Stakeholder Dialogue on Health Equity, July 28, 2009
Table Discussion Notes (as recorded)

Topic: Strategy
Facilitator: Bob Gardner, Wellesley Institute

Question: To guide our strategy and chart progress, we need a clear sense of where we are going – of what 'success' looks like. What would an equity-driven hospital or community provider look like in both the short and longer terms? What would an equity driven local health system look like – in one year; in five years? Has analyzing and preparing the equity plans highlighted any 'quick wins' that should be moved on soon? How do we make sure that any 'quick wins' at the same time help to move us towards longer-term goals?

Success needs to be defined within a few areas that are able to be examined in a year to determine progress

- Need for a combination of "quick wins" and more substantial initiatives

The following are descriptors of an equitable health system in 5 years:

- Difficult to jump from hospital perspective to broader providers – framing
- Move dialogue from hospital to health system
- An indicator would be that social determinants of health are integrated into the health system e.g. poverty
- Concept of health equity integrated into accreditation process, similar to patient safety
- Short term goal to develop a common understanding of what health equity means
- Entire system – beyond hospitals – involved in health equity planning
- Every "consumer" has full access/knowledge of where to go for appropriate care. At each step, consumer's needs are met in a way that suits them.
- Need clear plan that filters from LHIN down to providers – important to get moving – clarity of strategy; agreed upon deliverables by all parties
- Seamless system easily navigated by anyone; easy entry to system; responsive to social determinants of health; provides choice in care
- Health care decisions are being put through appropriate equity lens
- Inclusion of entire range of health equity issues (culture, age, sex, gender, etc.)

What would be fundamentally different if health equity in place across health system?

- Needs to go beyond disease approach
- Cross-representation of all ministries
- Inclusion of diversity/equity into hospital board structure leading to greater diversity in governance
- More formalized methods of engaging on the social determinants of health in a meaningful fashion

Data collection:

- Moving forward - important to keep long-range perspective while working towards quick wins
- Need for strong underlying structure to keep on target
- Broader consultations by hospitals/LHIN within and outside health system – education, legal system, Aboriginal groups
- Data collection – what exists? What do we need? E.g. where do ER visits come from?

Including health equity service accountability agreements, examples:

- Health-equity plan and consultations with all service providers
- Mandatory cultural competence training
- Formalized engagement with communities
- Formal response on how to work with uninsured
- Mandate collection of 2 indicators
- Equity being treated as programmatic

Topic: Data
Facilitator: Dianne Patychuk, Steps to Equity

Question: What kind of data is needed to underpin equity-driven planning and service delivery and for hospitals and other community providers to understand their communities' needs? What are examples of data measures that all hospitals and community providers could collect right away? Are there hurdles to collecting some of these measures for hospitals and community providers? What process should the LHIN institute to develop a coordinated strategy of health inequity data collection?

Socio-demographic data is required for equity planning, e.g.:

- Family status
- Language
- Race
- Poverty/income (source of income)
- Education

Conduct needs assessment @ LHIN level:

- Which indicators of need are optimal
- Who is there
- Who isn't there and who has needs
- Population
- Needs
- Utilization
- A good tool = CCIM's client self-assessment studies
    - Ontario common assessment of need

Data that could be collected right away:

- Postal code
- Age
- Sex
- Preferred language of service

Hurdles to data collection:

- IT systems – lack of common system – no ehealth system
- Staff training
    - cultural competence
    - authority and organizational commitment
    - Knowledge transfer
- Time and intake
- Communication
- Public acceptability
- Staff acceptability
- Costs
- Readiness
- Best practices missing

Create a coordinated data collection strategy:

- Focus on strategic priorities of province
    - Leverage the attention being paid to these priorities and apply on equity levels e.g. is there a social gradient with respect to ER wait times
    - Mental Health strategy

- Create an “Expert Panel”
  - Engage experts to develop an indicator set, but be sure to get stakeholder input
  - Canadian Institute of Health Information can participate - re: standard indicators
  - LHIN to identify priority populations
- LHIN to “influence” provincial decision making
  - Regarding new data-collections
  - System to be inclusive of equity index
- Any new funding initiative should be accompanied with equity measurement strategy
- LHIN can facilitate best practices sharing
- LHIN provide “snapshot” re: what we are doing now
  - e.g. common data set

Topic: Performance Measurement

Facilitator: Sanjeev Sridharan, Centre for Research on Inner City Health

Question: How will progress in addressing health inequities be monitored? What are examples of common health equity measures that can be compared across the various providers? Could we develop a system of some generic system-wide measures and some specific to individual hospitals/community providers? Given the different mission and roles of different hospitals and community providers, how do we combine standardization and specificity in the performance measurement system? How can this monitoring and evaluation be realistically and effectively incorporated into ongoing service accountability mechanisms? How can consideration and measurement of hospital/agency-level inequities be incorporated into existing strategic and operational planning and performance measurement tools including balanced scorecards?

- Institution based priorities vs. LHIN system level
- Appropriateness of care delivery
  - How do we decide this?
- How to bring all systems together, e.g. family health teams are linked to Ministry vs. hospitals linked to LHINs
- Measuring/monitoring at various levels because social determinants of health are impacted by so many indicators
- Ask meaningful questions then develop measures
  - Measures should be defined by the communities of interest
- There should be institution driven indicators and LHIN prescriptive – need for a mixed system
- What competencies are we trying to achieve/promote?
- Issue of transparency and accountability
  - Opportunity to build shared accountability e.g. community and hospital
- Start with directed data collection, then drive initiatives and measures
  - Sharing data across sectors
  - E.g. analysis of discharge planning as linked to prevention
- Measurement to drive action
  - Allows us to celebrate successes, plan future engagement
- Discuss role of public health
- Need common language and data
- Future updates to equity plans to demonstrate work
- Narrow to 2-3 priorities then bring 18 hospitals together to share data and leverage success
  - Annual Forum

Topic: Community Engagement
Facilitator: Marylin Kanee, Mount Sinai

Question: What kind of community engagement structures and processes are needed to ensure providers are well grounded in the communities they serve? How do we know if it is effective? What can providers do to reach individuals who are less likely to engage in the health care system?

Define Community
Communities are not homogenous.

Hospitals Direction
Must look at what different parts of the organization are doing - there can be many solitudes.
For there to be commitment and engagement regarding working with communities there must be some degree of centralization. A strategic direction on equity should be part of Senior Managers' performance evaluation. Organizational policy must reflect inclusion. The Board must support community engagement. There must be accountability throughout the organization. Goals need to be clear at every level of the organization.

Change
It is partly about clear communication and training, setting out what it would look like on a practical level. The culture within organizations is often about what you can get away with. Accountability is required. Hospitals can be especially difficult because they are so invested in being the experts. How do different levels of the organization get support for change?

Resource Community Capacity
For meaningful community participation, resources should go to the support of an independent voice for clients that the hospital is intended to serve. Follow the client council model where the hospital gives resources to develop a client group chosen by its community with staff hired by this group to do the work. Not all members of a community can represent their community well. Involvement must not be tokenism. Community representatives must communicate with their community, be accountable to them.

Engaging with the Community
One way of services meeting the needs of the diverse community is through strategic community partnerships. Need to hear from a variety of individuals and organizations representing community.
Survey instruments used to guide hospitals need to include client identified questions. Community engagement is a shift in models; therefore some transition is often needed. Mechanisms and tools for engaging with the community are needed e.g. CAMH policy on client and family participation at CAMH puts organization's support behind client participation on committees.

Measuring Effectiveness
How do you measure responsiveness to a community? Community/clients must define measures e.g. ability to make a difference on a committee. (Empowerment Council is devising a pamphlet on effective committee participation.)

Client Self Identified Needs
A study at Women's College Hospital found that professionals and clients see problems and needs very differently. Another study out of Ohio shows that meeting client self identified needs leads to better outcomes than meeting needs defined by a service providers. Client Council model can consolidate client voice. The person must be at the centre.

Topic: Performance Management
Facilitator: Rick Edwards, St. Joseph's Health Centre

Question: What are critical enablers or incentives (e.g. education, public reporting, accountability frameworks, etc.) for hospitals and community providers to: adopt health equity as a key lens for planning, to change organizational behaviour/culture and to enhance their reach to diverse, marginalized and vulnerable populations?

Building Incentives into the System:

LHIN has said "give us your reports" (this is the 1st step).
- LHIN request made it more tangible
- Everyone's concern

Create a common understanding
- 5 definitions in LHIN re: health equity

See Institute for Health Improvement Framework
- Critical enablers for transformational change; there are 7 starting with leadership

Leverage an executable strategy
- Accountability e.g. Hospital Accountability agreements
- Define what we have to measure, e.g. consistent high quality experience at every point
- Best practice, e.g. competency of care
- Have conversations, re: what we're going to measure
  - mainly defined by clients, e.g. have interpreter

Look for alignment with current measures, e.g.
- Quality and safety
- Incorporate equity theme questions into patient satisfaction
- What are emergency visit/ALC equity issues?

"Equity" language never used in medical school
- Incorporate equity into health professional training

Care more effective, efficient – stop wasting time
- Cultural competence

Creating a culture – senior leaders
- Detailed info on ALC patients through equity lens?
  - e.g. cultural nursing home
- For hospitals, creating partnerships

Linking it to a couple of agendas, e.g. housing dialogues

LHIN "value/affordability" task forces
- To bring organization and system conversations together
- System navigators
  - language, knowledge of system

Accountability demand from LHIN
- LHIN inventory of equity pilots, i.e. best practices

Mechanisms to get on Board/CEO agenda/attention – e.g. Board/CEO sign-off of plan
- Invite to equity session
- Aligning with quality and safety
- Clinical efficiency and effectiveness

LHIN says "here is what we expect over whole system"
- One or two things everyone has to do
- Then neighbourhood level
- Then organization level

"Context enabler"
- E.g. mental health/addictions at province's level

Enabler's Summary

- Align equity with what's important to them
  - In more familiar language
  - In quality and safety
  - In clinical efficiency and effectiveness
- Institute for Health Improvement framework for transformational change
  - Governance and leadership attention
- How? – Accountability, e.g. accreditation

HAPS/HAAS – include specific obligation/expectation