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INNOVATIONS IN POLICY AND PRACTICE

Quality improvement as a population health promotion opportunity to reorient the healthcare system

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Abstract

Background A quality improvement (QI) focus in systems strategically investing resources to achieve the Quadruple Aim (i.e., better population health, lower system costs, improved patient care, and an engaged and productive workforce) presents an opportunity to reorient health services towards population health promotion.
Setting An interdisciplinary team linked across a large regionalized healthcare system engaged in a (Saskatoon) Region-wide 90-day QI initiative focused on patient safety.
Intervention The team worked directly with healthcare teams to link cultural safety, patient-centeredness, and health equity to other dimensions of healthcare quality. The team provided data from health status reports, equity analyses of healthcare utilization, and stakeholder consultations and adapted QI methods, including A3 thinking and Plan-Do-Check-Act (PDCA) cycles.
Outcomes Throughout the 90 days, use of the terms “health equity” and “cultural safety” increased among healthcare teams and in region-wide communications. Within the year following the initiative, the Region made public and ongoing commitments to address health inequities.
Implications System-wide QI initiatives present opportunities to promote population health approaches, shift perspectives and language, and ultimately influence organizational culture. Learnings are relevant to health promotion practitioners attempting to engage healthcare partners, and for health systems strategically investing for improved population health.

Résumé

Contexte Les systèmes axés sur l’amélioration de la qualité (AQ) qui investissent stratégiquement des ressources à la poursuite du « quadruple objectif » (meilleure santé de la population, réduction des coûts du système, soins améliorés, main-d’œuvre engagée et productive) présentent la possibilité de réorienter les services de santé vers la promotion de la santé des populations.
Lieu Une équipe interdisciplinaire interconnectée au niveau d’un vaste système de soins de santé régionalisé a participé à une initiative d’AQ régionale (Saskatoon) d’une durée de 90 jours portant sur la sécurité des patients.
Intervention L’équipe a directement travaillé avec des équipes de soins de santé à établir des liens entre la sécurisation culturelle, l’approche centrée sur les patients, l’équité en santé et les autres aspects de la qualité des soins de santé. Les données utilisées provenaient de rapports sur l’état de santé, d’analyses de l’équité dans l’utilisation des soins de santé et de consultations avec les acteurs, et l’équipe a adapté des méthodes d’AQ comme le processus de pensée A3 et le cycle PDCA (penser-démarrer-contrôler-agir).
Résultats Sur les 90 jours de l’initiative, l’emploi des expressions « équité en santé » et « sécurisation culturelle » a augmenté au sein des équipes de soins de santé et dans les communications régionales. Au cours de l’année suivante, la région s’est engagée publiquement à aborder les inégalités de santé de façon continue.

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Implications Les initiatives d'AQ à l'échelle de systèmes offrent la possibilité de promouvoir des démarches axées sur la santé des populations, de changer les points de vue et le langage et, à terme, d'influencer la culture organisationnelle. Les leçons de cette expérience sont pertinentes pour les praticiens et les praticiennes de la promotion de la santé qui tentent de mobiliser leurs partenaires des soins de santé, ainsi que pour les systèmes de santé qui investissent stratégiquement dans l'amélioration de la santé des populations.

Keywords Health promotion · Quality improvement · Population health · Health equity

Mots-clés Promotion de la santé · Amélioration de la qualité · Santé des populations · Équité en santé

Introduction

Since the Ottawa Charter for Health Promotion called for action to reorient health services (World Health Organization 1986), concerns about fiscal sustainability have urged health systems to employ quality improvement (QI) to achieve the Quadruple Aim: better population health, lower system costs, improved patient care, and increased workforce engagement and safety (Sikka et al. 2015). For practitioners working across sectors to address the full range of health determinants, including healthcare, QI represents a strategic opportunity to reorient health systems towards population health promotion. The work of these practitioners often goes unnoticed, however, by systems defining quality as providing safe, efficient, effective, timely, patient-centered, and equitable healthcare services (Briere 2001). In this article, we reflect on our experiences as practitioners engaging healthcare partners to address health inequities within a regional health authority QI initiative.

Setting

The former Saskatoon Health Region[1] adopted Lean, a provincial QI strategy, in 2010 accompanied by a commitment to the Quadruple Aim ("Better Health, Better Care, Better Teams, and Better Value") in 2013 (Government of Saskatchewan n.d.). A 2014 population health status report that documented wide and persistent differences in health status and healthcare utilization between Saskatoon residents living in areas of highest and lowest deprivation was accompanied by the Chief Medical Health Officer's call for action to address barriers within healthcare that create or contribute to health inequity, including institutional racism (Neudorf et al. 2014). As a specific recommendation, the report called for the Region to embed equity, as a dimension of healthcare quality (Briere 2001), within its Lean QI system.

[1] As of December 4, 2017, all regional health authorities were integrated into the Saskatchewan Health Authority that serves the provincial population.

Intervention

Health equity and cultural safety in the "Safety Hoshin"

The goal of the Region's 2015 Safety Hoshin[2] was to prevent harm to patients, staff, and physicians through new approaches to safety. As the single region-wide priority for 90 days, preceded by 90 days of planning and followed by 90 days of "follow-on" work, the Hoshin required a high degree of participation and visibility throughout all levels of the organization.

Health Promotion and the Public Health Observatory (PHO), both departments within Population and Public Health, together with First Nations and Métis Health Service and Representative Workforce, struck a health equity and cultural safety team to function in an advisory capacity to the Hoshin leadership team. The team engaged patient representatives, QI experts, and organizational leadership and ethics consultants and brought together individuals from across departments who worked from similar principles towards a shared vision for population health and equity, but until then, used different approaches and language.

Effective framing with "A3 thinking"

As a first step, the team used a structured problem-solving and communication tool, known as an *A3*,[3] to concisely document the problem statement, root cause analysis, future state, implementation plan, metrics, and engagement plan. The team drew upon population data and close to 40 health sector consultations summarized in the health status report (Neudorf et al. 2014) to develop three key messages to frame the problem statement. First, people are harmed every day because the care

[2] *Hoshin Kanri* (also called *strategy deployment*) is a Japanese term meaning "pointing the direction" that represents a planning and implementation process used to deploy strategic priorities (*Hoshins*) throughout an organization. For a glossary of Lean terms, see www.saskatchewan.ca/government/health-care-administration-and-provider-resources/saskatchewan-health-initiatives/continuous-quality-improvement#saskatchewan-health-care-management-system.

[3] A3 refers to a European paper size that is roughly equivalent to 11-in. by 17-in. The A3 format documents a plan-do-check-act (PDCA) process on a single piece of paper.

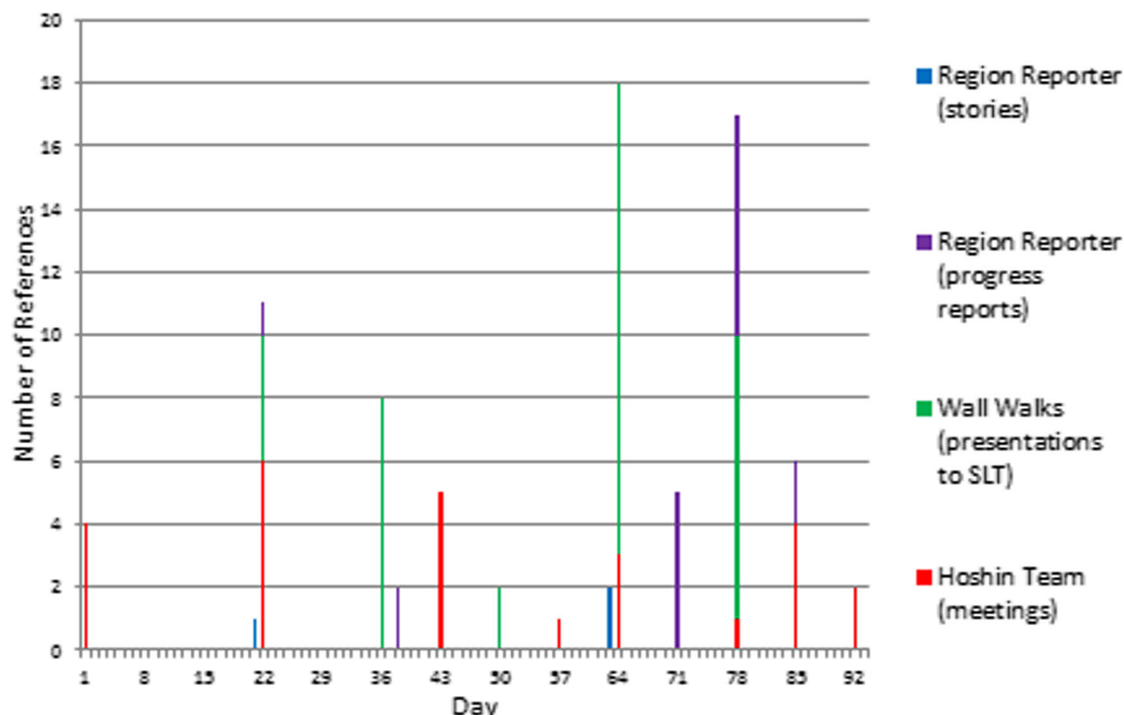

Fig. 1 References to the terms "health equity" and "cultural safety" during the 90-day Safety Hoshin in 2015, as documented in region-wide communications (*Region Reporter* stories and team progress reports), presentations to the Region's senior leadership team (SLT), and weekly team meetings

provided is not *culturally safe*, defined as the experience of safety by people themselves (First Nations Health Authority n.d.). Second, a lack of *cultural competency* among staff prevents delivery of *equitable healthcare services*, and perpetuates existing *health inequities*. Third, health inequities are costly, but avoidable. For the root cause analysis, the team identified institutional and systemic racism that exists across the Region. For the future state, the team identified healthcare leaders championing equity, cultural competency and cultural safety as measurable attributes of a high-quality healthcare system.

Adapting and promoting QI tools

Within the Region, a Healthcare Equity Audit guide (Public Health Observatory 2014) previously had been developed based on a Plan-Do-Check-Act (PDCA)[4] model and piloted as a tool to assist decision-makers in allocating health system resources. The plan implemented by the team involved developing an information package and meeting with every member of the Hoshin leadership team to raise awareness of the guide, link it to other QI tools and methods being used, and promote knowledge and facilitative attitudes for the concepts of equity and cultural safety.

Measuring and monitoring results

To measure impact, the team counted use of the terms "health equity" and "cultural safety" in Hoshin leadership team meetings, reports, and region-wide communications. Results of the monitoring throughout the 90 days showed an increased use, awareness, and discussion of the terms over time (Fig. 1).

The team also developed a set of recommendations for the Region to implement in the 90 days following. This follow-on work included formal commitments to health equity and cultural safety. Six months later, the Board endorsed a regional health equity position statement drafted by the team, and one year later, the Region publicly committed to respond to the Truth and Reconciliation Commission of Canada's calls to action for healthcare. In the months since, the 10-person team evolved to become a region-wide health equity and cultural safety network consisting of more than 100 members.

Discussion

Fran Baum (Baum 2007) identifies, as a feature of health promoting systems, committed leaders who champion social justice

[4] PDCA refers to an iterative improvement cycle based on a scientific method of proposing a change in a process, implementing the change, measuring the results, and taking appropriate action. It can be used to monitor a single project or guide an entire initiative.

principles and lead through complexity. Leadership in this context required investing in relationships—listening to learn, seeking out synergies, and being available to others—while communicating strong reasons for adopting QI compatible with health promotion values. Commitment was facilitated by setting measurable goals and time constraints (both external and self-imposed) and celebrating even small successes as a team. Having a physician (Medical Health Officer) co-lead the effort with a manager from First Nations and Métis Health also enhanced the credibility of the data and key messages among the Hoshin leadership team, which was led overall by physicians paired with health region administrators together as leads.

In our experience, cultural change happened not as a steady process, but in breakthrough moments that appeared often unexpectedly. More than a decade of equity-integrated health status reporting (National Collaborating Centre for Determinants of Health 2012) prepared us to recognize the Safety Hoshin as a high-profile and time-limited opportunity for focused top-down and bottom-up action to "crack the nut" of health equity described by Baum (Baum 2007). The intentional decision to integrate population health promotion efforts into QI meant that equity and cultural safety were finally adopted, with public commitments, as priorities for the entire health system.

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