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Chapter

How to Measure Organizational Health Literacy?

Osman Hayran and Seyda Dundar Ege

Abstract

Organizational Health Literacy (OHL) is defined as the ability of health organizations to provide services and information that are easy to find, understand and use, to assist people in decision making, and to remove existing barriers to all individuals who are seeking services. OHL is mainly related to communication, navigation, and leadership in organizations, which in turn leads to patient satisfaction, high quality of healthcare, better services for culturally diverse populations and people with disabilities, and risk minimization in healthcare services. Due to its multi-dimensional and complex nature, there are many criteria, ways, and methods for the implementation and evaluation of OHL. Although several measurement tools have been developed in the recent decade, valid and reliable scales are still needed to assess OHL levels in health care organizations. Brief information regarding these methods is presented in this section.

Keywords: organizational health literacy, healthcare organizations, assessment and evaluation, healthcare management, patient satisfaction

1. Introduction

Health literacy (HL) is an issue of increasing importance in the health sector due to its ability to use existing health services effectively and efficiently. It allows the acquisition of better outcomes from the services provided thus, reducing health expenditure. Study findings indicate that a significant number of successful results from health services are closely associated with the health literacy of individuals [1–3]. Its importance was better understood during the COVID-19 pandemic, because of the dependent relationship between individuals and the health care organizations.

The health literacy concept, which has been initially used to mean individuals’ ability to read drug prospectuses, health-related brochures, and understand health-related information, has changed and expanded over time. Today, health literacy is defined as “people's knowledge, motivation, and competencies to access, understand, appraise, and apply health information to make judgments and take decisions in everyday life concerning healthcare, disease prevention, and health promotion to maintain or improve quality of life during the life course.” [4], in essence, a lifelong learning activity that needs continuous improvement for individuals.

Over time, it has been understood that health literacy issue is not solely an individual burden, the health system and health organizations have an important role as well, so the “Organizational Health Literacy” (OHL) concept has been launched.
OHL is defined as the ability of health organizations to provide information and services that are easy to find, understand and use, to assist people in decision making, and to remove existing barriers to all individuals who are seeking services. Health literate health care organizations are organizations that provide the needed information and services to the people in an easier way of access, understanding, and use [5].

Literacy is not a genetic or an ordinary characteristic of the people. It is a phenomenon that emerges and develops under the influence of several variables. It is the product of a kind of interaction and that means there is a mutual and reciprocal action. For such action there must be at least two sides, a receiver and a sender or influencer. Additionally, it always occurs in an environment that has physical, social, and psychological characteristics. So, all of these variables regarding receiver, sender, and environment should be considered to understand the concept. That means health literacy is a product of an interaction between health-seeking individuals and the health care providers within the environment of health care organizations [6, 7].

Because measurement and evaluation methods of a feature is closely linked to its conceptualization, the concepts of HL and OHL should be clarified before discussing the measurement methods.

2. Health literacy (HL) and organizational health literacy (OHL)

The first use of the term health literacy was in the 1970s, during the times when health education was seen as a component of social policy, [8] and evolved in recent years. HL is expressed as the knowledge of individuals throughout their life course, which will guide behaviors and decisions related to themselves and public health, their knowledge of basic health information and services, their access to this information, their understanding of the information accessed, and then their use of this information for the development of health for the maintenance or improvement of quality of life. It is the degree to which individuals have the capacity to access, understand and interpret the basic health information, and services they need to make appropriate decisions associated with their health [4, 6].

Studies have reported that there is an association between low health literacy and various negative health behaviors as well as poor health-related outcomes, such as difficulties to interpret health messages and labels, poor medication adherence, high rates of hospitalization [9], frequent emergency room use, less frequent mammography rates [10], lower participation in preventive activities [11], inappropriate drug use, poor self-management of chronic conditions [12], high mortality rates [13], and increased health care costs [1, 14, 15].

Several definitions of health literacy [4, 16], as well as health literacy measures, were reported in different studies [15]. It is seen that more than 150 health literacy instruments were developed and used in the first decade of the 21st century according to various publications [17, 18].

Presence of different health literacy definitions and use of different measurement tools may be considered normal since they focus on different aspects of the concept and are complementary to each other. Here, the important thing to remember is that methods needed to measure health literacy are usually developed according to our understanding and definition of health literacy. In their study, Urstad et al. [15] have concluded that there will be a risk of missing information when the used measurement tools of health literacy are not consistent with the definition and concept of health literacy.
On the other hand, current health care systems have a complex nature and they are in rapid change and evolution. They usually are not designed according to the abilities of at least some of their service users and this characteristic makes it difficult for some patients to access and use the correct health information they needed. So, such systems should also be literate to help and increase the low literacy level of all patients.

The term OHL is relatively a new concept that emerged a few decades ago to address the challenges faced by individuals with predominantly limited HL. Because the service relationship in healthcare institutions and organizations is a mutual interaction, the literacy of institutions has become an important issue in recent years.

Features of the health organizations, such as a respectful approach to patients, easy access to services, easy information to understand, helpful navigation and signage systems, and correct answers given to every kind of question are important factors. These features are helpful to individuals for the correct use of the services, and they are as effective as the literacy of the individuals [5, 19, 20].

There are numerous studies showing that the development of OHL leads to positive effects on the health of patients and increases patient satisfaction [21–24]. Although there are various studies and ways on how an institution can become a health literate organization, agreed-upon methods to measure, and evaluate the level of OHL are still lacking. The existing methods are generally highly scoped, but their reliability and criterion validity are generally unknown since they are not used in interventional research.

3. Different approaches to measure OHL: conceptualization, implementation, and evaluation

OHL standards and measurement methods have become an increasingly important topic in the last decade. Although there is a strong interest in OHL, majority of the studies are theoretical, and methodological studies are limited. Presence of measurement methods with different characteristics causes confusion over OHL.

A recent review showed that at least 17 different measures were used to assess OHL. According to the findings of this scoping review, six major categories of OHL have been defined and the most prevalent topic is referred to as “communication with service users.” The following categories were, “easy access and navigation,” “integration and prioritization of OHL,” “assessments and organizational development,” “engagement support of service users,” and “information and qualification of staff” [25]. However, it was stated that no consensus has been reached on criteria that can describe a health care organization as a health literate organization.

Some criteria are focused on specific health facilities [26] or different aspects of OHL [26, 27] and/or interventions [26, 28], their evaluation [29] and implementation [30].

Another scoping review regarding OHL implementation has found that important factors that can be helpful for creating health literate organizations are ordered as, supportive leadership, a culture of change and innovation, awareness and participation of the staff, and engagement of service users [31]. However, different studies have also commented that still there is not a sufficient amount of evidence to assess the effects of OHL interventions on improved health outcomes or cost-effectiveness, and further studies are needed [26, 28].

As it was stated by Kaper et al. [31], interventional studies regarding the improvement of OHL have several weaknesses and the main limitations of the studies were
lack of an experimental design and lack of instruments measuring OHL outcomes with known reliability and validity. Studies were usually conducted on small sample groups and without a control group or based on baseline cross-sectional measurements. Nevertheless, it is concluded that the instruments used in these studies may be useful to observe and monitor the change over time and make comparisons between the organizations [31].

Following are the most frequently referred studies regarding the conceptualization, implementation, and measures of the OHL.

3.1 Ten attributes of health literate health care organizations

The idea of a health literate health care organization (HLHCO) was introduced by the National Academy of Medicine of the USA in 2012. It is based on the concept developed by Schilinger and Keller [32]. The main principle of this concept is that every organization in the health system has to create an environment to promote easy access to all kinds of health information and services, better communication, and effective use of health services [7].

The comprehensive study, prepared by Brach et al. in 2012 [5], is a milestone in OHL. In this study, detailed recommendations on what health literate organizations should and should not be are clearly stated and Ten Attributes of Health Literate Health Care Organizations are defined.

Ten attributes of Health Literate Health Care Organizations are as follows [5]:

1. Has leadership that makes health literacy integral to its mission, structure, and operations.

Health literacy is an organizational value for a health literate organization, and strategies of health literacy are internalized at every management level. They are perceived as part of the business and integral to its mission, structure, and operations. Leadership is the key to the success and sustainability of such an implementation.

2. Integrates health literacy into planning, evaluation measures, patient safety, and quality improvement.

Health literacy is integrated into the strategic and operational plans of a health literate organization. It is seen as an inseparable part of patient safety and quality improvement activities and is evaluated regularly.

3. Prepares the workforce to be health literate and monitors progress.

Every professional in the organization must be health literate and understand the meaning of being a health literate organization. So, they must be trained and educated by appropriate adult education methods for the establishment of a health literate organizational culture. Training and education activities must be continuous and monitored regularly. They must be organized under the responsibility of a training team and include every staff member.

4. Includes populations served in the design, implementation, and evaluation of health information and services.

Community participation and decision sharing are essential for the success of all health care activities including health literacy. Health literate organizations include representatives of the local people in the design, implementation, and
5. Meets the needs of populations with a range of health literacy skills while avoiding stigmatization.

Health literate organizations use communication methods that are as simple as possible. Written, visual or digital communication is not sufficient since some individuals may have difficulties. So, alternatives such as oral communication and escort guiding are useful methods. These methods must be available for and offered to every service user to reduce the low literacy-related stigma. This is particularly important for individuals who have limited health literacy.

6. Uses health literacy strategies in interpersonal communications and confirms understanding at all points of contact.

Health literate organizations create an environment that has linguistic and cultural competency to support health literacy strategies. Such an environment aims to provide clear communication during all interactions and for every kind of service including clinical, administrative, and financial services.

7. Provides easy access to health information and services and navigation assistance.

Health literate organizations design their facilities to help people to access information and services easily. They use a simple and easy-to-understand style of symbols, language, and signage.

8. Designs and distributes print, audiovisual, and social media content that is easy to understand and act on.

Health literate organizations design all printed materials, such as education documents, diagnosis and treatment guides, laboratory test results, insurance policies, bills, and various written directives in an understandable style and with easy-to-understand language. The same approach is true for the design and distribution of audiovisual and social media content.

9. Addresses health literacy in high-risk situations, including care transitions and communications about medicines.

“First, do no harm” is the number one principle of medicine since Hippocrates. However, due to the nature of the health services, there are several high-risk situations that cannot be eradicated in health facilities. Complications following surgical operations, adverse drug reactions, and absence of radical therapies are some examples of these situations. Health literate health care organizations identify such situations and inform patients appropriately.

10. Communicates clearly what health plans cover and what individuals will have to pay for services.

Health literate organizations communicate openly, clearly, and on time regarding financial issues such as coverage of the patient’s health plans, and how much they will have to pay for which services. They answer all relevant questions of the service users in an understandable language.

The ten attributes are related to health organizations, health care professionals, and various types of healthcare facilities that have direct responsibility for the provision of evaluation of services. Especially hearing the voices of individuals with low health literacy is important for designing user-friendly services.
health services. All kinds of hospitals, clinics, group practices, private physician offices, community health centers, pharmacies, health insurance companies, accreditation agencies, information technology and health education professionals, and administrative staff needed to have these attributes to become health literate. In other words, almost all components of the supply side of a health system must have these ten attributes.

“Ten attributes of health literate healthcare organization” has been used by many researchers in the following years.

In a study conducted by Kowalski et al. [33] a ten items survey tool “Health Literate Health Care Organization Ten Item Questionnaire” (HLHO-10) to represent the ten attributes was developed. It was applied as part of a larger study and cross-sectional data was collected from a key informant survey in 51 German hospitals, and found to be reliable and valid [33]. It was concluded to be a useful tool to assess the level of OHL that is which organizations are helpful to their users to access, find, understand, and use the correct information they needed as well as the services.

Later HLHO-10 has been used during a survey to assess the OHL of a group of hospitals in Turkey and investigate the relationships between OHL, patient satisfaction, and individual health literacy by Hayran and Ozer [21].

Bonaccorsi et al., have used the Italian version of the HLHO-10 scale in healthcare organizations in Tuscany. They have found that accredited hospitals have higher HLHO-10 scores and perceived quality increases with the increase in HLHO-10 scores, which is interpreted as OHL an integral element for the quality of care [34].

HLHO-10 scale was also adapted to measure and use the OHL level of the facilities established for individuals with various disabilities [35].

Ten attributes provided intellectual foundation to other action frameworks. At least two other concepts and tools were based on the principles of the ten attributes. These are, “Vienna Concept of Health Literate Hospitals and Healthcare Organizations” (V-HLO) [36] and “the Organizational Health Literacy Responsiveness self-assessment tool” (Org-HLR) [37].

3.2 V-HLO

(Vienna Concept of Health Literate Hospitals and Healthcare Organizations)

V-HLO is designed as a self-assessment questionnaire that includes 9 standards, 22 sub-standards, and 160 items [36]. It was tested by Pelikan and Dietscher in Austria and found to be successful [38].

This tool builds upon the “Ten Attributes of Health Literate Health Care Organizations.” However, the V-HLO expands the concept by introducing specific aspects tested in Health Promoting Hospitals (HPH) that were created by an international working group within the ‘International Network of Health Promoting Hospitals. It includes five standards published by WHO-EURO [39], 18 strategies of the HPH [40], and with reference to quality management concepts.

V-HLO considers the significance of organizational support for health literacy as a necessary precondition for sustainable implementation. This support is necessary for the implementation of interventions in relation to four action areas of the concept. These action areas are health literacy that is needed to gain adequate access to health care, to participate in treatment and care, to take adequate decisions and actions in relation to disease prevention and health promotion, and also lifestyle development.

These action areas are applied to three stakeholder groups, namely, patients, staff, and population.
Nine standards of V-HLO are as follows [38]:

1. Establishment of management policy and organizational structures for health literacy (includes 2 sub-standards)

2. Development of materials and services in participation with stakeholders (includes 2 sub-standards)

3. Qualification of staff for health-literate communication with service users (includes 2 sub-standards)

4. Provision of a supportive environment with health-literate navigation and access (includes 5 sub-standards)

5. Application of health literacy principles in routine communication with patients (includes 4 sub-standards)

6. Improvement of the health literacy of patients and their entourage (includes 2 sub-standards)

7. Improvement of the health literacy of the staff (includes 2 sub-standards)

8. Contribution to the health literacy in the region (includes 2 sub-standards)

9. Sharing experiences and being a role model (includes 1 sub-standard)

In the following years, the French version of V-HLO has been prepared and tested in three hospitals in Belgium. It was concluded to be an appropriate tool for hospitals that have the intention to raise their level of health literacy, create awareness and formulate strategies and actions [41].

3.3 OHL Self-AsseT

(Self-Assessment Tool to Promote Organizational Health Literacy in Primary Care Settings)

OHL Self-AsseT is a self-assessment tool that was developed by De Ganni et al. to evaluate the level of OHL in primary health care settings in Switzerland [42].

The rationale underlying this Project was the need for a specific tool to assess and enhance OHL in primary health care settings. As the authors have stated, most approaches to OHL have usually focused on inpatient care, and outpatient and/or primary health care services have rarely been included. However, especially the level of OHL in primary care settings is of great importance, because they are the first contact points of the well-designed health systems.

The tool has been developed and evaluated with the participation of various practice partners including general practitioners and community health care organizations as well as expert opinions. The aim of this tool is to make the needs assessment, identify the improvement areas, and implement the actions necessary for OHL.

The tool consists of three modules and six dimensions:

• A user manual containing instructions
**A checklist for self-assessment of the community health services**

**A handbook to measure the improvement of the check-list items**

Six dimensions of the tool were based on the ten attributes of a health literate health care organization [5], the nine standards of the V-HLO [38], and six dimensions of a health literate organization as used in the Tasmanian toolkit [HelloTAS] [43] and finalized after discussions with the representatives of primary care professionals the community health care organizations.

Six dimensions of the tool included the main content of the checklist. Then it was divided into 15 sub-dimensions including a total of 43 criteria (**Table 1**).

Authors have concluded that this tool may be helpful for a successful implementation of OHL in primary care settings because it was developed with the participation of various practice partners and shaped by expert opinions.

### 3.4 Org-HLR tool

**Development of the Organizational Health Literacy Responsiveness self-assessment tool and process**

In their study, Trezona et al. [37] developed the Organizational Health Literacy Responsiveness self-assessment tool (Org-HLR) and conducted an assessment process for supporting the health organizations with the application of the tool.

OHL responsiveness is the synonym term for OHL. It means the provision of health information and services in an equitable manner in terms of access and participation, taking into consideration the literacy needs and preferences of all service users.

<table>
<thead>
<tr>
<th>Dimensions</th>
<th>Sub-dimensions (number of criteria)</th>
</tr>
</thead>
</table>
| 1. Provision of easy access to primary care services and facilitated navigation | 1.1 Contact (5)  
1.2 Navigation within the primary care service (2) |
| 2. Communication in plain and easy to understand language | 2.1 Oral communication (8)  
2.2 Written communication (5) |
| 3. Promotion of health literacy for service users | 3.1 Empowering service users to use health information (1)  
3.2 Promotion of an active role and self-management of service users (2) |
| 4. Promotion of health literacy of staff members | 4.1 Know-how and professional competence (1)  
4.2 Personnel development (3)  
4.3 Staff members’ health (1) |
| 5. Incorporation of health literacy into management and organizational structure | 5.1 Health literacy as an organizational responsibility (2)  
5.2 Health literacy as a development goal (2)  
5.3 Organizational culture (2)  
5.4 User involvement – feedback (2) |
| 6. Promotion of health literacy at care interfaces, networks, and further activities of the organization | 6.1 Care interfaces (4)  
6.2 Networking and further activities of the organization (3) |

*Adapted from De Ganni et al. [42].*

**Table 1.**  
"Organizational Health Literacy Self-Assessment Tool for Primary Care" (OHL self-AsseT).
users, and supporting community participation during decision-making processes for health and well-being [37].

The self-rating Org-HLR tool and process were derived through co-design processes with a wide range of professionals working in the health and social services sectors, it has seven dimensions for assessment and they are divided into 24 sub-dimensions with 135 performance indicators.

Seven assessment dimensions are:

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 practices and standards
7. Workforce

3.5 OHL-Hosp

(Rating Scale for Secondary and Tertiary Care Hospitals)

A scale to assess the OHL status of different types of secondary and tertiary care hospitals has been developed by Dundar Ege and Hayran [44]. Forty-three 7-point Likert-type scale items were prepared by a comprehensive literature review and shaped by expert opinions. It was tested by the management staff of a sample group of 47 hospitals in Istanbul, including State hospitals, Private Hospitals, University Hospitals, Non-Profit Foundation Hospitals, and Accredited and Non-accredited Hospitals.

Five dimensions of OHL-Hosp were identified following the exploratory and confirmatory factor analyses. Internal consistency of the items of each dimension has been found significantly high and statistically significant (Table 2).

The scale consisting of 43 items and five dimensions is concluded to be a valid and reliable instrument to determine OHL levels of secondary and tertiary care institutions.

<table>
<thead>
<tr>
<th>Dimensions (number of items)</th>
<th>Eigenvalues</th>
<th>Variance (%)</th>
<th>Cronbach’s alpha</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Leadership and Regulations (16)</td>
<td>20.996</td>
<td>48.828</td>
<td>0.987</td>
</tr>
<tr>
<td>2. Communication (14)</td>
<td>5.014</td>
<td>11.661</td>
<td>0.946</td>
</tr>
<tr>
<td>3. Operational Access (6)</td>
<td>3.320</td>
<td>7.722</td>
<td>0.954</td>
</tr>
<tr>
<td>4. Indoor Access (4)</td>
<td>2.973</td>
<td>6.914</td>
<td>0.948</td>
</tr>
<tr>
<td>5. Outdoor Access (3)</td>
<td>1.638</td>
<td>3.810</td>
<td>0.841</td>
</tr>
</tbody>
</table>

Table 2. Dimensions and factor analysis findings of the OHL-Hosp scale.
3.6 The HLE2 assessment tool

(Health Literacy Environment of Hospitals and Health Centers: Access to Information, Care, and Services Through the Lens of Health Literacy)

This tool is the updated version of the “Health Literacy Environment of Hospitals and Health Centers” by Rudd and Andersen [45]. It was developed by Harvard University and published in 2019 [7]. Its original form has been widely used in the USA. It was also adapted to use in different countries including Australia, New Zealand and European countries.

It is helpful to identify and rate the factors that are related to the literacy of health organizations for improving health literacy and monitoring change over time.

The HLE2 tool is organized into five sections, 10 parts, and 135 criteria as it is presented in Table 3. Content of all sections is addressed through the lens of health literacy. Each section has a rating scale. Following data collection, a total score and a percentage score is computed for each section. An overall score tally of the HLE2 has not been recommended. Instead, actions to consider for the % score of each section are described.

The study is based on visitor observations and standards to be applied by officials and it is organized as a list of things to do for OHL. The list can be applied in the form of brainstorming sessions with active members of healthcare institutions.

3.7 Findings from comprehensive literature reviews

3.7.1 The work of Bremer et al.

In a scoping review [25] which was held in 2021, sixty studies on OHL are examined in-depth and common six main categories, 25 subcategories of attributes, and 494 criteria of OHL were identified.

The main categories were ordered as:

- Communication with service users

<table>
<thead>
<tr>
<th>Sections</th>
<th>Parts (number of criteria)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Organizational Policies</td>
<td>• Part 1 focuses on policies in written format (6)</td>
</tr>
<tr>
<td></td>
<td>• Part 2 focuses on policies on practice (6)</td>
</tr>
<tr>
<td>2. Organizational Practices</td>
<td>• Part 1 focuses on institutional resources (5)</td>
</tr>
<tr>
<td></td>
<td>• Part 2 focuses on orientation, development, and expectations (15)</td>
</tr>
<tr>
<td>3. Navigation</td>
<td>• Part 1 focuses on arrival (10)</td>
</tr>
<tr>
<td></td>
<td>• Part 2 focuses on wayfinding (19)</td>
</tr>
<tr>
<td>4. Culture and Language</td>
<td>(10)</td>
</tr>
<tr>
<td>5. Communication</td>
<td>• Part 1 focuses on Print Materials (20 items)</td>
</tr>
<tr>
<td></td>
<td>• Part 2 focuses on Forms (12 items)</td>
</tr>
<tr>
<td></td>
<td>• Part 3 focuses on Web Postings (18 items)</td>
</tr>
<tr>
<td></td>
<td>• Part 4 focuses on Patient Portals (14 items)</td>
</tr>
</tbody>
</table>

Adapted from “HLE2” [7].

Table 3.
The HLE2 assessment tool.
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• Easy access and navigation

• Integration and prioritization

• Assessments and organizational development

• Engagement and support of service users

• Information and qualification of staff

Among the reviewed articles published between 2006 and 2020, the majority were related to toolkits. This was followed by discussions, case studies, feasibility studies, surveys, workshop summaries, or evaluation studies.

“Ten Attributes of Health Literate Health Care Organizations” by Brach et al. [5] was the most frequently referred publication for the concepts used.

Reviewed studies have used 17 different assessment tools and instruments for the assessment of OHL. The HLHO-10 [33] and the HLE2 [7, 45] were the most frequently referenced tools among them.

The tools were usually designed as questionnaires and used during surveys. Some studies have used them in their original form while others have used a subset of items. Some studies have used the translated tools in a different language while others have adopted the measures for a different type of method.

Design of the assessment methods has also varied. Some studies have used standardized questionnaires and semi-structured interviews while others have collected the data by observations, checklists, and material assessments.

However, the authors have stated that the majority of the tools and instruments were not tested for validity and feasibility.

3.7.2 The work of Brega et al.

The goal of the study was to develop a valuable set of measures to inform OHL-related quality improvement activities. The study [46] was based on patient feedback and presented the standards that increase quality in healthcare organizations.

These are organizational structure, policy and leadership, communication, navigation, and patient participation. The results are similar to other studies.

3.7.3 The work of Lubash et al.

Communication has been deeply examined as the main standard of OHL in this study in 2021 [47]. A sensitive communication approach was assessed from the perspective of the patients’ health in complex care structures.

As an important finding of the study, better processing of the organization is perceived by patients that was related to significantly higher health literacy scores. On the other hand, better health literacy scores were related to more patient-reported social support provided by physicians and nurses as well as fewer unmet information needs.

It was concluded that investing in good processing of the organization can improve the communication that is sensitive to health literacy. This has the potential to encourage service user–provider relationships and it might reduce the unmet information needs of the service users.
3.7.4 The work of Farmanova et al.

In this meta-narrative review, Farmanova et al. have identified 20 health literacy guides with various contexts and scopes [27]. Most guides have been prepared for general healthcare organizations. Six of them were specific for primary care besides hospitals and pharmacies. One was specific to health literacy of nursing practices.

Most included dimensions of OHL in guides were verbal and written communication, and access and navigation. All guides have included these dimensions. Access and navigation referred to the physical environment as well as the provided services by the organization.

Thirteen key barriers under 3 broad themes were identified during the use of health literacy guides: barriers related to the leadership and cultural environment of the organization; barriers related to the design and planning of interventions needed for the improvement; and barriers referred to the health workforce.

Especially recent guides provided best practices and recommendations that are evidence-based to support OHL actions. However, it was found that most of the guides have not been tested and their applicability was unknown in organizational practices, and this finding raises questions regarding their effectiveness [27].

Authors have concluded that OHL seems to be a heterogeneous phenomenon and it can be theorized from many different perspectives and implemented in different ways.

4. Conclusions

There is a similarity among the criteria identified in the conceptualization of the OHL in various studies. However, despite the conceptual similarities and presence of many different techniques and scales to assess OHL, there is still confusion about conceptualization and operationalization [25].

“Ten Attributes of Health Literate Organizations” by Brach et al. [5], is the most detailed and broad-ranged study in terms of conceptualization of OHL and has been an intellectual foundation for several other studies. Many of the assessment tools and instruments were based on the principles described as ten attributes. Most frequently used examples are, HLHO-10 [33], V-HLO [36], and the Org-HLR [37].

HLHO-10 is designed as a questionnaire that rates each of the ten attributes on a Likert scale.

The V-HLO aims at the sustainability of OHL and expands the concept by introducing specific aspects tested in Health Promoting Hospitals (HPH) [39, 40]. It approaches OHL from the stakeholders’ view considering their impact zone.

The Org-HLR uses health literacy responsiveness as a system-level action. It aims to coordinate and integrate all health care services, and system navigation by intersectoral collaboration [37].

Another important instrument HLE2 Assessment Tool [7] has a long history and wider use and includes palpable criteria mostly based on observations regarding implementation details. It offers ‘to-do lists’, observation forms, and process management details that can also be used during brainstorming meetings in organizations.

Among the several criteria to describe OHL, “communication” seems to be the major and most common component in all studies. Possible benefit effects of HL-sensitive communication were examined in several studies [47] including specific groups such as cancer patients [48], culturally diverse patient groups [49], and concluded to be an important dimension of OHL.
“Ease of access and navigation” is another significant criterion to describe OHL that has been investigated in many studies. Zanobi et al. [26] and Bremer et al. [25] have identified many different interventions for easy access and navigation in their scoping reviews. Use of pathways with different color codes, directions prepared with a plain and standardized language, support from volunteer escorts, directions posted in commonly used languages, and navigation apps are some examples. However, no studies have been found to evaluate their effects.

In some studies, quality is considered the main aspect [46] and OHL is examined as an instrument to raise the quality of healthcare.

It is known that patient satisfaction and responsiveness are high in organizations with high OHL [21]; however, it is not possible to say the opposite and it is important not to confuse OHL with patient satisfaction or health care responsiveness.

According to a study conducted during the COVID-19 pandemic, OHL principles and guidelines may be helpful to promote human-centered health care and services even in times of crisis [50].

OHL has been examined in various countries, in different settings, and from different aspects by many researchers. Among the limited number of scales that have been presented in some studies, none of them was tested for validity and reliability [51].

Additionally, many patient health outcomes have been investigated, but it is seen that almost all of them were related to supportive interventions for patients. No study was found reporting the patient health outcomes that are related to staff.

The effects of environmental support on health care staff have been rarely studied. Only a few studies have reported outcomes related to the satisfaction and helpfulness perception of the staff [26].

Comprehensive work done by Brach et al. on the conceptualization of the OHL is a milestone as we have mentioned above [5]. It serves as an intellectual base for other studies. In studies, regarding the implementation and assessment of OHL, checklists based on on-site observation and interview forms based on general questions for qualitative evaluation purposes are used. Furthermore, in some studies, it is observed that checklists for self-evaluation and guidelines to assess the healthcare organizations including primary healthcare institutions are also used.

In a comprehensive systematic review, it was found that the practices, measurement, and evaluation criteria in the field of OHL are very diverse and differ from each other [52]. According to the results of the screening, there were 8 main measurement-evaluation tools used for OHL measurement-evaluation, among which HLHO-10 (Health Literate Health Organization-10) [33] and V-HLO (Vienna Health Literate Organization) [36, 38] were used more frequently.

No definitive list of actions for implementation was found as well as assessment and measurement of the OHL. As a matter of fact, the rapid change in health care systems, institutions, types of services, technologies, and even professions naturally will affect and change the ways of our understanding of OHL.

So, aims for the implementation, operationalization, and improvement of the OHL must be addressed in a systematic and flexible manner. This issue is particularly significant for the communication of health care organizations with service users.

As the last word, some recommended steps to facilitate organizational change when promoting OHL practices can be summarized as encouragement of leadership, presence of clear and effectively communicated change vision, and provision of staff training and education to promote OHL practices [53]. These are the most important steps during the journey to facilitate organizational change toward OHL.
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