Fit for Diversity: A Staff-Driven Organizational Development Process Based on the Organizational Health Literacy Responsiveness Framework

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ABSTRACT

Working toward equity in health requires attention to local needs. Organizational health literacy responsiveness is defined as the way health information and resources are made available and accessible to people. This case study aims to investigate the feasibility of the the Organizational Health Literacy Responsiveness (Org-HLR) process in developing a health literacy strategy in a Danish municipal rehabilitation unit. The Org-HLR investigates organizational health literacy responsiveness within six domains: (1) leadership and culture; (2) systems, processes, and policies; (3) access to services and programs; (4) community engagement and partnerships; (5) communication practices and standards; and (6) workforce. During three workshops, we applied the appropriate tools to allow staff and management to reflect upon and self-assess local organizational health literacy needs and develop and prioritize ideas for improvement. During the Org-HLR self-assessment, 62 ideas for improvement were identified. After prioritization, the unit produced an action plan with 11 items to develop health literacy responsiveness. The co-creational strategy ensured broad participation, which may increase the likelihood of successful implementation. To become health literacy responsive, organizations need to develop local strategies. This study confirmed the Org-HLR as a feasible approach to identify organizational health literacy needs and to guide organizational health literacy improvements. **[*HLRP: Health Literacy Research and Practice*. 2020;4(1):e79-e83.]**

Health literacy is an independent determinant of health, and the relationship between health literacy and preventive health behavior is well-established (Aaby, Friis, Christensen, Rowlands, & Maindal, 2017; Pelikan, Röthlin, & Ganahl, 2012). Health literacy is also associated with other social health determinants, (Bo, Friis, Osborne, & Maindal, 2014; Pelikan et al., 2012) and research suggests that health literacy constitutes an intermediary factor in the distribution of health and well-being, including chronic disease prevention (Stormacq, Van den Broucke, & Wosinski, 2019). However, addressing equity in preventive services through health literacy initiatives calls for comprehensive approaches, including organizational adaptions (Batterham, Hawkins, Collins, Buchbinder, & Osborne, 2016; Paasche-Orlow, Schillinger, Greene, & Wagner, 2006; Willis et al., 2014).

Organizational health literacy responsiveness is "the way in which services, organizations and systems make health information and resources available and accessible to people according to health literacy strengths and limitations" (IUHPE Global Working Group on Health Literacy, 2018, p. 6). Although there are few intervention studies on organizational health literacy responsiveness, several frameworks exploring the concept are available (Farmanova, Bonneville, & Bouchard, 2018). Recently, the Organizational Health Literacy Responsiveness (Org-HLR) framework was developed, involving seven domains characterizing health literacy responsive organizations: (1) external policy and funding environment; (2) leadership and culture; (3) systems, processes, and policies; (4) access to services and programs; (5) community engagement and partnerships; (6) communication prac-

tices and standards; and (7) workforce (Trezona, Dodson, & Osborne, 2017). Based on this framework, the Org-HLR process seeks to support organizations in analyzing strengths and weaknesses with regard to health literacy responsiveness, and to develop local action plans to address their challenges (Trezona, Dodson, & Osborne, 2018).

The aim of this organizational case study was to investigate the feasibility of the Org-HLR process in developing a health literacy strategy in a Danish municipal rehabilitation unit.

METHODS

The study was conducted at Randers Municipal Rehabilitation Unit (RMRU) in Denmark, with a catchment area of approximately 98,000 people. The unit offers public rehabilitation programs after referral from general practitioners or hospitals. All services are free of charge. RMRU is organized with eight therapeutic teams comprised of 3 to 10 staff members. At management level, the unit includes the head of unit, professional manager, and development manager (S.P.). The managers and four therapeutic teams were involved in the Org-HLR process.

We adhered to an early unpublished version (beta) of the Org-HLR process (**Table 1**) (Trezona et al., 2018). The process included three workshops each with an appertaining tool. A team of four researchers (including A.A. and H.T.M.) facilitated the workshops.

The reflection tool was comprised of five open-ended questions guiding group discussions about health literacy concepts. The self-assessment tool included 110 items distributed on 22 sub-domains within 6 of the 7 domains in the Org-HLR framework (external policy and funding environment was not included). Participants discussed and noted good practices, opportunities for future improvement, and scored the units performance on each item on a scale ranging from 0 (not at all) to 4 (fully). In the prioritization tool, participants assessed each improvement idea on importance (scale ranging from 1 [not important] to 5 [essential]) and urgency (low [any time], medium [within 6-12 months], or high [within 3 months]) and determined the resources required for the idea.

The tools were translated by a professional translator and a researcher (A.A.).

Ethics and Approvals

According to Danish law, no ethical approval is necessary for an organizational case study in which no personal data are involved. Data were stored and handled according to Danish Data Protection Agency (reference number 2015-57-0002).

RESULTS

Reflection Workshop

The research team extracted views on health literacy in RMRU and communicated these in a pamphlet. This provided a collective starting point for the self-assessment workshop.

Self-Assessment Workshop

Sixty-two ideas were generated through the self-assessment. Not all teams were able to respond to or distinguish between all items. In the following text, we indicate the average rating and summarize workshop findings within each domain.

Supportive Leadership and Culture

The average rating score for this domain was 2.77. The self-assessment identified a managerial commitment to equity. However, the allocation of financial resources is largely

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TABLE 1

The Org-HLR Process in Randers Municipal Rehabilitation Unit

Org-HLR Workshop	Content	Participants	Time
Reflection	Participants were guided by the reflection tool to discuss the local application of health literacy concepts	Staff and managers	2 hours
Self-assessment	Each participating therapeutic team performed an assessment of the local organizational health literacy responsiveness using the self-assessment tool	Staff from four therapeutic teams	4 hours
Prioritization	Staff and managers in communion rated and prioritized each improvement idea generated in the self-assessment workshop using the prioritization tool	Staff representatives from four therapeutic teams and managers	3 hours

Note: Org-HLR = Organizational Health Literacy Responsiveness.

defined by national program guidelines, and the commitment appears more as a managerial declaration of intent than a supported strategy.

Supportive Systems, Processes, and Policies

The average rating score for this domain was 1.72. Although some policies and procedures exist, the self-assessment disclosed unsystematic needs identification, monitoring, and evaluation. The teams expressed a need for an assessment tool to use on new referrals.

Supporting Access to Services and Programs

The average rating score for this domain was 2.29. The teams agreed that the unit has a user-friendly physical environment with easy access to services. Outreach activities were few, but not identified as an urgent need.

Community Engagement and Partnerships

The average rating score for this domain was 1.69. A lack of engagement of users in the development and evaluation of services was identified. All teams expressed a wish to improve this.

Communication Practices and Standards

The average rating score for this domain was 2.56. The teams judged oral and written communication to be appropriate and respectful. They acknowledged that no systematic evaluation of learning needs was conducted among users.

Recruiting, Supporting, and Developing the Workforce

The average rating score for this domain was 1.93. Health literacy is not yet integrated in staff recruitment and work environment. However, the participants felt that being part of this project had improved their health literacy skills and they expressed a desire to get systematic feedback within the field.

Prioritization Workshop

The pre-set timeframe proved insufficient to complete this workshop. Therefore, a research team member (A.A.) and the development manager (S.P.) in collaboration finished a draft prioritization that was approved by all participants in the workshop before the action plan was drawn. **Table 2** shows the action plan derived from the prioritization workshop.

DISCUSSION

This organizational case study has demonstrated the feasibility of the Org-HLR process in a municipal rehabilitation setting in Denmark. The process resulted in a health literacy responsiveness action plan developed by staff and managers based on self-assessment and prioritization of activities.

This is the first study to report on the Org-HLR process outside the Australian context in which it was developed. Existing literature supporting the effectiveness of health literacy responsiveness interventions is still limited (Farmanova et al., 2018). However, since the emergence of the first guides in 2006 many frameworks has been published and to some extent positively validated (Farmanova et al., 2018). The Org-HLR is one of the first frameworks developed empirically using a concept-mapping approach with health care professionals (Trezona et al., 2017).

A growing literature in health care accentuates co-design (a participatory approach involving staff, users, or other stakeholders in the development of health care initiatives) as central in bridging the gap between research-driven intervention development and successful implementation (Beauchamp et al., 2017; Greenhalgh, Jackson, Shaw, & Janamina, 2016; Jessup, Osborne, Buchbinder, & Beauchamp, 2018). We have not evaluated the workshop participants' experiences and understandings directly; therefore, we cannot report on the local adoption of health literacy concepts. However, a review by Willis et al. (2014)

TABLE 2

The Action Plan Resulting from the Org-HLR Process in the Randers Municipal Rehabilitation Unit

Org-HLR Domain	Urgency of the Activity Within 1-3 Months	Within 3-12 Months	After 12 Months
Leadership and culture	-	Develop and implement a local definition of vulnerability Develop and cultivate health literacy responsiveness in the unit	Implement equity and health literacy in strategy documents
Systems, processes, and policies	-	-	Advocate health literacy (responsiveness) as a local service quality goal
Access to services and programs	-	-	Improve collaboration with referring institutions to improve service access
Community engagement and partnerships	-	User satisfaction survey among users	-
Communication practices and standards	Implement tool for evaluation of user health literacy level and needs	Develop video-based user information	-
Workforce	Carry out staff training in equity, health literacy and needs identification	Carry out video-based supervision and feedback on communication and identification of health literacy level and needs	Implement equity and health literacy in introduction of new employees

Note. Org-HLR = Organizational Health Literacy Responsiveness.

identified strategies associated with improved organizational capacity for delivering health literacy responsive services. These include engaging staff to adapt to local contexts, creating ownership, ensuring broad involvement, promoting a learning culture, and strengthening teams (Willis et al., 2014). By empowering the staff throughout the Org-HLR process, we have strived to achieve that.

Before the Org-HLR process, the staff and managers in RMRU had limited knowledge on health literacy concepts. Even so, the Org-HLR process was effective in identifying feasible action within the Org-HLR domains (**Table 2**). However, some issues were not addressed in the action plan in spite of poor scores in self-assessment. For example, despite access to services and user involvement being frequent elements of organizational health literacy guides (Frosch & Elwyn, 2014; Geboers, Reijneveld, Koot, & de Winter, 2018; Koh, Brach, Harris, & Parchman, 2016) the RMRU action plan did not include improved outreach services or target the general lack of user involvement. In a context of limited resources, it is not surprising that not all organizational health literacy challenges can be addressed at once, but this only emphasizes the importance of regular follow-up activities to allow new priorities as daily practice, policies, and funding environments changes.

With regard to urgency of the initiatives, the action plan (**Table 2**) show a skewness toward communication and workforce domains. This may indicate a downside of the staff involvement if strategic elements are given a lower priority. Literature confirms the need for policy and strategic level interventions to improve equity and health literacy (Public Health England, 2015; Willis et al., 2014), and the observed distortion, if left unaddressed, may increase the risk of implementing isolated actions that come to nothing in a longer perspective.

STUDY LIMITATIONS

Our study has some important limitations. First, not all teams in the unit took part in the process (**Table 1**). This may have skewed the action plan toward the participating teams' needs. Second, the time span between the first two workshops was long (6 months), and a repetition of health literacy concepts was necessary before the

self-assessment. In the future, we would recommend more densified Org-HLR processes. Third, the translation process of the Org-HLR tools was not ideal. We focused on the immediate face validity, leading to some cultural adaptations. The tools were reported acceptable and meaningful by the participants, but they felt the self-assessment tool was too long and with too little distinction between items. leading to a repetition of statements. Further cultural adaption and validation is warranted. The results of the Org-HLR process in RMRU may not be directly generalizable to all other settings. However, because of its simplicity and the comprehensive guide and tools, the Org-HLR process as a method is easily carried out in other settings and may yield comparable action plans in other contexts. In our view, working toward improved organizational health literacy responsiveness using self-assessment and co-creation may prove a practical, well-accepted, and sustainable approach to local action against inequity in health.

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