

# In HIV primary care, health literacy, health outcomes, and community health worker utilization

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## COMMENTARY

The ability to comprehend and apply health-related information to make decisions is known as health literacy. Limited health literacy has negative health consequences, such as difficulties comprehending pharmaceutical labels or sticking to treatment regimens, as well as a worsening general health condition and a higher mortality rate. Access to healthcare is hampered for the 80 million adults in the United States with low health literacy, resulting in lower utilization of preventative services such as mammography screening and influenza vaccinations. Those of color and those with low socioeconomic position are disproportionately affected by health literacy, and people with HIV/AIDS are overrepresented in the population (HIV). Poor medication adherence is especially important for individuals living with HIV (PWH) who are on antiretroviral therapy (ART) to manage disease progression and achieve viral suppression. According to one study, less health literacy was linked to reduced CD4<sup>+</sup> T cell counts in PWH who identified as Black, indicating a weakened immune system. Furthermore, PWH with low health literacy may be hesitant to ask questions or communicate with providers, which can affect the quality of care they receive. PWH with low health literacy are less likely to obtain information from their doctors that they can comprehend, making it more difficult for them to control HIV and avoid transmission.

Incorporating community health workers (CHWs) into care teams at clinical HIV treatment centers is one way for improving PWH health outcomes. CHWs are culturally competent public health professionals who serve patient populations with health education, community outreach, care coordination, social support, and advocacy. For a range of chronic illnesses, such as diabetes, asthma, and hypertension, the importance of CHWs in improving health outcomes has been well documented. CHWs have recently been researched in HIV primary care settings. The use of CHWs is critical in assisting HIV primary care clinicians with a variety of responsibilities, including scheduling appointments, arranging transportation, and making home visits. Several studies have looked into the good impact CHWs have on PWH care, such as better linkage to care, retention in care, adherence to ART, and viral suppression. While the function of CHWs in aiding PWHs has been extensively defined, there are few studies that detail the most often used CHW services or details of CHW-patient contacts in this demographic. Furthermore, patient satisfaction with CHWs has been linked to health literacy, which could influence their willingness to use CHWs during treatment. In addition, the effect of health literacy on CHW utilization and health outcomes has yet to be investigated. In the first six months of working with a CHW, increased utilization of CHWs in HIV primary care clinics had an influence on health outcomes. In the first six months, participants had an average of six meetings with CHWs. Improvements in primary care visits, active ART prescriptions, and viral suppression were all significant findings. The importance of health literacy, on the other hand, was not considered in this study. It's crucial to look at the health literacy component since people with low literacy may have poorer health outcomes. Furthermore, patients with differing degrees of health literacy may have distinct requirements that CHWs must address during visits, or may require more time or encounters with CHWs. The goal of this study is to look at the impact of health literacy

on clinical outcomes and CHW utilization among HIV patients in primary care. A secondary goal is to determine the most frequently used CHW services among HIV primary care patients of all health literacy levels in order to better understand their requirements.

While the influence of health literacy on PWH is well-documented, little is known about how health literacy affects CHW care consumption in this population. The current study's findings show that health literacy was substantially related to obtaining coaching from CHWs, with those with low health literacy having more coaching encounters with CHWs. Individuals with low health literacy were also more likely to have an HIV primary care visit six months later. Individuals who received transportation coordination, concrete services, coaching, and emotional support from CHWs had a considerably higher frequency of interactions with CHWs than those who did not. This shows that these specific patient services (transportation coordination, actual services, coaching, and emotional support) require more assistance from CHWs in the HIV primary care context, regardless of health literacy levels. Help with HIV or non-HIV disease management or services, harm reduction education, HIV disclosure, safer sex, or life skills dialogues were all examples of CHW coaching in our study. A recent systematic review found 61 papers on the types/characteristics of CHW interventions, with CHWs in health education/coaching positions being one of them. The majority of the articles, however, were about cancer prevention and treatment, as well as cardiovascular illness. CHWs have been particularly successful in the management of diabetes for people with low health literacy, who have much more visits with CHWs than people with high health literacy. Ours is the first study to describe CHW coaching for PWH with varied degrees of health literacy. In an HIV primary care patient group, those with low health literacy had 3.58 times the chance of receiving coaching from a CHW and 3.91 times the chance of encountering a CHW than those who did not receive coaching. This shows that people with low health literacy need greater assistance accessing health care systems and HIV-specific illness management, necessitating more visits with CHWs than people with average or high health literacy. We detect no significant variations in rates of viral load suppression or HIV primary care visits at 6 months between health literacy categories in this cohort, indicating that CHWs play a vital role in the HIV health care team in assisting patients with their care and treatment. Factors that improve PWH retention in care have been extensively researched, and CHWs have proven to be beneficial in this area. According to one study, PWH from racial/ethnic minorities with behavioral health comorbidities who received peer support had considerably fewer gaps in HIV primary care than those who did not. A systematic analysis of programs using PWH as peers revealed favorable benefits in terms of linkage to care and retention in care.

Furthermore, insufficient health literacy might make it difficult for people to stay in care. However, a study that looked at the impact of health literacy on HIV clinical outcomes discovered that people with low health literacy did not have lower levels of ART adherence or retention. Similarly, our findings suggest that people with lower health literacy do not have a worse rate of care retention. In fact, compared to those with adequate health literacy, those with marginal health literacy were significantly more likely to have an HIV primary care visit at 6 months post-intervention. This shows

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that CHW-provided treatments, such as coaching, may help people with low health literacy stay in care longer. CHWs may be addressing other priority requirements for PWH with reduced health literacy, and medical care may be less of a priority. PWH, regardless of medical literacy status, have complex and varied demands, both clinical and non-clinical. These requirements, also known as social determinants of health (SDOH), encompass a variety of economic, social, and environmental elements. In a study of 15,964 PWH in the United States, 23% said they had at least one SDOH indication, while 25% said they had four or more. Furthermore, 31.7% had transportation issues, which is similar to the 32.5% of our group who received transportation assistance from a CHW. The most common reason for a CHW interaction, according to our data, was to provide emotional support.

Unmet needs for social determinants of health, as well as stigma associated with an HIV diagnosis, can have a major detrimental impact on mental health, which may explain why 88.2% of our group received emotional support from a CHW. In this group, logistic support was also widespread, such as creating appointment referrals, health care appointment reminders, and updating care plans and medical records. Because many PWH have co-occurring mental and substance use disorders, they often require complicated and multi-faceted care. Similarly, over a third of the people in our group had a mental health or substance abuse problem. As a result, logistical assistance, such as healthcare navigation and appointment reminders, is in high demand. CHWs offered logistical support to nearly half (46.9%) of the people in our cohort, demonstrating the value and necessity of this service in HIV primary care. While patient navigators have served in this capacity in some contexts, our research shows that CHWs can also help PWH with these needs. First, while CHWs can assist persons in becoming more knowledgeable about HIV, this program was not designed to promote overall health literacy. In this study, no locations tested CHWs for health literacy, which could help develop programs in the future where CHWs deal with people who have low health literacy. Second, while the CHW programs

included training on how to educate people about therapy and how to read and understand lab results, our research did not directly examine these changes. The goal of the CHW intervention was to provide treatment adherence information, motivation, and support as part of the coaching process. In previous trials of CHW peer intervention, HIV awareness increased but not significantly during a 12-month period. A knowledge score should be included in future investigations. Third, the participants in this study were a convenience sample of people who were willing to work with a CHW and were enrolled in a non-random manner. The effect of health literacy on CHW utilization and health outcomes can only be studied among those who interacted with CHWs because there is no control group. In terms of demographic features, however, there were no significant differences between those who continued in the trial and those who were lost to follow and Health Policy.

Fourth, this study only follows participants for six months, which is unlikely to be long enough to determine the influence of health literacy on CHW service consumption in this cohort. Finally, participants in this study came from ten different clinics. While we used clinic location as a control in our regression models, changes in populations and CHW programs models between sites may alter the generalizability of our findings. The inclusion of CHWs into HIV primary care clinics allowed for a more complete understanding of the types of services provided and their impact on treatment results throughout the trial. Health literacy was linked to receiving coaching from CHWs and having an HIV primary care visit at 6 months, but not to viral load suppression or the number of CHW interactions. Emotional support, coaching, concrete services, and logistical support were the most common reasons for CHW contacts. The goal of the meeting with the patient was substantially linked with the frequency of CHW encounters; however, health literacy status was not a predictor of CHW use. Individuals receiving these services, regardless of their level of health literacy, may require extra assistance from CHWs.