Cultural Safety in the SHR Safety Hoshin

Name: Cultural Safety in the Safety Hoshin
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Organization: FN&MH, RW, PPH, KPO, OLL, Safety, CFCC Steering Committee, Ethics
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1. Problem Statement

People are harmed in SHR every day because the care we provide is not *culturally safe*.[i]

- Building trusting relationships among health care providers and clients, especially those from vulnerable populations, is important and takes time.
- Whether intentional or not, Aboriginal people face racism on a daily basis that has a direct impact on their health and well-being. For example, First Nations patients/clients having left the health care system due to negative experiences with staff, not having received the care they needed.[ii] Institutional racism involves polices, practices and procedures of institutions that have an unfairly negative effect on people's access to and quality of services and opportunities.[iii]
- It is well documented that newcomer health is typically quite good upon arrival in Canada, but tends to decline over time. Newcomer populations face cultural, language and other barriers within the Region making it challenging for them to navigate the health care system.[ii]

The Region's failure to prioritize ***cultural competency*** among its staff prevents delivery of ***equitable health care services***, and perpetuates ***health inequities*** that exist in our Region.

- While we have begun to address cultural competency in the Region, experiences of discrimination vary across the system and directly impact patient/client care and outcomes.
- Recent analysis of the Region's HSMR data identified disparities in hospital standardized mortality rates (HSMR), where higher age-standardized mortality directly correlated to greater neighbourhood deprivation. Further analysis examined whether neighbourhood deprivation correlated with poorer health status at the time of hospital admission, but the average Charlson Index scores (a measure of pre-hospitalization co-morbidity) was not higher for the most deprived neighbourhoods, suggesting differences in hospital care may contribute to the observed inequity in hospital deaths.[iv]
- Overall, health inequities between residents living in the areas of highest and lowest deprivation have remained wide and persistent for many health conditions over the last 15 years, including injuries, intentional self-harm, diabetes, heart disease and mental health disorders. The average life expectancy of residents living in the most deprived neighbourhoods in Saskatoon is 9 years less than residents in the most affluent neighbourhoods.[ii]

Health inequities are costly.

- Analysis by the Canadian Institute for Health Information shows that the lowest income quintile (i.e., the 20% of the population who earn the least income) accounts for almost half of the estimated excess cost of acute care hospital stays for ambulatory care sensitive conditions.[v]

The Region's focus within Hoshins and other quality improvement initiatives to date has not included cultural safety as a component of patient/client safety, nor has it prioritized Equity as one of six aims (along with Safety, Effectiveness, Patient-Centeredness, Timeliness, and Efficiency) for health care system quality improvement.[vi]

The Safety Hoshin is an opportunity for the Region to PDCA tests of change to integrate cultural safety into quality improvement initiatives and organizational learning to promote health equity.

4. Implementation Plan

Action	Who	Date
Develop Health Equity and Cultural Safety Content Team structure	Content Team	17-09-15
Convene Content Team meetings	Co-Chairs	Weekly
Attend Content Team meetings	Content Team	Weekly
Attend Safety Hoshin Team meetings and events	Co-Chairs	Weekly
Contribute to Safety Hoshin report-outs	Co-Chairs	Weekly
Develop A3 and wall in Gemba room	Content Team	25-09-15
Support Hoshin leads and sub-teams in daily work (see below for detail)	Content Team	Ongoing
Work with KPO to embed health equity and cultural safety in Lean tools and processes (e.g., Value Stream Mapping, A3 and fishbone templates, RPIW)	Content Team	Ongoing
Develop and implement new tools to measure, monitor and improve cultural safety and health equity (e.g., definition of terms, KT tools, experience surveys and interview guides, SDOH data collection)	Content Team	Ongoing
Monitor and report on inclusion of health equity and cultural safety within the Safety Hoshin (e.g., Value Stream Mapping, develop A3, Safety Hoshin Team meetings, Regional report-outs)	Content Team	Ongoing

- **Mortality Review** (led by Dr. Pylypchuk and Janet Harding; SPH Medicine) – build on the HSMR analysis and incorporate SDOH data and cultural safety into the review.
- **Leadership and Management** for Safety (led by Betty Boechler and Petrina; SPH surgery and anaesthesia) – incorporate SDOH data into the review and possibly also into the SAS reporting system, and also ensure cultural safety concerns are reported and addressed.
- **Building Capacity for Safety and QI** (led by Dr. Babyn and Angie Palen; U of S residents in Radiology and Surgery) – ensure health equity and cultural safety concepts are included in the education curriculum.
- **Clinical Process Improvement** (led by Dr. James and Janet Harding; SPH) – the VSM showed that communication between patient/client and provider and between providers, as well as timeliness of physician response were factors, and it would be important to understand whether this is attributable to provider attitudes towards patients/clients (racism and other forms of discrimination).
- **Team Communication** (led by Dr. Cattell and Tammy Lucas; RUH pediatrics acute care) – would focus on the development of cultural competency and cultural safety training and education.
- **Performance and Psychological Safety** (led by Dr. Chaya, Donna Chalifoux, Beryl Ludwig; RUH ER) – expand the scope to include impact on patients/clients and families and support providers to recognize and actively respond to racism and other forms of discrimination.

2. Root Cause Analysis

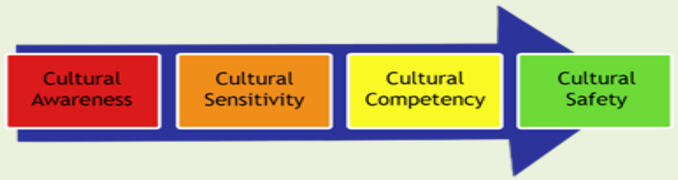
- Saskatoon Health Region's Medical Health Officers and Public Health Observatory staff held close to 40 health sector consultations to identify barriers to achieving equity in health care.[vii] We heard:
  - **We don't have good information:** data to improve patient, client and family-centred care is not systematically collected, used or shared. Health care providers often don't ask, and surveys of patient/client experience do not ask about experiences of culturally safe care. Without understanding patient/client needs, follow up care for complex needs are unmet (e.g. patients may have transportation challenges, live in poor housing circumstances or lack social supports).
  - **Staff don't have capacity to meet complex needs:** despite keen interest and understanding that health inequities are unfair and preventable, health care providers often feel powerless to respond to complex needs of patients within our complex system. In other words, system barriers mean missed opportunities for better care. Health care providers are also stretched to their limit making it challenging to find time to meet patient/client needs.
  - **Health care system itself creates barriers**: the structure and policies of the health care system are complex and often inadvertently perpetuate inequity by creating access barriers and placing undue burden on patients, health care providers and the system itself.
- First Nations and Metis Health and Representative Workforce has found:
  - **Region staff are not culturally competent**. Trauma-informed care, which takes up the impacts of historic, collective and intergenerational trauma, is not reflected in encounters with individual providers nor the Region itself (i.e., welcoming spaces, intake processes, etc.).
  - R**egion workforce is not representative of the population it serves**. Currently the Representative Workforce within the Region is 4.57%, falling short of the goal of 10%. Exit surveys and client, staff and community feedback indicate that lack of cultural competency in the Region is an ongoing issue.
- **Institutional and systemic racism exists across the Region**. Harm to patients, clients, families and staff occurs when polices, practices and procedures of institutions have an unfairly negative effect on people's access to and quality of services and opportunities. Harm to patients, clients, families and staff occurs when our organization's culture supports and allows discrimination.

3. Future State

- Health care system leaders champion cultural competency and cultural safety as the key links between health equity and health care system quality.
- Health equity and cultural safety are embedded in Lean tools and processes (e.g., value stream mapping, A3 and fishbone templates, RPIWs)
- Tools are used to measure, monitor and improve cultural safety and health equity (e.g., definitions of terms, KT tools, patient/client experience surveys and interview guides, social determinants of health data collection)
- The Region commits to provide culturally safe care. Staff are trained to respond to institutional and systemic racism and supported to provide safe, patient/client- and family-centred care.

5. Metrics

- Lean tools and processes developed
  - # of new tools developed
  - # of tools used by Sub-Teams during Safety Hoshin
- Tools to measure, monitor and improve cultural safety and health equity
  - # new tools developed
  - # of tools implemented during Safety Hoshin
- Education and training for cultural safety and health equity
  - # educational and training opportunities offered
  - # and % of Safety Hoshin team reached
  - # of Region staff reached
  - # of residents/students reached
  - # of Patient/Client and Family Advisors reached
- Monitoring and reporting on inclusion of health equity and cultural safety within the Safety Hoshin
  - # references within Communication materials
  - # references within Safety Hoshin report-outs
  - # references within Sub-Team A3s
  - Regional commitments to cultural safety (qualitative)
- Increased awareness of cultural safety among patients, clients, families and staff
  - Increased reporting of cultural safety incidents (SAS reporting system)



6. Engagement

- Membership of the Health Equity and Cultural Safety Content Team includes Representative Workforce, First Nations and Métis Health, Population and Public Health, KPO, Organizational Leadership and Learning – Respectful Workplace, Safety – Client Representatives, Client and Family Centred Care Steering Committee, Ethics
- Plan will be informed by consultations as part of planning for Aboriginal Health Summit and with Patient and Family Advisory Councils

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[i] See "Defining the Terms" (attached)
[ii] Neudorf, C., Kryzanowski, J., Turner, H., Cushon, J., Fuller, D., Ugolini, C., Murphy, L., Marko, J. (2014). Better Health for All Series 3: Advancing Health Equity in Health Care. Saskatoon: Saskatoon Health Region. https://www.saskatoonhealthregion.ca/locations_services/Services/Health-Observatory/Pages/ReportsPublicatlions.aspx
[iii] Wellesley Institute. (2015). First Peoples, Second Class Treatment. Toronto: Author. http://www.wellesleyinstitute.com/publications/first-peoples-second-class-treatment/
[iv] See "Briefing Note: Hospital Standardized Mortality Ratio and Charlson Index Equity Analysis" (attached)
[v] CIHI. (2010). Hospitalization Disparities by Socio-Economic Status for Males and Females. Ottawa, ON: Author. https://secure.cihi.ca/free_products/disparities_in_hospitalization_by_sex2010_e.pdf
[vi] Committee on Quality of Health Care in America, Institute of Medicine. (2001). Crossing the Quality Chasm: A New Health System for the 21st Century. Washington, DC: National Academies Press.
[vii] See "Advancing Health Equity in Health Care: A Summary of Health Care Sector Consultations" (attached)