



Steps towards Incorporating Health
Equity into a Performance Measurement
and Management Framework:

Analysis of the Hospital Health Equity Plans

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Introduction

Toronto Central Local Health Integration Network (TCLHIN) has been developing a comprehensive strategy and series of initiatives to address health inequities in Toronto. One such initiative was requiring each of the hospitals within its area to develop hospital equity plans. This arose out of two principles that underlay the overall equity strategy. The first was to use existing institutional levers and mechanisms to build equity into service planning and delivery. Some hospitals had equity-focused planning experience, many had equity or diversity staff or departments, all had significant planning capacities, and many hospital-based equity initiatives were underway. This meant that hospitals were a good place to first implement the decision to require equity plans as one means of driving change within provider institutions. In addition, hospitals were the first providers to sign Service Accountability Agreements. It was anticipated that one potential outcome of the equity plans could be building specific equity objectives and indicators into subsequent generations of the Agreements. Hospitals would be furthest advanced in this process.

A second principle in the LHINs' equity strategy was to build on existing networks and partnerships. The Hospitals Collaborative on Marginalized Populations had been established several years earlier with an explicit equity mandate. The Collaborative was seen to be the ideal forum to support a coordinated system-wide approach to developing the plans. It worked with the LHIN to develop the common template that all hospitals would use to develop and report their equity plans. The template was designed to yield what each of the hospitals were doing to address the problem of health inequities, with questions on: access, service gaps and challenges, priority setting and planning, promising practices, policies, procedures and standards, governance, targets and measurement, communications and potential roles for the Toronto Central LHIN. This report analyzes the 18 Toronto hospitals' responses to the equity template. This analysis will help the LHIN direct a systematic approach to addressing health inequities.

In their plans, the hospitals discussed a wide range of program and planning initiatives addressing health disparities and the needs of health disadvantaged populations. The report analyzes these activities and strategies in terms of a number of key common themes; one of the most important of which is identifying the mechanisms by which a TCLHIN-wide performance measurement system could make a difference to health equities.

1.1. Conceptual and Strategic Background

One of the remarkable aspects of addressing health inequities is that, despite the plethora of research on the causes of health outcomes, there is little guidance on what are the best policy and practice actions to respond to health inequities. As an illustration of this point, in her 2006 essay titled *State of the Art in Research on Equity in Health*, Barbara Starfield writes: "Despite the very large research



literature on social determinants of health, relatively little has been written that would inform the choice among policy alternatives to address inequities.”

Given the recent evolution of the Local Health Integration Networks, this project provides an opportunity to understand how the Toronto Central LHIN can coordinate and integrate activities within and between the hospitals to respond to problems of health inequities. While the problems of the underlying social determinants of inequities are reasonably well recognized, how to close the inequities gap is less well understood. A detailed and practical framework of action is required to address problems of health inequities.

This project aims to understand what hospitals are doing to respond to health inequities, how they have conceptualized health inequities, and how knowledge of such activities can help the LHINS develop a strategic response to health inequities.

This report sets out concrete recommendations for both immediate ‘quick wins’, and medium and long-term system-level changes to address and resolve inequities in access to and quality of health care within the Toronto Central LHIN. Quick wins are those actions that can be taken over the next year to respond to critical, immediate challenges identified on the hospital health equity plans. There is also a high likelihood of progress on these actions given that they build on/leverage initiatives already underway in the LHIN.

1.2. Key Themes

Table 1.1 describes some of the central themes from the hospital health equity plans. One of the first ‘quick wins’ is that the process of completing the plans has already contributed to building greater internal awareness and coherence to planning efforts around equity within the hospitals. The first ‘quick wins’ have already occurred: the very process of developing the equity plans has had a positive effect. Collecting the necessary program information and drafting the plans raised awareness of equity within the hospitals beyond those with specific equity or diversity responsibilities. The fact that the CEOs and board Chairs had to sign off meant that the exercise was taken seriously. The benefits of coordination and shared learning were reflected in the fact that almost all final plans were shared within the Hospitals Collaborative. In addition, in response to a problem identified by all hospitals in developing their plans, a workshop on equity-relevant service statistics was held in April 2009. This workshop can be seen as the first step in developing equity-focused data, indicators and performance management systems – which ties into a series of observations and recommendations made in later sections.

The LHIN and hospitals will need to work together to build on this momentum to address challenges such as defining success at hospital and system levels, promoting coordinated action and developing effective performance measurement and management systems.



Table 1.1: Central Themes

- **Hospitals are already doing a lot to address problems of health inequities.**
- Hospitals put **considerable thought and effort into developing the hospital health equity plans.**
- The process of completing the **template helped bring critical coherence to the efforts of hospitals** to address health inequities that needs to be sustained.
- **Hospitals are quite varied** in terms of their practices, capacities, information about equity and the nature of the issues they face. It will therefore be a considerable challenge to develop a standardized performance system for hospitals.
- **TCLHIN has an important role in translating provider plans into a system-wide response** to health inequities including defining success at the hospital and health care system levels, and promoting coordinated actions and accountability, chiefly through accountability agreements.
- **TCLHIN plays a crucial role in the development of a performance measurement and management system for health equity** for both hospitals and community providers. In the near term, hospitals are looking to the TC LHIN to help them incorporate health equity measurement into existing performance measurement and management processes.

1.3. Goals for the Health Equity Template

As described in the Statement of Work (Feb. 12th, 2009) the broader goals for the health equity plans (using the template developed by the Toronto Central LHIN and hospital members of the Hospitals Collaborative on Marginalized Populations) include:

- *“Provide a baseline of activity occurring in hospitals across the LHIN to promote and advance health equity (including current practices, gaps, improvement plans, and data collected)*
- *Inform how health equity may be addressed in the Hospital-Service Accountability Agreements (H-SAAs)*
- *Inform how similar equity information may be gleaned from the community sector*
- *Provide critical information for the Integrated Health Service Plan (IHSP) refresh*
- *Provide information to hospitals about practices occurring throughout the sector, to facilitate sharing of best practices and potential collaboration.”*

The specific goals of the Toronto Central LHIN for this analysis included:

- *“Develop an analytical framework in consultation with the LHIN with a view to developing information to be included in future hospital accountability agreements to address health inequity*



- *Collate the data using an appropriate analytical framework to produce a draft report that synthesizes key themes and issues across the reports*
- *Conduct engagement on the draft report with the Hospital Collaborative, and others as appropriate, to validate the draft report and determine next steps and actions to be taken on by the hospitals to address health equity in a systematic, collaborative way”*

1.4. Objectives of Analysis

The purpose of this analysis are descriptive, navigational, and knowledge development:

- *Descriptive:* What are the hospitals doing to respond to problems of health inequities?
- *Navigational:* How can the information on the actions of the hospitals help the LHIN develop a strategic approach to inequities?
- *Knowledge development:* How have different hospitals conceptualized solutions to problems of health inequities?

The specific goals of this analysis include:

- Analyze the 18 hospital responses to identify what the hospitals are doing to impact health inequities;
- Begin a process of developing a strategic framework to inform what the hospitals *can do* to impact health inequities.

1.5. The complexities of responding to health inequities: An oversimplified model

We start with a very simple model that describes some of the complexities involved in addressing health equities. Figure 1.1 describes three levels; the first level is that of the individuals—the potential clients of the health care system. Some of their needs are being met by the multiple providers in the community and hospitals. Also significantly, there are a number of individuals whose needs are *not* being met by the health system. At a second level there are the multiple providers of the health system (Figure 1.1 focuses on only a few examples of providers; this is enough to make our point). Finally at the third level there is a coordinating body like the TCLHIN that is tasked with ensuring that the complex system is coordinated. Different types of complexities abound in ensuring a systematic response to equities: ensure heterogeneous individual needs are being met by the system, ensure coordination between the various health care providers, ensure that the system does not disadvantage some individuals systematically (in multiple ways discussed below).



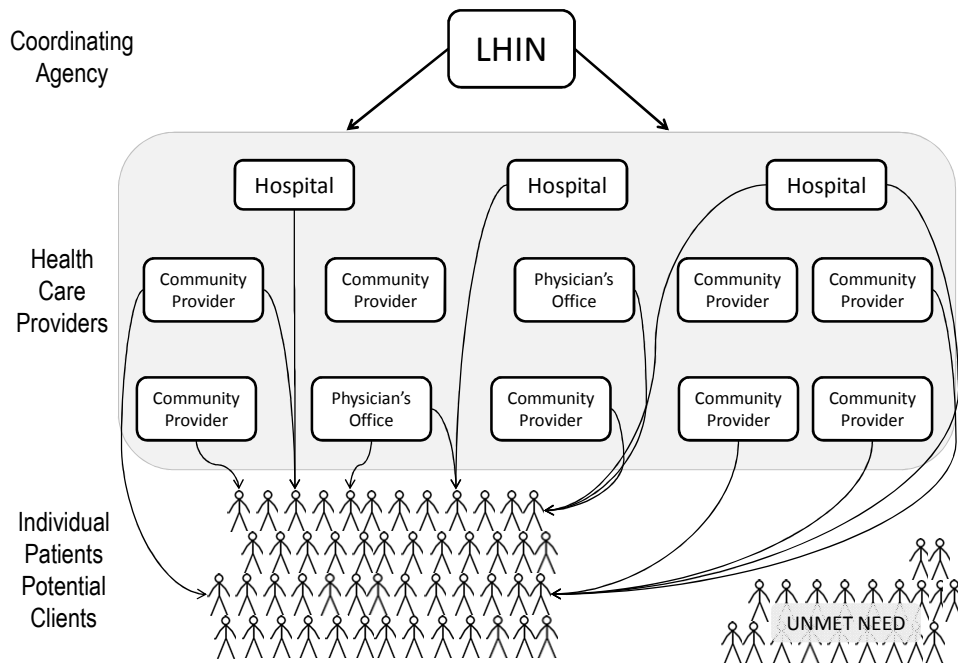


Figure 1.1. A multilevel model of health needs

Clearly Figure 1 is a gross oversimplification but it will suffice to make three points:

- Hospitals are *part* of the ecology of a complex system; a number of individuals' needs are being met through other providers;
- For some individuals there will need to be coordination between hospitals and community providers;
- There are a large number of individuals whose needs are *not* being met by either hospitals or community providers in the health care system.

1.6 Defining health inequities

The hospital template was guided by Gardner’s (2008) definition of health inequities as “differences in *health outcomes* that are avoidable, unfair and systematically related to social inequality and disadvantage.” (Emphasis added).

The above definition raises a few questions that are relevant to the approach that TCLHIN needs to take to respond to health inequities: How can coordinated LHIN action help enhance health outcomes? How does one know what differences in health outcomes are avoidable – and if so, by what kinds of policy and program actions?



Figure 1.1 also helps us understand the multiple ways in which a coordinating body like the LHIN can address health inequities at a system level:

a) Equity in meeting needs: The inverse care law describes that the availability of health care services are inversely related to individual needs (Hart 1978, Watt 2002). Based on the inverse care law, some individuals with the greatest needs will have very limited access to good medical care. In its coordinating role, TCLHIN can attempt to address this by ensuring that the overall health system reaches individuals who have unmet needs and that there are no systematic differences in unmet need by key socio-demographic groups, etc.

b) Equity in health care treatment: For those who come in contact with the health system, the goal is to ensure there are no systematic differences in the health services for individuals with similar health conditions. As an example, a hospital that serves individuals whose primary language is not English will need to ensure that information pamphlets that are available in English are also available in the other primary language(s) and that interpretation services are available.

c) Equity in quality and experience of health care services: This view recognizes that it might not be enough to ensure that individuals get the same set of services. The health system needs to ensure that individuals with similar needs receive a similar set of experiences and broadly similar quality of care, regardless of their gender, social position, ethno-cultural background, etc. This experience is most frequently measured by patient satisfaction scales; as example, providers need to ensure there are no systematic differences in patient satisfaction levels by socio-demographic groups.

However there is a conceptual problem with such a view: it is not clear if and how enhanced satisfaction will necessarily lead to improvements in health outcomes or reductions in health inequities. Such a view can inadvertently provide “perverse” incentives that might not result in reduced health equity in the system: As example, consider a recent finding from the Bulletin of the World Health Organization:

Contrary to published reports, people's satisfaction with the health-care system depends more on factors external to the health system than on the experience of care as a patient. Thus, measuring the latter may be of limited use as a basis for quality improvement and health system reform (Bleich, Ozaltin and Murray, 2009)

(d) Equity in health outcomes: The focus on reducing systematic differences is the core of the definition in Gardner (2008) (see related discussions in Sen (2000) and Culyer (2007)). Ensuring equality of outcomes is hard to plan for. Not only do we need sufficiently detailed data to understand the complex needs of individuals and populations, but also knowledge of what service interventions and program mixes works for whom and under what contexts. And, of course, so much of the roots of health disparities lie in broader social and economic inequality far beyond the health system.



The important point that emerges from the above points is the role of data not just for measurement and operationalization but also for planning a response to health inequities. Following on from Gardner(2008), the challenge is to translate these concepts into strategic actions in various settings. This is a difficult challenge, as described by Gerberding (2005): “There also is a paucity of data to inform decisions about which individual or contextual interventions (i.e., interventions that address the environment or that are most equitably available to people regardless of their socioeconomic status or behavior) will contribute the most to reducing disparities and improving health.”

Data is needed not just for measurement but also to plan actions for addressing inequities under any definition of health equity.

1.6. Organization of Report

The report is organized as follows: Chapter 2 discusses the methodology adopted in analyzing the health equity templates. The results are presented in Chapter 3. Chapter 4 discusses the conceptual issues in moving the findings to action. Strategic recommendations are discussed in Chapter 5.



2. Analysis

The analysis was informed by an evaluation framework; specific to such a framework was attempting to understand/explicate the “theory of change” by which hospitals can make a difference to health equities. The analysis paid special attention to the strategic and programmatic innovations in responses by hospitals to problems of health inequities. Key areas that we focused on include conceptualization of health inequities, the “connectivity” that hospitals develop with community groups and also other hospitals to respond to health inequities, examples of interesting and promising practices, and feedback to the LHIN on planning and systems level changes needed.

Some of the key conceptual issues that informed the analysis include:

- *The underlying framework of inequities:* There is a lack of clarity on the different ways hospitals define and understand health inequities. This project provided an opportunity to understand how hospitals conceptualize health inequities and also their implicit framework of action—what is the connection between hospital activities, hospital and community contexts, and short-, intermediate- and long-term impacts on health inequities?
- *Heterogeneity of hospitals:* This analysis did not attempt to rank hospitals or to create league tables of hospital responses to health inequities. It recognized that hospitals have very different resources, mandates and specialization, and are located in very different communities comprising different populations with different health needs and health problems. The analysis attempted to describe how hospitals are responding to such heterogeneity of individual and community needs.
- *Social determinants of health:* While the social determinant of health framework has been very successful in diagnosing the causes of health inequities, how to apply such a framework to inform hospital level action is considerably less clear. This project provided an opportunity to understand the hospital frameworks of action and if and how such frameworks can be guided by a social determinants of health approach.
- *Coherence in responding to health inequities:* Key to understanding promising practices in hospitals is exploring whether there is a *coherent* framework of action that guides the multiple steps that hospitals can take to respond to problems of health inequities.
- *Systematic processes of measurement:* The analysis also focused on the processes of measurement and the types of data that hospitals are collecting to measure their impacts on health inequities. The focus was on incorporating health equity considerations into a LHIN-level performance measurement framework.



2.1. Methodology

The methodology consisted of a three-step process:

(1) Hospital-specific analysis

Two researchers independently read and analyzed each of the 18 plans. The initial analysis focused on the following six themes:

- Hospital’s understanding of health inequities
- Hospital framework of action for responding to health inequities
- Connections, communications and networks
- Promising practices
- Governance
- Feedback to the TCLHIN

(2) Cross-hospital synthesis

In this step, the learning from the hospital-specific analysis was synthesized to craft a lessons-learned report. The analytical focus was on three aspects:

- Taking stock of where the hospitals were in responding to health equities;
- Feedback from the hospitals to develop a performance measurement and management system;
- Feedback to the LHINS to developing a system-wide approach to health equity.

The analysis questions and the specific items from the TCLHIN document “A Framework for Creating Health Equity” that guided the analysis are described in the tables below.

(3) Stakeholder dialogue

The results of the cross-hospital synthesis were then shared through presentations to a range of stakeholders. The results of the cross-hospital synthesis were presented separately to TCLHIN Senior Staff, Hospitals Collaborative for Marginalized Populations (at a special report-back meeting to the CEOs of the hospitals), a stakeholder dialogue meeting organized by TCLHIN and attended by a range of representatives of the hospital and community sectors, and the TCLHIN board.

The recommendations presented in Chapter 5 are based both on the cross-site synthesis and the above stakeholder dialogues.

2.2. Key Analytical Questions

The key analytical questions that guided the analysis are described in Tables 2.1, 2.2 and 2.3



Table 2.1. Taking Stock

Analysis Questions	Information Source from “A Framework for Creating Health Equity”
<p>How does the hospital’s governance reflect the underlying framework of action to respond to health inequities? (Note that this question is very narrowly operationalized in the question in the right-hand column).</p> <p>Is there a connection between proposed responses and the underlying problems? Are there examples of innovative thinking in responding to health inequities? Are hospital practices guided by a coherent strategic framework for understanding health inequities? Is this framework informed by a social determinants of health approach?</p> <p>What are some of the hospital-specific innovations regarding each of the following:</p> <p>Policies, procedures and/or standards to ensure</p>	<p>4) Do you collect information to evaluate how well your employees and Board of Directors reflect the communities you serve? If yes, please describe how well your employees and Board reflect your communities and indicate your data sources. If not, please explain why.</p> <p>1c) Are there any specific health equity gaps and challenges that require greater attention at your hospital?</p> <p>2a) Please briefly describe a maximum of 5 current hospital initiatives that help to improve access to health services by underserved or underrepresented populations?</p> <p>Which population do they target and/or which access barrier do they seek to remove?</p> <p>In what ways is success being measured and what outcomes yielded as a result? Please provide samples of related documents if any.</p> <p>2b) Are there hospital based initiatives that address the social determinants of health identified in 1b? Please describe briefly.</p> <p>3a) What specific policies, procedures and/or</p>



Table 2.2. Developing a performance measurement and management system;

Analysis Questions	Information Source from “A Framework for Creating Health Equity”
<p>Are there examples of innovative measurement frameworks in responding to health inequities? What role does a continuous improvement philosophy -- and an understanding dynamic processes needed to bring about change -- play in the response to health inequities?</p> <p>What are examples of interesting data that are being collected by hospitals to understand their impact on health inequities? Is there an explicit discussion that the hospital’s understanding of health inequities might be limited because of inadequate data, etc.? Do hospitals describe any data collection that might address some of the problems in the selection processes involved in health inequities?</p>	<p>5a) Please outline the goals and action plans to address your health equity and access priorities.</p> <p>5b) Please provide some examples of how you incorporate your access and equity objectives, or use an equity lens, in your initiatives to address the MOHTLC and LHIN priorities? (E.g. Strategic Plan, Wait Times Reduction, Patient Safety, Staff Interactions, Capital Projects including Facility Improvements, etc.)</p> <p>5c) What indicators and tools are used to monitor progress? (E.g. interpreter requests, accessibility plan implementation, balanced scorecards, patient compliments and complaints, etc.)</p> <p>5d) What information and data do you require in order to better identify and monitor health inequities?</p>

Table 2.3. Feedback to the LHINS

Analysis Questions	Information Source from “A Framework for Creating Health Equity”
<p>What are some examples of innovative feedback?</p> <p>Does the feedback recognize the systemic nature of health inequities?</p> <p>Does any feedback help provide the LHIN with concrete innovative ideas for integrating activities between hospitals? Between hospitals and communities?</p>	<p>7) Does your hospital have specific requests, actions or comments that the LHIN should consider to ensure a system-wide approach to improving health equity?</p>



3. Results

The results section is divided into the following sections:

1. Taking stock: Where are the hospitals in responding to health equities?
2. Feedback to TCLHIN: What can the TCLHIN do to develop a system-wide approach to health equities?
3. Data, performance measurement and management issues

3.1. Taking Stock

“Taking Stock” is divided into the following sections: Gaps, Promising Practices, Corporate Policies and Governance.

Gaps and Challenges

Many gaps arising due to growing needs and limited capacities were raised. The hospitals were asked whether there were “*any specific health equity gaps and challenges that require greater attention*” at their hospital. Table 1 in the Appendix provides full description of the gaps identified in the 18 hospitals. Addressing health inequities systematically will require gaps to be prioritized and addressed in stages.

Two of the hospitals were not able to report on gaps due to inconsistent data collection at their hospital. A third hospital did not believe that “any significant health equity gaps exist at present.” The remaining 15 hospitals reported on gaps identified by their staff as well as by their patients and community advisory groups. A few hospitals were commendably open and forthcoming in their process and reported significant gaps. One hospital with an especially strong Speech and Language Pathology service, as well as an extensive translation service, reported that their patient interviews revealed that despite these services, “many patients talked of the frustration of not being able to communicate. Other patients expressed concern for their roommates who couldn’t communicate.” The hospital also stated, “It was felt that patients who could not communicate freely were at risk of receiving less care than those who could communicate.” This example highlights that despite having targeted services in place, inequity persists, and impacting health inequities requires ongoing monitoring. Although this particular hospital may have a high proportion of patients with dysphasia and aphasia, most of the hospitals listed language and patient communication as a gap/challenge for them.

The following are gaps and challenges that almost all of the hospitals cited:

- Language interpretation, both spoken and signed
- Translation of patient materials into multiple languages



- Poverty and housing issues
- Increasingly multicultural patient demographics
- Lack of cultural sensitivity, diversity/ethnic/cultural training and education for staff, doctors, managers, Board members
- Non-insured client populations
- Need for greater case management and system navigation support for seniors, chronic mental health clients and those individuals who have language barriers

The following are gaps and challenges that were common to many hospitals:

- Patient advocacy
- Enabling clients/families to play a greater role in care planning
- Majority of clinics and services are only offered in the daytime
- Addictions and mental health challenges
- Staff, employees, managers, board members not reflective of community diversity
- Communication (related to language issues) -- few assessment and treatment clinics for communication impairments
- Not enough supportive housing and long-term care spaces to discharge patients to – noted that for younger patients (under age 50) spaces are practically non-existent
- Shortage of publicly funded outpatient therapy services
- Not enough primary care, GPs
- Elderly population increasing and not enough geriatric services
- Transportation, both availability of public transportation and cost-prohibitive for low income clients
- Low income clients needing special equipment and outpatient therapy
- Physical accessibility for the disabled -- although most hospitals have renovations underway or planned improvements

The following are gaps and challenges that are more localized or specialized according to the specialties/strengths/service areas of the various hospitals:

- Spinal cord outpatient therapy services, not enough
- Thalassemia and Sickle Cell services for adults
- Tuberculosis
- Eating Disorders
- Hepatitis B in Chinese community
- Chronic diseases such as diabetes
- Bariatric patients -- physical environment is not suitable despite demand
- Psycho-geriatric population with concurrent disorders; including agitated and aggressive seniors with dementia
- For disabled children, not enough services; lengthy and multiple waitlists
- Families with very ill or chronically ill children not able to absorb cost for care (specifically outpatient)
- Psychosocial needs of women
- Community services for youth



- Access to dental care, including youth, seniors, and disabled
- Out of province Cystic Fibrosis patients – not all provinces cover at-home services, they only fund acute care hospital services thus preventing home care options, and patients have to remain in an acute care bed
- Need for specialized fitness classes in the community for those with chronic disabilities and frail elderly to maintain their fitness levels
- Services for people who are homeless

Table 3.1. Summary of Key Gaps

<p>Service gaps for certain diseases/ailments/conditions and under-serviced groups/populations</p>	<ul style="list-style-type: none"> • Mental health challenges <ul style="list-style-type: none"> ○ Limitations to admitting more agitated and aggressive seniors with dementia ○ Continued growth in the psycho-geriatric population with concurrent disorders ○ Patients with a primary physical issue (e.g. broken hip, heart disease, etc.) but who also experience addictions and mental health challenges • Substance use challenges primarily involving alcohol, crack cocaine and marijuana • Continued growth and demand for services for Newcomers, Youth, and Elderly • Rise in chronic diseases requiring attention, such as diabetes • Service gaps: Thalassemia and Sickle Cell especially for adults, Tuberculosis, Community Mental Health and Addictions, Eating Disorders, and Hepatitis B. • Communication for deaf, hard of hearing, and dysphasic patients <ul style="list-style-type: none"> ○ Few assessment and treatment clinics for communication impairments ○ Lack of sufficient communication support
<p>Lack of sufficient outpatient and community services (associated with discharge difficulties)</p>	<ul style="list-style-type: none"> • Shortage of publicly funded outpatient therapy services and equipment <ul style="list-style-type: none"> ○ Low income clients needing special equipment and outpatient therapy ○ Income status affecting client’s ability to physically access health services, both primary and acute, and can often impede the hospital’s ability to discharge safely ○ Capacity for families (specifically outpatients) to absorb the costs associated with very ill and/or chronically ill children • Specialized services, such as those for disabled, often have very long waiting lists • Waiting lists for supportive housing sometimes 5 years long, lack



	<p>of supportive housing options, and access to long-term care spaces for ‘younger patients – under 50’ are practically non-existent, making discharge difficult</p> <ul style="list-style-type: none"> • Rehabilitative needs of ambulatory patients • Need for specialized fitness classes and recreational facilities in the community for those with chronic disabilities and frail elderly • General lack of GP’s, certain specialists, pediatricians • Need for better linkages between geriatric outpatient services and mental health & addictions services within the hospital and within community • Many clinics open only in daytime, making frequent appointments difficult for patients and their families who have to work in the daytime
<p>Language interpretation and translation need outpacing budgets</p>	<p>The demand for language services has been increasing rapidly – keeping pace financially has been a challenge High cost makes translation of written material difficult More effective communication with patients and families is needed</p>
<p>Growing cultural/ethno-racial diversity of patients and neighborhoods, but lack of diversity in staff</p>	<ul style="list-style-type: none"> • Need training and education throughout the organization regarding health equity, the health of marginalized populations, diversity issues, alternative treatments • Need to adopt theories of culture care and diversity into mainstream clinical care • Additional training of staff to manage equity related discharge issues • Resources to provide culturally competent and sensitive care
<p>Patient advocacy by family or other support person and health system navigation</p>	<ul style="list-style-type: none"> • Families who do not speak English well are not able to advocate in an effective way • Patients who have family and friends to act as advocates for them during their hospital stay may receive higher levels of service than those who do not • Need for greater case management and system navigation support for marginalized populations, specifically for seniors, chronic mental health clients, and those individuals who have language barriers
<p>Referrals from outside the catchment; lack of services outside the catchment</p>	<ul style="list-style-type: none"> • Identifying community inequities -- particularly when patients are referred from, discharged to, and from neighbourhoods from across the city and outside the city • Other provincial governments will only financially fund acute care hospital services thus preventing home care options



	<ul style="list-style-type: none"> • Although hospitals didn't identify gaps in services specifically for Aboriginal patients, Aboriginal communities outside of the TCLHIN which are not served well may benefit from programs with video conferencing; thus filling equity gaps within the Province
Miscellaneous	<ul style="list-style-type: none"> • Understanding populations who do not access services • Expanding reach to populations who are not currently accessing services • Access to dental care, especially for youth, elderly, and disabled • The physical environment for the disabled, while still being worked on, seems to have been addressed; however the physical environment for bariatric patients was cited by two large hospitals as an unaddressed area of need, despite demand.

Promising Practices

Hospitals described a versatile range of promising practices. The hospital plans included around a hundred initiatives that they are implementing to improve access to healthcare for underserved and underrepresented populations. Table 2a in the Appendix provides descriptions of all of the responses from the 18 hospitals. The overall impression from reading the descriptions is that the hospitals are very responsive to the needs of their patient populations. The hospitals seem to be responding both to larger trends, like the rise of chronic diseases such as diabetes in the general population, as well as to specific problems for smaller populations, like rehabilitation for hemophiliac patients or the management of spasticity.

Innovations could be grouped into the following categories (see Table 2b in the Appendix): inter-agency partnerships, inter-hospital partnerships, partnerships with community, Mental Health and Addictions Programs, Capacity Building, Outreach, Outpatient and Rehabilitative Services, Family and caregiver support and Education.

Grouping the initiatives into categories provides some clues that may assist the LHIN in developing a system-wide coherent plan and in helping define what success might look like. For example, in grouping the promising practices according to examples of inter-hospital partnerships, some patterns emerge of relatively simple arrangements between hospitals that share a common patient base or a common service area where each partner shares in the responsibility for services according to their expertise and capacity. There are a few examples of sub-acute and complex continuing care hospitals partnering with an acute hospital to set up patient flow processes and training, knowledge transfer, or sharing of human resources to either lessen the transfer of patients between the institutions for services or ease the process of transfer. Although these initiatives need to be evaluated, it seems reasonable to surmise that these types of hospital partnerships are promising in providing more comprehensive care for the patient over the continuum while utilizing resources more efficiently. Some of the partnerships have evolved



through a long history between the hospitals in a progression that's been beneficial to the hospitals as well as the patient group. And although facilitating other partnerships in a system-wide approach to impacting inequities remains a challenge, some trends revealed by the groupings could be used as springboards for developing a cohesive plan.

Although a number of the mentioned initiatives are “promising” in terms of addressing key access barriers, organizing equity-focused services in innovative ways, or meeting the needs of vulnerable populations, they need to be evaluated. The majority of the Promising Practices listed by the hospitals were only implemented between the fall of 2008 and the spring of 2009. It is too early to tell whether these efforts will impact inequities.

TCLHIN needs to take the lead in a strategic approach to evaluating promising practices and identifying practices that need to be “spread” across all of the hospitals and potentially the health care system.

The promising practices were also grouped for analysis by hospital type (acute care, complex continuing care, rehab, etc; see Table 3.2.) and grouped by categories, such as examples of partnerships, examples of mental health and addictions programs, examples of capacity building, etc. The groupings are intended to provide a broad overview of the initiatives as well as to provide an avenue for looking for trends in hospital responses. Detailed analysis by these groupings is in Table 2c of the Appendix). Some of the initiatives fit into more than one group (e.g., both a mental health program and an example of a partnership) but have been included only in a single group.



Table 3.2: Brief Summary of Promising Practices by Hospital Type

Complex Continuing Care	Most of the Promising Practices described by the CCC hospitals address many of the most prevalent gaps, commonly identified by most of the 18 hospitals. Perhaps because the CCC hospitals see their patients on an ongoing, continual basis, they are keenly aware of the challenges that their patients face and the gaps in the system. Their programs address the lack of: outpatient services, outreach services in the home and community, psycho-geriatric services, services that help patients navigate the system, and language and communication services.
Rehabilitation	The Promising Practices from the hospitals that primarily offer rehabilitation tend to centre around Family Support, Family and Patient Centred Care, Prevention and Management of disease/injury. The toll that a disability takes on a family is evident by these initiatives.
Specialty Hospitals	The Promising Practices from the Specialty hospitals often involve partnerships and collaborations aimed at addressing gaps and barriers for their specialty population group. There is a strong sense of advocacy and outreach in the nature of the initiatives coming from the Specialty hospitals.
Acute	Each of the Acute hospitals seem to have initiatives clustered around a few focal areas. For example one hospital has listed 6 promising practices that involve homeless people in different ways. Nearly all of the promising practices from another Acute hospital have a mixture of community outreach, education, and language: this hospital describes 6 community outreach initiatives and 3 education programs for patients, staff, newcomers to Canada, and other community groups. The focus at the third Acute hospital is less obvious, however, of its five promising practices, two are focused on women, two on mental health, and two on ethno-cultural aspects (one of these also has a mental health focus).
Sub-Acute	The Promising Practices from the Sub-Acute hospitals include four slow paced rehabilitation initiatives, partnerships with acute hospitals and rehabilitation hospitals, and some care giver support similar to the Rehab hospitals with family support. The slow paced rehabilitation initiatives seem to be addressing some needs not met by the services offered at the Rehabilitation hospitals and Acute care hospitals.
Community	Community hospitals, as befits their identification , list community partnerships in their Promising Practices. One hospital has a several initiatives involving primary care and partnerships with primary care physicians, and partnership with the police. The other hospital has partnerships with Community Health Centres, is part of a community network collaborative on health solutions, and lists their community advisory committee as a promising practice. Hospitals also have initiatives underway addressing elder/seniors health care.



Although a proliferation of practices and programs focused on one problem area doesn't necessarily translate to success at reducing the problem, it may indicate that there is infrastructure and/or human resources established at that hospital that lends itself to focus on a particular problem. The TCLHIN may want to use this information of which hospitals already have momentum in particular areas to build upon. If for example the TCLHIN wanted to address issues around advocacy, the Specialty Hospitals might be in the best position to get the ball rolling in that court.

Corporate Policies

All Hospitals had a range of corporate policies on rights, responsibilities, discrimination and harassment and also had mechanisms in place to ensure that the policies are followed.

Most hospitals had a number of rigorous policies and programs in place to:

- Ensure the delivery of culturally competent care ;
- Provide non-English language services corporately;
- Accommodate patients/clients, visitors and staff with disabilities and/or other special needs in compliance with the Ontarians with Disabilities Act.

Many hospitals mentioned that they had specialized programs for Aboriginal populations. For the most part, only a few hospitals reported specialized programs for French speaking populations. Table 3 in the Appendix describes some examples of programs for Aboriginal and Francophone populations. A few hospitals said that their data did not indicate there was a need for specialized programs for the Aboriginal and Francophone communities. They felt that most of the needs are already met by existing programs that may have "general applicability to all marginalized/disadvantaged groups."

Governance

The question on Governance in the template explored how closely did each hospital's board and staffs reflect the community they serve. The majority of the hospitals were not collecting information on how well their staff and Board reflect their community. *If more diverse governance is seen to be a priority, then hospitals will need to be encouraged to collect this information.*

Very few hospitals had a formal response to this question. A number of hospitals said that the staff were drawn from a variety of communities; others stated that the boards' representation maintained a balance between the corporate and community sectors. One hospital mentioned that they had not conducted a formal census of employees "in order to balance the need of privacy with the benefits of collecting the information." A few hospitals did acknowledge that "socio-economic and ethno cultural diversity is an acknowledged gap on our own Board." Only a few hospitals had done a formal census of their workforce including staff, physicians, volunteers and Board members. A few hospitals mentioned that they are developing a recruitment and engagement plan that includes a diversity strategy and one



hospital mentioned that the “development of Human Resources Information System is a longer term project. “

3.2. Developing a performance measurement and management system

One critical avenue within which to address many of the issues raised in the hospital equity plans is through the data and performance measurement systems. Tables 4 and 5 in the Appendix describes the full range of feedback from the hospitals for developing a performance measurement and management system.

Key issues and directions identified on how to develop a performance measurement system include:

1. *Leverage existing performance measurement systems:* There is a lot of existing activities in hospitals on performance measurement systems – the challenge is to integrate a health equity perspective within existing performance measurement systems. For example, how can existing balanced scorecards incorporate concepts and measurement of health equities?

Examples of existing performance measurement systems in hospitals include balanced scorecards, patient satisfaction surveys, wait times, measures of client participation in decisions, measures of client centred education, cultural sensitivity, and outpatient volumes.

“Client perspectives are monitored closely and results of patient satisfaction surveys are reported quarterly to the Quality of Patient Care Committee of the Board. An analysis, taking a health equity approach, will be applied to determine whether or not there are cultural barriers from the clients' perspective.

“Domains in the rehabilitation survey that are important from a health equity perspective are 'client participation in decisions' and 'client centred education'”

“The outpatient survey includes a question that is specific to cultural sensitivity and is administered in five different languages.

“Wait times for outpatient therapy is monitored closely in some programs such as the Spinal Cord and Musculoskeletal Programs.”

“Outpatient volumes are monitored closely for all programs and reported quarterly.”

2. *Development of a coordinated data strategy:* It is critical that data on inequities not be collected piece-meal—TCLHIN has a key role in leading the development of a coordinated strategy, setting out what kinds of data are to be collected, and for what purposes. Many hospitals identified a role for TCLHIN to help build networks for data collection and to develop a standardized database. A coordinated system of data collection could help identify the sources of health inequities. A database would also promote the learning between the hospitals on innovative responses to health equities.

“_____ acknowledges that we are limited in the social and demographic



information that is collected on our patients and rely primarily on catchment area data to understand our population. We request that any strategy to collect ethno-cultural or other demographics would be most useful if there was a coordinated and consistent strategy among all hospitals.”

3. *Examples of Data elements:* Hospitals had feedback on the types of data that need to be collected to measure health inequities. Table 3.3 describes some examples of measures that hospitals recommend to include in a data base of measures.

Table 3.3. Feedback on data elements

Type of Measure	Examples of Measures
Patient and Caregiver Characteristics	<ul style="list-style-type: none"> • Client Income or Range • Client’s original place of residence, address and/or postal code • Client Level of Disability • Client Current Living Arrangement/Situation • Client Immigration Status & Country of Origin • Caregiver Characteristics • Outpatient Client Demographic Information (e.g. information comparable to what is collected for inpatient population)
Aggregate patient level information	<ul style="list-style-type: none"> • Number of clients who have been connected to primary health care resources • Number of clients who self-report improved substance use behaviour • Demographic profile (ethnic, cultural, faith, linguistic, socio economic, etc.) of inpatients, residents and ambulatory clients • Information on cultural preferences (e.g. dietary, religious, etc.) of inpatients, residents and ambulatory clients • Information on the number of patients affected by health inequities and the nature of the health inequities • Information on individuals who are systemically filtered out for admission based on admission criteria and limitations on provider capacity to treat
Organizational Measures	<p>A number of the measures were on an organizational level—by this we mean information on staff and directors of the hospital</p> <ul style="list-style-type: none"> • Demographic profile (ethnic, cultural, faith, linguistic, socio economic, etc.) of staff and directors • Information on health equity/diversity/cultural competency training and educational offerings for Board of Directors and staff • Information on existing multi-language patient education materials available through other external agencies • Number of times language services are used • Number of partner organizations providing service with specific programs • Staff/Volunteer Demographic Characteristics.

4. *Integrate monitoring with evaluation:* There was also a recognition that a strategic approach to performance measurement needs to include both monitoring and evaluation components. For example, as discussed in Section 3.1, there needs to be greater clarity by which particular promising practices are chosen to be evaluated.

“Moving forward, to better identify and monitor health inequities, strategies/interventions will include an evaluation component to measure “change” or impact. Data on specific indicators will be important and should be collected in the following major domains: Access to Care, Clinical Effectiveness, Patient Centeredness, System Integration and Patient Safety. These domain indicators are recommended and used by organizations such as the Agency for Healthcare Research and Quality (AHRQ) and the Ontario Health Quality Council (OHQC).”

5. *Health inequities at multiple stages:* A number of hospitals stated that it is important not to conceptualize (and operationalize) inequities as a problem that happens only at a single discrete step (patient registration or discharge). There was a lot of feedback received on the importance of examining inequities at multiple points of the patient flow through the health care system. For example, there was feedback on the need for data that could examine the differentials in key demographic measures at different stages including accessing primary care, patient registration and post-discharge.

“It would benefit us greatly if we could gather ‘patient profile’ information via our electronic clinical documentation system such as: income, education, language spoken, cultural / ethno-racial background, religion, housing status, social support etc. It would be particularly useful if we could track this information throughout their stay within the health system e.g. from acute to chronic to discharge.”

Referral systems:

“Standardized and improved demographic data on admission from the various referral systems to the sub-acute sector (i.e. five differing systems of referral management are managed in this sector including electronic referral TC LHIN, paper referrals for palliative services, paper from other LHINS and a separate electronic system for strokes).”

Patient Registration process

“In order to identify and monitor gaps in access and equity, it is important for the Patient Registration process to be modified to include language, ethnocultural group, socioeconomic status and other indicators.”

Post-Discharge

“Monitoring patient outcomes post-discharge, ideally in coordination with the Toronto Central Community Care Access Centre (CCAC), will require the development of a performance management system for health equity, based on population and clinical care”.

6. *Need to get information on inequities at the primary care level:* The need for data that can distinguish between individuals who probably needed to access primary care but did not (unmet need) and those that did access the primary care system was identified. Understanding



differentials in access by key demographic measures would be quite critical in understanding unmet need. (The comment below refers to the sub-acute sector but similar comments can be made for other sectors)

“Access to acute service is often coordinated through primary care providers or accessed directly by a patient who lacks access to primary care services. Therefore information on access to primary care services in our catchment area would be helpful. In particular, examining differences in income, access to primary care, acute care and health outcomes in our community would be useful.”

7. *The need for an electronic tracking system:* There was feedback on the importance of developing an electronic data tracking system to record and monitor the flow of the client in the health system.

“LHINS could help facilitate the collection of such data collection including developing a web based system for data collection”

“Adopt a web based data collection system for racial and ethnic data collection such as HRET Disparities Toolkit for collection information about race, ethnicity and primary language from patients (<http://www.hretdisparities.org/index.php>). The toolkit provides training material for clinicians - to ask the questions in the best manner possible.

8. *Needs, utilization and quality gaps:* There are also data needed for examining the needs, utilization patterns and quality gaps in hospitals. Such data would not just be useful for monitoring and evaluation but would also help the hospitals plan their health equity activities.

“Data on the unique needs of various racial, cultural, ethnic, linguistic and socio-economic groups within service area. Data gathering should be coordinated and consistent across the LHIN.

- *Information on utilization patterns for culturally specific services (e.g. demand of language services)*
- *Data to indicate where quality gaps are present for patients stratified by race, gender, socio-economic status, language, etc.?”*

A coordinated system of data collection could help identify the sources of health inequities; it would also promote the learning between the hospitals on individual organizational responses to health equities

“One of the key factors to providing equitable care is the understanding of exactly where and for whom health inequities exist. The ability to collect demographic data regarding race, religion, language status and other demographic profiles from our patients would be instrumental to inform other data around both health status and outcomes and access and operational challenges with regards to certain populations. Collection of this data in a systematic fashion would allow for comparisons among all organizations in the Toronto Central LHIN catchment area that face similar challenges regarding vulnerable populations.”

9. *Defining short and long-term measures of success:* A number of hospitals want guidance from the LHIN in defining success in addressing health equities both in the short and long run. Fairly



basic issues of metrics of health equities still need to be resolved. Some of the questions that remain to be addressed include: *What is the “trajectory of success” for the performance measures? Can there be a standardized measure of success or should each hospital define success individually? Will the anticipated trajectory of success be linear? Would different hospitals (with different specializations) need to have very different performance measures?*

Many of the hospitals wanted guidance on defining benchmarks for addressing health inequities. Some of the questions that emerged from the analysis include: Given the wide heterogeneity in hospitals, how useful would benchmarks and targets be in addressing health inequities? How should information on national prevalence and incidence data on health inequities be used to develop benchmarks and targets?

“The need for a comprehensive list of metrics from all TC LHIN neighbourhoods, which are accessible to all organizations serving multiple communities.”

10. *System measures of health inequities:* In addition to hospital level measures of inequities, TCLHIN needs to focus on measurement at the system level: Hospitals need to know how they are doing relative to their immediate coverage areas and the overall LHIN system. This information would also help hospitals plan their actions to address gaps in services.

“Beyond internal data, there is also a need for access to population-level data to understand and monitor health inequities. Although the _____ regularly accesses secondary data sources, there are limitations with the specificity of variables reported at the population-level. Some examples include: lack of age, sex and income breakdowns for older adults living alone; use of single income indicator misses wide income differences between older adults; and data on activity limitations does not specify the severity or type of disability. Further, there are system-level gaps in information reported at the population-level or profiles available to support meaningful analysis and comparisons. For instance, many surveys such as the Participation & Activity Limitation Survey and Canadian Community Health Survey do not provide data at the municipal or small area levels. More ‘user-friendly’ access to population-level information, perhaps with the ability to roll-up or down between small and large geographic planning areas would support meaningful comparisons and analyses.”

There were also a number of suggestions to conceptualize the data system more broadly – broader than a hospital. A number of hospitals wanted to develop measures that would inform them how the hospital was performing in relationship to overall health equities and also in relationship to their immediate neighborhood. This would also help hospitals plan actions to address their gaps.

“Develop comprehensive population-profiles that are relevant and accessible to HSPs. There is an absence of system-level supports to understand population-level data and its linkage to client-specific data. As a result, HSPs and other community agencies are individually undertaking this work using different methodologies and data sources.”



“In respect of supporting a system-wide approach to improving access to medical programs and services and addressing inequities it would be useful if _____ and other hospitals had data that helped to identify the population being served and gaps in access that might be occurring. Furthermore, the Hospital believes value and improved outcomes would be achieved should a coordinated approach be established that is grounded in best practices and provides for clear measures of success.”

11. *Challenges of confidentiality and voluntary disclosure:* A few hospitals also spoke about the need for the TCLHIN to provide guidance about issues of data confidentiality (within the context of the Personal Health Information Protection Act (PHIPA)) and voluntary disclosure. Addressing data challenges surrounding confidentiality and voluntary disclosures will be key to collecting systematic data on potentially sensitive social and demographic information.

“We must use data to inform any strategies formed to address the health inequities that exist within our population, and this data must be comparable from organization to organization. Section 30 (2) of PHIPA notes that ‘a health info custodian shall not collect, use or disclose more PHI than is reasonably necessary to meet the purpose of the collection...’ - The purpose of the collection for hospitals is for the provision of health care. With guidance from the LHIN, organizations would be able to collect sensitive demographic data in a coordinated and comparable fashion to help inform research around the effects of social determinants of health on the provision of health care. This research could significantly influence the practice of care for vulnerable populations.”

3.3. Feedback on what the TCLHIN can do to develop a system-wide approach to Health Equities

One of the key questions the hospital template probed was “what can the TCLHIN do to develop a system-wide approach to health equities? Hospitals identified a number of areas on which to focus on. Table 6 in the Appendix provides the full range of feedback. The most common and prominent suggestions were:

1. *Developing Strategic Coherence:* In order to have significant and sustained impact on health equity across the system and continuum of health services, the TC LHIN’s challenge is to create a plan of action that promotes a coherent set of responses both within individual HSPs and across HSPs. A number of hospitals remarked that the process helped bring coherence to their work on inequities.

“We would like to commend the Toronto Central LHIN for taking leadership on this most important initiatives and we look forward to learning what other Hospitals are doing to ‘ensure equal opportunities for health for all’”.

One of the key questions that TCLHIN needs to address as it develops a performance measurement system is: How will the performance measurement process help bring coherence to hospital responses to health inequities? Key here will be to engage with a



variety of stakeholders in a sustained, ongoing manner on the purpose and use of the performance measurement systems

2. *A coordinated strategy to data collection and performance measurement:* Perhaps the most common feedback from the hospitals was the need for leadership from TCLHIN to help create a coordinated data and performance measurement system to understand and respond to health inequities, monitor and evaluate progress. Much of this feedback has already been summarized in Section 4.2.

Key feedback included a role for the LHIN to help build networks relating to data collection:

“Building networks/collaborations relating to both data collection, definition of key measures, development of a database – both tracking and sharing of data, provide tracking data.”

A number of hospitals wanted the TCLHIN to develop a coordinated approach to developing a database

“Develop a health equity database that facilitates the tracking and sharing of data between health service providers and provides health equity trends analysis to support HSPs with the submission of annual plans and eventually set health equity priorities for the TC LHIN catchment area, using an intersectional analysis.”

3. *Translation and Interpretation Services:* There was much feedback on the important role that the TCLHIN could play in helping develop a standardized and centralized service to respond to the need for multiple translators and interpreters in hospitals. Feedback included developing a centralized system, helping develop different delivery models, and also specific feedback for the TCLHIN to support the Toronto Hospital Interpreter Task Force.

“ Develop a TCLHIN centralized process and strategy for accessing and funding interpretation services and translating information into multilanguages”

“ Facilitate collaboration/development of different models for delivery of interpretation service; flexibility of options to ensure availability of appropriate wide range of languages;”

“The TC LHIN can also support the Toronto Hospital Interpreter Task Force in its proposal for the Partnership for Service Improvement Demonstration Project initiative.”

4. *Promoting use of “best practice”:* A number of hospitals felt that a key role for the LHIN would be to help promote “best practice” in addressing health inequities. Some ideas included the need for web based mechanisms to promote exchange of information, development of knowledge exchange networks and forums, and a central database of best practices.

“Develop web based mechanisms to communicate best practices and facilitate integration.”



“Promote knowledge exchange forums and networks on health equity.”

“There is also an opportunity for the TCLHIN to establish virtual networks of resource brokers within the system to share their knowledge and expertise related to health equity.”

“Create a central database of best practices.”

5. *Focus on specific problems and populations:* There were also feedback received on the role that the TCLHIN could play in addressing specific health inequity problems like mental health and specific populations like children and seniors. (This feedback fits with the TC LHIN’s approach of focusing on a few key issues and populations to achieve and accelerate system change).

“Mental health care needs to be addressed as well from a systematic standpoint, to address the fragmentation and variation in service levels within our LHIN and throughout the province.”

A number of hospitals also raised the role of LHINs in addressing senior’s issues.

Example of the feedback included:

“Specifically, the LHIN should incorporate the range, diversity and complexity of seniors into their planning process by:

- *Shifting policy to address the of lack of effective and efficient care delivery across providers (e.g. lack of continuity and coordination of care, system navigation, etc.);*
- *Providing more appropriate resourcing for community-based services, caregiver supports and delivery of culturally sensitive care;*
- *Promoting integrated care and case management for seniors and high risk groups (e.g. marginalized seniors, elders in transition, etc.); and*
- *Supporting equity initiatives related to elder health of the person rather than a disease or organizational focus.”*

A few hospitals discussed the related issue of paying attention to issues of health inequities at the discharge stage:

“Elimination of residency-related health inequities in the availability of, eligibility for and funding of health services and equipment. Such inequities create difficulties and delays in discharge planning, impede patients’ recovery and increase reliance on institutional care.”

“The TC LHIN can also work with MOHLTC to create a clear set of guidelines for equitable discharge to Long Term Care Homes (LTCHs). _____ believes that it would be more equitable if resources were made available so patients can wait for the LTCH of their



choice in a non-acute setting.”

6. *Standards for cultural competency:* Another important role for the LHIN was to set standards for cultural competency. Feedback included the need for a standardized curriculum across the continuum of care.

“Culturally congruent care training for staff from across the continuum with a standardized curriculum.”

“Set standards for culturally competent care - Do this with Accreditation Canada as was done by the accreditation body in the United States.”

7. *Funding:* A number of ideas were received for funding. Integrating a health equity lens within existing programs and policies might require dedicated resources; there is need to be specific about the resources needed to develop and implement a coordinated health equity strategy, which include funding for:

- setting standards for health equity
- communication/advocacy efforts
- enhanced access to outpatients clinics
- additional time for appointments
- strategic partnerships
- learning and implementing best practices
- developing enhanced services
- to address the issue of professional health interpretation and translation services
- for hospital-wide health equity training
- supporting transportation for patients

8. *Services to uninsured persons:* Feedback was also received for a potential role of TC LHIN to help support the hospitals in providing services to uninsured persons.

“Providing services for uninsured persons will continue to be a primary concern for the Hospital as we try to balance individuals with access to essential hospital services with the increasing need to recover costs. Hospital services for the uninsured require both as short term fix and a long-term systematic approach. An approach similar to Wait Times, where resources follow patients through the system, is one worth investigating.”

“Support low-income patients who do not have funds to cover the costs for services that are not listed by OHIP.”



9. *Developing networks and new partnerships:* The LHIN clearly has a role to play in stimulating new partnerships to address health equities, including developing a network of existing networks. Toronto already has a number of networks addressing problems of health equities (e.g. SETo). Additionally, there is an opportunity for the TC LHIN to take the lead in building partnerships with other LHINS.

“Leadership for the networks that address health inequities and promote integration of the services within the Toronto Central LHIN.”

“Recognizing the unique health equity needs in the TC LHIN, it will be vital for the TC LHIN to collaborate with other LHINS to develop a robust planning framework for vulnerable patient populations across GTA and Ontario.”

10. *Alignment with other priorities and drivers:* TCLHIN’s equity focus needs to be aligned with other key health system priorities and drivers. Hospitals specifically named ER wait times, ALC, patient safety, and quality of care.

11. *Developing a performance management system:* A key feedback was the role for the TCLHIN in performance management system that would focus on health equity as an important outcome.

“Initiate the development of a broad formal Health Equity advisory body that would include representation from across the range of TC LHIN health service providers, including community health centres, hospitals, community care access centres and others who receive funding to provide long-term strategic, planning and coordination advice as well as content expertise to TC LHIN.”

12. *Developing an intersectoral response:* A fairly fundamental question that needs to be addressed is : should response to health inequities be addressed solely within the health system? From a social determinants of health perspective, the organizations that might need to participate might come from multiple sectors. In light of the social determinants of health framework, how does TCLHIN plan to involve other sectors in responding to health inequities?

“Clarification on the scope of health equity-related issues that can or should be addressed within a public health system. There is evidence to suggest that the resources of the health system are already disproportionately allocated toward meeting the needs of disadvantaged and socially vulnerable populations. Considering the social determinants of health and the root causes of less than optimal health outcomes, other social service and private sector players (e.g., agencies involved in social housing, employment, immigration/settlement, etc.) should share responsibility for avoiding and re-dressing factors that lead to inequitable health outcomes.”



4. Building From Findings to Action: Conceptual Issues

“The combination of a population approach with long term productive relationships, between patients and professionals who know and trust each other, and who are guided by evidence and audit, is a powerful force not only for epidemiological research, but also for health improvement, and a fairer, more convivial society”.

Julian Tudor Hart, 2007

The hospitals have developed a wide range of programs and services responding to health disparities and the needs of health disadvantaged population and clients. The challenge now is to assess these activities at a broad system level, identify gaps and opportunities, and analyze how all of this can be pulled together into a coherent overall LHIN-wide strategy. A vital pre-condition for this is developing a clear strategic and conceptual framework within which action on health equity can be coherently planned and implemented. This chapter locates the analysis of the wide range of activities and directions hospitals are pursuing within the academic and practice literature and discusses the different mechanisms by which a coordinated approach can make a difference to health equities.

4.1. Pathways by which LHINs can impact Health Equities

What are the different pathways by which a LHIN system can address problems of health inequities? Gardner provides a discussion on of multiple strategic actions that the TCLHIN can do to address health equities (see Table 4.1). These points lead to a comprehensive systemic approach to health equities.

Gardner also argues for the “careful staging” of a response to health inequities. The feedback from the hospitals provides one way to arrange the staging of the various activities needed to respond to health equities.



Table 4.1: LHIN Actions to Promote Health Equity in Toronto (adapted from Gardner, 2008)

BUILD EQUITY INTO SERVICE PROVISION	“Toronto Central LHIN should use the levers and resources it controls in a systematic way to enable, encourage and ensure equity is built into all service delivery and into the very fabric of health service providers.”
	“Set clear and achievable expectations, such as requiring health equity plans from service providers.”
	Build equity into all aspects of ongoing performance management – from clear targets and indicators through incorporating equity into the service accountability agreements.
STRATEGICALLY TARGET INVESTMENTS AND INTERVENTIONS FOR GREATEST EQUITY IMPACT	<p>“Strategically target investments and service interventions to have the most impact on reducing language, navigation and other barriers to equitable access to high-quality care for all.”</p> <p>“Concentrate comprehensive and multi-disciplinary services in the most health disadvantaged populations and neighbourhoods.”</p>
BUILD EQUITY INTO SYSTEM TRANSFORMATION	<p>“Strengthen the services and spheres that can make the most difference to reducing health disparities – such as enhanced primary healthcare.”</p> <p>“Build equity into crucial directions for health reform – such as chronic disease prevention and management.”</p> <p>“Drive patient-centred care through an equity lens – so that well focused program interventions take account of the more challenging circumstances and greater needs of disadvantaged populations and that quality improvement is seen through an equity lens.”</p> <p>“Invest up-stream in health promotion and preventive services through an equity lens - concentrating specifically designed services in areas and communities with the greatest needs.”</p> <p>“Address the wider social determinants of health through cross-sectoral collaborations, integrated social, health and other comprehensive community-based services that reflect the lived experience of disadvantaged communities, and policy advocacy.”</p> <p>“Drive continuous service and system-level innovation through an equity lens – developing better sources of equity data, relying on solid local research, enabling front-line innovation, and creating forums to share promising practices and lessons learned.”</p> <p>“Implement all this through careful staging, momentum building and community mobilization, and by dedicating specialized staff and resources within the Toronto Central LHIN to really be able to focus on equity and diversity.”</p>



Figure 4.2 discusses the different pathways discussed in the literature by which a coordinating body like TCLHIN can impact health equities. The different mechanisms include coordination, measurement, enhancing programming and systemic benefits. Each of these mechanisms is discussed below.

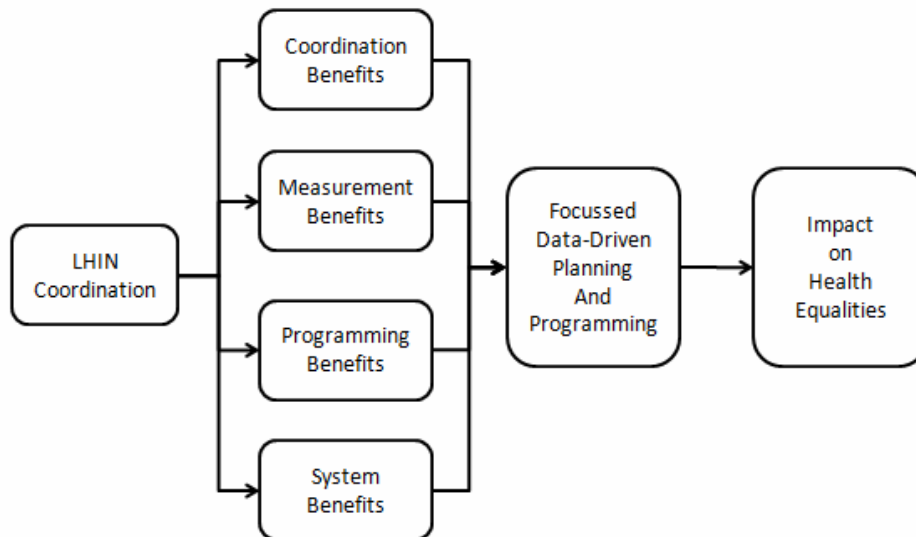


Figure 4.2. Pathways of Impacting Health Equities

Coordination benefits

By encouraging greater coordination and partnerships between hospitals and also between hospitals and community providers, LHIN actions can more effectively reach those with unmet needs, develop a comprehensive range of well-connected services to meet the full range of needs, ensure all have access to a seamless continuum of services, and ensure all can navigate through this system to get what they need. Key here is to understand the ways in which partnerships can lead to enhancements in collaborative problem solving (Sridharan and Gillespie, 2004) for the multiple organizations. However, for the most part these coordination benefits are not clearly understood:

“Partnerships have benefits but are complicated and time consuming. They have theoretical appeal in addressing health problems which require solutions that reach beyond traditional health boundaries to be more interconnected and inclusive. Evaluations of partnerships in the UK indicate their substantial coordination benefits. But reducing the impact of inequities also requires shifting to a conception of health that emphasizes the social and environmental context. This is the case even where partnerships have political support and health inequities are on the agenda. Partnerships are not a quick fix, but they are a necessary component of tackling the impacts of inequities on health. They create possibilities for reducing the impacts of inequities on health by providing a platform on which additional measures can be built.” (Lewis, 2004, p. 38)

Measurement benefits

The possibility also exists that the act of measurement can raise the coherence of a hospital's response to health inequities. Measurement targets might get individuals and groups within a hospital or community to work (and plan) toward a common strategic goal.

A focus on measuring health equity consistently over time can also raise the *salience* of equity as an important goal for all organizations. It sends a clear signal of the relative importance and prominence of health equities as a goal of TCLHIN.

A key insight from the recent evaluation literature is to treat the process of measurement itself as an intervention (Mark and Henry, 2003; Henry and Mark, 2002, Henry, 2005). The focus of this literature is on explaining how evaluations make a difference. Henry and Mark have conceptualized evaluation “as an intervention” and have attempted to understand the “ways in which evaluations, or the evaluation process itself, influences social betterment in the long term.” *Analogously, how can a system of measurement developed by the LHIN help make a difference to the responses by hospitals and community providers on health equities? How can the measurement process make a difference? The key message once again is measurement needs to inform the planning.* The measurement needs to identify gaps in the overall system as well as specific gaps for each hospital or community provider. It will not happen in itself. It needs a data-driven planning process that brings groups of people together working together towards a common goal.

One of the key areas that TCLHIN will need to address will be an overall equity-focused performance management, of which key components are:

- measurement – which in turn involves: measuring the right things – i.e. the most important drivers of system change and equity performance; collect the right indicators (Gallaher *et al.*, 2009)– not just clinical but reflecting ‘success’ in addressing disparities and needs of disadvantaged; and collecting, compiling and analyzing the data effectively
- building analysis of this data into resource allocation and priority setting, program planning, and continuous service improvement
- evaluating how well individual programs, institutions and system as a whole are performing against equity objectives and indicators, and adjusting accordingly

Measurement may be a vital pre-condition for the rest of an equity-focused performance management and resource allocation system.



Programming benefits

One obvious way of impacting health equities is by introducing new programs and policies, or by making enhancements to policies and programs based on knowledge of “best practices.”¹

The critical issue to ensure the benefits of improved programming is to develop an evaluative culture to learn about what works for whom in what contexts. Given the focus on inequities it may be especially important that our systems pay attention to the characteristics and needs of individuals who are normally considered hard-to-reach and do not engage with the health care system:

“There is a major challenge in attempting to reach individuals in hard-to-reach deprived areas. As example, there will be a challenge to deliver services “in time-poor settings where there may be neither the time, nor the resolve, nor the resources, to move beyond reactive care. The challenge is not only the political one of finding the resources; it is also knowing how best to use additional resources, in a culture in which both patients and professionals have become used to expecting less.”

Watts, O’Donnell and Sridharan, 2009

The key here once again is to develop a measurement system that can serve as a planning tool to ensure the continuity and flexibility of treatment for individuals with multiple problems, for those who most need help and guidance in coordinating and prioritizing their way forward. Such a data system needs to pay attention to multiple considerations including coverage, continuity, co-ordination and sustainability (Watt, O’Donnell and Sridharan, 2009) (see Table 4.2):

¹ Unless there are policies that ensure that patients receive similar or appropriately customized bundles of services, service provision can exacerbate inequities. However, even the most effectively targeted and designed programs alone may not reverse the foundations of health disparities in the wider determinants of health.



Table 4.2. Considerations for a systemic approach to health equities (adapted from Watt, O'Donnell and Sridharan, 2009)

Coverage	What proportion and sections of the target population are covered by programs?
Continuity	How do the programs maintain the continuity of care as individuals go through the health care system?
Co-ordination	How do the various programs coordinate and work effectively and efficiently together?
Sustainability	Have arrangements been established to sustain care for the long term?

It is also important in the above system to set goals and expect a trajectory of success that is realistic. Given the complex and dynamic context in which the multiple LHIN interventions are likely to operate in, impacts are likely to take time.

“In regard to policy evaluation, tracking and assessing the impact of mainstream policies and targeted interventions is recognized as a complex process. It takes time for potentially beneficial effects to be manifested, whether in improvements in social position, risk factors, or better health. Furthermore, established policies and new programs are operating in a dynamic social and policy environment. Their effects therefore may vary across contexts and cohorts and may be mediated through social and policy changes. Such realities make it difficult to disentangle and measure the net contribution of an individual intervention (or cluster of interventions) to changes in the social circumstances and risk exposure of the recipient groups.

(Graham, 2004, 117-118)

Moreover, attributing such impacts to specific policies or programs will provide methodological challenges:

“We must guard against the tendency to acknowledge the presence of complex relationships in shaping population health while employing analytic methods or program practices that exclude key parameters or assume independence among those that are included.” (Leischow and Milstein, 2006).

System benefits

A local health integration network will almost by definition need to take a systems perspective. Integration implies a move away from piece-meal, fragmented solutions; it implies thinking more



broadly of a network of solutions. One of the key problems that the TCLHIN may be attempting to solve is that of fragmentation.

Consider Stange (2009):

Underlying the current healthcare failings is a critical underappreciated problem: fragmentation—focusing and acting on the parts without adequately appreciating their relation to the evolving whole. This unbalance, this brokenness, is at the root of the more obvious healthcare crises of unsustainable cost increases, poor quality, and inequality. Fragmentation is at the heart of the ineffectiveness of our increasingly frantic efforts to nurture improvement.

It is important that it is not just the social determinants that drive the inequities, but also the effects of this fragmentation. Consider Stange (2009) once again:

In a fragmented system, it is easy to ignore the poor. Doctors treat whoever comes through the door, often oblivious to the many barriers to entry. Manufacturers make their products based on economic niche more than public good. Hospitals and healthcare systems strive to attract "the right case mix" to maximize profits, or just to stay in business. A patchwork of safety nets is stretched to their limits, and many people fall between the nets. The human and economic costs of unjustness are staggering for individuals and communities deprived of health and its benefits for society. Further, the spiral of spending on healthcare risks worsening inequities by siphoning resources from the social determinants of health that are even more important drivers of equitable population health.

The question is not simply: Does intervention "A" work? Rather, the question is: How best does the "ecology of services" offered from different organizations work as a whole to make a difference on unmet need and quality of services?

A systems approach offers the advantage of focusing on such connections: "it is a paradigm or perspective that considers connections among different components, plans for the implications of their interaction, and requires transdisciplinary thinking as well as active engagement of those who have a stake in the outcome to govern the course of change" (Leischow and Milstein, 2006). One of the key questions in the hospital template was how the TCLHIN could take a system-wide approach to health equities. Understanding how to develop such an ecology of coordinated services will provide considerable methodological challenges.

What a systemic perspective brings to addressing health equities is an understanding of how the parts of the system need to be structured and how such relationships can change over time: "Through studies grounded in an explicit systems orientation, we may recognize both the value of understanding health as a system of structured relationships and the value of the diverse methodologies that exist for learning how such systems are organized, how they behave over time, and how they can be better governed in dynamic and democratic contexts." (Leischow and Milstein, 2006)



Given the complexity of the various tasks, it is likely that the performance management system needs to be developed as an ongoing and cumulative process. Both the evidence base as well as the theories of what works, for whom and in what circumstances needs to be developed. The theoretical framework needs to spell out when impacts can be expected – the anticipated timeline of impact.

4.2. Leverage of Hospitals

Given that hospitals are a small part of the overall health system, what is the leverage that hospitals have to make a difference to health equities? Given that hospitals are a small part of the “ecology of health care,” how can the TCLHIN work with a range of community providers, other community groups, other non-health organizations as part of the solution? From a social determinants of health perspective, in addition to “downstream” hospital-based solution, how can more upstream solutions be also be incorporated as part of the TCLHIN? These and other conceptual issues discussed in this chapter needs to be addressed as TCLHIN moves towards a concrete set of actions to build health equities.



5. Recommendations for Action: Strategic Issues

As the analysis of the hospital equity plans is moved into action, most of the identified initiatives need to be related to priorities in the Integrated Health Services Plan-2 (IHSP-2) Balanced Scorecard: ER wait times, reducing ALC days, mental health and addictions, diabetes and value and affordability. All short, medium and long-term actions must fit together and be anchored in a coherent overall equity strategy.

Table 5.1 describes some of the central themes from the hospital health equity plans. Key points are that the process of completing the plans has already contributed to building greater coherence to planning efforts around equity and that the LHIN and hospitals will need to work together to address challenges such as defining success at hospital and system levels, promoting coordinated action and developing effective performance measurement and management systems.

Table 5.1: Central Themes

- **Hospitals are already doing a lot to address problems of health inequities.**
- Hospitals put **considerable thought and effort into developing the hospital health equity plans.**
- The process of completing the **template helped bring critical coherence to the efforts of hospitals** to address health inequities that needs to be sustained.
- **Hospitals are quite varied** in terms of their practices, capacities, information about equity and the nature of the issues they face. It will therefore be a considerable challenge to develop a standardized performance system for hospitals.
- **TCLHIN has an important role in translating provider plans into a system-wide response** to health inequities including defining success at the hospital and health care system levels, and promoting coordinated actions and accountability, chiefly through accountability agreements.
- **TCLHIN plays a crucial role in the development of a performance measurement and management system for health equity** for both for hospitals and community providers. In the near-term, hospitals are looking to the TC LHIN to help them incorporate health equity measurement into existing performance measurement and management processes.



5.1. Key steps in the next year

The Hospital Health Equity Plans revealed and reinforced a number of near-term actions or quick wins' that could be undertaken in the next year that would address significant health equity issues and accelerate progress on longer-term needs (i.e., developing a coherent system-level strategy, embedding health equity fully into performance measurement and management, and branching out beyond hospitals to other sectors – community care and primary care – to address health disparities system-wide). How these actions would contribute to the achievement of IHSP-2 priorities is also indicated.

1) Potential “Quick Win” Coordination: TCLHIN needs to develop and implement a near-term action plan in the next six months. In addition to addressing significant issues, implementing some of these initiatives can lead to greater buy-in from hospitals for the process of addressing health inequities. Such an action plan will need to be developed collaboratively with the hospitals and community providers.

It will need to leverage existing collaborations and activities; address barriers and challenges identified in TCLHIN planning and community engagement, and pull the range of equity-focused initiatives together into a coherent overall strategy. Initiatives that need immediate attention and where there are opportunities for immediate action and progress include:

- **Coordination of services for language interpretation/ translation services.** Lack of services and challenges of fragmentation and coordination were identified as critical barriers in many plans. The potential to build on existing interpretation resources and expertise and develop a more coordinated system is immense and realizable;
- **Coordinating best practice dissemination.** The very process of collecting program information on the large number of equity initiatives in the hospital plans and sharing the plans highlighted the fact that this kind of information has seldom been systematically shared. It points to the value of creating forums and mechanisms for exchanging promising practices and lessons learned.

Linkage to TC LHIN IHSP-2 priorities and Initiatives Underway

- A LHIN-wide language and interpretation service would reduce duplication and improve efficiency of interpretation services contributing directly to value and affordability priority. One of the Partnership for Service Improvement projects - Toronto Healthcare Interpretation Services – is a step toward creating a collaborative model for sharing translation and interpretation services among HSPs by using technology and pooling interpreter staff. There is an opportunity to elevate language and interpretation beyond a demonstration project to become a LHIN-led initiative to improve health equity and value and affordability. Enhancing language and interpretation services would also contribute to improving access of various populations in the TC LHIN to mental health and addictions and diabetes services and to appropriate care overall, thereby reducing ALC demands.
- Greater dissemination and uptake of health equity best practices would also contribute to IHSP-2 priorities.



2) Immediate action to develop a performance measurement and management system for health equity. These are all projects that could be initiated within months and have timelines of no more than a year. They will all build organizational and system momentum for change on equity and will together flesh out a coherent overall strategy.

- **Refresh Hospital Health Equity Plans:** Hospitals should be required to refresh their plan for addressing health equities within the next year. Some of the questions the plan needs to address include: What coherent set of activities do the hospitals propose to do to impact health inequities? What is their timeline of impact? How will success be defined in the short and long run?
- **A coordinated data collection strategy:** The TC LHIN could immediately establish a workgroup consisting of key hospital and community stakeholders to help address some of the data needs identified. The workgroup should make concrete recommendations for a hospital level data collection system to the LHIN within a year.

Important initiatives relating to data collection have already been undertaken or are underway. A TC LHIN workshop with hospital and some community HSPs was held in April 2009 on equity-focused data collection. The issue of equity-focused data and planning will also be a key topic for the TC LHIN's Health Equity Action Planning conference for the TC LHIN to be held in the winter of 2010.

- **Build Equity Into Service Accountability Agreements:** There is an opportunity to build obligations into the Hospital Service Accountability Agreements including that hospitals are to participate in "quick win" initiatives such as a TCLHIN interpretation service, and collecting a common dataset. (This could also include requiring hospitals to use the Health Equity Impact Assessment Tool to assess impact of decisions and practices on different populations).
- **Conduct a 'Taking Stock' Annual Forum for Health Service Providers:** The LHIN could take the lead in organizing an annual forum for health service providers to report on their equity-focused program planning, service delivery and outreach initiatives. This annual forum would provide opportunities to learn from the multiple stakeholders involved in addressing health inequities and to take stock on where the various organizations are in responding to health inequities. The LHIN could support other mechanisms for knowledge transfer instead of or in addition to forums, such as using the web and publications.
- **Project to make recommendations on integrating health equity perspectives within existing balanced scorecards or other strategic planning and performance management tools:** A critical task for the LHIN will be to provide guidance to incorporate health equity considerations into hospital balanced scorecards and other key planning processes. The LHIN will also need to explore if such integration of health equity considerations into balanced scorecards can be done uniformly across all hospitals. To implement this, TCLHIN needs to consider funding a collaborative project to help integrate health equity considerations into hospital balanced scorecards or similar tools. The project should consider how guiding principles and lessons learned in this hospital specific initiative can also be extended to other health service providers.



Linkage to TC LHIN IHSP-2 priorities and Initiatives Underway

These interrelated actions to begin developing a performance measurement and management capacity for health equity and to embed health equity into the LHIN's and individual hospital performance measurement and management system contribute to the achievement of all IHSP-2 priorities to some degree. This will have a particular impact on the ability to create indicators, measure, monitor, and improve equitability of MHA services involving hospitals and the equity dimensions of ALC (by identifying which populations are disproportionately impacted by ALC etc.) The ability to measure and begin to improve key health equity issues using accountability agreements and other levers will increase the value of health care for consumers in the TC LHIN.

The significance and impact of these recommendations will extend far beyond Toronto Central. TCLHIN should liaise with MOHLTC and other LHINs as its action plans are developed and as the specific projects progress. It is quite possible that some of these initiatives should be conceived as joint projects of Toronto Central and other LHINs.

Building into the mid and longer term

This final section sets out a number of vital mid to longer term challenges and possible lines of action, and makes recommendations for how they can be addressed. These issues could be themes in the various conferences planned over the next year. Key directions include:

- Analyzing the implications of the very different missions, scope of services and resources of the various hospitals: for example, what is the most effective mix of hospital-specific and common measures? How can this be incorporated into Service Accountability Agreements? It is important to note that these questions will be as critical and likely more complicated when the LHIN considers health equity measures for the community and long-term care sectors in years to come.
- Related to the point above, the TC LHIN and hospitals will need to figure out what indicators are best to assess at an individual hospital level, and what to monitor at a system-wide level. Where there are different equity objectives and indicators, how can they be effectively dovetailed?
- Developing better understanding of the cost of health disparities and the cost-effectiveness of different interventions
- Further developing a coherent evaluation and monitoring strategy to be able to assess progress, identify successful and promising programs and services, and build on what works well
- Building effective and responsive partnerships between hospitals and community. This includes thinking through how to use hospital and eventually community HSP health equity plans and accountability agreements as mechanisms to promote cross-sectoral partnerships (e.g. through joint hospital and community equity planning efforts on a sector or neighbourhood basis).



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