Nurturing Engagement-Capable Environments

Instaurer des environnements propices à la participation

INTRODUCTION

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Introduction

We are honoured to bring this special edition to you and hope that it will resonate with and cause you to think and rethink what it means to engage people as they intersect with the healthcare system. Being co-editors of this special edition has provided us with a unique opportunity to learn from the lived and professional experiences of people actively working to develop and nurture engagement-capable environments (ECE). Individually, and in partnership as co-editors, we bring a profound belief in the importance of ECEs as they affect the lives, health and healthcare of individuals, families and communities.

Healthcare Excellence Canada, a keen proponent of ECEs, sought to deepen its understanding of building resilient engagement practices, particularly as these efforts waned for many organizations in the early days of the COVID-19 pandemic.

[1] The views expressed herein are solely those of the author and do not necessarily reflect those of the Canadian Institutes of Health Research.

Commissioned research by Kuluski et al. (2024a) explored engagement efforts across the country, and an analysis of these cases sheds light on key ingredients to enable engagement work in times of crisis. Authors in this special issue were invited to offer their insights on ECEs based on their experiences of engagement during the pandemic. The result is a unique collection of articles and interviews that seek to understand both fractures in engagement and new engagement practices that developed during these disruptive pandemic years. Building on their lived and professional experiences, these authors suggest constructive ways for us to expand and enrich our understanding of what healthcare environments need, in times of crisis and beyond, to strengthen and sustain effective engagement between patients, communities and health providers to improve healthcare.

Reimagining and Reconfiguring Relationships

At its foundation, engagement is about relationships, and the articles in this issue invite us to reimagine the relationships that underpin engagement focused on improving health and care. Where the ECE model specifies distinctions between the roles of leaders, staff and patient/caregiver partners, the realities described by our authors are more nuanced and complex. Without denying the power differences inherent in our health system, a number of the articles show how effective partnership – in crisis and in routine times – requires stepping outside of existing roles to connect at a deeper level and to share power in a more dynamic way. Rouly and Boivin's (2024) account of what happens when a patient partner offers care to a clinical partner, von Plessen and Batalden's (2024) description of the interplay of experiences involved in co-producing healthcare and Boozary and Keresteci's (2024) focus on the leadership exercised by peer workers and community members are all examples we can learn from.

Broadening Our Understanding of "Environments"

A critical insight of the ECE model is that relationships do not exist in a vacuum but are shaped and structured by the environments in which people work together to improve care. The articles in this volume invite us to think about "environments" beyond the organizational contexts that are often described in cases of ECEs. Environments in these articles include communities at all geographic levels, from neighbourhoods to national contexts, and can be usefully conceived as *ecosystems* involving and impacted by many different actors working inside and outside of healthcare organizations (Rouly and Boivin 2024). As authors from the First Nations Wellness Circle (FNWC) (Trott et al. 2024) and Boozary and Keresteci (2024) remind us, environments of engagement are also shaped by past and ongoing harms resulting from colonialism and social policies that perpetuate inequality. These articles provide a number of suggestions for how to work together within complex environments that are marked by systemic power differences and inequities, including the use of trauma-informed approaches eloquently described by Pomeroy (2024) and viewing communities as a source of strength, asset and solution as described in the FNWC (Trott et al. 2024), by Boozary and Keresteci (2024) and by Kuluski et al. (2024b) in their final commentary.

Broader Integration of Health and Social Care

Healthcare does not exist in a vacuum but rather is part of a broader ecosystem that encompasses the many components of a community. As such, it is imperative that health systems proactively and intentionally engage with the communities they interact with and serve.

The importance of community engagement was brought dramatically to the forefront during the pandemic. The pandemic

did not cause inequities but rather exposed long-standing issues that advantage some communities while others are disadvantaged or ignored, leaving their healthcare needs unaddressed. Only when these communities were welcomed and included did we begin to see progress in developing and implementing programs that were able to address the needs of diverse communities. We learned that homogeneity in policy development did not serve individuals or communities well and, in many cases, caused harm when the latter were not engaged.

As these authors invite us to do, we see engagement efforts beyond traditional engagement with patients and caregivers within institutions, to encompass efforts within communities in order to advance a vision of healthcare that meets the needs of all peoples living in Canada.

Leadership and Culture

Leadership and culture are key to success if we are to realize the benefits of ECEs in healthcare. Persistent and bold leadership is required to see a new era of engagement become the norm, rather than the exception, particularly in times of crisis. Leadership has been shown to be an important component of developing and nurturing a culture of partnership that recognizes the need to co-design care delivery models and that builds the required infrastructure to sustain this culture.

Leadership must be willing to make decisions that are often at odds with the prevailing direction in the environment. Bravery in decision making leads to a culture where staff and those receiving care trust that their unique needs are recognized and supported by leaders who are willing to take a risk to support them. Boozary and Keresteci (2024) describe bold leadership within a large academic health centre that was willing to take risks, confident in their data and engagement practices to guide decision making and to co-produce solutions for care. Such bold leadership has been key to their success in implementing, then spreading and scaling transformative initiatives. During the pandemic, the leadership at the Holland Bloorview Kids Rehabilitation Hospital leaned into a culture they had nurtured for years and that allowed them to co-produce policies and practices that met the needs of those they serve (Baker et al. 2024). This was only possible because of the deep relationships that leaders and staff had with family leaders within their organization. Engagement is front and centre throughout the organization and is cited as "the heart of everything we do" (Baker et al. 2024: 33) Throughout this issue, a common thread woven through all the articles is a belief that organizational culture and bold leadership are key to sustainable and meaningful partnerships with patients and communities.

Conclusion

It is our hope that you will integrate what you learn from this special edition into your work in a way that advances the idea of ECEs. The lessons learned during the pandemic provide insights that lead us to partner with patients, caregivers and communities in different ways that will result in safe, high-quality and equitable care for all.

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