Author/s:
Mitchell, O;Malatzky, C;Bourke, L;Farmer, J

Title:
A modified Continuous Quality Improvement approach to improve culturally and socially inclusive care within rural health services

Date:
2018-06-01

Citation:
Mitchell, O., Malatzky, C., Bourke, L. & Farmer, J. (2018). A modified Continuous Quality Improvement approach to improve culturally and socially inclusive care within rural health services. Australian Journal of Rural Health, 26 (3), pp.206-210. https://doi.org/10.1111/ajr.12409.

A modified Continuous Quality Improvement (CQI) approach to improve culturally and socially inclusive care within rural health services.

Olivia Mitchell, BSc (Hons), PhD

Department of Rural Health, The University of Melbourne, PO Box 6500, 49 Graham Street, Shepparton, VIC 3630, Australia. Ph: +61 3 5823 4581

Christina Malatzky, BA (Hons), PhD.

Department of Rural Health, The University of Melbourne, Shepparton, Victoria, Australia

Lisa Bourke, BSc, BSW, MSc, PhD

Department of Rural Health, The University of Melbourne, Shepparton, Victoria, Australia

Jane Farmer, MA, PhD

Centre for Social Impact, Swinburne University, Melbourne, Victoria, Australia

Disclosure Statement

No conflicts of interest to disclose.

Acknowledgements

We would like to thank Dr Andrew Hamilton for his critical appraisal of the manuscript. We also acknowledge the Australian Government University Department of Rural Health program for funding this research.

DR. OLIVIA MARLENE MITCHELL (Orcid ID : 0000-0001-8558-7311)

Article type : Original Research

Corresponding author mail id :- olivia.mitchell@unimelb.edu.au

A modified Continuous Quality Improvement (CQI) approach to improve culturally and socially inclusive care within rural health services

Abstract

Background: The sickest Australians are often those belonging to non-privileged groups including Indigenous Australians, gay, lesbian, bisexual, transsexual, intersex and queer people, people from culturally and linguistically diverse backgrounds, socioeconomically disadvantaged groups, and people with disabilities and/or low English literacy. These consumers are not always engaged by or included within mainstream health services, particularly in rural Australia where health services are limited in number and tend to be generalist in nature.

Objective: To present a new approach for improving the socio-cultural inclusivity of mainstream, generalist, rural, health care organisations.

Design: This approach combines a modified Continuous Quality Improvement (CQI) framework with Participatory Action Research (PAR) principles and Foucault's concepts of power, discourse and resistance to develop a change process that deconstructs the power relations that currently exclude marginalised rural health consumers from mainstream health services. It sets up processes for continuous learning and consumer responsiveness.

Results: The approach proposed may provide a CQI process for creating more inclusive mainstream health institutions and fostering better engagement with many marginalised groups in rural communities to improve their access to health care.

Conclusion: The approach to improving cultural inclusion in mainstream rural health services presented in this paper builds on existing initiatives. This approach focuses on engaging on-the-ground staff in the need for change and preparing the service for genuine community consultation and responsive change. It is currently being trialled and evaluated.

Key Words: cultural inclusion, social inclusion, power, rural health services, generalist

What is already known on this subject?

- Culturally diverse groups are often marginalised in rural communities, particularly in regards to the provision of health-care.
- Mainstream, generalist rural health services need a process by which to deliver culturally and socially inclusive and responsive care to a diverse range of people.
- CQI is a recognised change mechanism within mainstream health care to improve the access to and use of services by marginalised consumers.

What this study adds?

- This study presents a new approach of a combined modified CQI methodology, PAR principles and Foucault's concepts of power to provide a tangible process for rural mainstream, generalist healthcare organisations to become more inclusive and responsive.
- This approach first deconstructs meanings, beliefs and attitudes reflected in health care practices through self-reflection, assessment and exploration of different knowledges, and then engages in CQI cycles to improve responsiveness to culturally diverse health consumers.

Introduction

A persistent challenge in rural health is how to engage the sickest people in the utilisation of health services. The rural service delivery environment is complex, with fewer health practitioners to deliver care, the challenges of geography and less choice of health and specialist services. Rural health services are often generalist in nature, trying to cater to the wide range of health needs in a local community (1). Adding to this complexity is the reality that rural Australians occupy a diverse range of social identities, many of which are marginalised. These include: Indigenous Australians; gay, lesbian, bisexual, transsexual, intersex and queer people (2, 3); people from culturally and linguistically diverse groups (4); socioeconomically disadvantaged groups (5); people with disabilities; and/or low English literacy (6). Mainstream, rural, health care services can be experienced by such marginalised groups as culturally inappropriate, unwelcoming and exclusive (7, 8) because these institutions reflect (and reinforce) the social hierarchies in broader society. It is the broader social hierarchies that underpin exclusion from mainstream health care and the poorer health outcomes experienced by marginalised groups (6). Evidence is clear that when health services are not culturally appropriate, health consumers rarely use them, and then mostly for emergency care (9).

An issue that currently permeates mainstream rural health services is a lack of understanding about culture and how it shapes communities and organisations. Mainstream health services often fail to understand the culture that exists within the service or the wider community, including how people think and understand the world and how dominant cultures work to exclude "Others" (10). The development of a culturally inclusive health service needs to be treated as a critical process that requires a continuous improvement approach (11); one which begins with health professionals understanding their own culture and then explores power relations where health professionals, services and systems exclude particular consumers because of standard practices, funding and approaches to care (12). Presented here is a new approach to improving the cultural inclusivity of mainstream rural health services. This approach combines CQI methodology with Participatory Action Research (PAR) principles and Foucault's concepts of power, discourse and resistance to provide a reflexive process for rural mainstream generalist health services to improve the delivery of culturally inclusive care.

Power and Rural Health

Power, from a Foucauldian perspective, is as a dynamic exchange visible through belief systems, actions and behaviours (13). Beliefs and actions inform and are informed by dominant societal institutions, such as health services, and influence relations between those providing and those receiving heath care (12). In a rural setting, the local health service is an important focal point for the community and can both influence and reflect the social hierarchies and power relations of that community. Racism, for example, present in the wider community impacts upon the culture of a health service as well as the social positions of local residents accessing care (14). Foucault (15) argued that power and knowledge are intimately connected; power produces knowledge and knowledge encourages actions of power. People's actions are structured by the knowledge and dialogue readily available to them in their environment. There is, therefore, a need within healthcare settings to deconstruct existing knowledges, to breakdown stereotypes, to question beliefs and values that reproduce exclusion, and present alternative ways of thinking and doing that make change possible. For instance, a health service might deconstruct notions of 'treating everyone the same' and interrogate whether this leads to equitable health outcomes. A process of improving the cultural and social inclusivity of health services that does not seek to challenge existing values, beliefs and social hierarchies (that reproduce exclusion) is unlikely to result in significant and enduring change (13). To enable different and more inclusive health care practices to emerge and gain legitimacy, alternative viewpoints, values and beliefs need to be prioritised by health services. Viewpoints might be promoted that encourage patient-centred care, where the consumer is not only consulted but is intimately involved in the planning of their care in a way that is socially and culturally meaningful. The focus becomes what is important to the patient rather than what is dictated by the healthcare provider or service.

CQI and Cultural Inclusion

Some existing models for improving the socio-cultural inclusivity of health services for marginalised people living in rural Australia (6, 11) have recognised the importance of health-care professionals reflecting on and learning about their own personal, professional and organisational cultures and how these influence health-care delivery. In recent years, several Continuous Quality Improvement (CQI) initiatives have been implemented to improve access to primary health-care settings for marginalised people living in different environments (16). CQI is a popular change process within health-care because it focuses on

quality patient care (17). Recently, CQI has been viewed as an appropriate change methodology for improving access to and utilisation of health services by Aboriginal people, who have the poorest health outcomes of any culturally distinct groups in Australia (7,8).

Durey et al. argue that health-care workers need to critically reflect on their own cultures and how their belief and value systems differ to those from historically, socially and politically different backgrounds (8). Thus, Durey et al.'s CQI-based model begins to examine the effects of power in the provision of health-care (8) and seeks to create change by altering the professional customs and expectations inherent when providing clinical care to Aboriginal Australians (8). Importantly, Durey et al. focus on the consumer and the necessity for both the health system and individual health-care providers to be flexible in the delivery of care in order to better accommodate specific cultural needs. However, the model focuses on nurses as change agents and is restricted to Aboriginal clients in urban-based hospitals. Rural health services need an approach that seeks to deconstruct and shift existing power relations in health care arenas - between health care systems, health institutions, health professionals and health care consumers (12). This new approach needs to encourage health service staff to reflect on their own cultural knowledges and practices and engage with local consumers to set up systems of care appropriate for all members of the local population.

A new CQI-based approach to a culturally inclusive rural health

The new approach proposed seeks to provide a "how-to" process for how rural health services can improve their inclusivity for marginalised health-care consumers. This approach combines the practicality of the CQI framework with PAR principles (to localise response) and Foucault's concepts of power, discourse and resistance (15, 18, 19) to create a mechanism through which to engage frontline staff with the concept of cultural inclusion. It begins with a focus on why inclusivity is particularly important for rural health services. The close theoretical association between CQI and PAR, specifically, the emphasis on the active participation of all stakeholders (20, 21) and self-determination, makes combining these two methodologies appropriate. Furthermore, Foucault's particular conceptualisation of power compliments the core premises of PAR because it recognises everybody's ability to exercise power, to resist as well as conform to dominant power relations (22). Thus, using a Foucauldian understanding of power enables both the constraints on, and the possibilities for transformation in the actions of all participants, each of whom has access to power, to be highlighted, interrogated and harnessed to effect change (22). Marrying these different

methodologies provides a comprehensive framework through which to examine the impact of dominant power relations in the provision of health care in rural areas, and effect change.

The process outlined is adaptable because it recognises the need to understand and alter the power relations that are working to exclude marginalised groups in particular contexts. Each context will differ because of the unique intersection between the local environment in which an organisation operates and wider social and health fields (1). It should be recognised however, that some societal and health discourses are particularly influential and are thus likely to be relevant in most localised settings. For example, racist discourses remain dominant in broader Australian society and the notion of clinical neutrality remains dominant in healthcare and are likely to manifest in the cultures of many mainstream health institutions (12). The proposed process is comprised of four main stages that require at least one full CQI cycle in each stage.

Stage 1: Readiness and Deconstruction. This stage aims to identify and begin deconstructing the dominant discourses sustaining exclusion. The goal in this stage is twofold. Firstly, this cycle/s produces valuable insight into the organisation's readiness for change by providing key stakeholders with an understanding of how and to what extent staff are influenced by dominant discourses reinforcing the exclusion of marginalised consumers. Secondly, it begins to instil a reflective way of thinking that encourages an organisation to be critical of how dominant ideas, when interrogated, become less stable/legitimate and are manifest within social hierarchies and organisational cultures. Ideally, this stage involves the health service partnering with an entity, such as a university or training body, that has the capability to deliver a series of tailored and comprehensive sessions for staff that challenge, non-confrontationally (23), dominant societal and health discourses.

Stage 2: Staff Engagement and Ownership aims to engage staff in the idea of a long term process of change by developing a fundamental understanding of why cultural inclusivity is important. At the end of this phase, there needs to be an organisational-wide understanding of why fostering a culturally inclusive environment is vital for improving the health outcomes of marginalised community members. Given the lack of services in rural environments, this is a key responsibility for mainstream rural health services. As with other areas in health, the perception that socio-cultural inclusion requires a commitment to a continual learning process must be strong. This stage involves the health service partnering with community advocacy groups or members of marginalised groups to ensure that staff are exposed to tangible

examples of why and how to improve the cultural inclusivity of their service. It is important in this and at all stages of the process that members of marginalised groups employed by the health service, (for example, Aboriginal health professionals) are not positioned as the sole agents responsible for 'managing' the need for the service to improve its cultural responsiveness. This approach adopts the premise that it is the responsibility of dominant groups and institutions, rather than the marginalised, to shift; this requires everyone within an organisation to be engaged in and responsible for a change process.

Stage 3: Community Engagement aims to involve staff from all levels of an organisation in collaborating with marginalised community members to redesign the delivery of health-care within the service. The goal is to co-design and introduce policies, structures and importantly, practices within the service that enable the delivery of culturally inclusive health care. This phase may require an experienced facilitator or meditator.

Stage 4: Institutional Responsiveness aims to consolidate the work done in the proceeding stages and address specific issues that emerged. Regular audits of the cultural inclusiveness of the health service may assist this process. The ultimate goal is to create an organisational culture that constantly seeks to understand the nature of culture and power, including how some practices may work to exclude certain community members and how, by privileging the perspectives of marginalised consumers, alternative practices can support the delivery of culturally inclusive health care.

Conclusion

One of the main failings of current initiatives aimed at improving cultural inclusiveness is that they leave leadership or management to engage with specific communities on behalf of the organisation and frontline staff remain unprepared and unengaged with the need for change (8). Change initiatives can thus be reduced to a series of checklist requirements that do not produce inclusive practice (see 13). Attention is usually given to what health professionals and organisations should do or say or believe in, rather than to the cultural beliefs held and how they permeate into the delivery of health care. Thus, this new approach to improving the social and cultural inclusivity of mainstream rural health services focuses on engaging all staff in the need for change, and preparing the service for genuine community consultation that directs practice change. This approach is currently being trialled and evaluated. It is clear that a long-term change process that moves beyond the limitations of

current initiatives is needed to tackle one of the most pervasive challenges in rural health - the exclusive cultures of mainstream health services.

References

1. Bourke L, Humphreys J, Wakerman J, Taylor J. Understanding rural and remote health: A framework for analysis in Australia. Health & Place. 2012;18(3):496-503.
2. Couch M, Pitts, M, Mulcare H, Croy, S, Mitchell, A, Patel, S. Tranznation: A report on the health and wellbeing of transgender people in Australia and New Zealand. Melbourne: Gay and lesbian health Victoria and The Australian Research Centre in Sex, Health and Society, LaTrobe University, 2007.
3. Leonard W, Pitts, M, Mitchell, A, Lyons, A, Smith, A, Patel, S, Couch, M, Barrett, A. Private Lives 2: The second national survey on the health and wellbeing of GLBT Australians. Melbourne: Gay and Lesbian health Victoira and the Australian Research Centre in Sex, Health and Society, LaTrobe University, 2012.
4. Victorian Government Department of Health and Human Services. Victorian refugee health and wellbeing action plan. Melbourne: Victorian Government; 2013.
5. Beard J, Tomaska N, Earnest A, Summerhayes R, Morgan G. Influence of socioeconomic and cultural factors on rural health. Australian Journal of Rural Health. 2009;17(1):10-5.
6. Renzaho A. Re-visioning cultural competence in community health services in Victoria. Australian Health Review. 2008;32(2):223-35.
7. Couzos S, Thiele DD. The international covenant on economic, social and cultural rights and the right to health: Is Australia meeting its obligations to Aboriginal peoples? Medical journal of Australia. 2007;186(10):522-24.
8. Durey A, Wynaden D, Thompson S, Davidson P, Bessarab D, Katzenellenbogen J. Owning solutions: A collaborative model to improve quality in hospital care for Aboriginal Australians. Nursing inquiry. 2012;19(2):144-52.
9. Belfrage M. Why" culturally safe" health care? Medical Journal of Australia. 2007;186(10):537.
10. Kumas-Tan Z, Beagan B, Loppie C, MacLeod A, Frank B. Measures of cultural competence: Examining hidden assumptions. Academic Medicine. 2007;82(6):548-57.
11. Ware V. Improving the accessibilty of health services in urban and regional settings for Indigenous people. Resource sheet no.27 produced for Closing the Gap Clearinghouse. Canberra: Australian Institute of Health and Welfare and Australian Institute of Family Studies; 2013.

12. Malatzky C, Bourke L. When the social meets health in rural Australia: Confronting the disconnect. Health Sociology Review. 2016.
13. Downing R, Kowal E. A postcolonial analysis of Indigenous cultural awareness training for health workers. Health Sociology Review. 2011;20(1):5-15.
14. Larson A, Gillies M, Howard PJ, Coffin J. It's enough to make you sick: The impact of racism on the health of Aboriginal Australians. Australian and New Zealand Journal of Public Health. 2007;31(4):322-30.
15. Foucault M. and Gordon C. Power/knowledge: Selected interviews and other writings, 1972-1977. Brighton, Sussex: Harvester Press; 1980.
16. Wise M, Angus, S., Harris, E and Parker, S. National appraisal of continuous quality improvement initiatives in Aboriginal and Torres Strait Islander primary health care. Melbourne: 2013.
17. Sollecito W, Johnson JK. McLaughlin and Kaluzny's continuous quality improvement in health care. Fourth ed. Burlington, Massachusetts: Jones & Bartlett Learning; 2011.
18. Foucault M. The subject and power. In: Faubion JD, editor. Essential works of Foucault 1954-1984 Volume 3, power. London: Penguin Books; 2002. p. 326-48.
19. Foucault M. The history of sexuality. London: Penguin; 1990.
20. Bailie R, Si D, O'Donoghue L, Dowden M. Indigenous health: Effective and sustainable health services through continuous quality improvement. Medical Journal of Australia. 2007;186(10):525-7.
21. Matthews V, Schierhout G, McBroom J, Connors C, Kennedy C, Kwedza R, et al. Duration of participation in continuous quality improvement: A key factor explaining improved delivery of Type 2 diabetes services. BMC Health Services Research. 2014;14(1):578-89.
22. Golob MI, Giles AR. Challenging and transforming power relations within community-based participatory research: The promise of a Foucauldian analysis. Qualitative Research in Sport, Exercise & Health. 2013;5(3):356-72.
23. Pedersen A, Walker I, Paradies Y, Guerin B. How to cook rice: A review of ingredients for teaching anti-prejudice. Australian Psychologist. 2011;46:55-63.