# Appendix 14: Guide for analysing the Six Dimensions

|  | **Yes** | **No** | **Don’t know** |
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| **Dimension 1: Leadership and management** |  |  |  |
| Your organisation’s mission statement, policies and programmes make an explicit commitment to health literacy. |  |  |  |
| There is responsibility and delegated authority to oversee health literacy (for example, a high-level health literacy taskforce, or an addition to a particular role such as chief medical officer). |  |  |  |
| Health literacy improvement goals are set, incentives to achieve those goals are provided and accountability for health literacy is established. |  |  |  |
| Fiscal and human resources are allocated to achieve health literacy goals. |  |  |  |
| Health literacy champions are established throughout the organisation. |  |  |  |
| Your organisation encourages other organisations to be health literate through influence, purchasing power and collaboration. |  |  |  |
| Your organisation contributes to local and national efforts to improve health literacy. |  |  |  |
| Health literacy is incorporated into all planning activities. |  |  |  |
| Measures are developed and data is collected to measure success in reaching health literacy goals and to identify areas for further improvement. |  |  |  |
| Rigorous evaluations of health literacy interventions and activities are designed and conducted. |  |  |  |
| Assessment, measurement and evaluation data is used to inform continuous health literacy improvement. |  |  |  |
| Health literacy is synthesised with other organisational priorities such as health targets, health inequalities, health inequities and health promotion. |  |  |  |
| Advice about health literacy is sought from experts in the field. |  |  |  |
| Other: |  |  |  |
| **Dimension 2: Consumer involvement** |  |  |  |
| A consumer council or similar is established to advise the Executive Leadership Team on how plans and initiatives will affect consumers, families and communities. |  |  |  |
| A culture is created that values consumer, family and community perspectives, and emphasises that communication is a two-way interaction between participants who have equally important roles. |  |  |  |
| Members of the populations your organisation serves are included on the Board. |  |  |  |
| Your organisation collaborates with members of relevant communities about programmes, service design, testing of interventions and development. |  |  |  |
| Feedback on health information and services from the communities who use them is obtained and used. |  |  |  |
| Community members are enlisted onto evaluation teams to assess the effectiveness of your organisation’s health literacy programmes. |  |  |  |
| There is a process for replacing community representatives on health literacy programmes as the representatives become experienced with and knowledgeable about health conditions, health vocabulary and health information. |  |  |  |
| Other: |  |  |  |
| **Dimension 3: Workforce** | |  |  |  |
| Goals are set for ongoing formal and informal health literacy training for all staff and members of boards. | |  |  |  |
| Health literacy skills of staff members are evaluated on an ongoing basis, training is provided for staff who do not meet appropriate standards and training is evaluated for effectiveness. | |  |  |  |
| Health literacy is incorporated into induction and other types of training (for example, consumer safety, quality improvement, cultural competence and patient-centred care). | |  |  |  |
| Staff are encouraged to attend external specialist training in health literacy. | |  |  |  |
| External health literacy professionals are brought in to augment in-house training resources. | |  |  |  |
| ‘Expert educators’ are developed to serve as role models, mentors and coaches of health literacy skills to others. | |  |  |  |
| Expectations are set that all staff will use health literacy approaches when they engage with consumers, families and communities. | |  |  |  |
| Your organisation uses a Universal Precautions approach to health literacy. | |  |  |  |
| Other: | |  |  |  |
| **Dimension 4: Meeting the needs of the population** |  |  |  |
| Systems are designed to maximise the capacity of individuals, families and communities to learn how to maintain good health, manage illness or disease, communicate effectively and make informed decisions. |  |  |  |
| All consumer and family surveys are easy to understand and to fill in, and help is provided to complete all surveys. |  |  |  |
| Advisory groups that include consumer groups with limited health literacy are established. |  |  |  |
| Communities or localities that may have low health literacy are identified. |  |  |  |
| Resources are allocated in proportion to populations and communities with low health literacy. |  |  |  |
| Partnerships or collaborations with communities or community organisations are created to build the health literacy of a specific community or locality. |  |  |  |
| Other: |  |  |  |
| **Dimension 5: Access and navigation\*** |  |  |  |
| Ongoing organisational assessments (including the physical environment) are conducted to assess and monitor health literacy performance and progress. |  |  |  |
| Health literacy aspects of all policies and programmes are assessed. |  |  |  |
| The environment is welcoming and does not impose high literacy demands. |  |  |  |
| Appropriate technology is used to overcome barriers for consumers and families with low health literacy. |  |  |  |
| Extra help (such as educators, navigators, social workers, case managers and follow-up between appointments) is provided for consumers who need it. |  |  |  |
| Consumers are asked if they have problems paying for medicine and accessing primary care services, and are referred to appropriate support services and programmes. |  |  |  |
| Facilities are designed to help people find their way. |  |  |  |
| All staff are trained to respond politely to navigational enquiries and without making assumptions about a person’s skills. |  |  |  |
| Related services are housed within the same facility (such as specialists, social services and health and wellness services). |  |  |  |
| Consumers and families are helped to understand the assistance and services offered, including enrolment in long-term conditions and wellness programmes. |  |  |  |
| Community health nurses, workers, navigators and other personnel identify and remove barriers to accessing services and information. |  |  |  |
| Consumers are helped to schedule appointments with other health care services such as primary care, laboratories and home help. |  |  |  |
| Systems share information among health practitioners rather than relying on the consumer to do so. |  |  |  |
| Systems ensure that lists of community and social service resources are always up to date and there are referral processes to these services. |  |  |  |
| Referral and follow-up processes are tracked to ensure consumers complete them. |  |  |  |
| Consumers are provided with access to their health records (either paper-based or through consumer portals). |  |  |  |
| Training is provided for consumers on how to use electronic systems where relevant. |  |  |  |
| Staff help consumers to anticipate next steps by explaining they have been referred to another service, how they will receive more information, what they need to do to confirm the appointment, what they will need to do to prepare for the appointment, what the costs are and what will happen after the appointment. |  |  |  |
| The parts of the health system that consumers have problems accessing and navigating are identified and analysed, including areas of inequalities and inequities. |  |  |  |
| In partnership with consumers and/or communities, strategies are put in place to improve access and navigation and these strategies are evaluated for effectiveness. |  |  |  |
| Partnerships with other parts of the health system are formed (for example, with pharmacies) to support consumers’ access and navigation. |  |  |  |
| Other: |  |  |  |
| **Dimension 6: Communication** |  |  |  |
| Clear and effective communication is a priority across all levels of the organisation and across all communication channels. |  |  |  |
| Communication failures are tracked and reported and root-causes are analysed to uncover and address the systemic causes of these failures. |  |  |  |
| Information collection is streamlined, targeting only essential information. |  |  |  |
| Written materials reinforce spoken communication and alternatives to written materials are available. |  |  |  |
| Consumer education materials are used in parallel with face-to-face interactions. |  |  |  |
| All consumer education materials are evaluated for appropriateness and effectiveness. |  |  |  |
| Appropriate and high-quality education materials are provided for consumers with low health literacy. |  |  |  |
| The quality of consumer education materials is checked. Any materials that are inadequate are removed from circulation and the reasons communicated to the provider of the materials. |  |  |  |
| *Rauemi Atawhai* is used when developing consumer education materials (including forms, notices and surveys) and the development process is monitored and documented. |  |  |  |
| Consumer information is easy to access on the website. |  |  |  |
| Consumer education materials are available in commonly used languages through high-quality translation services. |  |  |  |
| Scripts or examples are provided to health practitioners about how to use written materials in their interactions with consumers and families. |  |  |  |
| There is a system that encourages staff to report communication issues to an appropriate supervisor. |  |  |  |
| Physical spaces support effective communication. |  |  |  |
| A culture that values and practises meaningful informed consent is fostered. |  |  |  |
| Informed consent forms are easily understood by consumers and families and, if necessary, are reprinted in a range of commonly used languages. |  |  |  |
| Interpreter services are used in such a way that consumers can discuss their questions with the interpreter before they meet with the health practitioner. |  |  |  |
| Health practitioners check that consumers have understood what has been communicated to them. |  |  |  |
| Health practitioners use plain language and explain technical terms when talking with consumers and families. |  |  |  |
| Health practitioners use a range of health literacy strategies when communicating with consumers and families. |  |  |  |
| Health practitioners routinely provide written and verbal information about conditions, procedures and treatment, including the benefits, risks and likelihood of success. |  |  |  |
| Good communication practices are modelled and promoted between health practitioners as well as with consumers and families. |  |  |  |
| Families are involved in discussions with inpatients about hospital and follow-up care. |  |  |  |
| Discharge summaries are easy for consumers and families to understand. |  |  |  |
| Follow-ups are arranged with consumers within 24 hours of discharge and monitored to check that they took place. |  |  |  |
| Easy-to-understand language and decision aids are used when having end-of-life conversations with consumers and families. |  |  |  |
| Consumers and families continue to be offered information even if they have refused it previously. |  |  |  |
| Other: |  |  |  |

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