

## Table 5: Information and Data Needs



5d) What information and data do you require in order to better identify and monitor health inequities?

### Hospital 1: Complex continuing care and acute care

The evaluation of equity requires the analysis of data and methodologies to provide sound information about the degree of inequities and draw conclusions about how to achieve greater equity.

The \_\_\_\_\_'s internal data provides only limited information about the needs and inequities of clients or the diversity of its workforce. Some of the contributing factors include a voluntary disclosure process and challenges collecting information within Community/Ambulatory (i.e. outpatients) and Residential Services. Additional data that would complement what is currently collected and therefore, provide a better understanding of the \_\_\_\_\_ clients and workforce include:

- Client Income or Range;
- Client Origin (i.e. 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 & Prospective Client Demographic Characteristics;
- Outpatient Client Demographic Information (e.g. information comparable to what is collected for inpatient population); and
- Staff/Volunteer Demographic Characteristics.

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.

Overall, access to this additional data would help \_\_\_\_\_ identify health inequities, practice needs-based planning, develop appropriate interventions and most importantly, monitor changes over time.

### Hospital 2: Rehab

- Information regarding staff diversity and cultural competency education and training
- Benchmarks and targets that are relevant to non-acute specialty hospitals to measure

- performance
- Information regarding best practices in health equity that are relevant to non-acute specialty hospitals
- Better national prevalence and incidence data on childhood disability

### **Hospital 3: Complex continuing care and specialty**

Currently we are very limited in the information/data that we have available to us to monitor health inequities since we do not collect socio-economic indicators information on our patient population other than age and gender via our current data gathering processes.

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 tract this information throughout their stay within the health system e.g. from acute to chronic to discharge.

### **Hospital 4: Specialized Clinical care**

- \_\_\_\_\_ has identified the need to better collect client demographic data that more effectively captures the range of identities that clients have in order to provide more informed, responsive and culturally competent care. This includes categories like sexual orientation, race and disability.
- \_\_\_\_\_ needs to more strategically extend and focus its environmental scanning, data gathering and research scope to ensure timely tracking of rising mental health and addiction disparities for those from the most marginalized communities to better align with clinical, health promotion and public policy decisions.

### **Hospital 5: Specialty**

Information and data required to better identify and monitor health inequities will include the number of clients, reports on the patterns of services accessed, self reporting from the clients as well as information on the utilization of services overall and requests for new services.

In addition, a research project will be initiated to measure the potential savings in inpatient acute care and reductions in Emergency Department visits anticipated from the implementation of the Day Health Program. The primary measures will be:

- Number of acute patient days avoided by clients; and
- Number of emergency visits avoided by clients.

## Hospital 6: Specialty

\_\_\_\_\_ lacks sufficient, reliable demographic data about those whom we serve; (e.g., race, culture, aboriginal status, family configuration [single parents, street youth], employment & socio-economic status). . . . For example, analysis of who misses clinic appointment and the reasons would assist planning.

The IHELLPS indicators (Income & Food, Transportation, Housing, Education, Literacy, Legal Needs, Personal safety and Community Support) reflect some of the key components of the social determinants of health. If this type of data was more available to hospital clinicians/researchers/policy makers it would facilitate the creation of a system far more capable of improving health outcomes of all patients.

Continued research about the obstacles and barriers that affect marginalized communities served at \_\_\_\_\_ are priority foci for Social Work and Social Paediatrics. For example, research regarding the housing and living conditions of patients would help us understand what portion of our patients live in sub-standard residences and have to deal with bedbugs, vermin and heating concerns. Living in such conditions increases the chance of contracting infections and can also significantly increase recovery times after discharge. Sub standard housing is likely accompanied by food and transportation difficulties which contribute to the elevated levels of stress that are associated with living in poverty. This type of research would enable us to more fully understand the impact of the social determinants of health on the health of Toronto's paediatric population.

The issues related to health inequities are complex. A number of our clinicians and scientists at \_\_\_\_\_ are leading studies that identify at risk populations (e.g. immigrants, low SES families, aboriginals, children with single parent, etc.). For example, results from the collaboration of our \_\_\_\_\_ clinicians and scientists on children with asthma indicated that children with drug insurance coverage were less likely to have acute asthma episodes (adjusted odds ratio = 0.36; 95% CI, 0.15-0.85;  $P < .02$ ) or repeat ED visits. Risk factors identified can help target vulnerable populations for proper interventions, which may include efforts to maximize insurance coverage for asthma medications and strategies to improve asthma self-management through patient and provider education.

Systematic data collection will be important for long-term monitoring of health and outcomes in these patients so that evidence-informed decisions/policies can be made and health programs designed and targeted. 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).

## **Hospital 7: Acute**

Data required: a) Patient demographic data including race, language, sexual orientation, income, education, disability status, family structure, who is accessing inpatient clinics, who is accessing outpatient clinics, treatment, health outcomes; b) Ongoing collection of workforce demographic data

## **Hospital 8: Sub-acute**

Information about the ethnicity and cultural diversity of our patients would be helpful in determining if we are serving a representative group of patients from our catchment area. We work with our acute partners to identify gaps in care, and the quality of the data to support these consultations is always improving.

## **Hospital 9: Complex continuing care**

The Hospital would find benefit in having data and information on best practices and performance measures related health equity programs, especially those specific to sub-acute care. At present \_\_\_\_\_ relies upon community interactions and census data when determining the profile of the community the Hospital serves. In so doing that data must be used when planning and evaluating health equity programs. Moreover, it would be useful to gauge and improve the community's knowledge of complex continuing care and rehabilitation programs.

## **Hospital 10: Community and Specialty**

The following remarks were prepared by the Centre for Research in Inner City Health (CRICH) for St. Michael's Hospital, but arise from discussions at and work conducted for the Hospital Collaborative and represent \_\_\_\_\_'s position as well.

"Measurement of equity in healthcare provision is a significant challenge in Ontario, due to incomplete and fragmentary datasets and poor data quality. As electronic medical records become more common, standardized measures of disadvantage across the province (such as years of education, occupation, income/income support, English language skills and year of arrival in Canada, race/ethnicity, Aboriginal status and other indicators) are required if disadvantaged groups are to be recognized and their health needs addressed. This information is likely to be valuable to providers to assist them in individualizing a patient's care. It is also needed by the LHIN and the MOHLTC so that system integration, waiting list initiatives, emerging reimbursement models, education models and new and existing programs can identify and address the aspects of disadvantage that result in worse health and barriers to accessing appropriate primary and secondary care.<sup>1</sup>

Adding these patient characteristics to routinely collected health services data will greatly enable the measurement of equity in healthcare utilization. Toronto Central LHIN could play an important role in advocating for and instituting more effective reporting health system practices to support health equity initiatives.

Which measures and analyses will be most valuable in helping hospitals and LHINs to identify and monitor health inequalities is an important question, given privacy considerations, patient needs, and resource constraints related to data collection and analysis.

The Centre for Research on Inner City Health at St. Michael's Hospital with the Hospital Collaborative on Marginalized Populations is reviewing existing hospital-associated indicators to assess their rationale/logic, and evidence base for identifying and monitoring health inequalities in hospital settings. Feasibility of measuring these indicators, using routinely collected data, will be discussed. This review will be available in Spring 2009.

The following observations can be made now:

1. Two types of data will be required: administrative data and patient satisfaction data.
2. Linkages of new and existing data sets should be facilitated (*especially between hospital administrative and local community socio-demographic data*) for the purposes of hospital utilization analysis and service planning.
2. Standardization of data collection systems across institutions should be encouraged.
3. Careful consideration is due before evaluating or comparing hospitals on equity performance, because institutions face different social determinants of health challenges.”

## **Hospital 11: Acute**

Measurement of equity in healthcare provision is a significant challenge in Ontario, due to incomplete and fragmentary datasets and poor data quality. As electronic medical records become more common, standardized measures of disadvantage across the province (such as years of education, occupation, income, English-language skills and year of arrival in Canada, race, ethnicity, Aboriginal status, Religion, sexual orientation, gender identity, disability and other indicators) are required if disadvantaged groups are to be recognized and their health needs addressed. This information is valuable to providers to assist them in individualizing a patient's care. It may be helpful in system integration, waiting list initiatives, emerging reimbursement models, education models and new and existing programs can identify and address the aspects of disadvantage that result in worse health and barriers to accessing appropriate primary and secondary care (Glazier, 2005).

## **Hospital 12: Critical care**

- 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.

### **Hospital 13: Community**

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.

\_\_\_\_\_ 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. The utilization of and satisfaction with hospital services by various social demographic characteristics would help monitor the hospital's progress on the health equity front.

### **Hospital 14: Sub-acute**

1. 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)
2. Clarity on what information can be collected on health equities and best methods for this collection.
3. Sharing of data across the continuum to reduce duplication of data collection.

### **Hospital 15: Rehab**

The hospital does not specify what data or information is required in order to better identify and monitor health inequities. However the hospital mentions actions that are being taken to monitor health inequities and alludes to data requirements:

"An analysis [of client perspectives and patient satisfaction surveys], taking a health equity approach, will be applied to determine whether or not there are cultural barriers from the clients' perspective."

"Meeting the health needs of community dwelling frail elderly requires a system wide approach. We work with the Regional Geriatric Program and track and trend geriatric outpatient utilization, however, there are no volume targets and resources are limited."

### **Hospital 16: Acute**

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.

It will be important to collect more information on factors that impact discharge planning. Collecting this information will increase the involvement of discharge planners in the care of these vulnerable patient populations. Also, additional discharge data will create more robust data sets to positively impact health outcomes of vulnerable patient populations.

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.

## **Hospital 17: Rehab and complex continuing care**

\_\_\_\_\_ requires the following information and data to identify and monitor health inequities:

- Demographic profile (ethnic, cultural, faith, linguistic, socio economic, etc.) of staff and directors
- 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 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
- 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

## **Hospital 18: Specialty**

\_\_\_\_\_, with other members of the Hospital Collaborative on marginalized Populations, commissioned the following project from the Centre for Research on Inner City Health:

- Measurement of equity in healthcare provision is a significant challenge in Ontario, due to incomplete and fragmentary datasets and poor data quality. As electronic medical records become more common, standardized measures of disadvantage across the province (such as years of education, occupation, income/income support, English language skills and year of arrival in Canada, race/ethnicity, Aboriginal status and other indicators) are required if disadvantaged groups are to be recognized and their health needs addressed. This information is likely to be valuable to providers to assist them in individualizing a patient's care. It is also needed by the LHIN and the MOHLTC so that

system integration, waiting list initiatives, emerging reimbursement models, education models and new and existing programs can identify and address the aspects of disadvantage that result in worse health and barriers to accessing appropriate primary and secondary care (Glazier, 2005).

- Patient characteristics, routinely collected.
- Two types of data will be required: administrative data and patient satisfaction data.