Epi Monthly Report

VOLUME 18, ISSUE 5 MAY 2017

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Florida Department of Health in Miami-Dade County

Epidemiology, Disease Control & Immunizations Services

8600 NW 17th Street, Suite 200
Doral, FL 33126

Tel: 305.470.5660

Fax: 305. 470.5533

Understanding the Gap: Perceived Health Literacy Levels among Spanish-speaking Immigrants in Miami-Dade County, 2016

Emily Moore, MPH Christina Cordero, PhD, MPH

Background:

Health literacy levels are often a predictor of health outcomes; being health literate paves the way for correct health knowledge, self-efficacy and positive health behaviors. Inversely, low health literacy levels, also called "high health literacy demand," can negatively influence a patient's ability to navigate the healthcare system, understand provider instructions, or make healthy choices for themselves on a daily basis. Immigrants and refugees face particular health literacy demands when entering the United States Healthcare system. Studies have indicated that immigrants and refugees face cultural barriers, lack of understanding of medication, inadequate health education, and lack of communication between provider and patient. Miami-Dade County is home to a vast immigrant population from primarily Spanish-speaking countries. This study provided an assessment of health literacy skills in Spanish, the most widely spoken language among new immigrants and refugees to Miami, in order to gain a better understanding of the level of health literacy that these patients and clients have when they enter into Miami clinics, hospitals, and public health agencies.

Methods:

Patients seen in the Florida Department of Health in Miami-Dade County (DOH-Miami-Dade)'s Refugee Health Assessment Program (RHAP) and Family Planning Program (FP) completed a self-administered health literacy assessment during November, 2016. Participants were adult immigrants from Spanish-speaking countries who lived in the U.S. for ≤10 years. Three health literacy tools were translated and adopted to study participants' perceived health literacy ability and their actual health literacy scores. The structure of this assessment was based on previously published assessments that have been

designed as tools to measure health literacy. Portions from these published assessments provided guidance for the design of an original, comprehensive health literacy assessment that could be tested in Miami-Dade Clinics; the original tools themselves were not used. These tools were combined with five background questions and five questions screening for the perceived comfort level that participants have reading written health materials to create a comprehensive short assessment meant to give a full picture of the reading health literacy skills of the participant. Each question was assigned a three-level score and mean scores were divided into three categories: high, adequate, and low. The agreement was assessed; logistic regression models were used to determine predictors of agreement.

Statistical Analysis:

Distributions of participant characteristics were obtained for the entire study sample. Differences in distributions were compared to those with high health literacy perception and high health literacy score. The average proportion of right or wrong health literacy answers by perception score was calculated. For the overall study population and by participant characteristics, percent agreement was calculated to examine the level of agreement between health literacy perception and high health literacy score. Cohen's kappa (K) with 95% confidence intervals (CI) were also calculated to measure beyond chance agreement. The strength of agreement was interpreted as: nearly perfect (1.00-0.81), substantial (0.80-0.61), moderate (0.60-0.41), fair (040-0.21), slight (0.20-0) and none (<0) (CITE). The health literacy score was used as the gold standard for which sensitivity (Se) specificity (Sp) were calculated.

We compared differences in agreement by participant sex, age, country of origin, clinic location, how long they have lived in the U.S., and the source where they receive their medical information. We conducted a two-stage logistic regression analysis that includes an offset term to adjust for the probability of agreement due to chance for identifying covariates that are predictive of agreement. This method allows parameters to be interpreted as the true odds ratio for agreement divided by the true odds ratio under chance agreement. We obtained valid standard errors using the jackknife variance estimator.

Results:

Agreement varied by participant characteristics. 283 patients responded; 180 (64%) were female, 113 (40%) were between the ages of 25-34, and 78 (28%) reported living in the U.S. for 6-12 months. Participants that were female and ≥65 years were more likely to have higher health literacy scores. Agreement among high vs. adequate/low perception and literacy scores was 57% with a low Cohen's Kappa of K=0.13 (95% CI 0.02, 0.25). No characteristics were significant predictors of agreement. Lower agreement, however, was found among participants that were 18-24 years (49%), lived in the U.S. 6-12 months (49%), and received medical information from the internet/television (46%).

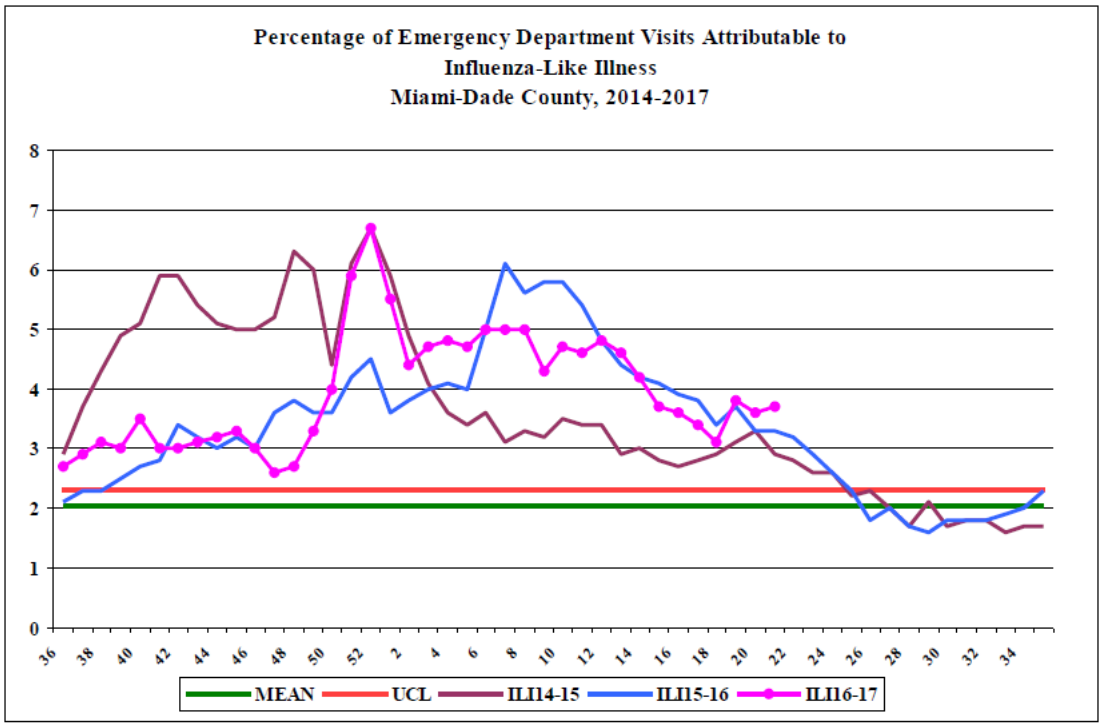
Higher agreement between high health literacy perception and high health literacy scores was more common among participants that were female, ≥55 years, and were of non-Cuban origin. The strongest predictors of agreement were participant sex and country of origin.

Conclusion:

Not all immigrant patients have a very accurate understanding of their own health literacy abilities. This incorrect skill perception could negatively impact patient care if clinicians and providers do not actively screen for patient understanding, even if the patient insists verbally that they have understood health information. Better oral and written communication of understanding between doctors and patients is needed. Doctors and clinicians should screen for understanding by having patients repeat written health or medication instructions back to them in their own words.

EDC-IS would like to acknowledge the RHAP and FP programs for allowing our team to distribute this assessment survey in the clinics

Influenza-Like-Illness, All Age



During this period, there were 30,368 ED visits; among them 1,126 (3.7%) were ILI. At the same week of last year, 3.3% of ED visits were ILI.

TO REPORT ANY DISEASE AND FOR INFORMATION CALL:
Epidemiology, Disease Control & Immunization Services

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Prevention Program 305-470-6877
Hepatitis 305-470-5536
Immunizations or outbreaks 305-470-5660
HIV/AIDS Program 305-470-6999

STD Program 305-575-5430
Tuberculosis Program 305- 575-5415

Immunization Service 305-470-5660

To make an appointment.....786-845-0550

PARTICIPATE IN INFLUENZA SENTINEL PROVIDER SURVEILLANCE

Florida Department of Health in Miami-Dade County NEEDS Influenza Sentinel Providers!

Sentinel providers are key to the success of the Florida Department of Health's Influenza Surveillance System. Data reported by sentinel providers gives a picture of the influenza virus and ILI activity in the U.S. and Florida which can be used to guide prevention and control activities, vaccine strain selection, and patient care.

- Providers of any specialty, in any type of practice, are eligible to be sentinel providers.
- Most providers report that it takes **less than 30 minutes a week** to compile and report data on the total number of patients seen and the number of patients seen with influenza-like illness.
- Sentinel providers can submit specimens from a subset of patients to the state laboratory for virus isolation **free of charge**.

For more information, please contact

Lakisha Thomas at 305-470-5660.

About the Epi Monthly Report

The Epi Monthly Report is a publication of the Florida Department of Health in Miami-Dade County: Epidemiology, Disease Control & Immunization Services. The publication serves a primary audience of physicians, nurses, and public health professionals. Articles published in the Epi Monthly Report may focus on quantitative research and analysis, program updates, field investigations, or provider education. For more information or to submit an article, please contact Emily Moore at (305) 470-6918.

Miami-Dade County Monthly Report
Select Reportable Disease/Conditions
April 2017

Diseases/Conditions	2017 Current Month	2017 Year to Date	2016 Year to Date	2015 Year to Date
HIV/AIDS				
AIDS*	37	152	209	143
HIV	107	454	581	470
STD				
Infectious Syphilis*	41	131	164	91
Chlamydia*	1068	4062	4065	3030
Gonorrhea*	274	965	884	551
TB				
Tuberculosis**	9	24	26	35
Epidemiology, Disease Control & Immunization Services				
Epidemiology				
Campylobacteriosis	35	179	166	155
Chikungunya Fever	0	0	0	7
Ciguatera Poisoning	1	3	0	4
Cryptosporidiosis	7	8	6	5
Cyclosporiasis	0	0	0	0
Dengue Fever	0	1	6	4
Escherichia coli, Shiga Toxin-Producing	2	18	2	7
Encephalitis, West Nile Virus	0	0	0	0
Giardiasis, Acute	14	38	72	57
Influenza Novel Strain	0	0	0	0
Influenza, Pediatric Death	1	1	0	0
Legionellosis	0	9	2	8
Leptospirosis	0	0	0	1
Listeriosis	1	4	3	0
Lyme disease	0	2	0	0
Malaria	1	3	1	0
Meningitis (except aseptic)	0	1	0	2
Meningococcal Disease	1	4	0	4
Salmonella serotype Typhy (Typhoid Fever)	0	0	0	2
Salmonellosis	54	162	143	138
Shigellosis	7	25	28	40
Streptococcus pneumoniae, Drug Resistant	0	4	1	0
Vibriosis	1	3	0	1
West Nile Fever	0	0	0	0
Immunization Preventable Diseases				
Measles	0	0	0	0
Mumps	0	0	2	1
Pertussis	2	11	8	10
Rubella	0	0	0	0
Tetanus	0	0	0	0
Varicella	2	16	32	15
Hepatitis				
Hepatitis A	11	31	8	8
Hepatitis B (Acute)	3	8	2	5
Healthy Homes				
Lead Poisoning	8	30	42	18

*Data is provisional at the county level and is subject to edit checks by state and federal agencies.

** Data on tuberculosis are provisional at the county level.