Evaluating the Ripple Effect of the Health Literacy Project Initiatives at the Organisational Level

Final Report - Executive Summary – January 2016

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Introduction

From 2013 the Centre for Culture Ethnicity & Health (CEH), HealthWest Partnership (HWP) and cohealth have invested in a project designed to build health literacy capacity through a systems response to redress health disparities. The Health Literacy Project objectives include:

- Build health literacy capacity of health and community organisations and professionals in the West
- Place based and localised impact
- Evolving and responsive to learnings
- Self-sustaining
- Redress health disparities
- Build evidence base for work.

The project initiatives have included: three health literacy training courses, senior executive sponsors workshops, health literacy Community of Practice (CoP) and public forums for health professionals working in HWP member agencies in the western metropolitan region of Melbourne. Overall the project is designed to develop the health literacy knowledge, skills and organisational capacity of the health and community service sector in the western metropolitan region of Melbourne. To date six agencies (HealthWest Partnership, cohealth, Western Health, Mercy Health, Royal District Nursing Service, Diabetes Victoria) have supported two staff each year to attend the 2013, 2014 and 2015 training courses, and to participate in the CoP, seminars and workshops.

Evaluation Focus

In 2015, in response to the increased commitment to health literacy as a priority area in the West *and the* 2013 and 2014 evaluation findings, the CEH, HWP and cohealth commissioned The University of Melbourne, Health Systems and Workforce Unit to evaluate the extent to which the health literacy project initiatives (i.e., training courses, Community of Practice (CoP), workshops, public forums) were creating a ripple effect within four organisations (cohealth, Diabetes Victoria, Western Health and Mercy Health).

Key evaluation questions included:

- What **changes at the individual level** (staff behaviour, roles, attitudes, skills, knowledge, relationships, capabilities) have resulted from staff participating in the health literacy project initiatives?
- What **changes at the organisational level** (culture, structures, governance, processes, practices) have resulted from staff participating in the health literacy project initiatives?
- What **changes at the systems level** (funding, regulations, education/training) have resulted from staff participating in the project initiatives?
- What is the **perceived impact on clients** from staff and organisations participating in the health literacy project initiatives?
- What ***enablers and barriers*** exist to changes in health literacy practices within the organisations at the individual, organisational and systems level?
- ***What is required*** at the individual, organisational and systems level to ***sustain the changes*** in health literacy practices with organisations?

Evaluation Approach

The evaluation was informed by two approaches:

1) **Case study approach** to provide *descriptive, explanatory and analytical evidence* about the processes, practices and causal links between the project initiatives and the changes resulting from

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staff and organisations participating in the initiatives. cohealth, Diabetes Victoria, Western Health and Mercy Health were selected for study on the basis of: staff participation in 2013, 2014, 2015 project initiatives; sector, organisation type, course participant work roles, organisational readiness and capacity for taking action on health literacy.

2) **Ripple Effect Mapping (REM)** is a qualitative participatory evaluation approach to conduct impact evaluation that engages stakeholders to retrospectively and visually map the "*ripple effect*" resulting from an initiative. To align the methodology to the evaluation questions, in collaboration with the funders an adapted REM methodology was used. Case study organisation specific group discussions facilitated by the evaluator were conducted about four evaluation foci:

1) Drivers for taking action on health literacy
2) Actions taken by organisation to build health literacy capacity
3) Ripple effects resulting from health literacy project; and
4) Contextual factors influencing implementing health literacy practices.

REM workshop participants were recruited by the case study organisations on the basis that they had participated directly in the health literacy training courses, Community of Practice, executive sponsors workshop or public forums, or were key organisation members who had participated in organisational related health literacy actions.

Workshop discussions were audio-recorded and transcribed. Transcripts were coded and analysed using the constant comparative thematic analysis approach which identifies emerging themes through a three step iterative coding process: open coding; axial coding and selective coding. The evaluation received ethics approval from The University of Melbourne Human Ethics Advisory Group.

Evaluation Context

The REM workshops were held at the case study organisation premises. Given that the workshops were designed to generate general evidence (e.g. not specific to any one organisation) about ripple effects, contextualising the research is essential.

- **cohealth** is a community health organisation, servicing a broad area of high-growth communities across Melbourne's northern, western and inner suburbs.
- **Western Health** is a large acute public hospital in two sites that employs nearly 6500 staff in Melbourne's northern and western suburbs.
- **Diabetes Victoria** is a peak body committed to minimising the impact of diabetes in the community, helping all people affected by diabetes and contributing to the search for a cure.
- **Mercy Health** is a Catholic organisation that employs over 6,500 people who provides a range of health care services including: acute, subacute hospital care, aged care, mental health programs, maternity and specialist women's health services.

Synthesis of Evaluation Findings

The four REM workshops with **27** participants confirmed prior evaluation findings that the Health Literacy project is creating and facilitating **splashes (outputs) and ripples (immediate outcomes)** at an individual, organisational and system level within organisations that have participated in the project. Synthesis of evaluation findings are presented under the four evaluation foci: drivers, actions, ripples and contextual factors – revealing those common to all, and those which were specific to organisation types.

1. Drivers for taking action on health litercy

Multiple **drivers** for taking action on health literacy were mentioned that can be clustered into external and internal organisational drivers:

- **External driver**s: Australian Commission on Safety and Quality in Health Care (ACSQHC) National Health Literacy Statement; Accreditation via ASCQHC Standard 2; Victorian Health and Wellbeing Plan
- **Internal drivers**: Organisation Strategic Plans; Priorities; Key Performance Indicators; Professional Development Plans; staff champions; Senior executive buy in/support; patient centred care movement; patient demographic diversity and patient care experiences.
- Drivers common to all four case study organisations included: having: staff champions, executive buy in; and patient demographic diversity.
- All organisations, except Diabetes Victoria mentioned Accreditation via ASCQHC Standard 2 as a key external driver. This may be partly due to Diabetes Victoria not being required to undertake Accreditation by the ACSQHC.

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- The workshops also revealed that in the absence of an explicit and coherent organisation health literacy policy (e.g., Health Literacy Plan / strategy) and structures (e.g., Health Literacy working group) taking action on health literacy required a combination of **internal** (e.g., staff champions) and **external drivers** (e.g., Accreditation via Standards 2). Furthermore, the workshop reinforced previous evaluation findings that **a supportive authorising environment** (via Senior Executives and Boards) were key drivers for taking action and an enabler for maintaining health literacy action momentum.
- Workshops participants also commented that **drivers and followers of health literacy exist** (i.e., Organisation Strategic Plans that include health literacy can be both driving Health Literacy or can be the product of a whole range of actions on health literacy. Furthermore, health literacy practices could be viewed as a **process or an outcome** (i.e., if good health literacy practices existed, then co-design and community engagement are the principles or symbols that demonstrate good health literacy practices).

2. Actions taken to build health literacy capacity

Multiple **actions (outputs or splashes**) to build health literacy capacity have been taken by case study organisations which can be clustered into two levels:

- **Individual level** (e.g., conducted workforce surveys; provided opportunities for consumer engagement);
- **Organisational level** (e.g., conducted organisational audits, developed Tip Sheets and tools; developed Health Literacy plans and strategies; established health literacy information exchange opportunities; participated in *'Drop the Jargon';* reviewed Human Resource Management policies; reviewed and developed Professional Development opportunities; embedded Health Literacy into Quality Reports)
- All four organisations undertook several common actions including: developing health literacy plans or tools, conducting health literacy specific surveys or audits, establishing structures; revising documents or procedures; and embedding health literacy principles or practices into Human Resource Management (e.g., Staff inductions) and Research Ethics Review Processes.
- Embedding Health Literacy principles and practices systemically via Human Resource Management and Research Ethics Review Processes were mentioned by cohealth, Diabetes Victoria and Mercy Health, but not Western Health. This may reveal the complexity and time required for incremental change in such processes to occur within large acute care public hospitals.
- Overall workshop participants did not mention nor link any one specific health literacy action to any one specific project initiative. In other words the Health Literacy project initiatives were **collectively and cumulatively** contributing to the health literacy actions within their organisations.

3. Ripple effects resulting from health literacy project

The evaluation has revealed that the health literacy project is creating multiple **common ripples (immediate outcomes)** that can be clustered at an:

- **Individual** (e.g., increased staff knowledge, skills, confidence; improved written information; increased opportunities and engagement of consumer in providing input/feedback; increased consumer access to health services; decreased consumer confusion about services); and
- **Organisational** (e.g., embedded health literacy principles and practices into Human Resource Management (e.g., reviewed staff induction, staff job descriptions; staff key performance indicators) and Research Ethics Review processes; increased authorising environment; improved organisational culture; expanded professional development training)
- Several ripples specific to organisation type included: the acute care organisation (Western Health, Mercy Health) participants mentioned: increased engagement of managerial staff (e.g., Outpatient Managers; Food Service Managers) in health literacy, beyond those directly participating in the project, as well as improved organisational culture and improved respectfulness amongst staff. Only cohealth workshop participants mentioned *perceived impact on clients/consumers* from the health literacy project initiatives, namely: increased consumer access to health services and decreased consumer confusion about services. This may reveal the time and effort required for organisational health literacy principles and practices to impact at the client/consumer level.
- Workshops participants also commented that **ripple effects were not linear,** with first and second order effects, but dynamic with multiple 'pockets of ripples' in multiple directions due to multiple drivers and contexts for taking action on health literacy. Ripples were often discussed as

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being invisible and having unintended consequences (e.g., improved communications between managers and patients). Ripples could also be **direct** (i.e., specific to project participants) and **indirect** (i.e., beyond project participants, such as Outpatient Managers or Food Service Managers).

- The workshops also confirmed that the health literacy project initiatives were supporting the development of **health literacy transformative change agents**. Workshops participants commented on how they had not just acquired new knowledge and skills, but it had led to ripples or changes in their outlooks, assumptions and expectations as a result of their experience with the project. Examples of transformative ripples included:
  - Health literacy lens informs all cohealth consumer representative activities
  - Health literacy principles and practices are now embedded into cohealth Human Ethics Review Processes and documents (e.g., Consent Form, Plain Language Statement)
  - Outpatient managers within Western Health have increased their receptivity to health literacy practices
  - Health literacy principles and practices are now embedded into Diabetes Victoria Human Resource Management processes (e.g., Job Descriptions, Staff Induction)
  - Health Literacy is now on the Mercy Health Board - Quality Committee Agenda

- The REM workshop participants also confirmed that overall the Health Literacy Project was contributing to **incremental ripples / change** processes within their organisations – getting traction, adoption, implementation and embedding health literacy principles and practices. The training course **mini—projects were playing a variable role** as a catalyst for taking action, due to variable knowledge about the mini-projects beyond the course participants. Workshop participants identified multiple other **opportunities for taking action** on health literacy, including: engaging Quality Managers in Acute Care; engaging health professionals early on in their career (e.g., Medical Interns). Participants reported that often **ripples were initially un-planned and ad hoc** and recognised that explicit plans and structures were required to sustain the ripples. For example potentially **sustainable ripples via systemic changes** (e.g., Human Resource Management Policies; Human Ethics Review Procedures; Capital Team) or via engagement of key roles (e.g., Quality Managers; Food Service Managers)
- Overall, workshop participants did not mention nor link any one specific health literacy action or ripple effects to any one specific project initiative. In other words the Health Literacy project initiatives were **collectively and cumulatively** contributing to the health literacy ripple effects within their organisations and beyond.

Appendix 1 provides a collated Health Literacy Project Ripple Map.

4. Contextual factors influences changes in health literacy practices

A common set of **enablers and barriers** emerged as influencing health literacy practices including:

Enablers	**Barriers**
Individual level: • Senior executive buy in taking action on health literacy • Internal staff championing health literacy principles and practices	**Individual level:** • Staff diversity • Staff turnover • Staff fatigue • Limited medical/clinical staff engagement • Terminology • Time constraints
Organisational level: • State, Regional, Organisational Strategic Plans • 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 principles • Accreditation via ACSQHC Standard 2	**Systems level:** • Navigating system is challenging • Ongoing service reforms • Increasing information via technology • Funding uncertainty

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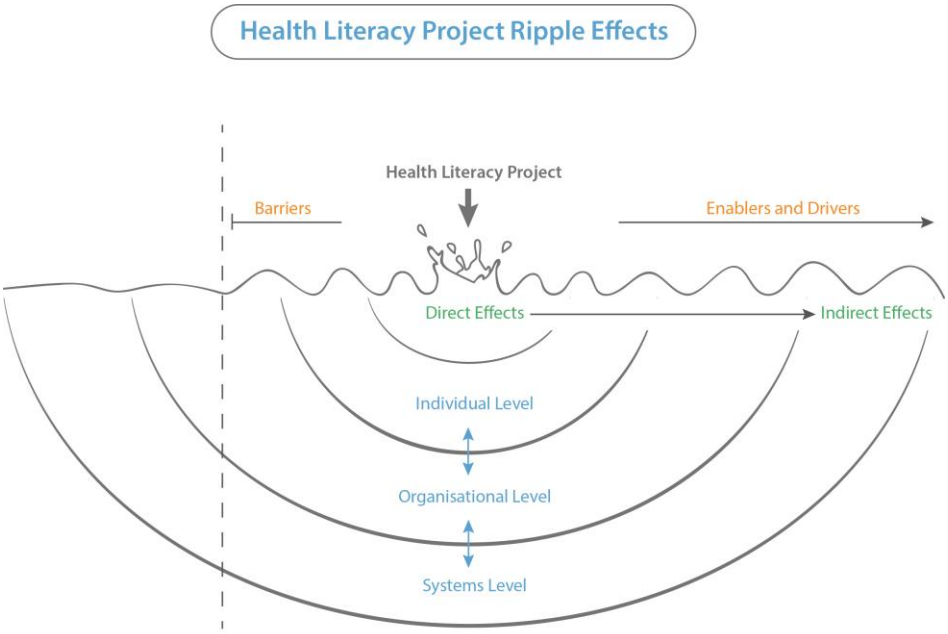

- One enabler specific to organisation types emerged namely: Accreditation via the ACSQHC Standard 2 was a key enabler for cohealth, Western Health and Mercy Health, except Diabetes Victoria, as they are not required to undergo external accreditation.
- Several barriers specific to organisation type included: the acute care organisation (Western Health, Mercy Health) participants mentioned:
    - Engaging medical / clinical staff in taking action on health literacy; and
    - Needing to show benefits for a service industry, as it is task focussed.

Figure 1 above is a visual representation of the complexity of the Health Literacy Project Ripple Effects.

Overall this evaluation has generated evidence that that the Health Literacy Project is contributing to ***transformative and incremental changes in health literacy practices*** within the four case study organisations.

A summary of the evaluation findings for each case study organisation is presented below:

- **cohealth** – as a community health organisation underpinned by co-design principles, cohealth demonstrates an increasing maturity as a health literate organisation. The combination of external and internal drivers has created a supportive authorising environment for taking action at the highest level as demonstrated by - organisation values (health literacy strategy; strategic plan); work practices (e.g., use of teach back) and symbols including: establishing structures (e.g., Health Literacy Interest Group) and embedded health literacy principles into systemic processes such as: Human Resource Management policies, Human Ethics Review policies). Impacts of health literacy practices upon consumers are becoming visible, despite ongoing barriers to maintaining health literacy action momentum, including perceptions that using health literacy practices takes extra time and time to see changes.

- **Western Health** – as a large acute care public hospital, despite being task focussed and driven by increasing patient demands and patient throughput, Western Health is committed to developing as a health literate organisation. The combination of external (Accreditation) and internal drivers (Executive support) has created a supportive authorising environment to engage staff in taking action and patients to provide ongoing feedback. Despite transformative and incremental ripples, engaging clinical (especially medical staff) and quality managers remains key barrier to influencing changes in health literacy practices across Western Health.

- **Diabetes Victoria** – as a state based information provider, Diabetes Victoria commitment to taking action on health literacy is driven by key internal drivers that has created a supportive authorising environment to establish key structures (Health Literacy Working Group) and commenced embedding systemically health literacy principle

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and practices into existing processes and policies (e.g., Human Resource Management policies, Human Ethics Review policies). Staff diversity and turnover remain barriers to maintaining health literacy action momentum.

- **Mercy Health** – as a large health care provider of acute, sub-acute, aged care and other services, Mercy Health has both external and internal drivers that have created a supportive authorising environment enabling strong managerial support across key organisation sections including: Multicultural Services, Ambulatory Care; Risk Management and Quality and Consumer Participation. Mercy Health has established key structures (e.g., Consumer Information Review processes; Community of Practice) and embedding systemically health literacy principle and practices into existing processes and policies (e.g., Human Resource Management policies, Human Ethics Review policies). Engaging medical staff in taking action on health literacy and needing to demonstrate return of investment remains key barriers to maintaining health literacy action momentum.

Reflections on case study sites and methodology

The four REM workshops with **27** participants generated rich evidence about the complexity of the ripple effects resulting from the health literacy project initiatives. The four case study sites/organisations provided a rich comparative base to explore the ripple effects, as they differed in foci (acute, community health service, and condition specific peak body), workforce, patient demographics and diversity.

The REM workshop participants were purposively selected by the case study organisation contacts on the basis of their participation (either directly in the health literacy project or indirectly by virtue of their roles in the organisations). Workshop participants included: Senior Executive Directors, Program Directors; Program Managers; Multicultural Services and Cultural Diversity Managers; Consumer Participation Managers; Prevention Managers Health Promotion Officers; Education Managers; Human Resource Managers; Communication Officers; Consumer representatives and Coordinators (e.g., Partnership, Leadership). It is important to recognise that the REM Workshop participants differed in their participation in the health literacy project initiatives.

For example, most of the cohealth workshop participants had participated in the training courses, senior executive sponsors workshops, and Community of Practice. Whereas, very few of the Western Health, Diabetes Victoria and Mercy Health workshop participants appeared to know about or had attended the Health Literacy Community of Practice. This finding may reflect and confirm previous health literacy project evaluation findings (2014) that a 'ceiling effect' exists on the capacity of health professionals attending professional development activities. This may also be partly due to the purposive selection of workshop participants by the case study organisations. It is also important to recognise that the workshop participants were not asked to reflect on the specific strategies that were used to build capacity (e.g., health literacy training courses, senior executive sponsors workshops, health literacy Community of Practice, public forums).

Overall the adapted REM methodology was effective as demonstrated by the rich, frank and honest views expressed by all workshop participants about health literacy practices within their organisation.

Key Emerging Propositions

To build upon and consolidate the investment in the health literacy project initiatives, the following propositions are presented structured according to the two foci: 1) Transformative changes; and 2) Incremental changes.

1. Transformative changes

The evaluation revealed that the health literacy project is contributing to transformative changes within each of the four case study organisations in differing ways.

1. Given the importance of having **internal drivers** (workforce, structures, processes) and **external *drivers*** (Accreditation), consideration could be given to exploring how the project could further support these drivers.

2. Given the persisting ***barriers*** to ripple effects, consideration could be given to exploring how project alumni and their organisation are responding to these factors and hence contribute to sustaining the transformative ripple effects.

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3. Given the recognition that to sustain ripples effects requires a planned approach with structures, consideration could be given to **exploring how structures** (e.g., Diabetes Victoria Health Literacy Working Group; Western Health Consumer Information Review Panel; cohealth Health Literacy Interactive Group) are sustaining the ripple effects.

4. Given the transformative changes that occurred in individuals who have participated in the Health Literacy Project, consideration could be given to further supporting these **'change agents'** to support self-sustaining health literacy practices.

5. Given that health literacy ripple effects are occurring within organisations that are not participating in all of the **health literacy project initiatives** (i.e., training courses, CoPs, executive workshops) to the same degree/extent, consideration could be given to further exploring – what combination of initiatives contributes most to self-sustaining health literacy practices.

2. Incremental changes.

The evaluation revealed that the health literacy project is contributing to incremental changes at predominantly an individual level and within specific sections/units at an organisational level.

1. Given the recognition that incremental changes are complex and take time within organisations, consideration could be given to identifying and recruiting staff to do the training courses - who work across organisational Units (e.g., Quality Managers).

2. Given the complexity of organisations, consideration could be given to identifying or further supporting ***mechanisms to*** best facilitate systemic changes – for example: within Western Health focusing upon the Quality Managers; or within Diabetes Victoria and cohealth supporting Human Resource Management processes (e.g., Staff Induction, Job Descriptions) or within Mercy Health supporting Human Ethics Review Processes - as mechanisms to facilitate systemic changes in self-sustaining health literacy practices.

3. Given the recognition that staff from both **strategic and clinical roles** need to be engaged in and take action on health literacy, consideration could be given to identifying and recruiting staff who work in strategic and clinical roles.

4. Give that limited resources exist to evaluate health literacy ripple effects, consideration could be given to embedding health literacy related questions into ongoing organisational '**quality assurance processes'.**

5. Given the variable knowledge about the **health literacy mini—projects** beyond the training course participants, consideration could be given building into Course Requirements – the commitment to evaluate the mini-project 6 and 12 month after the course.

6. Given that within the acute care setting, **engaging medical staff** in taking action on health literacy, continues to be a key challenge, consideration could be given to further exploring what strategies could work to engage medical staff or what a '**Medical co-design Health Literacy'** initiative would look like.

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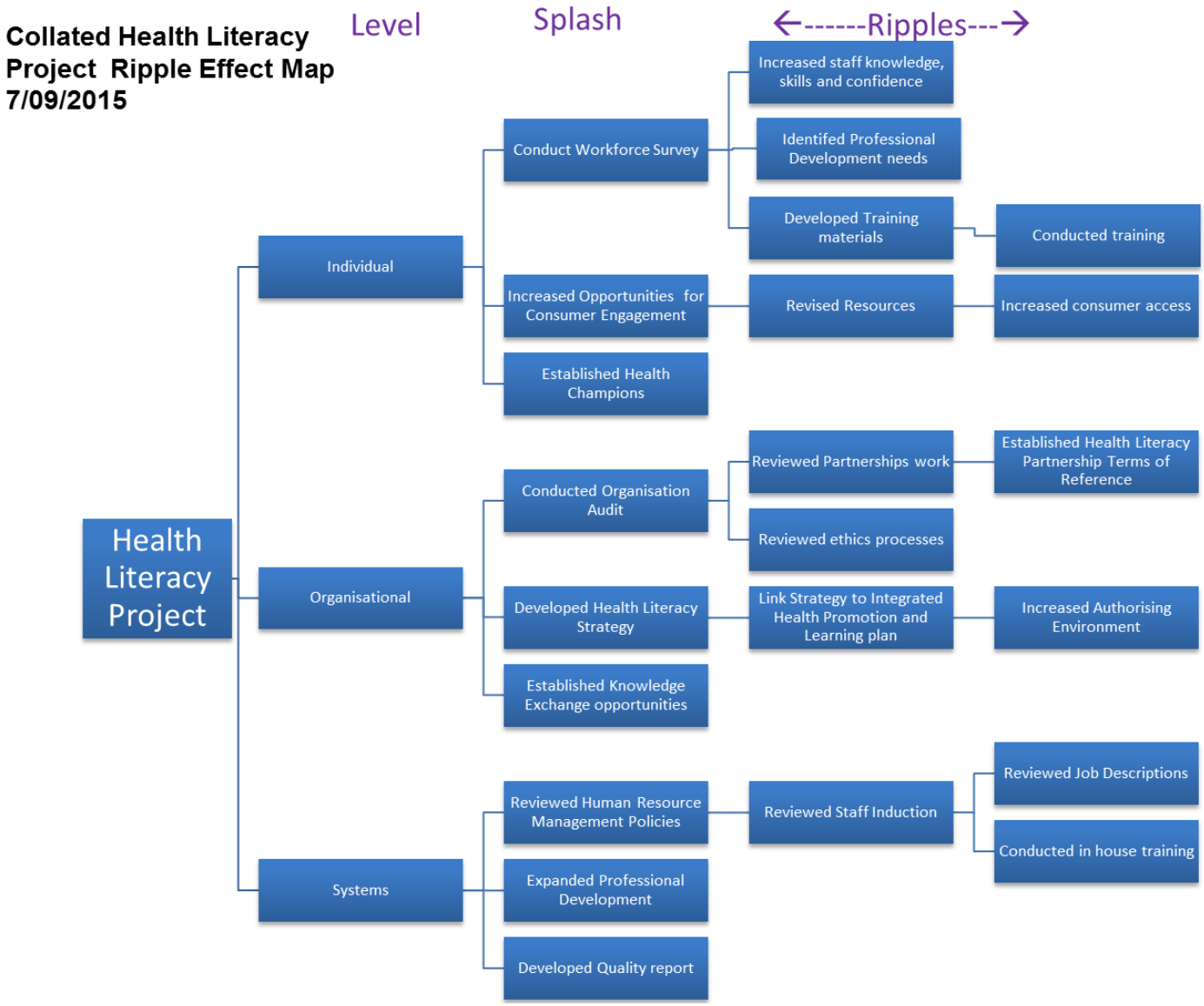
Appendix 1: Example of - Collated Health Literacy Ripple Effect Map



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