Evaluation of 2014 Health Literacy Professional Development Initiatives

Executive Summary – January, 2015

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Introduction

Health literacy is key to supporting people to better manage their own health and has the potential to improve health-related outcomes of disadvantaged populations. According to Australian Bureau of Statistics, 59% of Australians are functionally health illiterate, and an overwhelming majority (75%) are born in a non-English speaking country. Low levels of individual health literacy are associated with more use of health care services, poor knowledge and worse health outcomes. Melbourne's Western region is one of the most culturally diverse communities in Victoria, increasing the risk of low health literacy levels, which can impact on them accessing the health care system. Accordingly, health literacy is a key priority in the *Better Health Plan for the West*.

Health professionals have been found to often lack adequate understanding of health literacy issues, and health literacy practices are also not routinely used. In 2013, a collaboration developed between the Centre for Culture, Ethnicity & Health (CEH), HealthWest Partnership (HWP) and cohealth (previously Western Region Health Centre) to develop the knowledge, skills and organisational capacity towards health literacy of the health and community service sector in the western metropolitan region of Melbourne.

In 2013, the CEH, HWP and WRHC developed and delivered a health literacy demonstration course. Ten HWP member agencies participated in the course, with two people per organisation attending (total of 20 course participants. The University of Melbourne (Australian Health Workforce Institute, now Health Systems and Workforce Unit) evaluated the adoption and implementation of the Health Literacy Demonstration Course. The evaluation revealed that the course had built capacity as demonstrated by course participants:

- Developing *leadership* in Health Literacy (.i.e., inspire Health Literacy thinking and approaches within their organisations and other networks)
- Building *networks / partnerships* among course participants and established an interdependent forum / Community of Practice (CoP) for health literacy knowledge transfer and exchange;
- Developing health literacy *workforce knowledge and skills*;
- Developing ways to use and apply health literacy *resources* (tools, frameworks) and
- Serving as a catalyst for building *organisational infrastructure* (policies and procedures) to authorise and embed health literacy into routine practice.

The 2013 evaluation also revealed the importance for course participants having senior executive sponsors who were engaged and provided a supportive authorising to implement course learnings and lead or facilitate changes in health literacy practices. The 2013 evaluation presented six propositions. 1) revising the course to be more practically oriented; 2) establishing an on-line Health Literacy Community of Practice Forum; 3) utilising enablers and barriers within the course to build participant capability to adopt, implement and sustain health literacy approaches; 3) contextualising health literacy courses by revising the course selection processes obtaining more in-depth participants information about roles, readiness and capability to initiate change; 4) continuing the course quarterly workshop modular structure and exploring compressing course to run over a six month period; 6) developing an evaluation framework to assess the value of the 2013 health literacy course at the workforce, organisation and client level.

In 2014, in response to the increased commitment to health literacy as a priority area in the West, and the 2013 evaluation findings, the CEH, HWP and cohealth invested in:

- delivering a **health literacy development course** to another ten HWP member agencies in the West, with two people per organisation attending (total of 20 course participants). Course participants were chosen by the organisation CEOs. The course was comprised of four face to face one day modules over an eight month period. Following module one and three, participants were required to undertake a mini-project of approximately 40 hours within their organisation, to integrate health literacy practice across the organisation to embed learnings and create sustainable change;

- introducing an **Organisation Senior Executive Sponsors workshop**, in response to the evaluation finding that engagement from senior executives was important for course participants to lead or facilitate changes in health literacy practices; The workshop was not a stand-alone initiative, but designed to supplement the course by: providing a strategic view of health literacy in the West; workshopping the link between health literacy and accreditation standards; and discussing the enablers and barriers to supporting organisational health literacy;

- establishing a **health literacy community of practice**, in response to the 2013 evaluation finding that *networks* were being established amongst course participants and that Community of Practice (CoP) could facilitate health literacy knowledge transfer and exchange. The CoP was designed to provide opportunities to: share learnings, experiences, resources; problem solve; exchange information and to network, and was facilitated by a leadership group comprised of staff from: CEH, HWP, cohealth, RDNS, ISIS Primary Care and two consumer representatives from cohealth; and

- commissioning an **evaluation** of the 2014 initiatives by The University of Melbourne, Health Systems and Workforce Unit.

The 2013 and 2014 health literacy initiatives and evaluations were designed to build upon each other and ultimately to build health literacy capacity and the evidence base within the culturally diverse western metropolitan region of Melbourne.

Evaluation Focus

The University of Melbourne, Health Systems and Workforce Unit was commissioned to evaluate the extent to which the 2014 health literacy professional development initiatives were creating a ripple effect and building health literacy capability at the individual, organisational, regional and systems level. The evaluation had three foci and evaluation questions.

1. **2014 Health Literacy Course-** To what extent has the 2014 Health Literacy course had an impact upon course participants and their organisation CEOs?

2. **2014 Health Literacy Community of Practice -** What makes the community of practice work (or not), for whom and in what circumstances?

3. **The *Ripple effect* in the West -** What changes have occurred at the individual, organisational and systems level as a result of participating in the 2013 Health Literacy Course?

The *ripple effect* metaphor was used to illustrate several dimensions. Firstly, the health literacy initiatives were conceptualised as a *'Rock'* that would initially create a *Splash* (outputs at the individual and organisational level) leading to a *ripple effect* (immediate outcomes – or changes at the individual and organisational level) beyond the course participants and their organisations, and beyond the actual course - to have a longer term and multiplier effect in the West. Secondly, the health literacy initiatives (e.g., courses, CoP) were a '*means not an endpoint'* and part of a *'transformational change process not an event'* – facilitating the adoption and implementation of health literacy concepts into practice, at an individual, organisational, and systems level.

Evaluation approach

Given that the health literacy initiatives were in there forming (e.g., senior executive workshop, CoP) and refinement (e.g., course) stage of development a *formative evaluation approach* was used. The dynamic reform and organisational context within which the initiatives were occurring, led to the evaluator to also use a *participatory evaluation approach.* In practice, a participatory evaluation approach means establishing a partnership between the evaluator and the evaluation primary users, and getting up close and personal – to ensure the evaluator is immersed and sensitive to the complexities of the initiatives. To understand how and why the health literacy initiatives were creating a *ripple effect* a *realist evaluation approach* was also used, because it strives to examine what works, for whom, and in what circumstances. To further assist clarifying the 2014 health literacy initiatives and refining the funded evaluation plan, questions and data collection methods, a program logic model was developed, providing a visual representation about the assumptions about how an initiative is supposed to work, and the causal linkages between context, inputs, activities, outputs, and outcomes.

Data Collection Methods

Three data collection methods were used:
1) Qualitative semi-structured interviewing: aligned with the evaluators view that people's (e.g., course participants) knowledge, views, understandings, interpretations, and experiences were meaningful for constructing and explaining how and why the initiatives worked;

2) Most significant change technique is based on a qualitative semi-structured interviewing participatory approach that involved the generation of significant change stories from the 2013 health literacy course participants and their organisation senior executives.

3) Member validation in the form of an *Evaluation Participants Feedback workshop* was conducted to provide all evaluation participants with the opportunity to hear, discuss and add to the evaluation findings.

Overall the 2014 evaluation involved nine data collection activities:

1. one interview with 2013 course participants to explore individual and organizational changes resulting from participating in the 2013 course
2. one interview with 2013 course participant organisation sponsors to explore individual and organizational changes resulting from staff participating in the 2013 course
3. pre,-during and post course surveys of 2014 course participants (as part of the CEH quality improvement process) to explore changes in individual health literacy competency and changes in organizational health literacy
4. two rounds of interviews with 2014 course participants to explore course experiences and individual and organizational changes resulting from participating in the 2014 course
5. one interview with 2014 course participants organisation executive sponsors to explore health literacy drivers and individual and organizational changes resulting from staff participating in the course
6. one interview with a sample of the 2014 Health Literacy Community of Practice (CoP) Leadership Group to explore CoP purpose, implementation, impacts and sustainability of the CoP
7. one interview with Health Literacy Community of Practice participants to explore CoP purpose, implementation, impacts and sustainability of the CoP
8. one interview with 2014 course facilitators to explore experiences of facilitating the course; and
9. evaluation participant feedback workshop to hear, discuss and add to the evaluation findings.

Key Evaluation Findings

On the basis of **62** interviews overall the evaluation has revealed that the health literacy professional development initiatives are creating a ripple effect and building health literacy capability at the individual, organisational, regional and systems level. Synthesis of key evaluation findings are presented under the three evaluation foci: 2014 Health Literacy Course; Health Literacy Community of Practice; and the Ripple effect in the West.

2014 Health Literacy Training Course

Profile of Health Literacy Course Participants: Ten HWP member agencies participated in the 2014 course, with two people per organisation attending from a broad spectrum of sectors (Public health; Not for profit; Community Health; Acute care; Nursing education; Mental Health; Aged Community care; Primary health; Aboriginal health), organisations (Hospital; Medicare Locals; Community Health Centres; Primary Care Partnerships; Peak Health Organisations) and positions (Clinicians; Project officers; Managers; Coordinators; Educators; and Personal Assistant). Five of the ten agencies in the 2014 course had supported staff to attend the 2013 and 2014 health literacy courses – creating a receptive platform for further adopting, implementing and maturing health literacy practices across staff and organisations.

Course content: The 2014 course content was perceived by course participants as more comprehensive, applied, contextualised, responsive, adaptive and 'how-to' practically oriented. Overall participants commented that the content had increased the breadth and depth of knowledge about health literacy as not solely an individual trait, but that organisations have a key role to play.

Course structure: The four modules and two mini-project course structure was positively received by course participants, as it: enabled reflection; putting concepts into practice; provided immediate benefits (particularly the mini-projects), and facilitated mainly intra-organisational networking opportunities.

Course participant composition: Course participants were positive about having a mix of course participants from diverse sectors, organisations and roles, as it provided opportunities to hear and discuss other viewpoints, differing challenges and opportunities that exist. The pairing of participants from the sponsoring organisation was viewed positively by both participants and course facilitators – as it created a platform for sharing learnings, problems and generating solutions.

Overall comments by the 2014 course participants' revealed that the course developers and facilitators have learnt from, utilised and embraced the 2013 evaluation

findings, particularly as the course has become more how to / practically oriented, contextualized, responsive and adaptive with examples of implementing health literacy concepts into practice. This finding also provides evidence that the participatory evaluation approach was appropriate and useful, and that the working partnership between the course developers and the evaluator led to increased evaluation learnings utilisation, and fostered a culture of learning between all.

The health literacy course was designed to support participants facilitate change at the individual and organisation level – with course participants being '*agents of change'*. However, the evaluation findings revealed that there were mixed outcomes in participants leading or facilitating change upon their return to their organisations.

The evaluation revealed that course participants who were in Project Officer and Front-line roles (as compared with managerial, educational or decision-making roles) perceived themselves as having limited authority to facilitate or lead change within their organisations. While this was not a universal finding, it raises several issues. Given that health literacy is everyone's responsibility, does this finding suggest the need to further explore the characteristics or qualities required to be a health literacy change agent? Alternatively, given that course participants were recruited / nominated / chosen by their own organisation (and not the course or Health Literacy Steering group), does this finding suggest the need to review the selection process / criteria organisations are using to nominate staff to undertake the course and become health literacy change agents?

Organisation Executive Sponsors workshop

The evaluation revealed that the Organisation Executive Sponsors workshop was overall well received by course participants and senior executives. It provided the opportunity to: get senior executives attention and involvement in health literacy; to become knowledgeable about their staff commitments to health literacy; to demonstrate to their staff their support to implement health literacy practices; to become knowledgeable about the challenges facing other organisations in the Western region committed to health literacy action; and to demonstrate accountability of their organisations investment in health literacy. This finding also provides evidence of the utilisation of the 2013 evaluation findings – as a key finding was the importance for course participants having senior executive sponsors who were engaged and provided a supportive authorising to implement course learnings and lead or facilitate changes in health literacy practices. This finding also confirms the appropriateness of involving senior executives in the evaluation process, as it provided rich insights into the multiple drivers for engaging in health literacy action and the importance of maintaining health literacy momentum.

2014 Health Literacy Community of Practice

The evaluation revealed that the health literacy community of practice (CoP) is contributing to the health literacy *ripple* effect in the Western region – as demonstrated by the evidence that the three CoP events were attended by a large number of professionals who had not participated in either the 2013 or 2014 courses. The CoP events also revealed the increased visibility of commitment to investing in health literacy in the West. The CoP has created a *novel and local* space for the sharing, reflecting and learning of experiences, particularly from consumers. The CoP also provided a structure for 2013 course alumni to take up health literacy leadership roles (e.g., Health Literacy CoP Leadership Group).

While the health literacy CoP does appear to be contributing to building health literacy capacity and a ripple effect, CoP participants and the CoP Leadership group commented about whether the current CoP was 'fit for purpose' as the CoP had: multi-purposes, an all inclusive membership base, and is designed for all circumstances; and was perceived as lacking a sense of shared identity, ownership or "us" amongst its members.
Interviews with 2014 Course participants also revealed that the CoP appeared to be competing for participants time - indicating a possible 'ceiling effect' on how much time professionals can spend on professional development activities, especially when staff do not have dedicated time/resources allocated to health literacy – even when organizational management are generally supportive. Interviews with the CoP Leadership Group revealed that the CoP was being run as an organisation driven knowledge transfer and exchange event-based network rather than CoP with a group of people who are learning, innovating & interacting together on an ongoing basis.

The current health literacy CoP may not be 'fit for purpose'. In other words, the current novelty and local appeal of the health literacy CoP may not sustain engagement – thus consideration needs to be given if it is to remain an 'organisation driven knowledge transfer and exchange event-based network' versus a 'group of people who learn, innovate and interact together on an ongoing basis'. At a time of ongoing sector and organisational reforms and restructures, increasing workloads and fatigue, there is a need to reflect upon: What is the Health Literacy CoP intended to achieve?; For whom is the CoP designed for? For what circumstances is the CoP designed for?; and What leadership and governance structure fits the CoP purpose?

The Ripple effect in the West

Overall the evaluation findings suggest that the health literacy professional development initiatives are creating a *ripple effect* and building health literacy capability at the individual, organisational, regional and systems level.

Interviews with 2013 course participants and their organization senior executives revealed that the initiatives were creating an initial **splash (i.e., outputs)** – leading to changes at the individual level (e.g., increased participants knowledge, skills, information sharing, networking) and at the organisational level (e.g., audit of policies and practices, development and adoption of health literacy policies and procedures). Interviews also revealed a **ripple effect (immediate outcomes)** at the individual level (e.g., enhanced health literacy confidence, advocacy, leadership, partnerships, networks) and at the organisational level (e.g., dedicated resources to implement health literacy principles & practices; embedding health literacy organisationally into standard practice). These findings confirm that the health literacy capacity building initiatives (e.g., courses) are a '*means not an endpoint*', part of a *'transformational change process not an event', and* are acting a ***catalyst for action*** – resulting in incremental transformation in knowledge, attitudes, intentions and behaviours beyond the course participants and their organisations - to have a longer term and multiplier effect.

The interviews with 2013 course participants who had changed employment organisation during the 2013 course, provided further evidence of a ripple effect and of **transfer of training** – namely the generalisation and maintenance of health literacy knowledge, skills and practices in organisation workplaces not participating in the courses.

Overall the evaluation confirms that health literacy course are continuing to ***build capacity*** to implement health literacy concepts as demonstrated by: course participants developing leadership skills, building health literacy workforce knowledge and skills, developing organisational infrastructure, developing resources and building networks mainly within and outside participant organisations

To date five of the 10 HWP member agencies in the West have supported staff to attend the 2013 and 2014 health literacy courses. Interviews with these course participants and senior executive sponsors revealed that:

- It takes time to engage staff and organisations to see any incremental changes in health literacy practice;
- Staff in a managerial and educational roles and who are connected to decision makers were more likely to have the capability to lead or facilitate change (i.e., be 'agents of change');
- Multiple drivers (individual/person based drivers (e.g., supportive CEO, Board); organisation wide drivers(e.g., Accreditation / standards and/or Key Performance Indicators); and system-based drivers (e.g., quality improvement practices) are required to start to focus on health literacy and to maintain the momentum amongst and staff across the organisation;
- Need to build internal organisational self-sustaining capacity to focus on health literacy, and not be dependent upon and external organisation (e.g.,CEH);
- There is value in having access to a **"Health Literacy Advisor/ Mentor "** – a person who has the knowledge, skills and experience at engaging staff and organisations in health literacy; building evidence; developing and adopting health literacy policy and procedures;
- A **health literacy organisation maturity** was developing – increased awareness amongst staff, management and boards that health literacy is a priority; increasing use (or intentions to use) of health literacy concepts, frameworks and tools into practice; increased reflection and critical appraisal about the most appropriate staff to do the courses and be 'agents of change. The concept of health literacy '***magnet organisations*** could be considered – where organisations demonstrate: leadership in health literacy (i.e., inspire health literacy practices); health literacy workforce knowledge and skills; application of health literacy resources (frameworks and tools in practice; development of health literacy policy and procedures; and partnership approaches to addressing health literacy issues;
- A continual focus on supporting a cultural shift – health literacy is part of good person centred care and NOT additional work and not a fad is required; and
- A demonstration of how investing in health literacy practices will have practical impacts and benefits and converts into a business case is required.

Interviews with 2013 and 2014 course participants and their senior executives revealed that there is a core set of enablers and barriers to implementing health literacy practices at an individual, organisation; and system level (Table 1). This finding further highlights that a myriad of factors can influence the success of professional development courses as part of transformative change processes. Future course may need to consider how to further involve course participant alumni and their organisation to mentor or reveal how such factors can be addressed to optimise the implementation of health literacy practices.

Table 1: Summary of Enablers and Barriers to Implementing Health Literacy Practices

Implementation Enablers	Implementation Barriers
Individual • Compliance from clinicians • Senior management support, networks and know-how about organisation • Upper management buy-in • Support from frontline staff for health literacy • Cooperation from other team leaders • Dedicated staff training • Staff connected to decision makers • Staff in positions of authority to lead or facilitate change	**Individual** • Staff changes • Time constraints • Getting upper management buy-in and endorsement • Variable understanding about HL at upper management level • Competing priorities at upper management • Terminology – health literacy • Professional paternalism • Reforms & fatigue • No clear benefits to routinely using health literacy practices?
Organisational • Alignment between projects and organisation tasks e.g., accreditation • Supportive authorising environment	**Organisational** • Difficulty accessing project specific data (eg., patient complaints) • Ongoing organisation changes and re-structures • Organisation has multiple sites which differ greatly – organisation, priorities, and competing interests
Systems level • Health literacy project aligns with accreditation system / standards	**Systems level** • Funding cuts resulting in staff redundancies

Key Emerging Propositions

To build upon and consolidate the investment in health literacy initiatives, the following propositions are presented structured according to the three evaluation foci: Future Health Literacy Courses; Future Health Literacy Community of Practice; and the Ripple effect in the West, as they have future policy, practice and research implications.

Future Health Literacy Courses

1. The health literacy courses are designed to create agents of change to lead or facilitate changes in health literacy practices. Given that the evaluation revealed differing perceptions amongst course participants about their capability to be health literacy agents of change, and that organisations choose their staff to do the course, the selection process and criteria that organisations are using to choose staff to undertake the course may need to be reviewed.

2. Given that the current health literacy courses are targeted and been trialed with HWP member agencies in the West, exploration of the development of a regional health literacy course, utilising the *Better Health Plan for the West* as a positive policy platform' could be considered.

3. The health literacy courses to date have been targeted at health professionals. However, consumers are recognised as part of the workforce and can contribute to the co-design of the health care system. Given this, research investigating what education, training and support consumers require to contribute to the health literacy of organisations could be considered.

4. The current course content and structure (four modules, mini-projects, Organisation Senior Executive Sponsors workshop) is building individual capacity and a supportive organization authorising environment to implement course leaning into practice - thus needs to be maintained.

Future Health Literacy Community of Practice

5. The increasing interest across the Western region agencies in health literacy as demonstrated by participation in the three CoP events - warrants further investment in a Western region-wide health literacy knowledge transfer and exchange network events (face to face and on-line)

6. Given the cultural, organisational, social and diverse health outcomes in the western metropolitan region of Melbourne, piloting of topic (e.g., mental health) or setting (e.g., hospital) specific Health Literacy Community of Practices could be explored.

7. The evaluation revealed mixed opinions about the role of the Health Literacy CoP Leadership Group and composition, suggesting further exploration is required about what leadership and governance structure is fit for the CoP purpose?

8. The evaluation revealed mixed opinions about the identity and purpose of the current CoP, suggesting the need to further explore: What is the CoP intended to achieve? For whom is the CoP designed for? For what circumstances is the CoP designed for?

The Ripple effect in the West

9. The evaluation has revealed that the health literacy initiatives are creating a ripple effect amongst HWP member agencies and beyond at an individual and organisational level in the West. However, health literacy action momentum needs to be maintained. The role of health literacy mentors and health literacy magnet organisations, to further support the work of CEH, HWP and cohealth, could be explored as a way to support individuals and organisations to implement and self –sustain health literacy practices.

10. The evaluation (particularly senior executive interviews) revealed that it takes times to engage staff and organisations to see incremental changes in health literacy practices. Given this, further investment is required in evaluating longitudinally individual and organisational self-sustaining health literacy practice changes resulting from the health literacy initiatives.
11. Given the persisting set of enablers and barriers at the individual, organisation; and system level to implementing health literacy practices, researching how course participant alumni and their organisation are responding to these factors will contribute to understanding how to sustain the ripple effect.

12. The evaluation revealed evidence of a *'ceiling effect'* for professionals attending multiple professional development activities (e.g., course and the CoP). Exploration of the benefits of promoting future health literacy courses as a longer-term commitment to a 'community of practice' could be considered.

13. To date, the evaluation approaches have been formative to inform decision-making, and not summative to assess the outcomes resulting from the health literacy initiatives. Investment in developing and piloting an outcomes framework (outcomes, outcomes indicators, data sets) to assess the ripple effects of the health literacy initiatives at the individual (consumers, workforce), organisational, regional and systems level in the West is required

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