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Ente Ospedaliero Cantonale

Final report of the Equity Ticino - Pilot project: ”Patients' rights, equity and quality in hospital practices” 2023-2024

EquiTI Study

Ente Ospedaliero Cantonale (EOC), Ospedale Regionale di Mendrisio Beata Vergine (OBV)

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Impressum

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Executive Summary

Introduction

Equity Ticino pilot project: ”Patients' rights, equity and quality in hospital practices” 2023-2024 is a collaboration between the Ente Ospedaliero Cantonale (EOC) and the University of Applied Sciences and Arts of Southern Switzerland (SUPSI), funded by the Federal Office of Public Health (FOPH). The initiative, aligned with the Swiss Health Strategy 2030, addresses inequities in healthcare delivery by focusing on identifying and supporting the social vulnerability of patients with migration background, in particular forced migration background. Implemented at the Beata Vergine Regional Hospital in Mendrisio, this participatory action research aimed to create practical tools for improving equitable care. The research project was also conducted with the interest of the Canton of Ticino, specifically by the Office of the Cantonal Physician.

Objectives and scope

This study aims to improve the hospital system's ability to promote and guarantee patients' rights by enhancing knowledge among healthcare professionals, health authorities and institutions. The primary goal is to address patients' social vulnerabilities and improve healthcare quality. Key objectives include promoting equitable healthcare, developing tools to monitor equity, training healthcare professionals, and establishing systems to identify patient vulnerabilities and activate appropriate support.

Methodology

Using a participatory action research (PAR) framework, the methodology involved evaluating the hospital system's ability to equitably promote and guarantee patients' rights by an ethnographic analysis of care processes and practice. By discussing the observations, the team has defined and tested specific equity indicators. Solutions to identified problems were then developed, tested, and shared. This approach engaged professionals, patients, and interdisciplinary teams to co-create context-sensitive and practical solutions, emphasizing reflection, knowledge co-creation, and empowerment.

Key Outputs

The project fostered a culture of learning and reflection on health equity issues. This action-research dynamic on equity enabled the development of new tools, practices, and processes that can be adapted to other care contexts. EquiTI is indeed generalizable to other institutions interested in promoting equity in care, bringing innovation at both clinical and institutional levels. The following key outputs can be identified:

1. **E-Learning for Healthcare Professionals:**
   Training modules focused on equity, cantonal health law, and intercultural communication. Over 30 staff members participated, laying the groundwork for broader adoption.

2. **Vulnerability Triage System:**
   A systematic tool using indicators such as language barriers and social isolation to identify vulnerable patients. This system enables swift activation of mediation and social services.

3. **Patient Satisfaction Survey:**
   A tailored survey captured feedback on the clarity of communication and respect for cultural specificity, offering insights to refine practices.

The participatory approach empowered stakeholders and ensured that solutions were well integrated into existing workflows. The project also demonstrated how equity indicators can be operationalized to monitor and improve quality in clinical practices.

Strengths and innovations

1. Grafting the work of developing equity indicators onto the concept of capabilities[1] is an approach that allows improvement activities to be identified and monitored and generates debate and expertise on the issue.

2. Linking the issue of equity to legal provisions through the observation of everyday care practices is a successful starting point for involving social and administrative professionals at all levels.

3. The participatory action research methodology used has strong transformative potential in the medium term. The exchange of scientific, professional and practical knowledge based on ethnographic observations leads to interdisciplinary collaboration capable of generating effective questions and answers adapted to specific contexts.

4. Creating a dynamic of gradual involvement of active professionals in the context of project implementation to improve the capacity of their system to provide equitable and quality care empowers individuals and the organisation. Empowerment creates a "sense of importance and urgency" around the issue of equity, as it is already the case with other issues such as cost-effectiveness, patient safety or efficiency.

Challenges and lessons learned

Key challenges included the unpredictability of participatory timelines and the need for improved communication strategies between different hierarchical levels of project partners. However, the iterative process showed that linking equity to legal frameworks and focusing on communication were effective strategies for systemic change.

Recommendations

1. **Institutionalize Equity in Healthcare Practices**
   Healthcare institutions shall prioritize the integration of equity into their core practices. This includes developing and adopting systematic vulnerability triage tools to identify and address health inequities during patient intake and care. Institutionalizing these tools as part of routine healthcare institutions' operations can ensure more equitable care for all patients.

2. **Foster Interdisciplinary Collaboration and Empowerment**
   Decision makers of healthcare institutions should promote interdisciplinary collaboration within healthcare teams, as demonstrated by the EquiTI project. PAR encourages the active involvement of all stakeholders, including healthcare providers, patients, and

[1] The capability approach is a conceptual framework centered on two fundamental principles: first, the idea that having the freedom to attain well-being is a crucial moral priority, and second, the notion that well-being should be assessed based on individuals' capabilities and achieved states. Capabilities represent the various actions and conditions people have the potential to realize if they choose—such as maintaining good health, pursuing education, forming relationships, or exploring the world. Functioning, on the other hand, are the tangible accomplishments of these capabilities.

social services. Empowering staff at all levels, from medical personnel to administrators, can facilitate more inclusive and effective healthcare delivery.

3. **Expand and Scale Training Programs on Equity**
   To ensure healthcare professionals are equipped to address the complex social vulnerabilities of patients, it is essential to expand training initiatives. Specific training programs, e-learning modules focused on equity, cultural sensitivity, and communication should be incorporated into professional development programs, especially of doctors. Policymakers and sanitary institutions should support the development of training curricula that reflect the social determinants of health and integrate legal frameworks for equity into everyday care practices.

4. **Strengthen Monitoring and Evaluation**
   Ongoing monitoring and evaluation of equity interventions are crucial. Cantonal healthcare institutions should adopt quality indicators related to equity, such as patient satisfaction, vulnerability identification, and the activation of support services (e.g., social workers, cultural mediators). The EquiTI project has demonstrated that regular feedback from vulnerable patients is vital for improving communication and overall care. Policymakers and sanitary institutions should encourage the use of patient-centered surveys as a tool for continuous improvement in care delivery.

5. **Advocate for Systemic Policy Changes**
   At the national and cantonal levels, policymakers must advocate for systemic reforms that embed equity into healthcare policy. This includes funding and supporting systematic monitoring and research on health inequities at federal level, as well as incentivizing healthcare institutions and actors to adopt socially innovative practices that address the root causes of health disparities at cantonal level. Aligning healthcare policies with the principles of equity, as outlined in the Swiss Health Strategy 2030 and the Ticino Health Law, is a critical step toward achieving long-term systemic change.

Conclusion

The EquiTI project exemplifies the potential of participatory action research to drive systemic change in healthcare. By addressing equity as a core element of quality, the project has created a replicable model for promoting equitable and patient-centered care in diverse contexts.

Zusammenfassung

Einleitung

Das Pilotprojekt Equity Ticino „Patients' rights, equity and quality in hospital practices“ (Patientenrechte, Chancengerechtigkeit und Qualität in der Spitalpraxis) 2023–2024 ist eine vom Bundesamt für Gesundheit (BAG) finanzierte Zusammenarbeit zwischen dem Tessiner Kantonsspitalverbund (EOC) und der Fachhochschule Südschweiz (SUPSI). Die auf die bundesrätliche Strategie Gesundheit2030 abgestimmte Initiative befasst sich mit Ungleichheiten in der Gesundheitsversorgung. Dabei liegt der Fokus auf der Erkennung der sozialen Vulnerabilität von Patientinnen und Patienten mit (erzwungenem) Migrationshintergrund und deren Unterstützung. Dieses partizipative Projekt wurde im Regionalspital Beata Vergine in Mendrisio durchgeführt und soll die Entwicklung praktischer Instrumente zur Förderung einer gerechten Versorgung ermöglichen. Das Forschungsprojekt wurde auch mit Beteiligung des Kantons Tessin und insbesondere des Kantonsarztamts umgesetzt.

Zielsetzung und Anwendungsbereich

Diese Studie soll die Spitäler besser dazu befähigen, die Berücksichtigung der Patientenrechte zu fördern und zu gewährleisten, indem das Wissen von Gesundheitsfachpersonen, Gesundheitsbehörden und Institutionen erweitert wird. Das Hauptziel besteht darin, die soziale Vulnerabilität von Patientinnen und Patienten anzugehen und die Qualität der Gesundheitsversorgung zu verbessern. Zu den wichtigsten Zielen gehören die Förderung einer gerechten Gesundheitsversorgung, die Entwicklung von Instrumenten zur Überwachung der Versorgungsgerechtigkeit, die Schulung von Gesundheitsfachpersonen und die Implementierung von Systemen zur Erkennung von Vulnerabilitäten bei Patientinnen und Patienten sowie zur Bereitstellung geeigneter Unterstützungsmassnahmen.

Methodik

Unter Anwendung eines partizipativen Aktionsforschungsansatzes (PAR) wurde durch eine ethnografische Analyse der Versorgungsprozesse und -praktiken geprüft, wie Spitäler die Patientenrechte gerecht fördern und deren Berücksichtigung gewährleisten können. Bei der Besprechung der Beobachtungen definierte und testete das Forschungsteam spezifische Indikatoren zur gesundheitlichen Chancengleichheit. Anschliessend wurden im Team Lösungen für die ermittelten Probleme ausgearbeitet, getestet und ausgetauscht. Mit dem gewählten Ansatz wurden Fachpersonen, Patientinnen und Patienten sowie interdisziplinäre Teams einbezogen, um gemeinsam kontextsensitive und praktische Lösungen zu erarbeiten. Der Schwerpunkt lag dabei auf Reflexion, gemeinsamem Wissenserwerb und Empowerment.

Kernergebnisse

Das Projekt förderte eine Lernkultur und die Auseinandersetzung mit Fragen der gesundheitlichen Chancengleichheit. Die Dynamik der Aktionsforschung im Bereich der Versorgungsgerechtigkeit ermöglichte die Entwicklung neuer Instrumente, Praktiken und Prozesse, die auf andere Versorgungskontexte übertragen werden können. EquiTI lässt sich auch auf andere Einrichtungen anwenden, die an der Förderung der gesundheitlichen Chancengleichheit interessiert sind, und bringt sowohl auf klinischer als auch auf institutioneller Ebene innovative Ansätze ein. Die Kernergebnisse sind die folgenden:

1. **E-Learning für Gesundheitsfachpersonen:**
   Schulungsmodule mit den Schwerpunkten Chancengleichheit, kantonales Gesundheitsrecht und interkulturelle Kommunikation. Über 30 Mitarbeitende nahmen daran teil und legten damit den Grundstein für eine breitere Anwendung.

2. **Triage-System zur Erkennung von Vulnerabilität:**
   Dieses systematische Instrument nutzt Indikatoren wie Sprachbarrieren und soziale Isolation, um vulnerable Patientinnen und Patienten zu identifizieren. Es ermöglicht die rasche Aufbietung von Vermittlungs- und Sozialdiensten.

3. **Umfrage zur Patientenzufriedenheit:**
   In einer massgeschneiderten Umfrage wurden Rückmeldungen zur Klarheit der Kommunikation und zur Berücksichtigung kultureller Besonderheiten erfasst, die Erkenntnisse zur Verbesserung der Behandlungsprozesse lieferten.

Der partizipative Ansatz ermöglichte es den Stakeholdern, sich einzubringen und stellte sicher, dass die Lösungen gut in die bestehenden Arbeitsabläufe eingebunden wurden. Das Projekt zeigte auch, wie Gerechtigkeitsindikatoren eingesetzt werden können, um die Qualität in der klinischen Praxis zu überwachen und zu verbessern.

Stärken und Innovationen

1. Durch die Einbindung der Entwicklung von Gerechtigkeitsindikatoren in den Befähigungsansatz[2] können Verbesserungsmassnahmen ermittelt und überwacht, Debatten angestossen und Fachwissen zum Thema gewonnen werden.

2. Die Verknüpfung der Frage der Versorgungsgerechtigkeit mit den gesetzlichen Bestimmungen aufgrund von Beobachtungen im Versorgungsalltag ist ein guter Ausgangspunkt für den Einbezug von Fachpersonen des Sozial- und Verwaltungsbereichs auf allen Ebenen.

3. Die angewandte Methodik der partizipativen Aktionsforschung hat mittelfristig grosses Potenzial: Der Austausch von wissenschaftlichem, fachlichem und praktischem Wissen aufgrund ethnografischer Beobachtungen führt zu einer interdisziplinären Zusammenarbeit, mit der relevante, kontextbezogene Fragen und Antworten erarbeitet werden können.

4. Wenn Fachpersonen schrittweise in die Umsetzung von Projekten ihres Betriebs zur Verbesserung einer gerechten und qualitativ hochwertigen Versorgung einbezogen werden, stärkt dies sowohl die Beteiligung von einzelnen Mitarbeitenden am Thema als auch die Organisation als Ganzes. So wird ein «Gefühl der Wichtigkeit und Dringlichkeit» in Bezug auf die Versorgungsgerechtigkeit geschaffen, wie das bereits bei anderen Themen wie Kosteneffizienz, Patientensicherheit oder Effizienz der Fall ist.

Herausforderungen und Erkenntnisse

Zu den grössten Herausforderungen gehörten die Unvorhersehbarkeit der Termine bei partizipativen Arbeiten und die Notwendigkeit verbesserter Kommunikationsstrategien zwischen den verschiedenen Hierarchiestufen der Projektpartner. Der iterative Prozess zeigte jedoch,

[2] Der Befähigungsansatz (auch Fähigkeitenansatz) ist ein Rahmenkonzept, das auf zwei Grundprinzipien beruht: erstens auf der Idee, dass die Freiheit zur Erlangung von Wohlergehen eine zentrale moralische Priorität hat, und zweitens auf der Vorstellung, dass Wohlergehen anhand der Fähigkeiten und Errungenschaften des Einzelnen zu bewerten ist. Die Fähigkeiten stellen die verschiedenen Handlungen und Gegebenheiten dar, zu deren Umsetzung Menschen in der Lage sind, wenn sie sich dafür entscheiden, wie zum Beispiel die Erhaltung einer guten Gesundheit, das Absolvieren einer Ausbildung, der Aufbau von Beziehungen oder die Erkundung der Welt. Die Errungenschaften sind hingegen die konkreten Ergebnisse dieser Fähigkeiten.

dass die Einbindung der Versorgungsgerechtigkeit in rechtliche Rahmenbedingungen und der Fokus auf die Kommunikation wirksame Strategien für einen systemischen Wandel sind.

Empfehlungen

1. **Institutionalisierung der Chancengerechtigkeit in der Gesundheitsversorgung**

   Die Gesundheitseinrichtungen müssen die Einbindung der Chancengerechtigkeit in ihre Kernprozesse priorisieren. Dazu gehört die Entwicklung und Einführung systematischer Instrumente zur Vulnerabilitätserkennung, um gesundheitliche Chancenungleichheiten bei der Patientenaufnahme und -versorgung zu erkennen und anzugehen. Die Institutionalisierung dieser Instrumente als Teil der Routineabläufe von Gesundheitseinrichtungen kann eine gerechtere Versorgung aller Patientinnen und Patienten gewährleisten.

2. **Förderung der interdisziplinären Zusammenarbeit und des Empowerments**

   Die Entscheidungsträger von Gesundheitseinrichtungen sollten die interdisziplinäre Zusammenarbeit in Gesundheitsteams fördern, wie im Projekt EquiTI gezeigt. Die partizipative Aktionsforschung fördert den aktiven Einbezug aller Stakeholder, einschliesslich der Leistungserbringer im Gesundheitswesen, der Patientinnen und Patienten und der Sozialdienste. Die Befähigung von Mitarbeitenden auf allen Ebenen, vom medizinischen Personal bis zu Verwaltungsangestellten, kann eine inklusivere und effektivere Gesundheitsversorgung ermöglichen.

3. **Ausbau und Weiterentwicklung von Schulungsprogrammen zur Chancengerechtigkeit**
   Damit die Gesundheitsfachpersonen in der Lage sind, auf die komplexen sozialen Vulnerabilitäten von Patientinnen und Patienten einzugehen, ist der Ausbau des Schulungsangebots essenziell. Spezifische Schulungsprogramme und E-Learning-Module mit den Schwerpunkten Chancengerechtigkeit, kulturelle Sensibilität und Kommunikation sollten in Weiterbildungsprogramme, insbesondere für Ärztinnen und Ärzte, aufgenommen werden. Politische Entscheidungsträger und Gesundheitseinrichtungen sollten die Erarbeitung von Lehrplänen unterstützen, welche die sozialen Gesundheitsdeterminanten berücksichtigen und rechtliche Rahmenbedingungen für die Chancengerechtigkeit in den Versorgungsalltag einbinden.

4. **Verstärkte Überwachung und Evaluation**
   Das kontinuierliche Monitoring und die Evaluierung von Massnahmen für die Chancengerechtigkeit sind zentral. Die kantonalen Gesundheitseinrichtungen sollten Qualitätsindikatoren für die Chancengerechtigkeit einführen, zum Beispiel Patientenzufriedenheit, Vulnerabilitätserkennung und Aufbietung von Unterstützungsdiensten (z. B. Sozialarbeitende, kulturelle Vermittlung). Das Projekt EquiTI hat gezeigt, dass regelmässige Rückmeldungen von vulnerablen Patientinnen und Patienten für die Verbesserung der Kommunikation und der Gesamtversorgung essenziell sind. Politische Entscheidungsträger und Gesundheitseinrichtungen sollten den Einsatz von patientenzentrierten Umfragen als Instrument zur kontinuierlichen Verbesserung der Versorgung fördern.

5. **Engagement für systemische Änderungen in der Politik**
   Auf nationaler und kantonaler Ebene müssen die politischen Entscheidungsträger für systemische Reformen einsetzen, welche die Chancengerechtigkeit in der Gesund-

heitspolitik verankern. Dazu gehören die Finanzierung und Unterstützung einer systematischen Überwachung und Forschung zu gesundheitlichen Chancenungleichheiten auf Bundesebene. Ausserdem sollen sie Anreize für Gesundheitseinrichtungen und -akteure schaffen, sozial innovative Praktiken einzuführen, welche die Ursachen gesundheitlicher Chancenungleichheiten auf kantonaler Ebene angehen. Die Ausrichtung der Gesundheitspolitik auf die Grundsätze der Chancengleichheit im Sinne der bundesrätlichen Strategie Gesundheit2030 und des Tessiner Gesundheitsgesetzes ist ein entscheidender Schritt, um langfristige systemische Veränderungen zu erreichen.

Fazit

Das Projekt EquiTI ist ein Beispiel für das Potenzial der partizipativen Aktionsforschung zur Förderung eines systemischen Wandels im Gesundheitswesen. Durch die Auseinandersetzung mit der Chancengleichheit als Kernelement der Versorgungsqualität wurde im Rahmen des Projekts ein reproduzierbares Modell zur Förderung einer gerechten und patientenzentrierten Versorgung in unterschiedlichen Kontexten geschaffen.

Résumé

Introduction

Le projet pilote Equity Ticino « Droits des patient.e.s, équité et qualité dans les pratiques hospitalières » 2023-2024 est le fruit d'une collaboration entre le groupe hospitalier *Ente Ospedaliero Cantonale* (EOC) et la Haute école spécialisée de la Suisse italienne (SUPSI), financé par l'Office fédéral de la santé publique (OFSP). Cette initiative, qui s'inscrit dans le cadre de la stratégie Santé2030 du Conseil fédéral, traite des inégalités en matière de prestations de soins en mettant l'accent sur l'identification et le soutien des patient.e.s issus de la migration, en particulier de la migration forcée. Mis en œuvre au sein de l'hôpital régional *Beata Vergine* à Mendrisio, ce projet participatif visait à développer des outils pratiques en faveur de soins plus équitables. La conduite du projet a également bénéficié de l'intérêt du canton du Tessin et plus précisément de l'Office du médecin cantonal.

Objectifs et portée

L'étude vise à améliorer la capacité du système hospitalier à promouvoir et à garantir les droits des patient.e.s en renforçant les connaissances des professionnels, des autorités et des établissements de santé. Son principal objectif est d'examiner les facteurs de vulnérabilité sociale des patient.e.s et d'améliorer la qualité des soins. Elle a également pour but majeur de promouvoir des soins équitables, de développer des outils de suivi de l'équité, de former les professionnels de la santé et d'établir des systèmes permettant d'identifier les facteurs de vulnérabilité des patient.e.s et de mettre en œuvre le soutien approprié.

Méthodologie

Au moyen d'un cadre de recherche-action participative, la méthodologie employée consistait à évaluer la capacité du système hospitalier à promouvoir et à garantir équitablement les droits des patient.e.s au moyen d'une analyse ethnographique des processus et des pratiques en matière de soins. L'équipe s'est appuyée sur les observations réalisées pour définir et tester des indicateurs d'équité spécifiques. Elle a ensuite élaboré, testé et partagé des solutions aux problèmes identifiés. Une telle approche invitait les professionnels, les patient.e.s et les équipes pluridisciplinaires à définir conjointement des solutions pratiques et adaptées au contexte en mettant l'accent sur la réflexion, la cocréation de connaissances et l'empowerment.

Principaux résultats

Le projet a favorisé une culture d'apprentissage et de réflexion sur les questions d'équité en santé. La dynamique de recherche-action en matière d'équité a favorisé l'élaboration de nouveaux outils, pratiques et processus pouvant être adaptés à d'autres contextes de soins. En effet, il est possible de transposer EquiTI à d'autres institutions cherchant à promouvoir l'équité en santé grâce à des innovations aussi bien au niveau clinique qu'au niveau institutionnel. Les principaux résultats sont les suivants :

1. **Apprentissage en ligne pour les professionnels de la santé :**
   Des modules de formation axés sur l'équité, le droit cantonal en matière de santé et la communication interculturelle. Plus de 30 collaborateurs ont participé, jetant ainsi les bases d'une adoption à plus grande échelle.

2. **Système de triage selon la vulnérabilité :**
   Un outil systématique s'appuyant sur des indicateurs tels que la barrière de la langue et l'isolement social pour identifier les patient.e.s vulnérables. Ce système permet de mettre en œuvre rapidement les services de médiation et les services sociaux.

3. **Enquête de satisfaction auprès des patient.e.s :**
   Une étude sur mesure a permis de recueillir l'avis des patient.e.s sur la clarté de la communication et le respect des spécificités culturelles, fournissant ainsi des enseignements sur la manière d'améliorer les pratiques.

L'approche participative a permis aux parties prenantes de jouer un rôle actif (empowerment) et de veiller à ce que les solutions définies s'intègrent bien aux flux de travail existants. Le projet a également montré comment mettre en œuvre des indicateurs d'équité afin de contrôler et d'améliorer la qualité des pratiques cliniques.

Avantages et innovations

1. L'approche consistant à greffer l'élaboration d'indicateurs d'équité sur le concept de capabilités[3] permet d'identifier et d'assurer le suivi des mesures d'amélioration. En outre, elle donne lieu à des débats et à une expertise sur le sujet.

2. Mettre en lien la question de l'équité et les dispositions légales au moyen d'une observation des pratiques quotidiennes en matière de soins constitue un point de départ pertinent pour impliquer, à tous les niveaux, les professionnels des secteurs social et administratif.

3. La méthodologie de recherche-action participative utilisée recèle un fort potentiel de transformation à moyen terme. L'échange de connaissances scientifiques, professionnelles et pratiques fondées sur des observations ethnographiques engendre une collaboration interdisciplinaire dont peuvent émerger des questions et des réponses pertinentes, adaptées à des contextes spécifiques.

4. Impliquer progressivement des professionnels actifs lors de la mise en œuvre de projets en vue d'améliorer la capacité de leur système à fournir des soins équitables et de qualité permet de renforcer l'autonomie des individus et de l'organisation. L'autonomisation confère à la question de l'équité un caractère « important et urgent », tel qu'en bénéficient déjà les questions de rentabilité, de sécurité des patient.e.s ou encore d'efficacité.

Difficultés et enseignements tirés

Parmi les difficultés recensées, on relève principalement la nature imprévisible des échéances lors de travaux participatifs et la nécessité d'améliorer les stratégies de communication entre les différents niveaux hiérarchiques des partenaires du projet. Toutefois, le processus itératif a démontré qu'il était efficace de lier l'équité aux cadres juridiques et de mettre l'accent sur la communication pour parvenir à un changement systémique.

Recommandations

1. **Institutionnaliser l'équité dans les pratiques de soins**
   Les établissements de santé devraient avoir pour priorité d'intégrer l'équité dans leurs pratiques de base, notamment en développant et en adoptant des outils de triage systématique de la vulnérabilité, afin d'identifier et de traiter les inégalités en santé lors de l'admission et de la prise en charge des patient.e.s. Institutionnaliser ces outils afin

[3] L'approche par les capabilités est un cadre conceptuel axé sur deux principes fondamentaux : premièrement, l'idée que la liberté d'atteindre le bien-être est une priorité morale essentielle, et deuxièmement, la notion que le bien-être devrait être évalué selon les capabilités des individus et leurs accomplissements. Les capabilités représentent les diverses actions et conditions que les personnes ont le potentiel de concrétiser si tel est leur choix, par exemple rester en bonne santé, suivre une formation, établir des relations ou explorer le monde. Les accomplissements, en revanche, correspondent aux réalisations tangibles de ces capacités.

qu'ils relèvent des opérations de routine des établissements de santé permet de garantir des soins plus équitables pour tous les patient.e.s.

2. **Promouvoir la collaboration interdisciplinaire et l'empowerment**
   Le projet EquiTI a démontré que les responsables des établissements de santé devraient promouvoir une collaboration interdisciplinaire au sein des équipes de soins. La recherche-action participative encourage une participation active de toutes les parties prenantes, y compris des prestataires de soins, des patient.e.s et des services sociaux. Renforcer la capacité d'action du personnel à tous les échelons, du personnel médical au personnel administratif, peut contribuer à rendre les prestations de soins plus inclusives et efficaces.

3. **Élargir et amplifier les programmes de formation en matière d'équité**
   Il est essentiel de développer les initiatives de formation afin de garantir que les professionnels de la santé soient en mesure de répondre aux vulnérabilités sociales complexes des patient.e.s. Il conviendrait d'inclure des programmes de formation spécifiques et des modules d'apprentissage en ligne portant sur l'équité, la sensibilité culturelle et la communication dans les programmes de formation continue, en particulier ceux destinés au corps médical. Les décideurs politiques et les établissements de santé devraient soutenir l'élaboration de cursus de formation qui tiennent compte des déterminants sociaux de la santé et intègrent le cadre juridique relatif à l'équité dans les pratiques de soins quotidiennes.

4. **Renforcer le suivi et l'évaluation**
   Il est crucial d'assurer un suivi et une évaluation continus des interventions en matière d'équité. Les établissements de santé cantonaux devraient adopter des indicateurs de qualité liés à l'équité, tels que la satisfaction des patient.e.s, l'identification des facteurs de vulnérabilité et la mobilisation des services de soutien (p. ex. travail social, médiation culturelle). Le projet EquiTI a montré qu'il était essentiel de solliciter des retours réguliers de la part des patient.e.s vulnérables afin d'améliorer la communication et les soins dans leur ensemble. Les décideurs politiques et les établissements de santé devraient promouvoir le recours à des enquêtes centrées sur les patient.e.s comme outil pour améliorer continuellement les soins.

5. **Plaider pour des changements systémiques dans les politiques**
   Aux niveaux national et cantonal, il est impératif que les décideurs politiques plaident pour des réformes systémiques visant à intégrer l'équité dans les politiques de santé. Il s'agit notamment de financer et de soutenir le suivi systématique et la recherche sur les inégalités en santé à l'échelon fédéral ainsi que d'inciter les établissements et les acteurs de la santé à adopter des pratiques socialement innovantes pour traiter les causes profondes des disparités en santé au niveau cantonal. Aligner les politiques de santé sur les principes constitutifs de l'équité tels qu'ils sont définis dans la stratégie suisse Santé2030 et la législation tessinoise sur la santé représente une étape cruciale vers un changement systémique à long terme.

Conclusion

Le projet EquiTI illustre le potentiel de la recherche-action participative pour parvenir à un changement systémique dans les soins. En traitant l'équité comme un facteur essentiel de qualité, ce projet a permis de créer un modèle reproductible de promotion de soins équitables et centrés sur les patient.e.s dans divers contextes.

Sintesi

Introduzione

Il progetto pilota Equity Ticino: "Diritti dei pazienti, equità e qualità nelle pratiche ospedaliere" 2023-2024 è una collaborazione tra l'Ente Ospedaliero Cantonale (EOC) e la Scuola Universitaria Professionale della Svizzera Italiana (SUPSI), finanziata dall'Ufficio federale della sanità pubblica (UFSP). L'iniziativa, allineata alla Strategia sanitaria svizzera 2030, affronta le disuguaglianze nell'erogazione dell'assistenza sanitaria concentrandosi sull'identificazione e sul sostegno della vulnerabilità sociale dei pazienti con background migratorio, in particolare con background migratorio forzato. Realizzata presso l'Ospedale Regionale Beata Vergine di Mendrisio, questa ricerca-azione partecipativa mirava a creare strumenti pratici per migliorare l'equità delle cure. Il progetto di ricerca è stato condotto anche con l'interesse del Canton Ticino, in particolare dell'Ufficio del medico cantonale.

Obiettivi e campo di applicazione

Questo progetto ha sviluppato la capacità del sistema ospedaliero di promuovere e garantire i diritti dei pazienti, migliorando le conoscenze degli operatori sanitari, delle autorità sanitarie e delle istituzioni. L'obiettivo primario è affrontare le vulnerabilità sociali dei pazienti e migliorare la qualità dell'assistenza sanitaria. Gli obiettivi principali includono la promozione di un'assistenza sanitaria equa, lo sviluppo di strumenti per monitorare l'equità, la formazione degli operatori sanitari e la creazione di sistemi per identificare le vulnerabilità dei pazienti e attivare un supporto adeguato.

Metodologia

Utilizzando un quadro di ricerca-azione partecipativa (RAP), la metodologia prevedeva la valutazione della capacità del sistema ospedaliero di promuovere e garantire equamente i diritti dei pazienti attraverso un'analisi etnografica dei processi e delle pratiche assistenziali. Discutendo le osservazioni, il team ha definito e testato specifici indicatori di equità. Le soluzioni ai problemi identificati sono state poi sviluppate, testate e condivise. Questo approccio ha coinvolto professionisti, pazienti e team interdisciplinari per co-creare soluzioni pratiche e sensibili al contesto, enfatizzando la riflessione, la co-creazione di conoscenza e l'empowerment.

Risultati principali

Il progetto ha favorito una cultura dell'apprendimento e della riflessione sui temi dell'equità sanitaria. Questa dinamica di ricerca-azione sull'equità ha permesso lo sviluppo di nuovi strumenti, pratiche e processi che possono essere adattati ad altri contesti assistenziali. EquiTI è infatti generalizzabile ad altre istituzioni interessate a promuovere l'equità nelle cure, portando innovazione sia a livello clinico che istituzionale. Si possono individuare i seguenti risultati chiave:

1. **E-Learning per gli operatori sanitari:**
   moduli di formazione incentrati sull'equità, sulla legge sanitaria cantonale e sulla comunicazione interculturale. Oltre 30 membri del personale hanno partecipato, gettando le basi per un'adozione più ampia.

2. **Sistema di triage della vulnerabilità:**
   uno strumento sistematico che utilizza indicatori come le barriere linguistiche e l'isolamento sociale per identificare i pazienti vulnerabili. Questo sistema consente di attivare rapidamente i servizi di mediazione e sociali.

3. **Sondaggio sulla soddisfazione dei pazienti:**
   un sondaggio personalizzato ha raccolto feedback sulla chiarezza della comunicazione e sul rispetto delle specificità culturali, offrendo spunti per perfezionare le pratiche.

L'approccio partecipativo ha responsabilizzato le parti interessate e ha garantito che le soluzioni fossero ben integrate nei flussi di lavoro esistenti. Il progetto ha inoltre dimostrato come gli indicatori di equità possano essere resi operativi per monitorare e migliorare la qualità delle pratiche cliniche.

Punti di forza e innovazioni

1. L'innesto del lavoro di sviluppo di indicatori di equità sul concetto di capabilità[4] è un approccio che consente di identificare e monitorare le attività di miglioramento e di generare dibattito e competenze sul tema.

2. Collegare la questione dell'equità alle disposizioni di legge attraverso l'osservazione delle pratiche assistenziali quotidiane è un punto di partenza efficace per coinvolgere i professionisti sociali e amministrativi a tutti i livelli.

3. La metodologia di ricerca-azione partecipativa utilizzata ha un forte potenziale di trasformazione a medio termine. Lo scambio di conoscenze scientifiche, professionali e pratiche basate sull'osservazione etnografica porta a una collaborazione interdisciplinare in grado di generare domande e risposte efficaci adattate a contesti specifici.

4. La creazione di una dinamica di coinvolgimento graduale dei professionisti attivi nel contesto dell'implementazione del progetto per migliorare la capacità del loro sistema di fornire cure eque e di qualità responsabilizza gli individui e l'organizzazione. L'empowerment crea un "senso di importanza e urgenza" intorno alla questione dell'equità, come già accade per altre questioni quali l'efficacia dei costi, la sicurezza dei pazienti o l'efficienza.

Sfide e lezioni apprese

Le sfide principali sono state l'imprevedibilità delle tempistiche di partecipazione e la necessità di migliorare le strategie di comunicazione tra i diversi livelli gerarchici dei partner del progetto. Tuttavia, il processo iterativo ha dimostrato che collegare l'equità ai quadri giuridici e concentrarsi sulla comunicazione erano strategie efficaci per il cambiamento sistemico.

Raccomandazioni

1. **Istituzionalizzare l'equità nelle pratiche sanitarie**
   Le istituzioni sanitarie devono dare priorità all'integrazione dell'equità nelle loro pratiche principali. Ciò include lo sviluppo e l'adozione di strumenti sistematici di triage della vulnerabilità per identificare e affrontare le disuguaglianze sanitarie durante l'accoglienza e la cura dei pazienti. L'istituzionalizzazione di questi strumenti come parte delle operazioni di routine delle istituzioni sanitarie può garantire un'assistenza più equa per tutti i pazienti.

[4] L'approccio delle capabilità è un quadro concettuale incentrato su due principi fondamentali: in primo luogo, l'idea che la libertà di raggiungere il benessere sia una priorità morale cruciale e, in secondo luogo, l'idea che il benessere debba essere valutato in base alle capacità e agli stati raggiunti dagli individui. Le capacità rappresentano le varie azioni e condizioni che le persone possono potenzialmente realizzare se lo scelgono, come mantenere una buona salute, proseguire gli studi, instaurare relazioni o esplorare il mondo. I funzionamenti, invece, sono le realizzazioni tangibili di queste capacità.

2. **Favorire la collaborazione interdisciplinare e l'empowerment**
   I responsabili delle istituzioni sanitarie dovrebbero promuovere la collaborazione interdisciplinare all'interno dei team sanitari, come dimostrato dal progetto EquiTI. La RAP incoraggia il coinvolgimento attivo di tutte le parti interessate, compresi gli operatori sanitari, i pazienti e i servizi sociali. La responsabilizzazione del personale a tutti i livelli, dal personale medico agli amministratori, può facilitare una fornitura di assistenza sanitaria più inclusiva ed efficace.

3. **Ampliare e scalare i programmi di formazione sull'equità**
   Per garantire che gli operatori sanitari siano in grado di affrontare le complesse vulnerabilità sociali dei pazienti, è essenziale ampliare le iniziative di formazione. Programmi di formazione specifici, moduli di e-learning incentrati sull'equità, la sensibilità culturale e la comunicazione dovrebbero essere incorporati nei programmi di sviluppo professionale, soprattutto dei medici. I politici e le istituzioni sanitarie dovrebbero sostenere lo sviluppo di programmi di formazione che riflettano i determinanti sociali della salute e integrino i quadri giuridici per l'equità nelle pratiche di cura quotidiane.

4. **Rafforzare il monitoraggio e la valutazione**
   Il monitoraggio e la valutazione continui degli interventi per l'equità sono fondamentali. Le istituzioni sanitarie cantonali dovrebbero adottare indicatori di qualità relativi all'equità, come la soddisfazione dei pazienti, l'identificazione delle vulnerabilità e l'attivazione di servizi di supporto (ad esempio, assistenti sociali, mediatori culturali). Il progetto EquiTI ha dimostrato che un feedback regolare da parte dei pazienti vulnerabili è fondamentale per migliorare la comunicazione e l'assistenza complessiva. I politici e le istituzioni sanitarie dovrebbero incoraggiare l'uso di sondaggi incentrati sul paziente come strumento per il miglioramento continuo dell'assistenza.

5. **Promuovere cambiamenti politici sistemici**
   A livello nazionale e cantonale, i politici devono promuovere riforme sistemiche che integrino l'equità nella politica sanitaria. Ciò include il finanziamento e il sostegno di un monitoraggio e di una ricerca sistematici sulle disuguaglianze sanitarie a livello federale, nonché l'incentivazione delle istituzioni e degli attori sanitari ad adottare pratiche socialmente innovative che affrontino le cause alla radice delle disparità sanitarie a livello cantonale. Allineare le politiche sanitarie ai principi di equità, come indicato nella Strategia sanitaria svizzera 2030 e nella Legge sanitaria ticinese, è un passo fondamentale per ottenere un cambiamento sistemico a lungo termine.

Conclusioni

Il progetto EquiTI esemplifica il potenziale della ricerca-azione partecipativa per guidare il cambiamento sistemico nell'assistenza sanitaria. Affrontando l'equità come elemento centrale della qualità, il progetto ha creato un modello replicabile per promuovere un'assistenza equa e centrata sul paziente in contesti diversi.

Introduction

The EquiTI (Equity Ticino) project is a collaboration between the Ente Ospedaliero Cantonale (EOC) and the University of Applied Sciences of Southern Switzerland (SUPSI) on behalf of the Federal Office of Public Health (FOPH). In line with the Swiss Health Strategy 2030 and the Federal Quality Strategy, the project aims to promote equitable care for patients. The principles of equitable care are also enshrined in the health law of the canton of Ticino, a context in which multiculturalism of both carers and patients is the norm. However, despite these guidelines, the hospital environment, with its practices and procedures, makes it difficult to quickly identify the social vulnerability of patients. This invisibility of vulnerable situations on the part of the system can delay specific care, resulting in longer and more discontinuous treatment pathways, repeated visits to the emergency department or even potentially avoidable rehospitalisation. All these situations, where there is a correlation with language, nationality, age, gender, educational level or even employment status, reveal a problem in terms of equity of care.

The EquiTI project is a participatory action research aimed at responding to these challenges by developing innovative solutions. The principles guiding innovation in social work are the democratisation of knowledge, such as the recognition of professional and patient knowledge, together with the idea of creating solutions not 'for' society, but 'with' society (Maeder et al., 2024). Project activities are therefore participatory and circular, i.e. they always aim to create a dynamic in which one activity inevitably implies involvement in a subsequent one, involving more and more people, including carers and patients. This type of approach aims to promote the development of a shared culture in a community, in this case a 'culture of equity'.

The pilot project was developed at the Regional Hospital of Mendrisio (OBV), as this hospital site, in addition to immediately joining the Migrant Friendly Hospitals programmes since 2012, has over time developed a series of services and tools to improve the care of migrant patients. With private funding, the hospital has equipped itself with a cultural mediation service since 2017, and with an Innosuisse fund, it has further developed and consolidated the operation and territorial networking of this service. The hospital, which is now an active member of the Swiss Health Network for Equity, has also committed itself to the PRIORITY project – Panorama of Indicators on Equity in Healthcare[5] - also mandated by the FOPH, thus demonstrating a strong institutional will to work on the issue of equity. This wealth of experience has made the OBV Hospital a privileged site for the development and implementation of the EquiTI project. Thanks to the support of the Federal Office of Public Health, the hospital, together with its research partner SUPSI, developed this participatory action research project over a period of two years, with a one-year extension to allow for the development and further consolidation of the tools and to prepare for their dissemination to other EOC sites. The research project has also been carried out with the interest of the Canton of Ticino, in particular by the Office of the Cantonal Physician, whose suggestions were collected at the beginning of the project, followed by ongoing progress updates, and to whom the final results of the project will be presented in the first half of 2025.

The project team had to work on the creation of a common language for the interdisciplinary group and the continuous involvement of different internal and external experts throughout.

[5] PRIORITY Study – Panorama of Indicators on Equity Healthcare. Study mandated by the Federal Office of Public Health. Bern: FOPH.
Associated publication:(Buclin et al., 2024).

Transdisciplinarity facilitated the integration of very different points of view and the identification of original solutions. Participatory action research of this kind requires time and professionals who are willing to get involved and who share the premise that equity of care is central to hospital practice.

During the pilot project, the EOC-SUPSI project team identified challenges related to the identification of vulnerable patients, the training of caregivers and the ability to capture the point of view of socially disadvantaged patients, as they are typically not the ones activated through the usual quality and patient safety service channels. Three social innovations were therefore designed, developed and tested as solutions: a vulnerability triage system, e-learning training for all caregivers and finally a patient-specific survey focusing on the assessment of inpatient communication.

The research project has also been carried out with the interest of the Canton of Ticino, in particular by the Office of the Cantonal Physician, whose suggestions were collected at the beginning of the project, followed by ongoing progress updates, and to whom the final results of the project will be presented in the second half of 2025.

These innovative solutions were designed to be interdependent. The e-learning product was created to train staff on equity issues, with the aim of levelling knowledge and improving awareness of the importance of early identification of vulnerable patients. With improved knowledge, staff can activate appropriate social resources within the hospital and use the specific outreach tools developed in the hospital for this population. This in turn has an impact on the overall care of vulnerable patients, leading to a better perception of the quality of care, with a particular focus on the quality of communication and information received during their hospital stay. In addition to monitoring improvements in care, the surveys are also a tool for continuous training updates, as they can identify gaps in staff training. The interdependence of the project products was intended to create a virtuous circle that could potentially continue to support the community in improving the quality of care provided. In fact, it is not so much the 'what' that was proposed by the group and implemented organisationally, but rather the 'how'.

This final project report therefore focuses mainly on the research and development process that led the team to make EquiTI replicable in other care contexts. If EquiTI were to be developed elsewhere, the very nature of such a participatory social innovation project means that it could also lead to different products specific to the reality and context in which it is implemented.

1. Project background

1.1 Equity in Healthcare

Equity is an integral part of quality in the provision of services in the public interest, and therefore in hospital care. From a scientific point of view, equity in access to care does not mean equality and this aspect is becoming central in a society that is becoming less homogeneous in terms of conditions, needs and individual preferences, even in Switzerland (De Mestral et al., 2022; Guggisberg et al., 2020; Spiess & Schnyder-Walser, 2018; Weber, 2020)

The topic of health inequalities is one of the central issues in public health (Fassin & Hauray, 2010). For too long, it has been assumed that population health has improved as a result of

technological and clinical developments in medicine. However, public health studies have clearly shown that, on the contrary, while the overall epidemiological situation has improved, inequalities and gaps between social categories have not changed over the years. In some cases, they have even increased over the last 50 years. Switzerland, the context of this project, is no exception, as evidenced, for example, by studies of treatment during the SARS-COVID 19 pandemic (Hahn & Schoch-Spana, 2021; Mesa Vieira et al., 2020; Nezafat Maldonado et al., 2020; Rosenstein et al., 2022).

Fassin and Hauray focus their attention on the study of the social determinants of health as factors that have been shown to have an impact on the problem, and propose to address the issue of access to health through the concept of capital: economic, cultural, social and physical. The same approach is also taken, with reference to our country, in the recent report published by Health Promotion Switzerland and the Federal Office of Public Health, which analyses the situation and proposes future policy interventions by applying the concept of health inequalities (Weber, 2020). Finally, for an overview of the basic data on health inequalities in Switzerland, it is useful to consult the work of Spiess and Schnyder-Walser (2018), which highlights the inequalities that can still be observed in the field of health.

As defined by the WHO, health equity is "the absence of avoidable or correctable differences between different groups of people defined by social, economic, demographic, or geographic factors.

Although the issue is recognised and included in the vision and mission of hospitals in the context of quality and patient safety, at the organisational level it is difficult to identify areas of intervention for what appears to be a systemic problem. The starting question was to understand where equity is at stake in hospital practices and procedures. Therefore, rather than focusing on understanding whether the system is inequitable at a local level, the question was where and how does care become inequitable at the Hospital of Mendrisio and how do we identify the right resources for carers and patients to act on this issue?

1.2 Correlation between cantonal health law, quality and equity in hospital practices

In Switzerland and at the cantonal level, the legal framework for health provides access to health for all. This was the starting point of the project and the theme on which the various partners worked.

The Ticino health law contains several articles that aim to ensure equal treatment in health matters, regardless of the patient's demographic, geographical or socio-economic characteristics. In particular, two articles of the health law contain elements or provisions that can be directly linked to the concept of equality and non-discrimination:

> Art. 2 - Purpose
>
> (...)
>
> (The State) (...) promotes (...) (the) health of all citizens without distinction of individual and social status.
>
> (...)

Article 17 - Health Benefits

(...)

2. (...) (G) health professionals may not make the granting or provision of emergency health services conditional on insurance, social, religious, nationality or other conditions of the patients. (...)

The subject of equity is interesting to study, particularly because of the way in which the articles of the Ticino Health Law are interpreted in the procedures and practices of health professionals.

In this sense, other articles (or paragraphs) of the same law contain elements that, although they do not explicitly refer to the concept of equity, are worthy of interest because the way in which they are implemented can have important implications for the substantive equity of hospital care.

Art. 2 - Purpose

1. The State promotes and safeguards the health of the population (...) while respecting the freedom, dignity and integrity of the human person.

(...)

Art. 3 - Means

(...) the purposes of Article 2 shall be achieved in particular by:

(a) the protection of patients' individual freedoms and their psychophysical integrity;

(b) the education and health promotion of the population (...);

(...)

(d) the promotion of early diagnosis of treatable diseases (...) as well as the fight against social and widespread diseases and drug addiction;

(...)

m) the dissemination of palliative care towards the chronically and terminally ill.

Art. 6 - Information

1. Every health professional, within the scope of his or her professional competence, is required to inform the patient about the diagnosis, the treatment plan, the possible risks as well as any scientifically recognised alternative treatments. The information must be given in a clear and accessible manner to the patient and take account, in particular when communicating the diagnosis, of the patient's personality. Only if the information is likely to be seriously detrimental to the patient's psychophysical state or compromise the outcome of the treatment should it be given to a close person.

2. If the patient is incapable of discernment, the information shall be given to the trusted person designated by the patient, to the minor patient's legal representative or to persons with the right of representation (...).

3. The patient has the right, upon written request and within the time limits set out in Art. 67, para. 4, to consult the objective part of the health record and other objective health documents concerning him/her at any health professional, service or other health facility, and to obtain a copy thereof. (...)

4. The health care provider is not obliged to bring to the patient's knowledge or make available to the patient health information received from third parties (excluding objective data from laboratory analyses, radiological examinations or others) as well as personal observations. (...)

5. The patient has the right to know the names and professional qualifications of any health professional who participates or intervenes in the care or treatment.

Art. 7 - Informed consent

1. (...) (I)he informed consent of the patient capable of discernment, whether he is an adult or a minor, is required for any healthcare service (preventive, diagnostic, therapeutic, rehabilitative) proposed to him.

2. (...) (S)he capacity of discernment is presumed in minors who have reached the age of sixteen.

3. Consent (...) may also be expressed tacitly by implicit acts in the case of health services that are non-invasive or do not entail a significant risk for the patient or are not likely to invade the patient's intimate sphere.

Article 8 - Advance Directives and Precautionary Mandate

1. A person who is capable of discernment may, in binding directives, designate the medical measures to which he/she accepts or refuses to be subjected in the event that he/she becomes incapable of discernment and/or designate a natural person to discuss the medical measures with the attending physician and decide on his/her behalf in the event that he/she becomes incapable of discernment.

(...)

Art. 9 - Resignation

1. A patient who is capable of discernment may revoke his or her consent at any time and thus discontinue treatment, refuse healthcare services or discharge from an in-patient facility.

(...)

Art. 18 - Conscientious objection

(...)

3. The objector must in any case give the patient the information necessary for obtaining, by means of

other health professionals, of the services refused.

(...)

Art. 19 - Inpatient health facilities

1. (...) patients have the right to spiritual assistance, accompaniment of death and the presence of close persons. Inpatient care must not deprive the patient of any civil and constitutional rights.

2. (...) (R)estrictions concerning visits must be based solely on overriding health and/or organisational grounds.

(...)

It is the application of these articles that may or may not be equitable in itself. That is, patient rights such as the right to information, informed consent, advance directives, free choice, restraint and treatment without consent, professional confidentiality, access to medical records, the right to be accompanied, or organ and tissue donation, are all open to interpretation with or without sensitivity to the differences in our society.

Ensuring equal rights requires the integration of an equity approach into professional procedures and practices, taking into account the different resources available to people. The reference here is to the “capabilities approach” developed by Amartya Sen, a theoretical framework that is also of interest in the field of health (Abel & Frohlich, 2012; Anand & Dolan, 2005; Sen, 2002)This approach can also be found in the ICF (International Classification of Functioning, Disability and Health) model, in which health and 'diversity' are no longer considered as an

individual dimension, but as a social one. The vision of diversity promoted by the capabilities approach thus shifts the focus from the person as the bearer of potential deficits to the interaction between the person and the environment/society. Specifically, capabilities is a concept that aims at analysing devices, processes, architectural structures, etc., in terms of their capacity to accommodate diversity, i.e. how many opportunities there are in a given context for the individual to choose and act freely and thus assert his or her rights.

Considering the equity dimension in hospital procedures and practices to promote and guarantee patients' rights was proposed to the partners as an opportunity to improve the quality of care without social, economic or cultural discrimination. Starting from the observation that it is not always clear where "equity and patients' rights" are at stake at the organisational, process and system levels, the common challenge was to be able to promote the co-construction of tools to improve knowledge and skills on equity, the capacity for self-assessment and finally the monitoring of one's own hospital practices and procedures.

2. Objectives and scope of the project

In a social innovation project, the first objective is to make the community itself the protagonist. After creating a sense of belonging and encouraging participation, the community is helped to formulate its specific and concrete needs in relation to the problem identified. This is followed by supporting the confrontation and integration of knowledge and skills within the group and the search for common solutions. These can be processes, tools or others. Finally, the group is helped to define its own monitoring system: on the one hand, to understand to what extent the innovations developed have an impact on the defined objectives and, on the other hand, to support the continuous identification of other aspects to be improved.

General objectives

EquiTI aims to develop and support the improvement of the quality of care, with particular reference to equity, by promoting the consideration of the social conditions of patients by caregivers from entry to exit, as well as the knowledge and, where necessary, the development of professional tools. Two general lines of work have therefore been identified:

- Active involvement of care professionals and involvement of patients in this issue. This means raising awareness, promoting the creation of expert groups and gradually involving all care professionals by developing original solutions and products.

- Creating a circular dynamic based on the ability of professionals to monitor their own practice, evaluate their own competence and identify possible points for improvement by comparing themselves with objective data and what the patients say, in order to constantly generate new targets for improvement.

Once adhesion has been created and participation encouraged, the community is accompanied in formulating its specific and concrete needs with respect to the identified problem. Following this, the confrontation and integration of knowledge and skills within the group and the search for shared solutions is supported. These may be processes, tools or other. Finally, the group is accompanied in defining its own monitoring system: on the one hand to understand the extent to which the innovations developed have an impact on the federating problem, and on the other hand to support the continuous identification of further aspects to be improved.

Specific objectives

The specific objectives (SO) of the pilot EquiTI were initially formulated with the Quality and Patient Safety Service, the Cultural Mediation Service and the hospital management, in collaboration with the SUPSI Centre for Research and Documentation on Migration. This was a first pilot group to launch and promote the project. The group's work was supported by a previous research experience in which different care situations were analysed, and the material was then reviewed during project preparation to identify correlations with the articles of the cantonal health law relating to equity in the organisation of work and care in the hospital (see SO 5). On this basis, the following objectives were formulated

1. Creation of a joint project group capable of monitoring, evaluating and possibly reformulating care practices and tools available to caregivers by identifying possible new challenges for the quality of care in terms of equity;

2. Supporting and coordinating the project team in developing a set of indicators that can guide innovation in this context and promote its transferability to others;

3. Informing and training health care personnel on equity issues, particularly as they are enshrined in health legislation that frames care practices in their own contexts;

4. Improving the hospital system's ability to identify and integrate patients' social vulnerabilities into treatment plans from the moment of admission and at all subsequent stages, through better knowledge of patients;

5. Creating support tools that make the integration of vulnerability a functional element of the care plan, without overburdening caregivers.

3. Methodology

EquiTI is a participatory action research (PAR) project in the field of social innovation in public health. PAR is a distinctive methodological approach that combines research and practical intervention to generate meaningful knowledge through the active participation of stakeholders.

The principles of this particular methodology, whose founding father is Kurt Lewin (1946), are as follows

1. Participation: The active involvement of participants in the research process, ensuring that their voices and experiences are integrated.

2. Cycle of reflection and action: An iterative process of planning, action, observation and reflection that allows for learning and adaptation along the way.

3. Co-creation of knowledge: Research is seen as a collective activity in which researchers and participants work together to generate new knowledge.

4. Contextualised: PAR takes into account the local context and the specific realities in which it is applied, making the results more relevant and practical.

5. Empowerment: The aim is to strengthen the capacities of participants, helping them to understand and address the challenges that affect them.

6. Critical reflection: The importance of analysing and critically reflecting on experiences and outcomes in order to improve the process and future outcomes.

7. Change-oriented action: PAR aims to bring about concrete changes at both individual and community level by addressing real problems.

In the PAR approach, participants are not just study subjects, but active collaborators who contribute to defining objectives, collecting data and analysing results.

This participation ensures that the experiences and voices of the subjects are represented and valued. Kurt Lewin (1946) introduced this idea of a cycle of action and reflection early on and emphasised the importance of participation. PAR is therefore based on a continuous cycle of planning, action, observation and reflection. This iterative approach allows participants to learn from experience and adapt strategies according to the results obtained. Each cycle feeds into the next, promoting continuous improvement. Peter Reason and Hilary Bradbury (2001) have explored the basic principles and practices of PAR in their work, particularly in the Handbook of Action Research, emphasising the importance of the co-creation of knowledge. Research is viewed as a collective activity (Reason & Bradbury, 2008). Researchers and participants work together to generate new knowledge, each contributing their own experience and expertise. This co-creation of knowledge leads to more relevant and applicable results. The PAR methodology also emphasises the importance of the local context and specific realities. This is crucial to ensure that the solutions developed are appropriate and relevant to the problems faced by the participants, making the research more effective. Finally, one of the main aims of PAR is to empower participants (Zuber-Skeritt, 1996). Through the research process, the skills and competences of those involved should be strengthened, helping them to understand and address the challenges that affect them.

Critical reflection is an essential part of the PAR process. Participants and researchers are encouraged to reflect on experiences and outcomes, analysing what worked and what could be improve. This process of reflection is crucial for learning and growth. PAR is a methodology that aims to bring about concrete changes at both individual and community level. The actions taken are not an end in themselves, but are aimed at solving real problems and improving the lives of those involved.

PAR offers a powerful and dynamic methodological approach to address complex issues and promote social change. Through active participation, knowledge co-creation and contextual focus, PAR not only contributes to the generation of new knowledge, but also promotes the empowerment of participants, leading to significant and lasting results.

From a methodological point of view, one wonders how such an approach can promote the transferability of a project to other places. However, although the focus is on the production of shared and situated knowledge and action, the reflexivity and questioning that guided the project team is an extremely valuable transferable product.

To illustrate the value of this project for other organisational contexts wishing to work on the complex issue of health equity, we can use a 'classic' example from the world of development cooperation.

Similar to the idea of promoting the development of food autonomy by providing a fishing rod instead of fish in a village by the river, this approach even aims at a more emancipatory step, i.e. providing the methodology for making the fishing rod and examples of its possible use, on the assumption that no community will be willing to invest in this work if it does not first recognize the issue of food autonomy as well as the interest of catching fish to respond to this problem.

In our case, it is necessary firstly to recognize that equity in health is a right of all patients and that it is necessary to improve this aspect in Switzerland, and secondly that equity is strongly correlated with the communication and relationship processes between patients and caregivers (see LSAN), but also between the different actors in the social and health network, as shown by the quality indicators (readmissions and use of emergency services).

4. Project phases: the project in practice

The EquiTI project is divided into two Work Packages (WP), each of which is subdivided into several phases, which are described below. WP1 is a work package for the analysis, design, development and testing of innovative solutions. WP2 is dedicated to the communication and extension of the project to other hospital sites. WP1 was carried out with the project group of the Ospedale Regionale Beata Vergine in Mendrisio, while WP2 also involved the General Management, in particular the Quality and Patient Safety Service of the EOC. Given the inductive methodology of the project, WP2 was reformulated by the project group during the course of the project and became a consolidation package of the pilot project in order to allow its extension in the future. This change was initiated by the project team when discussing the expansion strategy, as critical issues and challenges emerged that the project needed to respond to before taking a step outward. The concept behind this decision was that, taking into account the experience of 'contamination' of other innovations between different hospitals, a strategy of generating demand from the other institutions themselves was chosen. According to the expert group, in order to attract the interest of other sites, a project needs to be attractive and appear useful and well-functioning, clearly presenting itself as a benefit to the organisation requesting its implementation. This local knowledge and experience of the group members was valued in line with the social innovation approach and supported the group's decision to reformulate WP2 as a consolidation. The change was conceived as functional to the achievement of the WP2 objective, which remained unchanged, i.e. to extend the EquiTI project to other hospital sites in the Canton of Ticino. Forcing the transfer prematurely could also have had a negative impact on what had been developed internally by undermining the project team, a fundamental element of the participatory action research approach.

4.1 Work Package 1

4.1.1 Analysing the situation and developing innovative solutions

The first phase was aimed at producing and sharing data and information on the subject and at consolidating the project group. This phase allowed the group to shift its gaze and translate the theoretical concepts, in this case those inherent to equity, into professional and local terms. It is a matter of observing, in care practices and practices, "what one talks about and what one actually deals with" in the care relationship. After reformulating the terms and translating the

knowledge into local and localized knowledge, analysis and discussion by the group was promoted, also stimulating the integration of possible external viewpoints. The group aimed to identify the challenges and needs of their organization. Once this is done, it is ready to outline the activities to be carried out, organizing the group from the planning to the distribution of tasks.

To carry out this phase, it was necessary to use different methodologies specific to participatory action research. The use of ethnography was proposed in order to learn in detail about procedures (analysis of documents and tools used by caregivers) and care practices. In addition, situations of care for vulnerable patients were collected and analyzed (through social services or mediation services) to illustrate possible problems of equity specific to the organization. The ethnography aimed to concretize equity, i.e. to answer the question: Where and when is equity in patient care at stake in this organization? The observations and clinical vignettes were useful for the construction of the interviews with nursing staff and with experts on equity in care, both internal (General Management, Quality and General Patient Safety Service) and external to the hospital (consumer associations, cantonal doctor). At this stage, the intervention of a coordinator from outside the group was necessary, who could be a researcher already active or active for the survey, on condition that he/she is competent in managing and leading groups and capable of activating a cooperative learning dynamic.

The research partner deepened the data and confronted the pilot group of the project (the initiators) to outline initial hypotheses, to identify and involve new key persons in the light of the "places" of the organization where equity was at stake. Through the confrontation with the data and the involvement of the heads of the various hospital services or clinical experts identified, the group was developed into an operational group for the project.

At the first meeting, the group discussed the data collected and the proposed analysis. It should be noted that data analysis of ethnographic observations is also carried out with the help of professional experts. This means that scientific knowledge and professional knowledge were brought into dialogue from the beginning. From the analysis, possible innovations were proposed, already identified by the facilitating group and involving the other group members. The comparison of proposals was essential and leads to the development of further points of view, sometimes distorting and sometimes refining the hypotheses of the initial project group. In the case of this pilot project, hypotheses were reformulated over several months, refining and sometimes destroying certain ideas. It is therefore essential that the group is able to accommodate, integrate and possibly take the time to find a possible third way in the face of the criticality highlighted by one or another member of the group.

Each activity to be developed was then discussed and evaluated, always taking into account the SO (Specific Objectives) of the project in order not to deviate from the outline and to ensure that each member can take responsibility for it. During the design process, critical issues or unknowns arise that need to be verified in order to assess the feasibility and commitment required for the solutions envisaged by the group. It was therefore necessary to define and organize the verification of each point, so that the group could later come together with the necessary information to decide on the activities to be implemented.

This method was valid and effective for the development of innovative solutions, but it could lead to a certain unpredictability of the project schedule, which had to be adapted according to the needs of the group that was the focus of the piloting. For some solutions, piloting may be quick, for others it may be longer, especially for those innovations that affect more structural

aspects of the organization, such as the IT framework or internal transversal directives that go beyond the boundaries of the hospital and therefore the OBV site management. The minutes and summaries drawn up by the coordinator were therefore essential for highlighting and making sense of any deviations from the roadmap hypothesized in the initial design. This material, which makes up the project diary, was also fundamental for keeping track of and welcoming possible new group members during the project, by providing information on all the steps and reasoning developed by the project group.

4.1.2 Indicator development and testing strategy in the pilot project

The data from the qualitative research was analysed through discussions with experts on the topic from outside the project group (clinical ethics expert, quality and patient safety expert, consumer rights expert, public health expert). Based on the results, the project group has defined the challenges, how to address them and possible solutions to be implemented. The main concept around which the reflections and proposed solutions were developed is that of communication. According to the group's analysis, equity in clinical practice is closely linked to the organization's ability to relate to the patient's social vulnerability at different levels.

Three assumptions were shared by the group and related questions guided the social innovation and indicator development:

1. Equity depends on good communication between patients and carers about possible vulnerabilities: are the possible social and clinical vulnerabilities of patients identified by the system?
2. Equity depends on good communication between carers: how to monitor the quality of communication between professionals?
3. Equity depends on carers being aware that the social determinants of health are key elements in the whole care process and that it must be adapted to the patient's situation: how can carers' skills in terms of social and legal knowledge and communication skills be assessed?

From the analysis carried out by the project team, a fourth question arose which guided the implementation strategy:

- How can equity be monitored if there are no activities that are systematically and directly related to the factors that the group has identified as determinants of care processes?

This last question led the group to position itself and make explicit the need for the hospital to design and implement specific activities to improve the system's ability to provide equitable and quality care.

Concrete solutions were then developed in the form of tools for hospitals and caregivers onto which quality indicators could be grafted, innovative products with the potential to improve the quality of care and enable the production of equity monitoring data.

In analyzing the situation, the group identified the need to create a systematic tool for identifying vulnerabilities that would be less dependent on the sensitivity and competence of individual health workers. Secondly, the group highlighted the lack of adequate and systematic training

for all health workers on cantonal health law and patients' rights, equity in health and intercultural and inclusive communication in health care. Finally, the group recognized the lack of an effective system for listening to patients, especially the most vulnerable.

A first solution was to develop e-learning training for all healthcare staff. A second innovation was the development of a tool to collect patients' views on the quality of communication during hospitalisation. A third tool was developed to identify social vulnerability and activate social or mediation services. These products, which are presented in detail in the next chapter, were improved and tested in the second part of the project during WP2.

At the end of the first WP, the equity indicators associated with these products were tested, but did not yet fully correspond to what the group had developed in terms of their functioning. The vulnerability triage was initially implemented in a paper version due to the complexity of the changes in the hospital IT system. The e-learning training was prepared by a group of lecturers and subject matter experts and then placed on the hospital's internal moodle platform, but only tested by the project group and a few others. The collection of patients' views was carried out twice, with changes in the way the data was collected. The group was still not entirely satisfied, as the patient interviews were considered to be rather cumbersome to conduct and dependent on the work of the cultural mediator. Cultural mediation is a service that did not exist in other sites. This first pilot phase therefore produced remarkable results, but the objectives of automating triage, disseminating training and optimizing the survey were only partially achieved.

4.2 Work package 2

4.2.1 Situation analysis and extension organization

The second part of the project involved extending the products of WP1, the equity monitoring indicators, to other hospital sites, specifically from the Ospedale Regionale di Mendrisio to the other sites of the Ente Ospedaliero Cantonale.

In organising this phase, the project team was analysing the situation and objectives based on the results of the pilot phase of the first part. The development of the capacity to monitor and improve equity in patient care results in a series of specific products on which to base indicators. The questions to be answered in this second phase were the following

- How can specific products and indicators be transferred to other contexts?
- How to ensure that the extension environment is willing to invest in the adaptation of these products and their use in the clinic?

At this stage, it was essential for the group to define roles and pool their knowledge and networks to facilitate the construction of project communication strategies appropriate to the context and organizational culture. At this stage, the project team has expanded to include new partners who can facilitate the transfer.

4.2.2 Pilot project transfer strategy

The group worked on how best to engage and involve key actors from other hospital sites, recognizing the fundamental importance of the active participation of different actors with different roles within the hospital as a key ingredient in creating functional and workable solutions

to project objectives. Several observations emerged about the relationships between hospitals and departments that need to be taken into account when organizing the transfer. A key issue raised by the group was the need for what was perceived as a costly investment in order to use the products at other sites, as they had been developed by the end of the first phase. In other words, at the start of the second phase, when the products were assessed for transferability, the group felt that they were not sufficiently developed and consolidated in their use to make a credible case for their adoption in other hospital sites. It was therefore necessary to test the patient survey and online training for longer, to better assess their burden and impact and, above all, to insist on the objective of automating the triage activities still carried out on paper. The latter had not yet been achieved due to the time needed to implement the tool at the hospital IT level.

The group then drew up a strategy to extend the project by introducing activities to further develop and consolidate the products of WP1 within the Mendrisio Regional Hospital. As part of the strategy, it was decided to involve the General Management of the Ente Ospedaliero Cantonale in order to publicise the project activities and demonstrate the benefits and impact on the quality of care provided in the hospital. At the same time, it was decided to communicate the project transversally to the different departments (medicine, paediatrics, surgery) through the involvement of professionals working on several sites, in order to explore and assess how to promote the interest and subsequent adoption of these solutions.

The training of professionals and the promotion of events to disseminate equity issues were identified as key to promoting transfer by generating demand from partners. The project team therefore committed to continue these activities independently to achieve this objective beyond the end of WP2.

5. Pilot Project Products

5.1 E-learning training for staff

During WP1, the need for further training of staff, particularly doctors, on issues related to equity, patients' rights, health determinants and intercultural communication emerged. The question of being able to measure nurses' skills led to reflection on the existence of a possible indicator on this topic. The project team therefore decided to create a T0 situation in which there are carers and a T1 situation in which 30% of these carers have received training and are therefore more competent to provide equitable care. It is worth mentioning that the hospital's medical staff come from different cantons or even from abroad, so the group felt it was of paramount importance to provide basic training in cantonal health law, social determinants of health, networking and intercultural communication. For this reason, an e-learning training course was created, divided into three modules covering the above topics. The total duration of the training is about 30 minutes.

5.1.1 Indicator related to staff skills

Formulation	Number of (health) personnel who completed equity training

	Number of (health) personnel selected by management
Reference value (ideal)	Hospital health workers should complete e-learning training in an increasing proportion: 30% per semester

5.2 Patient satisfaction survey

To monitor the quality of outreach communication, it was recognised that it was difficult to get the point of view of the patients most at risk of inequity during treatment, both because of language barriers and because of the dynamics of the relationship between institutions - using traditional service data collection techniques - and vulnerable people. The project team therefore sought a solution to make the collection of this data feasible. Two problems were identified: identifying vulnerable people within the wards, and finding an appropriate way of communication to obtain their views. The solution was to use a vulnerability triage system (see below) and a telephone survey based on three simple questions and an open-ended section for patients to comment on their experience of care. The team identified the post-operative visit as the time to engage patients to collect their experiences. However, after an initial trial on the surgical ward, it was decided to abandon the use of the telephone and switch to an informal interview with the cultural mediator (or possibly a social worker) to collect data.

The surveys included questions about how well patients felt their cultural and linguistic specificity were met, whether they felt respected by hospital staff, and whether they were satisfied with the information and communication they received. The results of these surveys, particularly in relation to freedom of expression, were used to further develop the training packages.

5.2.1 Indicator related to the quality of communication from the patients' point of view

Formulation	Satisfaction of vulnerable patients (according to project criteria) with respect to: - quality (clarity and completeness) of the information received before and during hospitalisation, as well as at discharge, - satisfaction with the passage of information between health professionals
Reference value (ideal)	• ≥ 70% positive scores The questions are rated from 1 to 10, where a score of 1 to 5 corresponds to poor satisfaction, 6 to 8 to sufficient/fair satisfaction, and 9 to 10 to very good satisfaction. Scores above 6 are considered sufficient and correspond to a positive score.

5.3 Vulnerability triage system

The nursing anamnesis in hospitals collects a lot of patient data, but it is not possible to clearly identify the social vulnerability of patients and take this into account, especially during transitions between wards or even during shift work. The project team therefore asked which data collected from the nursing history could indicate social and clinical vulnerability. Identifying these required in-depth reflections on which social vulnerability factors specifically affect the clinic and how they may already be labelled. This step of translating knowledge from theory to clinical practice was crucial. The group then analysed and agreed which elements in practice could be identified as vulnerability factors, weighing their pros and cons in their application to everyday patient and case management. The group then identified the need to think in terms of the combination and aggregation of certain factors which, taken individually, may not provide a sufficiently clear indication to justify an in-depth examination of the patient's personal situation. In addition, the fundamental question arose as to where the information on the alleged social and clinical vulnerability should have been communicated in order to be visible and effectively retrievable. Initially, the possibility of including a visible coloured flag-type alert in the medical record was discussed, but the reflections of the group members working in the clinic highlighted the difficulty in professional practice of paying attention to active alerts in this format in the medical record in a context where these are becoming more numerous.

The triage system, initially developed in paper form and later computerised, uses a set of 7 indicators to assess vulnerability, defined as follows:

- Language barrier: Refers to the patient's difficulty in communicating effectively with healthcare staff or support services because of a language difference. This can complicate the care process and require the use of interpreters or other means of communication. It also includes all situations related to the presence of communication barriers such as aphasia, sensory deficits or other clinical conditions that prevent effective verbal communication.
- Home Aids Needed at Discharge: Indicates whether the patient needs home care services after being discharged from the hospital. This may include assistance with personal hygiene, medication management, meal preparation, etc.
- Social isolation condition: Refers to the lack of meaningful social interactions or a social support network for the patient. Social isolation can have a negative impact on the patient's mental and physical health.
- Lives in emergency housing: Indicates whether the patient is living in a temporary and precarious housing situation, such as homeless shelters or other emergency accommodations. This may adversely affect the patient's stability and well-being.
- Patient groomed in appearance and personal hygiene: Refers to the patient's ability to maintain good personal hygiene and a groomed appearance. This can be an indicator of their overall mental and physical health.
- Secondary psychiatric diagnoses: Indicates the presence of additional psychiatric disorders in addition to the primary diagnosis. This can complicate treatment and require an integrated approach to patient care.

- Readmission occurred within 30 days or at least 3 annual hospitalisations: Reports to the frequency with which the patient is readmitted to the hospital within a short period (30 days) or the number of annual hospitalisations (at least 3). This can be an indicator of the severity of the patient's condition or the ineffectiveness of the current treatment plan.

Patients identified as vulnerable are referred to social work professionals, who can take appropriate action via a dashboard. After consulting the dashboard, the professionals proceed to assess and organise, for example, an intercultural mediation or interpretation intervention, the activation of the social service in a rapid manner to immediately set up collaboration with the external support network.

5.3.1 Indicator related to the ability to identify vulnerability and activate specific measures

Formulation	Number of times the social service, mediation service or interpretation service was activated Number of vulnerable patients (negative/positive score)
Reference value (ideal)	Social resources (social service, cultural mediation service or interpreting service) are activated for at least 75% of patients considered vulnerable

The three equity indicators are strongly correlated and can be transferred to other healthcare contexts with the necessary steps for further co-development depending on the context of use. In addition to the imagined surveys, it is clear that the potential for automatic detection at the hospital entrance of vulnerable patients with the possibility of also capturing their specificity, represents an innovative and interesting database for future health system monitoring work.

6. Potential of the Equity Ticino project: results, strengths and weaknesses

This chapter summarises the strengths and weaknesses of the pilot project on the basis of the joint evaluation carried out by the project team, which, as a reminder, is made up of the management and various professionals from the hospital site where the pilot project took place, including the medical director, the general manager, the quality and patient safety manager, the doctor and head of the emergency department, the chief and head of the surgical department, the clinical nurse specialist, the head of the cultural mediation service and, finally, the Supsi research and support team.

6.1 Evaluation of project products and results

For the evaluation, the group was asked to reflect on the project's development process and objectives, and finally to assess its achievements and outputs. Below is a summary of the evaluation of the project outputs:

- E-learning: it was widespread, with some 30 people using it remotely and others using it in person thanks to the training courses organised by the cultural mediation. It is possible to disseminate it more widely, e.g. during staff induction days or as a prelude to thematic workshops.
- Vulnerability triage system: it is currently in operation and no case has been overlooked. The mediation service consults it regularly and it is noticeable that currently, perhaps also due to the visibility efforts of the service, vulnerability cases are also reported quickly by the different departments.
- Patient survey: this is a useful activity to collect suggestions for improvement from the most vulnerable patients, who are rarely listened to. The very fact of listening to these people is an added value of this tool, much more than the objective data that can be collected (the score in relation to the questions on the form). Similar to the use of the pain scale in the emergency room, it is a tool to support communication with the patient, the quantification of pain is not the more interesting data in its clinical use.

In terms of the project's objectives, the group's assessment of the project is positive. Initial expectations about the use of e-learning have not been met from the point of view of the professionals who have benefited from e-learning so far, but a lot has been done and what has been done is considered valuable and has set in motion a dynamic that will last beyond the end of the project.

At the end of the project there are more people involved in equity in OBV and the strength of the project also lies in the freedom to adapt to the context and the participation of different members of the organisation with different functions.

In addition, it would be useful to extend the content of the project (improving equity in care through better knowledge and skills in intercultural communication, cantonal health law and equity in care) through training. It is planned to develop a training programme in the coming months. The training courses, designed more as workshops, could be adapted to specific services (e.g. emergency rooms) or be open to exchange with professionals (e.g. local social services). They should be aimed at both nursing and medical staff.

6.2 Strengths of the project

To sum up, the Equity Ticino project is distinguished by three fundamental strengths:

- Creation of an equity development dynamic by the project group, with a multiplier effect of people involved in the issue and the creation of ad-hoc tools and resources for carers.
- Development of a dashboard of indicators, i.e. assessment tools that not only indicate how well or poorly one is doing in terms of equity, but also provide better knowledge on how to improve one's clinical practices or procedures;

- Creation of an implementation manual allowing other realities to replicate this experience that has a concrete impact on the three levels of social innovation, i.e. organisational, process and finally institutional.

6.3 Critical points

Despite the positive results, the project revealed some critical issues. Mainly the issue of timing. The timing of the implementation and development of a participatory action research project is not very predictable in the design, as the strong anchoring in the reality of the context and the appropriation by the professionals working there is a priority.

It would have been desirable to invest more in the communication of the ongoing project, in particular the involvement of new partners, in order to organise and implement a transfer of the project from the beginning of the WP1 activities, in order to facilitate the work of the key persons in devising the extension strategy. However, the impact of the project and its momentum is strong, and the hospital has determined the next step to improve equity for the entire EOC.

A series of workshops will be held in the semester following the end of the project in order to disseminate knowledge of the project, its products and key learnings. Then "key" professionals will be identified to undergo ad-hoc training with the SUPSI partner on intercultural communication and thus try to implement the project dynamic in the strategic areas of the EOC and then ideally, beyond. In addition, the Swiss Health Network for Equity and the Federal Office on Public Health will be the dissemination platforms for the project at the national level to stimulate replicability in other cantons.

7. Key learning

1. Grafting the work of developing equity indicators onto the concept of capabilities is an approach that allows improvement activities to be identified and monitored, and generates debate and expertise on the issue.

2. Linking the issue of equity to legal provisions through the observation of everyday care practices is a successful starting point for involving social and administrative professionals at all levels.

3. The participatory action research methodology used has strong transformative potential in the medium term. The exchange of scientific, professional and practical knowledge based on ethnographic observations leads to interdisciplinary collaboration capable of generating effective questions and answers adapted to specific contexts.

4. Creating a dynamic of gradual involvement of active professionals in the context of project implementation to improve the capacity of their system to provide equitable and quality care empowers individuals and the organisation. Empowerment creates a "sense of importance and urgency" around the issue of equity, as is already the case with other issues such as cost-effectiveness, patient safety or efficiency.

8. Final recommendations

It is recommended that the training be used to disseminate the project and facilitate its further expansion. Training can improve the knowledge and skills of health and social professionals working in care institutions. Indeed, they are key players in promoting the good use of the project's operational tools and, ideally, in ensuring their improvement and development over time according to the context.

Through training, certain principles of equity and quality in care can be disseminated, including the principle of "nothing about me without me[6]". On the basis of this principle, direct feedback from vulnerable patients can continue to be taken into account through careful and interpersonally competent administration. Meeting with patients and collecting qualitative data is an approach that may be difficult to justify against other principles, such as cost-effectiveness. However, this practice ensures the circularity of the three equity indicators identified and the related activities and tools developed.

In order to provide quality training that is effective in disseminating good practice to improve equity of care, it is essential that OBV uses the indicators regularly and disseminates its data effectively. The use of indicators also provides up-to-date material for systemic, organisational and staff training discussions.

[6] This expression refers to the concept of *patient public involment* (Hewlett et al., 2006)

9. Conclusions

One of the main characteristics of the EquiTI project is its applied and participatory nature. In addition to the joint project coordination group between SUPSI and OBV, a broader and more interdisciplinary working group has been set up, composed of various professionals working at the level of the OBV hospital sites, the general management of the Cantonal Hospital Board and the institutions. Another fundamental aspect of the project is the strong emphasis placed not only on the creation of equity indicators but also, and above all, on the development of instruments capable of positively influencing them. These two elements extended the timeframe for the development of these tools, as they were constantly co-constructed and shared with the working group to ensure that they were as closely aligned as possible with the real challenges faced by OBV staff on a daily basis.

Another strength of the project lies in the circularity of the tools and activities developed. The e-learning training is designed to improve staff competence on equity issues, which should make them more aware of the importance of early identification of vulnerable patients and activation of appropriate social resources within the hospital. This, in turn, should theoretically improve the overall care of vulnerable patients and lead to a better perception of the quality of information and communication received during their hospital stay. Surveys could identify particularly sensitive issues, which could then become the subject of further in-patient training, thus continuing a virtuous circle aimed at improving equity of care.

There are good prospects for extending the activities and tools developed during the project to other EOC sites. In fact, the project has been able to generate a dynamic of involvement of a growing number of professionals who, empowered on the issue of equity as a fundamental element of equity, are promoting a "sense of importance and urgency".

The cultural mediation service has played a central role throughout the project, making issues of quality and equity in patient care visible, disseminating knowledge of the project tools and promoting their use. This role does not exist in other sites and it would be appropriate to suggest the creation of this role in certain contexts.

In order to further strengthen and disseminate the results of the project at cantonal level, meetings are planned in the first part of 2025 with both the EOC General Management and the Cantonal Medical Office.

The federal recognition of the project and the membership of the members of the coordination group in the national association Swiss Health Network For Equity is an important element to invest in the future in order to legitimise the work carried out by certifying the expertise of the Ospedale Regionale di Mendrisio in this field. This recognition reinforces the dynamic of extending good practices and tools to other care contexts.

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