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1. What is your vision for the field of health literacy?

AI has been expanding its use into the healthcare field and projected to take over many roles. While this might be helpful in many Large Language Models, healthcare and AI systems should continue to remain human-centered and have checkpoints for quality, accuracy, and human discernment.

There is also high interest in navigating AI use in multilingual translations at an affordable rate while maintaining the reliability of the medical translations. While many healthcare agencies and organizations are facing massive budget cuts and reduction of DEI priorities, some organizations will slip on using proper medical translation channels. This gives room fosr solutions moving forward – which should still include the human checkpoint to double check the work, while using AI to reduce cost for full document translations from scratch.

Academic programs have seen reduction in student enrollment due to various factors, but the education of public health, pre-health care, paraprofessionals, and healthcare professions should still include Health Literacy principles. Concepts such as Plain-Language, Person-First Language, and catering content to target demographics (of various ages, abilities, etc.) should be included when drafting content for patients and the public. This will help maintain the professional skills needed for human-centered work.

Advocacy and policies will need to reinforce that healthcare and Health Literacy remain human-centered where AI is a supportive tool and not a replacement for needed quality, safety, and compassionate perspectives brought in by human personnel. An example of this in my work has been proposing a letter to the patient at the beginning of tough topic documents to soften the information provided while showing compassion and support to the patient.

2. What are your greatest concerns for the field?

Not just in Health Literacy or healthcare, but in large in all industries, AI programs can be used to advance the field, reduce employee staffing costs, but will need specialized staff in both their respective specialties with AI knowledge to act as key checkpoint personnel in workflows. This will present barriers for new graduates and seasoned professionals in obtaining secure employment without both skills and experience. Additional barriers would probably be in policies in all Socioecological Model levels to support maintaining human-centered checkpoint requirements in workflows.

I also recognize that newly graduated professionals are struggling to get their foot in the door of healthcare or related public health jobs [1, 2, 3]. This is in part due to the economy after the Pandemic, and the fast-moving AI developments, but not all hope is lost. There are several ways to boost portfolios and change perspective on options of one's career paths. Some examples and discussions I have had with students and hiring committee members include actual work experience in any field to show work ethic and workforce experience,

any experience in healthcare or target industry would be nice to have but if not, seeking volunteer experiences, certifications (some are free online), AI skill development as it related to their field of interest, and any entry level job to get a foot in the door. I have also recommended students with employment to consider staying in the company and trying to move into management, HR, employee health, employee environmental health/safety, and other opportunities within their current employer.

3. Which historical or contemporary figure do you believe best represents the principles of health literacy?

Professor Temple Grandin is a contemporary figure that has shaped my perspectives on individualized therapeutic interventions, multimodal learning methods, and catered patient education content development to target learners. Professor Grandin started her life as a child with mutism diagnosed non-verbal with brain-damage (era 1940's). Over time, with her mother's persistence (along with other key people in her life) encouraging various learning methods to help Temple learn, she eventually surpassed the limitations put on her by society. She went on to not only complete high school, but excel in university in the agricultural sciences earning her M.S. in Animal Sciences at Arizona State University and Ph.D. in Animal Sciences at University of Illinois. She is now a renowned global speaker and a faculty professor at Colorado State University for over 30 years. Her achievements and story have made broad impacts on the world of Autism and to families of children with learning difficulties.

Due to my professional start in special education, it has set my foundation for Health Literacy by working closely with children, adults, and families of people with varied learning needs. I am hopeful that human-centered, compassionate and thoughtful design of patient educational content can truly impact the workflow and end users' health outcomes. Strategic design will provide patients with education, resources, and skills for self-advocacy.

4. What is the most misunderstood aspect of health literacy?

Making content within Health Literacy standards is not "dumbing down" content. Content should be easy to understand the first time read, with complementary images, diagrams, tables, and related features for reading ease for patients of broad backgrounds and comprehension abilities. Writing in Plain Language using Person-First Language has not been readily taught in foundational level course work in many health-related majors (and departments/fields like Marketing or Business within healthcare) which has caused dissociation of the importance of Health Literacy in content workflow. Additionally, I have witnessed a prominent disconnect from staff that may have come with high language levels through their upbringing, high academic achievement, or personal bias causing conflict when editing documents to meet patient Health Literacy needs.

Departments and roles that are not clinical may have higher disconnect and lack of sufficient Health Literacy training. This can cause issues in workflows, communications, perspective, proper terminology, and publication errors. It would be strategic to offer annual continued learning courses on basics of Health Literacy concepts for all staff as this would improve the workforce knowledge and in turn the communication skills needed in a healthcare setting.

It has also been common to see clinical staff claiming certain terminology within their specialty and the patient's treatment protocols are terms that patients should already know. This is not always true, and all medical terms should be introduced with a simple version of what that term means, then using the simple term throughout communication to make comprehension easier for patients and their families/caregivers.

Proper use of Person-First Language is not readily taught in academics, and not always readily upheld from staff to staff, or even supervisor to staff. Person-First Language knowledge gap is when staff use language such as "diabetic patient" instead of "patient with diabetes" or "autistic person" instead of "patient with autism". These are disrespectful ways to speak or write about patients which could also leave room for legal issues or even lawsuits. This concept should also be included in the proposed annual staff training modules.

An example of provider disconnect was when a former ICU nurse rejected a proposed project due to their personal bias claiming the project was not needed for patients. The bias comes in several layers in this scenario because most ICU patients will not be discharged directly from ICU but will be sent to a step-down unit and so forth before discharge education and resources will be provided to patients and their families/caregivers. An added bias layer could also come from their high-income level influencing their disconnect of the average patient population needs with the current economic hardships many households face. The clinician also claimed that patients should have access to smart devices and how to use them, yet data from Electronic Medical Records department did not reflect this claim. This caused a hard pause in the project for over two years before being able to restart with new staff supporters ("champions") to push the project forward. The new project supporters come from out-patient background and treatment support program that understands the need of the product to support patient's comorbid conditions or complex cases. This product will be addressing their appointments, health information, health education, resources, programs, and more – in turn supporting Health Literacy and advocacy for patients.

5. What is your favorite tool or resource to improve health literacy?

My favorite tools to support Health Literacy are infographics, and use of supportive images, diagrams, tables or charts that make tough topics or lengthy information easier to digest and comprehend. It would be useful to have templates made in collaboration with Patient Education and Marketing to meet Health Literacy workflows and organizational brand kit guidelines. This would also improve productivity long-term to have templates ready to edit for quicker production and approval when departments have juggling priorities.

6. Where would you most like to see health literacy make an impact?

Policies in all levels of Socioecological Model should be addressed, but at the least the healthcare sector that serve diverse populations, rural communities, and school system. It is well known that policies from federal, state, local, and organizational levels had broad impact on community members and patient health outcomes, but a large foundation of Health Literacy is missed due to a stressed education system that has been cutting health education over the past decades. Not only have general literacy rates been falling since the Pandemic, but has continued to struggle Post-Pandemic [4, 5, 6]. Some contributions toward reduced literacy rates within the academic system may be from lack of health education not being a core subject, decreased monetary allowance for health education, aside from reduce staffing limitations [7, 8, 9].

A mindful and strategic effort to reintegrate health education should be at every academic level in conjunction to general literacy skill development. Including health education into the general sciences for preschoolers through adolescence, high school, and required college courses would in turn increase health literacy, understanding of controllable lifestyle behaviors, and hopefully instill healthy preventative practices by individuals throughout their lifetime [10, 11, 12, 13, 14, 15, 16]. Although there are certain environmental factors, current social norms, and family influences that may not be able to effectively change, the strategic design will hopefully be engrained into the intrapersonal level presenting in forming a stronger front lobe and hippocampus for controlled executive function [17, 18, 19].

7. How do you handle setbacks or resistance in health literacy initiatives?

Getting supporters, or "champions" in key roles such as administrators, managers, physicians, and clinicians onboard with your initiative can bring respect and authority to the project. This does require a foundation of interpersonal rapport, organizational networking, and strategic planning of the project. When faced with rejection, take a step back to assess the presentation of the project scope, communications about the project, and revise the project to re-propose the project at a later time. After trial and error, it has been helpful to take time to build the reasoning, framework, and milestones where you account for workload and cost during budget limitations such as now. This thoughtful consideration will be more appealing to key parties you are recruiting as organizations and healthcare systems are pressured to continue performing under these tight budget constraints.

Despite administrative changes, funding limitations, high workloads, both for young professionals to seasoned professionals, keeping eyes on the prize, focus in on purpose or "why" can aid you in your relentless efforts. There is also a component of self-grace when we cannot push the needle by yourself, and you may need to look at acknowledging small wins for your patients and community. Creative low-cost solutions using community partnerships, interdepartmental collaboration, and being flexible is necessary to overcome ebbs and flows of the economic and uncontrollable pressures. Finding a supportive community, peers, or mentors can ease the day-to-day stressors in the field while managing emotions in other areas of life. If you are deeply passionate about your initiative and cannot implement at your site, look into proposing your plan with outside organizations such as non-profit groups, community centers, and private businesses so long as you are mindful to avoid conflicts of interest or employee contract restrictions.

8. How do you define success in health literacy?

There are a few ways I have seen success in Health Literacy when patients take advantage of health programs provided, use the knowledge and skills they developed when participating in the available programs to manage their health and treatment. I especially enjoy when I am able to see the product being used in the clinical setting where user feedback has been more than positive, eliciting feelings of encouragement, hope, and confidence to make informed health decisions.

9. What innovation—whether technological, policy-related, or educational—do you believe holds the most promise for improving health literacy?

Innovation in technology is fast moving and can have great use in expediting workflow, translations, and game-based education. Policies should include a human-centered design where human personnel are required in the workflow, specialists should be required in various stages of product development to ensure content accuracy and human touch, as well as safe-guarding key roles that should be designated for human personnel where technology should remain used as tools to aid work. Technology education should become basic course work in healthcare related majors to keep up with the progress of AI in the world platform.

10. If you could shape the future of health literacy, what is one transformative change you would implement?

To achieve deep, transformative change in the future of Health Literacy, we need both initiatives and policy implementation that establish Health Literacy as a standard—through academic and organizational systems. This involves:

- Foundational training in general literacy.
- Reintegrating health sciences and physical education into core curricula from preschool through post-graduate programs.
- And implementing standardized, annual continuing education on key principles, basic health knowledge, and common medical terminology within organizational structures—especially in healthcare industries.

These efforts could elevate entire generations and empower staff with the confidence to apply Health Literacy in how they speak, teach, treat, respond, and function in their role and while working with patients.

Other Resources:

Multimodal Learning:

- Health Literacy and Multimodal Adapted Communication
- Using Health Literacy and Learning Style Preferences to Optimize the Delivery of Health Information
- Interventions to Improve Care for Patients with Limited Health Literacy

Bias in AI:

- A Comprehensive Review of Bias in AI Algorithms
- Notes from the AI frontier: Tackling bias in AI (and in humans)
- AI pitfalls and what not to do: mitigating bias in AI
- Discrimination, Bias, Fairness, and Trustworthy AI

Systems & Organizational Approaches:

- Literacy and Health Outcomes
- Healthy People 2030 Language and Literacy
- Improving Health by Improving Health Literacy
- Health Literacy, Social Determinants of Health, and Disease Prevention and Control
- Impact of low health literacy on patients' health outcomes: a multicenter cohort study
- CDC National Action Plan to Improve Health Literacy
- Development of the Systems Thinking for Health Actions framework: a literature review and a case study
- Systems thinking can help health leaders standardize clinical information for teams

- A systems approach to healthcare: from thinking to practice
- Systems Thinking for Public Health: A Case Study Using U.S. Public Education
- Unlocking the Power of Systems Thinking and Organizational Learning
- UO - Thinking in Systems: Improving Organizational Effectiveness and Culture
- Using systems thinking methodologies to address health care complexities and evidence implementation
- MGMA - Excellent healthcare leadership requires systems thinking
- Systems thinking in, and for, public health: a call for a broader path

Navigating Employment:

- Indeed - Why Hiring for Adaptability Matters (And Three Ways To Identify It)
- 5 Skills to help you build a resilient career in times of economic uncertainty
- LinkedIn - Recession-Proof Hiring: Strategies for Attracting Top Talent in Economic Downturns
- 25 Essential Business Acumen Interview Questions You Should Know
- 10 Crucial Strategies for Job Searching in a (Looming) Recession
- Why Candidates with Business Acumen Make Better Employees
- Top 60 Behavioral Interview Questions to Ask Job Candidates
- Interviewing for Resilience: Techniques to Assess Adaptability
- Hiring During a Recession: Why It's More Difficult Than You Expected
- The Impact of Economic Shifts on Hiring and Job Searching
- Forbes - How To Stand Out In An Oversaturated Market In 2025