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for Health Promotion
in Hospitals and Health Care

International Self-Assessment Tool for Organizational Health Literacy (Responsiveness) of Hospitals (OHL-Hos)

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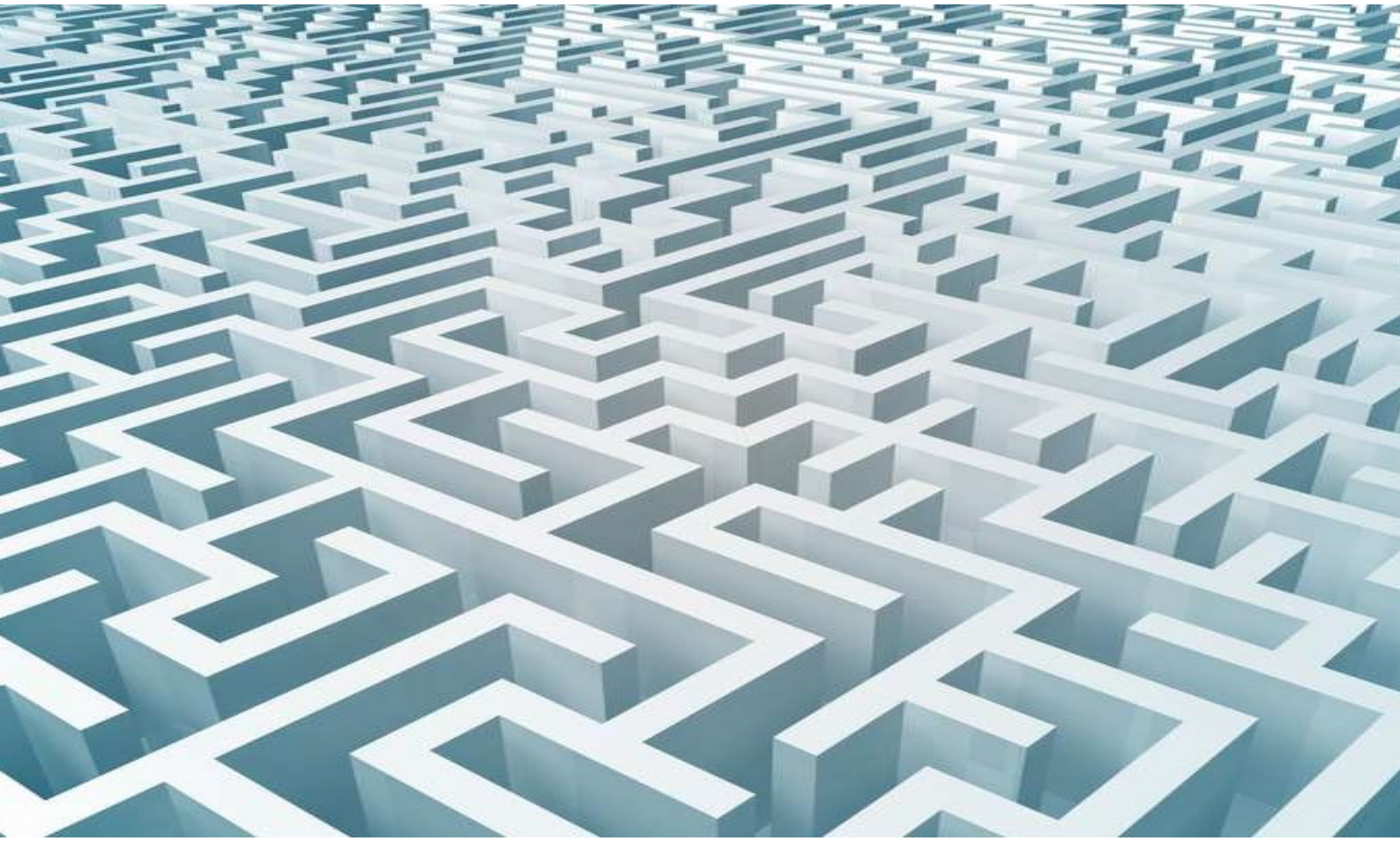

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Introduction

One of the most important recent trends in health literacy (HL) research, practice and policy is the understanding of health literacy as a relational concept (Kwan et al. 2006, Parker 2009, Rudd & Anderson 2006). This means that the actual health literacy of an individual in a specific situation depends on the individual´s personal competencies, but also on the demands and complexities of the situation/system where decisions and actions have to be taken. The interaction of an individual's personal health literacy abilities with the complexity of health systems is now widely acknowledged (Brach et al. 2012, DeWalt et al. 2013, Kickbusch et al. 2013, Koh et al. 2013). Specific terminology and concepts (Megetto et al. 2017, Farmanova et al. 2018) have been proposed to capture this relationship: "health literate healthcare organizations" (HLHCO) (Brach et al. 2012), "health literacy friendly settings" (Kickbusch et al. 2013), "organizational health literacy" (OHL) (Dietscher & Pelikan 2015) and "organizational health literacy responsiveness" (Org-HLR) (Trezona et al. 2017). This understanding has led public health professionals, researchers and policy makers to advocate for the need to address the system level factors that impact people's health literacy (Brach 2017, Trezona et al. 2017, 2018, Pelikan 2019). That is, healthcare organizations need to improve their organizational health literacy/ their health literacy friendliness/ their health literacy responsiveness by organizational development or change management.

Following this conceptual paradigm shift, from focusing on the individual to focusing on the organization, a task force of the Institute of Medicine of the National Academies in the US defined "ten attributes of health literate healthcare organizations, that is, healthcare organizations that make it easier for people to navigate, understand, and use information and services to take care of their health" (Brach et al. 2012). Based on The Ten Attributes, a number of instruments and tools have been offered to assess organizational health literacy or responsiveness of healthcare organizations as a precondition to improving it. Of these, the first comprehensive self-assessment tool for hospitals was developed, piloted and validated by a team in 2014/2015 from Vienna/Austria (Dietscher et al. 2015, 2017, Dietscher & Pelikan 2016, Pelikan & Dietscher 2015, Pelikan 2019). The Vienna WHO Collaborating Centre for Health Promotion in Hospitals and Healthcare (WHO-CC-HPH) in cooperation with the Austrian Network of Health Promoting Hospitals and Healthcare Institutions (ONGKG) developed and piloted the „Vienna Concept of Health-Literate Hospitals and Healthcare Organizations" (V-HLO) and a related self-assessment tool.

The V-HLO took into account a broader understanding of health literacy by using the HL definition of the HLS-EU consortium (Sorensen et al 2012). It linked OHL more explicitly and closely to quality management by using the procedure proposed for development of standards by the International Society for Quality in Healthcare (2007). Furthermore V-HLO linked the concept of HLHCO explicitly to health promotion, especially to the settings approach as developed for Health Promoting Hospitals (Pelikan et al 2005). Instead of a list of attributes, a matrix model was defined, including not only patients as stakeholders, but also organizational staff and the regional population. In addition to healthcare as domain, OHL also links to accessing, living or working in the hospital, to disease prevention and to health promotion (cf. table 1). With the understanding that application of organizational health literacy (OHL) requires a comprehensive change in organizations´ practices and processes, the Vienna team drew on models of (Total) Quality Improvement and models of organizational change or organizational development. Based on the above mentioned matrix model, 9 standards with 22 sub-standards and 160 measurable indicators were defined for a self-assessment tool in German language, mostly based on indicators already been used in the US. This self-assessment tool was piloted in 9 hospitals in Austria, leading to improvement of terminology and categories used for the tool (Dietscher & Pelikan 2017).

In 2016 the the international Network of Health Promoting Hospitals and Health Services (HPH) launched an International Working Group on „Health Promoting Hospitals and Health Literate Healthcare Organizations (HPH & HLO)“. Its first task was: “Adaptation to and translation of tools and indicators for different healthcare contexts based upon the “Vienna Concept of a Health Literate Healthcare Organization (V-HLO)” and recent developments for monitoring, benchmarking and improving organizational HL in healthcare”. Researchers on organizational health literacy from 11 different countries (Austria, Australia, Belgium, Canada, Denmark, Germany, Israel, Italy, Norway, Switzerland and Taiwan) worked together in person-to-person meetings at HPH international conferences and in virtual meetings. As a first step, the German V-HLO tool was translated into English, later also into French (Henrard et al. 2019), Italian and Mandarin, and piloted in different national contexts.

Finally, the working group developed this *international version* of the self-assessment tool based on the V-HLO by adapting it to different healthcare contexts on the basis of feedback received from different national contexts. Besides improving wording of standards, sub-standards and indicators, and adding several indicators, the international version of the tool has now 8 instead of 9 standards (by integrating the previous sub-standard 8.1 into standard 6 and previous sub-standard 8.2 together

with standard 9 into new standard 8). These 8 standards now have 23 sub-standards (cf. also table 1).
The revised tool was presented at the 27th International HPH conference in Warsaw May 31st 2019, where planning of translations of the revised tool and piloting and validating in different countries were discussed.

In the meantime, recent international publications were analysed and integrated into the tool and final editing was conducted.

Background

Health literacy matters for healthcare, because the percentage of patients and citizens with limited health literacy is considerable (HLS-EU consortium 2012, Sørensen et al 2015, Pelikan & Ganahl 2017, Pelikan et al 2019) and limited or low health literacy has serious effects on use of healthcare and its outcomes. People with low health literacy have less knowledge about their health conditions and treatments, poorer overall health status and higher rates of hospitalisation than people with high health literacy (Berkman et al. 2011, Herndon et al. 2011, Wolf et al. 2005, Tokuda et al. 2009). Research also indicates that there is an association between low health literacy and a person´s ability to take part in decision-making, to keep appointments, to adhere to recommended disease treatment, to implement health promoting behaviours, and to engage with preventative health services (Institute of Medicine 2004, Ishikawa et al. 2008, Van der Heide et al. 2014). Furthermore, there is a social gradient of health literacy, thus health literacy contributes to health disparities. HL is associated with healthy lifestyles, with indicators of health status and with utilization of the healthcare system (HLS-EU Consortium 2012, Sørensen et al. 2015, Diane Lewin-Zamir et al. 2016, Pelikan & Ganahl 2017, Pelikan et al. 2019).

What is health literacy and what is a health literate healthcare organization?

Health literacy still is an evolving concept with quite a number of definitions and a growing number of instruments for measurement. The definition and model of health literacy proposed by the consortium of the HLS-EU study (Sørensen et al. 2012) is an integrated and comprehensive definition based on existing definitions and models. *"Health literacy is linked to literacy and entails people's knowledge, motivation and competencies to access, understand, appraise, and apply health information in order to make judgments and make decisions in everyday life concerning healthcare, disease prevention and health promotion to maintain or improve quality of life during the life course."* (Sørensen et al. 2012) This definition was not only used by the Health Literacy Europe (HLS-EU) and many following surveys, but also by WHO´s Health literacy: the solid facts (Kickbusch et al. 2013). Therefore, the „Vienna Concept of Health-Literate Hospitals and Healthcare Organizations"(V-HLO) adopted this definition for personal health literacy.

Regarding health literate healthcare organizations, the need to reduce the complexity of health systems and improve the way healthcare organizations provide information and services was first advocated by the Institute of Medicine (IOM, USA) in their 2004

report “Health Literacy: a prescription to end confusion” (Institute of Medicine 2004) and finally in their report in 2012 (Brach et al. 2012). According to this report “a health literate organization is one that supports low literate patients to navigate, understand, and use information and services to take care of their health”.

The organizational health literacy concept advocates for a universal precautions approach, offering healthcare services in a way that assumes all patients may have low health literacy and therefore structuring services in ways that reduce complexity and barriers to access for all (DeWalt et al. 2010). The concept promotes the responsibility of healthcare organizations to ensure meeting the health literacy needs and preferences of all people and communities they serve (Altin et al. 2015b, Parker 2009, Rudd 2003, Trezona et al. 2017). Research indicates that the organizational approach of focusing on the informational needs of patients is an effective strategy to improve patient outcomes and healthcare quality (Campbell 2004, Ferreira 2005, Jack et al. 2009, Wolf et al. 2011). Research on implementing organizational health literacy concepts and guidelines, and on common key barriers (or facilitators) for implementation has been summarized by different authors (Brach 2017, Farmanova et al. 2018, Lloyd et al. 2018, Pelikan 2019, Kaper et al. 2019). Furthermore, as argued by Brach (2017) for the US, Lloyd et al (2018) for Australia and Pelikan and Dietscher (2015a) for Austria, for successful implementation at the organizational meso level, it is important to have adequate support through health policy at the societal macro level, for which different national examples exist (e. g. for Austria, Australia, New Zealand, USA). A vehicle for accomplishing this, is to include organizational health literacy standards or indicators in health service accreditation systems (Megetto et al, 2017).

How can the self-assessment tool be used for designing healthcare organizations towards more organizational health literacy?

This self-assessment tool offers an instrument enabling a procedure to self-assess and diagnose the actual status of organizational health literacy of a hospital or another healthcare organization as a basis for selecting, adjusting and implementing measures to improve it. The tool is comprehensive, while also modularized. Thus it can be used either for a comprehensive, total assessment, or for an assessment of selected, specific aspects of organizational health literacy. It is a tool for initiating and monitoring organizational change, for sparking discussions and reflections and shaping strategies to eliminate literacy barriers to, and enhance health literacy within the organization. For implementation measures, a number of intervention tools and concepts have been developed, tested and collected for initiating system-level

changes concerning organizational health literacy in healthcare organizations [Abrams et al. 2014, Cifuentes et al. 2015, Dietscher et al. 2015, DeWalt et al. 2010 / Brega et al. 2015 (1st / 2nd edition), Centers for Disease Control and Prevention (no date), Kickbusch et al. 2013, Rudd and Anderson 2006, WHCA Action Guide 2009 (Part 1 and 2)].

The self-assessment tool is designed to assist presidents, chief executive officers, program directors, quality management staff / human resources development, and health promoters at healthcare organizations (hospitals) to consider, assess and improve the health literacy responsiveness of their organization to better serve their patients, staff and local population.

This tool can help organizations with little or no experience of addressing organizational health literacy as well as those that are already engaged in improvement of organizational health literacy responsiveness.

How the 8 standards are related to stakeholders and domains of healthcare organizations

The following matrix provides an overview on how the 8 standards and 23 sub-standards are addressing the three main stakeholder groups and the four domains according to the Vienna HLO-model (Dietscher, Pelikan 2017).

Table 1: Positioning of the 8 standards and 23 sub-standards of the International Self-Assessment Tool for Organizational Health Literacy (Responsiveness) of Hospitals (OHL-Hos).

<table>
<tr><th>HL Stakeholders / HL Domains</th><th>Patients</th><th>Staff</th><th>Community</th><th>Organizational structures & processes</th></tr>
<tr><td>Domain 1
Access to, living & working in the organization</td><td colspan="3">Standard 4:
Provide and support easy navigation and access to documents materials and services.</td><td rowspan="4">Standard 1:
Implement organizational health literacy best-practices across all structures and processes of the organization.
Standard 2:
Develop documents, materials and services with stakeholders in a participatory manner.</td></tr>
<tr><td>Domain 2
Diagnosis, treatment & care</td><td>Standard 5:
Apply health literacy best-practices in all forms of communication with patients.</td><td>Standard 3:
Enable and train staff for personal and organizational health literacy.</td><td rowspan="3">Standard 8:
Contribute to promoting personal and organizational health literacy in the region.</td></tr>
<tr><td>Domain 3:
Disease management & prevention</td><td rowspan="2">Standard 6:
Promote personal health literacy of patients and relatives beyond discharge.</td><td rowspan="2">Standard 7:
Promote personal health literacy of staff with regard to occupational risks and personal lifestyles.</td></tr>
<tr><td>Domain 4:
Healthy lifestyle development</td></tr>
</table>

8 standards for assessing health literacy (responsiveness) of a healthcare organization

The self-assessment instrument is structured into 8 standards, 23 sub-standards and156 indicators.

Table 2: Standards and Sub-Standards of the International Self-Assessment Tool for Organizational Health Literacy of Hospitals (OHL-Hos)

Standard 1: **Implement organizational health literacy best-practices across all structures and processes of the organization.**	Sub-Standard 1.1 The management of the organization is committed to implementing, monitoring and improving organizational health literacy. Sub-Standard 1.2 The organization makes organizational health literacy an organizational priority and secures adequate infrastructures and resources for implementing it. Sub-Standard 1.3 The organization ensures the quality of organizational health literacy interventions by quality management.
Standard 2: **Develop documents, materials and services with stakeholders in a participatory manner.**	Sub-Standard 2.1 The organization involves patients in the development and evaluation of patient-oriented documents, materials and services. Sub-Standard 2.2 The organization involves staff representatives in the development and evaluation of stafforiented documents, materials and services.
Standard 3: **Enable and train staff for personal and organizational health literacy.**	Sub-Standard 3.1: Personal and organizational health literacy is understood as an essential professional competence for all staff working in the organization.
Standard 4: **Provide and support easy navigation and access to documents, materials and services.**	Sub-Standard 4.1 The organization enables first contact via user-friendly website and phone. Sub-Standard 4.2 The organization provides information necessary for patients and visitors for getting to the organization. Sub-Standard 4.3 Support is available to help patients and visitors to navigate the hospital. Sub-Standard 4.4 Health information for patients and visitors is easy-to-understand and available for free.

Standard 5: **Apply health literacy best-practices in all forms of communication with patients.**	Sub-Standard 5.1 Verbal communication with patients is of high quality and easy-to-understand. Sub-Standard 5.2 Written materials are of high quality, easily accessible, and easy-to-understand. Sub-Standard 5.3 Digital services and new media are of high quality, easily accessible, and easy-to-use. Sub-Standard 5.4 Information and communication is offered in the languages of relevant patient groups by specific, trained personnel and for all provided materials. Sub-Standard 5.5 Communication which is easy-to-understand and to act on, especially in high-risk situations, is accepted as a necessary safety measure.
Standard 6: **Promote personal health literacy of patients and relatives after discharge.**	Sub-Standard 6.1 The organization supports patients in improving health literacy with regard to self-management of specific health conditions. Sub-Standard 6.2 The organization supports patients in improving health literacy with regard to development of more healthy lifestyles. Sub-Standard 6.3 Upon discharge, patients are well informed about their future treatment and recuperation process.
Standard 7: **Promote personal health literacy of staff with regard to occupational risks and personal lifestyles.**	Sub-Standard 7.1 The organization supports staff in improving their knowledge and skills for self-management of occupational health, safety risks and healthy lifestyles.
Standard 8: **Contribute to promoting personal and organizational health literacy in the region.**	Sub-Standard 8.1 The organization contributes to the improvement of personal health literacy of the local population. Sub-Standard 8.2. The organization supports the dissemination and further development of organizational health literacy in the geographic region and beyond.

Instructions on how to use the Self-Assessment-Tool

The indicators for each sub-standard operationalize concrete observable **or measurable elements**. Indicators are rated for degree of fufillment in the unit which is self-assessed. Four categories for degree of fulfilment are defined: fulfilled completely (76-100 %), fulfilled to a larger extent (51-75 %), fulfilled to a lesser extent (26-50 %) or not fulfilled (0-25 %). In addition there is a fifth category to indicate that this specific indicator is not applicable for the organization. For each indicator the instrument offers additional space for comments. Comments can be used to explain or justify the assessment.

To facilitate the evaluation, an Excel tool is available for the entry of the results of the individual standards, which can be provided by the authors upon request.
Annex 1 contains a template for action plans where improvement measures which are derived from the self-assessment can be recorded.

Procedure of self-assessment: In order to adequately take into account the different perspectives in an organization, the self-assessment, and further development and implementation of improvement measures should take place within an **interdisciplinary, interhierarchical** framework. The following steps, which have been proven in instrument testing, are recommended:

Table 3: Process of self-assessment by the International Self-Assessment Tool for Organizational Health Literacy of Hospitals (OHL-Hos)

Steps	Details
Step 1	**Obtain a self-assessment mandate from the responsible management of the unit and clarify the scope of the assessment:** The aim of self-assessment is a diagnosis concerning organizational health literacy as a basis for selecting and implementing improvement measures. This can be done either for the **entire organization** or for a **department or smaller organizational unit**. It must also be decided whether the self-assessment should be carried out for all eight standards or just for a selection of standards that are particularly important for the organizational unit.
Step 2	**Management has to appoint a person to coordinate the self-assessment:** This person should have a good reputation both at the management level and among the employees, good coordination skills, and be allocated the necessary time resources.
Step 3	**Formation of the assessment team:** The assessment team should consist of between 5 and 10 people. Ideally, people from the following areas should be involved: Management Quality management Health promotion Human resource development Medicine, nursing, therapeutic professions, preferably from different departments Building services engineering/maintenance Patient-ombudsman/woman, self-help and patient representatives. Communications/spokesperson
Step 4	**Individual assessments:** Each team member first makes an individual assessment using the tool. He/she reviews each indicator from a personal perspective. The whole assessment of the hospital /healthcare organisation / unit of a hospital takes about three hours per person. Ideally the individual assessments of all team members are captured in one table (excel-sheet), so they are easily compared and discussed in the following team meeting.
Step 5	**Collecting documents if possible:** To assess *some* of the indicators (indicated with *), the team/auditors will need to **collect supporting materials/documents** which support their assessment from organization staff. This step should be seen as a supplement to step 4 and should take place at the same time.

Steps	Details
Step 6	**Development of a joint assessment:** The different individual assessments are brought together in a team meeting. Experience has shown that this takes about **three hours**. It is recommended that a moderator be appointed to facilitate the discussion. Recommended is: First, for each sub-standard, identify those indicators that have very similar assessments - these do not initially require further discussion. Second, for indicators with considerably varying assessments, clarify and discuss the underlying reasons. Different assessments can often be attributed either to different perspectives based on the views of different professional groups or different organizational units. **In this discussion, try to focus on which assessment best describes the overall situation of the unit. Document any major variation in the comment fields, based on occupation, position or organizational unit perspectives** - this information will be helpful for later planning of improvement measures.
Step 7	**Selection and implementation of improvement measures:** The joint assessment should produce a diagnosis of the strength and weaknesses concerning organizational health literacy of the institution or of the specific unit. On this basis using the Deming or Quality Circle (Plan - Do - Check - Act), areas can be defined for selecting and implementing measures for improvement of specific aspects of organizational health literacy. This can be done either by the assessment team or in a new constellation (e.g. a health literacy team). In any case, planned measures must be supported by the responsible management. Diverse toolboxes on implementing a health literate healthcare organisations (Abrams et al. 2014, Cifuentes et al. 2015, Dietscher et al. 2015, DeWalt et al. 2010 / Brega et al. 2015 (1st / 2nd edition), Centers for Disease Control and Prevention (no date), Kickbusch et al. 2013, Rudd and Anderson 2006, Trezona 2018, WHCA Action Guide 2009 (Part 1 and 2), are already available and provide information for the selection of appropriate measures.

International Self-Assessment Tool Organizational Health Literacy (Responsiveness) of Hospitals (HLO-Hos)

General data concerning the self-assessment in the health service

Name of the organization Click here to enter text.
Who is responsible for coordinating the self-assessment (name, position in the organization)? Click here to enter text.
For which part of the organization do you conduct the self-assessment (e.g. whole organization, department, or unit)? Click here to enter text.
Who else is involved in the self-assessment (name, department, position in the organization)? Click here to enter text.
Which of the following categories best describes the area where your organization is situated? ☐ Village, rural area (<3,000 inhabitants) ☐ Small town (≥3,000 and < 15,000 inhabitants) ☐ City (≥15,000 and <100,000 inhabitants) ☐ Large city (≥100,000 and < 1,000,000 inhabitants) ☐ Metropolis (≥1,000,000 inhabitants)
How many employees (full-time equivalents) work in your organizations? Click here to enter text.
Please indicate the number of employees per occupational / professional group in your organization (including employees employed through third parties): ☐ Physicians Click here to enter text. ☐ Nursing staff Click here to enter text. ☐ Other health professions e. g. therapists, pharmacists, medical-laboratory assistants Click here to enter text. ☐ Management and administration Click here to enter text. ☐ Maintenance staff e. g. cleaning, kitchen Click here to enter text. ☐ All other staff Click here to enter text.

General data concerning the self-assessment in the health service

How many in-patients does your organization treat per year (number of hospitalizations)?
Click here to enter text.

How many out-patients does your organization treat per year (number of patient visits)?
Click here to enter text.

Please indicate the main nationalities /language groups of your patients [adapt categories to the country/region; below, as an example, the version for Austria; ranked by size of sub-population in Austria]

☐ German
☐ Croation/Serbian/Bosnian
☐ Turkish
☐ Polish
☐ Russian
☐ Slovak
☐ Hungarian
☐ English
☐ Others: Click here to enter text.

Please indicate the main nationalities /language groups of your staff [adapt these categories for Austria to your country/region]

☐ German
☐ Croation/Serbian/Bosnian
☐ Turkish
☐ Polish
☐ Russian
☐ Slovak
☐ Hungarian
☐ English
☐ Others: Click here to enter text.

What are the main areas of expertise of your organization?

☐ General and acute care hospital
☐ Specialized hospital for: Click here to enter text.

Who is entitled to become a patient in your organization?

☐ public at large
☐ limited access, e.g. service provision limited to patients of a specific insurance company or private patients, etc.

General data concerning the self-assessment in the health service

Is your organization for-profit?

☐ not-for-profit
☐ for-profit
☐ both

Who is the owner of your organization?

☐ governmental owner on federal level
☐ governmental owner on regional and local level
☐ insurance company, e.g. health, accident, pension and private insurance
☐ charitable institution, e.g. NGO
☐ confessional institution/owner
☐ private organization, private person, other private institutions

Is your organization involved in vocational training of health professionals?

☐ No, no training
☐ Yes, continuous training for staff
☐ Yes, basic training (academic or non-academic), e.g. physicians, nursing staff in training
☐ Yes, specialized training, e.g. academic hospital

Standard 1: Implement organizational health literacy best-practices across all structures and processes of the organization.

Rationale: This standard can be seen as a precondition for all other standards. It influences the extent to which organizational health literacy or responsiveness is accepted (→ glossary) and can be achieved within the organization. Without making organizational health literacy a responsibility and an integral element of an organization´s structures, processes, culture and quality management, an organization cannot execute comprehensive implementation of organizational health literacy. A health literate healthcare organization (→ glossary) requires capacity building, i. e. infrastructures and resources, for being health literacy responsive in *all* decision making and acting within the organization. A committed management – which makes health literacy integral to the vision and mission, structures and processes, and all operations of the organizations – is one of the most crucial preconditions to developing health literate organizations (Brach et al., 2012). Leaders have to drive change management and continuous quality improvement (New Zealand Ministry of Health 2015) by reinforcing goals and expectations, and by modelling expected behaviours (Brach 2017).

Sub-Standard 1.1. The management of the organization is committed to implementing, monitoring and improving organizational health literacy.	Yes 76-100%	Rather Yes 51-75%	Rather No 26-50%	No 0-25%	N/A
Indicator 1.1.1 The management of the organization drives the organizational health literacy culture by reinforcing goals and expectations for the organization, and by defining expected behaviors for the staff. *Comments:* Click here to enter text.	☐	☐	☐	☐	☐
Indicator 1.1.2. The management of the organization ensures that health literacy is implemented for all relevant aspects of the organization, explicitly measured, regularly monitored, and continuously improved. *Comments:* Click here to enter text.	☐	☐	☐	☐	☐

Indicator 1.1.3 The management of the organization is committed to driving health literacy improvement activities across all departments. *Comments:* Click here to enter text.	☐	☐	☐	☐	☐
Indicator 1.1.4. The management of the organization serves on oversight committees for organizational health literacy. *Comments:* Click here to enter text.	☐	☐	☐	☐	☐
Indicator 1.1.5. The management reviews metrics of success of each health literate intervention. *Comments:* Click here to enter text.	☐	☐	☐	☐	☐

Sub-Standard 1.2. **The organization makes organizational health literacy an organizational priority and secures adequate infrastructures and resources for implementing it.**	**Yes** 76-100%	**Rather Yes** 51-75%	**Rather No** 26-50%	**No** 0-25%	**N/A**
Indicator 1.2.1. Policy documents such as the mission statement, goals, and policies (→ glossary), explicitly define health literacy as an organizational priority.* ***Comments:*** Click here to enter text.	☐	☐	☐	☐	☐
Indicator 1.2.2. Specific responsibilities for organizational health literacy are clearly defined. *(E. g. through a health literacy officer, a health literacy team)* ***Comments:*** Click here to enter text.	☐	☐	☐	☐	☐
Indicator 1.2.3. Financial resources for promoting organizational health literacy are defined and allocated in business / operational plans. ***Comments:*** Click here to enter text.	☐	☐	☐	☐	☐
Indicator 1.2.4. Qualified personnel for promoting organizational health literacy is defined and allocated in business / operational plans. ***Comments:*** Click here to enter text.	☐	☐	☐	☐	☐
Indicator 1.2.5. Specific interventions for implementation of organizational health literacy are planned and implemented. *(E. g. for improving information, communication, navigation)* ***Comments:*** Click here to enter text.	☐	☐	☐	☐	☐

Indicator 1.2.6. Organizational health literacy is promoted by all organizational units and policies *(E. g. in the units and policies for quality management, health promotion, risk management, human resource management, facility management)* ***Comments:*** Click here to enter text.	☐	☐	☐	☐	☐
Indicator 1.2.7. The organization demonstrates awareness of and respect for the values, needs and preferences of cultural groups within the community. ***Comments:*** Click here to enter text.	☐	☐	☐	☐	☐

Sub-Standard 1.3. **The organization ensures the quality of organizational health literacy interventions by quality management.**	**Yes** 76-100%	**Rather Yes** 51-75%	**Rather No** 26-50%	**No** 0-25%	**N/A**
Indicator 1.3.1. Organizational health literacy is integrated into the existing quality management system*					
a.) by definition of criteria and indicators ***Comments:*** Click here to enter text.	☐	☐	☐	☐	☐
b.) by regular assessment ***Comments:*** Click here to enter text.	☐	☐	☐	☐	☐
c.) by monitoring and improving of activities ***Comments:*** Click here to enter text.	☐	☐	☐	☐	☐
Indicator 1.3.2. Patient surveys include questions about the quality of information and communication.* *(E. g. comprehensibility of information provided)* ***Comments:*** Click here to enter text.	☐	☐	☐	☐	☐
Indicator 1.3.3. Staff surveys include questions about the quality of information and communication.* *(E. g. comprehensibility of information about occupational health and safety)* ***Comments:*** Click here to enter text.	☐	☐	☐	☐	☐
Indicator 1.3.4. Patient surveys use clear, everyday words and phrases.* ***Comments:*** Click here to enter text.	☐	☐	☐	☐	☐

Indicator 1.3.5. Staff surveys use clear, everyday words and phrases.* *Comments:* Click here to enter text.	☐	☐	☐	☐	☐
Indicator 1.3.6. Patient health literacy is part of performance measurement of the organization. *Comments:* Click here to enter text.	☐	☐	☐	☐	☐
Indicator 1.3.7. The organization uses "mystery patients" (→ glossary) or "walking interviews" (→ glossary) to assess how easy it is for patients/visitors to navigate the organization.* *Comments:* Click here to enter text.	☐	☐	☐	☐	☐
Indicator 1.3.8. The organization uses "mystery patients" to assess the quality of communication with and the quality of information for patients (verbal, written, visual). *Comments:* Click here to enter text.	☐	☐	☐	☐	☐

Standard 2: Develop documents, materials and services with stakeholders in a participatory manner

Rationale: The involvement of all relevant stakeholders in the design and evaluation of documents, materials and services helps to ensure that their development and implementation are adequate in addressing the needs of these stakeholders (Thomacos and Zazryn 2013). This is the foundation for enabling and empowering different stakeholders for easy access to, navigation and use of the healthcare facilities. Healthcare organizations exist to serve the needs of individuals and communities, therefore organizations need to engage them in all aspects of service and product design and evaluation (Trezona et al. 2017, p. 7). For a healthcare organization that has taken first steps towards becoming a health literate healthcare organization it is particularly important to listen to the voices of individuals with limited health literacy (Brach 2017, p. 213). A health literate healthcare organization uses the results of the feedback of relevant stakeholders to adopt improvements.

Sub-Standard 2.1. The organization involves patients in the development and evaluation of patient-oriented documents, materials and services.	**Yes** 76-100%	**Rather Yes** 51-75%	**Rather No** 26-50%	**No** 0-25%	**N/A**
Indicator 2.1.1 All documents and services relevant for patients are developed and tested together with patient advocates and representatives of patient groups.* *(E.g. information sheets, legal information, informed consent forms, apps)* ***Comments:*** Click here to enter text.	☐	☐	☐	☐	☐
Indicator 2.1.2. The navigation system of the organization is tested by patients and is improved following the outcomes. ***Comments:*** Click here to enter text.	☐	☐	☐	☐	☐

Indicator 2.1.3 Guidelines and procedures for staff on patient communication are developed and tested not only with representatives of staff but also of patients. *(E.g. persons with limited reading skills, members of specific ethnic groups.)* ***Comments:*** Click here to enter text.	☐	☐	☐	☐	☐
Indicator 2.1.4. (Former) Patients or trained simulated patients are involved in the training of staff in order to provide feedback on staff's oral communication skills. ***Comments:*** Click here to enter text.	☐	☐	☐	☐	☐
Indicator 2.1.5. The organization implements mechanisms and procedures to enable feedback and complaints by patients concerning comprehensibility of documents, materials and services. ***Comments:*** Click here to enter text.	☐	☐	☐	☐	☐
Sub-Standard 2.2. **The organization involves staff in the development and evaluation of staff oriented documents, materials and services.**	**Yes** 76-100%	**Rather Yes** 51-75%	**Rather No** 26-50%	**No** 0-25%	**N/A**
Indicator 2.2.1. The organization involves staff representatives in the development and evaluation of staff-oriented communication materials and services. ***Comments:*** Click here to enter text.	☐	☐	☐	☐	☐

Indicator 2.2.2. The navigation system of the organization is tested by new staff members or colleagues from outside of the organization and is optimized following the outcomes. ***Comments:*** Click here to enter text.	☐	☐	☐	☐	☐

Standard 3: Enable and train staff for personal and organizational health literacy

Rationale: Staff training in health literacy is an important dimension of capacity building for organizational health literacy responsiveness and communication. Health literacy training has been shown to improve the communication skills of staff and to achieve desirable outcomes (Blake at al. 2010; Coleman 2011; Mackert et al. 2011). Patients who report optimal communication with staff demonstrate high patient satisfaction, patient optimism about treatment, trust in providers, correct diagnoses, and a better assessment of the quality of care (Schillinger et al. 2004). Health literacy training is especially important for staff that has health education roles (Brach et al. 2012). A health literate healthcare organization has to establish a set of health literacy competencies required by staff and has to assess regularly the knowledge, skills and competencies of staff in relation to health literacy. Staff of health literate organizations has to be trained in patient-centered communication skills to ensure that messages are understood in every conversation (Dwamena et al. 2012; Silverman et al. 2013) and thus guarantee equality in treatment and contribute to an inviting atmosphere – without stigmatizing.

Sub-Standard 3.1. Personal and organizational health literacy is understood as an essential professional competence for all staff working in the organization.	**Yes** 76–100%	**Rather Yes** 51–75%	**Rather No** 26–50%	**No** 0–25%	**N/A**
Indicator 3.1.1. Documents such as job descriptions, selection criteria for applicants, staff development plans etc. include health literacy as a main competence.* *Comments:* Click here to enter text.	☐	☐	☐	☐	☐
Indicator 3.1.2. The organization ensures that staff – especially those with patient contact and new staff – are trained in health literacy and patient-centred communication. *Comments:* Click here to enter text.	☐	☐	☐	☐	☐

Indicator 3.1.3 Staff training on patient communication follows principles of health literacy and refers to all situations that involve communication. ***Comments:*** Click here to enter text.	☐	☐	☐	☐	☐
Indicator 3.1.4. Staff – especially those with patient contact – regularly get feedback on how effective they communicate. *(E.g. by using routine feedback forms on the communication quality of staff).* ***Comments:*** Click here to enter text.	☐	☐	☐	☐	☐
Indicator 3.1.5. Internal health literacy experts serve as role models, mentors and teachers of health literacy competences to others. ***Comments:*** Click here to enter text.	☐	☐	☐	☐	☐
Indicator 3.1.6. Staff are offered trainings with regard to:*					
a.) Use of clear, everyday words and phrases. ***Comments:*** Click here to enter text.	☐	☐	☐	☐	☐
b.) Providing easy-to-understand and easy-to-apply information. ***Comments:*** Click here to enter text.	☐	☐	☐	☐	☐
c.) Active listening, encouraging questions. ***Comments:*** Click here to enter text.	☐	☐	☐	☐	☐

d.) Use of methods and techniques such as chunk-and-check (→ glossary) or teach-back (→ glossary). ***Comments:*** Click here to enter text.	☐	☐	☐	☐	☐
e.) Effective risk communication as the basis for informed patient consent on medical treatment. ***Comments:*** Click here to enter text.	☐	☐	☐	☐	☐
f.) Motivational interviewing (→ glossary) ***Comments:*** Click here to enter text.	☐	☐	☐	☐	☐
g.) Use of written and audio-visual materials to support communication *(E. g. decision aids).* ***Comments:*** Click here to enter text.	☐	☐	☐	☐	☐
h.) Basic knowledge on designing easy-to-understand print materials. ***Comments:*** Click here to enter text.	☐	☐	☐	☐	☐
i.) When and how to use an interpreter (→ glossary), and how to effectively collaborate with interpreters. ***Comments:*** Click here to enter text.	☐	☐	☐	☐	☐

Standard 4: Provide easy navigation and access to services, documents, and materials.

Rationale: Easy accesss to and navigation of health services is an important aspect of using healthcare services adequately. Therefore, the organization has to provide a design and features that help people find their way. It uses language, symbols and signage that is easy to understand, also by users with low levels of personal (health) literacy (Rudd and Anderson 2006). Research indicates that patients with sufficient health literacy skills and positive experiences regarding navigation and access to health information and services are more satisfied with the care received by their healthcare organization than those with non-sufficient health literacy skills and negative experiences (Altin and Stock 2015). Therefore, the provision of easy-to-access health information and services (navigation assistance included) is an important factor for being able to find health information and for making informed decisions, which in turn leads to improved health outcomes.

Sub-Standard 4.1. The organization enables first contact via user friendly website and phone.	**Yes** 76-100%	**Rather Yes** 51-75%	**Rather No** 26-50%	**No** 0-25%	**N/A**
Indicator 4.1.1. The organization's contact information, location, and arrival information is easy-to-find via internet search engines. *Comments:* Click here to enter text.	☐	☐	☐	☐	☐
Indicator 4.1.2. The organization's website is easy-to-use, also for people with low digital health literacy and/or low health literacy competences. *(E.g. by use of plain language, by flexible font size, read-aloud function).* *Comments:* Click here to enter text.	☐	☐	☐	☐	☐
Indicator 4.1.3. The website is available in various languages based on the composition of the local population. *Comments:* Click here to enter text.	☐	☐	☐	☐	☐

Indicator 4.1.4. The website provides evidence-based information on frequent treatments and cites the scientific sources appropriately. *Comments:* Click here to enter text.	☐	☐	☐	☐	☐
Indicator 4.1.5. The website is easily accessible via smartphones and tablets. *Comments:* Click here to enter text.	☐	☐	☐	☐	☐
Indicator 4.1.6. The organization can easily be reached by telephone 24 hours a day, not only by an automated system, but by a person. *Comments:* Click here to enter text.	☐	☐	☐	☐	☐
Indicator 4.1.7. If there is an automated phone system, there is a clear option to repeat menu items. *Comments:* Click here to enter text.	☐	☐	☐	☐	☐
Indicator 4.1.8. Telephone communication is available in most native languages of patients. *Comments:* Click here to enter text.	☐	☐	☐	☐	☐
Indicator 4.1.9. People at a hotline or an information desk are qualified to adequately answer patient enquiries. *Comments:* Click here to enter text.	☐	☐	☐	☐	☐

Sub-Standard 4.2. The organization provides information necessary for patients and visitors for getting to the organization.	Yes 76-100%	Rather Yes 51-75%	Rather No 26-50%	No 0-25%	N/A
Indicator 4.2.1. The naming of locations on maps is consistent with the terms/wording used within the organization. *Comments:* Click here to enter text.	☐	☐	☐	☐	☐
Indicator 4.2.2. The healthcare organization provides patients with easy-to-understand information about directions from the patient's home, including public and private transportation options. *Comments:* Click here to enter text.	☐	☐	☐	☐	☐
Indicator 4.2.3. The healthcare organization negotiates with local transportation services to assist patients by displaying adequate signage, clear announcements, and location information at public transportation stations. *Comments:* Click here to enter text.	☐	☐	☐	☐	☐
Indicator 4.2.4. Signage of the organization and its entrances is clearly visible when approaching the hospital grounds. *(E.g. on access roads, public transport)* *Comments:* Click here to enter text.	☐	☐	☐	☐	☐
Indicator 4.2.5 Admission departments are clearly marked and visible. *Comments:* Click here to enter text.	☐	☐	☐	☐	☐

Sub-Standard 4.3. Support is available to help patients and visitors to navigate the hospital.	Yes 76-100%	Rather Yes 51-75%	Rather No 26-50%	No 0-25%	N/A
Indicator 4.3.1. To support navigation, an information desk is available at all main entrances. *Comments:* Click here to enter text.	☐	☐	☐	☐	☐
Indicator 4.3.2. To support navigation, printed maps are available for free. *Comments:* Click here to enter text.	☐	☐	☐	☐	☐
Indicator 4.3.3. Maps clearly indicate the individual's location in the hospital through easy-to-understand symbols or "You are here" signage.* *Comments:* Click here to enter text.	☐	☐	☐	☐	☐
Indicator 4.3.4. The staff responsible for the admission of patients appropriately directs patients and visitors to their respective unit and staff. *Comments:* Click here to enter text.	☐	☐	☐	☐	☐
Indicator 4.3.5. New information and communication technologies support navigation. *(E.g. speech-based electronic assistance, kiosks with touch-screens, smartphone-apps.)* *Comments:* Click here to enter text.	☐	☐	☐	☐	☐

Indicator 4.3.6. Staff is trained to direct and assist disoriented patients. ***Comments:*** Click here to enter text.	☐	☐	☐	☐	☐
Indicator 4.3.7. Staff or volunteers with various language skills support the navigation of patients and visitors in the organization. ***Comments:*** Click here to enter text.	☐	☐	☐	☐	☐
Indicator 4.3.8. Signage design is based on appropriate height, location, color, and font size. ***Comments:*** Click here to enter text.	☐	☐	☐	☐	☐
Indicator 4.3.9. Signage applies wording and symbols commonly used by patients to describe the care they are receiving.* *(E.g. Kidney Ward instead of Nephrology Ward)* ***Comments:*** Click here to enter text.	☐	☐	☐	☐	☐
Indicator 4.3.10. A consistent wording and use of symbols is applied for all locations and rooms within the organization.* *(E.g. always "toilette" or always "WC" or always "rest room")* ***Comments:*** Click here to enter text.	☐	☐	☐	☐	☐

Indicator 4.3.11. Color codes are applied consistently across the organization and support navigation from different starting points. *(E.g. green color for the intensive care ward)* ***Comments:*** Click here to enter text.	☐	☐	☐	☐	☐
Indicator 4.3.12. Signage is available between buildings if the organization contains multiple buildings.* ***Comments:*** Click here to enter text.	☐	☐	☐	☐	☐
Indicator 4.3.13. Signage is available in the native languages of the major patient groups* ***Comments:*** Click here to enter text.	☐	☐	☐	☐	☐
Indicator 4.3.14. Navigation support for visually impaired patients is available. ***Comments:*** Click here to enter text.	☐	☐	☐	☐	☐
Sub-Standard 4.4. **Health information for patients and visitors is available for free.**	**Yes** 76-100%	**Rather Yes** 51-75%	**Rather No** 26-50%	**No** 0-25%	**N/A**
Indicator 4.4.1. Patients are informed about deductibles or other costs for treatment or services in advance. *(E.g. on the website and by telephone enquiry)* ***Comments:*** Click here to enter text.	☐	☐	☐	☐	☐

Indicator 4.4.2. Patients are informed about their patient rights. *Comments:* Click here to enter text.	☐	☐	☐	☐	☐
Indicator 4.4.3. A physical or virtual patient information center comprising free health information is available. *Comments:* Click here to enter text.	☐	☐	☐	☐	☐
Indicator 4.4.4. Various formats of easy-to-understand information regarding disease prevention such as diabetes, cardiovascular diseases, and cancer are available at multiple locations for free. (E.g. brochures, audio, video, web based) *Comments:* Click here to enter text.	☐	☐	☐	☐	☐
Indicator 4.4.5. Various formats of easy-to-understand information regarding healthy lifestyles are available at multiple locations for free. *Comments:* Click here to enter text.	☐	☐	☐	☐	☐
Indicator 4.4.6. Easy-to-understand menu information is available at bedside and in the cafeteria/canteen indicating nutrients and calories to support healthy choices. *Comments:* Click here to enter text.	☐	☐	☐	☐	☐

Standard 5: Apply health literacy best-practices in all forms of communication with patients.

Rationale: Patients in healthcare are increasingly understood as partners and active co-producers of health and not just as the objects of treatment. This shift in the patients' role requires more patient participation and shared decision-making in the context of increasing complexity and possibilities of healthcare. Good communication in healthcare has a huge impact on a diversity of health outcomes and on workplace satisfaction of healthcare professionals (Street et al. 2009; Sator et al. 2015). Patients with limited health literacy report worse communication with their providers than those with sufficient health literacy (Schillinger et al. 2004). Furthermore, patients with limited literacy are less likely to ask questions of their providers (Katz et al. 2007). Misunderstandings in communication lead to less accurate diagnoses and less effective treatment decisions, to poorer compliance with prescriptions, and thus to more frequent complications, referrals and emergency treatment (Berkman et al. 2011). A health literate organization takes the communication needs of different patient groups into account by ensuring that all communication in all formats is clear and easy to understand (New Zealand Ministry of Health 2015, p. 34). It uses patient-centered communication to promote health literacy responsiveness in all situations of communication (Brach et al. 2012; Silverman et al. 2013). This is true not only for high-risksituations and in clinical relevant discussions, such as admission, anamnesis/intake, visit and discharge, but also when explaining an invoice/bill, directions or coordinating appointments. (Brach et al. 2012).

Sub-Standard 5.1. Verbal communication with patients is of high quality and easy-to-understand.	Yes 76-100%	Rather Yes 51-75%	Rather No 26-50%	No 0-25%	N/A
Indicator 5.1.1. Guidelines for verbal patient communication which follow health literacy best practices *(E. g. plain language, teach back)* are applied to all clinically important situations of communication.* *Comments:* Click here to enter text.	☐	☐	☐	☐	☐
Indicator 5.1.2. Communication guidelines consider the diverse needs of different patient groups*					
a.) Patients of different linguistic, ethnic and cultural backgrounds *Comments:* Click here to enter text.	☐	☐	☐	☐	☐

b.) Patients with impaired visual capabilities ***Comments:*** Click here to enter text.	☐	☐	☐	☐	☐
c.) Patients with impaired hearing capabilities ***Comments:*** Click here to enter text.	☐	☐	☐	☐	☐
d.) Patients with impaired intellectual capabilities ***Comments:*** Click here to enter text.	☐	☐	☐	☐	☐
e.) Patients with the need to involve relatives/caregivers. ***Comments:*** Click here to enter text.	☐	☐	☐	☐	☐
Indicator 5.1.3. Patient information about diagnosis and therapy is given sufficiently extensive, in a clear and personalized way, following the current state of evidence to enable patients to make appropriate treatment decisions together with staff. *(E.g. shared decision making, use of decision aids)* ***Comments:*** Click here to enter text.	☐	☐	☐	☐	☐
Indicator 5.1.4. Staff use clear language and avoid jargon and technical terms when communicating with patients (written and verbal). ***Comments:*** Click here to enter text.	☐	☐	☐	☐	☐
Indicator 5.1.5. Patients are encouraged to ask questions concerning their condition and treatment options. *(E.g. using Ask Me 3-campaign (→ glossary); SPEAKUP (→ glossary))* ***Comments:*** Click here to enter text.	☐	☐	☐	☐	☐

Indicator 5.1.6. Patients are allowed and encouraged to bring family, friends or informal caregivers to meetings with staff. ***Comments:*** Click here to enter text.	☐	☐	☐	☐	☐
Indicator 5.1.7. Patient consultations take place in rooms/space that support effective communication. *(E.g. private counseling space, quiet environment)* ***Comments:*** Click here to enter text.	☐	☐	☐	☐	☐
Indicator 5.1.8. Sufficient and designated time is ensured for patient consultations. *(E.g. by discipline or department specific guidelines and procedures)* ***Comments:*** Click here to enter text.	☐	☐	☐	☐	☐
Indicator 5.1.9. Patient consultations are conducted when patients are attentive. *(E.g. not immediately after anesthesia)* ***Comments:*** Click here to enter text.	☐	☐	☐	☐	☐
Indicator 5.1.10. Patients are encouraged to arrange consultations with staff, when convenient for them. ***Comments:*** Click here to enter text.	☐	☐	☐	☐	☐

Sub-Standard 5.2. **Written materials are of high quality, easily accessible, and easy-to-understand.**	**Yes** 76-100%	**Rather Yes** 51-75%	**Rather No** 26-50%	**No** 0-25%	**N/A**
Indicator 5.2.1. Written (printed and/or online) materials follow design guidelines for better understandability (font size, line spacing, color scheme, use of images).* (*E.g. patient orientation materials, legal materials, informed consent forms, medical history forms, discharge forms and follow-up notifications)* ***Comments:*** Click here to enter text.	☐	☐	☐	☐	☐
Indicator 5.2.2 Written materials are used to reinforce and support verbal communication and as memory aid for patients, but never instead of verbal communication. ***Comments:*** Click here to enter text.	☐	☐	☐	☐	☐
Indicator 5.2.3 To support patient communication, staff is trained to use high-quality written and audio-visual materials, which contain action-oriented information and are easily accessible. *(E.g. leaflets, photo-novellas, cartoon illustrations, multimedia tutorials, podcasts, DVDs, 3-D models, patient portals etc., which include easily detectable contact details of the organization (telephone numbers, e-mail- and web-addresses).* ***Comments:*** Click here to enter text.	☐	☐	☐	☐	☐

Indicator 5.2.4 Written and audio-visual materials are revised periodically to ensure best quality and accuracy of information *(e.g. based upon current evidence).* Materials include a statement of last update and the information source so that the quality of the original information source can be assessed independently.* ***Comments:*** Click here to enter text.	☐	☐	☐	☐	☐
Indicator 5.2.5 Patients are supported to complete required documents and forms (e.g. for registration). ***Comments:*** Click here to enter text.	☐	☐	☐	☐	☐
Sub-Standard 5.3. **Digital services and new media are of high quality, easily accessible, and easy-to-use.**	**Yes** 76-100%	**Rather Yes** 51-75%	**Rather No** 26-50%	**No** 0-25%	**N/A**
Indicator 5.3.1. Guidelines for the quality and distribution of digital services and new media are used to support communication and information transfer.* ***Comments:*** Click here to enter text.	☐	☐	☐	☐	☐
Indicator 5.3.2. All digital services and new media which are available via online portals, app download centers etc. are technically correct, easy-to-understand, contain action-oriented information and are adequate for target groups. ***Comments:*** Click here to enter text.	☐	☐	☐	☐	☐

Indicator 5.3.3 Digital services and new media are pre-tested with representatives of target groups and patients before distribution. *Comments:* Click here to enter text.	☐	☐	☐	☐	☐
Indicator 5.3.4 Training in the use of digital services and new media is offered upon demand for staff *Comments:* Click here to enter text.	☐	☐	☐	☐	☐
Sub-Standard 5.4. **Information and communication is offered in the languages of relevant patient groups by specific, trained personnel and for all provided materials.**	**Yes** 76-100%	**Rather Yes** 51-75%	**Rather No** 26-50%	**No** 0-25%	**N/A**
Indicator 5.4.1. All major written, audio-visual or digital materials are available in the languages of relevant patient groups. *(E.g. information sheets, informed consent forms)* *Comments:* Click here to enter text.	☐	☐	☐	☐	☐
Indicator 5.4.2. Staff knows when and how to access and utilize oral and written language assistance services as well as how to work with interpreters / translators. *Comments:* Click here to enter text.	☐	☐	☐	☐	☐
Indicator 5.4.3. Protocols prohibit the use of children or untrained staff or volunteers as medical translators. *Comments:* Click here to enter text.	☐	☐	☐	☐	☐

Indicator 5.4.4. Patients are informed about professional translation services routinely at admission and on demand. ***Comments:*** Click here to enter text.	☐	☐	☐	☐	☐
Indicator 5.4.5. If needed, professional translation services are always available for medical examinations and consultations with clinical staff and also provide assistance in completing forms or documents. *(E.g. in house interpreters, telephone / video interpreting)* ***Comments:*** Click here to enter text.	☐	☐	☐	☐	☐
Indicator 5.4.6 There is a coordination office for the provision and scheduling of translation services in native language. ***Comments:*** Click here to enter text.	☐	☐	☐	☐	☐
Indicator 5.4.7. Interpreters / translators are specifically qualified / certified in inter-cultural medical translation.* *(E.g. language certificates, letter of recommendation).* ***Comments:*** Click here to enter text.	☐	☐	☐	☐	☐
Indicator 5.4.8 All interpreters / translators are trained to use clear, everyday words and phrases.* ***Comments:*** Click here to enter text.	☐	☐	☐	☐	☐

Indicator 5.4.9. Guidelines for reporting, documenting and processing problems and complaints with regard to translation services are available. Problems are monitored and improvement measures are implemented.* *Comments:* Click here to enter text.	☐	☐	☐	☐	☐
Sub-Standard 5.5. **Communication which is easy-to-understand and to act on, especially in high-risk situations, is accepted as a necessary safety measure.**	**Yes** 76-100%	**Rather Yes** 51-75%	**Rather No** 26-50%	**No** 0-25%	**N/A**
Indicator 5.5.1. The organization considers communication errors as adverse events and reacts by analyzing the origin of detected errors and by improving communication processes. *Comments:* Click here to enter text.	☐	☐	☐	☐	☐
Indicator 5.5.2. A reporting and performance monitoring system for communication errors is available. *Comments:* Click here to enter text.	☐	☐	☐	☐	☐
Indicator 5.5.3. Feedback from patients regarding patient safety, hospital hygiene etc. are routinely included in risk management. *(E.g. patient surveys, feedback forms, patient complaints)* *Comments:* Click here to enter text.	☐	☐	☐	☐	☐

Indicator 5.5.4. A list of processes and procedures is available, that pose a higher risk to patients, and therefore require a heightened level of assurance to ensure that patients have fully understood the information provided.* *(E.g. patient communication about diagnosis, therapies, consent forms, filling in forms, preparation for surgeries, transferals)* ***Comments:*** Click here to enter text.	☐	☐	☐	☐	☐
Indicator 5.5.5. There exist specific guidelines and staff trainings on communication in situations that pose a higher risk to patients* *(E.g. breaking bad news, new therapies, preparation for surgeries)* are available. ***Comments:*** Click here to enter text.	☐	☐	☐	☐	☐
Indicator 5.5.6. Taking medication is explained in detail (including clarification that medicines prescribed in the hospital can differ from those distributed in pharmacies). ***Comments:*** Click here to enter text.	☐	☐	☐	☐	☐
Indicator 5.5.7. Aids such as pill boxes, charts, etc. are used to increase comprehensibility of taking medicines correctly. ***Comments:*** Click here to enter text.	☐	☐	☐	☐	☐

Indicator 5.5.8. The organization's emergency plan contains easy-to-use information for patients regarding evacuation. It also addresses people who are illiterate, with hearing or visual impairment and / or different intellectual capabilities, and other vulnerable types of patients. *Comments:* Click here to enter text.	☐	☐	☐	☐	☐

Standard 6: Promote personal health literacy of patients and relatives during hospitalization and after discharge.

Rationale: For many patients, a hospital admission is just a recurrent episode in an ongoing career of living with a chronic condition. Therefore, improving personal health literacy and empowering for self-management is an important aspect of any treatment of chronic patients in healthcare. Research indicates that patients in disease-specific self-management groups have fewer hospital admissions for acute exacerbations and fewer unscheduled visits to their physician than patients who are not part of disease-specific self-management groups (DeWalt et al. 2006). Therefore, the aim is to provide patients with the necessary information and skills to deal competently and responsibly with their health after discharge (Brach 2017). Patients benefit from organizational support in gaining and improving their personal health literacy with regard to their disease-specific self-management, their navigating of and interacting effectively with health services in the future and their developing more healthy lifestyles. In this way, they gain more confidence in dealing with their disease and are empowered to more actively participate in their treatment as co-producers of health outcomes. Inpatient stays offer a "window of opportunity" and a "teachable moment" for changes in patients´ knowledge, competences, motivations and behaviours.

Sub-Standard 6.1. The organization supports patients in improving health literacy with regard to self-management of specific health conditions.	Yes 76-100%	Rather Yes 51-75%	Rather No 26-50%	No 0-25%	N/A
Indicator 6.1.1. Patients are informed in a clear and personalized way about the possible self-management of their disease /health condition in their everyday life. *Comments:* Click here to enter text.	☐	☐	☐	☐	☐
Indicator 6.1.2. The organization offers patient education on self-management of the most important chronic diseases / health conditions. Alternatively, patients are referred to other adequate providers. *Comments:* Click here to enter text.	☐	☐	☐	☐	☐

Indicator 6.1.3. The organization explicitly informs patients about appropriate self-help organizations and similar support offers. *Comments:* Click here to enter text.	☐	☐	☐	☐	☐
Indicator 6.1.4. The organization encourages patients to take upcoming symptoms seriously and to use services already in advance of agreed appointment, if necessary. *Comments:* Click here to enter text.	☐	☐	☐	☐	☐
Indicator 6.1.5. The organization offers education on how to support patients for relatives and other informal caregiver*s.* Alternatively, they are referred to other adequate providers. *Comments:* Click here to enter text.	☐	☐	☐	☐	☐
Indicator 6.1.6. The organization offers education in navigating of and effectively interacting with health services after discharge.* *(E.g. preparation for doctor-patient conversation)* *Comments:* Click here to enter text.	☐	☐	☐	☐	☐
Sub-Standard 6.2. **The organization supports patients in improving health literacy with regard to development of more healthy lifestyles.**	**Yes** 76-100%	**Rather Yes** 51-75%	**Rather No** 26-50%	**No** 0-25%	**N/A**
Indicator 6.2.1. Patients' lifestyles and need for changes are routinely checked and documented. *Comments:* Click here to enter text.	☐	☐	☐	☐	☐

Indicator 6.2.2. Relevant information and training for change of lifestyle is provided or referred to. *Comments:* Click here to enter text.	☐	☐	☐	☐	☐
Indicator 6.2.3. Staff informs patients about educational health courses in the region. *Comments:* Click here to enter text.	☐	☐	☐	☐	☐
Sub-Standard 6.3 **Upon discharge, patients are well informed about their future treatment and recuperation process.**	**Yes** 76-100%	**Rather Yes** 51-75%	**Rather No** 26-50%	**No** 0-25%	**N/A**
Indicator 6.3.1. There is a clear and easy to understand care plan (written and verbally communicated) for patients who require complex interventions and multidisciplinary teams for treatment.* *Comments:* Click here to enter text.	☐	☐	☐	☐	☐
Indicator 6.3.2. Upon discharge, patients are thoroughly informed about how to take care for themselves at home and about where to get support if needed. *(E.g. wound care, medication, nutrition, needs and options for caring assistance)* *Comments:* Click here to enter text.	☐	☐	☐	☐	☐
Indicator 6.3.3. If needed, relatives or social services are involved in discharge management. *Comments:* Click here to enter text.	☐	☐	☐	☐	☐

Indicator 6.3.4. The organization has a follow-up telephone service to ensure that patients or relatives can manage with the information received upon discharge. ***Comments:*** Click here to enter text.	☐	☐	☐	☐	☐
Indicator 6.3.5. Patients are supported in scheduling their post-discharge appointments with other services. ***Comments:*** Click here to enter text.	☐	☐	☐	☐	☐
Indicator 6.3.6. There are procedures in place to ensure that patients meet their scheduled appointments. *(E.g. follow-up telephone service)* ***Comments:*** Click here to enter text.	☐	☐	☐	☐	☐
Indicator 6.3.7. Clinical findings that were not conveyed to patients during hospital stay are conveyed to them following discharge. ***Comments:*** Click here to enter text.	☐	☐	☐	☐	☐
Indicator 6.3.8. The responsibility to pass on clinical findings to other organizations that are relevant for further treatment rests with the organization in consent with the patient. ***Comments:*** Click here to enter text.	☐	☐	☐	☐	☐
Indicator 6.3.9. During discharge, patients routinely receive up-to-date lists of relevant health and social services as well as of appropriate self-help groups. ***Comments:*** Click here to enter text.	☐	☐	☐	☐	☐

Indicator 6.3.10. During discharge, Patients routinely receive contact details of relevant patient advocates and patients' ombudspersons. *(E.g. in case of complications or complaints).* ***Comments:*** Click here to enter text.	☐	☐	☐	☐	☐
Indicator 6.3.11. The organization's website provides information about the self-management of common health conditions or refers to adequate partner websites. ***Comments:*** Click here to enter text.	☐	☐	☐	☐	☐

Standard 7: Promote personal health literacy of staff with regard to occupational risks and personal lifestyles.

Rationale: Health of staff in healthcare services, especially in an aging healthcare workforce, is a relevant challenge for healthcare services. Staff´s health is endangered by a number of specific occupational risks, which in many institutions are on the rise. Staff's health is partly determined by their personal health literacy. Therefore health literacy of staff should be improved not only for better communication with patients, but also in relation to promoting their health.

Studies have indicated that workplace health promotion is important in the prevention of non-communicable diseases among employees. Health promoting organizations have shown benefits such as lowered disease prevalence, reduced medical costs, improved productivity and a higher level of personal health literacy (Dietscher 2012). A health literate healthcare organization promotes health literacy of staff both with regard to the self-management of occupational health and safety risks and with regard to healthy lifestyles of staff (Wong 2012).

The health literacy of staff impacts the quality of patient communication. Only an organization – with staff being health literate and healthy – is able to address the healthcare needs of their clients and patients adequately and foster their health-literacy skills. If staff does not understand their own health needs, it is hard to support patients to make good decisions about their health.

Sub-Standard 7.1. **The organization supports staff in improving their knowledge and skills for self-management of occupational health, safety risks and healthy life-styles.**	**Yes** 76-100%	**Rather Yes** 51-75%	**Rather No** 26-50%	**No** 0-25%	**N/A**
Indicator 7.1.1. The organization understands improvement of health literacy of staff as a management responsibility. *Comments:* Click here to enter text.	☐	☐	☐	☐	☐
Indicator 7.1.2. Leadership / management is sensitive to effects of their communication on staff health and adapts their management style accordingly. *Comments:* Click here to enter text.	☐	☐	☐	☐	☐

Indicator 7.1.3. Performance reviews include status information on occupational health and safety, and on how staff can maintain their health. ***Comments:*** Click here to enter text.	☐	☐	☐	☐	☐
Indicator 7.1.4. Staff is informed about occupational health and safety risks already during initial staff training.* ***Comments:*** Click here to enter text.	☐	☐	☐	☐	☐
Indicator 7.1.5. The organization regularly provides trainings on managing occupational health and safety risks.* ***Comments:*** Click here to enter text.	☐	☐	☐	☐	☐
Indicator 7.1.6. The organization uses materials such as posters, flyers, new media and electronic devices, to raise staff's awareness of occupational health and safety risks.* ***Comments:*** Click here to enter text.	☐	☐	☐	☐	☐
Indicator 7.1.7. Staff are encouraged to report on working conditions risky for health and to make suggestions for improvement. ***Comments:*** Click here to enter text.	☐	☐	☐	☐	☐
Indicator 7.1.8. The organization provides measures for prevention or self-management of chronic conditions of staff. ***Comments:*** Click here to enter text.	☐	☐	☐	☐	☐

Indicator 7.1.9. The organization uses materials, to raise staff's awareness of lifestyle issues for health.* *(E.g. posters, flyers, new media and electronic devices)* ***Comments:*** Click here to enter text.	☐	☐	☐	☐	☐
Indicator 7.1.10. The organization offers trainings on healthy lifestyles for staff, or informs staff about regionally available courses and programs on healthy lifestyles *(E.g. Information sheets, brochures)* ***Comments:*** Click here to enter text.	☐	☐	☐	☐	☐

Standard 8: Contribute to promoting personal health literacy of the local population and to dissemination of organizational health literacy in the region served.

Rationale: To promote personal health literacy of the local population, a health literate healthcare organization provides easily accessible, evidence-based health information. It drives health education and promotion initiatives to build skills for health literacy in the local population, and it also conducts interventions to improve health literacy in particular for hard to reach and vulnerable population groups. Healthcare services can act as a role model and advocate not only for better health, but also for better personal and organizational health literacy in their region. Sharing experiences of health literacy practices via publications, presentations and other media, leads to increased awareness and can stimulate organizational change beyond the own organization. By disseminating results and experiences with organizational health literacy across organizational boundaries, more people and institutions can benefit from an organization's experiences and strategies to promote health literacy. Therefore, a health literate healthcare organization has the responsibility to share its knowledge and experience of implementing organizational health literacy with other organizations. Sharing experiences within relevant communities highlights the importance of cooperation and peer learning for creating networks, which play an important role in supporting organizational change (Pelikan et al. 2005).

Sub-Standard 8.1. The organization contributes to the improvement of personal health literacy of the local population	Yes 76-100%	Rather Yes 51-75%	Rather No 26-50%	No 0-25%	N/A
Indicator 8.1.1. The organization provides evidence-based and non-commercial information about relevant health topics issues to the local community it serves. *(E.g. through health fairs, public lectures).* *Comments:* Click here to enter text.	☐	☐	☐	☐	☐

Indicator 8.1.2. The organization drives health education and promotion initiatives to build skills for health literacy in the local population. *(E.g. by organizing workshops on workplace health promotion in local companies, or facilitating guided tours to the hospital for students from local schools)* ***Comments:*** Click here to enter text.	☐	☐	☐	☐	☐
Indicator 8.1.3. The organization conducts interventions to improve health literacy of hard-to-reach patients / citizen groups at the local level. *(E.g. interactive meetings with socio-economically disadvantaged groups or migrant communities)* ***Comments:*** Click here to enter text.	☐	☐	☐	☐	☐
Sub-Standard 8.2 **The organization supports the dissemination and further development of organizational health literacy in the geographic region and beyond.**	**Yes** 76-100%	**Rather Yes** 51-75%	**Rather No** 26-50%	**No** 0-25%	**N/A**
Indicator 8.2.1. Health literacy activities and outcomes are part of the organization's public reporting.* ***Comments:*** Click here to enter text.	☐	☐	☐	☐	☐
Indicator 8.2.2. The organization communicates experiences with organizational health literacy practices via publications, presentations, and other media.* ***Comments:*** Click here to enter text.	☐	☐	☐	☐	☐

Indicator 8.2.3. The organization participates in health literacy research and development projects. ***Comments:*** Click here to enter text.	☐	☐	☐	☐	☐
Indicator 8.2.4. The organization contributes to wider (policy) goals or action plans in the field of health literacy. ***Comments:*** Click here to enter text.	☐	☐	☐	☐	☐
Indicator 8.2.5. The organization offers health literacy best practices for the professional training of doctors, nurses, and other relevant professional groups also outside of the organization. ***Comments:*** Click here to enter text.	☐	☐	☐	☐	☐

Glossary

Ask me three	Ask Me 3® is an educational program that encourages patients and families to ask three specific questions of their providers to better understand their health conditions and what they need to do to stay healthy. What is my main problem? What do I need to do? Why is it important for me to do this? Designed by health literacy experts, Ask Me 3 is intended to help patients become more active members of their health care team, and provide a critical platform to improve communications between patients, families, and health care professionals. See: http://www.npsf.org/for-healthcare-professionals/programs/ask-me-3
Chunk-and-Check	Chunk and check can be used alongside teach back and requires you to break down information into smaller chunks throughout consultations and check for understanding along the way rather than providing all information that is to be remembered at the end of the session. See: http://healthliteracy.org.uk/index.php?option=com_k2&view=item&id=49:chunk-and-check&Itemid=193
Health literacy responsiveness	„The provision of services, programs and information in ways that promote equitable access and engagement, that meet the diverse health literacy needs and preferences of all people, and that support individuals and communities to participate in decisions regarding their health and wellbeing, which is achieved through supportive culture and leadership, supportive systems, policies and practices, and an effective workforce.“ (Trezona et al. 2017, p. 9)
Health literate healthcare organization	A health literate healthcare organization makes it easier for all stakeholders (patients / relatives, staff / leadership and citizens) to access, understand, appraise and use disease- and health relevant informationand tries to improve personal health literacy of these stakeholders for making judgements and taking decisions in everyday life concerning healthcare (co-production), disease prevention and health promotion to maintain or improve quality of life during the life course. To achieve this comprehensive concept systematically and sustainable, a health care organization will have to apply principles and tools of quality management, change management and health promotion and to build specific organizational capacities (infrastructures & resources) for becoming more health literate. (Pelikan 2017)

Interpreter	(Medical) interpreters are working in a clinical context to provide accurate interpretation and translation of critical medical information in direct service to patients, or physicians and other health care providers who are seeing patients who cannot speak or understand English, when specifically required by the provider. They interpret critical medical advice and information given by the provider into equivalent terminology in the patient's native language. See: https://jobdescriptions.unm.edu
Motivational Interviewing	Motivational Interviewing is a clinical approach that helps people with mental health and substance use disorders and other chronic conditions such as diabetes, cardiovascular conditions, and asthma make positive behavioral changes to support better health. See: https://www.stephenrollnick.com/
Mystery patients	„Mystery Patient“summarizes procedures for measuring the quality of service in the health sector in which patients or clients who appear undercover are used. These test patients or clients evaluate the quality of the service provided according to a specified observation catalogue. Companies in the healthcare sector who use Mystery Patients gain information about the quality of their services. See: https://www.mysterypanel.de/mystery-patient.html
Health literacy policies	Policies are used as a way of standardizing the delivery of care. Health literacy policies reflect a universal precautions approach to delivering health literate care, one which assumes that every individual is at risk of misunderstanding and benefits from clear communication and uncomplicated care pathways. The following are illustrations of common types of health literacy policies: All patient education materials will go through reviews by editors and patient volunteers. Readability guidelines and health literacy principles will be followed. Only qualified interpreters will be used to communicate with patients with limited English proficiency. Patients will not be discharged until they can teach-back the signs of deterioration and what to do about them, as well as how to follow discharge instructions. Clinicians must ask patients how they will perform self-management activities, such as e.g. wound care. Policies are not always precise, but can give cues regarding expected behavior without detailing what that means. Lack of precision is sometimes necessary to permit flexibility that lets the policy fit into local work flow and culture. Policies are used to drive change (Brach 2017, p. 218)

SPEAK UP	In March 2002, the Joint Commission, together with the Centers for Medicare and Medicaid Services, launched a national campaign to urge patients to take a role in preventing healthcare errors by becoming active, involved, and informed participants on their healthcare team. The campaign features brochures, posters, and buttons on the following patient safety topics: Help prevent errors in your care Help avoid mistakes in your surgery Information for living organ donors Five things you can do to prevent infection Help avoid mistakes with your medicines What you should know about research studies Planning your followup care Help prevent medical test mistakes Know your rights Understanding your doctors and other caregivers What you should know about pain management See: https://www.jointcommission.org/speakup.aspx
Strategic Plans for health literacy	Strategic plans include concrete goals across multiple health literacy domains and spell out precisely what actions are going to be undertaken to achieve these goals. Also, strategic plans include information about, who will undertake those actions, and how accomplishments will be measured. Inherent in the strategic plan, is a logic model for how change will happen and which outcomes will be achieved (see Brach 2017).
Teach back	Teach-back is an easy-to-use technique to check that the health professional has clearly explained information to the patient and that the patient has understood what they have been told. This technique goes beyond using questions such as “Is that clear?” and “Have you understood everything?” Instead, the health professional asks the patient to explain or demonstrate, using their own words, what has just been discussed with them. See: http://www.scottishhealthcouncil.org/patient__public_participation/participation_toolkit/teach-back.aspx#.W9o_PTipWig
Walking Interview	The walking interview will help to gain insight into physical characterstics of your healthcare facility that enhance or diminish one´s ability to find one´s way. People entering a healthcare facility for the first time can often see details of the environment that people working within the facility may no longer notice. As a result, newcomers can offer insights to those for whom the workplace has become routine. The walking interview focuses on an assessment of the literacy environment. The Walking Interview is an activity that involves locating and finding one’s way around a healthcare facility. The Walking Interview will help identify what is helpful for people and what gets in the way as they try to navigate a healthcare facility. It offers opportunities for the staff of healthcare facilities to identify barriers as well as aids for navigation of facilities (see Rudd and Anderson 2006, p. 99).

Annex 1: Action Plan – Organizational Health Literacy Development Priorities

Based on the self-assessment and the results of the consensus workshop, the assessment team will be able to identify one or more development priorities for the health organisation where it has self-identified that it is not meeting the standards or sub-standards. An action plan can then be developed to address those issues, using the template provided below.

Development Objective	Action, Intervention	Responsible	Time frame	Expected Outcome

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