Beginning Early: Reflective Practice Development in a Pre-health Course on Health Literacy and Health Disparities

Jody L. Lounsbery, PharmD, BCPS; Anna Milone, PharmD, BCPS; Claire Fenimore, BA; Amy L. Pittenger, PharmD, MS, PhD
University of Minnesota College of Pharmacy

Abstract

Background: Learning reflective practices and understanding the complexity of health literacy and health disparities need to start early in health professions training. The primary objective of this inquiry was to evaluate the feasibility and effectiveness of using reflection categorization for assessing learner progression on reflective practice development. The secondary objective was to evaluate student reflection as a strategy for introducing and advancing pre-professional learners' understanding of health literacy and health disparities.

Case Description: Within an online undergraduate health literacy course, two written reflection assignments were coded using Kember's four categories: habitual action, understanding, reflection, and critical reflection. Students received feedback based on this reflection categorization to promote development of reflective practices. However, reflections were not graded using the reflection categorization.

Case Themes: Most (78%) students were at the level of understanding for the first reflection. For the second reflection, 29% of students were at the reflection level, demonstrating health literacy application and describing the important contributing role of personal context to health outcomes. Sixteen (33%) students progressed in their level of reflection. Within the reflections, students discussed knowledge gained and plans for future application.

Conclusion: Using a structured reflection activity allowed pre-health students to begin developing reflection practices. Through reflection, students were able to describe and apply health literacy and health disparities knowledge.

Keywords: reflection, health literacy, health disparities, pre-health students, online learning

Background

Health literacy is a phrase and concept that is incorporated into health professional programs and clinical settings. Communication with patients, families, and caregivers is central to achieving clinical outcomes. However, health literacy is more than simply understanding definitions of medical terminology; it is the ability to use information to make well-informed decisions.[1] Furthermore, organizations have a responsibility to address health literacy equitably,[1] which requires addressing health disparities and acknowledging the influence social, physical, and economic environments have on interpretation of information and decision making.[2] There is no shortage of examples of miscommunication within the healthcare setting leading to tragic outcomes,[3] but the extensive and broad health disparities within our healthcare system, and the complex reasons for them, have recently received greater focus.

Health professional education programs know that health literacy and health disparities are critical areas of care that must be addressed, but how to most effectively address and evaluate the success of the approach or approaches is undetermined.

Corresponding author: Jody L. Lounsbery, PharmD, BCPS
Associate Professor
University of Minnesota College of Pharmacy
7-174 Weaver Densford Hall
308 Harvard St SE, Minneapolis, MN 55455
Phone: 612-301-1490; Email: loun0015@umn.edu

Challenges, such as packed curricula and lack of established approaches and assessment strategies, are stated as reasons for the lack of progress on this common goal across the health professions education programs.[4] Addressing topics as systemic and complex as health literacy and health disparities will require the use and evaluation of multifaceted and longitudinal approaches, including pre-professional education. Teaching topics such as health literacy and health disparities should focus on application[5] and start early, in undergraduate studies rather than solely in health professional curricula.[6] As a result, a health literacy course for undergraduates was designed for the purpose of preparing future health professionals to be reflective practitioners, who are knowledgeable and empowered to address health disparities.

In 2018, a 15-week asynchronous online undergraduate course was designed to focus on health literacy and its implications for patients, healthcare providers, and the healthcare system at large. The course involves 10 weeks of instructor-facilitated small group discussions with course topics including defining and measuring health literacy, disparities in healthcare, cultural competency, communication strategies, strategies to improve health literacy for individuals and at the system level, and navigating health insurance. Students are divided into small groups of six to nine students and an instructor, and begin the semester with video introductions. For each discussion week, instructors introduce the week's topic with a short, recorded presentation and/or applicable newspaper or journal article. Students are provided an initial discussion prompt for the week, available to them the Thursday before the week begins.

Students are expected to respond (with 200 words minimum and include a source) to the initial prompt by Monday at midnight. On Tuesday, the instructor posts a detailed response to each group, making sure to highlight contributions by each student and amplify student insights, specifically mentioning each student by name. Instructor responses end with the next questions or activities for the group to engage with for the week. By Wednesday at midnight, students are expected to respond to the Tuesday prompt with another post of at least 200 words with a source. To encourage dialogue among group members, students are also asked to post questions to at least two different group members. By Friday, students are expected to answer any question(s) asked of them by their group members. See Appendix A for an example of a week's discussion prompts. To encourage the creation of safe and productive spaces, students remain in the same groups all semester. In tandem with the outward-focused writing in the discussions, students also engage in reflective writing at specific points during the semester. Students begin the course by writing personal learning objectives, to aid in applying course content in a personally meaningful way. Creating personal learning objectives is a critical component of the course and has been shown to foster learner engagement and enrich the student learning experience.[7] In addition, there are two reflection assignments that provide students with space to revisit their objectives and consider their own reactions to the content. Reflection also provides the space for students to consider their own role in addressing health disparities and the ways their current life experiences offer opportunities to intervene. The two course instructors are experienced in online education and practice in underserved populations.

Guided reflection is a key activity for confronting and processing potentially uncomfortable and dissonant ideas regarding sources of health disparities.[8] Developing intentional habits of reflection are essential for becoming a reflective practitioner[9] and an understanding of health literacy and health disparities needs to begin before entry into a health professional program. The course was designed to draw on established theoretical frameworks of reflective practice and critical consciousness.[9,10,11]

The primary objective of this inquiry was to evaluate the feasibility and effectiveness of using reflection categorization for assessing learner progression on reflective practice development. The secondary objective was to evaluate student reflection as a strategy for introducing and advancing pre-professional learners' understanding of health literacy and health disparities.

Case Description

Fall 2020 was the fifth offering of the course, with each offering having successful outcomes of students demonstrating understanding of health literacy and health disparities topics. To further emphasize reflective practice, we explored the use of reflective categorization to help students construct their own understanding of health literacy and the impact of health disparities. For the Fall 2020 semester, the reflection activity (Reflection 1 and Reflection 2) was revised to incorporate the use of four reflection categories described by Kember et al.: habitual action, understanding, reflection, and critical reflection.[12] (Table 1) The reflection categorization was used to provide a clear definition of the reflection categories and a progression roadmap for learners. This, combined with the personal learning objectives each student created at the beginning of the course, fostered a sense of personal responsibility and agency.

Table 1. Reflection Categorization by Kember et al.[12]

Reflection category	Definitions
Habitual action	• The answer shows no evidence of the student attempting to reach an understanding of the concept or theory which underpins the topic. • Material has been placed into an essay without the student thinking seriously about it, trying to interpret the material, or forming a view. • Largely reproduction, with or without adaptation, of the work of others.
Understanding	• Evidence of understanding of a concept or topic. • Material is confined to theory. • Reliance upon what was in the textbook or the lecture notes. • Theory is not related to personal experiences, real-life applications or practical situations.
Reflection	• Theory is applied to practical situations. • Situations encountered in practice will be considered and successfully discussed in relationship to what has been taught. There will be personal insights which go beyond book theory.
Critical reflection	• Evidence of a change in perspective over a fundamental belief of the understanding of a key concept or phenomenon. • Critical reflection is unlikely to occur frequently.

Reflection is a commonly used educational strategy, but a clear purpose for the assignment and timely and personalized instructor feedback is not always employed, leaving students to potentially misunderstand the intended outcome and minimize the importance of the activity. To address this issue, the reflection categorization was explained to students at the beginning of the course to emphasize the importance of the activity and to make explicit the learning roadmap beyond this particular course. Students were provided the definitions of the four categories in the assignment directions. The reflection categorization also served as an intentional way to support learners as they were confronted with potentially distressing topics, providing students with a structure for processing and also receiving feedback. Students were asked to not only gain understanding of health literacy principles and be exposed to health disparities data, but also attempt to examine health disparities through their own lived experience and identities.[10,11]

To emphasize the goal of examining health disparities through their own lived experience, both Reflection 1 and Reflection 2 directed students to consider their progress on the personal learning objectives they created at the beginning of the course. Reflections were required to be one to two pages in length, double spaced. Reflection 1 was due in week nine of the course and Reflection was due in week 15. The reflection assignments were designed as a measure of both expanded understanding of health literacy and health disparities and personal sense of empowerment to make a difference (See Appendix B for reflection directions and prompts). The reflection categorization (Table 1) was used to provide feedback to students to promote the growth and development of reflective practices. A rubric was used for grading, and assessed structure, mechanics, if questions posed were thoughtfully answered, and if specific examples were provided. When grading the assignments, instructors provided written comments, including the level of reflection. However, students' reflection grades were not based on their level of reflection as described in the assignment directions (Appendix B).

For the inquiry, four investigators independently reviewed both reflections and coded each submitted reflection into one of the four reflection categories. The whole reflection was reviewed to determine the reflection category. The category of reflection and any comments justifying the selected category were recorded into a spreadsheet. Then the investigators met to discuss any discrepancies and came to a consensus on how each reflection should be coded. Any reflections with discrepancies in coding were reviewed and discussed as a group until the group reached consensus. The number of reflections within each category for each reflection assignment and the number of students who moved categories between the two reflections were analyzed using descriptive statistics. Comments from student reflections on their development were categorized by two instructors. At the same time, a summary of the types of reported insights gained on health disparities and health literacy was developed. The project was determined to be not human research by the Institutional Review Board at the University of Minnesota.

Case Analysis
For the Fall 2020 offering, 54 students enrolled in the course and 52 completed it. Fifty-one (98%) students passed the course and one student received an incomplete. The majority of students were seniors (63%) in sciences/health-related majors (63%). In course introductions, 33 (63%) students stated that they intended to pursue a health-related career. Examples of those intended careers included genetic counselor, pharmacist, physician, physician assistant, nurse, nurse practitioner, health services manager, and health coach.

The reflection categories coded for each reflection are shown in Table 2. Most (78%) students were at the level of understanding for Reflection 1. For Reflection 2, 29% of students were in the reflection level compared to 10% for Reflection 1. The majority (60%) of students remained at the same level of reflection for both assignments (Table 3). Sixteen (33%) students progressed in their level of reflection, including one student who moved from habitual action to reflection over the course. In the reflections, students discussed the following topics: difficult topics in a safe learning space, knowledge gained, plans for future application, and the reflective categories (Table 4).

Table 2. Reflection Levels for Reflection 1 (n=49) and Reflection 2 (n=51)[a]

Reflection level	Reflection 1 n (%)	Reflection 2 n (%)
Habitual action	6 (12)	3 (6)
Understanding	38 (78)	33 (65)
Reflection	5 (10)	15 (29)

[a]Three students did not submit an assignment for Reflection 1 and one student did not submit an assignment for Reflection 2.

Table 3. Student Reflection Levels from Reflection 1 to Reflection 2 (n=48)[a]

Comparison of reflection level	n (%)
Same level	29 (60)
Habitual action to habitual action	1
Understanding to understanding	25
Reflection to reflection	3
Progression in level	16 (33)
Habitual action to understanding	4
Habitual action to reflection[b]	1
Understanding to reflection	11
Regression in level	3 (6)
Understanding to habitual action	1
Reflection to understanding	2

[a]Four students did not have submissions for one of the assignments.
[b]One student moved two levels.

Table 4. Categories of Comments from Student Reflections with Example Quotes

Category	Example Quotes
Difficult topics in a safe learning space	"…We all ask each other thoughtful questions. Group members have asked me questions that were difficult to answer - in a good way. They have really challenged me to think deeper and find solutions to issues I present." "I think myself and my group mates have created a space where we can openly discuss difficult or heavy topics without judgement. This has allowed me to learn and grow as a person more than in previous classes where I would often write things that I knew the professor wanted to hear."
Knowledge gained	"My viewpoint on illness and social economic [sic] status has changed from a not [sic] understanding how people could choose to not have health insurance to being empathetic towards people who have to make this tough decision." "My health literacy grew in the sense that I started understanding where to look for information and the best resources to use. This simple skill I have gained in this class will help me in the long run."
Plans for future application	"Once this course has ended, I can take this experience and apply it into my future career of being a physician assistant. Culture was a big aspect throughout this course, and I think being aware of patient's [sic] culture can help to better provide them care." "Looking back on the second half of the course, I would say this experience has changed me and helped me see how I can address health literacy in my career. This experience will allow me to keep health literacy and communication strategies at the forefront of my mind as I enter graduate school for my clinical work...With the feedback I received, I was able to see more clearly how learning about health literacy could be applied to my volunteering work." "I have made a bigger attempt to learn more about their culture and incorporate that in their day to day lives (celebrating their cultural holidays in addition to American holidays)."
Reflective categories	"My last reflection was put into the 'Understanding' category, and I agreed with that assessment. I tried to use more specific examples in this reflection, and apply things I have learned to more realistic situations that may occur in the future for me." "When looking back at my previous reflection… I believe I was struggling trying to find real life applications… So, I was certainly surprised that I was able to apply my knowledge about strong communication with your doctor to a real experience. Even though it wasn't my direct experience, I am very happy that I was able to help my families [sic] understanding of healthcare visits and encourage them to be willing to communicate."

Instructor Summary of Student Insights from Reflection Assignments

In both reflections, many students discussed how they now recognize their own privilege in healthcare settings and will bring this awareness with them into their future careers. Students also discussed feeling more informed about systemic racism and disparities in the healthcare system. Some students discussed learning about their own implicit bias and plans they have for continued learning and growth. Multiple students described the importance of action from both individual healthcare providers and the healthcare system to address gaps in health literacy and to reduce health disparities. Students proposed strategies they will use to improve patient and community-wide health literacy in their future health careers. Interestingly, many students also discussed how this will change their personal behavior as a patient, such as asking more questions, clarifying information when they feel confused, and using reliable sources of health information.

Students also reported the value of hearing multiple viewpoints from their group members during discussions, which fostered diverse voices when considering complex course topics such as implicit bias and health disparities. Students discussed feedback from their peers and instructors and expressed appreciation for being asked difficult questions by group members.

Exploration of Case Impact

In this undergraduate, asynchronous online course of primarily pre-health profession learners, the combination of reflection practices and new health literacy and health disparities knowledge increased awareness of the health professional's role in addressing health disparities and the possibility to influence change through culturally-informed practice (Table 4). By the end of the course, 29% of students demonstrated skills at the level of reflection in Kember's reflection categories (Table 2), meaning they were able to apply what they learned, as well as share personal context to health literacy and health disparities.

Giving structure and explicit definition to the reflection assignments may have provided learners with an enhanced sense of purpose to the activity. Reflection as an educational activity is commonly used, but not consistently implemented or guided. There is suggestion that assessing reflection corrupts the key purpose of reflection and that students may not engage with the activity in a way that enhances personal learning.[13,14] The use of reflection in this design was to address these documented challenges; specifically, not assigning a grade based on level of reflection and providing individualized feedback based on the learner's own personal learning goals.

These are learners early in their career journeys, so finding that many students began and remained at the understanding level of reflection is not surprising given that the reflection level requires personal application. Many of these learners simply may not have had an opportunity to apply. Additionally, some students faced challenges with application of their learning as the opportunities for experiences during the COVID-19 pandemic were limited for some. Despite this, 33% of students were able to progress along the reflection continuum (Table 3), and most students were able to articulate the importance of practicing reflection even without reaching the level of reflection.

In the reflection assignments, students were able to articulate an expanded understanding of health disparities and also state ways they can make a difference now and in the future. Systemic and complex societal issues, such as health disparities, can seem overwhelming to an individual and lead to deferring to government, healthcare systems, and other mechanisms to address the problem. The structure of the course was intentionally countering this common response by having students examine these issues through their own personal goals and the ways their current life experiences offer opportunities to intervene. Health literacy topics are complex, posing challenges for creating meaningful and engaging educational activities.[15] The hope of this design was to create a sense of empowerment among a group of early health professional students by nurturing the habit of reflective practices, following recommendations to focus on application and starting in undergraduate studies.[5,6] While this course experience showed some movement towards Kember's highest level of reflection (reflection), ways to increase the percentage of students who are able to move into this category over a semester needs to be explored. Further, incorporating this strategy into other educational experiences to expand the number of students practicing this important skill as they move towards becoming practicing healthcare professionals should be explored.

One limitation of this inquiry is that it was an evaluation of a single offering of this course. In addition, a potential unintended consequence of the reflection categorization could be learners trying to contrive experiences to meet a higher reflection category. Even though the reflection category feedback was separate from the grade received and the directions explicitly acknowledged that it may not be possible to meet the higher reflection criteria due to lack of application opportunities, some students may have still viewed the reflection categorization as a type of assessment. However, the instructors did not find this to be the case. A few students may have tried to relate experiences that were somewhat tangential, but the experiences they were describing seemed authentic.

Conclusion

Health literacy and health disparities are important considerations for clinical practice, and health professionals must understand and acknowledge the influence of health disparities, culture, and environment on interpretation of

information and decision making. Learning reflection practices and beginning to understand these complex topics needs to start early in training. Through reflection, students were able to describe and apply health literacy and health disparities knowledge. Using a structured reflection categorization for feedback allowed pre-health students to begin developing reflection practices.

References
1. Santana S, Brach C, Harris L, et al. Updating health literacy for Healthy People 2030: Defining its importance for a new decade in public health. *J Public Health Manag Pract*. 2021;27(Suppl 6):S258-S264. doi:10.1097/PHH.0000000000001324
2. Healthy People 2030. Healthy People 2030 Framework. Accessed November 5, 2022. https://health.gov/healthypeople/about/healthy-people-2030-framework.
3. CRICO Strategies. Malpractice risk in communication failures. 2015 Annual Benchmarking Report. 2015. Accessed November 5, 2022. https://www.rmf.harvard.edu/~/media/0A5FF3ED1C8B40CFAF178BB965488FA9.ashx
4. Institute of Medicine (US) Committee on the Health Professions Education Summit. Challenges Facing the Health System and Implications for Educational Reform. In: Greiner AC, Knebel E, eds. *Health Professions Education: A Bridge to Quality*. National Academies Press (US); 2003. Accessed November 5, 2022. https://www.ncbi.nlm.nih.gov/books/NBK221522/
5. Rich R, Paschal A. US college students' perceptions of social determinants of health, health equity and racial health disparities. *Health Educ J*. 2020;79(6):700–711. doi:10.1177/0017896920910175
6. Benabentos R, Ray P, Kumar D. Addressing health disparities in the undergraduate curriculum: An approach to develop a knowledgeable biomedical workforce. *CBE Life Sci Educ*. 2014;13(4):636-640. doi:10.1187/cbe.14-06-0101
7. Rojanasarot S, Milone A, Balestrieri R, Pittenger AL. Personalized learning in an online drugs and US health care system controversies course. *Am J Pharm Educ*. 2018;82(8):6391. doi:10.5688/ajpe6391
8. Hase, S., Kenyon, C. *Self-Determined Learning: Heutagogy in Action*. 2013. Bloomsbury; 2013.
9. Schön DA. *The Reflective Practitioner: How Professionals Think in Action*. Basic Books; 1983.
10. Cavanagh A, Vanstone M, Ritz S. Problems of problem-based learning: Towards transformative critical pedagogy in medical education. *Perspect Med Educ*. 2019;8(1):38-42. doi:10.1007/s40037-018-0489-7
11. Halman M, Baker L, Ng S. Using critical consciousness to inform health professions education: A literature review. *Perspect Med Educ*. 2017;6(1):12-20. doi:10.1007/s40037-016-0324-y
12. Kember D, McKay J, Sinclair K, Wong FKY. A four-category scheme for coding and assessing the level of reflection in written work. *Assess Eval High Educ*. 2008;33(4):369-379. doi:10.1080/02602930701293355
13. Ross J. Performing the reflective self: Audience awareness in high-stakes reflection. *Stud High Educ*. 2014;39(2):219-232. doi: 10.1080/03075079.2011.651450
14. Myers KD, Bridges-Rhoads S, Cannon SO. Reflection in constellation: Post theories, subjectivity, and teacher preparation. *J Early Child Teach Educ*. 2017;38(4):322-341. doi:10.1080/10901027.2017.1389789
15. Stars I. Health literacy as a challenge for health education. *SHS Web Conf*. 2018;40(3):02004. doi:10.1051/shsconf/20184002004

Appendix A: Example Discussion Prompts

Initial Prompt

Week 4 Discussion (posts due Monday, Wednesday, Friday)

Begin this week's discussion by taking the IAT race bias test found here: https://implicit.harvard.edu/implicit/
1. Click on Project Implicit Social Attitudes on the left side of the screen.
2. Read the Preliminary Information and decide whether you would like to proceed
3. Choose "Race IAT"
4. Follow the instructions

Next, if you have not already, review the learning materials in the Canvas site for Week 4.

For your first post, describe your reactions to the results of the test. Does implicit bias have an impact on patients? Why or why not? How does this relate to health literacy? Instructors will give feedback on your thoughts on Tuesday along with further questions for you to consider.

Instructor Response Template (posted on Tuesday)*
Within each discussion group, student comments are incorporated into the example the response below. Instructors incorporate a summary or direct quote from each student's response to highlight contributions by each student and amplify student insights. Each student is specifically mentioned by name. Instructors address any questions that arise and may give feedback such as gentle instruction on the use of inclusive language.

Thank you for your thoughtful posts. As a group, you had mixed reactions to the race IAT and I appreciate that no one took a defensive stance. Of note, it is not a requirement to share your results, but I do think it is helpful for discussion. And I hope you feel that this is a safe and nonjudgmental space to do so. The difficult and uncomfortable topics we cover in the course are more meaningful when we share more personal experiences and reflections. We all have unconscious biases, and we need to recognize them. This is an opportunity to learn and reflect.

Some of you shared how their background, experiences, and environment likely influenced their results. A few of you questioned the test itself. Of course no test is completely reliable, especially when trying to measure something like implicit bias which is not an objective measurement. The research behind the test is fascinating; however, and I encourage you to explore it further if you are interested. Research does show that awareness of implicit biases is effective in minimizing the impact on patient care, and we need some mechanism for self-reflection and illumination of implicit bias. All of you agree that implicit biases impact patients and health care.

The purpose of this week's materials and having you take the race IAT is to highlight that we all have implicit bias. Implicit bias is unconscious bias. Having an unconscious bias is not the same as being consciously prejudiced or endorsing discrimination. Implicit biases are pervasive. Everyone has them. Dr. Williams discussed how many implicit biases are developed from societal norms and how a person can have an implicit bias even against a group they identify with. For example, a patient with obesity with an implicit bias against patients with obesity. The race IAT illustrates one method of measuring one type of implicit bias. There are many implicit biases (race, weight, gender, education, employment, etc.). We need to be aware of biases and not deny or ignore them. And we know from the literature that it does have an impact on patient care.

I'd also like to highlight that in many cases, the impact of implicit bias may not be at the level of an individual provider and patient. Implicit biases may be institutionalized. Even if individual healthcare providers are not demonstrating implicit bias, patients may still be impacted by implicit bias in the structure of the healthcare system.

This is an uncomfortable topic to discuss, and an uncomfortable truth, but we do believe that we cannot have a robust discussion around health literacy and disparities in healthcare without discussing the disparities in health outcomes by race and the implicit and institutional bias behind those disparities. I look forward to our further conversation.

For your next post, review the video, Where You Live Has a Huge Impact on Your Health: https://www.youtube.com/watch?v=zNzFnHL-8Zk. Use the following link to explore how life expectancy in America compares with life expectancy in your area. https://www.rwjf.org/en/library/interactives/whereyouliveaffectshowlongyoulive.html

This graphic, from Advancing Health Equity in Minnesota: Report to the Legislature, shows that three miles can make a significant difference in life expectancy. It is a map of Interstate 94 between Minneapolis and St. Paul. At various points, the map shows the life expectancy of a child born at that point.

How does where you live change the determination of your health outcomes? How could this change if you were someone else of another race? What stood out to you the most after reviewing this week's learning materials?

As a reminder, discussion posts should be at least 200 words. We want to see you engage in the learning materials, share your experiences, and reflect meaningfully on the prompts. Be sure to include a source that is properly cited in APA style (and not the same source you cited for Monday's post). Remember to ask a question of at least two group members. If you can, make sure that everyone in the group has been asked a question! Also, please use names when asking questions so group members know to respond to your questions. I look forward to reading your responses!

Appendix B. Reflection Assignment Directions and Prompts

Assignment Purpose

Reflecting on our learning processes can be an invaluable learning tool in understanding how and what we retain, in discerning how we have arrived at our conclusions about various ideas and concepts, and in thinking about what we have gained and how to improve on our strengths and weaknesses in the future. Reflection forces us to take a few minutes to dwell on our experiences as learners because we must identify the things that worked and did not work for us in the process, while at the same time, asking ourselves why? What changes in my role as a learner could have helped me gain more from this experience? Too often as learners, we focus only on the goal and not the process that got us there.

To promote the growth and development of reflective skills, we will be using a framework for providing feedback on reflections this semester. The level of reflection will be evaluated based on the four categories outlined below. You will not receive a grade based upon the category of your reflection, but we believe you will benefit from seeing your level of reflection as you progress through the semester and towards achieving your personal learning goals. See the Reflection Rubric for how your reflection will be graded.

Reflection 1
We have completed the first seven weeks of the course, including a discussion on the definition and measurement of health literacy, self-diagnosis, and an introduction to health disparities. Examine your personal reactions regarding this journey so far. How have your various identities (education, where you live, SES, race, ethnicity, cultural capital, values, etc.) influenced your current level of health literacy and your own health outcomes? Did you experience any changes in your own viewpoint as it relates to health literacy, self-diagnosis, or health disparities? Why or why not?

Refer back to your personal learning objectives for the course. How have you used these to guide your exploration of the learning materials or engagement in the discussions? How is your progress on your personal learning objectives? How has this progress impacted you, and how do you see it impacting you in the future?

Finally, are there any ongoing issues in your group, or anything that could be improved? How can you, your groupmates, and your instructor best support your learning?

Reflection 2
As you reflect back on the last half of this course, how have you or haven't you been changed by this experience? How will you apply this experience in your life once this course has ended?

Reflect on your progress on your personal learning objectives. What evidence do you have that you achieved your personalized learning objectives? Be specific. What else would be beneficial to learn?

How did you apply the feedback you received on the first reflection?

It can also be helpful to have an "elevator pitch" on health literacy to quickly describe what it is and why it's important. Create your own 2-3 sentence summary of health literacy.