Continuous quality improvement for cultural responsiveness in rural health care

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Introduction

A persistent challenge for rural health services is that they are typically generalist in nature and face pressures of providing quality care in complex rural health environments (1). Many smaller rural health services face the day-to-day operational trials of maintaining their financial feasibility, confronting medical and allied health workforce shortages, a lack of local supporting specialty services and the struggle to deliver quality health care across large geographical areas (1). Adding to this complexity is the cultural and social diversity of rural Australia, where residents occupy a wide array of social identities, many of which are marginalised (2-5). One of the main challenges in rural health is how to engage the sickest people in the utilisation of health services.

Health and life-expectancy disparities between Aboriginal and Non-Aboriginal Australians continue to persist (6). If this is to change, then mainstream, rural health services must become more culturally responsive to Aboriginal people (7). In rural areas, resources to meet the complex cultural-health needs of diverse peoples are often scarce (8). As a result these services can be experienced by patients as culturally in appropriate, unwelcoming and exclusive (9, 10), meaning that consumers rarely use them and then only for emergency care (11). In recent years, Continuous Quality Improvement (CQI) has been used to assist health services to improve access and the delivery of health care for Aboriginal communities (12). CQI is a an appropriate model for improving cultural responsiveness in mainstream health services for Aboriginal people because of its focus on participatory action and quality patient care (13).

In an effort to assist health services in meeting this challenge, the former Victorian Government Department of Human Services developed the “Continuous Quality Improvement tool: Aboriginal health in acute health services and area mental health services (CQI tool)”(14). The CQI tool was developed in 2012 after the formal review of the “Improving Care for Aboriginal People” (ICAP) and the “Koori Mental Health Liaison Officer” (KMHLO) programs revealed that health services needed greater assistance in designing a process for cultural inclusivity for Aboriginal people (15). The ICAP program was designed to assist mainstream acute health services to improve the cultural responsiveness of their health service for Aboriginal and Torres Strait Islander people and is supported by a 30% loading of the Weighted Inlier Equivalent Separation (WIES) funding scheme (15). The KMHLO program was designed to provide resources to fund an effective full time equivalent position in rural areas to undertake a direct role in supporting Aboriginal clients and support the delivery of culturally responsive care (15).

The CQI tool structures assessment of the health service’s cultural responsiveness on the four key result area’s (KRAs) that underpin the ICAP and KMHLO programs: Engagement and Partnerships, Organisational Development, Workforce Development and Systems of Care. The CQI tool was designed to be a self-reflexive process to assist health services in developing more comprehensive mechanisms to drive organisational change and make health services more culturally responsive to Aboriginal patients and clients. Consisting of two parts, the CQI tool first asks the health service to reflect on where they currently stand as an organisation and rate themselves on a scale of 1-4 in
regards to where they are in achieving each of the four KRA’s (14). The second part of the tool involves documenting the planning and future actions needed to progress the cultural responsiveness of the health service (14).

The CQI tool is available to all Victorian acute health services regardless of size, and all area mental health services. However, reporting on the CQI tool to the now Victorian Department of Health and Human Services (DHHS) is a requirement only for acute health services receiving WIES funding and for all area mental health services. Therefore many small to medium sized rural health services that are not WIES funded are not required to submit a report on the CQI tool. Furthermore, while reporting on the tool is a requirement for WIES funded health services, it is not mandatory, meaning that health services who fail to submit a report on the CQI tool to the Department of Health and Human Services do not attract any financial or operational penalty (14).

Aboriginal people are reported to represent approximately 0.9% of the Victorian population, (although this proportion may be an under representation) (16) and of that population, just over half live in regional and rural areas. This means that the cultural responsiveness of all rural Victorian health services for Aboriginal and Torres Strait Islander Australians is particularly important, as many Aboriginal people may be seeking health care in rural Victorian settings. The present study aimed to identify the main barriers and enablers to uptake and completion of the CQI tool by rural health services in northern Victoria and gather information about how the tool has been used and reported on within these health services. From these findings, the study explores what might increase engagement and utilisation of cultural competency tools by rural health services.

Methods

A total of 15 interviews were conducted with CEO’s, Executive Directors, Clinical Services Directors/Managers, Quality Managers, Community Engagement Managers and Aboriginal Health Liaison Officers from mainstream “regional”, “rural” and “small rural” health services across the greater Goulburn Valley region in Victoria (17). Participant recruitment involved researchers contacting the health services within this area and requesting an interview with the appropriate person within each health service.

A semi-structured approach was employed to the interviews. While similar global questions were asked of all participants, the order and precise wording evolved with each interview (18) to concentrate on topics of particular interest to the individual participant and their health service (19). The topics raised of all participants included their knowledge of and use of the CQI tool, if/how progress against the tool was reported and if there was anything that contributed or hindered implementation of and reporting on the CQI tool. Interviews ranged in duration from 30-60 minutes and were conducted either in person or over the phone. Each participant was provided with either an e-copy or a hardcopy Plain Language Statement, and to ascertain consent, each participant was asked to sign a hardcopy consent form, a copy of which accompanied the Plain Language Statement given to all participants. The audio-recordings of each interview were transcribed verbatim into a word document, which researchers used to analyse the data. A content analysis of the transcripts was undertaken to identify the common responses among participants. Three key areas of conversation associated with the uptake and use of the CQI tool are presented here.
Results

Varied experience with the CQI tool

When initially asked about their experience of the CQI Tool, participant responses could be allocated into one of the following four categories: (1) they had never seen the tool or used it (four participants); (2) they had seen and used it, but had not reported on it (three participants), (3) they had seen the tool and used it, but have not consistently reported on it since 2012 (four participants) or (4) they have used and reported on the tool each year since 2012 (4 participants). Interestingly, of the four health services that had used and reported on the tool since 2012, all of these were larger rural or regional WIES funded hospitals that were required to report on it.

For the seven health services associated with the first two categories, there were a number of reasons identified for these services having or not having used the tool or reported on it to DHHS. Three health services (Participants 6, 7, 9) expressed that there had been significant staff turnover within the organisation since 2012 which had obstructed the continuity of responsibility for cultural responsiveness within the organisation:

“I think that [the CQI tool and report] was done in 2012/2013, so when I came on board in early 2016 I picked all that up and went that’s useless now because half those people aren’t here anymore…..so I essentially started from scratch” (Participant 9).

Participants from two health services suggested that the person responsible for the portfolio had held the position for some time, but the availability of the tool was unknown to them (Participants 13 and 14). A further two expressed that they were participating in some other activity related to Aboriginal cultural responsiveness under the Koolin Balit: Victorian Government strategic directions for Aboriginal people 2012-2022 (20) plan (Participants 8 and 14). Another suggested there was confusion in their health service about the exact purpose of the tool (Participant 9) and one expressed that the CQI tool lacked relevance for their particular organisation:

“We had a look at the tool and felt that it really didn’t address anything that we were doing here at all. It wasn’t helpful in trying, obviously there’s not dollars attached to a place this size and trying to get people to outreach” (Participant 10).

Furthermore, there was an overarching sense of confusion by participants in regards to which plan, tool or reporting structure they should be using to improve cultural responsiveness for Aboriginal people. Of the health services who participated in the present study, two health services are receiving funding under Koolin Balit (Participants 14 and 8) (20), two are further developing an Aboriginal Health Action Plan that had been initiated as part of the Home and Community Care program (HACC) (Participants 7 and 11), and one is using the “Working with Aboriginal People in Communities, Health and Community Services Audit” (Participant 3) (21). A further four health services are incorporating Aboriginal responsiveness as part of their diversity plan (Participants 10, 13, 15, 9), one is extending a community participation plan that incorporates cultural responsiveness for Aboriginal people (Participant 6) and one is using a modified progress report incorporating the CQI tool (Participant 12). Another health service has incorporated their ICAP, Reconciliation Action plan and the CQI tool under one umbrella and focussed responsiveness efforts on reporting on the CQI tool (Participant 1), two health services specifically drive their cultural responsiveness around reporting on the CQI tool (participants 2 and 4) and one health service has Koolin Balit project workers co-ordinating their audit and cultural responsiveness program in addition to other members of the organisation completing the CQI tool (Participant 5). The diversity of approaches and structures utilised to approach cultural responsiveness was apparent.
Overall lack of feedback

A common concern expressed by participants was a general lack of feedback received from DHHS after submitting their CQI tool reports. “And there’s never, ever been feedback, categorically never been feedback” (Participant 2). Of the fifteen health services involved in the study, only eight had submitted at least one report on the CQI tool to the DHHS since 2012. Participants from those eight health services indicated that they had not received any feedback from the DHHS, two were unsure if they had received feedback because they were not involved with the reports submitted, and one had only just submitted their first report in 2016 and had hence not had time to receive feedback. While two participants suggested that their health service had received acknowledgement of their most recent report by DHHS, these services had yet to receive any formal feedback about the report content. This lack of feedback was expressed as a concern and potential barrier to utilization of the tool by a number of participants:

“... the response from the Department, you know we’d be diligently submitting our reports, we were deafened by the silence, there was absolutely no feedback, no response from the Department about any of the reports that we put in” (Participant 1).

Interestingly, not one of the participants from these eight health services said they had received feedback from DHHS on the content of their CQI tool reports.

Accountability

As mentioned earlier, while reporting on the CQI tool is a requirement for WIES funded health services and area mental health services, it is not mandatory. Nor does a lack of reporting to DHHS attract a penalty. Of the eight health services who had submitted reports, three participants commented on this without being asked.

“... it’s interesting because no one actually cared whether I submitted the report or not...It [Aboriginal cultural responsiveness] really dropped off my radar because we live in a world where the demands on us for reports are horrendous and if there’s no one jumping up and down and saying why haven’t you done it, why haven’t you done it, you ain’t going to do it because obviously it’s not important (Participant 12).

Another was also pleased that reports were not asked for: “…As far as the reporting, as I said, I’m wrapped they haven’t kept asking…” (Participant 11). Further, a number of participants commented that the training and reporting requirements placed upon them are the same as the larger regional and metropolitan services but that rural and small rural services are not resourced to be able to manage a considerable amount of this training and reporting. They also indicated that clinically focussed areas are often prioritised over culturally focussed education and reporting requirements.

Discussion

The results revealed that experience with the CQI tool varied greatly between health services however all of the health services who participated in this study were engaged in some activity to improve cultural responsiveness for Aboriginal peoples. As acknowledged earlier, in Victoria, health services have had access to a variety of tools, frameworks and resources to help direct and implement inclusive practices, many of which are currently being used to implement more inclusive practice. While in some instances this may have created confusion for health services about which of these strategies to choose, it has also allowed these services the flexibility to tailor their approach towards cultural responsiveness for their specific context and community. In nearly all instances these health services tend to assign the portfolio of Aboriginal cultural responsiveness to a single individual within the organisation as opposed to a whole of organisation approach. This then becomes
problematic for the organisation when there is staff turnover or changes in role continuity. A number of the participants interviewed commented that this had impacted upon knowledge and use of the CQI tool in their health service. In some instances, knowledge and use of the tool had ceased completely when the person responsible for the portfolio had left the organisation or moved into a different role. In some instances, it was also inferred that the progression of cultural responsiveness within the health service had stagnated. If rural health services are to move forward and assist with closing the health gap between Aboriginal and non-Aboriginal Australians, then the responsibility needs to be distributed across the organisation and driven from a board and senior management level.

Another theme to arise from this study was the apparent disconnect between the expectations of the DHHS compared to rural health services regarding the self-reflexive nature of the CQI tool and feedback mechanisms for the submitted CQI tool reports. The CQI tool was initially designed to be used by health services to reflect on what they can do to respond better to the complex social and health needs of Aboriginal communities. Some health services embraced this element of the tool and were actively exploring ways to internally assess and improve their inclusive practice. However, others expressed a lack of understanding of this nature of the CQI tool and instead viewed the tool more as a checklist or another report on which to be assessed by an external agency i.e. the DHHS. As such, there was an expectation by these health services that they would receive feedback on the CQI reports submitted to the DHHS. Hence, there is a need to reconcile these differences in expectations around the CQI tool in terms of reporting and feedback between rural health services and the DHHS.

The third main theme revealed in this study was a conceptual disconnect between how rural health services viewed accountability for completing and reporting on the CQI tool and the requirements for DHHS. Currently, if a health service fails to submit a CQI tool report and they are technically required to do so, they are not penalised. This is consistent with the self-reflexive nature of the CQI tool. However, while many participants did express a genuine interest in improving cultural responsiveness within their service, it was suggested that unless they were required to do so and/or held responsible for submitting the CQI tool report, then it would most likely not be submitted. This brings into question the degree of accountability mainstream rural health services feel towards responding to Aboriginal health needs and how genuine the change is that is occurring within these health services. If mainstream rural health services will only become culturally responsive because they are made to, then this is a significant concern for closing the health gap.

Conclusion

Based on these findings, the following recommendations are suggested to improve uptake and reporting on the CQI tool by rural Victorian health services:

- Rural health services consider an “all of organisation” approach to Aboriginal cultural responsiveness, where more than one person within the health service is responsible for directing cultural responsiveness across the organisation, in order to improve the continuity and progression of changes within the health service.

- That there is greater consultation between DHHS and mainstream rural health services to facilitate agreement on the expectations of all parties in relation to review and feedback on the progression of cultural responsiveness.
• The accountability of mainstream rural health services for providing culturally responsive health care is reviewed and

• Appropriate resourcing to assist compliance in developing a culturally responsive health service is explored.

If the cultural responsiveness of rural Victorian health services is to improve, then there is a need for institutional change and appropriate resourcing at a government level.

References


Presenter

Olivia Mitchell holds a Bachelor of Science degree with Honours and a PhD in Pharmacology from the University of Melbourne. From 2006 to 2015, Olivia worked in the pharmaceutical and medical devices industries where she developed knowledge and expertise in the business of health care, the challenges faced by rural residents in accessing health care and dominant health care practices. In 2013 Olivia re-engaged with the academy and accepted a teaching position within The University of Melbourne Department of Pharmacology. In 2015, she accepted a research-focused position in the Culture and Rural Health stream of research at The University of Melbourne Department of Rural Health (DRH), based in Shepparton, Victoria. Olivia is currently involved in several research and community engagement projects and has a particular interest in improving access to health care for marginalised social groups. Throughout her career Olivia has won a variety of academic and industry awards.