What Structural Features Make Porous Carbons Work for Redox-Enhanced Electrochemical Capacitors? A Fundamental Investigation

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Be Wise: A complementary and alternative medicine health literacy skill-building programme

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Abstract

Background: Health literacy has been found to be the strongest predictor of health status; and without adequate health literacy, consumers may not understand/adequately evaluate the myriad of choices available. Older rural residents tend to use self-prescribed complementary and alternative medicine (CAM) therapies and glean information about these therapies primarily by word of mouth/media.

Objectives: The purpose of this article is to describe the Be Wise health literacy skill building programme and the participants' evaluation of the programme.

Design: The programme involved four sessions delivered over 7 weeks at seniors' centres in rural communities.

Method: Data were collected initially ($N = 127$), at the end of the sessions ($N = 67$) and after 5 months ($N = 52$).

Setting: Participants were primarily rural Caucasian women, mean age 76 years, and most had an associate/baccalaureate degree.

Results: Questions were worded to ascertain satisfaction with the programme, usefulness of the information provided, willingness to recommend the programme, and the likelihood of using the programme. All scores were most favourable ranging from 3.35 to 4.41 on a 5-point scale. A question regarding the usefulness of the Be Wise programme in managing health received at mean score of 3.55 on a 5-point scale. Written comments on the questionnaires were overwhelmingly favourable.

Conclusion: Delivering programmes to older adults in small rural communities has special challenges and rewards. Participants were enthusiastic about learning more about making informed health care choices. There is a compelling need for continued programme development and long-term outcomes evaluation.

Keywords

Complementary and alternative medicine; health literacy; health literacy skill-building; older rural adults

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A rancher is driving 20 miles back to the ranch after helping with a blood drive in the local town. She ponders the conversation that the volunteers had about the use of herbal products and thinks she should probably use them. She is taking several prescription medicines but decides not to talk with her health provider about it because he may not approve of her using alternative therapies. Another rancher is heading home after a farm bureau meeting. Over coffee, there was a discussion of various dietary supplements. He decides he should take supplements but does not know which are right for him or how to get accurate information about them.

Both of these events raised relevant and critical health literacy questions or more specifically questions about complementary and alternative medicine (CAM) health literacy.

Introduction

Health literacy has been defined as 'the degree to which individuals have the capacity to obtain, communicate, process and understand basic health information and services needed to make appropriate health decisions' (US Patient Protection and Affordable Care Act, 2010). It has been found to be the strongest predictor of an individual's health status, more so than age, income, employment status, education or race/ethnicity (Berkman et al., 2004; Seminole County Patient Safety Initiative, 2006). The degree of health literacy influences the ability of individuals to monitor their health and productively engage with the health care system and has been a major public health priority that was included in the US 2010 and 2020 Healthy People priorities (US Department of Health and Human Services, 2000, 2013).

Complementary or alternative medicine (CAM) therapies are health care approaches that are not typically part of conventional health care or that may have origins outside usual Western practice. They include natural products such as herbs, vitamins and other dietary supplements and mind/body practices such as yoga, meditation and acupuncture (National Center for Complementary and Integrative Health, 2020). Individuals use CAM for a variety of reasons including perceived cost, dissatisfaction with regular health providers, perceived preventive or restorative properties and ease of purchase (Altizer et al., 2013; Arcury et al., 2015).

Natural products and dietary supplements are the most commonly used types of CAM and are readily available for purchase over-the-counter. While some of these products may have significant therapeutic value, others may present untoward health consequences if the dose, expected effects/side effects and potential interactions with food and/or other medications are not adequately understood. Individuals with low health literacy may not adequately understand and evaluate the myriad of choices that confront them.

In a series of studies exploring the use of CAM by elderly rural dwellers, we found that use of CAM was approximately the same rate as of their more urban counterparts. Consistent with the characteristics of rural populations, participants who used CAM tend to use self-directed modalities rather than therapies provided by alternative practitioners, tend to glean information about these therapies primarily by word of mouth or from the media and used CAM inconsistently. Some did not seek information about the effects or risks of CAM, and when they did, the information sources they used were informal and those that the Institute

of Medicine (2005) expressed concern about as not being reliable (Nichols et al., 2005; Shreffler-Grant et al., 2007).

Rural dwellers are self-sufficient, rely on social systems for information, are ageing, and are among those identified as suffering from health disparities (Holmes and Levy, 2015). Rural communities have fewer health-related resources, poorer Internet access, lower income levels, lower educational levels and less health insurance coverage. Rural populations are ageing, and with that are more likely to suffer from poor health literacy and chronic illnesses (National Center for Chronic Disease Prevention and Health Promotion, 2011). Sudore et al. (2006) linked limited literacy in older people to disparities in health and health care access. Yamashita et al. (2018) suggested that lifelong learning activities may help mediate the impact of educational levels on health status for older individuals. The programme described here provides an example of such a programme.

The *Be Wise* programme

The intent of the programme titled *Health Care Choice: Be Wise* was to deliver and evaluate a skill-building intervention to enhance literacy about complementary and alternative therapies, specifically natural products. The development of the Be Wise programme was approved by the Montana State University Institutional Review Board for the Protection of Human Subjects. The programme was implemented with older adults in eight rural communities in two northwestern states in the USA and consisted of four skill-building sessions held over a 7-week period in centres and living facilities for the elderly in each community.

The sessions were developed based on the team's prior research, evidence from the relevant literature and a conceptual model developed to guide the team's exploration of CAM health literacy The key components of the model that guided content selection for the four skill-building sessions were: information needed to assess a product or treatment; how to find and assess information about a product; and how to take an active role in health decision-making (Shreffler-Grant et al., 2013). Although the programme focused on dietary supplements and natural products, the skills acquired can be used with other types of self-prescribed health care such as over-the-counter medicines. A PowerPoint presentation and script outline were used to enhance the session information and to ensure consistency of the programme delivery across sites. Copies of the PowerPoint slides were provided as handouts. Only two of the investigators (JS-G and EN) served as presenters, again to promote consistency of the programme.

Site selection

The Be Wise programme was designed to be provided face to face to older adults in small rural towns (less than 8,000 population). Several potential rural towns in a northwestern state in the USA were identified and local contacts made. Centre directors and the directors of seniors' living facilities, natural social gathering places for older individuals in small towns, were conducted. Two of the team members travelled to visit each potential site to identify the expectations of centre directors and participants. An important part of the discussion was

the willingness of the director to support the programme by hosting the sessions and helping recruit participants. Recruitment strategies included the distribution of flyers around town, an article in the local newspaper and announcements at seniors' centre and seniors' living centre meetings.

Be Wise programme delivery

The Be Wise programme was open to any adult in the community, not just members of the seniors' centre or living centre. While the intent was for participants to attend all four sessions, the reality was that some people dropped in only for a session or two. Thus, the team designed each session to be self-contained with each session covering related, but different, material.

First session

The first session included information on health literacy, an overview of the programme, the responsibilities of participants and completion of the first questionnaire. Those who chose to participate agreed to attend four skill building sessions and complete a series of questionnaires. The session content included an overview of health literacy, its meaning, and importance to health, as well as a brief overview of dietary supplements and natural products. After the programme overview and introductory information had been presented, those interested in participating in the programme completed the first questionnaire that included basic demographics and several scales to assess general and CAM health literacy. A total of 127 participants completed the first questionnaire (see Table 1 Demographics). The same general and CAM health literacy scales were also included in the second and third questionnaire with results reported elsewhere (Shreffler-Grant et al., 2020).

Second session

The focus of the second session was on how to be safe in terms of what an individual needs to know about using dietary supplements, natural products and other self-prescribed over-the-counter health products. While many dietary supplements pose a relatively low risk, the skill-building content included red flags to look out for when considering the use of a supplement or other self-prescribed remedy. Examples of red flags included: overly impressive language making claims that sound too good to be true. Additional red flags were the inclusion of words such as cure-all, totally safe, all natural, scientific breakthrough, or contains a secret ingredient and promises of no-risk money-back guarantees.

Other important considerations when taking a natural product or any over-the-counter medication were the amount (dose), the anticipated effect, possible interaction with other medications and the availability and cost of the product. The importance of talking with one's health care provider about using dietary supplements was included in each session. It was reiterated that the intent was not to discourage or encourage the use of dietary supplements. The programme was designed to help participants be better informed if they choose to use dietary supplements or other over-the-counter medicines or products.

Third session

The focus of the third skill-building session was on how to seek out and evaluate general health information as well as information on natural products and dietary supplements. A variety of sources of information were detailed including family, friends, health care providers, media and the Internet. The content included considering the source and purpose of the publication or person providing information; who the sponsor of the information was; who wrote the information; clues to the accuracy; who reviewed the information; currency (up-to-date) and how to contact the source for further information. A portion of the content was focused on searching for and evaluating information on the Internet. The importance of discussing herbal products with a health care provider or other professional such as a pharmacist was reinforced. In anticipation of the content in the fourth session, participants were given the booklet 'A Guide for Older People: Talking with Your Doctor', a US National Institute on Aging (2016) publication designed to help enhance individuals' ability to work as a team along with nurses, doctors, pharmacists and other health care providers to solve health problems and to maintain health.

Fourth session

The focus of the fourth session was on forming partnerships with health care providers, tracking health information and communicating with health care providers. The importance of active engagement with one's provider and personal health care was emphasised. Tools to facilitate partnerships with the health care provider were also distributed and discussed including the booklet provided during Session 3 and My Health Companion (MHC).

MHC provides a structure for tracking and maintaining health information and enhancing health literacy. Such a health information management tool can facilitate more informed decision-making and foster productive interactions with the health care system (Weinert and Cudney, 2012; Weinert et al., 2010). Participants were asked to use the MHC for the next 5 months and to share their opinion of the usefulness of this health information tracking device on the third questionnaire.

At the conclusion of the fourth session, participants completed the second questionnaire that contained programme evaluation questions and questions related to their anticipation of using the information provided in the Be Wise programme. A total of 67 participants completed the second questionnaire.

Following in-person sessions

After a 5-month interval, the third questionnaire was mailed to those who had completed the second questionnaire. The intent was to assess retention of the skill-building information provided by the Be Wise programme and to gather programme evaluation information from the participants' perspectives. A total of 52 participants returned the completed third questionnaires.

Participant evaluation of the Be Wise programme

In the second questionnaire, completed at the end of the fourth programme session, three 5-point programme evaluation questions were asked. Participants rated their satisfaction with the programme: mean of 4.13 (*SD* = 1.07). On the question 'How useful will the information in the Be Wise programme be in making informed health decisions', the mean was 4.16 (*SD* = .739). They were also asked if they would recommend the programme to others, which generated mean score of 4.41 (*SD* = .894).

Included in the second questionnaire were five less-direct programme evaluation questions about how likely participants were to use the skill-building information provided in the programme. The questions were phrased as to how likely they were to use the information on: health literacy for decisions about their own health (mean 4.09, *SD* = .803); seeking/evaluating health information (mean 4.04, *SD* = .729); information on safe use of natural products (mean 4.04, *SD* = .903); and communicating with their health care provider (mean 4.58, *SD* = .543). The question on the likelihood of using the Internet to access health information received the lowest mean score (3.35, *SD* = .153; see Table 2).

In the third questionnaire, the same five questions were asked to assess actual use of the information on: health literacy for decisions about health (mean 2.96, *SD* =1.27); seeking/evaluating health information (mean 3.24, *SD* = 1.25); the safe use of natural products (mean 3.18, *SD* = 1.25) and communicating with health care providers (mean 3.29, *SD* = 1.44). The question on the use of the Internet to access health information again received the lowest score (mean 2.79, *SD* = 1.49). Based on a paired *t*-test, all the scores were statistically significantly lower in the third questionnaire than in the second. (see Table 2)

Included in the third questionnaire was an overall evaluation question 'How useful was participating in the Be Wise programme to managing your health?' (mean 3.55, *SD* = 1.06). Additional evaluation questions were included to assess the perceived impact of participating in the Be Wise programme. As seen in Table 3, all the 5-point questions had a mean score of 3 except for the question regarding the use of the computer to seek health information, which had a mean score of 2.79 and *SD* = 1.49. (see Table 3)

The use of MHC was also evaluated in the third questionnaire, which included six questions with 6-point response options. Those who used MHC indicated they would strongly recommend it to others (5.13, *SD* = 1.09). The MHC was rated most useful in better preparing for visits to health care providers (4.20, *SD* = 1.13) and helping to better organise/track personal health information (4.47, *SD* = 1.20; see Table 4).

Discussion

Delivering a programme such as Be Wise to older rural residents posed some challenges and the need for careful planning. Financial and other time constraints dictated that the programme be delivered at two sites on two consecutive days on each trip. Thus, the towns needed to be geographically close to each other. For example, one combination was a site in a town with a population of 4,134 that was 138 miles from the second site, which was a town with a population of 4,594. This was an ideal combination for delivery of the

programme over two days although the most direct route between the two towns involved crossing a very high mountain pass. At times, snow covered the ground and icy roads made this a long slow white-knuckle drive.

Another consideration was the time of year to present the programmes. Favourable seasons for driving such as the summer months were not ideal for participants as this is a time for visitors and for travel, as well as a very busy farming/ranch season. Avoiding the holidays was also a consideration and thus the only 7-week stretch of time to present the programme was February/March and September/October. Despite some inclement weather, the team was successful in safely delivering the programme without cancelling or changing the schedule at any site. To deliver the programme, and to involve a sufficient number of participants, required over 9,200 miles on the road.

Participants provided data on questionnaires at the beginning of the programme, at the end of the fourth session and 5 months after the fourth session. There were 127 useable first questionnaires, 67 second questionnaires and 52 third questionnaires. While the intent had been to have 80 useable questionnaires by the third and final questionnaire, the attrition rate was higher than expected. However, by adding additional sites for the presentation of the programme, an adequate number of participants was recruited in order to provide meaningful results. Retention of participants was a challenge during project implementation. As noted above, quite a few more ($N = 127$) participated in the initial session than at the fourth session ($n = 67$), and 5 months later when the third questionnaire was sent, 52 people participated. The demographic characteristics of those who were retained were not significantly different than those who were not. No consistent causes of attrition were identified, although inclement weather, doctors' appointments, illness, local funerals, the arrival of unexpected guests and so on accounted for at least some of the attrition.

In the second questionnaire three questions were worded to directly ascertain participants' satisfaction with the programme (4.13, $SD = 1.07$), the usefulness of the information provided (4.16, $SD = .739$) and whether they would recommend the programme to others (4.41, $SD = .894$). The high mean scores indicated overall satisfaction with the Be Wise programme. Questions were also included to assess their likelihood of using the information provided in the programme. The scores on four of the five questions were most favourable (mean of 4.04–4.58 on 5-point questions) and provided a clear demonstration of the usefulness of the skill-building information provided in the programme sessions. The scores for the fifth question on using the Internet to access health information was not as high (mean of 3.35 on 5-point questions). Although most participants had access to a computer with Internet connections at the seniors' centre, seniors' living centre and/or at home, some participants indicated that they did not use computers at all. Even though a portion of the third programme session described the use of the Internet to access health information, the participants who did not use computers were not intending to use it as a source of health information.

To gain an idea as to the actual use of the skill-building information, the questions in the second questionnaire involving willingness to use were re-worded as 'How much have you used' in the third questionnaire. All scores were statistically significantly lower on the third

questionnaire indicating that, while the participants anticipated using the programme information, they did not actually do so over the intervening 5-month period. In one sense, this was disappointing but given that all but one of the mean scores in the third questionnaire were at or above 3, this indicates that patici-pants used the information to a modest degree. Again, the scores on the question regarding the use of the computer to access health information were low (mean score of 2.80) and not a surprise.

In the third questionnaire, eight questions were included to assess the overall usefulness and impact of participating in the Be Wise programme. The mean scores were all favourable (mean scores of 3.09–3.55) except again for the use of the computer to access health information (mean score of 2.80).

The use of MHC was also evaluated in the third questionnaire. Unfortunately, there was not a high use of the MHC but as can be seen in Table 4, those participants who did use it indicated that they would strongly recommend it to others. It was rated most useful in better preparing for visits to their health care provider and helping to better organise/track their personal health information.

Written comments on the questionnaires were transcribed and majority of them were very favourable. A few examples are: ‘very informative and applicable programme’; ‘a very good and informative programme’; ‘would highly recommend it’; ‘I was pleased with the way it was presented and was able to ask questions’; ‘get the word out to more people’, ‘programme gave me more confidence in making wise choices’.

Conclusion

While the quantitative evaluation scores for the Be Wise programme provided useful information, they do not fully capture the usefulness and impact of the programme. Without more detailed long-term exploration, it is not possible to know how exposure to the skill-building content might play a critical factor in participants’ actual health care decisions. A longer time for the use of MHC may demonstrate more clearly its usefulness in helping to take a more active role in health care decisions.

Prior to developing the Be Wise programme, a pilot study of parts of the programme had been conducted. This helped with the development of the session content and affected the logistics of delivery. One factor that was clear from the pilot and the investigators’ years of rural health research experience was that face-to-face interaction is critical. With this, however, came the challenges of getting financial support to recruit an adequate number of participants from sparsely populated areas, retaining older individuals in the project, having adequate financial resources for transport to present the programme and dealing with seasonal scheduling issues. Perhaps providing the programme on a weekly basis rather than every other week would have helped with retention. The other work demands of those who conducted the programme, however, precluded travelling 4 weeks in a row. A weekly more compressed schedule would also not allow time for the participants to reflect on the content.

Overall, Be Wise programme content and take-home materials were favourably evaluated and this skill-building intervention resulted in enhanced CAM and general health literacy

among older rural adults (Shreffler-Grant et al., 2020). With these outcomes, it can be concluded that participating in the Be Wise project provided important skills for making more informed health care choices and thus enhanced engagement in the participants' personal health and health care.

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Table 1.

Demographic characteristics of participants.

Variable	1st questionnaire, *N* = 127	2nd questionnaire, *N* = 67	3rd questionnaire, *N* = 52
	Frequency (%)	**Frequency (%)**	**Frequency (%)**
Gender	Men = 36 (28.3)	Men = 15 (22.4)	Men = 11 (21.2)
	Women = 91 (71.7)	Women = 52 (77.6)	Women = 41 (78.8)
Age	Mean 76.15 *SD* = 10.66	Mean 76.52 *SD* = 0.41	Mean 76.98 *SD* = 9.73
	Mode 79	Mode 78	Mode 81
Education	High school/less = 43 (36.8)	High school/less = 25 (39.1)	High school/less = 17 (34.7)
	Assoc/Bach = 54 (46.2)	Assoc/Bach = 32 (50.0)	Assoc/Bach = 25 (51)
	Post Bachelors = 20 (17.1)	Post Bachelors = 7 (10.9)	Post Bachelors = 7 (l4.3)
Marital	Not coupled = 79 (67.5)	Not coupled = 46 (71.9)	Not coupled = 36 (73.5)
	Coupled = 38 (32.5)	Coupled = 18 (28.l)	Coupled = 13 (26.5)
Race	White = 115 (97.5)	White = 63 (98.4)	White = 48 (98.0)
	American Indian = 3 (2.5)	American Indian = 1 (1.6)	American Indian = 1 (2.0)

Table 2.

Be Wise programme evaluation based on responses to the second and third questionnaires.

Question	Range	2nd questionnaire Mean (*SD*)	3rd questionnaire Mean (*SD*)
How likely to use information provided on health literacy?	1 Not at all likely	4.09 (.803)	2.96 (1.27)
	5 Extremely likely	*N* = 47	N 47
How likely to use skill building on seeking/ evaluating health information?	1 Not at all likely	4.04 (.729)	3.24 (1.25)
	5 Extremely likely	*N* = 46	*N* = 46
How likely to use internet to access health information?	1 Not at all likely	3.35 (153)	2.79 (1.49)
	5 Extremely likely	*N* = 43	*N* = 43
How likely to use information about safe use?	1 Not at all likely	4.04 (.903)	3.18 (1.25)
	5 Extremely likely	*N* = 45	*N* = 45
How likely to use information on communicating with health care provider?	1 Not at all likely	4.58 (.543)	3.29 (1.44)
	5 Extremely likely	*N* = 45	*N* = 45

Included those who completed both the second and third questionnaires.

Table 3.

Impact of the Be Wise programme – responses to the third questionnaire.

Question	Range	Mean (*SD*)
How useful was the Be Wise programme in managing your health?	1 Not useful	3.55 (1.06)
	5 Extremely useful	*N* = 40
How much impact did the Be Wise programme have on:	1 Very little impact	3.37 (1.11)
Ability to interact with health care providers	5 Great deal of impact	*N* = 49
How much impact did the Be Wise programme have on:	1 Very little impact	3.26 (1.11)
Better manage your health?	5 Great deal of impact	*N* = 47
How much impact did the Be Wise programme have on:	1 Very little impact	2.80 (1.47)
Use computer to seek health information	5 Great deal of impact	*N* = 46
How much impact did the Be Wise programme have on:	1 Very little impact	3.31 (1.19)
Understand safe use of natural products	5 Great deal of impact	*N* = 48
How much impact did the Be Wise programme have on:	1 Very little impact	3.42 (1.33)
Seek health information from a variety of sources	5 Great deal of impact	*N* = 48
How much impact did the Be Wise programme have on:	1 Very little impact	3.51 (1.27)
Know what questions to ask health care providers	5 Great deal of impact	*N* = 47
How much impact did the Be Wise programme have on:	1 Very little impact	3.09 (1.47)
Evaluate health information	5 Great deal of impact	*N* = 47

Table 4.

Evaluation of My Health Companion – responses on third questionnaire.

Question	Range	Mean (*SD*)
How much did you use My Health Companion"?	1 Never used it at all	2.93 (1.47)
	6 Used it a lot	*N* = 45
Would you recommend the My Health Companion" to others?	1 Would not recommend	5.13 (1.09)
	6 Would highly recommend	*N* = 31
How useful was My Health Companion in:	1 Not at all useful	3.71 (1.05)
Helping to better manage your health?	6 Extremely useful	*N* = 28
How useful was My Health Companion in:	1 Not at all useful	4.20 (1.13)
Better prepare for visits to your health care provider?	6 Extremely useful	*N* = 30
How useful was My Health Companion in:	1 Not at all useful	3.97 (1.27)
Strengthening your partnership with your health care provider?	6 Extremely useful	*N* = 30
How useful was My Health Companion in:	1 Not at all useful	4.47 (1.20)
Helping to better organise/track your personal health information?	6 Extremely useful	*N* = 30

Only including those who reported having used My Health Companion.