

EXECUTIVE SUMMARY

ANALYSIS OF THE HOSPITAL RESPONSES TO EQUITY TEMPLATES

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1. 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 brief report is part of a larger synthesis of the equity plans completed by the 18 Toronto Hospitals. The plans were based on a template 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 provides a summary on the key results and ideas for action 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.

As the analysis of the hospital equity plans is moved into action, all 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 1 in the Appendix 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.

The remaining sections of this summary are organized as follows:

- Taking stock: Where are the hospitals in responding to health equities?
- Feedback to TCLHIN: What can the TCLHIN do to develop a system-wide approach to health equities?
- Data and performance measurement and management issues
- Suggestions for immediate LHIN and hospital action
- Next steps in identifying mid to longer term initiatives and building momentum for the overall equity strategy and coherent system-wide action

2. TAKING STOCK

2.1. Promising Practices

Hospitals described a very versatile range of promising practices. The hospital plans included around a hundred initiatives, some of which involved groups of practices that they are undertaking to improve access to healthcare for underserved and underrepresented populations (see Appendix, Table 2, for examples of promising practices). Examples of promising initiatives include outpatient services, outreach services in the home and community, psycho-geriatric services, services that help patients navigate the system, language and communication services, support services to caregivers, and even temporary accommodation. *The overall impression from reading the descriptions of these initiatives 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 and management of spasticity.

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 inequalities.

TCLHIN needs to take the lead in taking 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.

2.2. 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 very diverse and rigorous policies and programs in place to:

- Ensure the delivery of culturally competent care and also address the needs of Aboriginal and Francophone communities;
- 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.

2.3. 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.

2.4. Gaps

Many gaps arising due to growing needs and limited capacities were raised. Addressing health inequities systematically

will require gaps to be prioritized and addressed in stages.

Table 3 in the Appendix describes a sample of key stated gaps. Some of the main gaps identified by the hospitals were:

- *Service gaps for certain diseases/ailments/conditions and under-serviced groups/populations – mental health challenges, particularly related to psycho-geriatric population; substance use; meeting the rise in chronic diseases, namely diabetes; Communication challenges for deaf, hard of hearing, and dysphasic patients;*
- *Language and interpretation needs outpacing budgets;*
- *Lack of sufficient outpatient and community services ;*
- *Physical environment for bariatric patients;*
- *Need for case management and system navigation support for marginalized populations*

3. FEEDBACK TO TCLHIN: WHAT CAN THE TCLHIN DO TO DEVELOP A SYSTEM-WIDE APPROACH TO HEALTH EQUITIES?

Hospitals identified a number of areas to focus on to develop a system-wide approach to health equity in the Toronto Central LHIN. The most common and prominent suggestions were:

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 an organized and coherent set of responses both within individual HSPs and across HSPs.

A coordinated strategy to data collection and performance measurement: a coherent strategic response is dependent upon reliable and relevant data and information 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. This feedback is summarized in Section 4

Translation and Interpretation Services: There was much feedback on the important role that TCLHIN could play in helping develop a standardized/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.

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.

Focus on specific problems and populations: There were also feedback received on the important role that the TCLHIN could play in addressing specific health inequity problems like mental health and/or 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).

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.

Other feedback

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.

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.

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. This feedback was received from hospitals that were located close to the boundaries of other LHINS and hospitals that provide unique or highly specialized Provincial services.

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.

4. 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. Key issues and directions identified in how to develop such a data and performance system include:

Leverage existing performance measurement systems: There is a lot of existing activities in hospitals in terms of

performance measurement systems – the challenge would be to integrate a health equity perspective within existing performance measurement systems. As example, how can existing balanced scorecards incorporate concepts and measurement of health equities?

Development of a coordinated data strategy: It is critical that data is not 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 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.

Integrate monitoring with evaluation: There was also a recognition that a strategic approach to performance measurement needs to include both monitoring and evaluation components. There needs to be explicit criteria by which particular promising practices are chosen to be evaluated.

Health inequities at multiple stages: It was 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.

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.

Linkage to TC LHIN IHSP-2 priorities and Initiatives Underway

The Resource Matching and Referral system being implemented in the TC LHIN is an important tool to monitor patient flow and access to appropriate care

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.

Defining short and long-term measures of success: A number of hospitals want guidance from the LHIN in defining success in addressing health inequities both in the short and long run. Fairly basic issues of metrics of health inequities still need to be resolved.

Defining benchmarks and targets: 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?

System measures of health inequities: An additional question that the TCLHIN needs to focus on is 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.

Challenges of confidentiality and voluntary disclosure: A few hospitals also spoke about the need for the LHIN 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 collect systematic data on potentially sensitive social and demographic information.

5. 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). These actions would contribute to the achievement of IHSP-2 priorities.

1) Potential “Quick Win” Coordination:

TCLHIN needs to develop and implement a near-term action plan in the next six months. Initiatives that need immediate attention and where there are opportunities for immediate action and progress include:

- **Coordination of services for language interpretation/translation services and coordinating best practice dissemination.** 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.

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.
- 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

- **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 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 fall 2009 Health Equity Action Planning conference for the TC LHIN.

- **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 TC_LHIN interpretation service, and collecting a common dataset. (This could also include obligating 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.

6. BUILDING INTO THE MID AND LONGER TERM

The full report 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 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 health system measures? . 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) .

Appendix: Highlight Tables from Analysis of Hospital Equity Plans

Table 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.

Table 2. Some Examples of Promising Practices

There were a number of holistic, integrated models of care for seniors, such as Geriatric Day Hospitals, offering inter-disciplinary outpatient and rehabilitative services; and The IMPACT Clinic which provides “a unique model of care for seniors 65+ with multiple chronic illnesses” by providing a comprehensive assessment and management plan, co-created with the patient and family members along with an interprofessional health care team, and in which the elderly patients have their needs addressed at one time with various specialists rather than at separate appointments, and a number of geriatric outreach and community programs.

There were unique strategies to enhance access to “exceptional care,” such as an outpatient clinic team “identifying community health services near to a patient’s home to eliminate travel time; facilitating flexible appointment times to accommodate complicated lives; helping non-insured patients access coverage for life-saving drugs; helping refugees navigate the claims process; creating partnerships with other specialties in the hospital such as endocrinology and nephrology, which allow patients to see their specialist in the HIV clinic and greatly facilitates coordination of care.”

There were mental health and addiction programs to serve hard to reach and underserved populations, such as Portuguese-speaking, African Canadian youth, Spanish-speaking, aboriginal people, women, heroin users, and the Chinese community. There were programs that benefit family members and caregivers, such as the Alzheimer Day Program, which while offering recreational activities in a safe environment for those afflicted with Alzheimer’s, also provides caregivers with a much needed break or the opportunity to continue working in paid employment.

There was a range of research programs, including a research study examining cross-cultural healthcare within a neonatal setting; development of technologies to assist family caregivers who make it possible for people with disabilities to continue living at home; a program designed to help children aged 7-11 whose parents have a history of problematic alcohol and/or drug use to develop skills, reduce risk factors, and enhance protective factors.

One hospital conducts workshops to develop inclusive working environments, and developed a session for caregivers to improve communication between families and staff, as well as a mandatory day-long workshop for staff and for family members of Veterans to help find common ground in the patient’s healthcare.

These are only a sample of the wide variety of initiatives undertaken by the hospitals in addressing inequities.

Table 3. A Sample of Key "Stated" Gaps

- *Service gaps for certain diseases/ailments/conditions and under-served groups/populations* Mental health challenges
 - Limitations to admitting more agitated and aggressive seniors with dementia
 - Continued growth in the psycho-geriatric population with concurrent disorders
 - Patients with a co-morbid primary physical issues (e.g. broken hip, heart disease, etc.) but also experience addictions and mental health challenges
- Substance use challenges primarily involving alcohol, crack cocaine and marijuana
- Rise in chronic diseases such as diabetes requiring greater attention
- Service gaps mentioned include: Thalassemia and Sickle Cell especially for adults, Tuberculosis, Community Mental Health and Addictions, Eating Disorders, and Hepatitis B.
- Communication challenges for deaf, hard of hearing, and dysphasic patients
 - Few assessment and treatment clinics for communication impairments
 - Lack of sufficient communication support

Lack of sufficient outpatient and community services

- Shortage of publicly funded outpatient therapy services and equipment
- Needs of low income clients for special equipment and outpatient therapy
- Income 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 for outpatient services) to absorb the costs associated with very ill and/or chronically ill children
- Specialized services often have very long wait lists
- Waiting lists for supportive housing sometimes 5 years long, lack of supportive housing options, and access to long-term care spaces for 'younger patients – under 50 -- are practically non-existent, making discharge difficult
- Rehabilitative needs of ambulatory patients
- Need for specialized fitness classes and recreational facilities in the community for those with chronic disabilities and frail elderly
- Lack of access to family physicians/primary care, certain specialists and pediatricians among certain populations.
- Ensure far better linkages between geriatric outpatient services and mental health & addictions services within the hospital and community
- Many clinics open only in daytime, making frequent appointments difficult for patients and their families who have to work

Language interpretation and translation needs outpacing budgets

Growing cultural/ethno-racial diversity of patients and neighborhoods, but lack of diversity in staff.

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 a few hospitals as an unaddressed need, despite demand.

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

The Methodology in a Nutshell

The analysis consisted of a two-step process:

Hospital-specific analysis

Two researchers independently read and analyzed each of the 18 plans. The focus was 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

Cross-hospital synthesis

In this step, the learning from the hospital-specific analysis were 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 was informed by an evaluation framework; specific to such a framework was attempting to understand the pathways by which hospitals can make a difference to health equities. The analysis of the hospital templates was done within in the context of the mechanisms by which the hospitals can impact health equities.