

Report on the Health Equity Data Workshop

“Who are we serving?”

A half day workshop on health equity data for hospitals was held on April 6th at Mt. Sinai Hospital. It was open to hospitals and other Health Service Providers. The workshop was well attended - over 100 registered. There were representatives for all 18 hospitals in the TCLHIN, Community Health Centres and others in Toronto Central, Central and other LHINs, MOHLTC, Public Health.

Sponsors

The workshop was sponsored by
Hospital Collaborative on Marginalized Populations
Toronto Central Local Health Integration Network
Access Alliance Multicultural Health and Community Services
Health Equity Council
Wellesley Institute
Toronto Community Health Profiles Partnership
Mount Sinai Hospital

Goals of the workshop

This workshop was designed to provide examples of how hospitals can use existing data to understand their gaps and challenges in ensuring those with the greatest health needs and access barriers are being equitably served; as well as, whether they are receiving equally good quality of care.

A second goal was to gather feedback that leads to recommendations for strategies for new data collection and health equity indicators.

This workshop is one step towards defining common indicators and coordinated strategies to address data and knowledge gaps to support action to reduce health disparities. It is acknowledged that there is a need for clearly defined roles for LHINs, MOHLTC, and research institutes in further supporting health equity information strategies. Not all service providers have the capacity to analyze their data.

Context

Hospitals in the TCLHIN submitted their Health equity plans to the TCLHIN in February 2009. The framework for the report template was developed by Bob Gardner of the Wellesley Institute and requires data to 1) build equity into all planning and service delivery and 2) to target specific investments and programs to disadvantaged populations and critical access and quality barriers.

The Hospital Collaborative on Marginalized Populations developed the template completed by all hospitals. A common challenge faced by most hospitals was the lack of health equity data and information - what should be collected, who should define what is collected, how to collect data from patients.

Janine Hopkins from the TCLHIN, a key sponsor for the workshop, described success as embedding equity into all plans and embedding equity data into all metrics. One of critical next steps is gaining a deeper understanding of all the dimensions of equity, and how different factors interrelate and contribute to the health of individuals and communities. Bob Gardner further set the stage for operationalizing health equity through building on solid commitments and promising local initiatives, and cleverly using available data.

Speaker notes related to health equity data and analysis methods

Kwame McKenzie (Psychiatrist, Medical Director of Diversity & Mental Health, Social Equity Research Unit, CAMH). Kwame presented his experience in the United Kingdom where health equity information at a local level is used to target high impact changes. In the UK undertaking Health Equity Audits (HEAs) and Equality Impact Assessments (EQIAs) are specific legal obligations of planning and performance. HEAs use equity information to identify how fairly services or other resources are distributed in relation to the health needs of different groups and areas. He provided an example of redistribution of coronary revascularization services in West Hertfordshire in Scotland. A significant improvement in occurred over three years (2001-03) in redistributing the number of revascularization procedures per one million people per year.

Dianne Patychuk Dianne is a social epidemiologist who demonstrated how census data and client postal codes can be used to define income groups with differences in health needs in order to identify and track health service inequities among them. For example, local data shows higher income groups are receiving more specialist services and procedures than lower income groups who need them more. Dianne referenced a shareable and easy-to-use tool for health care providers created by Access Alliance in which all census tracts in Toronto are scored according to income, no English language, disability, recent immigrants, racialized groups, education level and age. Client postal codes linked to census tracts enable service users to be profiled according to the population (i.e. are we serving people equitably according to needs and access barriers?); and, to identify potential service inequities and track impacts of changes. The Health Equity Council Indicators Group have three groups of indicators representing a continuum of care: getting to care (reducing access barriers), service quality and

discharge/community follow-up. The impacts of improving equity across the continuum would be: lower rates of missed appointments; reduced readmissions, complications, risk, ALC days, and lengths of stay; as well as improved quality of care and costs saved.

Ted McNeill from Sick Kids Ted McNeill provided an example of using health equity information in an analysis that was undertaken by SickKids. He examined utilization data related to low income families whose children's health were treated at the hospital. The Canadian Institute for Child Health in 2000 reported that Canadian children living in low-income families are more likely to experience a greater incidence of a variety of illnesses, hospital stays, accidental injuries, mental health problems, lower school achievement and early drop-out, family violence and child abuse. Sick Kids partnered with United Way to use their findings published in "Poverty by Postal Code." "High poverty neighbourhoods" were defined as having 26% to 72.8% of families below Stats Canada's Low Income Cut-Offs (LICO). They comprise 120/500+ census tracts. The United Way identified the postal codes (FSA's) that were associated with the high poverty census tracts and when mapped to SickKids data showed disparities when compared to children living in other Toronto neighbourhoods in the rate of admissions (higher), average length of stay (longer), resource intensity weighting (more complex), unplanned re-admissions (more likely), clinic visits (slightly more), missed clinic appointments (more likely) and patient deaths (more likely).

Research projects using health equity data Dianne compiled eight published projects of GTA hospitals that used patient language and ethnoracial data. These serve as helpful starting points for hospital equity data collection. A range of methods included: patient "census", chart audits, telephone follow-up surveys, preferred language on admission, identifying ethnicity using last names, and data collection for diabetes surveillance. For example, Princess Margaret Hospital in Toronto surveyed patients in 202 clinics. Questionnaires were in Chinese, Italian, Spanish, Portuguese. Patients not served in their own language or using a family member as an interpreter had less realistic expectations of cure and poorer quality of life (Tchenn, Tannock et al. *Brit J of Cancer* 2003 (9), 641-647). In another study, patients with limited English proficiency had 6% longer length of stay, greater for stroke (3.6 days) and diabetes (1.8 days). These conclusions were drawn from a study of consecutive hospital admissions, (59,547 records), at Toronto Western, Toronto General, Princess Margaret Hospital. (John-Baptiste et al. *J Gen Intern Med.* 2004:19:221-228). Research at CAMH indicates that people of white/European ancestry comprise a greater proportion of mental health service users with African/Caribbean population and South Asians and Chinese populations

underrepresented . (Koegel, et al 2004, Durban et al, 2002 Health Systems Research and Consulting Unit CAMH).

Interpretation and Translation Services In further emphasizing the importance of language barriers, Elizabeth Abraham, Healthcare Interpretation Network & UHN, presented the business case for trained language interpreters. Data comparing English speaking and low English speaking patients - show a cost benefit for using trained interpreters related to mortality and morbidity rates and service utilization for chronic, manageable diseases (Diabetes, asthma, asthma with bronchitis and hypertension). Service utilization data included proportions of admissions, emergency visits, outpatients visits and estimated cost of physician time. Effective communication is necessary for safety, risk management, quality and consent. Failure to provide an interpreter (medical error based on mis-communication) has been grounds for successful claims against hospitals in the US.

Health Equity Indicators - Centre for Research on Inner City Health (CRICH) CRICH in collaboration with the TCLHIN Hospital Collaborative on Marginalized Populations reviewed scholarly and grey literature to identify equity measures for in-hospital use. Their review identified 706 possible equity indicators, which were screened and synthesized on the basis of six criteria into a list of 10 recommended 'starter' indicators that can be readily implemented by hospitals to measure and monitor equity. These indicators comprise seven indicators measuring equity in hospital care (grouped into two themes - 'cultural competency' and 'quality of care') and one for each of the three LHIN priority populations (i.e. the elderly, people with mental illness, and people with diabetes mellitus).

First steps in accessing and using health equity data

Dianne Patychuk (9Steps to Equity) and Katherine Smith (Toronto Central LHIN) describe resources that can help hospitals to do equity-based utilization analysis and compare access, service utilization and outcomes for subgroups by using census tract data and hospital data. In the absence of individual patient information on socioeconomic and ethnicity, postal codes and census data can be used to disaggregate the population into population subgroups for comparative analysis.

Hospitals can sign on to

Intellihealth (intellihealthontario@ontario.ca) maintained by MOHLTC for hospital data in databases such as DAD, NACRS, NRS, CCRS. Intellihealth is used to create a link to postal codes which can then be linked to census tract data and socio-demographic factors. Hospitals may be able to access census data through joining a data collaboration led by the City of Toronto (hlow@torono.ca) which

includes a joint census purchase at a low cost, and neighbourhood level health indicators can be accessed at www.torontohealthprofiles.ca

Discussion and Evaluation The forum brought together a broad representation of health care in the TCLHIN (over 100 attended) and based upon feedback in the evaluation forms there was a general appreciation for the opportunity to learn about available data and methods pertaining to health equity. The discussion generated several questions for which there are no immediate answers, however, the questions will lead to recommendations from the Hospital Collaborative.

Questions from the audience

Are hospitals committed to collecting and tracking data on language, socio economic status, age race and ethnicity?

Is there funding for new data collection?

Are hospitals willing to work together on data collection?

Who is responsible for data collection?

Are there any legislative barriers to data collection?

Can we build on good practices within hospitals to address inequities?

How can we work best across sectors such as with different campaigns related to health promotion?

How do we involve front line workers?

How do we address non-OHIP status peoples?

Can we apply the data initiatives to the Integrated Health Service Plans?

Success Conditions

In addition to identifying key questions such as those above, participants highlighted what needs to be in place to move forward on equity and diversity relevant data collection and planning:

- keep the overall goal of integrating equity - based on solid data and evidence -- into hospital and provider planning in mind;
- providers and community partners need to be involved early in defining the necessary data requirements;
- solid information and data is one critical pre-condition for a success overall strategy on health equity - need to ensure that data collection and monitoring is sustainable;
- need to clarify at system level what data will be collected and for what purposes to ensure consistency and reliability. The Province and LHIN need to set the overall framework;
- build on interesting and effective experience and practices from other jurisdictions and on local initiatives.

Next Steps:

The working group on health equity data propose that the Hospital Collaborative use the presentations from the workshop and the discussion points to develop recommendations to the TCLHIN

An important first step is to recommend that the TCLHIN set expectations for health service providers to apply an 'equity lens' to all plans, and funding proposals related to clinical services.