

Health Literacy Review

A guide

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Section 1: An introduction to health literacy reviews

This guide will help you to carry out a health literacy review and build a health-literate organisation.

The guide provides advice on how to prepare for a health literacy review and gives you templates and examples of tools to adapt for your review. It also has background information on health-literate organisations and health literacy.

1.1 What is health literacy?

In New Zealand, health literacy has been defined as ‘the capacity to obtain, process and understand basic health information and services in order to make informed and appropriate health decisions’ (Ministry of Health 2010). In this definition the focus is most obviously on consumer capability. However, internationally support is growing for a stronger focus on how health systems, health care providers and practitioners can support consumers to access and understand health services.

If your organisation is new to the idea of health literacy, building awareness and understanding of it is a critical first step. Many leaders and health practitioners are not familiar with health literacy research. Appendix 1 lists some influential texts on health literacy and health-literate organisations which you could circulate and discuss.

1.2 Health literacy demands

Because of the way health systems and services are designed and delivered, consumers face a series of demands on their health literacy. These demands impact on consumers’ ability to access health information, care and services.

Health literacy demands are the tasks consumers and families need to do to access health services from a health organisation or service. Many of these demands occur within a health service. Others are at transition points such as admissions, transfers to and from services, and discharges, which are relevant because it is here that consumers often lose contact with health services although no one intended it.

Examples of health literacy demands are when consumers must:

- read a letter about an outpatient appointment
- make a phone call to confirm the appointment
- follow instructions in the letter to prepare for the appointment
- arrange time off work to attend the service
- arrange transport to the service
- navigate an unfamiliar environment to find a service
- attend the appointment

- interact with health practitioners by answering questions, providing a history and following instructions about tests
- read any written material that the health practitioners give them
- ask questions about anything they don't understand
- check instructions they have to follow (often provided orally with no written reminders).

1.3 What is a health-literate organisation?

A health-literate organisation makes health literacy a priority. It makes health literacy part of all aspects of its service planning, design, delivery and performance evaluation to reduce the health literacy demands on consumers.

A health-literate organisation:

- makes health literacy everyone's business – leaders, managers, and clinical and non-clinical staff
- designs systems, processes and services that allow consumers to access services easily
- supports operational staff to use health literacy approaches and strategies
- eliminates confusing communication that could prevent consumers from accessing treatment easily
- actively builds health literacy of consumers to help them to manage their health
- makes sure operational staff understand that, no matter how high a consumer's level of health literacy is, stress and anxiety affect their ability to understand and remember new information.

1.4 The health literacy review framework: the Six Dimensions

Drawing on international best practice, the following **Six Dimensions** of a health-literate organisation have been developed in New Zealand. They form **the framework for a health literacy review**.

1. **Leadership and management.** How is health literacy an organisational value, part of the culture and core business of an organisation or service? How is it reflected in strategic and operational plans?
2. **Consumer involvement.** How are consumers involved in designing, developing and evaluating the organisation's values, vision, structure and service delivery?
3. **Workforce.** How does the organisation encourage and support the health workforce to develop effective health literacy practices? Has it identified the workforce's needs for health literacy development and capacity? Has the organisation's health literacy performance been evaluated?
4. **Meeting the needs of the population.** How does service delivery make sure that consumers with low health literacy are able to participate effectively in their care and have their health literacy needs identified and met (without experiencing any stigma or being labelled as having low health literacy)? How is meeting the needs of the population monitored?

5. **Access and navigation.** How easy is it for consumers to find and engage with appropriate and timely health and related services? How are consumers helped to find and engage with these services? How well are services coordinated and are services streamlined where possible?
6. **Communication.** How are information needs identified? How is information shared with consumers in ways that improve health literacy? How is information developed with consumers and evaluated?

Appendix 1 describes how the Six Dimensions were developed.

1.5 What is a health literacy review?

You can conduct a health literacy review to gain a better understanding of the health literacy demands created by a health service and how they affect consumers and families. It will help your organisation identify what supports and what challenges consumers and families when they are accessing your services and managing their health.

For example, a health literacy review could focus on:

- a known service issue for your organisation
- a service that is interested in health literacy and wants to improve the health outcomes of consumers
- services related to an area of high health needs.

By taking time to understand health literacy and consider undertaking a health literacy review, your organisation's leaders can clarify the need for change and build support for it. They can also clearly identify:

- the purpose of a health literacy review
- the potential benefits of undertaking the review
- the resources required to complete the review
- the problem the review would address
- the scope of the problem
- the resources needed to address the problem
- the desired outcome.

1.6 A health literacy statement

Developing a health literacy statement helps to build a shared understanding of health literacy across your organisation and to create a health-literate organisation. This could be a step towards undertaking a health literacy review.

Ideally a statement will:

- communicate the key elements of a system view of health literacy
- provide definitions and goals that will guide the review
- set out the rationale for becoming a health-literate organisation.

Appendix 2 has some examples of health literacy statements you could adapt for your organisation.

Section 2: Preparing for the review

This section describes how to establish the review team and prepare for a health literacy review. Establishing the review team and identifying the focus of the review are the first priorities. You can then undertake the other preparatory tasks in any order or alongside each other.

2.1 Establish the review team

A review needs a dedicated team of at least three people who can allocate regular time to review activities. Not all members of the review team need to participate as reviewers but a minimum of two reviewers is recommended.

The review team will need to meet regularly – such as for one hour in each week of the review – to share information, resolve issues and plan for the next step. Two of its first tasks will be to:

- agree the timeframes for the review
- identify responsibilities and expectations of each team member.

This will help team members set aside adequate time to complete review tasks. The total time commitment is likely to average nine hours a week for each person, with a team of three people, including weekly meetings.

Following the preparatory work, a health literacy review can take six to eight weeks, depending on the scope of the review and the availability of reviewers. The whole process – from the decision to carry out a review to finalising a Health Literacy Action Plan – could take up to six months.

Oversight committee and project sponsor

A leadership group is needed to oversee the review and support the review team. This oversight committee will receive project reports, provide feedback and help resolve issues. It is helpful to use an existing leadership group for this role as it can then provide ongoing support for implementing the Action Plan.

All parties need to agree on the role and activities of the oversight committee. This includes confirming the process for finalising the review report. This process needs to suit your organisation and ensure the integrity of the review. For example, the review team may be best placed to prepare the draft report and incorporate feedback from stakeholders before presenting the review report to the oversight committee for sign-off.

The project sponsor may be part of, or report to, the oversight committee. The project sponsor could be a member of the Executive Leadership Team or a clinical leader and should report to (other) organisational leaders.

Capability of the review team

The review team needs members who have expertise in health literacy, how the health system operates, and the processes and procedures used in your organisation and the service under review (the team does have an opportunity to build health literacy knowledge – see section 2.3). Reviewers also need to be culturally competent.

You might decide to include people external to your organisation as members of the review team or as advisors. People can also be seconded to the review team as needed, such as focus group facilitators or clinical experts. Another option is to delegate some tasks, for instance, document collection or document analysis, to people outside the review team. Such decisions will be determined by the resources available in your organisation.

2.2 Identify the focus of the review

The review team, with the support of the oversight committee, needs to identify a potential focus of the health literacy review and seek agreement from service leaders. For example, you could review:

- a known service issue for your organisation, such as high non-attendance rates in outpatient clinics
- a service that is interested in health literacy and wants to improve the health outcomes of consumers
- issues highlighted by consumer feedback, such as confusing hospital discharge processes
- the services related to an area of high health needs, such as type 2 diabetes.

Alternatively, you might decide to start with a high-level strategic review of your organisation. Rather than reviewing a specific service, a strategic review looks at your organisation's overall policies, systems and processes to identify the changes needed for it to become a health-literate organisation. For more information on a strategic review, visit the website for the guide: www.health.govt.nz

After deciding on the focus of the review, the review team will identify the systems, processes and related services that affect the service, issue or health area (which will be identified here simply as 'the service') being reviewed. This is an opportunity for the review team to become familiar with the service and the patient journey in order to understand the health literacy demands the organisation or service places on consumers and families.

2.3 Team building and health literacy orientation

During the health literacy review, the team will look at the role and responsibilities of a health care organisation in supporting health literacy (and operating as a health-literate organisation). This includes identifying how your organisation:

- supports consumers to engage with services
- enables its health workforce and leaders to make improvements.

Members of the review team, as well as key leaders and service staff, will need time to discuss their understanding of health literacy and the Six Dimensions of a health-literate organisation (see section 1.4). The review team could hold workshops and training sessions to develop consensus around health literacy. Either an external facilitator or a member of the review team with expertise in health literacy could lead these workshops. Appendix 3 sets out topics to cover in introductory workshops as well as the resources that support a shared understanding of health literacy.

The review team members might also become more aware of health literacy issues by:

- navigating an unfamiliar health service – starting in the public car park, using signs along the way and noting the questions they have and the decisions they make
- observing the questions, concerns and interactions of consumers and families in a service reception area
- analysing the clarity and relevance of information sent to a consumer about a health service or appointment.

Reviewers can then discuss their experiences and feelings at a review team meeting. A person with health literacy expertise should facilitate this discussion to help reviewers identify and explore the health literacy demands and organisational processes involved in those activities.

2.4 Confidentiality

During the review, reviewers may have access to confidential information about the organisation, staff, consumers and families. The reviewers need to agree, with the service under review and the oversight committee, how information will be kept confidential. Review team members who are not employed by your organisation might have to sign confidentiality agreements.

Review team members should:

- never attribute any of the data collected to any named individual (or role title if this can identify an individual)
- assure all participants of privacy and confidentiality.

Reviewers also need to agree with the project sponsor and clinical leaders on what process they will follow if they identify consumer safety issues during the review. For example, they need to establish what to do if they observe that clinical practice is not in line with current clinical guidelines. (See also section 2.10.)

2.5 Ethics

An observational study using the approach described in this guide does not usually require ethics approval from a Health and Disability Ethics Committee. However, if the review is to involve consumers under the age of 16 or other vulnerable populations, ethics approval may be required. In addition, the review team should check with your organisation's ethics committee about whether a locality assessment is required.

Whether or not a formal ethics process is required, it is good practice to provide information sheets and consent forms for consumers, families and staff who reviewers would like to interview and observe during the review.

If the review includes photographing signage, sites, staff, consumers and/or their families, then the review team needs permission to collect and use the photographs.

2.6 Conflict of interest

The reviewers and any other team members involved in analysing the data collected during the review need to be independent of the service under review. For example, someone who has been involved in developing consumer information and education resources should not be directly involved in reviewing those resources because it is inherently difficult to examine your own work. Each team member needs to identify areas where they might have a conflict of interest and ask another team member to review these areas.

2.7 Publicising the review in advance

Publicity about the health literacy review will inform staff and encourage them to participate. Informing staff about the benefits of a health literacy review will also help to prepare them for interviews and observations, as well as analysis and action planning, which they might otherwise see as time-consuming.

If your organisation has a communication team, the review team should work closely with it to publicise the review before it starts. Later, the two teams should work together to share progress and findings and promote the activities in the Health Literacy Action Plan.

2.8 Planning

The review team needs to develop a project plan that specifies the purpose and focus of the review, timeframes, milestones and the roles of the team members. Typically, a health literacy review will have four phases:

- preparation
- collecting data
- analysing and reporting the review findings
- developing the Health Literacy Action Plan.

Preparation

The review team should use your organisation's project planning process and templates to develop a project plan and seek feedback from key personnel, including the oversight committee and stakeholder groups. Depending on the requirements of your organisation, the project plan might include information about how the review will be communicated within your organisation or a separate communication plan might be needed.

In the preparation phase, the reviewers have the chance to become familiar with the patient journey and identify existing data about the service being reviewed.

Collecting data

The reviewers collect data through document analysis, interviews and observations. The data needs to provide evidence of how the service being reviewed reflects the Six Dimensions of a health-literate organisation:

- Dimension 1: Leadership and management
- Dimension 2: Consumer involvement
- Dimension 3: Workforce
- Dimension 4: Meeting the needs of the population
- Dimension 5: Access and navigation
- Dimension 6: Communication.

The project plan needs to identify the data collection activities, timeframes and responsibilities for each member of the review team.

Analysis and reporting

The Six Dimensions provide the framework for analysing and presenting the findings of the review in the draft report. The review team might analyse the data collected during the review or engage other staff to help analyse the data. All members of the team need to discuss the data analysis in order to confirm findings and develop themes.

The review team might need to share some or all of the initial findings with:

- a clinical expert to confirm that the findings reflect accepted practice
- leaders from the service under review to establish whether the findings sufficiently reflect all aspects of the service or whether more information needs to be gathered.

After analysing the data and responding to the initial feedback in the report, the team can seek wider feedback from the service being reviewed as well as from consumers and families. In this way, the team can gain further comments and raise awareness and understanding of health literacy and service improvement. It can then finalise the review report.

Developing the Health Literacy Action Plan

The review team – either independently or in partnership with the service being reviewed, the oversight committee and stakeholders – will develop a draft Health Literacy Action Plan based on the findings of the review. Ideally, the team will invite staff from the service that has been reviewed to come up with a list of actions to address health literacy. If the team considers that these actions are feasible and can improve health literacy, those actions can become the foundation of a Health Literacy Action Plan.

2.9 Preparing for data collection

The data collection methods used in the health literacy review are document collection, observations and interviews.

To prepare for the review, the review team will identify the most appropriate and effective ways to collect the information needed and how it will carry out these methods. The review needs to collect data that provides evidence of how the Six Dimensions are reflected (or not reflected) in the service. To become familiar with a service, reviewers may complete some document reviews and observations before interviewing consumers and staff. However, the remaining interviews, observations and document reviews are likely to happen concurrently.

Reviewers need templates and other tools to record what they have done and what they have found throughout the review, particularly during interviews and observations.

The review team will prepare information sheets and consent forms for staff and consumers, which it may adapt from existing documents in your organisation. The information sheets and consent forms should contain information about confidentiality.

Preparing for document collection

Documents are an important source of information about how your organisation prioritises and delivers on health literacy.

Two types of documents need to be collected and analysed:

- organisational documents, which can be analysed for evidence of health literacy policies, plans and approaches
- documents for consumers, which can be analysed to identify the health literacy demands placed on consumers.

Service and organisational leaders can help reviewers develop a list of documents to collect for analysis. It is advisable to take an all-inclusive approach to collection at the start of the review, accepting all suggestions of documents that might be relevant. Later in the review, as reviewers' understanding of the service grows, they will be able to identify the documents that are relevant and focus their analysis on those.

Organisational documents

Organisational documents can provide evidence of organisational thinking, planning, communication, actions, reporting and measurement in relation to health literacy. Your organisation may already have documents that:

- describe health literacy initiatives
- contain information relevant to health literacy, such as documents about improving self-management, communication, patient-centred care and patient satisfaction.

The range of organisational documents relevant to health literacy includes:

- strategic and operational plans
- minutes of meetings (boards, executive leadership teams and other high-level teams)
- budgets and other planning and funding documents that allocate resources
- staff development plans
- needs assessments
- Whānau Ora service plans
- policies and procedures
- communication such as Chief Executive's newsletters and blogs, websites, Facebook and Twitter communication
- Consumer Council charter, terms of reference and minutes
- minutes of other relevant committees
- staff health literacy training packages, including any online modules
- Continuing Medical Education programmes and training schedules, including details of training courses
- staff induction programmes
- staff handbooks
- policies and procedures in relation to staff recruitment and induction
- criteria for selecting internal health literacy trainers or external health literacy providers
- public health reports
- community committees' paperwork, for example, terms of reference and minutes
- information about inequalities and inequities within the area served by your organisation or the service being reviewed
- information about services in your organisation that work with populations that might have low health literacy
- information on government targets for populations with low health literacy
- research reports on populations with low health literacy
- call centre key performance indicators
- information about consumers' complaints about and experiences with your organisation or service being reviewed.

Some documents will be publicly available or widely available in your organisation. There may be some concern about giving reviewers access to other documents where they are regarded as sensitive or confidential. Reviewers will need to negotiate access on a case-by-case basis.

Reviewers will analyse organisational documents from a health literacy perspective, as described in section 3.6 and demonstrated in appendix 4. Appendix 5 provides a template for reviewing organisational documents.

From their observations and interviews as described in sections 3.2 to 3.4, reviewers can also check how a service implements the health literacy policies and approaches outlined in organisational documents.

Documents for consumers

The review team will prepare a list of documents for consumers that it is to collect and analyse from a health literacy perspective. Appendix 6 provides a template for reviewing documents for consumers.

The range of documents for consumers that are relevant to health literacy includes:

- appointment and referral letters
- information to prepare consumers and families for tests and assessments
- consumer portals
- your organisation's website
- brochures, posters and other promotional material
- consumer information embedded in clinical pathways and support material for health practitioners using those pathways
- consumer questionnaires
- informed consent and other forms
- discharge summaries
- consumer medication information
- information about how consumers can give feedback about their experiences with the service being reviewed.

Preparing for observations

The review team will develop an observation list to identify who or what is to be observed (see appendix 7 for a template). The two types of observations used in a health literacy review are:

- clinical observations of health practitioners during consultations with consumers and families
- environment and process observations of the experiences of patients and families in your organisation or the service being reviewed (also known as the patient journey).

Observations of clinical interactions

Reviewers will observe how clinical staff interact with consumers and families to understand the health literacy demands of this experience. The number of interactions they observe needs to be sufficient for them to form reliable conclusions. When observations stop revealing any new information relevant to the review, this indicates the reviewers have made enough of them.

Health practitioners and consumers and families must agree to be observed. Consumers and families need to understand that they can refuse to be observed and this will not jeopardise their treatment in any way. The review team should include this information in information sheets and consent forms.

Possible clinical observations are:

- practitioners with consumers
- group education sessions for consumers and families.

The review team will also prepare some guidance for reviewers around what to look for during observations (see appendix 8 for an example of a Clinical Observation Guide). During clinical observations reviewers will take notes (based on the Clinical Observation Guide) on what people say and do. Later, the review team will analyse these notes to:

- identify the strategies practitioners used with consumers and their families to build health literacy
- check that the health practitioner communicated clearly from the consumers' perspective.

Section 3.3 provides further guidance on how to carry out clinical observations.

Environment and process observations

When observing more 'public' settings – such as reception areas – the review team should inform staff in these areas about the review, what it is observing and why. Some staff may be reluctant to be observed. By making sure that staff understand the purpose of the review and giving them a chance to discuss their concerns, the team can help them understand that being observed can be a positive experience. However, if staff refuse to be observed, the reviewers must respect this decision. At other times, physical constraints or other barriers might make observation inappropriate.

If your organisation has already carried out way-finding exercises or involved consumers in designing signs for a particular area, the review team should use this data to inform its review.

Possible environment and process observations include:

- navigation activities to locate a service and health practitioner – finding parking and using parking machines; using lifts; following maps; reading signs; asking for directions
- waiting areas – instructional signs; process descriptions; greeting methods
- call centre operators, such as bookings and enquiries
- volunteers and staff providing navigation assistance
- reception staff interactions with consumers and families, such as greeting, consumer questions, tone, information provided and process explanations
- hard copy information and forms given to consumers and families
- staff training, including induction and any health literacy training.

Section 3.4 provides more information about carrying out environment and process observations.

Preparing for interviews and focus groups with staff

An interview is an in-depth conversation to identify the interviewee's perspectives on health literacy and any past or current health literacy initiatives. Individual interviews are generally more likely to suit the purpose of data collection. However, reviewers may also need to facilitate focus groups or undertake a staff survey to gather information.

Individual interviews

The review team will develop a plan that identifies the staff to be interviewed (see appendix 9 for a template). In developing this list, they can identify the rationale for including staff and role holders. The team may add to the list once interviews get under way because interviewees often tell reviewers about other relevant people to interview.

To get representation of a wide range of stakeholders, reviewers will need to interview many individuals. These individuals include organisational and service leaders, health practitioners, support staff (including navigators), community health workers, administration staff and trainers or educators. Below is a list of some possible staff to interview. The review team may identify others as well.

Leaders

Chief Executive
Service leader
Board chair or designated members of the Board
Executive Leadership Team
Planning and funding staff
Facilities manager
Human resources manager
Practice managers

Clinical staff

Heads of department
Director of nursing and similar professional leaders
Consultants
General practitioners
Nurses
Staff who deliver consumer education sessions
Staff involved in obtaining informed consent and discharging consumers
Allied health professionals
Māori health providers
Community health workers
Other health practitioners working with identified low-literacy populations

Administration staff and volunteers

Reception staff
Call centre staff
Staff and volunteers who provide navigational assistance, including security and cleaning personnel
Staff who manage, develop and validate consumer education materials and resources (including clinical staff)
Interpreter services manager and interpreters
Internal and external communication staff
Internal and external health literacy trainers
Training and development/learning and development team

Community representatives

Chair of consumer council or a similar body
A range of people representing different communities, for example, mana whenua, disability communities, or groups
Community Advisory Board members
Community liaison people

The review team will also prepare a list of questions and follow-up questions relevant to the roles of interviewees.

Staff survey

By developing a printed or electronic staff survey, reviewers can collect information from a large group of people. This survey can provide a starting point for gathering ideas to be further explored through individual interviews or focus groups. Enough staff need to complete the survey to support a valid result. Appendix 10 provides possible questions for a staff survey.

Focus groups

Focus groups could be valuable in some settings because they can identify themes rather than individual responses. For health practitioners or administrators, focus groups of their peers might create a natural discussion group. However, reviewers need to design and manage focus groups carefully when members of the group also work together. For example, the interviewers should not ask questions that might put staff at risk by exposing 'poor' practice.

Focus groups must follow procedures to safeguard confidentiality. For example, names of individuals must not be linked to comments or themes. Through information sheets and consent forms, group participants must be informed of the review process and assured that notes taken will not record the names of individuals. Reviewers should not use focus groups to discuss sensitive information or topics.

Preparing for interviews with consumers and families

The review team will prepare a list of situations in which it might interview consumers and families and discuss it with the service being reviewed (see appendix 9 for a template). Reviewers conduct these interviews to find out whether consumers and families:

- understand the purpose of the consumer's appointment
- understand what the consumer needs to do following an appointment
- have had their questions answered
- have experienced challenges or assistance in accessing health services.

Interviews will not capture all aspects of the consumer and family experience but they are another information source.

Reviewers will interview consumers and families, both:

- before the clinical appointment, when the focus is on what a consumer already knows, expects and wants to know from the appointment
- after an appointment, when focus is on what a consumer learnt from the appointment, whether they still have questions and what they will do next.

Consumer interviews are usually brief. At times it may not be possible or appropriate to interview consumers and families after an appointment. Some consumers and families might be willing to be interviewed over the phone at a later date.

Some consumers might also like to participate in focus groups or might like to be interviewed with their family or community group. Again, the review team must take precautions to protect the privacy of participants.

Reviewers could take notes during interviews. However, if they are to concentrate on engaging with interviewees (staff, consumers and families), it might be easier to either:

- record the interview electronically, with the interviewee's permission (audio interviews are transcribed for analysis and require a specialised resource)
- have two reviewers to participate in an interview – one to speak with the interviewee while the other takes notes.

Focus groups need a facilitator to engage with participants, while a reviewer who is not participating in the discussion takes notes.

The review team will need regular opportunities to discuss whether interviews and observations are still generating new information. Once they confirm that they are discovering little new information, they have reached a stage known as data saturation. That is, they have carried out a sufficient number of interviews and observations to have an accurate understanding of a service or process.

2.10 Maintaining a health literacy focus

At the core of a review, the review team needs to identify the underlying reasons for service issues and determine whether these are due to health literacy factors. If service issues relate to the model of care or the design or delivery of services without involving health literacy, the team should note them separately and refer these findings to the appropriate person. For example, the team may find that consumers are not attending scheduled appointments because of either:

- health literacy factors such as confusing appointment letters, poor referral discussions, complex rescheduling processes or low reading literacy
- other factors such as cost and transport barriers, or dissatisfaction with health services.

2.11 A final check

By the end of the preparation phase, the review team, oversight group and project sponsor will be in place. The review team will have identified a focus for the review, and reviewers will have been trained and will be familiar with the patient journey.

The review team will also have the following documents ready once it has finished its preparations.

- Ethics approval (where relevant)
- Information sheets and consent forms for consumers, families and staff
- Consent forms for photographs
- Publicity before the review to explain what will happen
- Project plan with detailed information about activities, timeframes and responsibilities of each member of the review team; roles and responsibilities of oversight committee; process to address any consumer safety issues; communication plan
- Communication plan (if separate from project plan)
- List of documents to be collected (both organisational and for consumers)
- List of observations
- Guidance for reviewers carrying out observations
- Existing data including from any previous way-finding exercises

- Schedule of staff interviews
- List of questions and follow-up questions for staff interviews
- Staff survey (if relevant)
- Focus group procedures and questions (if relevant)
- List of possible consumer and family interviews
- List of possible questions for different contexts with consumers and families (eg, pre- and post-consultation)
- Visual of Six Dimensions (Appendix 11)

Section 3: Carrying out the review

3.1 Gathering information from staff

The review team will inform staff about the review. In particular, it will:

- explain procedures for confidentiality
- explain what is involved in consenting to participate in the review, either by being interviewed or observed
- assure staff that survey participation is voluntary
- assure staff that, if they consent to participate, they can choose not to answer specific questions, or ask for an interview, discussion or observation to be stopped at any time.

Staff survey

A survey gathers high-level feedback from a large group of staff about their understanding and perceptions of health literacy and their practices that are relevant to health literacy. For example, it could ask staff to describe communication practices and barriers across a service. This information can provide a starting point for gathering ideas for reviewers to explore further through individual interviews or focus groups. (For an example of a staff survey, see appendix 10.)

The review team will circulate the survey at the start of the review. For the results to be valid, it needs a sufficient number of staff to complete the survey.

Interviews with staff

Ideally staff interviews will be semi-structured discussions rather than strict question and answer sessions. The role of the reviewer is to enquire, listen carefully and probe for clarification. The reviewer needs to ask each interviewee about:

- their understanding of health literacy
- how health literacy is practised in your organisation or the service being reviewed.

With this information, the review team can identify how health literacy is conceptualised in the service and your organisation. Reviewers may use the following prompts as a starting point for all interviews with staff.

Interview prompts for leaders and staff

- What do you think health literacy means?
- How does health literacy affect your work/service/organisation?
- Who do you think has responsibility for health literacy in your work/service/organisation and why?
- What do you do about health literacy in your work/service/organisation?
- What could be done to improve health literacy in your work/service/organisation?

After using these prompts, a reviewer might explain the Six Dimensions of a health-literate organisation using the visual in appendix 11 and discuss them with the interviewee. From this point on, questions asked during the interview need to be tailored to the role of the interviewee.

Focus groups

Focus groups might be needed to gather information from your organisation's leaders or operational staff. In these settings the reviewer, or person facilitating the group, needs a process to follow and question prompts that:

- are appropriate to a group context
- protect participants from exposing poor practice or knowledge gaps.

Reviewers or facilitators may use the following prompts as a starting point for focus groups.

Question prompts for focus groups of leaders and staff

- How is health literacy an issue for your work/service/organisation?
- What do you do about health literacy in your work/service/organisation?

3.2 Interviews with consumers and families

Reviewers will get permission from consumers and families for observations and interviews. Appendix 12 sets out a suggested script for asking a consumer to participate in the health literacy review and a follow-up letter if they agree to it. Reviewers will make sure that:

- consumers and families know their participation is voluntary
- their agreement to participate is properly documented according to any ethics requirements.

Arrange an appropriate interview space in the health service where consumers and families feel they can talk about their experiences safely and confidentially.

The question prompts need to encourage consumers to share their experiences and tell their stories. A good way to start is to ask people general questions about their visit to the service, before following up with more probing questions about matters relating to health literacy. Reviewers should avoid using the words 'health literacy' with consumers as they are unlikely to be familiar with this term.

Reviewers may use the following prompts as a starting point for interviews with consumers and families before and after a consultation.

Question prompts for consumers and families

Before a consultation

- Why are you visiting the service today?

After a consultation

- What happened during your visit?
- What did the doctor/nurse ask you today?
- Why do you think they asked these questions?
- What did the doctor/nurse talk to you about?
- Did you have any questions for the doctor/nurse?
- What do you have to do now/next to manage your health condition?

3.3 Observations of clinical interactions

While observing a health practitioner interacting with a consumer, the reviewer writes down the words spoken by each party as accurately and in as much detail as possible. To focus their observations, they use the Clinical Observation Guide developed during the preparation stage. (See appendix 8 for an example of a Clinical Observation Guide.)

Reviewers need to:

- observe enough interactions between representative groups of staff and consumers and families to form reliable conclusions
- be guided by their own judgement, as well as by the health practitioners and consumers and families being observed
- be prepared to stop recording information or withdraw from the observation if asked, or if it seems appropriate or helpful in the circumstances.

Reviewers will meet regularly to discuss what they are recording in their observations so that they can check whether they have collected sufficient data or have missed some aspect of the service. Based on these discussions, they may need to extend or alter the list of observations.

3.4 Observing the environment and processes

Environment and process observations take into account the physical environment of the service and the actions consumers and families had to take to physically get to the service.

These observations work best when the reviewer is unfamiliar with the environment. A reviewer will walk through the service to observe the environment. They may take photographs (with permission) of signs and other aspects of the environment to demonstrate findings from this part of the review.

Ideally a reviewer will accompany a consumer who is new to a service as they walk from the parking area, or another arrival point, to the service's clinical reception area (and repeat this activity with at least five separate consumers). The reviewer will:

- ask the consumer to 'think aloud' – to verbalise what they are seeing and thinking – as they negotiate the environment and find their way to the service
- write down these thoughts and actions.

See appendix 13 for a checklist for observing the physical environment for this part of the review.

The following is a summary of the four aspects that the reviewer will consider when observing the environment and reviewing the processes of the service.

1. Getting to the appointment

- Receiving the appointment letter
- Confirming the appointment (by phone or text or through a website)
- Preparing for the appointment (arranging child care or time off work)
- Finding driving or public transport instructions
- Calculating the time to get to the service
- Finding parking
- Finding the entrance to the building
- Negotiating with the child's school or child care facility (if the appointment is for a child)
- Arranging an interpreter (New Zealand Sign Language or a spoken language)
- Arranging a support person to attend the appointment (if relevant)
- Following other instructions in preparation for the appointment, for example:
 - making a list of medicines
 - bringing X-rays
 - restricting food and drink
 - going without medicine
 - stopping smoking for a particular time
 - providing evidence of eligibility for free health services.

2. Finding the service

- Finding the way to the service using signs and images
- Asking people for directions
- Referring to the appointment letter

3. At the service

- Interactions with staff, such as the welcome by staff, and information and instructions (including any form filling)
- The use of environmental print such as posters and noticeboards
- The adequacy and accessibility of the physical environment such as seating, walkways and access to toilets
- Delays and how these are communicated to consumers
- How consumers are called for their appointments

4. Leaving the service

- Tests to be done or medicines to be collected in another part of the building
- Leaving the building
- Returning to the car or public transport
- Paying for car parking

During the journey to the service, a reviewer can draw a consumer's attention to noticeboards and other environmental print (for example, posters in lifts). They then ask:

- if a consumer noticed this information
- if the consumer would refer to it
- what the consumer understands from it.

Before the consultation, the reviewer will also check with the consumer about whether:

- information they received orally or in writing at the service was helpful
- they had any difficulty with the appointment letter or forms (for example, the reviewer could ask the consumer to highlight any words or questions that were hard to understand or difficult to answer; this feedback then becomes a focus of a consumer interview).

After the consultation, the reviewer could ask a consumer about the interaction and their understanding of what happens next. The information from the consumer then becomes a focus for a consumer interview. If consumers are required to do other tasks after the appointment, such as having further tests or picking up medicines, the reviewer could:

- accompany them while they do these tasks
- record how they find their way to the relevant places.

3.5 Document collection and analysis

Documents collected and analysed as part of a health literacy review provide:

- a record of how health literacy is described and practised
- a record of health literacy plans and initiatives
- examples of health literacy demands placed on consumers.

One person on the review team may be responsible for gathering the organisational documents and documents for consumers on the list. However, the other team members are likely to come across more documents as the review progresses and should collect these where possible and appropriate. After collecting the documents, the review team will analyse them to see how your organisation describes health literacy.

See the appendices for:

- an example of an analysis of an organisational document (appendix 4)
- a template for reviewing organisational documents (appendix 5)
- a template to review resources for consumers (appendix 6).

3.6 Analysis and reporting

It is now time to analyse the data collected during the review and report the findings to the oversight committee who agreed to the review. This is where the reviewers begin to develop ‘the story’ of the review.

The review report will identify:

- the health literacy demands that your organisation or the service being reviewed places on consumers and families
- what your organisation or service is doing well to reduce health literacy demands and build consumer health literacy
- what your organisation can do to further reduce or eliminate the demands
- how staff can build the health literacy of consumers and families.

Analysis

The review team can match the information from the interviews, observations and document analysis against the Six Dimensions. Appendix 14 provides a guide for this analysis.

The team should leave final analysis and conclusions until it has collected all the information, when it will be better able to determine the relevance and importance of data. It can analyse information in a range of ways. For example, one approach is to:

- brainstorm a list of key findings or themes
- attach relevant data to each key theme to help team members identify whether there is sufficient information to generate and support themes
- weight information, giving higher weighting to data from direct observations where it conflicts with statements from interviews.

The following are key questions for the review team at this stage.

- Is any of the information surprising? Why? What does that mean? Did we collect information from enough sources and the right sources?
- Did we achieve data saturation? If not, what needs to happen at this stage?
- Does the information make sense – across the Six Dimensions and within each one?
- Do we have enough information for analysis, do we need more information, or do we need to report that we cannot collect enough information for a particular Dimension, giving the reasons why?
- If we have used other information because there is no specific health literacy information, can we explain the links between that information and health literacy?
- Are the critical topics for health literacy clear? (These could be both within and across Dimensions.)
- What are the similarities and differences across the information?

Below is an example of possible findings from a health literacy review of attendance issues at an outpatient service. These findings are presented under the Six Dimensions of a health-literate organisation.

Health literacy review findings: non-attendance at outpatient clinics

Dimension 1: Leadership and management

- New interventions to lift participation (such as offering extra support to families with a history of non-attendance) have reduced non-attendance.
- Current initiatives for improved primary and secondary care coordination provide a platform for more discussion during a referral (from primary care) of what to expect (in secondary care/outpatients).

Dimension 2: Consumer involvement

- Consumers are invited to provide written feedback on hospital services.
- Consumers have little control over appointment bookings.
- Consumers are not involved in the design of outpatient services.

Dimension 3: Workforce

- Most staff are unfamiliar with health literacy (or view it as a patient skill deficit).
- All staff participate in cultural competence and communication training.

Dimension 4: Meeting the needs of the population

- Medical information is unfamiliar to and complex for consumers.
- Consumers are unsure of who to contact to discuss the clinical aspects of appointments.

Dimension 5: Access and navigation

- Appointment letters are difficult to understand.
- Consumers assume another appointment will be made if they miss an appointment.
- Consumers do not recognise the cost (to the hospital) of non-attendance.
- Consumers are unsure of what to expect from the outpatient service (as it is not discussed during primary care referral).

Dimension 6: Communication (and Dimension 3: Workforce)

- Consumers are unsure of the reason or need for an appointment.
- Consumers are unsure about how or why to change an appointment.
- Primary and secondary care organisations and services use unfamiliar and inconsistent terms.
- Appointment letters and instructions are confusing for consumers.

3.7 Writing the review report

The report tells ‘the story’ of the health literacy review that the review team started to develop in section 3.6. Depending on the decision of the oversight committee (see section 4.1) the report will include:

- a description of the review’s purpose, process or methods and findings
- the recommendations that will form the basis of the Health Literacy Action Plan.

The review team will determine how to present the findings and what to emphasise in the report, as appropriate for the audience for the review.

The review team will also think about the structure and tone of feedback provided to the service as a result of the review. Service teams need to be engaged in efforts to improve health literacy and make their workplace a health-literate organisation. The purpose of the review is not to be critical but rather to uncover the strengths and weaknesses of your organisation or service in relation to health literacy.

The review team will update the oversight committee on the findings and potential recommendations of the review, particularly if some aspects are contentious or need immediate attention. The health literacy review might also prompt action on other issues.

The report writers will:

- decide on the key findings from the review and use these findings to frame the report
- describe what the review showed in relation to each of the Six Dimensions
- describe the similarities and differences across the Six Dimensions
- support key points with relevant information
- include quotes or statements to illustrate key points
- avoid identifying people, for example, by describing someone as a health practitioner rather than a senior clinician if the latter description will identify them
- organise the content in a logical order, for example, by Dimension or process
- use clear headings and subheadings to help readers navigate the report
- distinguish between findings (facts that came from the review), conclusions (reviewers' interpretation of the information) and recommendations (actions and solutions that result from review findings).

The report should clearly link the review findings and conclusions (supported by the data collected during the review) to the recommendations that will inform the Health Literacy Action Plan. Some recommendations might be implemented easily and quickly. However, the review should not lose sight of wider organisational goals and longer-term actions that need to be addressed, for example, by creating a health literacy strategy.

Getting feedback on the draft report

Feedback on the draft report will come from:

- first, the project sponsor and/or identified managers or leaders in the service being reviewed
- next, the oversight committee and other stakeholders.

The review team might also hold a series of meetings to seek views on any anomalies in the report, find out initial reactions to the findings and reach agreement on how to present the final report. An alternative approach is to present the findings orally and gather feedback at the presentation.

The review team may work closely with the oversight committee and stakeholder groups as it refines the report and recommendations and develops the Health Literacy Action Plan.

The review team will then present its final review report for sign-off to the oversight group (or follow the process agreed in the preparation phase).

Presenting the final report

After the oversight group signs it off, the final report will be sent to the project sponsor, stakeholders and service staff. Distributing it may be the responsibility of either the review team or the oversight committee. This will be followed by meetings to discuss the review findings, answer any questions and confirm the next steps. One of the next steps will be to communicate the findings to wider audiences in the way identified in the original communication plan or any amended plan. Depending on the situation, this wider communication might happen once a draft Health Literacy Action Plan has been developed as this gives external stakeholders an opportunity to focus on future improvements.

A short presentation for wider audiences could be developed, focusing on the key findings of the review (and possibly how these findings will be addressed by the draft Health Literacy Action Plan). Health literacy reviews may be a new concept for most audiences, so the presenters will need to explain what a system-wide approach to health literacy is.

Section 4: Health Literacy

Action Plan

The Health Literacy Action Plan is the product of the review process. It is a living document to be implemented, promoted, adapted as necessary and monitored. Your organisation and the services responsible for its implementation will own the Action Plan.

The Health Literacy Action Plan is based on the review's findings and recommendations. It provides a blueprint for improving and progressing health literacy over the short, medium and long term. The Action Plan describes actions the service and your organisation will undertake and how these actions will be measured. It could also be beneficial to outline the health literacy issues that the Action Plan is addressing so that its rationale is clear.

The Health Literacy Action Plan will:

- make health literacy business-as-usual in your organisation
- integrate health literacy into your organisation's systems and processes
- keep health literacy visible and recommend practical ways of implementing health literacy.

4.1 Developing the Health Literacy Action Plan

The review team can develop the Action Plan in a number of ways. The first step begins with writing the review report, when the review team seeks the oversight committee's agreement on whether the review report is to contain either:

- recommendations for improvement, which then become an outline for the Health Literacy Action Plan, or
- the findings of the review only, with future actions (an Action Plan) developed separately.

While conducting the health literacy review and writing the report, the review team might develop recommendations for health literacy improvements that form the basis of an Action Plan. These could include suggestions that staff and consumers make during the review. The review team could either:

- include these ideas in the review report, or
- circulate them for feedback alongside the report.

Alternatively, staff and stakeholders could discuss the review findings, as presented by the review team, and take part in generating ideas for the Health Literacy Action Plan. The review team could then develop the Action Plan – or it could pass on this responsibility to your organisation's service team as it is likely to be responsible for implementing the majority of the Action Plan.

Each action needs to have a timeframe and performance measure. The health literacy issues that the actions are addressing can provide a framework for organising the Action Plan's implementation.

When deciding on measures to include in the Action Plan, it is useful to consider:

- outcome measures, which are those that are important to consumers and providers
- process measures, which relate to how a service performs
- composite measures, which combine both process and outcome measures and prevent a process change from having an unintended consequence for consumers (DeWalt and McNeill 2013).

For more guidance on developing an Action Plan, see:

- appendix 15 for a template for a Health Literacy Action Plan
- www.health.govt.nz for examples of the Health Literacy Action Plans developed during the trial of this guide.

4.2 Launching the Health Literacy Action Plan

The Chief Executive or service leaders could launch the Health Literacy Action Plan. Following the launch, your organisation will continue to communicate with stakeholders and consumers about the Action Plan's progress.

4.3 The critical role of leaders

Organisational leaders are critical to the success of a Health Literacy Action Plan. They:

- commit the resources to implement the Action Plan
- promote the Action Plan throughout the organisation
- keep it visible – ideally, making reports on progress against the Action Plan a standing agenda item at leadership team and operational team meetings
- identify where to integrate Action Plan activities into existing systems and processes so that the activities are sustained.

4.4 Stakeholders

Stakeholders can also increase the visibility of the Health Literacy Action Plan and its implementation, and promote the Action Plan throughout the organisation.

The stakeholder group needed to support the Action Plan might be different to the stakeholders involved in the review. Ideally stakeholders will meet regularly and receive reports on progress, insights, lessons learnt and any barriers (including lack of resources) that are hampering the Action Plan's implementation.

4.5 Change management

The Health Literacy Action Plan describes changes that need to be made in the service and your organisation. How to respond to any resistance to change can be built into the Action Plan. For example, it could include messages for leaders and managers about how the Action Plan is benefiting the organisation and the people it serves.

Your organisation could also create case studies and stories showing how the Health Literacy Action Plan is making a difference to the organisation and the people it serves. Your organisation's health literacy champions can share their experiences and use stories and case studies to engage staff and create more champions.

4.6 Tips for success

Research shows that when implementing a system change, strong leadership, adequate resources and dedicated promotional activities are essential for success.

Research (The Health Foundation 2014) has identified the following tips for spreading good practice.

- Get a range of people, including clinical and managerial leaders, involved in both implementing and disseminating ideas.
- See people as active change agents, not passive recipients.
- Emphasise how the initiatives address people's priorities.
- Target messages differently for different audiences.
- Provide support and training to help people understand and implement change.
- Make time and funds available to disseminate information about the change.
- Use a wide range of approaches such as social media, opinion leaders and professional networks.
- Evaluate the success of innovations and improvements as well as how far they have been made within teams and organisations and more broadly. The things that are measured tend to get more emphasis, so measuring how far these changes have spread might help to keep them as a priority.

References

DeWalt DA, McNeill J. 2013. *Integrating Health Literacy with Health Care Performance Measurement: Discussion paper*. Washington, DC: Institute of Medicine.

Ministry of Health. 2010. *Kōrero Mārama: Health Literacy and Māori. Results from the 2006 Adult Literacy and Life Skills Survey*. Wellington: Ministry of Health.

The Health Foundation. 2014. *Spreading Improvement Ideas: Tips from empirical research. Evidence scan*. London: The Health Foundation.

Appendix 1: Six Dimensions – background information

This appendix briefly outlines the tools and frameworks that were considered in identifying the Six Health Literacy Dimensions that are the basis of the review process set out in this Guide.

After the tools and frameworks described below were analysed, the Ten Attributes framework was selected as the basis for the Six Dimensions because it is comprehensive and covers all aspects of a health care organisation. The Ten Attributes framework was developed in the United States of America and was modified to reflect the New Zealand health care system. Some of the Ten Attributes have been combined (for example, Attributes 1 and 2) and Attribute 10 has been omitted because it is not relevant in New Zealand. The Ten Attributes framework encompasses the seminal work of three earlier tools (Rudd and Anderson 2006; Jacobson et al 2007; Agency for Healthcare Research and Quality 2010).

Of the international health literacy review tools and frameworks that were reviewed, the best-known is Rudd and Anderson's (2006) *The Health Literacy Environment of Hospitals and Health Centers. Partners for Action: Making your healthcare facility literacy-friendly*.

This seminal document has been used as the foundation for the development of other review tools: *Is Our Pharmacy Meeting Patients' Needs? A pharmacy health literacy assessment tool user's guide* (Jacobson et al 2007) and *Health Literacy Universal Precautions Toolkit* (Agency for Healthcare Research and Quality 2010).

These later review tools focus on reviewing the interactions and experiences of health practitioners delivering services as well as the experiences and interactions of consumers. These interactions and experiences provide evidence of health literacy 'in practice'.

The authors of these tools and frameworks encourage others to use evidence developed by applying the tools and approaches to examine organisational policies, processes, culture and values.

In 2012 the Institute of Medicine published *Ten Attributes of Health Literate Health Care Organizations* (Brach et al 2012). This framework does not include any review tools. It provides a rationale for each attribute as well as a range of initiatives various health care organisations are implementing under each attribute.

The following international and national tools and articles were also considered when developing the Six Dimensions.

International tools and articles

- Agency for Healthcare Research and Quality. 2011. CAHPS Item Set for Addressing Health Literacy.
- Agency for Healthcare Research and Quality. 2013. Guide to Patient and Family Engagement in Hospital Quality and Safety.

- Agency for Healthcare Research and Quality. 2015. Health Literacy Universal Precautions Toolkit. 2nd ed.
- American Medical Association. 2008. Communication Climate Assessment Toolkit.
- ASHP Foundation. 2012. Leading Change in a Complex Health Care System.
- Bailey et al. 2013. The progress and promise of health literacy research.
- Barrett et al. 2008. Health Literacy Practices in Primary Care Settings: Examples from the field.
- Bonomi et al. 2002. Assessment of Chronic Illness Care (ACIC): a practical tool to measure quality improvement.
- Busjeet. 2013. Planning, Monitoring, and Evaluation: Methods and tools for poverty and inequality reduction programs.
- Carman et al. 2013. Patient and family engagement: a framework for understanding the elements and developing interventions and policies.
- Center for Medical Home Improvement. 2008. The Medical Home Index: Adult.
- Centers for Disease Control and Prevention. 2008. Capacity Building for Diabetes Outreach.
- Centers for Disease Control and Prevention. 2011. Making Health Literacy Real: The beginnings of my organization's plan for action.
- Centers for Disease Control and Prevention. 2014a. CDC Clear Communication Index: A Tool for Developing and Assessing CDC Publication Communication Products.
- Centers for Disease Control and Prevention. 2014b. Organizational Attributes.
- Chin et al. 2013. 5 Imperatives: Addressing healthcare's innovation challenge.
- Clinical Excellence Commission. 2013. Health Literacy Guide.
- Department for Business Innovation and Skills. 2010. Impact Assessment Guidance.
- Donetto et al. 2014. Using Experience-based Co-design to Improve the Quality of Healthcare: Mapping where we are now and establishing future directions.
- Gazmararian et al. 2010. The development of a health literacy assessment tool for health plans.
- Groene and Rudd. 2011. Results of a feasibility study to assess the health literacy environment: navigation, written, and oral communication in 10 hospitals in Catalonia, Spain.
- Institute of Medicine. 2012. How Can Health Care Organizations Become More Health Literate? Workshop summary.
- Jeffs et al. 2013. The effect of an organizational network for patient safety on safety event reporting.
- Lin et al. 2011. Service design and change of systems: human-centered approaches to implementing and spreading service design.
- McCormack et al. 2013. Recommendations for advancing health literacy measurement.
- Mende and Roseman. 2013. The aligning forces for quality experience: lessons on getting consumers involved in health care improvements.
- Oliver et al. 2014. Making Our Health and Care Systems Fit for an Ageing Population.
- Paasche-Orlow et al. 2006. How health care systems can begin to address the challenge of limited literacy.
- Parnell et al. 2014. Health Literacy as an Essential Component to Achieving Excellent Patient Outcomes.

- Royal College of General Practitioners. 2014. Health Literacy: Report from an RCGP-led health literacy workshop.
- Swensen et al. 2013. High-impact Leadership: Improve care, improve the health of populations, and reduce costs.
- Taylor et al. 2014. Systematic review of the application of the plan-do-study-act method to improve quality in healthcare.
- The Health Foundation. 2014a. A Framework for Measuring and Monitoring Safety: A practical guide to using a new framework for measuring and monitoring safety in the NHS.
- The Health Foundation. 2014b. Shine: Improving the value of local healthcare services. How healthcare teams took on the challenge to improve quality while reducing the cost of services.
- The Health Foundation. 2014c. Perspectives on Context: A selection of essays considering the role of context in successful quality improvement.
- The Health Foundation. 2014d. Helping Measure Person-centred Care: A review of evidence about commonly used approaches and tools used to help measure person-centred care.
- The Joint Commission. 2007. ‘What Did the Doctor Say?’ Improving health literacy to protect patient safety.
- The Joint Commission. 2010. Advancing Effective Communication, Cultural Competence, and Patient- and Family-centered Care: A roadmap for hospitals.
- US Department of Health and Human Services. 2010. National Action Plan to Improve Health Literacy.
- Weiss. 2007. Health Literacy and Patient Safety: Help patients understand. Manual for clinicians.
- West et al. 2014. Developing Collective Leadership for Health Care.
- World Health Organization. 2011. Good Practice Appraisal Tool for Obesity Prevention Programmes, Projects, Initiatives and Interventions.
- Wynia and Osborn. 2010. Health literacy and communication quality in health care organizations.

National tools and articles

- Accident Compensation Corporation. 2008. Guidelines to Understanding the Audit Standards for Safety Management Practices: ACC Workplace Safety Management Practices Audit Guidelines.
- Accident Compensation Corporation. 2012. How to Implement Safer Workplace Practices: A guide to workplace health and safety.
- Bay of Plenty District Health Board. 2012. Excellence through Patient and Family Centred Care: Literature review.
- Flanagan et al. 2014. Learnings from a Project to Develop a Generic Self-management Care Plan for Long Term Conditions.
- Health Quality & Safety Commission. 2013. Quality and Safety Guide.
- Ministry of Health. 2013. The Well Child/Tamariki Ora Quality Improvement Framework.
- Signal et al. 2008. The Health Equity Assessment Tool: A user’s guide.
- Stephenson. No date. Health Promotion Infrastructure: A thinkpiece.
- Thomsen. 2014. Bridging the Communication Gap: What do primary healthcare practitioners in New Zealand know about health literacy? What are their attitudes towards it, and do they implement any internationally developed health literacy tools?

From the Ten Attributes Framework, the following Six Dimensions were developed for the New Zealand context. These Dimensions form the framework for this Guide.

1. **Leadership and management.** How is health literacy an organisational value, part of the culture and the core business of an organisation? How is it reflected in strategic and operational plans?
2. **Consumer involvement.** How are consumers involved in designing, developing and evaluating the organisation's values, vision, structure and service delivery?
3. **Workforce.** How does the organisation encourage and support the health workforce to develop effective health literacy practices? Has it identified the workforce's needs for health literacy development and capacity? Has the organisation's health literacy performance been evaluated?
4. **Meeting the needs of the population.** How does service delivery make sure that consumers with low health literacy are able to participate effectively and have their health literacy needs identified and met (without experiencing any stigma or being labelled as having low health literacy)? How is meeting the needs of the population monitored?
5. **Access and navigation.** How easy is it for consumers to find and engage with appropriate and timely health and related services? How are consumers helped to find and engage with these services? How well are services coordinated and are services streamlined where possible?
6. **Communication.** How are information needs identified? How is information shared with consumers in ways that improve health literacy? How is information developed with consumers and evaluated?

The Six Dimensions are applied to examine how staff, consumers and families interact, and to review relevant policies, processes, structures and culture in a particular health service or health care organisation. The aim of these activities is to identify the causes of health literacy barriers and opportunities for improvement.

The following table provides the rationale for each dimension.

New Zealand's Six Dimensions	Rationale
1. Leadership and management. How is health literacy an organisational value, part of the culture and core business of an organisation? How is it reflected in strategic and operational plans?	Leaders and managers have a critical role in developing a health-literate organisation. They drive an organisation's health literacy culture by articulating and reinforcing goals and expectations, and by modelling expected behaviours. Leaders and managers in a health-literate health care organisation ensure that health literacy is built into all aspects of the organisation, explicitly measured and monitored, and continuously improved.
2. Consumer involvement. How are consumers involved in designing, developing and evaluating the organisation's values, vision, structure and service delivery?	A commitment to patient-centred care, consumer safety and quality improvement involves more than the activities of managers, clinical leaders and other staff. A health-literate health care organisation involves consumers and their families in all aspects of service delivery – not just the evaluation of consumer experience.
3. Workforce. How does the organisation encourage and support the health workforce to develop effective health literacy practices? Has it identified the workforce's needs for health literacy development and capacity? Has the organisation's health literacy performance been evaluated?	The health workforce plays a crucial role in communicating oral and written information to consumers and families and ensuring they understand that information. A health-literate health care organisation provides health literacy training and coaching to its entire workforce to improve communication and build health literacy.
4. Meeting the needs of the population. How does the delivery of services make sure consumers with low health literacy are able to participate effectively and have their health literacy needs identified and met (without experiencing any stigma or being labelled as having low health literacy)? How is meeting the needs of the population monitored?	Because health literacy is diverse and ongoing, health care organisations will find it difficult to identify who in their consumer population has low health literacy. A health-literate health care organisation adopts a universal precautions approach so that staff do not make assumptions about who might or might not need assistance.
5. Access and navigation. How easy is it for consumers to find and engage with appropriate and timely health and related services? How are consumers helped to find and engage with these services? How well are services coordinated and are services streamlined where possible?	Health care organisations develop and use systems that place demands on consumers and families. A health-literate health care organisation reduces the demands its systems place on consumers and families and helps them to access and navigate systems.
6. Communication. How are information needs identified? How is information shared with consumers in ways that improve health literacy? How is information developed with consumers and evaluated?	Health care organisations communicate with consumers and families orally, in writing and increasingly using technology. A health-literate health care organisation ensures that all communication, in all formats, is clear, easy to understand and easy for consumers and families to act on.

References for Appendix 1

Accident Compensation Corporation. 2008. *Guidelines to Understanding the Audit Standards for Safety Management Practices: ACC workplace safety management practices audit guidelines*. Wellington: Accident Compensation Corporation. URL: www.acc.co.nz/PRD_EXT_CSMP/groups/external_lexies/documents/guide/wcm2_020286.pdf (accessed 23 February 2015).

Accident Compensation Corporation. 2012. *How to Implement Safer Workplace Practices: A guide to workplace health and safety*. Wellington: Accident Compensation Corporation. URL: www.acc.co.nz/PRD_EXT_CSMP/groups/external_ip/documents/publications_promotion/wcm000924.pdf (accessed 23 February 2015).

Agency for Healthcare Research and Quality. 2010. *Health Literacy Universal Precautions Toolkit*. Rockville, MD: Agency for Healthcare Research and Quality. URL: www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/literacy-toolkit/index.html (accessed 10 April 2015).

- Agency for Healthcare Research and Quality. 2011. *CAHPS Item Set for Addressing Health Literacy*. Rockville, MD: Agency for Healthcare Research and Quality. URL: <https://cahps.ahrq.gov/surveys-guidance/item-sets/literacy/index.html> (accessed 19 November 2014).
- Agency for Healthcare Research and Quality. 2013. *Guide to Patient and Family Engagement in Hospital Quality and Safety*. Rockville, MD: Agency for Healthcare Research and Quality. URL: www.ahrq.gov/professionals/systems/hospital/engagingfamilies/guide.html (accessed 23 February 2015).
- Agency for Healthcare Research and Quality. 2015. *Health Literacy Universal Precautions Toolkit*. 2nd ed. Rockville, MD: Agency for Healthcare Research and Quality. URL: www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/literacy-toolkit/index.html (accessed 10 April 2015).
- American Medical Association. The Ethical Force Program. 2008. *Communication Climate Assessment Toolkit*. URL: <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/the-ethical-force-program/patient-centered-communication/organizational-assessment-resources.page> (accessed 23 February 2015).
- ASHP Foundation. 2012. *Leading Change in a Complex Health Care System*. URL: www.ashpfoundation.org/transformational/TransformationalChange110212.html (accessed 23 February 2015).
- Bailey SC, McCormack LA, Rush SR, et al. 2013. The progress and promise of health literacy research. *Journal of Health Communication: International Perspectives* 18(S1): 5–8.
- Barrett SE, Puryear JS, Westpheling K. 2008. *Health Literacy Practices in Primary Care Settings: Examples from the field*. The Commonwealth Fund. URL: www.commonwealthfund.org/~media/files/publications/fund-report/2008/jan/health-literacy-practices-in-primary-care-settings--examples-from-the-field/barrett_hltliteracypracticesprimarycaresettingsexamplesfield_1093-pdf.pdf (accessed 25 February 2015).
- Bay of Plenty District Health Board. 2012. *Excellence through Patient and Family Centred Care: Literature review*. URL: www.hqsc.govt.nz/our-programmes/consumer-engagement/publications-and-resources/publication/352 (accessed 23 February 2015).
- Bonomi AE, Wagner EH, Glasgow RE, et al. 2002. Assessment of Chronic Illness Care (ACIC): a practical tool to measure quality improvement. *HSR: Health Services Research* 14: 791–820.
- Brach C, Keller D, Hernandez LM, et al. 2012. *Ten Attributes of Health Literate Health Care Organizations*. Washington, DC: Institute of Medicine of the National Academies.
- Busjeet G. 2013. *Planning, Monitoring, and Evaluation: Methods and tools for poverty and inequality reduction programs*. Washington, DC: World Bank. URL: http://siteresources.worldbank.org/EXTPOVERTY/Resources/ME_ToolsMethodsNov2.pdf (accessed 23 February 2015).
- Carman KL, Dardess P, Maurer M. 2013. Patient and family engagement: a framework for understanding the elements and developing interventions and policies. *Health Affairs* 32: 2223–31.
- Center for Medical Home Improvement. 2008. *The Medical Home Index: Adult. Measuring the organization and delivery of primary care for all adults and their families*. URL: www.medicalhomeimprovement.org/pdf/CMHI-MHI-Adult-Primary-Care_Full-Version.pdf (accessed 25 February 2015).
- Centers for Disease Control and Prevention. National Diabetes Education Program. 2008. *Capacity Building for Diabetes Outreach: A comprehensive tool kit for organizations serving Asian and Pacific Islander communities*. URL: <http://ndep.nih.gov/media/capacity-building-toolkit.pdf> (accessed 23 February 2015).

- Centers for Disease Control and Prevention. Office of the Associate Director for Communication. 2011. *Making Health Literacy Real: The beginnings of my organization's plan for action*. URL: www.cdc.gov/healthliteracy/pdf/planning_template.pdf (accessed 23 February 2015).
- Centers for Disease Control and Prevention. Office of the Associate Director for Communication. 2014a. *CDC Clear Communication Index: A tool for developing and assessing CDC public communication products*. URL: www.cdc.gov/ccindex/pdf/clear-communication-user-guide.pdf (accessed 23 February 2015).
- Centers for Disease Control and Prevention. 2014b. *Organizational Attributes*. URL: www.cdc.gov/healthliteracy/planact/steps/index.html (accessed 23 February 2015).
- Chin WW, Hamermesh RG, Huckman RS, et al. 2013. *5 Imperatives: Addressing healthcare's innovation challenge*. URL: www.hbs.edu/healthcare/Documents/Forum-on-Healthcare-Innovation-5-Imperatives.pdf (accessed 23 February 2015).
- Clinical Excellence Commission. 2013. *Health Literacy Guide*. URL: www.cec.health.nsw.gov.au/__documents/programs/partnering-with-patients/hlg/hl-guide-combined.pdf (accessed 23 February 2015).
- Department for Business Innovation and Skills. 2010. *Impact Assessment Guidance*. London: Department for Business Innovation and Skills. URL: <http://webarchive.nationalarchives.gov.uk/+http://www.web.bis.gov.uk/assets/biscore/better-regulation/docs/10-898-impact-assessment-guidance.pdf> (accessed 25 February 2015).
- Donetto S, Tsianakas V, Robert G. 2014. *Using Experience-based Co-design (EBCD) to Improve the Quality of Healthcare: Mapping where we are now and establishing future directions. Final report*. London: King's College London. URL: www.kcl.ac.uk/nursing/research/nuru/publications/reports/ebcd-where-are-we-now-report.pdf (accessed 23 February 2015).
- Flanagan P, Moffat J, Healey K, et al. 2014. *Learnings from a Project to Develop a Generic Self-management Care Plan for Long Term Conditions*. URL: www.hiirc.org.nz/page/49789/learnings-from-a-project-to-develop-a-generic/?;jsessionid=A748FB11020CDC58D61386FA14D358Fo?section=8959 (accessed 25 February 2015).
- Gazmararian JA, Beditz K, Pisano S, et al. 2010. The development of a health literacy assessment tool for health plans. *Health Communication* 5(Suppl 2): 93–101.
- Groene RO, Rudd RE. 2011. Results of a feasibility study to assess the health literacy environment: navigation, written, and oral communication in 10 hospitals in Catalonia, Spain. *Journal of Communication in Healthcare* 4(4): 227–237.
- Health Quality & Safety Commission New Zealand. 2013. *Quality and Safety Guide*. Wellington: Health Quality & Safety Commission New Zealand.
- Institute of Medicine. 2012. *How Can Health Care Organizations Become More Health Literate? Workshop summary*. Washington, DC: The National Academies Press.
- Jacobson KL, Gazmararian JA, Kripalani S, et al. 2007. *Is Our Pharmacy Meeting Patients' Needs? A pharmacy health literacy assessment tool user's guide*. Rockville, MD: Agency for Healthcare Research and Quality.
- Jeffs L, Hayes C, Smith O, et al. 2013. The effect of an organizational network for patient safety on safety event reporting. *Evaluation & the Health Professions* 37: 366–378.
- Lin MC, Hughes BL, Katica MK, et al. 2011. Service design and changes of systems: human-centered approaches to implementing and spreading service design. *International Journal of Design* 5(2): 73–86.

- McCormack L, Haun J, Sorensen K, et al. 2013. Recommendations for advancing health literacy measurement. *Journal of Health Communication* 18(1): 9–14.
- Mende S, Roseman D. 2013. The aligning forces for quality experience: lessons on getting consumers involved in health care improvements. *Health Affairs* 32(6): 1092–100.
- Ministry of Health. 2013. *The Well Child/Tamariki Ora Quality Improvement Framework*. Wellington: Ministry of Health.
- Oliver D, Foot C, Humphries R. 2014. *Making Our Health and Care Systems Fit for an Ageing Population*. London: King's Fund. URL: www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/making-health-care-systems-fit-ageing-population-oliver-foot-humphries-mar14.pdf (accessed 23 February 2015).
- Paasche-Orlow MK, Schillinger D, Greene SM, et al. 2006. How health care systems can begin to address the challenge of limited literacy. *Journal of General Internal Medicine* 21: 884–7.
- Parnell T, McCulloch E, Mieres J, et al. 2014. *Health Literacy as an Essential Component to Achieving Excellent Patient Outcomes*. Institute of Medicine of the National Academies. URL: www.iom.edu/~media/Files/Perspectives-Files/2014/Discussion-Papers/BPH-EssentialComponent.pdf (accessed 23 February 2015).
- Royal College of General Practitioners. 2014. *Health Literacy: Report from an RCGP-led health literacy workshop*. London: Royal College of General Practitioners. URL: www.rcgp.org.uk/clinical-and-research/clinical-resources/~media/Files/CIRC/Health%20Literacy%20Report/Health%20Literacy%20Final%20edition%2029%2007%202014.ashx (accessed 23 February 2015).
- Rudd RE, Anderson JE. 2006. *The Health Literacy Environment of Hospitals and Health Centers. Partners for Action: Making your healthcare facility literacy-friendly*. Boston, MA: National Center for the Study of Adult Learning and Literacy.
- Signal L, Martin J, Cram F, Robson B. 2008. *The Health Equity Assessment Tool: A user's guide*. Wellington: Ministry of Health.
- Stephenson P. No date. *Health Promotion Infrastructure: A thinkpiece*. Auckland: Health Promotion Forum of New Zealand. URL: www.hauora.co.nz/assets/files/Occasional%20Papers/Health%20promotion%20infrastructure%20thinkpiece%20.pdf (accessed 23 February 2015).
- Swensen S, Pugh M, McMullan C, et al. 2013. *High-impact Leadership: Improve care, improve the health of populations, and reduce costs. IHI White Paper*. Cambridge, MA: Institute for Healthcare Improvement.
- Taylor MJ, McNicholas C, Nicolay C, et al. 2014. Systematic review of the application of the plan-do-study-act method to improve quality in healthcare. *BMJ Quality & Safety* 23: 290–8.
- The Health Foundation. 2014a. *A Framework for Measuring and Monitoring Safety: A practical guide to using a new framework for measuring and monitoring safety in the NHS*. London: The Health Foundation. URL: www.health.org.uk/public/cms/75/76/313/4773/A%20framework%20for%20measuring%20and%20monitoring%20safety.pdf?realName=Z6mDZZ.pdf (accessed 23 February 2015).
- The Health Foundation. 2014b. *Shine: Improving the value of local healthcare services. How healthcare teams took on the challenge to improve quality while reducing the cost of services. Learning report*. London: The Health Foundation. URL: www.health.org.uk/public/cms/75/76/313/4692/Shine%20-%20improving%20the%20value%20of%20local%20healthcare%20services.pdf?realName=VVh5L4.pdf (accessed 23 February 2015).

The Health Foundation. 2014c. *Perspectives on Context: A selection of essays considering the role of context in successful quality improvement*. London: The Health Foundation. URL: <http://www.health.org.uk/public/cms/75/76/313/4708/Perspectives%20on%20context.pdf?realName=7ISYoA.pdf> (accessed 23 February 2015).

The Health Foundation. 2014d. *Helping Measure Person-centred Care: A review of evidence about commonly used approaches and tools used to help measure person-centred care*. London: The Health Foundation. URL: www.health.org.uk/public/cms/75/76/313/4697/Helping%20measure%20person-centred%20care.pdf?realName=Lnl7Fn.pdf (accessed 23 February 2015).

The Joint Commission. 2007. *‘What Did the Doctor Say?’ Improving health literacy to protect patient safety*. Oakbrook Terrace, IL: The Joint Commission. URL: www.jointcommission.org/assets/1/18/improving_health_literacy.pdf (accessed 23 February 2015).

The Joint Commission. 2010. *Advancing Effective Communication, Cultural Competence, and Patient- and Family-centered Care: A roadmap for hospitals*. Oakbrook Terrace, IL: The Joint Commission. URL: www.jointcommission.org/assets/1/6/aroamapforhospitalsfinalversion727.pdf (accessed 23 February 2015).

Thomsen J. 2014. *Bridging the Communication Gap: What do primary healthcare practitioners in New Zealand know about health literacy? What are their attitudes towards it, and do they implement any internationally developed health literacy tools?* URL: <http://researcharchive.vuw.ac.nz/bitstream/handle/10063/3478/thesis.pdf?sequence=3> (accessed 25 February 2015).

US Department of Health and Human Services. Office of Disease Prevention and Health Promotion. 2010. *National Action Plan to Improve Health Literacy*. URL: www.health.gov/communication/hlactionplan/pdf/Health_Literacy_Action_Plan.pdf (accessed 23 February 2015).

Weiss BD. 2007. *Health Literacy and Patient Safety: Help patients understand. Manual for clinicians*. Chicago: American Medical Association Foundation.

West M, Eckert R, Steward K, et al. 2014. *Developing Collective Leadership for Health Care*. London: King’s Fund. URL: www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/developing-collective-leadership-kingsfund-may14.pdf (accessed 23 February 2015).

World Health Organization. 2011. *Good Practice Appraisal Tool for Obesity Prevention Programmes, Projects, Initiatives and Interventions*. Copenhagen: World Health Organization.

Wynia MK, Osborn CY. 2010. Health literacy and communication quality in health care organizations. *Journal of Health Communication Quality: International Perspectives* 15(S2): 102–115.

Appendix 2: Health literacy statements

A health care organisation may develop a health literacy statement to prepare for a health literacy review or to support the implementation of a Health Literacy Action Plan.

A health literacy statement can provide purpose and guidance to an organisation as it becomes a health-literate organisation. It is important that the statement reflects an organisational perspective on health literacy, positioning health literacy as a systemic and service commitment, rather than as an issue of consumer skill deficit.

Example 1: Health literacy statement with a service quality focus

At ABC Healthcare we are committed to providing health-literate services to our community and building health literacy with our consumers, in order to improve health outcomes.

Example 2: Health literacy statement with an organisational focus

At DEF Healthcare, we are committed to:

- understanding health literacy as a system issue in our organisation
- reviewing our services from a health literacy perspective
- understanding and reducing the health literacy demands our organisation places on our consumers
- integrating health literacy into our systems and procedures
- providing health literacy training for our staff.

Example 3: Health literacy statement with an organisational focus

GHI Healthcare is committed to being a health-literate organisation. This means our policies, processes, services and teams will be focused on providing health care and information that meet the health literacy needs of our consumers and families.

Example 4: Health literacy statement with a service delivery focus

At JKL Healthcare we will use health literacy approaches when working with consumers and families.

Appendix 3: Initial health literacy training for reviewers

This lesson plan is in two parts:

- building shared understanding of health literacy and a systems approach to health literacy and how it informs health literacy reviews
- how to carry out a health literacy review.

Duration

This session plan has been designed for a four-hour time slot. It is possible to split this into two sessions delivered at different times.

Framework

This session plan is based on the Before During After (BDA) Framework.

- Before the session, the facilitator will find out what participants already know.
- During each session or part of the session, the facilitator will build new knowledge onto participants' existing knowledge base.
- At the end of each session or part of the session, the facilitator checks that participants have achieved the intended outcomes for that session or part of the session. If not, the facilitator takes responsibility for not achieving the outcomes and, as necessary, goes back to build the necessary knowledge.

Objectives for this session

Build shared understanding of:

- health literacy definitions
- health literacy statistics in New Zealand
- how health literacy has evolved
- the impact of low health literacy
- a systems approach to health literacy
- health literacy demands
- health literacy barriers in health care organisations
- Six Dimensions of a health-literate health care organisation – where they came from and how they were developed
- overview of the process of a health literacy review – planning and preparation, carrying out the review, developing a health literacy action plan and implementing the plan
- carrying out a health literacy review
- benefits of carrying out a review.

Resources

- Laptop and data show for showing videos
- Whiteboard and markers
- Flip charts and marker pens
- Post-it notes
- Flip chart paper for car park
- Six Dimensions graphic
- Question and answer cards
- Situations
- Cards numbered 1–6
- Small prize
- *Kōrero Mārama*
- Child's outpatient journey
- Health literacy videos
- Copies for each participant of:
 - Background information about health literacy
 - Three Steps to Better Health Literacy: A guide for health professionals
 - Ten Attributes of a Health Literate Health Care Organization Guide
 - this guide

These documents have been circulated as background reading prior to the training session.

Time	Activity	Resources
5 minutes	<p>Welcome and housekeeping</p> <p>Welcome all participants.</p> <p>Give housekeeping information.</p> <p>Show objectives of training session on flip charts.</p> <p>Explain it is a full session and, if people have questions about the review process, we will answer these as we go through.</p> <p>Encourage people to ask questions throughout session.</p> <p>Do a quick round of introductions if everyone doesn't know each other already.</p>	Flip chart page with objectives
30 minutes	<p>What is health literacy?</p> <p>Hand out Post-its to every participant.</p> <p>Ask them to write down what they think health literacy is, using a separate Post-it note for each idea.</p> <p>Draw a horizontal line on a whiteboard or piece of flip chart paper.</p> <p>Label one end 'patient issue' and label the other end 'systems issue'. Label the middle 'health professional issue'.</p> <p>Ask participants to come up one at a time and stick their Post-its on the line where they think their definition sits.</p> <p>Go through each Post-it and move it if it is in the wrong place.</p> <p>Explain why you are moving it.</p> <p>Label the top of the drawing 'Evolution of Health Literacy'.</p> <p>Ask participants to look at page 2 of the 'Background information' booklet. Looking at the flip chart, where do they consider their current thinking to be?</p> <p>Explain that a health literacy review takes a systems view. The patient still has responsibility but the barriers that systems create and the role of health professionals become much more prominent.</p> <p>Hand out a copy of the definition from <i>Kōrero Mārama</i>.</p> <p>Explain it is a very old definition. Ask where it sits on the continuum (patient issue).</p> <p>Ask who will provide patients with information and help them to understand (health professionals and providers).</p> <p>Explain that the role of systems and health professionals is implicit in this old definition but it is there.</p>	<p>Post-its</p> <p>Flip chart or whiteboard</p> <p>Background information about health literacy</p> <p>Relevant page from <i>Kōrero Mārama</i></p>
15 minutes	<p>Health literacy statistics</p> <p>Give out question and answer cards about New Zealand health literacy statistics – eg, largest group with low health literacy, percentage of people, number of people, other groups (older, younger and so on).</p> <p>Ask participants to match up questions and answers.</p> <p>Check they have it right.</p> <p>Refer them to page 3 of the 'Background information' booklet.</p> <p>Make sure they understand Pākehā adults are the single largest group with low health literacy in New Zealand and why.</p>	<p>Question and answer cards or Post-its</p> <p>Background information</p>
10 minutes	<p>Impact of low health literacy</p> <p>Brainstorm with participants what they think the impact of low health literacy is.</p> <p>Encourage them to think of stories from their own roles.</p> <p>If necessary, offer prompts that people are more likely to:</p> <ul style="list-style-type: none"> • go to hospital • use emergency services • not participate in screening • know less about illness, medicines and treatment • manage long-term conditions • get injured at work. 	Flip chart or whiteboard

Time	Activity	Resources
15 minutes	<p>Systems approach to health literacy</p> <p>Ask participants to work in pairs.</p> <p>Give them a situation that is relevant to their service or the service being reviewed – eg, patient coming in for annual diabetes review.</p> <p>Ask them to write down all the systems in their organisation that impact on this visit – eg, Standing Orders, Clinical Guidelines, training of practice nurse, funding requirements from your primary health organisation, Ministry’s Quality Standards for people with diabetes.</p> <p>Say you are going to give a prize to the pair that comes up with the best list (have a suitable small prize available).</p> <p>Ask them to record lists on flip charts.</p> <p>After five minutes, ask them to share the results.</p> <p>Look at each flip chart and point out similarities and differences.</p> <p>Point out what is a system and what isn’t.</p> <p>Explain that in a health literacy review you are looking at all those systems to see if health literacy is part of that system.</p> <p>Award the prize.</p>	<p>Situations</p> <p>Small prize</p>
10 minutes	<p>Health literacy demands</p> <p>Hand out a copy of the child’s journey through an outpatient clinic.</p> <p>Explain that this lists all the health literacy demands placed on a parent.</p> <p>Ask them to go through the patient journey.</p> <p>After five minutes, go around the group and find out what surprised them.</p> <p>Explain that they don’t see the demands because they work in the system and have become used to them.</p>	<p>Child’s outpatient journey</p>
5 minutes	<p>Recap</p> <p>Go around the group. Ask them to state one thing they learnt from the last two hours.</p> <p>Explain that they can’t repeat something that someone else has already said.</p> <p>If necessary, refer them to lists of objectives.</p>	
30 minutes	Break (or this could be the end of the session)	
20 minutes	<p>Six Dimensions of a health-literate organisation</p> <p>Hand out question cards to people with numbers 1 to 6 on them.</p> <p>Ask them to write in the title of the Dimension that corresponds to the number on their card.</p> <p>If they can’t remember, they can ask someone else.</p> <p>Refer them to the guide or appendix 1 in the guide.</p> <p>Hand out the Six Dimensions graphic.</p> <p>Ask them to work in pairs or small groups.</p> <p>Give each group a Dimension.</p> <p>Ask them to write down examples of what they would be looking for as a reviewer under that Dimension.</p> <p>At the end, ask them to put their lists up.</p> <p>Ask everyone to have a look at them.</p> <p>Remind the group where the Six Dimensions came from (Ten Attributes) and refer to it as part of their pre-reading.</p>	<p>Six Dimensions graphic</p> <p>This guide</p>

Time	Activity	Resources
30 minutes	<p>Overview of health literacy review</p> <p>Ask participants to work in small groups.</p> <p>Hand out pieces of paper, each of which is marked with the numbers 2 (Preparing for a review), 3 (Carrying out a review) or 4 (Health Literacy Action Plan). If you have a big group, and there are too many people to work in just three small groups, divide the bigger group into six smaller groups and give two groups number 2, two groups number 3 and two groups number 4.</p> <p>Ask them to complete the title that corresponds to the number from the section in the Guide.</p> <p>Ask participants, without referring to the Guide, to brainstorm as many things as possible that they would be doing in that section of the review.</p> <p>After five minutes, ask them to draw a line under the list and then look at the Guide and add or delete sections as needed.</p> <p>Ask each group to put their list up.</p> <p>Ask each group what they found easy to remember and what they found hard to remember and why.</p>	This guide
30 minutes	<p>Benefits of a review</p> <p>Look at either all or one or two of the videos on the guide web page (choosing the video(s) most relevant to the focus of your review).</p> <p>Play the videos and then discuss with the group what benefits people on the video talked about.</p> <p>If necessary, play the video again to confirm observations.</p> <p>Ask the group whether they think they will get similar benefits from the review or different benefits.</p> <p>Ask them to give reasons.</p> <p>Record these on flip charts.</p> <p>At the end, clarify what the group thinks will be the benefit of this health literacy review.</p>	Health literacy videos Flip chart
30 minutes	<p>Carrying out a health literacy review</p> <p>Ask the group to look at section 3 of the guide and select one aspect they would like to practise in this short time.</p> <p>If possible, set people to work on different activities – eg, document analysis, interviews, clinical observations, patient journey and environmental observation.</p> <p>Ask them to write, on a piece of flip chart paper, a plan of the steps they need to practise, what they need and who can help them.</p> <p>Remind them that the appendices in the guide have useful templates and some of the videos are helpful too.</p> <p>After 20 minutes, ask each person to share their plan.</p>	Guide Flip chart
10 minutes	<p>Evaluation</p> <p>Write three words down the left-hand side of a piece of flip chart paper:</p> <p>Plus</p> <p>Minus</p> <p>Interesting</p> <p>Ask each participant to think about the last two hours and talk about something in each category. Say you really want their feedback.</p> <p>Record and discuss feedback.</p> <p>Farewell.</p>	Flip chart

Appendix 4: Example of a review of an organisational document

This page comes from the Northland District Health Board’s Health Services Plan 2012–2017. The table underneath indicates a possible approach to reviewing this page.



Benefits/costs	Performance measures	Implementation	Accountability
medium to long-term. Action costs will need to be estimated during planning.			
<p>Building on the success of current collective intersectoral action, the expected impact is an increase in the proportion of Northlanders leading healthy lifestyles and amelioration of health risk factors. In turn this would reduce the prevalence of long-term conditions (LTCs), alcohol/drug-related adverse events and reduce Ambulatory Sensitive Hospitalisation (ASH) rates. Associated with these reductions will be cost savings for patients, whānau, and the health system.</p> <p>The costs associated with intersectoral collective action will depend on the scope and nature of collaboration. We note that Waikato DHB’s Project Energise cost approximately \$2 million (2011/12).</p>	<p>Increase in proportion of children and adults with a healthy Body Mass Index (BMI)</p> <p>Decrease in incidence of alcohol/drug related adverse events</p> <p>Increase in number of Healthy Homes referrals and interventions for high needs populations/whānau</p> <p>Reduce ASH particularly for Māori, people with LTCs and children</p>	<p>Local Food Accords for priority areas (2014)</p> <p>TLA alcohol/gambling regulations and commercial use permits (2013)</p> <p>Improved targeting of ‘Healthy Homes’ initiative (2012)</p> <p>Roll-out of primary school exercise programme (2014)</p>	<p>GM Planning, Māori, Primary & Population Health</p> <p>GM Child, Youth, Maternal & Oral Health</p>
<p>Improving the health literacy of people (and their whānau) with LTCs will result in better patient adherence to care plans, improved self-management, and more timely patient follow-up. In turn, patient health outcomes will improve with slower disease progression and less reliance on health professional services. This will result in better quality of life for patients and reduced care health costs for patients, whānau, and the health system.</p>	<p>Increase percentage of Northlanders with LTCs who are <u>health literate</u></p> <p>Decrease in ASH for Māori and people with long-term conditions</p> <p>Decrease in the percentage of Northlanders in specialist mental health services who would have been in the service for longer than one year</p>	<p>2012 (Whakamana Hauora)</p> <p>2013 for other initiatives</p>	<p>PHO CEs (for their respective areas/ populations)</p>

In this document, health literacy is positioned as a consumer issue

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Document: Northland DHB Health Services Plan 2012–2017 (page 36)

References to health literacy (link to Six Dimensions where relevant)	How it is positioned	Implications for review (link to Six Dimensions where relevant)
Specifically refers to people with inadequate health literacy becoming more health-literate	As a consumer issue	A change of focus is needed from health literacy as a consumer issue to understanding the role of the district health board, its systems and processes, and staff in developing the health literacy of consumers and families. (Dimensions 1 to 6)

Appendix 5: Template to review organisational documents

Document

References to health literacy (link to Six Dimensions where relevant)	How it is positioned	Implications for review (link to Six Dimensions where relevant)

Appendix 6: Template to review resources for consumer

Name / title of resource	
Produced by	
Published / revision date	
What is the purpose of this resource?	
Who is the target audience?	
Resource type eg, DLE pamphlet	
Access points (how does consumer get the resource)	
Other languages	
Resource content	
The content aligns with the purpose of the resource.	
Information in the resource follows a logical sequence – ie, the likely priorities of the reader.	
The resource uses simple and familiar words that reflect the language of the target audience.	
The resource uses the active voice.	
Medical terms and technical or difficult concepts are explained using simple, familiar words and examples or analogies.	
Key terms are used consistently throughout the resource.	
Numbers are clear and easy to understand – eg, probabilities are expressed as frequencies rather than %; numbers are expressed qualitatively ('very few people' rather than '1 out of 10,000 people').	
Each paragraph contains one concept, idea or message.	
Key points are summarised or emphasised where appropriate.	
The topic areas in the resource have informative headers.	
It is clear what a reader is meant to do with the resource/information.	
The design features help the reader find information easily – eg, consistent use of fonts, headings, tables; limited use of upper case, italics and underlining; effective use of white space.	
The resource uses visual aids whenever these can make content clearer.	
Visual aids reinforce the content that surrounds them.	
Visual aids reflect the main audience – eg, appropriate age ranges, gender.	
Graphics and colour contrast remain effective when photocopied or printed in black and white.	
PEMAT score	Understandability: Actionability:
Summary: What works well Comment on how this resource helps build health literacy	
Summary: What could be improved Comment on any improvements to:	
<ul style="list-style-type: none"> • purpose and relevance • usability, accessibility and navigation • overall building of health literacy 	

Appendix 7: Template for planning observations

Observations

List staff and/or situations to be observed – may be the same as or different from those interviewed. Consumers and families will only be observed as part of their interaction with staff (clinicians and reception/administration staff).

Name of group or person	Perspective	When	Where	Contact person	Who is organising the observation	Organised Y/N

Appendix 8: Clinical Observation Guide

What reviewers should look for

Consumer:

- is confident in responding to clinician
- uses body language that matches confident response
- asks questions
- clarifies if not sure
- before consultation, is able to state why they are there and what they expect to happen
- at end of consultation, is able to confirm what happened, what they have to do or what will happen next, and that the consultation met their expectations (from before the consultation).

Clinician:

- asks questions to find out background information – eg, consumer’s knowledge of their condition or their concerns
- asks questions to find out specific information
- gives information in logical steps
- gives information in manageable chunks
- uses everyday language or, if they use technical words, explains them
- uses visuals to explain, eg, how the body works
- uses written materials and explains why they are giving them to the consumer, what part the consumer needs to read and what they expect the consumer to do
- helps people anticipate the next steps
- if relevant, goes over consumer’s medicines and explains what each medicine is, why the consumer needs to take it, how it works, how it needs to be taken, any foods to avoid, side effects and how long the consumer will be taking medicine
- reinforces what needs to be done, emphasises key points and acknowledges what the consumer is doing well
- monitors body language, checks if consumer gives any indication of uncertainty and asks questions
- at the end, checks that they have been clear by getting the consumer to explain what they are going to do (does not ask ‘Do you have any questions?’ or ‘Do you understand?’).

Appendix 9: Template for planning interviews

Interviews

List general categories of the people to be interviewed and/or situations in which they are to be interviewed; for example:

- clinicians
- reception/administration staff
- consumers and families before appointment
- consumers and families in clinic
- consumers and families after appointment
- consumers and families in hospital
- clinicians in primary care
- consumers and families in primary care appointments.

Name of group or person	Perspective	When	Where	Contact person	Who is organising the interview	Organised Y/N

Appendix 10: Possible questions for staff survey

Thank you for answering this survey.

Your answers are confidential and you will not be identified.

A. General questions about health literacy

This section contains general statements about health literacy. Please tick the box that best describes your attitude to each statement. Only use N/A if the statement doesn't apply to you.

	No	Not sure	Yes	N/A
Health practitioners play an important role in building the health literacy of New Zealanders.				
Every time information is given to consumers and families about their health, it is an opportunity to check and build health literacy.				
Everyone is likely to experience low health literacy at some stage, for example, when diagnosed with an illness or condition they have not had before.				
The largest single group with low health literacy in New Zealand is Pākehā adults.				
If a consumer does not follow instructions, this is a sign of low health literacy.				
I can recognise when a consumer has low health literacy.				
I know a range of strategies I can use with consumers who have low health literacy.				
I understand what a Universal Precautions approach to health literacy means.				
I understand what the term 'health literacy demands' means.				
I understand how health literacy has evolved from a consumer skill deficit approach to a systems approach.				
I can explain a systems approach to health literacy to my colleagues.				

B. Communication

This section assesses how confident you feel about communicating information to the consumers and families you work with.

Please tick the box that best describes your response.

How confident are you that you can effectively communicate with consumers and families about their health in each of the following situations?	Not at all confident	A little confident	Neither confident nor unconfident	Quite confident	Totally confident	N/A
Time is limited.						
The consumer has a number of conditions.						
The consumer is taking a number of medicines.						
The steps that the consumer must follow to care for their health have changed.						
The consumer and their family ask a lot of questions.						
The consumer and their family are new to you and your service.						
The consumer does not follow medical instructions.						
The consumer and their family do not understand English well enough for easy communication.						
The consumer and their family do not seem that interested in the consumer's health.						
The consumer and their family have a number of barriers to caring for the consumer's health, such as difficulties with transport and cost of medicines.						
Overall, how confident are you about communicating with consumers and families?						

C. In your clinic or practice

This section lists statements about how your clinic/practice delivers its services.

Again, please tick the box that best describes your clinic today.

	We do not generally do this	We could improve	We are doing this well	N/A
We regularly ask our consumers and families for verbal or written feedback on the quality and effectiveness of our services.				
We use multiple strategies to encourage consumers and families to ask questions about their health.				
We use ordinary language to explain medical and health terms.				
We talk through any written information we provide to consumers and families about their health, and explain why they need to read it and what they need to do with the information.				
We manage the information given to consumers and families so they are not overwhelmed.				
We regularly find out what consumers and their families know about their health.				
We regularly check that consumers and their families have understood the information we have given them by asking them to repeat key points.				
We have access to other staff who can support consumers and families needing help with transport and other issues.				
We regularly ask consumers to bring their medicines with them to their appointments.				
We regularly explain full details about all new medicines to our consumers and families, for example, what it is for, how it works, side effects, serious side effects, how the medicine should be taken and why, any interactions.				
We regularly explain risks to our consumers and families so they can make informed decisions.				
Do you have any comments you would like to add?				

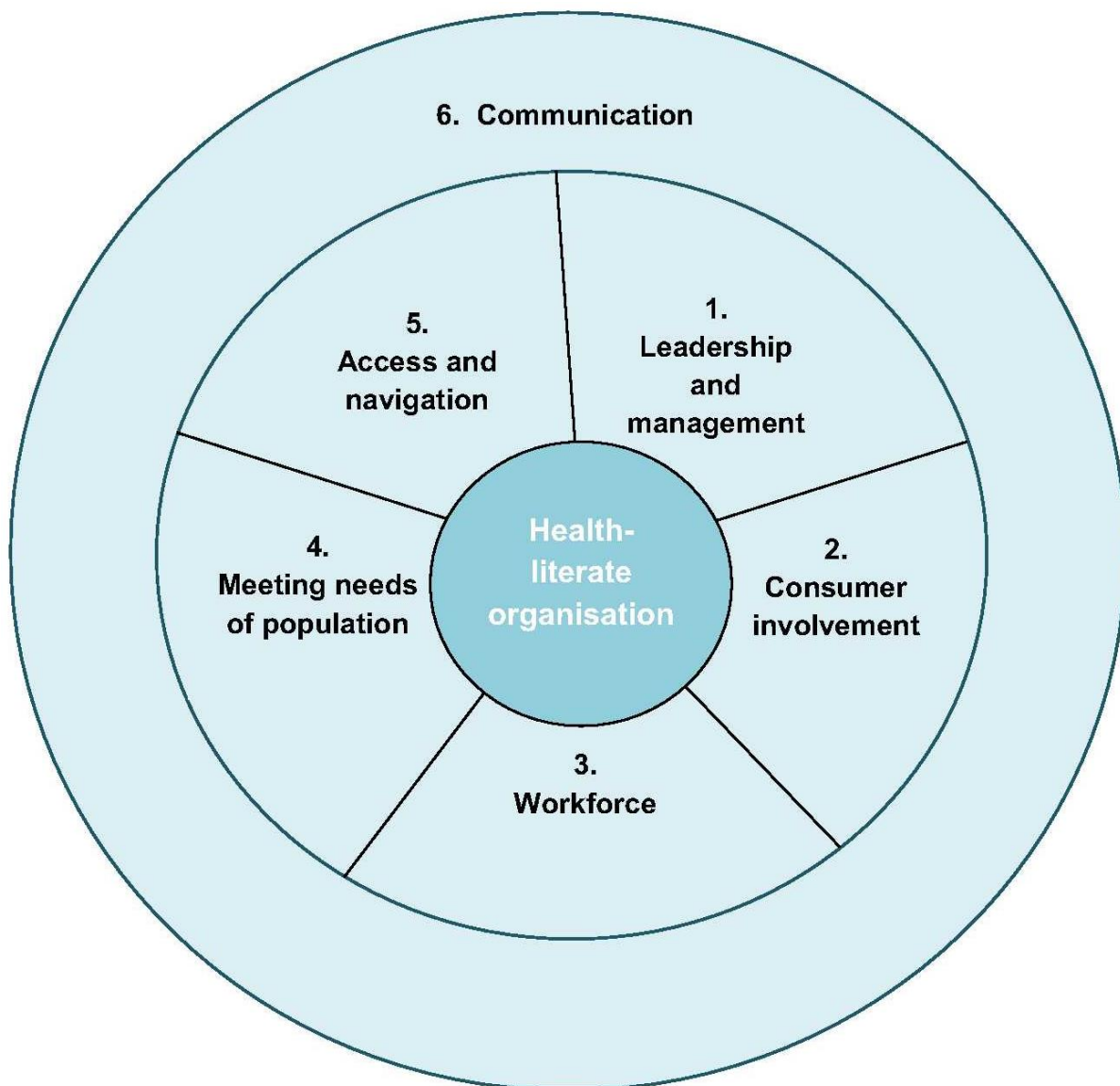
D. Personal information

This section asks you for some information about yourself. This information will be kept confidential.

What is your role?	
How many years have you worked as a health practitioner?	
How many years have you worked at your current clinic/practice?	<input type="checkbox"/> Fewer than 5 <input type="checkbox"/> 6 to 10 <input type="checkbox"/> More than 10
Do you work:	<input type="checkbox"/> Full time? <input type="checkbox"/> Part time?
Which ethnic group do you belong to?	<input type="checkbox"/> NZ European <input type="checkbox"/> Māori <input type="checkbox"/> Samoan <input type="checkbox"/> Cook Island Māori <input type="checkbox"/> Tongan <input type="checkbox"/> Niuean <input type="checkbox"/> Chinese <input type="checkbox"/> Indian <input type="checkbox"/> Other (please specify)
Are you:	<input type="checkbox"/> Male? <input type="checkbox"/> Female?

Thank you for taking the time to complete this survey.

Appendix 11: Six Dimensions visual



Appendix 12: Suggested script and letter to consumer

Possible script for a health practitioner to use when asking a consumer to be observed while they are finding their way to the service.

Hi

My name is _____ and I am a _____ at the _____ clinic.

We are trying to make it easier for patients to find their way to our service.

You have recently been referred to our service. I am ringing to ask if you can help us. We are doing a project to check how easy it is for patients to find their way to our service and we are looking for someone who hasn't been here before to help us. What we would like you to do is meet someone an hour or so before your appointment outside the building. This person will walk with you to our service and you will tell them everything you look at to find your way.

You don't need to write anything down – the other person will do that. We won't use your name if you don't want us to.

Would you be okay to do that?

I will get _____ to contact you and make the arrangements.

Thank you so much for agreeing to help with this.

Letter to consumer

Thank you for agreeing to help us to make it easier for patients to find and use our service.

I will meet you at [time] at [place].

Here is a picture of me so you know what I look like. I will ring you the day before to check that it is still okay for you to do this.

Please ring me on _____ if you have any questions.

Appendix 13: Checklist for observing and rating the environment

	Yes	Needs improvement	No
A. Telephone			
1. When a phone call is answered (either in person or by a phone system), the caller has an option to hear information in a language other than English.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. If there is a phone system, the caller has an option to speak with the operator.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. If there is a phone system, the caller has an option to repeat menu items.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Information is offered (either by a person or the phone system) using plain, everyday words.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Entrance			
5. The name of the organisation/service is clearly shown on the outside of the building.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. All entry signs can be seen from the street.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. All signs use plain, everyday words.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Entrance area			
8. There is a map.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. The map includes a key.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. The map shows the present location with a 'you are here' marker.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Maps are available for people to take with them.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. An information desk is near the entrance.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. A sign shows where the information desk is.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Assistance			
14. Staff or volunteers are available at or near the main entrance to help people.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Multilingual staff or volunteers are available at or near the main entrance to help people.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Staff or volunteers wear a uniform or name tag to identify them.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Signage			
17. Maps are posted at various places around the building.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Consistent language is used for locations on signs throughout the building.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Consistent symbols/graphics are used on signs throughout the building.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Overhead signs use large, clearly visible lettering.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. Wall (eye-level) signs use large, clearly visible lettering.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. Signs are written in English as well as in the primary languages of the people being served.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. Colour codes are used consistently on the walls or floors throughout the building to mark paths to and from various parts of the building.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	Needs improvement	No
F. Service area/department			
24. The name of the clinic/service area is clearly visible.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. Sign-in procedures are clearly visible.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26. Staff offer to help consumers complete paperwork.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27. Materials for consumers have been developed with consumers.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28. Materials for consumers are written in the primary languages of the people being served.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Adapted from Rudd RE, Anderson JE. 2006. *The Health Literacy Environment of Hospitals and Health Centers. Partners for Action: Making your healthcare facility literacy-friendly*. Boston, MA: National Center for the Study of Adult Learning and Literacy.

Appendix 14: Guide for analysing the Six Dimensions

	Yes	No	Don't know
Dimension 1: Leadership and management			
Your organisation's mission statement, policies and programmes make an explicit commitment to health literacy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
There is responsibility and delegated authority to oversee health literacy (for example, a high-level health literacy taskforce, or an addition to a particular role such as chief medical officer).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Health literacy improvement goals are set, incentives to achieve those goals are provided and accountability for health literacy is established.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fiscal and human resources are allocated to achieve health literacy goals.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Health literacy champions are established throughout the organisation.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Your organisation encourages other organisations to be health literate through influence, purchasing power and collaboration.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Your organisation contributes to local and national efforts to improve health literacy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Health literacy is incorporated into all planning activities.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Measures are developed and data is collected to measure success in reaching health literacy goals and to identify areas for further improvement.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rigorous evaluations of health literacy interventions and activities are designed and conducted.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Assessment, measurement and evaluation data is used to inform continuous health literacy improvement.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Health literacy is synthesised with other organisational priorities such as health targets, health inequalities, health inequities and health promotion.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Advice about health literacy is sought from experts in the field.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dimension 2: Consumer involvement			
A consumer council or similar is established to advise the Executive Leadership Team on how plans and initiatives will affect consumers, families and communities.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A culture is created that values consumer, family and community perspectives, and emphasises that communication is a two-way interaction between participants who have equally important roles.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Members of the populations your organisation serves are included on the Board.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Your organisation collaborates with members of relevant communities about programmes, service design, testing of interventions and development.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feedback on health information and services from the communities who use them is obtained and used.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Community members are enlisted onto evaluation teams to assess the effectiveness of your organisation's health literacy programmes.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
There is a process for replacing community representatives on health literacy programmes as the representatives become experienced with and knowledgeable about health conditions, health vocabulary and health information.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No	Don't know
Dimension 3: Workforce			
Goals are set for ongoing formal and informal health literacy training for all staff and members of boards.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Health literacy skills of staff members are evaluated on an ongoing basis, training is provided for staff who do not meet appropriate standards and training is evaluated for effectiveness.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Health literacy is incorporated into induction and other types of training (for example, consumer safety, quality improvement, cultural competence and patient-centred care).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Staff are encouraged to attend external specialist training in health literacy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
External health literacy professionals are brought in to augment in-house training resources.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
'Expert educators' are developed to serve as role models, mentors and coaches of health literacy skills to others.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Expectations are set that all staff will use health literacy approaches when they engage with consumers, families and communities.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Your organisation uses a Universal Precautions approach to health literacy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dimension 4: Meeting the needs of the population			
Systems are designed to maximise the capacity of individuals, families and communities to learn how to maintain good health, manage illness or disease, communicate effectively and make informed decisions.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
All consumer and family surveys are easy to understand and to fill in, and help is provided to complete all surveys.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Advisory groups that include consumer groups with limited health literacy are established.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Communities or localities that may have low health literacy are identified.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Resources are allocated in proportion to populations and communities with low health literacy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Partnerships or collaborations with communities or community organisations are created to build the health literacy of a specific community or locality.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dimension 5: Access and navigation*			
Ongoing organisational assessments (including the physical environment) are conducted to assess and monitor health literacy performance and progress.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Health literacy aspects of all policies and programmes are assessed.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The environment is welcoming and does not impose high literacy demands.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Appropriate technology is used to overcome barriers for consumers and families with low health literacy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Extra help (such as educators, navigators, social workers, case managers and follow-up between appointments) is provided for consumers who need it.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Consumers are asked if they have problems paying for medicine and accessing primary care services, and are referred to appropriate support services and programmes.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Facilities are designed to help people find their way.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
All staff are trained to respond politely to navigational enquiries and without making assumptions about a person's skills.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Related services are housed within the same facility (such as specialists, social services and health and wellness services).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Consumers and families are helped to understand the assistance and services offered, including enrolment in long-term conditions and wellness programmes.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Community health nurses, workers, navigators and other personnel identify and remove barriers to accessing services and information.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No	Don't know
Consumers are helped to schedule appointments with other health care services such as primary care, laboratories and home help.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Systems share information among health practitioners rather than relying on the consumer to do so.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Systems ensure that lists of community and social service resources are always up to date and there are referral processes to these services.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Referral and follow-up processes are tracked to ensure consumers complete them.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Consumers are provided with access to their health records (either paper-based or through consumer portals).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Training is provided for consumers on how to use electronic systems where relevant.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Staff help consumers to anticipate next steps by explaining they have been referred to another service, how they will receive more information, what they need to do to confirm the appointment, what they will need to do to prepare for the appointment, what the costs are and what will happen after the appointment.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The parts of the health system that consumers have problems accessing and navigating are identified and analysed, including areas of inequalities and inequities.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In partnership with consumers and/or communities, strategies are put in place to improve access and navigation and these strategies are evaluated for effectiveness.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Partnerships with other parts of the health system are formed (for example, with pharmacies) to support consumers' access and navigation.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dimension 6: Communication			
Clear and effective communication is a priority across all levels of the organisation and across all communication channels.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Communication failures are tracked and reported and root-causes are analysed to uncover and address the systemic causes of these failures.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Information collection is streamlined, targeting only essential information.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Written materials reinforce spoken communication and alternatives to written materials are available.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Consumer education materials are used in parallel with face-to-face interactions.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
All consumer education materials are evaluated for appropriateness and effectiveness.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Appropriate and high-quality education materials are provided for consumers with low health literacy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The quality of consumer education materials is checked. Any materials that are inadequate are removed from circulation and the reasons communicated to the provider of the materials.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Rauemi Atawhai</i> is used when developing consumer education materials (including forms, notices and surveys) and the development process is monitored and documented.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Consumer information is easy to access on the website.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Consumer education materials are available in commonly used languages through high-quality translation services.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Scripts or examples are provided to health practitioners about how to use written materials in their interactions with consumers and families.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
There is a system that encourages staff to report communication issues to an appropriate supervisor.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical spaces support effective communication.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A culture that values and practises meaningful informed consent is fostered.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Informed consent forms are easily understood by consumers and families and, if necessary, are reprinted in a range of commonly used languages.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Interpreter services are used in such a way that consumers can discuss their questions with the interpreter before they meet with the health practitioner.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No	Don't know
Health practitioners check that consumers have understood what has been communicated to them.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Health practitioners use plain language and explain technical terms when talking with consumers and families.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Health practitioners use a range of health literacy strategies when communicating with consumers and families.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Health practitioners routinely provide written and verbal information about conditions, procedures and treatment, including the benefits, risks and likelihood of success.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Good communication practices are modelled and promoted between health practitioners as well as with consumers and families.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Families are involved in discussions with inpatients about hospital and follow-up care.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Discharge summaries are easy for consumers and families to understand.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Follow-ups are arranged with consumers within 24 hours of discharge and monitored to check that they took place.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Easy-to-understand language and decision aids are used when having end-of-life conversations with consumers and families.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Consumers and families continue to be offered information even if they have refused it previously.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

* Note: This checklist does not cover the physical environment – see Appendix 13.

