Building health literacy responsiveness in Melbourne's west: a systems approach

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Abstract

With high health inequities among some population groups, health professionals and organisations are increasingly taking action on health literacy. This case study demonstrates how a systems approach to health literacy responsiveness created change across a region. From 2013 to 2017 the Health Literacy Development Project incorporating a training course and community of practice (the Project) targeted the health and community services system in Melbourne's west. The Project created a ripple effect that built health literacy responsiveness at the individual and organisational level. This contributed to increased use of health literacy practices and led to systems change across the region. Creating change within the health and community services system is extremely challenging. This case study provides some evidence that a systems approach can support change in the health literacy responsiveness of a regional health and community services system over a 4-year timeframe.

What is known about the topic? Health professionals and organisations are increasingly looking to use systems approaches to take action on health literacy. Health literacy responsiveness is an emerging field with limited peer-reviewed studies available.

What does this paper add? This case study offers insights into how a systems approach to health literacy responsiveness can support change within a regional health and community services system.

What are the implications for practitioners? A systems approach is a viable and realistic approach for public health practitioners seeking to improve health literacy responsiveness within a region by building workforce capability and embedding health literacy practices within organisations.

Introduction

A strong and equitable health and community services system should emphasise the need to provide health-related information and services in ways that are relevant, accessible and appropriate for users.[1–4] Also known as health literacy responsiveness, this occurs when health information, resources, supports and environments are provided in a way that is accessible to people with different health literacy strengths and limitations.[5] This is particularly important in areas such as Melbourne's rapidly growing west where indicators of low health literacy are prevalent.

Moreover, the recent National Statement on Health Literacy,[6] Victorian Health Priorities Framework 2012–2022[7] and Victorian Health and Wellbeing Plan 2011–2015[8] require organisations to consider and respond to the health literacy needs of their communities.

In response to these regional challenges and external drivers, health literacy was identified as a strategic priority for the western region of Melbourne and the Health Literacy Development Project (the Project) was initiated. The Project aimed to use a systems approach to enhance health literacy responsiveness across the health and community services system in Melbourne's west. Systems approaches consider the system as a whole rather than focusing on individual components and have proven successful within health systems.[9] Additionally, systems-level responses are an effective way to meet the needs of subpopulations and at-risk groups.[10]

Setting

The Project was undertaken in the western metropolitan region of Melbourne. This region is rich in cultural diversity, with more than 45% of the population speaking a language other than English at home.[11] The region also has high levels of disadvantage, with some of the lowest Socioeconomic Indexes for Area rankings in Melbourne and Victoria.[12]

Participants

The Project was led by the local Primary Care Partnership (HealthWest PCP) who partnered with a local community health organisation (cohealth) and a training provider (Centre for Culture, Ethnicity & Health). The Project targeted health and community services and local governments in Melbourne's west.

Methods

The Project used two main interrelated components to build workforce knowledge and skills to create change within organisations and influence the local health and community services system.

The Health Literacy Development Course (HLDC): In 2012 a health literacy expert was engaged to work with the training provider to develop the HLDC, which was piloted in 2013. The HLDC consisted of four face-to-face modules and two supported work-based assignments delivered over 8 months. Following the successful evaluation of the pilot, the HLDC was delivered again in 2014, 2015 and 2016. Each year 20 participants were nominated by executives from 10 organisations. Overall, 23 organisations participated between 2013 and 2016, including 18 local organisations (see **Table 1**). Two consumer representatives also participated in 2016.

Based on the pilot evaluation, an Executive Sponsors' Workshop was incorporated into the HLDC from 2014 onwards to engage executives in the process and to provide an authorising environment for participants to create change in their own organisations.

The Health Literacy Community of Practice (HLCoP): Based on evaluation findings, the HLCoP was established in 2014 to provide further opportunities for HLDC alumni and other practitioners to build on informal networks, share learnings, resources and research, and inform regional projects. The HLCoP was coordinated by a leadership group of partners, consumer representatives and other interested organisations. Meetings were themed and included presentations from local organisations and leaders in the field. Seven quarterly meetings were coordinated during 2014–15, attracting 224 attendees.

A Health Literacy Alliance was established in 2016 as a result of evaluation findings to facilitate peer support, problem solving and regional action for a growing number of practitioners with a formal role in health literacy. The HLCoP continued and remained a key learning and networking opportunity for other practitioners with meetings held less frequently.

Annual evaluations were conducted by a researcher from the University of Melbourne using qualitative methods including interviews, focus groups and case studies. The evaluation terms of reference were:

- 2013: evaluate the adoption and implementation of the HLDC.
- 2014: evaluate the extent to which the Project was creating a ripple effect and building health literacy capability at the individual, organisational and systems level.
- 2015: evaluate progression of ripple effects within organisations participating in the Project.

Evaluations received ethics approval from the Human Ethics Advisory Committee from the Melbourne School of Population and Global Health.

Additional evaluation surveys were conducted by project lead HealthWest PCP of:

- Local organisations in 2013 (n = 7) and 2016 (n = 18) to assess changes in health literacy practices in the region over time.
- HLCoP participants in 2015 (n = 41), with reflections sought from the leadership group.
- Health Literacy Alliance participants in 2017 (n = 10).

Evaluations were developmental, meaning that evaluation findings were used to plan and enhance ongoing Project activities, increasing their relevance and effectiveness.

Table 1. Organisations participating in the Health Literacy Development Course from 2013 to 2016

Type of organisation	**Participating organisations (*n*)**
Health service • Community health • Hospital • Mental health • Primary care	 5 2 2 1
Community service	4
Local government	3
Primary Care Partnership	2
Medicare Local	2
Peak consumer body	1
Health insurer	1
Total number of organisations	**23**

Outcomes

The independent evaluation of the 2013 pilot found that the HLDC: provided participants with knowledge, practical direction and opportunities to share learnings; built capacity in the region by developing leadership, networks and partnerships, and workforce knowledge and skills; and served as a catalyst for organisations to authorise and embed health literacy into routine practice. The 2014 and 2015 independent evaluations suggested the Project: created a ripple effect, building the capacity to respond to health literacy needs at the individual and organisational level (see **Table 2**); acted as a catalyst for action across the region; and contributed to significant changes in health literacy practices within the four case-study organisations. Actions taken to achieve this were often consistent across organisations, including conducting health literacy assessments, developing health literacy plans and tools, establishing structures and incorporating health literacy into documents, policies and processes. A common set of drivers and enablers also emerged as influencing health literacy practices within organisations (see **Table 3**). A vignette has been provided to illustrate how participation in the Project has influenced health literacy practice at partner organisation cohealth (see **Box 1**).

A survey of local organisations indicated that health literacy practices are increasingly being applied within the region. In 2016, half of the respondents (9 of 18) reported making good progress or having embedded health literacy practices, compared with none in 2013 (see **Fig. 1**). Many health literacy practices are being implemented in greater proportions (see **Table 4**) with a small number of practices noted as areas for improvement (e.g. embedding health literacy into staff position descriptions).

Supporting the workforce through a community of practice was successful. HLCoP participants indicated that: it created a valued local space for sharing and reflecting upon and learning from experiences, particularly from consumers; information received was useful (81%) or somewhat useful (19%); and topics were relevant (71%) or somewhat relevant (29%) to their work. Health Literacy Alliance participants indicated that the Alliance had assisted their work through: peer learning and support from others in a similar role; sharing ideas, resources and information; a better understanding of priorities and work across the region; generation of ideas; and increased health literacy knowledge and skills. The majority found the Health Literacy Alliance very or quite useful (70%).

Table 2. Ripple effects reported in case study organisations

Individual effects	• Increased staff knowledge, skills, confidence • Improved written information for consumers • Increased opportunities and engagement with consumers for providing input and feedback • Increased consumer access to health services • Decreased consumer confusion about services
Organisational effects	• Health literacy principles and practices embedded into human resource management (e.g. reviewed staff induction, position descriptions, staff key performance indicators) and research ethics review processes • Increased authorising environment • Improved organisational culture • Expanded professional development training

Table 3. Factors influencing health literacy practices in four case study organisations

Implementation drivers	Implementation barriers
Individual level: • Senior executive buy-in and action on health literacy • Internal staff championing health literacy principles and practices	Individual level: • Staff diversity • Staff turnover • Staff fatigue • Limited medical and clinical staff engagement • Terminology • Time constraints
Organisational level: • Inclusion of health literacy in organisational strategic plans reflect health literacy principles • Health literacy embedded in human resources management plans and research ethics review processes	Organisational level: • Maintaining momentum given multiple other priorities • Service industry organisations are task focussed • Lack of visible benefits of taking action on health literacy
Systems level: • Ongoing service reforms driven by health literacy and person-centred approaches • Accreditation via National Safety and Quality Health Service Standards -- Standard 2 • Inclusion of health literacy in national, state and regional plans e.g. Victorian Health and Wellbeing Plan	Systems level: • Navigating system is challenging • Ongoing service reforms • Increasing information via technology • Funding uncertainty

Figure 1: Self-reported use of health literacy practices in local organisations in 2013 and 2016.

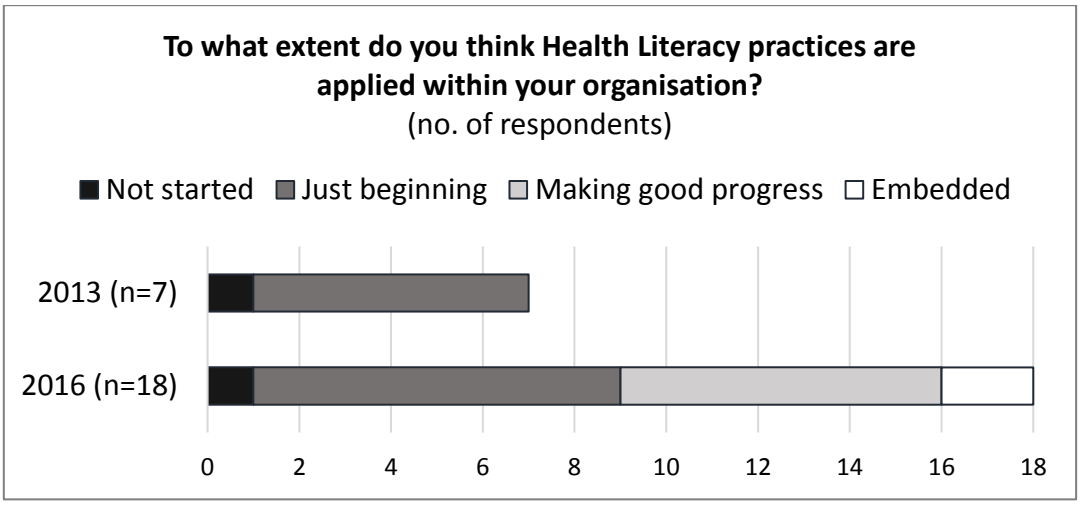

Table 4. Responses to survey assessing health literacy practices of local organisations in 2013 and 2016. Bold indicates positive change. N/A, not applicable

Survey statement	**2013 (*n* = 7)**	**2016 (*n* = 18)**	**Difference**
Health literacy is embedded in our strategic plans	27%	39%	**+12%**
Our organisation has a health literacy policy	0%	33%	**+33%**
Health literacy is a key element of other organisation policies	Not asked	39%	N/A
In our organisation health literacy is embedded in our written communication policy guide	29%	44%	**+15%**
In our organisation health literacy is embedded in our web communication policy guide	29%	33%	**+4%**
In our organisation we have allocated staffing to health literacy	27%	50%	**+23%**
In our organisation health literacy is embedded into the position descriptions of our staff	27%	17%	−10%
In our organisation we have formally assessed or audited our organisation's health literacy practice	0%	39%	**+39%**
In our organisation community engagement and participation strategies are inclusive of and accessible to people with low health literacy	71%	89%	**+18%**
In our organisation staff are encouraged to use health literacy communication strategies with all consumers	29%	89%	**+60%**
In our organisation we produce materials in languages other than English	86%	72%	−14%

Box 1. Vignette: making cohealth easy to understand, access and use

The health literacy landscape at cohealth has been informed by many factors including involvement in the Project. cohealth has historically been driven by a human rights approach to health service delivery and by a desire to make the organisation and health information easy to understand, access and use for communities. A focus on marginalised populations and reducing health disparities is central to this commitment and approach.

cohealth was part of the Project as both partner and participant. As partner cohealth actively contributed to the Project's development. As participant cohealth tested and learned from it, trialling innovations internally. In this way, cohealth engaged in cycles of improvement and refinement throughout the Project's duration.

According to the 2015 University of Melbourne evaluation, the following resulted from cohealth's participation:

- Six staff members undertook the Health Literacy Development Course training;
- An organisational Health Literacy Plan was developed and endorsed;
- Health literacy surveys and audits were conducted to determine organisational readiness, understanding and benchmarking;
- A Health Literacy Working Group and other structures were established to guide planning efforts; and
- Health literacy was embedded into documents and procedures.

The following outcomes were identified from cohealth's involvement:

- An increasingly authorising environment through senior leadership engagement, improved organisational culture and expanded professional development;
- Increased staff knowledge, skills and confidence;
- Improved written and visual information for consumers;
- Health literacy embedded into cohealth Human Ethics Review processes and documents;
- Development and application of a health literacy responsive approach that informs all activities with consumer representatives;
- Increased opportunities for consumers to access and provide input into services; and
- Decreased consumer confusion about services.

Most significantly, the evaluation identified that cohealth staff were becoming health literacy change agents. Staff commented that they had not just acquired new knowledge and skills, but that this had led to ripples and changes in their outlooks, assumptions and expectations as a result of their experiences with the Project.

cohealth demonstrates increasing health literacy responsiveness. The combination of external and internal drivers has created a supportive authorising environment for action, as demonstrated by successfully embedding health literacy into organisational values, work practices, structures and systems.

Discussion

Creating systems change is an extremely challenging and multifaceted process. Finding the appropriate levers to generate large scale change to improve the quality and safety of services is an ongoing challenge. The following key lessons emerged that resonate with existing evidence with regard to education and learning[13] and creating change:[14]

Internal and external drivers: The key internal and external drivers identified in the evaluation and summarised in **Table 3** greatly increased the interest in and uptake of the Project among local organisations. Identifying and utilising drivers as levers for action was critical to build momentum and commitment for action within organisations.

Workforce development: Building workforce capability was the first step of the Project. Instead of theoretical knowledge, the HLDC provided shared practical and experiential learning among participants. The HLCoP provided further opportunities for the workforce to build its skills and knowledge. The HLDC intentionally built the capability of executives and senior staff as well as practitioners, adding to the organisations' capacity and generating an authorising environment through a shared commitment to action.

Creating change: The Project was designed to support participants to act as change agents, facilitating change at both individual and organisational levels. This was often difficult in large and complex environments with competing priorities and continual staff turnover. By focusing on key elements of organisational change (policy development, action plans, staff training and senior commitment), the Project supported participants to create change and improved uptake of the principles and practices of health literacy responsiveness.

Partnership and leadership: A commitment to sustained partnership and leadership was integral to the Project's success. This included a strategic partnership bringing complementary expertise and skills, the allocation of monetary and in-kind resources and steering the Project through the 4-year planning, development and implementation period. HealthWest PCP used its partnership expertise to engage local organisations in the Project. Participating organisations also demonstrated significant leadership and partnership internally through the investment and allocation of resources required for long-term organisational change.

Planning and evaluation: The Project benefitted from the developmental evaluation methodology, which allowed for regular review and monitoring of the Project and for improvements to be implemented as necessary. A commitment to ongoing and independent evaluation created an evidence base to support the Project's efficacy and local organisations' interest in participating. Participating organisations also committed to ongoing review and evaluation through their own planning and evaluation cycles. Sharing skills and knowledge contributed to a stronger evidence base for improved organisational practice.

A limitation of the Project was that its impact on consumer experiences and health outcomes was not evaluated. It was decided that the timeframe was insufficient to produce significant, measurable change in these domains. Understanding how systems change affects consumers is a priority for ongoing health literacy work in the region.

Conclusion

This case study provides some evidence that the systems approach used in the Project built health literacy responsiveness in participating individuals and organisations, contributed to increased use of health literacy practices and led to systems change across the region over a 4-year timeframe. Outcomes and lessons will have implications for future systems change projects.

Competing interests

The authors declare that they have no competing interests.

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