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Design Prototypes for Measuring Structural Stigma in Health-Care Settings

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Abstract

This report is part of a larger Mental Health Commission of Canada initiative examining mental health- and substance use-related structural stigma in health-care settings. It builds on consultations and an environmental scan, which identified (1) an absence of any quality-of-care measurement or audit tools specific to such structural stigma, (2) widespread interest in developing new measures or tools, and (3) support and early feedback on a small number of prototype measures. Using the Institute of Medicine's six quality of care pillars as an organizing framework, this report suggests potential quality measurement indicators or audit tools that standards creators, regulators, and policy- and decision makers could use to assess structural stigma. The aim is to operationalize mental health- and substance use-related structural stigma as clinical and health outcomes, highlight performance deficits, and minimize avoidable differences in outcomes through a design that easily and effectively aligns with existing health system quality-of-care measurement and monitoring processes.

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Introduction

The early rapid prototypes listed in this report were created and collected by the author using human-centred design methods, observation, "human factors" quality-of-care methods, participant observation, ethnography, key informant interviews, literature reviews, consultations with a broad range of stakeholders, external scans and insights, and empathic needs assessment.[1] The items are mainly intended to serve as partly developed starting points for the co-production of measures and indicators to monitor structural stigma related to mental health and substance use (MHSU) in health care contexts. We anticipate and hope that these early prototypes undergo iterative re-designs[*] in several contexts and cultures, and that they are pilot tested and ultimately implemented. Some are better suited to cultural and organizational audit methods and standards development, including new required organizational practices (ROPs) (e.g., Accreditation Canada). Others may be more appropriate to performance measurement and new MHSU quality dashboard indicators for tracking, monitoring, and reporting (e.g., the Canadian Institute for Health Information [CIHI]).

These new indicator and measure prototypes attempt to make explicit documentable human factors in quality processes that tacitly exclude MHSU care, including the risk of implicit cognitive bias to quality and safety.[2] It is hoped that these prototypes will also serve as innovative conceptual models and "exemplars" that expand the field of possibility for identifying structural stigma outcomes in MHSU care. A 2019 report from Canada's chief public health officer,[3] which included a stigma-to-outcomes model that expanded on the Mental Health Commission of Canada's (MHCC's) structural stigma framework,[4] provides a process map for how levels of MHSU structural stigma develop. The prototypes in this report, however, look fo identify manifestations of structural stigma rather than measure stigma conceptually. This identification occurs in relation to health outcomes, enacted actions, and performance deficits by creating key performance indicators (KPIs) such as lack of access to services, quality gaps, and monitoring deficits.

Throughout this process, the principles that support our intervention strategy include "what gets measured gets done" and "strategic dashboards can influence how resources get deployed."

Co-production consultations

This phase of work builds on 2019-20 consultations and an external scan,[5] through which researchers set out to conduct a range of activities to identify promising partners for the design, development, and implementation of a structural stigma audit tool. The process involved inquiring, networking, and developing relationships with potential partners, key system influencers, and decision makers. Thirteen agencies were contacted across a small sampling of the health regulatory and performance measurement field, locally, provincially/territorially, nationally, and (more selectively) internationally. Early rapid prototypes were shared as concrete examples of what new audit items and performance measures could look like (as a way to stimulate the iterative design process with those in roles and responsibility for auditing and measuring health-care quality). The prototypes were designed to serve as catalysts for raising awareness and transforming unconscious and/or implicit bias about MHSU care.

[*] By co-production agencies and professionals responsible for health-care quality performance and monitoring.

They were also created with the hope of informing policy development, inducing decision makers, influencers, and agents of change to improve MHSU care, and including people with lived and living experience (PWLE) in the process.

Four co-production consultations were held in 2020:

- Accreditation Canada: September 29
- CIHI: October 5
- the MHCC's Hallway Group:* October 8
- the MHCC's Youth Council:† November 4

As reported in the external scan,[6] these prototype indicators/measures may be grouped under the following categories:

- cultural or organizational audit — including ROPs
- performance measurement — a quality dashboard or indicator
- equity measurement — as "stratifiers" for other outcome measures related to inequities or disability
- legal — development of health legislation to enshrine the principle of parity for MHSU and disability/human rights

Gaps found in metrics and monitoring:

- funding of MHSU services, relative to budget percentage and need
- patient/client/PWLE perceptions of care
- policy and legislation gaps in addressing structural inequity, parity, and quality rights
- the hidden, implicit, or noticeable absence of indicators on quality dashboards
- institutional external reviews/processes and oversight of monitoring gaps for MHSU (e.g., ROPs)
- narrative as a strategy for transformative learning and awareness and implicit and/or unconscious bias
- education on structural stigma

Quality of care pillars

The Institute of Medicine's[7,8] six quality pillars, which are commonly used as an organizing principle for quality of care, refer to health care that is safe, effective, patient-centred, timely, efficient, and equitable (SEPTEE). Although local modification and renaming are common, we use the original pillars in the hopes of establishing a continued co-production process that allows for a real world health-care context, practical effectiveness, generalizability, ease of adoption, and sustainability.

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* The Hallway Group consists of people with lived and living experience (PWLE) of a mental illness, either personally or through a loved one. Their role is to provide expert advice on specific initiatives, projects, and key priority areas through the much needed critical lens of PWLE.

† The MHCC created the Youth Council in 2008 as a way to listen to young PWLE (age 18 to 30) of a mental health problem or illness, either personally or through a family member or friend.

Safe

MHSU health care that is safe must include

- the existence of and adherence to standard care pathways for MHSU presentations in emergency departments (EDs) (to combat diagnostic overshadowing[*] and possibly for evidence-based medical/physical stability protocols)
- a standard pathway clinical algorithm in ED presentations for acute intoxications, overdoses, or confusion in clients who are elderly or who are experiencing psychosis, including the percentage of adherence rates
- ROP and dashboard monitoring to determine the documented percentage of ED physical exams for MHSU presentations
- dashboard monitoring to track the percentage of all admitted hospital MHSU inpatients who have a physical examination within 48 hours (or other benchmark to be determined)[†]
- a process to document the accuracy of the CTAS/CEDIS triage assignment by relative percentage for MHSU in EDs compared to physical health and the use of the more accurate e-CTAS[‡]
- a workplace safety system to track and compare MHSU versus non-MHSU health-care providers with respect to disability, sick days, and illness leave or injury rates with a view to measuring anonymous occupational health and HR data against benchmarks on structural and infrastructure support for MHSU care delivery
- adequate care environment (ED, inpatient, ambulatory, community care) infrastructure and space to safely care for persons needing MHSU services (compared to what is provided for physical health care) with audits of physical care tools such as safe beds, modern restraints, locks, video monitoring equipment, safety alarms and personal buzzers, and adequate support for security staff
- MHSU care environments that are in keeping with the principles of design and location for triage, risk, acuity, and clinical care needs[9,10,§]
- a thorough initial medical/physical stability assessment for MHSU patients to combat the risk of implicit and cognitive bias in providers, which may lead them to prematurely refer and transfer patient responsibility to MHSU providers[11,**]
- a requirement that code white (or behavioral) emergency policies and practices be led by a clinician, not security staff

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[*] That is, practitioners' failure to identify and diagnose health issues for people living with MHSU concerns as a result of ignoring and overlooking physical health concerns.

[†] The most common cause of death for persons with mental health concerns is cardiorespiratory illness.

[‡] The Canadian Triage Acuity Scale categorization determines prioritization and clinical actions.

[§] Are MHSU care locations integrated with physical care needs or are they segregated spaces? In the ED, if MHSU care is delivered in a separate area, is it done for justifiable clinical reasons? Are locations of MHSU inpatient units, ambulatory facilities, and entire care organizations aligned with clinical care needs? Are MHSU care locations meant to support integrated versus segregated care and allow structural availability of integrated physical health services to prevent safety risks of diagnostic overshadowing? (For MHSU care, "geography is destiny.")

[**] Are they still being cared for by the ED team as the most responsible physician (MRP) until MHSU consultation is complete or is responsibility immediately transferred to MHSU care providers by default?

- a stipulation that policies and practices related to code purple (hostage taking) and code black (bomb threat) *not* include MHSU clinical staff (remove the implicit association of MHSU as bad, morally weak, or criminally dangerous)
- a provision that policies and practices related to code yellow (missing patient) use the same language and response for all missing persons, with no mention of or distinction made between mental or physical disorders
- the existence of a hospital behavioral emergency response team (or behavioral de-escalation response team), the MHSU equivalent of critical care response team for cardiorespiratory risks that exists in many hospitals (may be an exemplar item)
- an ED clinical-decision unit (CDU) whose access and services include eligibility for persons with an MHSU diagnosis
- MRP attendance (and consultation assessment) on initial ED presentations for MHSU patients, at a level equivalent to all other organizational health specialty services (to reduce safety risks due to cognitive bias and referrals to MHSU services without an adequate medical/physical stability assessment)[*]
- stratified safety culture surveys for MHSU staff, which are reported separately from global surveys for all organizational staff
- the presence of and adherence to a least restraint policy (organization-wide) based on current best evidence
- adoption and use of the most modern restraints available organization-wide for all clinical services
- safe access to the same post-anesthesia recovery and post-interventional treatment procedures (e.g., electroconvulsive therapy [ECT], IV ketamine, repetitive transcranial magnetic stimulation [r-TMS]) for MHSU patients as for non-MHSU patients, including clinical staff, equipment, and post-anesthetic requirements (e.g., recovery room nurses, post-anesthesia care units, physical locations)
- equivalent quality and safety review processes and categorizations for MHSU and non-MHSU critical incidents, which includes relating the criteria of "expected death" versus "unexpected death" to the diagnostic condition[†]
- the inclusion of clinical care provider (e.g., a nurse) or other health organization employee injuries, (due to or associated with a patient's clinical condition and care) within the mandate (and as part of) a clinical quality of care organizational review process and categorization (e.g., critical incidents) rather than be exclusively part of an occupational health/HR process.

[*] Policy already exists for the interprofessional assignment of most responsible physicians and providers.

[†] Currently, any death by suicide is categorized as a critical incident. This suggests an unexpected clinical error or failure rather than a recognized morbidity and mortality risk from an illness and clinical condition. Contrast this with cardiac deaths that occur in cardiovascular illnesses, where a death is only categorized as a critical incident if it is unexpected or not part of the patient's condition. Here, no association, blame, or survivor guilt results for providers and family members due to personal error or failure.

Effective

MHSU health care that is effective must include

- a pharmacist team member to complete a medication reconciliation for MHSU patients in EDs and inpatient units, as is done for non-MHSU patients in medical-surgical units
- a rapid access addiction medicine (RAAM) clinic or low-barrier access to a walk-in addiction service
- a medically supported withdrawl management/detoxification service or clear pathway algorithm for responsibility for this clinical care service
- access to community-based psychotherapy
- a formal memorandum of understanding or partnership agreement for MHSU patients' physical health care, including a standard pathway algorithm or flow process between stand-alone MHSU hospitals or care facilities and non-MHSU physical health care hospitals or facilities
- an MHSU chief quality officer role to serve on organizational or hospital and board quality committees (exemplar item)
- MHSU most responsible service pathways that are equivalent to other non-MHSU services
- access to evidence-based treatments, such as ECT, r-TMS, clozapine clinics, and psychotherapies
- an embedded, integrated physical health-care provider for MHSU services[12] in community mental health clinics (reversed co-location shared and integrated collaborative care), especially for PWLE with serious mental illness and MHSU concerns who face barriers or are unable to access timely primary physical health care or a family or general practitioner (e.g., assertive community treatment, early psychosis intervention, RAAM)
- continuing education on MHSU requirements among non-primary MHSU health-care services (e.g., rounds, topics in conference, in-services for interns, mandatory annual professional learning (benchmarks to be determined)
- access to peer support.

Patient Centred

MHSU health care that is patient centred must include

- measures of patient satisfaction and perception of care, enhanced by adding MHSU-specific care to generic score cards, which could be used to create a patient satisfaction tool and a scoring practice comparable to that of medical-surgical services (i.e., an MHSU satisfaction score greater than, say, 80 per cent)
- physical locations, waiting room areas, and care environments for MHSU services with conditions that are equivalent to those of non-MHSU services
- signage and service designations that use language in keeping with current MHSU standards (with PWLE-provided input and satisfaction)
- available or accessible MHSU information for the purpose of patient and family education
- the use of stand-alone provider engagement surveys (e.g., by Pulse) and satisfaction scores on clinical care-related items for MHSU staff, comparable to those for physical health-care providers (e.g., "I have the tools I require to meet the needs of my patients"), with a view to conducting a stratified assessment of care against the quadruple aim

- equitable access and provision of after-hours MHSU care with on-call rooms and reserved or dedicated parking access that is equivalent to allocations for non-MHSU providers
- the presence of patients and family members in mandatory terms of reference for boards and senior executive teams, with placements (including PWLE or MHSU patient- and family-centred care representatives) on organization boards, senior leadership teams, and senior committees (an equity, diversion, and inclusion [EDI] for MHSU implicit bias and an exemplar practice)
- access to outdoor space for MHSU patients, especially for those requiring involuntary admission, who are unable to leave inpatient units for safety reasons (Should minimum standards for the treatment of patients under such conditions be considered for health-care facilities as they have been for jails in the criminal justice system?)
- making recovery-oriented and trauma-informed care part of any policy or organization-wide mission, vision, or values, including MHSU services and beyond (e.g., trauma-informed care in EDs, as proposed by the Institute for Healthcare Improvement).

Timely (access to services)

MHSU health care that is timely must include

- MHSU wait time measures for services and assessments by registered nurses, social workers, occupational therapists, psychiatrists, psychologists, and addiction services, such as a 30-day wait time to see a specialist, an equivalent wait time for MHSU and non-MHSU patients between the ED presentation and a physician's initial assessment, and targets on the wait time for followup care after an ED visit or hospital discharge (e.g., 30 days, which would be akin to cancer care wait times)
- a ratio metric for MHSU services in number of days, linked to clinical outcomes (e.g., percentage of ED 30-day recidivism, inpatient average length of stay, percentage of overdose deaths in the area)
- continuity of care information, such as percentage discharge notes for MHSU (e.g., PWLE to follow up with service provider within seven days)
- information on access in relation to the availability of resources (e.g., percentage of MHSU providers per 100,000 persons and/or population in a geographic region).

Efficient

MHSU health care that is efficient must include

- funding for MHSU with a budget allocation as a percentage of the global health budget (by organization/hospital, system or region, province or territory, or country) including, e.g., percentage of gap targets (MHSU parity), the OECD international global comparators scorecard and ranking
- budget equity between MHSU and non-MHSU clinical programs over time in terms of increases, decreases, cuts, and discretionary "strategic investments" (e.g., changes to surgery budget versus MHSU budget)
- budget for and the number/ratio of acute ambulatory and urgent followup clinical staff and employees for MHSU compared to non-MHSU clinical services (medical-surgical) (e.g., staff number for fracture care or diabetes clinics versus the MHSU urgent clinic)

- tracking the ratio of allied health staff per inpatient bed for MHSU versus non-MHSU services (e.g., discharge planners, social workers)
- eligibility for a capital equipment budget that includes MHSU, following the same measures and financial percentage of the hospital/organizational global budget*
- a measure to correlate health needs with resources (How does the MHSU population health burden and health system priority ranking align with the percentage of health budget allocation by the system or organization, and what is the degree of disconnect?)[13]
- an understanding of the budgetary cost and percentage of MHSU hospital beds (MH and SU separate) per 100,000 people
- the integration of organizational MHSU and non-MHSU health performance data to enable the visualization of reporting and quality dashboard items on same document and prevent their segregation
- the adoption of the same integrated funding agreement template for MHSU and non-MHSU services (e.g., rather than having one health services accountability agreement for medical-surgical and one for MHSU)
- measuring and monitoring the funding percentage ratio between contributions by charitable foundations and those by the hospital (e.g., the dollar contribution coming from chariable foundations versus the hospital, organization, or system for new capital projects and new services) with a view to establishing an allocation for MHSU that is equitable to other clinical services.

Equitable

MHSU health care that is equitable must include

- a stand-alone and separate health disparity indentifier for MHSU monitoring (along with those of gender, 2SLGBTQ+, race, disability, and others.) for all organizational EDI measurement or audit processes, implicit bias training requirements, and continuing education offerings (e.g., annual mandatory employee training or credentialing requirements for health-care providers, employees, managers, and executives†)
- a measure of capital investment in MHSU treatment services and its relative ranking (e.g., how long it has been since the last new build or renovation of their physical space) compared to other health services (medical-surgical)‡

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* The medical equipment capital allocation committee decides where surgical equipment, scopes, diagnostic imaging, CT and MRI machines, EKG monitors, IV poles, and neonatal incubators resources are allocated. MHSU infrastructure for care capital resources do not generally qualify for — and rarely get — any allocation from this budget. Because MHSU services are mostly understood as cognitive rather than procedural (at this time), "equipment" for care provision (e.g., rooms for assessments and interviews, group rooms, magnetic locks, video monitoring equipment, computers, telephones, and clinical staff) are considered ineligible and structurally out of scope for a "medical equipment budget." As a result, MHSU services must compete with non-clinical budget allocations for physical care space (as part of the facilities or building budget), for clinical staff (as part of the HR budget), and for computers and phones (as part of the IT budget).

† The MHCC's structural stigma training module (under development) is one such offering.

‡ Mental health care facilities are often found in the oldest, most decaying parts of a hospital/organization/location and are among the last to be renovated, newly built, or relocated.

- an assessment of the condition of physical MSHU care environments for ED, inpatient, and outpatient services, compared to rest of the organization or hospital (e.g., paint, furniture, cleanliness)
- an understanding of the relative remuneration (target to be determined within 10 per cent) of MHSU providers for equivalent work or roles compared to non-MHSU providers (e.g., MD specialty inequities)
- a determination of the charitable funding provided by foundations for MHSU versus non-MHSU as a percentage of the dedicated and discretionary charitable funds an organization allocates
- identifying funding amounts from agencies for research, scholarships, and innovation for MHSU versus non-MHSU as a percentage of the budget, with targets (to be determined)
- a comparison of policies and procedures for housekeeping services (Is the frequency of cleaning for MHSU clinical care [ED, inpatient, outpatient] the same as for non-MHSU environments?)
- an assessment of designations, categorizations, and language used for MHSU clinical spaces (Are outpatient MHSU clinical spaces designated as equivalent to clinical assessment or treatment rooms [as opposed to offices tantamount to administrative spaces]?)
- an evaluation of inpatient bed categories and their designation equivalencies (Are acute MHSU beds given the same acuity determinants as non-MHSU beds?; e.g. for MHSU, 1 = acute care unit, 2 = ward beds, whereas for medical-surgical beds, 1 = Intensive care unit, 2 = step-down unit, 3 = acute ward beds)
- an appraisal of whether the geographic locations of MHSU clinical facilities and services (ED, inpatient, outpatient) are integrated to the same extent as non-MHSU facilities and services, using a patient-centred, quality-of-care rationale for what is best for the patient (i.e., the principles of form follows function and low barrier access)*
- having equitable employee/provider recruitment and hiring policies to require equivalent police background checks for all staff, including those in MHSU care (e.g., via health professional credentialing and licensing or HR processes)
- knowledge of the percentage of MHSU health-care providers or PWLE who are in leadership roles for the hospital/organization and on senior leadership teams or governance boards
- integrating MHSU into the same parts and sections of workplace leave insurance forms (disability, illness) as is medical illness, instead of segregating MHSU diagnoses (i.e., medical versus psychological/non-medical)
- an acknowledgment on organizational/licensing body self-attestations and in HR forms and policies that every health concern and illness may impair a person's ability to perform and function in a given role, rather than using a separate category and reporting/questions section for MHSU.

* Situating MHSU services in segregated areas and locations is implicitly out of keeping with these principles of clinical care needs (geography is destiny).

Other frameworks and processes to consider for new prototype development

Legislative policy

- Create an MHSU Parity Act for Canada.[14]

Equity measurement outside of direct health-care contexts

- Make MHSU a separate, stand-alone disability, disparity, health equity category in Health Equity Impact Assessments[15] (e.g., in the Ontario Ministry of Health and Long-Term Care template) instead of a broad category of disability.
- Add MHSU as a separate category or stratifier item to the Statistics Canada General Social Survey.[16]

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