerability Index Scores, particularly on the language and minority population themes. Program efforts were focused in the 87121, 87105, 87102, 87108 zip codes, where vaccine hesitancy rates are between 3.99% and 6.79%.

The New Mexico Department of Health COVID-19 Data Dashboard showed that American Indians were 3.7 times more likely to be hospitalized and 2.4 times more like to die of COVID-19 complications. The vaccination rate among American Indians was 60.2% compared with 68% of the total county population. For Hispanics, the rate was 47.6%. For Black/African American, the rate was 43.8%. Below are risk factors for health disparities in Bernalillo County.

| **BERNALILLO COUNTY** | | |
|---|---|---|
| | **COUNT** | **PERCENTAGE** |
| **HOUSEHOLDS WITH MORE PERSONS THAN ROOMS** | 7,110 | 2.7% |
| **UNINSURED (civilian, non-institutionalized)** | 55,324 | 8.2% |

| | | |
|---|---|---|
| **LIMITED ENGLISH PROFICIENCY (Persons age 5+ who speak English "less than well")** | 48,799 | 7.6% |

*Data source: 2015-2019 American Community Survey. United States Bureau of the Census.*

**Populations of Focus Table 1**

Total Goal Numbers to be reached over the two-year grant program by project partners:

| Population Type | % of Population in Bernalillo County | Count | Project Year 1 | Project Year 2 | Total |
|---|---|---|---|---|---|
| American Indian/Alaska Native | 4.5% | 30,517 | 300 | 465 | 765 |
| Asian or Pacific Islander | 3.0% | 20,073 | 250 | 260 | 510 |
| Black or African American | 3.1% | 20,995 | 325 | 325 | 650 |
| Hispanic | 50.3% | 342,044 | 4,275 | 4,275 | 8,500 |
| White | 39.1% | 265,961 | 3,287 | 3,287 | 6,575 |
| Total | 100.0% | 679,590 | 8,437 | 8,612 | 17,000 |

**Total Goal Number of Participant(s)**

| Race and Ethnicity | Total Reached | Total Goals From Focus Table |
|---|---|---|
| Black/African American | 681 | 650 |
| American Indian/Alaska Native | 1512 | 765 |
| Asian | 682 | 510 |
| White | 8574 | 6575 |
| Native Hawaiian/ Other Pacific Islander | 17 | - |
| Two or More Races | 135 | - |
| Other/ Prefer not to answer | 1872 | - |
| Hispanic | 10466 | 8500 |

| Client Language | Total |
|---|---|
| English | 4460 |
| Spanish | 4343 |
| Vietnamese | 51 |
| Mandarin | 155 |
| Korean | 8 |
| Navajo | 0 |
| Other | 308 |

| Gender | Total |
|---|---|
| Female | 5013 |
| Male | 4184 |
| Non-Binary | 14 |
| Self-Described | 10 |
| Prefer not to answer | 82 |

| Age | Total |
|---|---|
| <1 | 5 |
| 1-4 | 54 |
| 5-12 | 252 |
| 13-17 | 398 |
| 18-29 | 1305 |
| 30-39 | 1932 |
| 40-49 | 2203 |
| 50-64 | 2333 |
| 65-74 | 528 |
| 75-84 | 144 |
| >=85 | 220 |
| Unknown age | 87 |

**Total Number of Community-Based Organization (CBO) partners during the project period. Please include a list of the various types of CBOs.**

The following types of community-based organizations partnered with the project:

- City Government Office (1)
- Youth Leadership Organization (1)
- Culturally-Appropriate Mental Health & Case Management Services (2)
- Refugee and Immigration Services (2)
- Community-based Health Centers (3)
- Faith-based Community Organizations (2)
- Senior Centers (1)
- Culturally-based Resource Centers (3)

**Total Number of Minority-Serving Institution (MSI) partners during the projectperiod.**

15 Total – 1 of which is federally designated – University of New Mexico

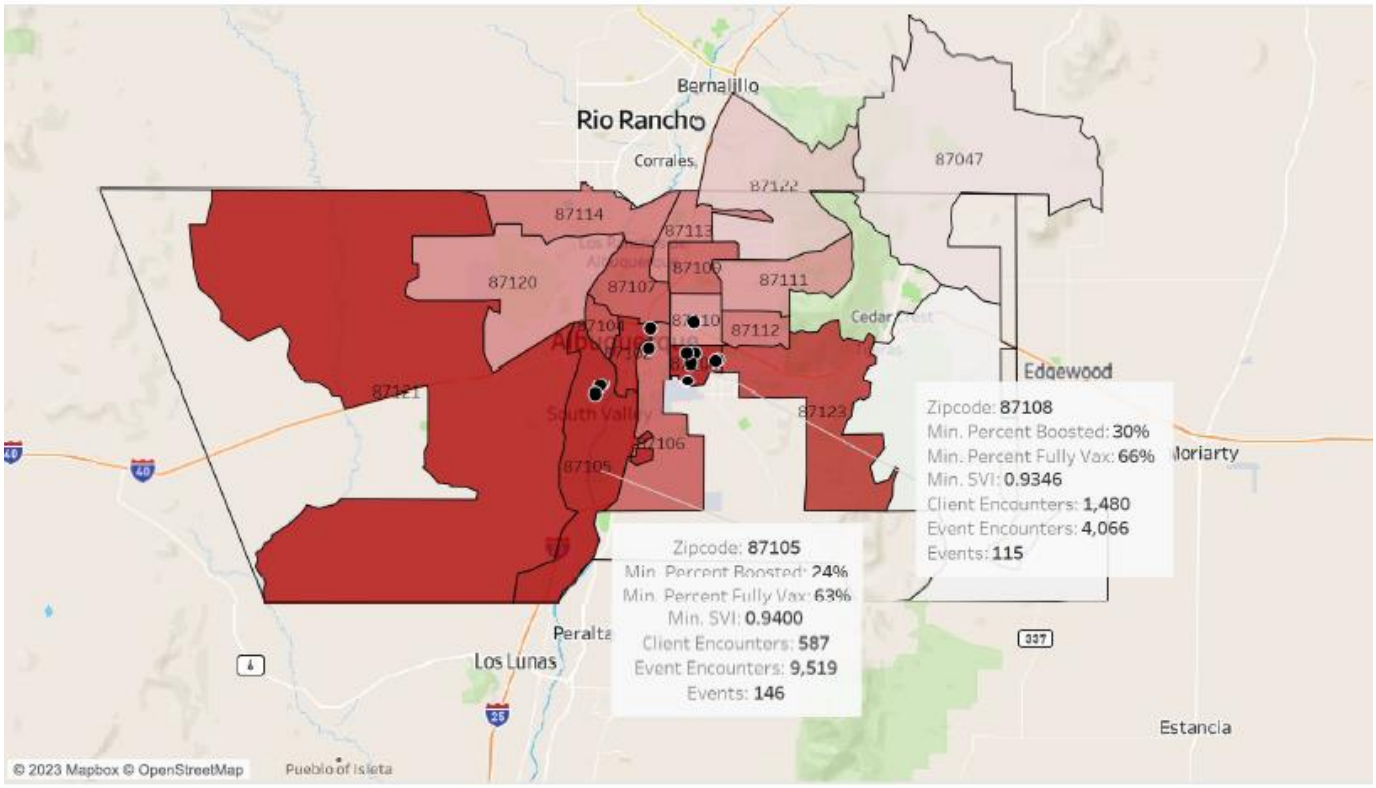
**Provide information on the geographic areas of scope (you may include a visual map to accompany your narrative response)**

HEALTH SCIENCES
OFFICE FOR COMMUNITY HEALTH

Activities from January 2022 - June 2023

## City of Albuquerque Health Literacy Project

### Heat Map of Albuqerque with highlighted work in prioritized areas based on Social Vulnerablity Index



**Completion of Project Objectives.**

| | |
|---|---|
| **GOAL 1:**<br>By January 2022, create a solid infrastructure for project activities that will contribute to project operational success and sustainability | |
| Create all requisite project infrastructure. | Met |
| Obtain IRB approval as appropriate | Met |
| Create capacity to track and evaluate project activities | Met |
| Launch partnership and project activities | Met |
| Obtain county and sub-county-level SVI, COVID-19, and community activity data (such as the timing/location of community events like emergency food distributions) to identify COVID-19 hot-spots, areas with low vaccination rates, and community opportunities for outreach as available | Met |
| **GOAL 2:**<br>By the end of year 1 (June 2022), identify existing COVID-19 HL resources and information and integrate them into project activities and materials | |
| Use existing resources and information as much as possible in order to avoid "reinventing the wheel," reduce duplication, and ensure that project COVID-19 HL content is as up-to-date as possible | Met |
| **GOAL 3:**<br>By October 30 2021, finalize training curricula and training materials | |
| Develop a culturally sensitive COVID-19 HL curriculum and training tailored for CHWs | Met |
| Tailor curriculum and training to specific populations and contexts | Met |
| **GOAL 4:**<br>By the end of year 2 (June 2023), enhance partner organization alignment with CLAS standards | |
| Assess extent to which organizational partners operate in alignment with CLAS standards | Met |
| Conduct follow-up assessment of partner alignment with CLAS standards to measure change at end of project | Met |
| **GOAL 5:**<br>By November 2021, deliver initial COVID-19 HL trainings to partner organizations and CHWs | |
| Deliver trainings to give CHWs accurate and timely information and innovative | Met |

| | | |
|---|---|---|
| strategies to facilitate client COVID-19 HL screening and education | | |
| **GOAL 6:**<br>By the end of year 2 (June 2023), partners will implement the intervention with technical assistance and support from OCH. | | |
| | Met | |

**Project Expectations:**

| OMH Project Expectations | N/A<br>Met<br>Not Met | Identify the project goal and objective in alignment with each OMH expectation. Summarize key activitiesand strategies critical to successfully achieving each expectation |
|---|---|---|
| **Disparity Impact and Health Equity Promotion Expectations** | | |
| Develop a disparity Impact statement using local data (e.g., CDC SocialVulnerability Index) | Met | Completed |
| Identify Racial and Ethnic Minority Populations at the highest risk for health disparities, low health literacy, and not being engaged or reached through existing public health messages and approaches for promoting COVID-19 public health recommendations (e.g., for testing, contact tracing, vaccination, and other efforts to mitigate the impact of the virus) | Met | With partnership with NMDOH we were able to obtain bi-weekly to monthly of Bernalillo Country's ZCTA (almost identical to Zip codes in Metro Areas) of current vaccination rates along with the most recent Social Vulnerability Index rating of each area. The SVI incorporates information about a zone and provides a measure of how much "potential negative effects on communities caused by external stresses (will have) on human health" [citing CDC website SVI definition]. Having detailed Zip Code level data on which areas were likely to be more impacted by the external stress of Covid-19 and current vaccination trends allowed the team to display this information geographically on an interactive map. Partners in the project referenced this information overlaid with project outreach data for each area, and used the project's data and NMDOH data to direct their efforts to areas with higher SVI risk and focus on areas where Covid risk remained high and vaccination rates needed to be raised. |
| Reduce the differences in health that occur by particular categories: gender, race or ethnicity, income, education, disability, living in a rural locality, or sexual orientation with the target population in the DisparityImpact Statement. | Met | During the project, we scaled up culturally- and gender- sensitive program activities to include training all Partner staff as they commenced and we expanded our efforts to create language-appropriate products and processes. We translated and disseminated tools and resources in 14 languages: Arabic, Dari, English, Japanese, Kinyarwanda, Kirundi, Korean, Mandarin, Pashto, |

| | | |
|---|---|---|
| | | Spanish, Swahili, Ukrainian, and Vietnamese.<br><br>We excelled at promoting equity and including attention to CLAS standards in our health literacy approach by conducting the vast majority of client encounters and outreach events in the client's preferred language: 93% of all client encounters were in the client's preferred language, with fully 39% in Spanish. |

| Health literacy plan implementation and sustainability Expectations | | |
|---|---|---|
| Ensure the identification of effective approaches for improving healthoutcomes with the ultimate goal of promoting these approaches' dissemination, adoption, and sustainability. | Met | Our CHW-led approach proved to be effective. Instead of our target 17,000 encounters, we had nearly 50,000. |
| Utilization of NCLAS standards to increase the availability, acceptability,and use of COVID-19 public health information and services by racial and ethnic minority populations and others considered vulnerable for notreceiving and using COVID-19 public health information. | Met | During the project, we scaled up culturally- and gender- sensitive program activities to include training all Partner staff as they commenced and we expanded our efforts to create language-appropriate products and processes. We translated and disseminated tools and resources in 14 languages: Arabic, Dari, English, Japanese, Kinyarwanda, Kirundi, Korean, Mandarin, Pashto, Spanish, Swahili, Ukrainian, and Vietnamese.<br><br>We excelled at promoting equity and including attention to CLAS standards in our health literacy approach by conducting the vast majority of client encounters and outreach events in the client's preferred language: 93% of all client encounters were in the client's preferred language, and 39% were in Spanish. |
| Promotion of changes in the healthcare delivery system broadly that advance Healthy People Objectives. | Met | Healthy People 2030 and their various workgroups collate population-level data along 300+ objectives, sorted in to three categories, to produce evidence about national community-level health trends. Those are publicly reported throughout the decade as a means of monitoring population health trends, prioritize health needs, and surface policy and program opportunities with the power to create a healthier nation over time. Core Objectives contain Leading Health Indicators that represent the highest-impact health trends with evidence-based solutions via policy, program, and structural interventions. Community Health Workers are one such structural intervention. We demonstrated that |

| | | |
|---|---|---|
| | | supplying CHW's with training about how to integrate Health Literacy practices into their community education and outreach efforts, and to increase access to medically accurate Covid-19 information, delivered by trusted peer health ambassadors to highly-vulnerable populations who are at risk for poorer Covid outcomes including Covid misinformation. |
| Improve health indicators align with Healthy People 2030 | Met | See below |
| HC/HIT-01- Increase the proportion of adults whose healthcareprovider checked their understanding | Met | Project life met 14,070 adults 18 years or older. |
| HC/HIT-02- Decrease the proportion of adults who report poorcommunication with their healthcare provider | Met | Project life saw interactions with adults 18 and over move from approximately 78% having good communication about their health care to 100% of interaction increasing communications about health care. |
| HC/HIT-03- Increase the proportion of adults whose healthcareproviders involved them in decisions as much as they wanted | Met | Project life saw the proportion of adults being involved in their health care as much as they wanted at 100% for all active quarters. |
| Improve access and utilization of healthcare. | Met | Through our 15 partner agencies and their CHWs, we logged nearly 50,000 encounters. |
| Provide guidance for new and/or revised policies for improving and sustaining adherence to COVID-19 and other public health recommendations using evidence-based and culturally and linguistically appropriate health literacy strategies. | Met | The ABQ HLP demonstrated a model of supportive integration between Health Literacy and Community Health Workers that expanded accessible Covid-19 prevention and mitigation messaging among diverse urban communities who speak 20+ different languages. When specially trained community health workers - whom are experts in helping the at-risk public to navigate complex health and other systems - received training on some core Health Literacy modalities, like TeachBack and PlainLanguage, they reported improved community and individual engagement with accurate Covid-19 information that easily integrated with and complimented their baseline interventions (medical homes, food access, housing, etc). This "added-value" of medically accurate Covid-19 |

| | | |
|---|---|---|
| | | information increased access to Covid-19 vaccines, and pushed-back on Covid misinformation and disinformation. In a complimentary function, our evidence-based and linguistically accessible CHW program partners were able to leverage Covid conversations to increase outreach to their baseline services. Among their highly vulnerable peer communities who were hearing facts about Covid 19, individuals and families were often newly connected to expert complex health and social systems navigators for the first time. |

| **Community-based partnership Expectations** | | |
|---|---|---|
| Partner with local community-based organizations, including local health departments and community health centers, to develop and implement the following: | Met | We partnered with diverse organizations including the University of New Mexico, the UNM Hospital Office of Health Literacy, the NMDOH, City of Albuquerque Agencies, multiple clinics and health centers, and multiple community agencies. |
| Health Literacy Plan to ensure cultural and linguistic appropriateness for racial and ethnic minority populations | Met | We partnered with the UNM Health Literacy Office to lead this component of the work. |
| Plan for sustaining adherence to COVID-19 and other future public health recommendations | Met | CHWs from 15 organizations were trained extensively throughout the operation of the project and this knowledge will continue to be used and impact the way that the partner agencies work with respect to COVID-19 and other future public health recommendations. |
| Increase availability, dissemination, adaptation, and use of culturally and linguistically appropriate, evidence-based healthliteracy practices and interventions | Met | We created various project products, including the COVID-19 flipchart, in 14 languages. Our CHWs had nearly 50,000 encounters during the operation of the project. |
| Ensure accurate, accessible, acceptable, and actionable training, health literacy practices, and interventions resources for the identified populations | Met | See narrative below |

| **Quality Improvement and Evaluation Expectations (Page: 7, 63-86)** | | |
|---|---|---|
| Partner with Minority Serving Institutions, when possible, to establishand implement an ongoing quality improvement process and project evaluation | Met | CABQ partnered with the Office for Community Health at the University of New Mexico as the Program Evaluation Partner. UNM is a Federally-recognized Minority Serving Institution. |
| Use Quality Improvement Processes to refine the health literacy interventions that support improvements in the disparities identified inDisparity Impact Statement and whether there were any changes in the access, use, and outcome of COVID-19 vaccination, testing, and relatedactivities. | Met | We used Quality Improvement Processes to refine our CHW health literacy intervention throughout the life of the project. COVID-19, itself, required that we develop a nimble, fluid strategy to address the myths and needs in the community, and to deal with pandemic restrictions and challenges. In addition, we continuously improved our project operational procedures and processes in order to enhance implementation and to ensure quality outcomes.<br><br>During the project, the COVID-19 booster gap closed for those living in high versus low SVI geographies, reducing this disparity nearly three-fold (13.4% to 4.9%) in six months. Seventy-two percent of clients indicated that they were very likely or somewhat likely to get the COVID-19 vaccine. The most common reasons for not getting vaccinated were:<br>1. Haven't gotten around to it: 244 instances<br>2. Doesn't trust the COVID-19 vaccine: 98 instances<br>3. Concerned about side effects: 82 instances |
| Measure the impact on health outcomes, participation, empowerment, equity, and sustainability. | Met | See preceding box and narrative below. |

| | | |
|---|---|---|
| Change in the access, use, and outcomes of COVID-19vaccination, testing, and related activities and Project data related to the Healthy People 2030 objectivesHC/HIT-01, HC/HIT-02, HC/HIT-03, and IID-D02 | Met | Project used data from partners from NMDOH to track progress related to vaccination to support and orient activities. |

**Partners**

| Partner(s) Name | OrganizationType | Partner Outcomes |
|---|---|---|
| ACCESS | Youth Leadership | Clients: 23<br>Unique Clients: 23<br>Events: 137<br>Event Encounters:1385 |
| CABQ Senior Affairs | City Government Office | Clients: 0<br>Unique Clients: 0<br>Events: 5<br>Event Encounters: 480 |
| Casa de Salud | Community-based Health Clinic | Clients: 3145<br>Unique Clients: 2907<br>Events: 48<br>Event Encounters:11,848 |
| Centro Savila | Culturally-appropriate Mental Health & Case Management | Clients: 805<br>Unique Clients: 805<br>Events: 0<br>Event Encounters:0 |
| CHWI - Health Literacy | University | Trainings & Coordination Core Team<br>Events: 1<br>Event Encounters:130 |
| First Choice Community Health Care | Community-based Health Clinic | Clients: 1726<br>Unique Clients: 901<br>Events: 126<br>Event Encounters:13041 |
| First Nations Community Health Source | Community-based Health Clinic | Clients: 2080<br>Unique Clients: 1976<br>Events: 7<br>Event Encounters:615 |
| God's Warehouse | Faith-based Services | Clients: 202<br>Unique Clients: 202<br>Events: 1<br>Event Encounters:250 |
| Lutheran Family Services | Faith-based Services<br>Immigration & Refugee Services | Clients: 141<br>Unique Clients: 131<br>Events: 8<br>Event Encounters:173 |
| New Mexico Asian Family Center | Culturally-appropriate Resource Center | Clients: 409<br>Unique Clients:324<br>Events: 115<br>Event Encounters:7371 |

| | | |
|---|---|---|
| Office of African American Affairs | Culturally-appropriate Resource Center | Clients: 26<br>Unique Clients: 18<br>Events: 30<br>Event Encounters:1117 |
| One Hope Centro de Vida at East Central Ministries | Faith and Community-based Health Clinic | Clients: 649<br>Unique Clients: 579<br>Events: 55<br>Event Encounters:2409 |
| Perfectly Imperfect | Community-based Counseling Services | Clients: 599<br>Unique Clients: 598<br>Events: 2<br>Event Encounters:39 |
| Salud Morena | Culturally-appropriate Behavioral Health Center | Clients: 0<br>Unique Clients: 0<br>Events: 42<br>Event Encounters:1519 |
| United Voices for Newcomer Rights | Culturally-appropriate Resource Center<br>Immigration & Refugee Services | Clients: 242<br>Unique Clients: 167<br>Events: 31<br>Event Encounters:1422 |

**SECTION II: MAJOR ACCOMPLISHMENTS:**

| **GOAL 1:**<br>By January 2022, create a solid infrastructure for project activities that will contribute to project operational success and sustainability | |
|---|---|
| Create all requisite project infrastructure. | We created all requisite project infrastructure. |
| Obtain IRB approval as appropriate | We submitted the IRB on 9/27/21 and received a "Not Human Subjects Research" determination 9/28/21. |
| Create capacity to track and evaluate project activities | To capture the data that was occurring out in the field done by the partner organizations. For the first few months an excel spread sheet was given to the partners to track encounters and then summarize and submit as part of a monthly report. After working with method for several months and discussing difficulties with the supervisors at the partner sites we shifted towards a web-based collection portal that would allow partners to submit data as it happened. This method of data collection would no longer require the sites to summarize their data but instead we would summarize their data and provide it to them along with a dashboard visualization of the whole project's data that could be supported by the row detailed data. Consulting with both CHW's and Lead CHW provided the feedback that the portal made their duties to record data faster, more simplified and less likely to be lost though accident. The web-based data portal allowed data collectors to record from computers or was compatible with a smart phone interface and was available in either English or Spanish as the reporter preferred. The single portal allowed options to report on either an individual encounter, events, de identified stories, or for the site supervisor to submit their monthly report, and had options to email a receipt to one's own email form confirmation on data submission. |
| Launch partnership and project activities | Completed |
| Obtain county and sub-county-level SVI, COVID-19, and community activity data (such as the timing/location of community events like emergency food distributions) to identify COVID-19 hot-spots, areas with low vaccination rates, and community opportunities for outreach as available | With partnership with NMDOH we were able to obtain bi-weekly to monthly of Bernalillo Country's ZCTA (almost identical to Zip codes in Metro Areas) of current vaccination rates along with the most recent Social Vulnerability Index rating of each area. The SVI incorporates information about a zone and provides a measure of how much "potential negative effects on communities caused by external stresses (will have) on human health" [citing CDC website SVI definition]. Having detailed Zip Code level data on which |

| | |
|---|---|
| | areas were likely to be more impacted by the external stress of Covid-19 and current vaccination trends allowed the team to display this information geographically on an interactive map. Partners in the project referenced this information overlaid with project outreach data for each area, and used the project's data and NMDOH data to direct their efforts to areas with higher SVI risk and focus on areas where Covid risk remained high and vaccination rates needed to be raised. |
| **GOAL 2:** By the end of year 1 (June 2022), identify existing COVID-19 HL resources and information and integrate them into project activities and materials | |
| Use existing resources and information as much as possible in order to avoid "reinventing the wheel," reduce duplication, and ensure that project COVID-19 HL content is as up-to-date as possible | Completed |
| **GOAL 3:** By October 30 2021, finalize training curricula and training materials | |
| Develop a culturally sensitive COVID-19 HL curriculum and training tailored for CHWs | We developed all curriculum and training products as planned. |
| Tailor curriculum and training to specific populations and contexts | The information presented in the trainings supports CHWs to work in a culturally and contextually appropriate way with diverse communities.<br>Our staff with data expertise (Heidi Fredine—Senior Research Scientist II, and Kelli Kasper, Data Scientist) developed a targeted outreach approach using data from the Department of Health to identify areas with COVID-19 inequities/disparities and tailor outreach to populations of interest. |
| **GOAL 4:** By the end of year 2 (June 2023), enhance partner organization alignment with CLAS standards | |
| Assess extent to which organizational partners operate in alignment with CLAS standards | We conducted a CLAS standards assessment with each partner organization to identify cultural and contextual strengths and are in the process of creating improvement goals/plans tailored to each organization. |
| Conduct follow-up assessment of partner | During the project, we scaled up culturally- and gender- sensitive |

| | |
|---|---|
| alignment with CLAS standards to measure change at end of project | program activities to include training all Partner staff as they commenced and we expanded our efforts to create language-appropriate products and processes. We translated and disseminated tools and resources in 14 languages: Arabic, Dari, English, Japanese, Kinyarwanda, Kirundi, Korean, Mandarin, Pashto, Spanish, Swahili, Ukrainian, and Vietnamese.<br><br>We excelled at promoting equity and including attention to CLAS standards in our health literacy approach by conducting the vast majority of client encounters and outreach events in the client's preferred language: 93% of all client encounters were in the client's preferred language, and 39% were in Spanish. |
| **GOAL 5:**<br>By November 2021, deliver initial COVID-19 HL trainings to partner organizations and CHWs | |
| Deliver trainings to give CHWs accurate and timely information and innovative strategies to facilitate client COVID-19 HL screening and education | Trainings were a key component of our work. We conducted many trainings, including:<br>• Health Literacy concepts and approaches<br>• Social Determinants of Health (SDoH) concepts<br>• COVID-19 virus education, vaccine information, and approaches/responses to vaccine hesitancy<br>• A COVID-19 educational flipchart designed by members of our team in collaboration with the NMDOH to use in client encounters<br>• Motivational Interviewing (MI) skills and strategies<br>• Teachback skills and strategies<br>• Stages of Behavior Change skills and strategies<br>• Health Coaching skills and strategies<br>• Mapping, Planning & Outreach strategies |
| **GOAL 6:**<br>By the end of year 2 (June 2023), partners will implement the intervention with technical assistance and support from OCH. | |
| Implementation was extremely successful. Rather than the 17,000 proposed encounters, we had nearly 50,000. If you consider that even ¼ of those encounters succeeded in changing someone's mind, led them to social distance, wear a mask, or get vaccinated, or spread this information to others, the cascading impact of our work created a ripple effect in the community that undoubtedly saved lives. | |

## SECTION III: EVALUATION METHOD

### Data Tracking

To capture the data that was occurring out in the field done by the partner organizations. For the first few months an excel spread sheet was given to the partners to track encounters and then summarize and submit as part of a monthly report. After working with method for several months and discussing difficulties with the supervisors at the partner sites we shifted towards a web-based collection portal that would allow partners to submit data as it happened. This method of data collection would no longer require the sites to summarize their data but instead we would summarize their data and provide it to them along with a dashboard visualization of the whole project's data that could be supported by the row detailed data. Consulting with both CHW's and Lead CHW provided the feedback that the portal made their duties to record data faster, more simplified and less likely to be lost though accident. The web-based data portal allowed data collectors to record from computers or was compatible with a smart phone interface and was available in either English or Spanish as the reporter preferred. The single portal allowed options to report on either an individual encounter, events, de identified stories, or for the site supervisor to submit their monthly report, and had options to email a receipt to one's own email form confirmation on data submission.

### Idea Group

As we implemented this project, it became clear that the experience of CHWs in the project learning about and using health literacy concepts and approaches was revealing some unexpected outcomes. In order to explore and understand this dynamic, rather than conducting interviews or focus groups with CHWs, we wanted to honor the fact that the CHWs in this project were developing new ways of doing health literacy work, and that in our work as a team, we were co-creating ideas and approaches that have the potential for contributing to a new model for health literacy promotion. So instead, we convened what we call an "Idea Group" of CHWs from the project to engage in structured dialogue to evaluate and discuss the work we had been doing, to develop analytical insights about this process, and to co-author the discussion presented here.

### Ripple Effects Mapping

Ripple Effects Mapping (REM)[1] is an innovative participatory evaluation technique that provides a way to document the "radiant" impacts of a program in a way that captures the dynamics of context. REM reveals interconnections between program elements, activities and impacts in a way that helps to understand what actually happened. REM uses software to create visual "maps" that can tell the story of change and impacts. REM captures and documents complex processes – the "ripples" that happen in the program or in the community. REM is useful for analyzing impacts that are difficult to measure with other evaluation methods and can capture and identify unforeseen or unintended impacts, both negative and positive. Invisible changes such as building social connections (which are the precursors of change), changes in policy, shifts in narrative, and cultural transformation can be documented and mapped visually.

[1] Chazdon S, Emery M, Hansen D, Higgins L, Sero R. *A Field Guide to Ripple Effects Mapping*. U Minnesota Libraries Publishing; 2017.

Kollock DH, Flage L, Chazdon S, et. al. Ripple Effects Mapping: A "Radiant" Way to Capture Program Impacts. *J Ext*. 2012;50(5):1-5.

Hansen D, Higgins L, Sero R. *Advanced Facilitator Guide for In-Depth Ripple Effects Mapping*. Washington State University; 2018.

**Discuss challenges and delays of the planned approach and methods used to resolve the issue(s).**
The primary problem encountered in implementing this project was related to recruiting, hiring, and retaining project personnel. Positions we would post did not have applicants or did not have qualified applicants. Ironically, COVID-19 job market impacts also impacted our project. Individuals with language, lived experience, and community-based skills who applied for the positions posted through the university were not deemed qualified or eligible for employment by the university screeners and we found it challenging to identify individuals with the skills and background that would align with our health equity perspective. Although it was surprisingly difficult to achieve internal policy change around this issue, we believe we have been able to overcome a significant structural barrier to community-engaged, CHW-led health equity work such as that we are engaged in for this project. With changes to the policy/process that allowed us to do so, we re-wrote the position description with new, more appropriate requirements. Therefore, our project is creating structural change that will have a lasting impact on health equity work moving forward.

Other challenges included:

- COVID-19 "fatigue" (people are tired of hearing about the pandemic, diminished use/requirements for masks/social distancing, need for multiple vaccines/boosters)
- Lack of media literacy among the populations we serve makes misinformation a bigger challenge.

**List any statistical software used.**

- REDCap
- R & R Studio
- Tableau
- Microsoft Excel
- Notepad ++

**Provide copies of all survey instruments utilized during the project period.**

See Attachment

**Designing a Data Dashboard**
Our data and evaluation team created a project data dashboard to provide a quick view of de-identified, aggregated data incorporated from two sources:

1. Primary data from each of our CBOs
2. Secondary COVID vaccine data from the New Mexico Department of Health (NMDOH) through a partnership with the NMDOH Health Equity Specialist for the Northwest Region

The primary data was collected electronically through a series of surveys housed on a Microsoft Teams' data portal and powered by REDCap, a web-based application for managing databases used by UNM. CBOs could record: 1.) Individual Encounters, interactions and demographics of clients, 2.) Community Events, details about events attended or hosted in the community, 3.) CHW Stories, highlights of clients' experiences, and 4.) Supervisor Monthly Partner Site Summary, a synopsis of key events, trainings or challenges faced by participating CBOs. Bimonthly updates to the dashboard were cumulative in nature and reflected real-time data collection.

In addition, every month we received secondary COVID vaccine data from the NMDOH allowing us to map the percentage of individuals fully vaccinated and boosted by Albuquerque zip code. These "heatmaps"[2] were layered and paired with the CDC's SVI data showing densities of high social need and areas where project activities occurred. The highest SVI rates were in Downtown, the South Valley, the International District, and along the I-25 Corridor. The highest counts of client encounters were in 87121 and 87105, neighborhoods in the city's Westside and South Valley. The zip code 87105 also had the highest number of community events, a total of 138 events over the project. The city map pinpointed our partner organizations which were concentrated in neighborhoods with high SVIs and low COVID vaccine rates. Through regular communication with the NMDOH, the project team was able to continuously improve outreach activities to align with populations and CBOs in zip codes with the highest need.

**Encounters and Reach**

The AHLP reached 44,690 individuals in Albuquerque, nearly 2.5 times the goal of 17,000 individuals. This total included 9690 individual encounters and 35,000 people at 567 outreach events.

**Approaches**

Plain Language was the most common Health Literacy tool used. CHWs documented 3688 uses of plain language. Other Health Literacy tools employed included flip charts (823), teach back (342), motivational interviewing (306), and addressing myths (252).

**Trainings**

Trainings were a core feature of the AHLP and were primarily conducted by Zoom. We held a multi-day training to launch the work at the beginning of 2022, and throughout the project, we had weekly check-ins, monthly workshops, and a series of on-site open house events at the facilities of agency partners. Importantly, trainings provided up-to date health information about the COVID-19 virus, testing, and vaccines, and identifying and addressing disinformation. We trained CHWs to understand what health literacy is and introduced health literacy concepts, together with other skills trainings and workshops, including Motivational Interviewing (MI), health coaching strategies, and understanding SDoH. Holistic design was an innovative cornerstone to our health literacy approach in this project.

We conducted 10 trainings at which teach-back and plain language strategies were taught and practiced. One training focused specifically on plain language, and as there were multiple languages spoken among the CHWs, this provided a fruitful, critical discussion of the concept of "plain language" in languages other than English. Four separate trainings were offered to individual community partner agencies, three were community-based organizations and one was a community-based clinic.

**COVID-19 Health**

The COVID-19 booster gap closed for those living in high versus low SVI geographies, reducing this disparity nearly three-fold (13.4% to 4.9%) in six months. Seventy-two percent of clients indicated that

[2] A heatmap is a "graphical representation of data that uses a system of color-coding to represent different values." https://www.optimizely.com/optimization-glossary/heatmap/#:~:text=A%20heatmap%20is%20a%20graphical,specific%20webpages%20or%20webpage%20templates.

they were very likely or somewhat likely to get the COVID-19 vaccine. The most common reasons for not getting vaccinated were:

1. Haven't gotten around to it: 244 instances
2. Doesn't trust the COVID-19 vaccine: 98 instances
3. Concerned about side effects: 82 instances

**Health Literacy**

As we continuously reminded ourselves during this project, this was first and foremost a Health Literacy Grant—It is Health Literacy Concepts that are at the core. We had to learn how to interface that with the work CHWs and CBO's were already so good at doing in the community. Health literacy concepts were both new and not new. We did many, many trainings through the AHLP, so it is self-evident that some people learned some things, but we also recognize that the work we have been doing together has been teaching all of us new things.

The AHLP gave CHWs skills and strategies that increased their confidence to approach people and increased their effectiveness in talking about a challenging subject, including how to deal with misinformation and learning how to speak to people and connect to people in a way that engages them rather than turning them off. We made strides with CHWs, CBOs and the grant awardees in shifting from health literacy as a vague concept (an adjective you can put in front of any noun to transform it to "health literate") into specific actions and communication strategies that enable clients to access necessary health information using the skills they already have. This more complex understanding of health literacy evolved from this: "if you are teaching a health care topic, like COVID, doing so means you are doing health literacy" into this: "here are some strategies for overcoming the difficulty of communicating complex ever-changing biomedical COVID information in ways that people can understand with the skills they have."

**Language Access**

Language access**,** having verbal information, written materials and websites in their clients' primary language was perhaps the most important tool, emphasized over and over again in workshops, meetings, training sessions and in the Idea Group as well. Through partnership and training from the UNM HLO, CHWs engaged in COVID Health Literacy health promotion with clients in over 12 different languages, including Spanish, Swahili, Mandarin, Vietnamese, Dari, and Arabic. The clients' preferred language was used during interactions 94% of time. Forty-five percent of encounters were in a language other than English. Of those, Spanish was the most common language spoken by clients—used in over 40% of individual encounters. This is reflective of the Albuquerque's rich diversity and an indication of the project's success in reaching a broad swath of the city.

**Plain Language**

We know that there is a power dynamic of exclusion when you use jargon. Data showed that many CHWs self-reported the use of plain language. CHWs promoted its use as a primary tool for understanding and clarity. For them, this was not an additional skill but integral to doing the work as trusted community messengers. However, learning up-to-date COVID-19 virus, testing and vaccine information brought them into the world of "experts." Through the work of the AHLP, CHWs empowered people to become critical thinkers about their own health.

CHWs talked about a need to "reconstruct" information, and recognized the use of jargon as "the power dynamic of exclusion." They re-affirmed that "technical language" which they needed to learn in order to understand and reconstruct COVID information "doesn't always translate into action." One CHW expressed it this way: "Before this program, we only thought about what aspect to say and then we just communicated in a way that actually made our community members afraid to accept the information. When we use plain language now they say thank you for the plain language. Plain language makes them not so afraid of the health information." The familiar understanding of the CHW role as "the bridge between the power and the client—the physician, the people who develop the rules and the health system" expanded. While holding fast to the belief that "CHWs don't speak to [clients] in the same way as the physicians and experts" they came to a fuller awareness of the degree to which complicated health information needs to be "reconstructed" or "plain-languaged," an insight that might be important for the broader CHW community.

The AHLP demonstrated the power of simple language. CHWs said:

- "Literacy is another form of empowerment."
- "Instead of walking away and feeling like it is too complicated for me, it is the opposite. Literacy means empowering the community—giving them the tools to understand and become energized and powerful. Giving them the ability to navigate. People feel confident."
- "You need to be empowered to use resources or to make decisions."
- "The role of a CHW is to be the bridge between the power and the client—the physician, the people who develop the rules and the health system--we don't speak to them [clients] in the same way as the physicians and experts."
- "I work with Spanish-speaking clients. They often believe that they don't have the ability to understand. They always assume the information is too advanced. But when you have specific things they can go back and think about, they realize they know the information. They remember not the general information, but the specifics and they can go back and say "I know what you are saying." Separating a small piece of information is valuable.
- "Asking a very specific question, something that my client is able to answer, empowers them to have more questions."

**Teach-Back**

A much smaller number of CHWs reported using teach-back in their encounters with clients. During the course of the project, the question arose as to whether or not the clinical model—useful for teaching providers to have conversations with their patients in the structured environment of an exam room or at the hospital bed—needed to be altered for different settings in which CHWs do their work (*e.g.,* outreach, phone calls, spur-of the moment conversations). Our Idea Group focused on this issue and we were able to document a CHW perspective on teach-back and its use in their work.

CHWs said:

- "The more I practice teachback, the more ways I see it can be applied in all parts of my life."
- "We have done this our whole lives—the idea that the message is getting through—this is how we ensure that they are understanding what we are sharing and not falling through the cracks."

- "Without teach-back you don't know what the other person has gotten from what you are giving them."
- "I just didn't know that what I was doing was teach-back. But after the training we started taking responsibility for that—that was the most important part of the training. Before that, we were putting the responsibility for understanding on the client—we would give them instructions… We provided steps and they might have a question, but then we would put the responsibility on them to whether or not they could do it on their own—and they are always going to say yes. The "teach" was happening on my part, but not the teach-back. I wasn't providing the space for the client to do that."

**Empowerment and Trust – Positive Attitudes about the Teach-back Method**
**CHWs' Ownership of Teach-Back**
Idea Group conversations showed that CHWs valued teach-back, which focuses on 5 T's including "Taking responsibility" and "Tell me." For many CHWs, it was already a familiar strategy. "We have done this our whole lives. Just the idea that information falls through the cracks is important. Without teach-back you don't know what the other person has gotten from what you are giving them." One person said, "It already belongs to us," and another, "I just didn't know it was teach back."

**Teach-back was understood as a strategy for empowerment and trust**
As one CHW said, "Teach-back opens up an opportunity—you don't close people down or push them away. It is a strategy for building trust." Conversations with the CHWs reinforced the idea that, "You need to be empowered to use resources or to make decisions." One person said, "**Instead of walking away and feeling like it is too complicated, it is the opposite.** Literacy means empowering the community—giving them the tools to understand and become energized and powerful."

In terms of the specific T's CHWs supported the two central steps," taking responsibility"—that is pointing the finger at yourself as the person who is overtly responsible for the clarity of the message, and "tell me," including the instruction to ask specific questions. One CHW said, "After the training we started taking responsibility [for clarity]—that was the most important part of the training. Before we were putting the responsibility for understanding on the client—we would give them instructions… We provided steps and they might have a question, but then we would put the responsibility on them to whether or not they could do it on their own—and they are always going to[ tell us] yes. The "teach" was happening on my part, but not the teach-back. I wasn't providing the space for the client to do that."

As for the "tell me" step, one CHW articulated the importance of asking specific question. "Asking a very specific question, something that my client is able to answer, empowers them to have more questions." In another Idea Group conversation, one of the Group said, "I work with Spanish-speaking clients. They often believe that they don't have the ability to understand. They always assume the information is too advanced. But when you have specific things they can go back and think about, they realize they know the information. They remember not the general information, but the specifics and they can go back and say 'I know what you are saying.' Separating a small piece of information is valuable. Asking a very specific question, something that my client is able to answer, empowers them to have more questions."

**Resistance and Change—Teach-back in the CHW framework**

Most of the group agreed on the need to refocus the first step in two ways. The clearest change needed was the use of the word "triage." The group discussed the initial intent behind the word, as used in the emergency room, where sickest patients must be given priority. Similarly, in clinical settings, we encourage providers to prioritize the 2 or 3 pieces of information that the patient must remember to do at home. The intended purpose is to alleviate the deluge of information a patient might receive upon a new diagnosis, or at discharge.

CHWs quickly identified "triage" as medical jargon and substituted "prioritize" instead. They also recognized that in quicker, more informal CHW encounters, the amount of information may be less, and in any case, is not the driving concern. The CHWs had a more radical re-framing to make when it came to whose priorities were important.

"For CHWs, the outcome is different…we want our clients to ask questions and be engaged. We always want our clients to come back to us. It's not so much that you are sure your patient will take the right medication but that they would feel comfortable coming back to ask you about the medication. Another participant said "We prioritize the needs of the patient and trust over getting the information right. We want the patient to go home with the right information based on what the patient needs. You need to meet the patient where they are."

**Expansion of Tools**

Other than the key change in the first step of the 5 Ts tool, CHWs expanded on the second step. In the original model, a tool was anything that helped the health care worker to clarify the information and helped the patient to retain it. Examples included pens and highlighters for marking important information on written documents, documents that were reader-friendly and used graphics, and body language or gestures.

Mood was identified as a useful tool—coming to the patient with a positive attitude.

First-hand experience was considered important. CHWs from one of the clinics gave the example of going themselves to the clinics where patients were referred, before sending them. CHWs would find out who in the clinic spoke Spanish and what forms and documents were necessary to pass along to their patients before the patients went to the clinic.

**A New Step**

CHWs, who had been trained in Motivational Interviewing early in the grant period, discussed the idea of incorporating a further step into the 5 steps for teach-back. Specifically, they considered asking clients permission to share information before doing so.

**SECTION IV: DISSEMINATION EFFORTS**

| Title | Venue |
|---|---|
| **Changing the Story in Albuquerque: Promoting COVID-19 Health Literacy to Improve Health Equity**<br><br>Leyna Aragon | April 2022.<br><br>Southwest Anthropological Association (SWAA) Annual Conference,<br>Albuquerque, New Mexico |
| **Community Health Workers Enhance Health Literacy for COVID-19 Vaccine Equity: An Ecosystem Grows in Albuquerque**<br><br>Leyna Aragon<br>Lisbeth Duron Pacheco<br>Emily Fontana<br>Heidi Fredine<br>Eddie Rojas-Alvarado<br>Terry Schleder | April 2022<br><br>New Mexico Public Health Association Conference,<br>Albuquerque, New Mexico |
| **COVID-19 Pandemic: Impacts on Albuquerque and Major Lessons for Policy-Makers, Social Equity Practitioners, and Emergency Management.**<br><br>Michelle Melendez<br>Billystrom Jivetti<br>Timothy Green<br>Terry Schleder<br>Ken R. Ziegler<br>Heidi Fredine<br>Janet Page-Reeves<br>Kelli Kasper | October 2022.<br><br>The Pandemic Divide Conference: How COVID Increased Inequality in America.<br>The Samuel Dubois Cook Center on Social Equity<br>Duke University<br><br>https://sites.duke.edu/thepandemicdivide/files/2022/10/Billystrom-Jivetti.pdf |
| **Dedicated web-page on the CABQ website for the public** | December 2022<br><br>https://www.cabq.gov/office-of-equity-inclusion/about-office-of-equity-inclusion/albuquerque-health-literacy-program |
| **Sharing Data Collection Strategies to Track AHL Performance Measures**<br><br>Janet Page-Reeves | December 2022<br><br>HHS OMH collaborative meetings. |

| | |
|---|---|
| Molly Bleecker | |
| **Automation of the Data Pipeline when using RedCap**<br><br>Kelli Kasper<br>Mariana Bustillos<br>Heidi Fredine | February 2023<br><br>The Art & Science of Data<br>University of New Mexico,<br>Albuquerque, New Mexico |
| **Innovating a Teach-Back Model for CHW-Led Promotion to Improve COVID-19 Health Equity**<br><br>Eddie Rojas-Alvarado<br>Leyna Aragon<br>Joshua Bradshaw<br>Teresa Caraveo<br>Lisbeth Duron Pacheco<br>Emily Fontana<br>Fred Hernandez<br>Mireya Jurado<br>Colleen McClusky<br>Hanna Nguyen<br>Terry Schlader<br>Alma Torres<br>Jenny Vazquez<br>Janet Page-Reeves | October 2023<br><br>To be submitted to the *Journal of Health Literacy Research & Practice*<br><br>Category: "Best Practice Article" |
| **Partnering with Community Health Workers to implement health literacy practices in the COVID-19 pandemic: Impacts in Albuquerque**<br><br>Heidi Fredine<br>Terry Schleder | November 2023 (accepted)<br><br>American Public Health Association Conference<br><br>Atlanta, GA |

As a result of our data collection presentation to the Health Literacy Learning Collaborative, we were contacted by other awardees (Colorado, Florida, South Carolina) with requests for technical assistance. Various members of the team held meetings with these different stakeholders and discussed our work, approach, data collection system, tools, and processes. And in the case of Florida, we provided instructions and some training about how to set up a data collection system.

- The PI and members of the Health Literacy team met with LaDonna Brown and her team regarding Health Literacy and the types of training and support that we offer our CHWs and supervisors. LaDonna Brown is the Bilingual Health Literacy Program Manager for the Durham County Public Health in North Carolina. Upon meeting with LaDonna and her team, we reviewed and discussed our goal and mission for CHWs, supervisors, partner organization, communities,

and populations. We showed them the structure of our 4-Day Trainings, our Outreach Meetings, our tools, our data collection systems, and methods of Teach back, Motivational Interviewing, Health Literacy, Health Coaching, Stages of Change, the COVID Flip Chart, Resiliency. We discussed other goals and ideas we have had for our team. We will continue to discuss and collaborate ideas that we are using and seeing in our work and in our community, as well as compare ideas and theories that will help improve Health Literacy.

- The PI met with Dr. Bruno Sobral from the Colorado School of Public Health at Colorado State University to discuss our data capture approach and project design.
- The PI and the Data Scientist met with Dr. Qasimah Boston from Virginia Union University (HBC) with the Richmond City award in Florida. We provided her and her staff with information about our data collection and tracking instruments.

**SECTION V: LESSONS LEARNED AND RECOMMENDATIONS:**

From 2021 to 2023, the City of Albuquerque (CABQ) Office of Equity and Inclusion partnered with the University of New Mexico Office for Community Health (UNM OCH) and 17 community agencies to implement the **Albuquerque COVID-19 Health Literacy Project (AHLP),** an innovative, culturally and linguistically appropriate, community health worker (CHW)-led, health literacy-infused approach to reduce COVID-19-related health disparities in Albuquerque, New Mexico. At the time we began this work, American Indian, Black, and Hispanic populations were disproportionately affected by COVID-19 in terms of the percentage of new cases each week, with American Indians 3.7 times more likely to be hospitalized and 2.4 times more like to die. There was urgent need for CABQ to have an evidence-based, culturally and linguistically appropriate public health response system – one that was creative, agile, and sensitive to community needs while enhancing prevention, education, and outreach strategies to reduce COVID-19 health disparities among racial and ethnic minorities and other socially vulnerable populations that have been demonstrated to be at high risk for negative COVID-19-related health outcomes. It became clear that there was a critical need for trusted health messengers with enhanced communication skills. COVID-19 provided a stunning reminder of how difficult it can be to comprehend a complex and quickly-moving health problem and transmit this information—for everyone—but especially for populations for whom the health care system is not designed. These disparities are reflected in statistics for Albuquerque using the CDC's Social Vulnerability Index (SVI) which uses Census data to map factors that negatively impact health. Our ability to implement coherent, effective public health practices to prevent or mitigate COVID-19 was driven by a toxic and damaging combination of complex ever-changing information, lack of information, disinformation, myths disseminated via social networks and social media, and distrust.

AHLP developed a multi-sectoral, CHW-led "ecosystem" to disseminate COVID-19 health education. The UNM Hospital Health Literacy Office (HLO) guided our use of health literacy practices including teach-back, plain-language and improving language access. The HLO is a unique hospital-based, health literacy-focused program created a decade ago specifically for the purpose of addressing health inequity among the hospital patient population. The teach back training model used for training CHWs was developed for use by health care workers in hospital settings, at bedsides or in exam rooms. It was based on a standardized, operational definition of teach back and five specific observable components. These observable skills--triage (or focus the information), tools, take responsibility, tell me and try again--help people learn the steps, see when they are used, and pinpoint adjustments.

The AHLP was created to promote COVID-19 health equity by leveraging efforts of the CABQ to respond to the pandemic with data about who and where in Albuquerque was experiencing disparate impact and to integrate that work with a community-generated vision for connecting the public health response infrastructure to work with people in the places where they live. The idea was to create a data-driven, community-informed response. The UNM OCH implemented and evaluated the AHLP. OCH has a long history of working with community partners to address negative social drivers of health (SDoH) and developing CHW work in Albuquerque and statewide. Albuquerque has a robust network of CBOs with cultural and community-specific expertise, and a strong infrastructure of nonprofit organizations working on health promotion issues that we mobilized to be part of the AHLP. The OCH Community Health Worker Initiatives (CHWI) created a training and support infrastructure to provide CHWs with the knowledge, skills and tools for COVID-19 health literacy work. The UNM Hospital HLO guided integration of health literacy practices into the work. We collected and visualized data to identify geographies of need, map project outreach activities, and monitor population health indicators of coordinated service efforts. CHWs conducted outreach through events, phone calls, individual in-person meetings, group meetings, spur-of the moment conversations, and shorter and less structured CHW conversations.

The AHLP operated from July 2021 to June 2023. The first 4 months involved preparation and planning to launch the initiative. Implementation with CHWs and in the community began in November 2022, and was ongoing throughout the project. A total of 17 community partner agencies participated in the AHLP initiative, with some attrition over time. Because of pandemic social distancing requirement, most of the trainings took place over Zoom. During the trainings, we introduced the teach-back strategy using a model developed by the UNMH Health Literacy Office.[3] The teach-back model was intended for and has primarily been used for training clinical staff to use teach-back with their patients. We conducted the teach-back trainings with CHWs for this project from early December 2021 and lasted through the grant period, until June 2023.

**Facilitators and barriers**

Teach back is not a difficult concept but overcoming communication habits takes time and practice. CBOs and CHWs are extremely busy and we accommodated the time they had. Therefore, inadequate training and practice time was a barrier to incorporating teach back training into real-life conversations

A barrier, which also became an opportunity, was lack of understanding of health literacy. The work of the project gained ground in shifting the notion that health literacy, especially low health literacy, is an individual problem. As we worked with CHWs and developed a community-based practice for the work, we moved the concept of health literacy more into the realm of health equity. That is, CHWs internalized the extent to which it is the responsibility of health care organizations to remove barriers to accessing, using and understanding health care rather than a deficit-based understanding that a individuals lack the requisite skills.

[3] Anderson KM, Leister S, De Rego R. The 5Ts for Teach Back: An Operational Definition for Teach-Back Training. Health Lit Res Pract. 2020 Apr 9;4(2):e94-e103. doi: 10.3928/24748307-20200318-01. PMID: 32293689; PMCID: PMC7156258.

**SECTION VI: PROMISING PRACTICES**

Our multisectoral approach showed a robust impact in vaccine uptake in communities that are experiencing high social vulnerability and succeeded in using health literacy as a vehicle for improved population health in an urban area. The choice to rely on CHWs as avenues for information is in and of itself a starting point for a health literacy project, as a central premise of health literacy is that the voices of those who use health care information can be the most successful deliverers, especially among populations as culturally and linguistically diverse as those in Albuquerque. In other words the CHWs in community health centers (CHCs), community clinics, and in non-medical community-based organizations (CBOs) in Albuquerque were already skilled at using linguistically, and culturally appropriate communication that takes into account individual contexts, links outreach and education to people's experiences, and involves clients in improving their own health literacy. As one CHW noted: "You ARE the community—you are an extension." Another described her role as "a bridge for cultural differences." To this existing community-driven communication locus, we offered training in specific health literacy best practices: teach-back and plain language training,

**The AHLP was incredibly successful**. Our team gave COVID-19 health literacy work a hands-on, intimate quality. We engaged people and ourselves in ways that we never envisioned and it paid off. We learned new ideas, strategies, and tools. We all learned so much. They figured out how to engage things and people who did not want to be engaged. And we did it during a pandemic when reaching people really was a foundational problem. With this trailblazing when no one knew exactly how to do this work, we created new mechanisms for bringing work you were already doing to improve COVID-19 outcomes in new ways.

**The AHLP helped us transcend the pandemic**. This project brought us all together. It reinvigorated the work that had already been going on. It resuscitated work that had gone stagnant or dormant because of the pandemic. It created new opportunities for future collaboration & partnerships. And the AHLP provided important lessons-learned.

**The AHLP transformed the way that CHWs work.** It highlighted how multifaceted the work can be, it showed how synergistic the work can be both in clinical and community settings, it showed how this work can facilitate and strengthen the workforce, and it expanded CHWs to new spaces and to work in new ways

**The AHLP enhanced our community-engaged practice.** We learned more about each other, we learned about the capacity of CHWs and CBOs and what we can reasonably expect from them, and it helped us learn how to design things that will work in the future

**The AHLP highlighted the key importance of language.** We learned that we need to include money for this as part of the practice. The partnership with the CABQ and resources provided through the grant allowed the project to access interpretation and translation services. This was hugely important from the perspective of CHW work. And we learned that we need to make timelines that allow time for interpretation and translations—and the importance of native language trainings for CHWs.

**The technology we used gave us new insights.** We learned the kinds of platforms for engaging partners and clients—zoom, open houses, outreach events, newsletter. We learned how data visualization really expands the ability of partners to understand and do the work. We learned that we need to budget for viewer licenses for partner agencies to be able to use data platforms.

**The AHLP reinforced the importance of information in the work we do.** We needed the most accurate and updated information about COVID-19. **We needed information about where to work and who to work with to make the work most impactful. We needed information** about each other and each other's work. We needed information about how to do the work and how to do it most effectively. We needed information about how to work together and share to expand the impact of the work.

**The AHLP created connections.** Our open houses, outreach events, and cross-site meetings helped CHWs and partners doing the work to know that they weren't alone in this work. In the community, the AHLP helped people connect with information and services. Connections we made with Health Councils, coalitions, and the NMDOH helped us to connect our work with others across the state. And connections we made with other awardees helped us to develop relationships for sharing strategies and approaches that have a cross-fertilization effect on the work that we are doing and the work being done in other states.

## SECTION VII: SUSTAINABILITY

**Discuss the extent of your program's ability to implement its sustainability plan as intended.Identify program components/activities that will be sustained beyond the OMH funding period.**

While there are no plans or funding sources to sustain the Albuquerque Health Literacy Project, we are confident that the learnings and connections made between CHWs and organizations will lend themselves to future collaborations. We firmly believe that the emergency preparedness aspects of this work will serve us well when we are faced with the next health emergency.