

Cross-Cutting Learning

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- The very process of developing the equity plans had positive effects. It raised awareness and the profile of equity within the hospitals; and the fact that CEOs and Board Chairs signed off meant that the exercise was taken seriously. The development of the template for capturing the plans by the Hospitals Collaborative on Marginalized Populations demonstrated the benefits of coordination and shared learning from the outset – reflected later on in the fact that almost all the final plans were shared within the Collaborative.
- A large number of concrete service initiatives addressing particular disadvantaged populations or access barriers were described. The scale of these efforts demonstrated that hospitals are clearly committed to addressing health inequities within their service planning and delivery. The system challenge is how to build on the promise of these local initiatives: there need to be forums and means to share promising practices and lessons learned, and systematic ways for the LHIN to scale up those initiatives that work.
- Gaps in services and under-served populations were identified in the plans, including inadequate interpretation to meet language needs, insufficient community services and the need for better case management and navigation support for the most vulnerable patients.

The LHIN can play a vital role in convening providers and enabling coordinated action to address these gaps. Recommendations included an annual ‘taking stock’ forum in which equity initiatives can be shared and assessed, and working groups to address particular gaps and service challenges.

- The Toronto hospitals’ mandates, resources and experience with equity-focused planning and issues varies significantly. The latter means that hospitals’ starting points, readiness and capacity for equity-driven organizational change and service shifts will vary – which in turn highlights the importance of collaboration and hospitals learning from each other. The variations in scope and size of hospitals raises the question of whether generic equity objectives and indicators will work for all? LHINs will need to consider the balance between system-wide –and necessarily more general – objectives and measures, and more specific expectations and indicators for individual hospitals and types of hospitals (e.g. academic versus community).
- Equity will only become a core part of routine planning and service delivery when it is incorporated into the incentives, drivers and requirements of the performance management system. This means leveraging existing mechanisms by building equity indicators into balanced scorecards and other tools

and into service accountability agreements and resource allocation decisions. It also requires carefully defining short and long-term measures of success: for example, these measures will need to include not just better services for those who walk in the doors, but better assessment of 'reach' – of outreach and support for those who need services but have traditionally not been able to make their way through the system. This also requires a flexible and longer term view of meeting objectives: for example, achieving the key equity objective of 'reaching' more marginalized people for diabetes treatment will cause incidence and statistics to increase – an apparent failure.

- Most of the challenges raised by the hospital equity plans need to be taken up in a system-wide coordinated way. For example, all the hospitals found that they cannot do better equity planning or assess the impact of their initiatives without far better data on patient's socio-economic situations, language needs and many other social determinant-type factors, easily matched to service utilization and outcomes data. But each hospital developing their own different equity data collection and definitions would be a nightmare. Recommendations included creating working groups of experts and practitioners to define data requirements and the most effective data collection and management systems.
- Some challenges need to be led by the LHIN. Only the LHIN – certainly working in close collaboration with service providers – can drive system-wide coherence around equity priorities and interventions. Similarly, identifying the most pressing gaps or barriers and the most promising

initiatives, and then allocating resources to those spheres and interventions that will have the most impact on health disparities, can only be effectively done centrally.