Evaluation Centre *for* Complex Health Interventions
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Building Equity In: Analysis of Toronto Central LHIN Hospital 2010 Equity Plans

Commissioned Report

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Introduction

All hospitals within Toronto Central LHIN refreshed their equity plans in 2010. As in the first generation of these plans in 2009, a template was developed within the Hospital Collaborative on Marginalized Populations, and the Collaborative again proved to be a crucial forum for collectively discussing equity challenges and sharing information and insight. Also as in the first generation, these plans were analyzed by the Evaluation Centre for Complex Health Interventions of the Li Ka Shing Knowledge Institute and the Wellesley Institute.

Developing two generations of plans has accomplished several objectives:

- it further highlighted access and quality barriers and the need to explicitly address the health needs of disadvantaged populations;
- it showcased the increasing number and wide range of initiatives that hospitals have been developing to do just that, showing concretely that action is possible;
- the analyses, coordination and discussion necessary to prepare the plans mobilized more and more champions, programs and commitment within hospitals, and continued to lay a solid foundation of equity-planning mechanisms and experience;
- by building on the first plans, and planning towards the future, this process further embedded equity within hospital service delivery, performance management and working cultures; and
- it identified the challenges still to be addressed.

Analytical Framework

METHODOLOGY

The Hospital Collaborative on Vulnerable and Marginalized Populations created a template within which all the hospitals developed their reports. We built upon the framework of this template to identify a number of key categories and questions that we used to analyze each report. We then conducted two levels of analysis:

- analyzing each hospital's responses in terms of the analytical framework – e.g. what did hospital A say about whether they have established formal equity planning or coordinating forums, what specific equity initiatives were developed, etc.;
- then analyzing responses to the particular questions or issues across the hospitals – e.g. how many hospitals established equity planning forums and how do they appear to be working? What patterns can be seen within the large number of quite varied equity initiatives underway or planned? Our goal was to identify broader patterns and implications, and success conditions and promising directions moving forward.

Building on a key finding from the first report, the very different mandates, scope of services, client and care requirements, and resources of the 18 hospitals requires suitably differentiated analysis. For some cross-hospital comparative analyses, we broadly grouped the institutions as:

- Acute Academic : UHN, Sunnybrook, Mt. Sinai, St.

Michael's, CAMH, Sick Kids, Women's College, recognizing there were important differences in specialization and focus within them;
- Acute Community: St. Joseph's, Toronto East General;
- Sub-acute, Complex Continuing Care and Rehab: Providence, Toronto Grace, Baycrest, Bridgepoint, Runnymede, West Park, Casey House, Holland Bloorview Kids Rehab, Toronto Rehab;

For other purposes, categories were analyzed together:

- for example, all the acute hospitals, regardless of their size and specialities, face similar challenges in building equity into planning and delivering quality services;
- all institutions face challenges of language, interpretation and cultural competence in this diverse city, and all have found that they need to take social determinants of health and the circumstances in which their patients live into account, especially for planning discharge, follow-up and referrals.

Findings

BUILDING FROM THE FIRST GENERATION EQUITY PLANS

A number of specific issues that emerged from the first hospital plans have been addressed:[1]

- three hospitals (and Toronto Public Health) are undertaking a pilot project on how to effectively collect income, immigration, social-economic and other equity-relevant patient information;
- interpretation was identified as a crucial issue, and the potential to develop more coordinated or centralized services was explored and many initiatives have been developed at hospitals (taking telephone translation to patients' beds, collecting language preference at admission);
- streamlining services for non-insured people has been addressed through a research conference organized by the Women's College network and partners, within the Hospital Collaborative, and by Community Health Centres.

Overall, understanding and implementing equity has clearly broadened and deepened. Almost all hospitals spoke of how they built upon their 2009 plans:

- for those hospitals that had been developing comprehensive strategies, refreshing their plans solidified and extended the range and depth of implementation;
- for others, it highlighted how equity can — and needs to be — incorporated into their priorities and work.

This highlights the value of building continuity and potential through the years by regularly updating equity plans.

Strategic and Mission Commitments

A number of hospitals point to their mission and values as committing them to equity.

Such high-level commitment is certainly valuable, but it does not directly imply action on equity. Driving equity into action requires a coherent strategy; explicitly planned and coordinated, with sufficient resources and clear accountabilities to support effective and consistent implementation of equity initiatives; embedding equity in hospital performance measurement through concrete targets and indicators and performance management by tracking and monitoring progress against these objectives; aligning equity with quality and other institutional and system drivers; and developing specific initiatives that address access barriers or the needs of health disadvantaged populations. Hospitals have been making significant progress on all these fronts.

Institutionalizing Equity

A number of hospitals have established specific health equity planning or coordinating forums and many have assigned specific responsibilities or deliverables to senior management and dedicated staff and other resources to equity issues.

TASK FORCES OR OTHER PLANNING FORUMS

Five hospitals have ongoing equity councils, task forces or other planning forums. Their nature and mandate varies; but they demonstrate the potential of bringing people from across the hospital together to concretely plan and coordinate action on equity.

DEDICATED MANAGEMENT AND OTHER RESOURCES

All acute and many other hospitals have assigned equity responsibilities to management staff. A number have specific departments or management positions focussing on equity. Many of these have evolved out of earlier programs around diversity, and many combine responsibility for equity and diversity. Several also

1 Our analysis of the first equity plans can be found at http://www.torontoevaluation.ca/tclhin/index.html

include responsibilities for community engagement.

Some hospitals have assigned equity responsibilities or deliverables to particular Vice-Presidents or other senior managers. For example, one has its Vice-Presidents undertake at least three equity initiatives within their portfolios.

Embedding Equity Into Planning Processes

Several hospitals have explicitly incorporated equity criteria or objectives into their planning processes.

Three have included equity in their balanced scorecards, and four others are planning to.

A number have built equity into other routine planning mechanisms and goals in innovative ways, including:

- analyzing how to incorporate equity into operations, research and service delivery;
- considering equity factors and impact in budget planning and decisions;
- tracking equity on the hospital dashboard and reporting quarterly on progress against equity indicators and objectives;
- undertaking an inventory of equity activities in high-volume patient departments.

HEALTH EQUITY IMPACT ASSESSMENT (HEIA)

Versions of equity-focused impact assessment are being used in many leading jurisdictions and HEIA is being promoted by MOHLTC across the province.[2] HEIA's goal is to ensure that equity considerations are taken into account in planning within healthcare and in other sectors.

Under the template, each hospital was required to apply HEIA to at least one program or issue. Experience has found that using the tool helps to build awareness and commitment to equity deeper within organizations. From the range of issues to which HEIA was applied, the enthusiasm of many hospitals in using the tool and the fact that several hospitals are going to use HEIA in other areas or more routinely, it would appear that this potential is being realized in many and could be valuable in all.[3]

Explicitly requiring HEIAs may be a lesson to other LHINs and sectors on how to kick-start equity planning. It also shows how momentum can be built: one hospital now requires HEIA as early as possible for all key policy development, project planning or capital procurement; and several others are using it more broadly across their programs.

Embedding Equity in Performance Measurement/Management

DATA AND INDICATORS

In addition to the cross-hospital data project noted above, many are developing or experimenting with equity-relevant data and indicators:

- one requires each program to include at least one equity indicator in its quality reports to the Board;
- another is collecting race, ethno-cultural background and sexual orientation at intake;
- several others collect information on languages spoken or preferred;
- another is integrating equity reporting across all programs.

These kinds of initiatives could potentially "travel well" and be adapted in other hospitals. Other indicators were quite program specific:

- assessing screening rates for immigrant women from different regions of origin;
- assessing pathways of care for different ethno-cultural groups.

These examples may reflect the benefit of drilling down to very specifically identify access barriers and develop indicators to track progress.

Alignment With Quality Drivers

QUALITY PLANNING

A number of hospitals emphasized quality in their plans:

- one has adapted a quality improvement framework in which equity is one of six key dimensions;

2 MOHLTC released their final version of the HEIA template and workbook in April 2011, and is committed to providing training and support resources, and to establishing means to share users' experience, at http://www.health.gov.on.ca/en/pro/programs/heia/.

3 The fact that the Wellesley Institute is frequently asked to provide workshops to hospitals and other providers also indicates continuing interest and potential in HEIA (notes for all these workshops, planning and service scenarios developed to facilitate discussion, several primers and links to practical resources are available at http://wellesleyinstitute.com/policy-fields/healthcare-reform/roadmap-for-health-equity/heath-equity-impact-assessment.

- several others reported consulting the Ontario Health Quality Council (now Health Quality Ontario) and adopting its attributes of high-performing health systems.

Several have built equity into patient satisfaction collection and monitoring:

- one has developed a customer service survey designed to identify any discrepancies in service by language, ethnicity or other equity dimensions;
- one added accessibility and other equity questions to NRC Picker patient satisfaction instruments;
- another translated the NRC Picker survey into seven languages.[4]

TRAINING AND SERVICE IMPROVEMENT

A number of hospitals provide equity and cultural competence training:

- one has developed curricula on providing culturally appropriate care;
- another developed an extensive train-the-trainer program, and offered it to staff of other hospitals as well;
- several have created workbooks and manuals;
- one developed a community outreach program involving Chinese speaking health professionals from the hospital;
- an evaluation in another hospital indicates promising effects of cultural competence training and resources on service quality;
- a hospital has partnered with other agencies to create a virtual equity toolbox of resources and organizational best practices.

TAKING SDOH INTO ACCOUNT

Few hospitals comment explicitly on how wider determinants and social circumstances are considered in service delivery. But several interesting examples were reported:

- one comprehensively works to ensure social determinants are considered in all aspects of clinical service delivery, health promotion and public policy development;
- another has community health navigators who identify patients who may be at risk of social isolation and follow-up more intensively with them.

4 NRC Picker has developed the most widely accepted and used instruments to assess patient satisfaction and quality care within hospitals -- providers can adapt them to their own situations to some degree: http://www.nrcpicker.com/member-services/patient-experience/.

Equity Initiatives

One of the most striking patterns across the 18 reports is the range and depth of equity initiatives underway, with some of the larger hospitals listing dozens.[5] Illustrative of this range are:

- many outreach and clinical service programs with particular immigrant or ethno-cultural communities;
- five hospitals have developed programs and partnerships addressing Aboriginal health;
- working to incorporate the views of disadvantaged populations through community advisory panels and other means;
- dental clinics for disadvantaged patients and children;
- engaging immigrant women around breastfeeding and well-baby care;
- translation of hospital materials, including into multi-media resources;
- taking telephone-based interpretation to patients' bedsides;
- collecting and using socio-economic, language and other equity-relevant information;
- considering social and economic circumstances in navigation, discharge and outreach planning.

Several promising features were also notable:

- many involved partnerships with other hospitals, public health, Community Health Centres and other community providers;
- translation and other resources developed in one hospital were offered to others – often through the Hospital Collaborative;
- several tied their care and delivery initiatives to equity-orientated research and evaluation.

The focus of these initiatives varied: some were about building equity into overall programs and delivery, and some were more specifically addressing particular disadvantaged populations or access barriers. That there are so many initiatives indicates how equity is being incorporated into the fabric of ongoing quality and service innovation.

From these reports, it is not possible to tell how the initiatives have been implemented or what has actually happened to front-line delivery or the quality of care as a result. Nor can we know the patient health outcome impact for a number of years. But they do constitute an impressive and growing catalogue of concrete initia-

5 Will list all reported equity initiatives in an Appendix that hospitals can consider for their own circumstances.

tives driven by equity concerns or objectives, and certainly indicate promising directions.

Implications, Opportunities and Options Moving Forward

This section builds from the overall findings to identify common patterns, challenges, opportunities, success conditions and implications, and sets out observations and options moving forward to further embed equity in hospital practice. It then leads into a series of concrete recommendations for Toronto Central LHIN and hospital partners to consider.

Key themes are:

- the need for coherent overall equity strategies within each hospital and across the hospital and wider health sectors through the LHIN;
- embedding equity into core working cultures, planning processes, performance measurement and management, operational practice and service delivery;
- ensuring that the diverse components of these strategies and the many equity service and planning initiatives are focused and aligned not just within each hospital, but across the health system and with wider provincial priorities.

Embedding Equity in Planning, Coordination and Management

A number of hospitals have emphasized equity in their strategic plans or developed equity visions. Moving these strategic commitments into organizational practice, the key challenge is focus, coherence and alignment: linking the many specific equity activities and initiatives into a coordinated and consistently implemented overall strategy. Critical to this is institutionalizing equity within hospital processes and working cultures.

Having task forces, working groups or other planning forums certainly facilitates being able to develop and implement comprehensive equity plans and activities. While it may be too early to conclude what particular form of coordinating/planning bodies will work best, it is safe to say that without such mechanisms to coordinate and implement equity, impact will be more difficult.

Clear high-level responsibility and authority is another success condition for driving an equity agenda. Several hospitals have regular reporting to their boards and senior executives on equity issues. Having equity plans signed off by the Board Chairs and CEOs has proven useful for ensuring high-level attention.

A number of hospitals have dedicated units and assigned management responsibilities, but practice is by no means consistent. While significant resources and units may be possible only for the larger hospitals and the most effective structures will vary by institution, clear delineation of responsibility and prioritization of equity planning and management is possible at all. This is an opportunity for the LHIN and hospitals to share best practices and clarify understandings. There could be a clear expectation that all hospitals will delineate exactly where and how responsibility for equity strategy and planning will be assigned.

Equity has been incorporated into balanced scorecards, quality reports or other routine planning and management processes in some hospitals. Health Equity Impact Assessment is being increasingly used. While it will be some time before we can assess the effectiveness of these different mechanisms, embedding equity into planning processes and core organizational drivers is clearly vital. Here again, the potential of sharing best practices and enhancing consistent expectations will be important.

Embedding Equity in Performance Measurement/Management

Building equity into performance indicators will be a key lever for driving change, and promising innovations are well underway. But, as was emphasized in our first report, indicator development and operationalization has to be part of an integrated performance measurement and management system.

Moving forward, two directions will be especially important:

- to see performance measurement as an ongoing cycle directed towards continuous improvement and learning: indicators are developed and tracked; progress is measured, assessed and adapted; measured, assessed and adapted again, and so on.
- performance management systems will need to be differentiated and nuanced: "one size fits all" indicators will not work. A system of cascading indicators and performance measures will need to be developed appropriate to the different kinds of hospitals and programs, more on that below.

SUCCESS CONDITION = EQUITY-RELEVANT DATA

Solid data is a pre-condition of effective planning and performance measurement systems. This builds upon a key theme of our analysis of the first generation of plans and on the initiatives that arose out of it. A strategy to collect and use reliable and actionable equity-relevant

data could include:

- identifying elements of equity-relevant data essential to planning and performance management;
- identifying how these data can be systematically collected in all hospitals, while recognising that not all hospitals have the same needs and service/patient mixes, and therefore not all hospitals will use the data in the same ways.

Steps could be to:

1. **complete the data pilot test currently underway in three hospitals;**

2. **undertake a rapid evaluation and call a consensus conference within six months:**

   - in other words, this is not to be an academic research project, proceeding at a publication and peer-reviewed pace;
   - but is applied research to solve the pressing need for equity-relevant data to underpin performance planning, measurement and management;
   - the goal is data that is good enough to act on.

3. **develop a data collection protocol for all hospitals, to be operational within 18 months:**

   - endorsed by TC LHIN and embedded in Hospital Service Accountability Agreements (H-SAAs) moving forward;
   - tied to Quality Improvement Plans (QIPs) and other initiatives under the Excellent Care for All Act (ECFAA);

4. **build this into an ongoing monitoring and evaluation framework:**

   - that would guide each hospital's planning and continuous improvement;
   - and roll up to the LHIN to be incorporated into ongoing accountability mechanisms;
   - while recognizing that the system will need to be dynamic – to be adapted and improved through experience and ongoing research.

Embedding Equity in Service Delivery and the Quality Agenda

Quality improvement will continue to be a key provincial and system priority, and the Excellent Care for All Act provides a lever for further embedding equity into ongoing service and quality improvement:

- All hospitals were required to develop Quality Improvement Plans by April 1, 2011. While hospitals could choose additional indicators beyond core requirements and equity indictors were discussed in the Health Quality Ontario guidelines, equity was not one of the core dimensions required in this first iteration of QIPs. It may very well be that more explicit equity indicators will be developed and required in subsequent years. Regardless, individual hospitals can still report on equity within their QIPs.
- Executive compensation will be linked to quality performance – building equity into this framework provides a further powerful change driver.

Toronto Central LHIN and its partner hospitals can lead in insisting that there cannot be quality without equity, and demonstrating how this can be implemented in practice. However the Quality Improvement Plans evolve, the LHIN can:

- require that all Toronto Central hospitals include specific equity indicators in their next Quality Improvement Plans;
- work with the Hospital Collaborative to develop equity indicators that will be appropriate for the different types of hospitals. The goal would be that all Toronto Central hospitals would monitor and report on just a few common equity indicators. This would allow effective tracking over time and benchmark comparisons;
- require hospitals to identify populations at risk for suboptimal quality and outcomes as part of their QIPs – and integrate this analysis with implementing their equity plans;
- require that any data collected for quality improvement purposes must be stratified by equity dimensions.

Many hospitals cited service reforms geared to enhancing overall quality and effectiveness, but some were not always clear about how they will reduce inequities. We need to drill down further: does quality of care or patient experience vary by language, race, background or social circumstances? Have systemic differences in the quality received by different types of patients been identified? How are quality improvement efforts considering equity barriers; is care adjusted or enhanced to take account of the greater challenges and fewer resources available to disadvantaged populations? For example, one hospital tries to identify patients at risk of social isolation and with fewer home supports in discharge and continuing care coverage. Others are considering how equity factors can be built into assessing patient

satisfaction.

We have emphasized the importance of aligning equity with provincial and system drivers such as quality. Part of this can be looking to the future – to emerging trends in key areas. One such promising trend could be the increasing emphasis within quality improvement on patient-based design. TC LHIN and its partner hospitals could pioneer how equity could be built into patient-based design: ensuring the full diversity of patient voices and experience are included, ensuring even the most complex and challenging needs and circumstances are considered, etc.

Building on the Potential of Local Initiatives/Innovation

One of the most important findings of this report is the large number of equity initiatives underway across the sector. Many hospitals have identified unmet needs, service gaps or access barriers, and have designed programs to address the specific needs of health disadvantaged individuals or communities. This section identifies the key success conditions for realizing the potential of all these initiatives. As emphasized throughout, one such success condition is developing a consistent and coherent strategy to anchor and guide the many individual initiatives.

Some hospitals will need to more explicitly identify equity barriers and challenges within their planning. For example, several spoke of providing services to seniors or people with disabilities as equity issues. While these groups face serious issues because of their conditions, the equity implications need to be explicitly analyzed: how do the needs of seniors or people with disabilities vary depending upon their background or social and economic circumstances; e.g. are the needs of older immigrants with language challenges being met? How do the cost of drugs, home and community services, and adaptive supports that have to be paid for privately limit health opportunities for seniors and people with disabilities — and how can hospitals take such barriers into account?

Several hospitals reported various service improvement or flow initiatives. Here also, hospitals need to specify the equity components or linkages in the initiatives they cite: e.g. the specific access or quality barriers they are addressing with the particular program, the specific disadvantaged populations that are being targeted for support, and how services have been adapted or customized to take these equity barriers or challenges into account for particular populations. In other words, the "theory of change" underpinning the initiatives — the key assumptions, components, pathways of change, levers and objectives — often may need to be articulated more clearly. This is not just a planning issue. Clear theories of change allow systematic evaluation across different hospitals and service contexts.

This highlights the need for clear and consistent understanding of the complexity and depth of health equity analysis needed:

- this may require further discussion within the sector to elaborate these common understandings;
    - an option for Toronto Central to consider would be to work with existing equity planning forums, such as the Hospital Collaborative, the coordinating forum for Toronto Community Health Centres (GT CHCs) and other appropriate stakeholders, to develop guidelines on what exactly equity means and how it can be operationalized (similar to its process around community engagement);
    - these guidelines could be web-based and interactive so that hospitals could comment, debate and share lessons learned Wiki style;
- but the fact that understanding has so clearly been enhanced from the first generation of plans could indicate that this very process of coming together at the Hospital Collaborative and internally around the equity plans; systematically analyzing the patterns and implications of the resulting plans in this report; and then coming together again to collectively discuss common implications, challenges and next steps will support clearer common understandings of equity moving forward.

The need to build individual equity initiatives into a coherent overall strategy applies at the system level as well. Pilot and demonstration projects are crucial drivers of innovation, but to have a significant lasting impact, the equity innovations that are working well need to be institutionalized. This requires forums and infrastructure to share innovations across the hospital sector — and beyond — and evaluation to identify effective equity initiatives.

INNOVATION KNOWLEDGE MANAGEMENT

The challenge is identifying promising practices, sharing lessons learned widely, and scaling up and adapting the most effective equity initiatives as appropriate. There are several directions that can be considered:

- Create forums in which equity innovations and lessons learned are effectively shared. Conferences such as Healthy Connections are a crucial part of

this, but there need to be more systematic ongoing means to collect and share lessons learned.

- One goal will be identifying initiatives that could "travel well" and considering where and how they could be spread.
- Web- and data-based means of collecting, sharing and analyzing equity-based innovations could be effective. Wiki-style interactive mechanisms would encourage ongoing elaboration and discussion.
- Similarly, more explicit communities of practice can be encouraged. The Hospital Collaborative has proven to be an essential forum for the analysis and coordination of equity initiatives. It and the process of developing equity plans has also contributed to more collective discussion among particular sectors – such as those concerned with transitions and complex continuing care, training, interpretation and many other specific issues.
- Some practices can be seen as exemplars that all could learn from. These can be identified as promising practices to be more fully investigated -- either in the next round of equity plans or in the increasing emphasis on evaluation that we are recommending. In the future, it is possible that equity innovations and organizational practices proven to be effective could be required of all.
- The LHIN – and MOHLTC – could enact funding and other incentives for innovation.

Some of the initiatives that could 'travel well' were more about process than particular service developments:

- for example, when one program between a hospital and community-based partner was criticised by trans patients, the partners realized that they needed to reach out to the trans community more explicitly, and adapted their services as a result. The general point of engaging with the specific populations affected by the particular service or issue can be adapted to many situations and challenges.
- a number of hospitals developed cross-hospital and multi-disciplinary task forces or councils to address equity issues. This idea should be adapted to every institution.

EVALUATION

TC LHIN requirements, equity planning processes and the general commitment of hospitals has led to a wide and promising range of equity-driven initiatives. To build on this potential, we need to know what works effectively, for addressing which disadvantaged population's needs or access barrier, and if/how it could be adapted elsewhere – we need effective evaluation.

TC LHIN could develop a system-level equity evaluation strategy to assess and leverage these many initiatives. Its goals would be to evaluate which initiatives are working well, for whom and in what contexts:

- Many initiatives are directed towards particular populations, recent immigrants, isolated seniors, homeless people; or particular barriers like language or poverty. An evaluation strategy could deepen understanding of evaluating the "for whom" element of this realist perspective and create practical and actionable knowledge to assess initiatives and improve delivery.
- The evaluation strategy would also need to recognize that the various initiatives all operate in specific organizational contexts, large teaching hospitals, continuing care, etc.; and program contexts like psychiatric care for recent immigrants or reproductive health for street involved youth. By analyzing a range of initiatives working within similar settings and programs, we would build up rich knowledge of how equity innovation can work in these different contexts.

A second direction could be for TAHSN (the Toronto Academic Health Science Network) and other hospitals involved in research to prioritize evaluation of equity and population-based initiatives within their research programs.

Developing such a grounded and equity-driven evaluation strategy is a significant opportunity to advance the science and impact of evaluation more generally.

FILLING OUT THE EQUITY PICTURE

A positive result of the information sharing and evaluation discussed above will be more extensive and reliable evidence on the large number and wide range of equity initiatives. By continually sharing and building on this evidence and intelligence, we will be able to gradually fill out the overall equity picture. As more practice experience is shared, data collected and evaluations conducted, hospitals and the overall health system will be able to better identify unmet needs, service gaps and emerging challenges. This, in turn, will help to identify priority initiatives and investments, and help adjust the overall equity strategy moving forward.

This also highlights a critical role for the LHIN:

- to enable effective forums and infrastructure to identify gaps, opportunities and synergies;

- to ensure that individual hospital equity strategies, plans and initiatives complement and build on each other;
- to build addressing gaps and opportunities into individual H-SAAs moving forward.

We have emphasized the potential and importance of being able to collect, collate, share and assess the fuller picture of equity that is emerging. This cannot mean just from within the hospitals, who will be generating increasing amounts of equity-focused data, practice knowledge, evaluation and research, but also from other sectors. For example, the Community Health Centres focus on systematically supporting the most health disadvantaged populations and are developing joint projects to address common equity challenges.

Conclusions: Building Equity Momentum

Critical success conditions for individual hospitals — at whatever stage they are — to move their equity planning and operationalization to the next level include:

- a coherent overall strategy;
- a clear framework for change or 'theory of change' setting out the key components, pathways and levers to drive their strategy into action;
- allocating staff and other resources, and developing effective planning forums, management responsibilities and accountability processes;
- dynamic and flexible operationalization, so that programs and implementation are continually adapted, thorough evaluation, evidence and experience;
- building a learning culture of continuous improvement and equity innovation.

Success conditions for advancing equity across the hospitals sector include:

- clear and consistent LHIN priorities and overall directions;
- sharing equity innovation, evaluation and data;

and across the healthcare system as a whole within Toronto Central:

- coordination of hospitals, CHCs and other providers;
- consistent and effective collaboration between hospitals and community partners;
- collaboration and coordination beyond the LHIN system — e.g., with public health and other sectors and agencies concerned with the social determinants of health.

CASCADING EXPECTATIONS

The challenge for the LHIN and hospitals is to develop a coherent overall strategy and common components, that can be dovetailed with specific priorities for individual hospitals. This will be especially important as equity expectations and deliverables are built into accountability agreements and performance management systems in the near future.

We began from an analytical framework that differentiated the types of hospitals and this has been confirmed by our findings:

- the different types of hospitals have very different mandates, patient and service mixes, size and scale of resources, and traditions;
- even within particular types of hospitals the service mixes and dynamics will vary depending upon population, catchment characteristics and community needs, and areas of specialization;
- the focus and types of equity initiatives undertaken varies.

A cascading system of expectations and requirements needs to be developed:

1. **areas where all hospitals and the sector as a whole face common challenges and should have common expectations to:**

   - understand the equity barriers and challenges of their particular populations and adjust their service mixes accordingly;
   - provide culturally competent care, including interpretation and translation in the main languages of their populations;
   - embed equity into quality improvement, strategic and operational planning processes and performance management;
   - undertake HEIA in appropriate circumstances, including for any significant service re-alignments or cuts;
   - systematically collect common equity-relevant data;
   - undertake appropriate partnerships and collaborations with other hospitals and other service providers within and beyond the LHIN to better serve disadvantaged populations and address access barriers;
   - proactively share lessons learned with other hospitals and beyond.

2. **principles and priorities that apply to the more specific dynamics and drivers of particular types of hospitals:**

- e.g. acute hospitals could consider how to apply an effective equity analysis/lens to wait times and ALC priorities;
- e.g. rehab and continuing care hospitals could work towards common ways to build understanding of the social resources and circumstances in which patients live into discharge and follow-up planning.

3. **adaptation of overall equity principles, priorities and strategic direction to the specific context of individual hospitals:**

- particular hospitals may need to address particular communities in their catchment or speciality areas – homeless people, racialized communities, refugees from conflict situations – or may need to take particular community needs and characteristics into account – e.g. particular languages of their population base;
- specific expectations can be included that capture these requirements.

These cascading expectations and deliverables need to be built into H-SAAs moving forward. Timing will need to be carefully considered: developing the next generations of the equity plans will need to be dovetailed with negotiating the next round of accountability agreements.

ACTION RECOMMENDATIONS

Analyzing these success conditions and issues highlights five broad areas where the hospitals and the LHIN can consistently implement key directions. We make a series of inter-connected specific recommendations within each.

BUILD EFFECTIVE EQUITY STRATEGIES

Refreshing the equity plans has been important to identifying such possibilities. Continuing to build momentum through further generations of these plans, and through sharing and building upon lessons learned in implementation, will be a key part of driving equity forward.

Our first recommendation is that:

1. **The hospitals continue to refresh their equity plans at least every two years. Toronto Central LHIN should also continue to commission or undertake an analysis of these updated plans and report on how it will integrate the hospital equity plans and the recommendations from the analysis of the updated plans into its ongoing overall equity strategy.**

As with the first generation of equity plans, the LHIN should convene forums and other appropriate means to discuss this report.

The timing for updating the plans should be linked to the cycle of negotiating the H-SAAs. We argue below that deliverables resulting from these hospital equity plans, from discussion of this report, and from current LHIN equity planning need to be built into the negotiations that will begin later this year. Assuming the two-year cycle of H-SAAs continues, the next generation of hospital equity plans should be completed in the fall of 2012, to be analyzed and discussed in spring-summer 2013, and be ready for incorporation in HSSA negotiations in late 2013.

Assuming the Quality Improvement Plans remain a key provincial requirement, and assuming that equity can be successfully integrated into this process, the nature and scope of the equity plans may change:

- some core elements may be integrated into the QIPs and will not need to be repeated in specific equity plans or in H-SAAs;
- in years to come, it could be that equity is fully integrated into other dimensions of quality in the QIPs and other mechanisms, and separate equity plans are no longer necessary.

A number of areas have been identified where the LHIN, working with hospital partners and other stakeholders, can clarify common understandings and expectations:

- common understandings of equity in hospital settings, and resources and tools to help consistently operationalize this understanding and equity objectives (for example, resources on how to most effectively use HEIA within hospital and program settings, how equity can be built into quality and service improvements, etc.);
- how equity can/should be embedded into planning and management processes – from consistently including in balanced scorecards, through common equity data and indicators, to incorporating equity into quality improvement and reporting.

The Hospital Collaborative will remain an effective forum to initiate and coordinate these discussions and resource development. Our second recommendation is:

2. **Toronto Central LHIN should continue to partner with the Hospital Collaborative on Vulnerable and**

Marginalized Populations so that it can be the forum for detailed discussion on operationalizing equity and for developing successive generations of hospital equity plans.

ALLOCATE RESOURCES AND RESPONSIBILITIES

We have emphasized the importance of embedding equity within hospital planning processes, operational structures and working cultures. Taking this further, to be serious about driving their equity strategies into action, hospitals have to allocate sufficient resources and ensure responsibilities and deliverables are clear.

Hospitals have established task forces and other models for policy and program coordination, and developed innovative management processes. These have proven successful not just in enhancing coordinated action, but in more generally providing a face and forum to build equity awareness and interest within the hospitals. This potential should be built on in all hospitals.

3. **All hospitals should establish an appropriate cross-hospital equity task force or planning forum within one year. While the particular form and mandate will vary depending upon the needs and circumstances of the hospital, all should create effective multi-program forums for the coordination of equity-related planning, service delivery and initiatives.**

4. **All hospitals should assign clear equity deliverables and responsibilities within senior management within one year. Here also, while the particular management structures and processes will vary significantly, a pre-condition for consistently operationalizing equity in every hospital is clear management responsibilities.**

EMBED EQUITY IN PLANNING AND PERFORMANCE MEASUREMENT

Leading hospitals have shown that equity planning is not just an exercise that is undertaken separately and sporadically; rather, equity has to be a critical dimension in ongoing strategic and operational planning.

5. **All hospitals should incorporate equity dimensions and objectives into their balanced scorecards or other planning mechanisms. All hospitals should use Health Equity Impact Assessment for appropriate policy and program development, including for any significant program and resource re-alignments.**

Having good equity-relevant data is an indispensable success condition for planning; assessing patient needs and service gaps; creating effective indicators, targets and program and hospital deliverables; monitoring progress against expectations; and evaluating impact. Some data simply is not being collected and pilots and initiatives are underway to determine how best to rectify this. In many cases, there already is a huge amount of patient, administrative, treatment and outcome data being collected; but we need to be able to stratify the data by equity dimensions.

6. **Toronto Central LHIN and hospital partners should develop a comprehensive equity-relevant data collection strategy. While implementation will need to be carefully dovetailed, the goal should be to have a sufficiently comprehensive equity data collection protocol operational in all hospitals by the end of 2012.**

Key to institutionalizing equity within performance management and resource allocation is developing evidence-based and effective indicators. There is a huge international research and professional literature to be drawn upon and many interesting local initiatives underway. Several hospitals are already requiring programs to develop and report on equity indictors. All should.

7. **All hospitals should identify a manageable number of appropriate and effective organization-wide and program-specific equity indicators. Hospitals should develop a coherent overall performance measurement and management strategy that integrates data collection, targets, measurement, monitoring and performance management by mid-2013.**

Good data plus effective evidence-based indicators allows equity targets to be set and progress systematically tracked and monitored.

8. **Toronto Central LHIN and all hospitals should develop a cascading system of equity targets and deliverables in 2013, including:**

a) **equity deliverables that hospitals report on to the LHIN and that are built into their accountability agreements;**

b) **deliverables that programs within the hospital report**

up to their Board;

c) more specific equity deliverables for sub-program, practice teams, managers, etc.

EMBED EQUITY IN ACCOUNTABILITIES AND DELIVERABLES

We have emphasized that a pre-condition of driving equity strategies into action is building equity objectives into ongoing quality and performance measurement and tracking. The goal is to develop a comprehensive equity performance measurement system that can link progress on achieving equity targets to accountability mechanisms: managers responsible for particular equity initiatives, specific programs and the hospital as a whole need to be expected to deliver on their identified equity targets.

It will be crucial for the LHIN to embed concrete expectations for operationalizing equity in ongoing accountability moving forward. Timing will be important: negotiations will begin by the end of 2011 for the renewed 2012-13 H-SAAs, and priorities and deliverables based upon this generation of equity plans and current LHIN equity priority directions will need to be built in.

9. Toronto Central LHIN should work with hospitals partners to incorporate priorities and projects identified within the 2010 equity plans and equity deliverables identified within ongoing strategy discussions into the next generation of H-SAAs.

The Hospital Collaborative is the most effective forum within which to initiate these discussions. It should be asked to recommend by December 2011:

- one or two standard equity deliverables to be built into all H-SAAs – for example collecting the standard equity-relevant data that is developed out of current pilot projects, participating in centralized interpretation programs, etc.; and
- the most effective range of cascading expectations and deliverables that can be adapted for the different types of hospitals and for specific hospitals.

The goal would be that all Toronto Central hospitals would be monitoring and reporting on just a few common equity indicators. This would allow effective tracking over time and benchmark comparisons.

It is also critical to align equity within provincial and system drivers such as quality improvement and the *Excellent Care for All Act*. The key lever will be building equity into quality improvement plans and other requirements under ECFAA.

10. Toronto Central LHIN should require that all Toronto Central hospitals include at least one specific equity indicator in their 2012 Quality Improvement Plans, and that any data collected and reported for quality improvement purposes must be disaggregated by equity dimensions.

Here also, the Hospital Collaborative will be an effective forum within which to initiate discussion on how to develop equity indicators that will be appropriate for the QIPs of the different types of hospitals.

DRIVE INNOVATION

The LHIN can play a key role in enabling equity-focused innovations through establishing resources, incentives and drivers; supporting innovative working cultures within its own organization, the hospital sector and beyond; and creating forums and infrastructure to exchange and spread innovation.

11. Working with the hospitals and other stakeholders, Toronto Central LHIN should:

a) prioritize key strategic areas for equity innovation and allocate specific ear-marked resources to fund promising equity initiatives; and

b) include expectations on hospitals to fund and support a defined amount of front-line and organizational equity innovation in H-SAAs.

12. Toronto Central LHIN should ensure a systematic infrastructure to identify promising innovations, share information and lessons learned, assess and evaluate effective practices, and scale up and spread innovation is created. This could include conferences, web-based communities of practice and other forums to enable equity innovation.

At the same time, there should be a proactive responsibility on all hospitals to share lessons learned and promising practices, and they should begin by all posting their equity plans.

13. Toronto Central LHIN should develop an equity-orientated evaluation strategy that supports ongoing learning and equity innovation and implementation.

These innovation sharing principles and mechanisms need to extend beyond the hospitals to capture and build upon the considerable on-the-ground equity innovation in other sectors as well.

Leading on Equity

This series of recommendations is based upon the best of what is already happening. They will drive coherent directions and consistent implementation across hospitals; enable learning from each other and building continuous equity-driven innovation; and embed equity into the core fabric and culture of Toronto hospitals. At the same time, the recommendations are also designed to be flexible enough to be adapted to the unique traditions, service needs and resources of the individual hospitals.

The equity work currently underway across the hospitals and moving forward on this suite of recommendations has enormous potential to enhance the health and health equity of all residents. Some of these directions can be very much leading edge: embedding equity into performance measurement and management, integrating equity into quality improvement, building the full diversity of people's needs into patient-centred care, etc. Toronto Central hospitals and the LHIN have a chance to be national and international leaders in delivering on the promise of health equity.

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