Title

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Authors

Casillas, Alejandra
Flores-Uribe, Erika
Abhat, Anshu
et al.

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Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

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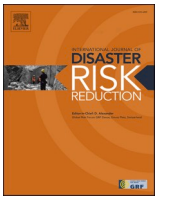

The language of COVID-19: Health systems must now prioritize responsive in-language and culturally-tailored messaging

On July 21, 2020, KQED reporter Adriana Morga reported the story of a child who who called into a national radio show a few months after the onset of the pandemic. The child's parents were workers at McDonald's- both sick with Coronavirus-19 Disease (COVID-19) , and had multiple questions about their recovery and return to work. However, the child's parents didn't speak English and had no access to a regular primary care physician. Instead, they had their daughter call the radio station during a live Q + A segment with COVID-19 experts, to ask these questions. Morga's heartbreaking recounting of this moment, *"When a 10-Year-Old Translated Her Parents on Live Radio, Thousands recognized Themselves,"* encapsulates the epitome of the dire communication gap that exists for so many of our medically underserved patients of color—and the measures that they must resort to, for basic health information.

During the first year of the COVID-19 pandemic in our home of Los Angeles County, , 69% of those seeking tests for acute Coronavirus-19 infection were from racial and ethnic minority groups, and also had the highest rates of percent positivity [1]. Unfortunatelythese disproportionately impacted communities received health communications much later than mainstream populations, with these messages also lacking the linguistic and cultural tailoring to be truly effective [2,3]. This created a double jeopardy early in the pandemic—because these communities, especially those who were Limited English Proficient (LEP), already at risk for poor health outcomes (in part due to limited health literacy), *were then* are also at higher risk for contracting COVID-19 [4,5].

One major reason for this unjust reality is that historic and contemporary structural racism has relegated communities of color to be overrepresented in essential and service occupations, where work hazards are common, and where such employees remain at the bottom of the priority chain for workplace protections [5]. Essential workers in janitorial and sanitation services, meat-packing plants, delivery services, grocery stores, and factories continue to be at high risk of contracting COVID-19 infection [5]. Employers in these settings are less likely to provide paid sick leave or health insurance, forcing sick employees to remain at work [6]. Furthermore, these populations more commonly live in neighborhoods with overcrowded living conditions, multi-generational households, and unsafe housing structures [6]. A consequence of this devastating "perfect storm" in Los Angeles: in our safety net hospitals, patients of color constituted nearly 80% of the hospitalizations for COVID-19 during pandemic surges, and were at higher risk for overall morbidity and mortality [1]. Similar findings have been noted from other major cities in the United States [7].

Thus, it is imperative that public agencies effectively communicate with their local diverse communities with timely, accurate and culturally- and linguistically-appropriate health information, especially tailoring these messages to address those with limited health literacy and/or who are LEP. The Los Angeles County Department of Health Services (LAC DHS) is one example of an agency who has reached out in this way. The LAC DHS is the second largest municipal health system in the nation, and operates 26 safety net health centers and four acute care hospitals, in addition to providing care in the juvenile justice system and the LA County jails. LAC DHS cares for about 2.3 million patient-visits each year, where 54% of the patient population is LEP.

In March 2020, LAC DHS immediately created a COVID-19 Patient Facing Communication Committee (PFC) in response to the COVID-19 crisis. The goal of this response was to provide *in-language (preferred patient language)* and *culturally-tailored* information for COVID-19 prevention and exposure precautions, testing and acute care, and social support resources to LAC DHS primary care enrollees, and uninsured Los Angeles residents (enrolled in our safety net program, My Health LA). Herein, we present recommendations (Table 1) to the broader medical and public health community as a concrete call to action for health systems to deliver responsive, in-language, and culturally-tailored messaging, for their diverse communities of color—who are at higher risk for COVID-19, but also vulnerable to falling through the crisis information gap.

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Table 1
Recommended strategies for health systems to deliver responsive, in-language, and culturally-tailored messaging to diverse communities.

	LAC DHS Strategy implemented	Key consideration for local tailoring
1	Link county emergency management operations to the health system's communication team. Our public facing communications are managed in this way during the pandemic— having activated LA County's crisis communications, the Joint Information Center (JIC). The JIC works directly with LAC DHS's Emergency Communications team and leverages resources (bullet points 2–6 below) to develop and disseminate tailored messaging during our state of emergency.	Health system creates an emergency communication team athat works with emergency management operations to ensure consistent and culturally-tailored messaging, both with the health system and to external partners.
2	Update patient databases for preferred personal contact information (phone, text, patient portal and/or email) and preferred language for all primary care patients and new patients. Reach out to patients via health educators and community health workers to ensure correct contact information and facilitate patient portal access. Also ask and document patients' preferred mode of receiving updates (e.g. text messaging, automated phone calls, website, social media outlets, television, newspaper outlets).	Capture patients' preferred mode of receiving updates (e.g. text messaging, automated phone calls, website, social media outlets, television, newspaper outlets) to develop the most effective dissemination strategies.
3	Review and edit all patient-facing materials (including digital communication and websites) to appropriate literacy levels, identical to the standards for in-person patient education and medical questionnaires/forms. Translate these communications into all "threshold languages." For California, "threshold languages" are tracked by the Medi-Cal Eligibility Data System (these are languages identified to be spoken at a high proportional rate within a geographic region of the state).	Translate all patient-facing materials (including digital communication and websites) to achieve culturally and linguistically appropriate tools at 3–6th grade literacy levels to effectively address all members of the health system and local communities.
4	Create Patient Family Advisory Councils (PFACs) and then involve these for co-design of messaging outreach strategy planning. It is critical to create a PFAC that is representative of the local patient population (race, ethnicity, language).	Ensure your health system PFACs adequately represent the constituents of your health system and local communities.
5	Assemble a dedicated team of clinicians, PFACs and health educators who work directly with local cultural media (local television, radio, newspaper, and social media like social network platforms) in threshold languages of your patient populations. Have this same team reach out to local essential businesses (grocery stores, restaurants, factories) where these workers from communities of color are concentrated.	Work closely with local media sources and businesses using a community-health system partnered approach to provide the most reliable information possible based on our present understanding of the pandemic and emerging treatments (vaccines).
6	Disseminate tailored health information through trusted communication platforms such as community clinics, community-based organizations, faith-based organizations (churches) as well as local resource distribution events, like food drives. This is particularly important among communities where distrust in health centers is pervasive, due to a long history of racism in healthcare. Shopping centers and essential worker employment sites may be effective and easily accessible "safe" places to educate and share information.	Disseminate culturally and linguistically tailored health information through traditional and locally determined communication platforms. Be mindful of who might be the most effective messengers for different messages and audiences.

Finally, we call on health systems to partner with patients, with culturally- and linguistically-specific local organizations, and local community pillars and cultural representatives to deliver appropriate messaging of COVID-19 health programs and services, and provide updates regarding pandemic education, information/mis-information, prevention and treatment strategies, vaccinations, as well as the social implications of the pandemic on vulnerable communities as these evolve. As health leaders, it is our moral responsibility to paint the language of COVID-19's threat and recovery path forward as plainly as possible— so that our most at-risk communities, including those families that recognized themselves in Ms. Morga's story, are not left behind in future crises.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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Alejandra Casillas[a,*], Erika Flores-Uribe[b], Anshu Abhat[b], Gerardo Moreno[a], Arleen Brown[a], Peter G. Szilagyi[a], Keith Norris[a]
[a] *David Geffen School of Medicine, University of California Los Angeles, United States*
[b] *Los Angeles County Department of Health Service, United States*

[*] Corresponding author.
E-mail address: acasillas@mednet.ucla.edu (A. Casillas).