"Who are we serving?"
A workshop on hospital-based strategies to identify health service inequities

April 6th, 2009, Toronto Ontario

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

About the Workshop

Without good data, it is difficult to identify health disparities or to measure whether people with the greatest health needs, access barriers and least resources are being equitably served and are receiving equally good quality of care. A group of organizations came together with the Hospital Collaborative on Marginalized Populations to sponsor a workshop on what hospitals could do now using existing administrative and community data to begin to address these information gaps. Mount Sinai Hospital hosted the event. Other sponsors include: Toronto Central LHIN, Alliance Multicultural Health and Community Services, the Health Equity Council, Toronto Community Health Profiles Partnership, and the Wellesley Institute. 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.

About the Workshop (cont'd)

About 100 people attended this workshop including hospitals who have recently submitted their health equity reports to Toronto Central LHIN and to Central LHIN as well. We are also joined by staff from the Ministry of Health and Long-term Care, a CCAC, several Community Health Centres, other community services, research organizations, Canadian Institute for Health Information, Toronto Public Health and others interested in moving forward on reducing health inequities.

The speaking notes or slides from the presenters have been combined into this one document to make this information available to workshop participants and others.

Agenda

8:30 Welcome and introduction
- Joseph Mapa, ***President and CEO Mt Sinai Hospital***

8:45 Setting the scene
- Janine Hopkins, ***Senior Director, Community Engagement and Corporate Affairs, Toronto Central LHIN*** **(pgs 3-6)**
- Bob Gardner ***Director of Policy and Research, the Wellesley Institute*** **(pgs 6-9)**

9:00 What is possible
- Kwame McKenzie **(English experience)** ***Medical Director of Diversity & Mental Health; Senior Scientist, Social Equity Research Unit, CAMH*** **(pgs 9-18)**
- Dianne Patychuk (Using the information we have) ***Access Alliance Multicultural Health and Community Services; the Health Equity Council*** **(Pgs 19-31)**

9:45 Snapshots: moving forward
- Ted McNeill (**Pgs 31-40),** Dianne Patychuk **(Pgs 41-48),** Elizabeth Abraham **(Pgs 48-52),** Carlos Quinonez **(Pg. 53)**

11:15 First steps: resources and tools:
- Katherine Smith/Dianne Patychuk **(Pgs. 54-64)**

11:45 Next steps: building consensus on indicators and data **(p 64)**

Towards a More Equitable Local Health System
Janine Hopkins, Toronto Central LHIN

Good morning and thank you for being here today.

Toronto Central LHIN is proud to be one of the sponsors of today's event. The range of people here today speaks to the level of commitment to health equity throughout the TC LHIN and other LHINs. Thanks to a solid base of research, the relationship between equity and outcomes is no longer a matter of opinion, but a fact. We know for example that:

- Diabetes is twice as high in low income versus high income neighbourhoods
- New immigrants are more likely to have cardiovascular disease because of language and other barriers to getting appropriate health care
- More low income people are living with pain and disability because they are receiving 60% fewer hip replacements than people with higher incomes

- Health equity is a major cause for the TC LHIN – because of the great diversity of our LHIN and the unique range and complexity of inequities that play themselves out here. We know that one of the most effective ways we achieve a more healthy population is by removing disparities in access to and in the quality of services people receive.
- It's great to see that the burgeoning research and policy work on health equity is attracting growing media and public attention.
- One of critical next steps is gaining a deeper understanding of all the dimensions of equity, and how the different factors interrelate and contribute to the health of individuals and communities. We need to measure the right indicators so we can set the right targets and effective strategies that will achieve lasting improvements.

Janine Hopkins Toronto Central LHIN, Speaking Notes

- TC LHIN's commitment to health equity extends from our Board throughout the organization. The Board identified and communicated the LHIN's commitment and expectations about health equity over a year ago. There have been number of important reports and events on health equity that are informing us.
- Bob Gardner's paper on health equity serves as a framework for the TC LHIN There is a richness of experiences from other jurisdictions and within our own hospitals and communities that we will be hearing more about this morning.
- Health equity is embedded in the LHIN's work: engagement methodologies, make up of our advisory groups and committees, and the criteria we use to evaluate proposals and design programs.

Janine Hopkins Toronto Central LHIN, Speaking Notes

- TC LHIN is focussing our investments and implementation efforts on health issues that have a high impact on disadvantaged and marginalized populations – chronic disease management, mental health and addictions and ER-ALC strategy. In particular, TC LHIN is one of the early implementation sites for the provincial diabetes strategy. We are working with ICES and other partners to analyze the needs and gaps in our LHIN and will be designing a coordinated model of primary care that will improve diabetes management within the highest needs populations and neighbourhoods. We will be implementing the diabetes information system or registry that will, among other things attach people without access to primary care, to a primary care team or practitioners. We will also be rolling out a diabetes management project for urban Aboriginal communities this year.

Janine Hopkins Toronto Central LHIN, Speaking Notes

- We can't accomplish everything at once. Work needs to be thoughtful, evidence informed and carefully staged. Different streams of key Health Equity work are converging.
- Hospital health equity plans, which many of you were involved in developing, is the first time our hospitals have been asked to document the current equity challenges, gaps, practices and improvement plans. Leadership hospitals are taking individually and together shines through the 18 reports that we received - the amount of effort and the depth is obvious. The LHIN is working with partners the Wellesley Institute and the Centre for Research on Inner City Health (CRICH) to analyze the plans. We are fortunate to have Sanjeev Sridharan, Director of the Evaluation Program at CRICH and Associate Professor of Health Policy, Management and Evaluation at the University of Toronto leading this work. We will all be able to benefit from his extensive

international research and policy experience in health equity. Following analysis in May, there will stakeholder dialogues with the Hospital Collaborative on Marginalized Populations, and other partners, to engage on the findings and to plan next steps in June and July. The LHIN will be looking at how we can incorporate health equity into the next Hospital Service Accountability Agreements and the findings will inform the next Integrated Health Services Plan that we are developing and will inform our engagement with our communities over the spring and summer.

- We'll take a similar approach with community providers.
- The Ministry of Health and Long-Term Care identifies equity as a key pillar. The Toronto Central LHIN is collaborating with the Health Equity Branch at the MOHLTC to develop a health equity assessment tool. This tool will enable health service providers and the LHIN to systematically assess the

impact of programs on equity which will be critical to improving performance. We are glad to hear from Bob Gardner that there will be an upcoming consultation with the Hospital Collaborative on Marginalized Populations about the Tool. Today's workshop is another important element for advancing our knowledge about health equity.

- In September, the LHIN and other partners are planning an Equity conference as a follow up to the very successful Healthy Connections event last year. This event will be an opportunity to continue knowledge sharing about experiences and innovations. You will receive more information about this soon.
- There is a great sense of excitement and common purpose about health equity in Toronto. There is an opportunity to improve the health and wellbeing of many, many people today and the future and make our communities more compassionate and more inclusive for all the people who live and receive health services here. Thank you and have a great morning.

Janine Hopkins Toronto Central LHIN, Speaking Notes

Setting the Scene

Building Data and Tools to Advance Health Equity, From the Hospital Health Equity Plans Forward Who Are We Serving?

Hospital Health Equity Data Workshop

April 6, 2009

Bob Gardner

WELLESLEY INSTITUTE
a decade of advancing urban health

10 YEAR ANNIVERSARY 1998–2008

Setting the Scene

- all our work – hospital executives, equity and diversity coordinators and mobilizers, clinicians and providers, researchers, and decision makers – depends upon good data and information
- I had two big themes in my equity framework for TC LHIN:
  1. build equity into all planning and service delivery
  2. target specific investments and programmes to disadvantaged populations and critical access and quality barriers

  – both depend upon really good data and info

Setting the Scene II

- big picture:
  - this is an era of evidence-driven policy making, and data-driven resource allocation and performance management
  - solid commitment to health equity at Provincial and LHIN level
  - but if we can't develop good indicators and objectives for equity, measure how well we are doing, use equity/diversity relevant data to assess gaps and challenges, and prove that our interventions work in reducing disparities
  - then we won't be able to put equity into action
- but, real progress on this is possible:
  - there are many sources of existing data and we can cleverly mix and match them
  - we can learn from other jurisdictions and collectively work out what kinds of data and processes are needed

Setting the Scene III

- we don't have perfect data, and there is a great deal we don't know
- but we can't let this paralyze us – we know enough to act on equity
- lots of promising local initiatives:
  - health ambassador type programmes out of Access Alliance and other CHCs in which peer health promoters from particular ethno-cultural or local communities go out into those communities
  - Women's College Network on Uninsured Clients addressing the really desperate situations of people facing horrendous barriers
  - networks of hospital and other interpreters getting together to figure out how to provide better services
  - none of these initiatives has complete data on the community they are supporting or the problem they are trying to solve
  - but they are moving

Participants in Recent Consultations on HEIA Defined Success For Equity-Driven Planning As…

- when operationalizing health equity becomes more than the work of the "equity people"
- when senior managers ask: "Are we paying attention to health disparities?" "How can we include more diverse people in this program?" "What barriers do we have to look for?" "Are we as effective as we could be at supporting every population?" i.e., has enough awareness of health equity to ask these questions in their service planning and evaluation
- when an organization embeds HEIA across its existing and prospective decision-making models so that health equity becomes a core value and one of the criteria to be weighed in all decisions

Vision

- in the not so distant future:
  - Toronto Western knows what % of older people are more comfortable speaking Portuguese or Vietnamese in its area – and can compare that to % receiving interpretation services
  - UHN, TPH, St Christopher's House and other community agencies, and TC LHIN know where these people are – and who are socially isolated or vulnerable -- so that next time there is a power outage or other emergency, support can be dispatched to their homes
  - we can compare health outcomes and service utilization among people at different income levels or with different immigration experiences – and we can design programmes to reduce these disparities
  - we know which people live in poverty or poor housing, so that additional customized support is available when they are discharged from hospital – so they don't come right back
- this workshop – and other initiatives mentioned – are part of getting from here to there

Health equity – UK experience

Kwame McKenzie
CAMH

Outline

- Legal framework
- Health equity in practice
- Delivering Race Equality

Legal framework

Equality enshrined in law

- The Race Relations Act (1976)
- The Sex Discrimination Act (1975)
- The Disability Discrimination Act (1995)
- The Human Rights Act (1998)
- The Sex Discrimination (Gender Reassignment) Regulations (1999)
- The Race Relations (Amendment) Act (2000)
- The Employment Equality (Religion or Belief/ Sexual Orientation/ Age (2003/ 4)
- The Disability Discrimination (Amendment) Act (2005)
- The Equality Act 2006/7 (Gender / Sexual Orientation/ Religion and Belief).

Legal frameworks

- Equality and human rights legislation places specific obligations upon public bodies, including the NHS
- Chairs, Chief Executives, Board Directors and Non-Executive Directors personally responsible for compliance with legislation.
- Equality and human rights applicable to service issues and to employment

Kwame McKenzie, CAMH

Frameworks linked to action

Undertaking Equality Impact Assessments (EQIAs) is a specific legal obligation

- Using the evidence to create a meaningful dialogue with communities (especially seldom heard from groups) is central to effective commissioning and service provision.
- This creates an evidence-based approach.

Kwame McKenzie, CAMH

Commissioners and providers

- Many layers of responsibility
- Commissioners and providers have equality duties under the law
- Commissioners and providers also have to deliver strategies set by the Department of Health

Who policies legal side

• Commission for equality and human rights is charged with policing equality legislation Investigations and recourse to law

Kwame McKenzie, CAMH

Legal obligations

- Gender, disability and race
  - General and Specific duties
- Others – sexuality, age, religion general duties under law without specific requirements

General Race Equality Duty

- Eliminate unlawful discrimination
- Promote equality of opportunity
- Promote good relations between people of different racial groups.

Kwame McKenzie, CAMH

Race Equality Specific Duties

- Publish an Equality Scheme
- Monitor existing and new functions
- Equality impact assessment
- Information made available / accessible to all
- Train employees to understand race equality
- Publish results of employment ethnic monitoring annually and other metrics such as performance assessment, grievances, disciplinary action and employees who leave the organisation.

Kwame McKenzie, CAMH

But…

Two trains of equalities action

as an employer and

as a health provider

Kwame McKenzie, CAMH

Health equity
UK's health paradox

- Country becoming more healthy
- Health disparities between rich and poor becoming wider
- Difference between determinants of health and determinant of inequity of health
- Focus is on determinants of inequity (those inequalities that are remediable through service provision or policy)

Kwame McKenzie, CAMH

Direction on policy

- Lens of equity and equality since 1980s
- Many reports and policy documents over the decades
- (eg Acheson and Saving Lives: our Healthier Nation)
- Development of 9 public health observatories to help with data but also local data required
- Last policy = Tackling Inequalities – action plan
- Influenced:
  - NHS Priorities and planning framework 2003-2006
  - Primary health care trusts (commissioners) – decisions need to informed by Health Equity Audit

Kwame McKenzie, CAMH

Minister of health 2003

- Work needed at a national and a local level
- Aim in 2004 was to reduce inequalities infant mortality and life expectancy at birth by 10% by 2010
- Plan get local information and target high impact changes in each locality
- Use inequality information to inform planning
- Tool to do this is health equity audit

Kwame McKenzie, CAMH

Health Equity audits

- **Health equity audits** identify how fairly services or other resources are distributed in relation to the health needs of different groups and areas, and the priority action to provide services relative to need. (This may include resources such as services, facilities, and the determinants of health). The overall aim is to distribute resources relative to health need, otherwise inequities occur which lead to health inequalities. The **HEA cycle is not complete until something changes which is likely to reduce inequalities demonstrably**. For NHS services, that would probably be resource allocation, commissioning, service provision or care outcomes.

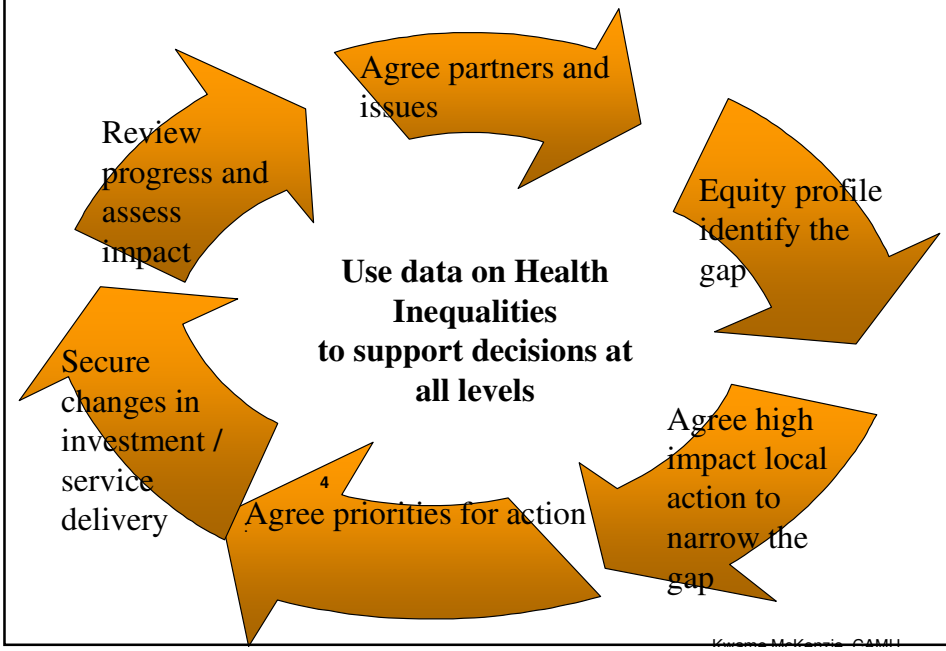
Kwame McKenzie, CAMH

Tools

- Self assessment rating scale.
- Red / amber / green on a number of statements can be found at.
- HAD website – type in health equity audit to google

Kwame McKenzie, CAMH

Health Equity Audit Cycle (Equality Impact)



Kwame McKenzie, CAMH

Process
NHS 24 Scotland lesson learned

- Legal compliance is a powerful tool and motivator for identifying and implementing change.
- Spreading ownership across the stakeholders of the organisation is important.
- Engaging external stakeholders from the very start and sustaining a long-term relationship is vital.

Kwame McKenzie, CAMH

Outcome
Department of health guide

CHD NSF Linked Equity Improvement in West Hertfordshire

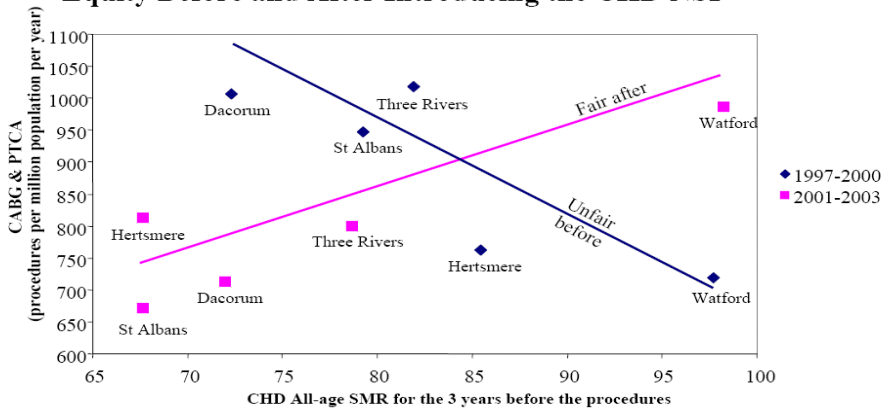
The introduction of the NSF in West Hertfordshire focused upon equitable development of cardiology services.

This included a £300,000 shift in recurrent resources towards areas of highest need.

The next chart shows an improvement in the fairness of the distribution of coronary revascularisation procedures before and after the introduction of the CHD NSF in West Hertfordshire.

Kwame McKenzie, CAMH

The Improvement in W Hertfordshire Coronary Revascularisation Equity Before and After Introducing the CHD NSF



Source: Local finance information system and ONS; all denominators are based on Census 2001 projections

Delivering Race Equality

Improving mental health for BME groups

- DRE in mental health
- Disparities in rates of illness, service use and outcomes for BME (Black and Minority Ethnic) groups
- Possibly in breach of race equality duty
- Need strategy
- Strategy – community engagement, information, appropriate and responsive services

Kwame McKenzie, CAMH

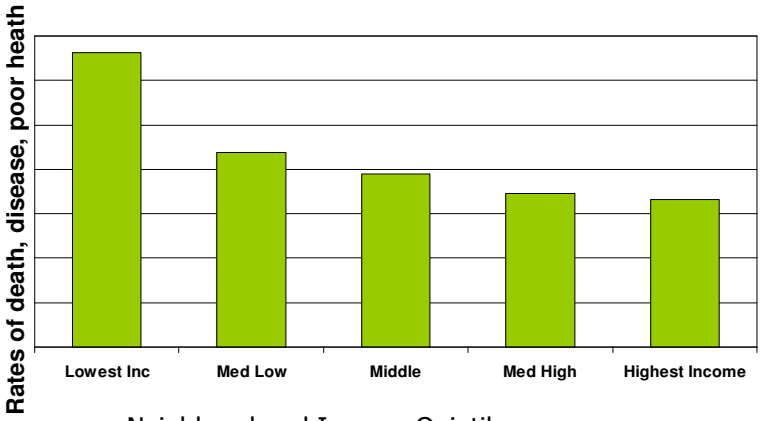
"Who are we serving?" What is possible using the information we have

Dianne Patychuk
Access Alliance Multicultural Health and Community Services, and
Health Equity Council
April 6, 2009

Health Disparities

- There are persistent, recurring differences in health for most conditions, and causes of death among population groups
- How can hospitals influence and reduce these disparities?

Premature Deaths (most causes), Chronic Diseases, Self-rated Health all worse in lower income groups



Patychuk Steps to Equity/08

Dianne Patychuk, Access Alliance, HEC

"The Subcommittee believes it is unacceptable for a privileged country like Canada to continue to tolerate such disparities in health. Our challenge is to find ways to improve the health of all Canadians to equal that of those who experience the best regardless of their ethnicity, social or economic position".

Fourth Report of the Subcommittee on Population Health of the Standing Senate Committee on Social Affairs, Science and Technology April 2008

Dianne Patychuk, Access Alliance, HEC

What if….?

- Everyone had the same health as the 20% of the population with the highest income or living in the highest income neighbourhoods?
- How many “excess” deaths, and diseases can be attributed to socio-economic inequaltities?

Dianne Patychuk, Access Alliance, HEC

Income-gap attributable death and disease: # is per year in Ontario

- 3,216 Excess deaths under age 75 (2001)
- 61,909 Excess potential years of life lost <age 75
- 170,000 Excess cases of diabetes (2004/05)
- 16,000 Excess New cases of Diabetes
- 70,000 Excess cases of COPD (2006/07)
- 42,000 Excess cases of IHD (2006/07)
- 41,000 Excess cases of Osteoarthritis (2006/07)

Calculations: deaths and PYLL is R Wilkins, Statistics Canada; others are prepared by D Patychuk (HEC AGM, May 2008). using quintile data for diseases available on the ICES in-tool.

Dianne Patychuk, Access Alliance, HEC

Cost of Health Disparities

- Reducing "Excess" illness could cut health care costs by up to 20%*

Health Care Share

- But how much can hospitals and other health service providers influence and reduce these disparities?

Health Disparities Task Group, Federal Territorial Provincial Advisory Committee on Population Health, 2004

Dianne Patychuk, Access Alliance, HEC

The health care system's influence is often described as 20-25%, with socio-economic conditions accounting for half.

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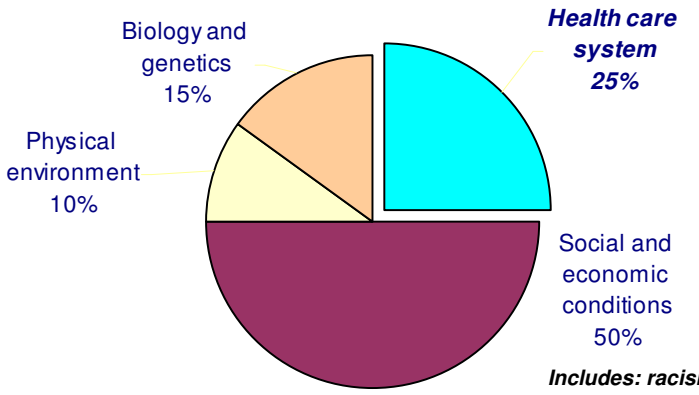


Includes: racism/ discrimination, income, housing,

Source: Canadian Institute for Advanced Research, cited by The Conference Board of Canada www.conferenceboard.ca

Public Health Agency of Canada http://www.phac-aspc.gc.ca/canada/regions/ab-nwt/resources/present/ppt_02-10-02_s47.htm

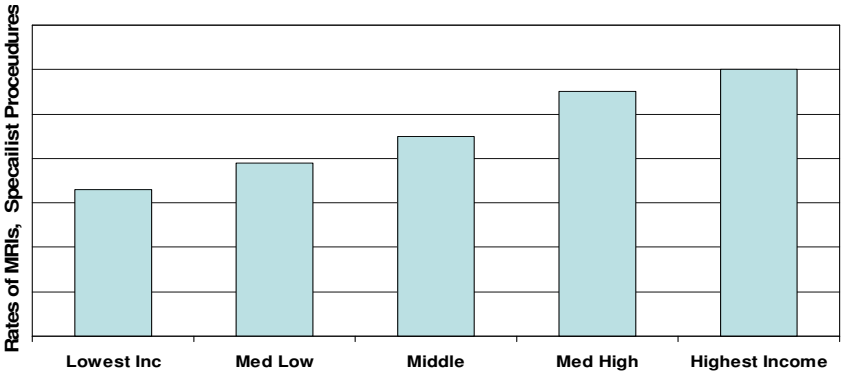
Dianne Patychuk, Access Alliance, HEC

Health Service Equity

- Lower income, marginalized, ill or disabled groups with greater health needs should receive equally good quality of care without discrimination. It should be culturally appropriate and linguistically accessible.
- Lower income, marginalized, ill or disabled groups with greater health needs should at least be receiving equal benefit from prevention services designed for the whole population and should be receiving **MORE** diagnostic and specialist services than people with better health who need them less….

BUT THEY ARE RECEIVING LESS…….

Rates of MRIs, Hip Replacements, Specialist Procedures are higher in high income groups than lower income groups who need them more



Dianne Patychuk, Access Alliance, HEC

Health Service Inequities

When lower income, marginalized, ill or disabled groups with greater health needs experience:

- Barriers to access to health care
- Lower rates of prevention and screening
- Equal or Lower rates of specialist services, surgical procedures and diagnostic procedures
- Different treatment, medication, referrals
- Discrimination (unintentional, overt, embedded)
- Discharge or follow-up care that doesn't take circumstances/living situation into account
- Lack of support to equally benefit from services

Dianne Patychuk, Access Alliance, HEC

Equity – Health Continuum

Health Equity Council Indicators Work Group

Getting to Care (Access Barriers)	Service Quality Improvements	Discharge/Community
Transportation Language Child Care Telephone Time off work No OHIP Fear/Lack of Power Past Experience Lack of support	Preconceived stereotypes (staff) Inflexible policies and procedures Lack of culturally and linguistically appropriate care Wayfinding, Consent, Rights Different Quality	Hand-over to homecare, CCAC, primary care Supports arranged (transportation, housing, etc.) Ensure follow-up care

Dianne Patychuk, Access Alliance, HEC

Results for Clients/Community

- Being understood
- Being treated with respect, dignity,
- Receiving equally good care… without discrimination
- Not having to wait to get help when you need it
- Getting there

Dianne Patychuk, Access Alliance, HEC

Results for Health Services

- Lower rates of Missed Appointments
- Reduced Readmissions
- Reduced complications that could have been prevented
- Reduced Risk to Reputation, Complaints, Litigation
- Shorter Lengths of Stay
- Reduced ALC days
- Improved Quality of Care
- Costs Saved

Dianne Patychuk, Access Alliance, HEC

Can we use the quintile approach to measure service equity across the continuum?

- Given that most hospitals do not currently collect patient social, income, housing, ethno-racial, language, etc. on patients, can we group our patients into different population clusters by using their postal codes which link to detailed census information?
- This is the same methodology used by Statistics Canada and other organizations (ICES, Public Health, researchers, etc.) to demonstrate health status and health service inequities.

Dianne Patychuk, Access Alliance, HEC

First Step with Client Data

- Geocode client 6-digit postal code to a census tract
- Then match client census tract with the Statistics Canada data for that census tract
- To make the tool sharable and easy-to-use, Access Alliance coded census tracts into quintiles
- To access this tool to contact: stepstoequity@gmail.com

Dianne Patychuk, Access Alliance, HEC

A Tool to Create Comparison Populations

At Access Alliance we ranked all 500 Census Tracts in Toronto for total population and for seniors according to:

- income,
- no English language,
- disability,
- recent immigrants,
- racialized groups,
- education

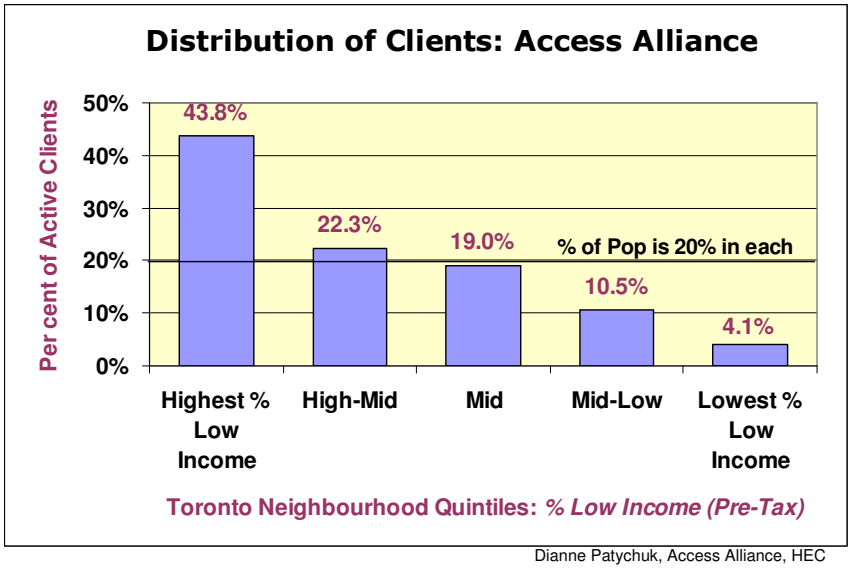
A score of 1-5 was assigned to each cluster of CTs representing 20% of the population for each variable. 1 = highest need/highest access barrier and 5 = lowest need/barriers

Dianne Patychuk, Access Alliance, HEC

Comparing Clients Served to Local Populations

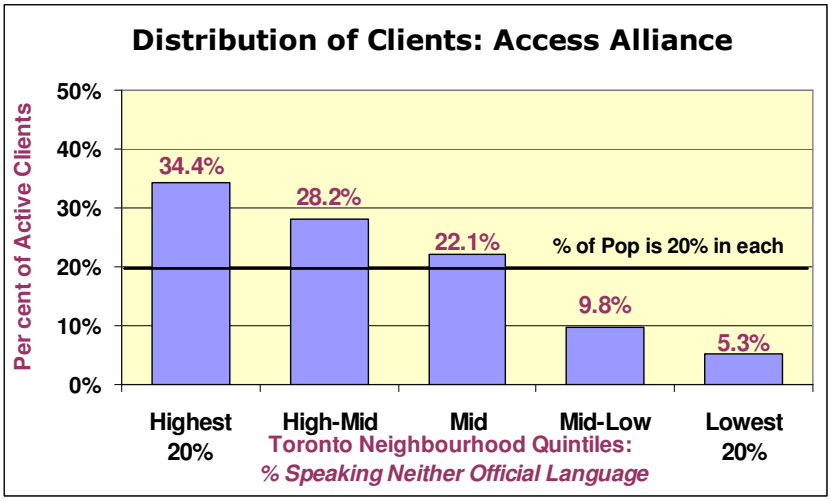
- Access Alliance's priority population is marginalized recent immigrants and refugees groups living in underserved low income communities.
- When we link the CT for each client with the quintile code for each equity variable we can compare our clients with the population. An equal % of the population live in neighbourhoods with each of the five ranks (20% in each).
- If more than 20% of our clients live in neighbourhoods with the higher percent of recent immigrants, low income population, people that do not speak English, we see that we are serving our target communities where the needs and access barriers are greatest. This is the case as the following graphs show.

Proportionately more clients live in low income CTs



Dianne Patychuk, Access Alliance, HEC

Proportionately more clients live in CTs with no English or French



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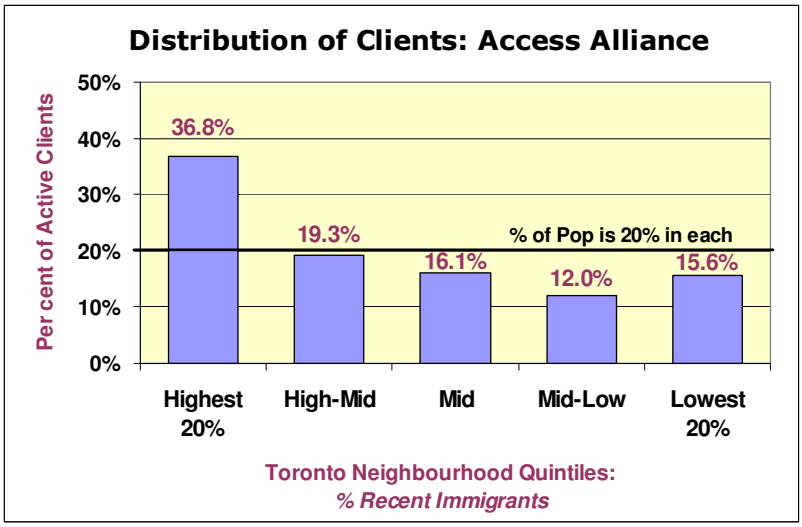
Proportionately more clients live in high recent immigration CTs



Dianne Patychuk, Access Alliance, HEC

Adapting for service catchments

- We tested this for other agencies who had catchment areas that were only part of the city, by distributing the catchment area population across the quintiles and comparing actual clients to catchment area population. It worked.

Other Ways

- Some hospitals can geocode their clients to Dissemination Areas (smaller more homogeneous populations than Census tracts); for others FSAs (postal code forward sortation areas – first 3 digits) may be enough to group clients into two or more groups with different levels of disadvantage, need or access barriers as indicated by area they live in compared to other areas of the city

Dianne Patychuk, Access Alliance, HEC

Next Steps

- Once client groups are created their experience through the continuum of care can be tracked and compared. Potential service inequities can be identified and potential impacts of changes in practices can be tracked.
- In the First Steps Tools and Resources Section today, you will hear more about how to access geocoding tools, and census and community data to compare client information with the local population; to better describe who is being served and who is not being served well enough, across your continuum of services provided.

Dianne Patychuk, Access Alliance, HEC

Equity Lens

- If we are ready to use an equity lens: to always ask if what we are doing, planning or deciding will benefit the people who need it the most and who have existing barriers; and, to take steps to mitigate consequences, reduce barriers, tailor strategies to ensure that what we do reduces rather than widens existing disparities;
- …. then we can measure our efforts using available data and simple tools available to us.

Dianne Patychuk, Access Alliance, HEC

Looking Ahead: Equity is one of 13 "Risk Categories" that Ministry, LHINs and HSPs are encouraged to take into account

Equity – Risk is uncertainty that services will have an equitable impact on the population.

Ministry of Health and Long-Term Care. New Directions January 2009

Dianne Patychuk, Access Alliance, HEC

New plan promotes good RISK management practices

13 categories of risk

RISK	DESCRIPTION
Compliance/ Legal	Uncertainty regarding compliance with laws, regulations, standards, policies, directives, contracts and Memorandums of Understanding may expose the ministry to the risk of fines, penalties, litigation.
Equity	Uncertainty that policies, programs, services will have an equitable impact on the population.
Financial	Uncertainty of obtaining, using and maintaining economic resources; meeting overall financial budgets/commitments; preventing, detecting or recovering fraud.
Governance / Organizational	Uncertainty of having appropriate accountability and control mechanisms such as: organizational structures and systems processes, systemic issues, culture and values, organizational capacity, commitment, and learning and management systems, etc.
Information / Knowledge	Uncertainty regarding the access to or use of accurate, complete, relevant and timely information. Uncertainty regarding the reliability of information systems.
Operational or Service Delivery	Uncertainty regarding the performance of activities designed to carry out any of the functions of the ministry/unit, including design and implementation.

Children, Poverty and Health Care Utilization: Applying a Health Equity Lens

Ted McNeill PhD., RSW
Health Equity Workshop
April 6, 2009

Focus

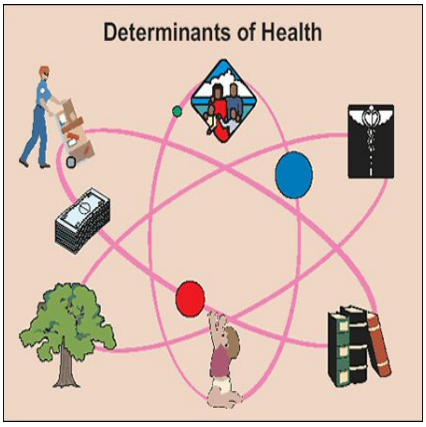
1. Context: Poverty and child health
2. Research: Poverty and health care utilization at SickKids

Ted McNeill, HSK

Social Determinants of Health

"….remarkable sensitivity of health to the social environment and to what have become known as the social determinants of health."

(WHO, The Solid Facts, 2003)



Ted McNeill, HSK

Children, Poverty and Health

Canadian children living in low-income families are more likely to experience:

- 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

(Canadian Institute for Child Health, 2000)

Ted McNeill, HSK

The growing income divide in Canada…

From 1995 to 2005, GDP per capita in Canada grew by 27% in real dollars.

- The highest 20% of families saw after-tax incomes grow by more than 22%.
- The lowest 20% saw gains of 9%.

Campaign 2000, Summoned to Stewardship (2007)

Ted McNeill, HSK

Methodology

- Partnered with United Way to use their findings published in “Poverty by Postal Code”
- Dramatic increase from 30 to 120 “high poverty” neighbourhoods in Toronto between 1981 and 2001.
- “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

Ted McNeill, HSK

Methodology: Census tracts → postal codes

- The United Way identified the postal codes (FSA’s) that were associated with the high poverty census tracts
- FSA’s are the first 3 digits of postal code
- 43/96 FSA’s were associated with high povery neighbourhoods
- Mapped high poverty FSA’s to SickKids data
- Comparison group: Other 53/96 FSA’s

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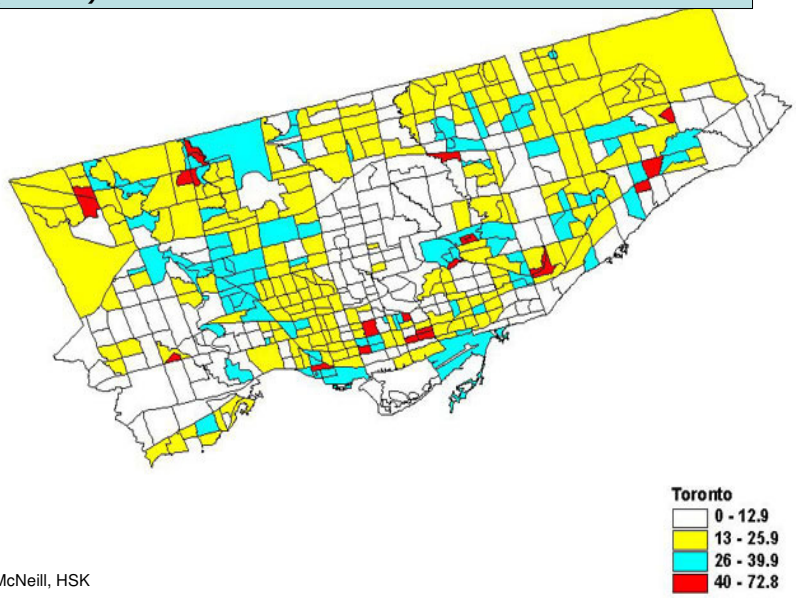
City of Toronto – Family Poverty rates (2001)



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Comparing the Two Populations
in the Two Postal Code (FSA) Groups: Rates

	High Poverty Areas 43 FSA's	Other Toronto 53 FSA's
% Families <LICO	**25%**	**14%**
Range of % < LICO	**19%-44%**	**5%-21%**
% Children < LICO	**40%**	**22%**
Range of % < LICO	**21%-64%**	**0%-40%**
% Lone Parent Families	**32%**	**28%**
% Recent Immigrants	**14%**	**7%**
% in Racialized Group	**61%**	**29%**

Using 2006 Census Data for Postal Code FSAs (not previously available

* 2006 Census Data prepared by Access Alliance Multicultural Health and Community Services

Ted McNeill, HSK

The Distribution of the Population

Between the Two Postal Codes Groups (FSA's)

	High Poverty Areas 43 postal codes	Other Toronto 53 postal codes
# Children	**58%**	**42%**
# Children in Low Income Families	**72%**	**28%**
# Families	**56%**	**44%**
# Families <LICO	**68%**	**32%**
# Lone Parent Families	**61%**	**39%**

Using 2006 Census Data for Postal Code FSAs (not previously available

* 2006 Census Data prepared by Access Alliance Multicultural Health and Community Services

Ted McNeill, HSK

Anticipated findings…

- Based on:
  - (i) 58% of total children in high poverty neighbourhoods
  - (ii) increased likelihood of these children experiencing various health conditions
  - We might anticipate utilization rates for health services to be > 58%... but it is not quite so straightforward

Ted McNeill, HSK

Profile of Care by Neighbourhood

Activity	High poverty neighbourhoods (43 FSA) (Average 25% of families below LICO* (Stats Canada)	Other Toronto neighbourhoods (53 FSA) (Average 14% below LICO)
Admission	4056 (56%)	3207 (44%)
Day Surgery	1621 (52%)	1509 (48%)
Emergency	25894 (52%)	24162 (48%)

Data from Apr 1/06 – Sept 30/07 prepared by Majid Kiakojouri, Health Records

Ted McNeill, HSK

Utilization and Resource Intensity

	High Poverty FSA's (43/96)	Other FSA's (53/96)
Admissions	3408 (56%)	2665 (44%)
Total length of stay	26050 (62%)	15942 (38%)
Average length of stay	7.6 days	6.0 days
Resource Intensity Weighting	2.0	1.5

Based on data from Apr 1/06 – June 30/07 prepared by Majid Kiakojouri, Health Records

Ted McNeill, HSK

Readmissions…

Re-admit Code	# High Poverty	# Rest of Toronto	% High Poverty	% Rest of Toronto
< 7 days (unplanned)	83	64	**56%**	44%
8-28 days (unplanned)	134	75	**64%**	36%

Based on 2007 data (Majid Kiakojouri, Health Records)

Ted McNeill, HSK

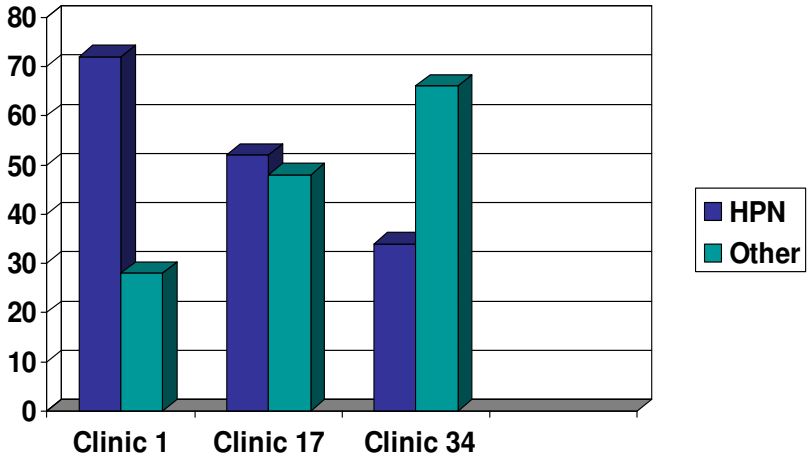
Clinic visits

	High Poverty FSA's (43/96)	Other FSA's (53/96)
Clinic visit	124493 (52%)	116317 (48%)

Data for 34 clinics between 2005 – 2007 prepared by Magid Kiakojouri, Health Records

Ted McNeill, HSK

Differential profile by clinic…



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Clinic "No shows…."

Year	# High Poverty	# Rest of Toronto	% High Poverty	% Rest of Toronto
2005	3825	2583	**59.7%**	40.3%
2006	4179	2691	**60.8%**	39.2%
2007	4328	7477	**57.9%**	42.1%

Based on 2005 - 2007 data (Majid Kiakojouri, Health Records)

Ted McNeill, HSK

Number of Deaths (2005 – 2008)

	High poverty neighbourhoods (43 FSA) (Average 25% of families below LICO* (Stats Canada)	Other Toronto neighbourhoods (53 FSA) (Average 14% below LICO)
Deaths	142 (65%)	76 (35%)

Number of deaths include those outside Sickkids if we were notified of death

Based on data (2005 – 2008) prepared by Majid Kiakojouri, Health Records)

Results summary

- Children and families from 'high poverty neighbourhoods' in Toronto constitute:
  - 56% of Admissions
  - 7.6 versus 6.0 average LOS
  - 62% of Total Length of Stay
  - 2.0 versus 1.5 Resource Intensity Weighting
  - 56% - 64% of unplanned re-admissions
  - 52% of clinic visits
  - 60% of missed clinic appointments
  - 65% of patient deaths

Ted McNeill, HSK

Equity-focused Data Collection: from research projects to patient surveys to routine data collection

Dianne Patychuk, Steps to Equity
April 6, 2009

Current State

- Community Health Centres collect client country of birth, year of immigration, education, family income (with variable success).
- Hospitals do not routinely do so, but hospital examples do exist. These slides show examples of client data collection – experience that we can build on.
- Ontario Human Rights Commission supports data collection that will be used to achieve equitable access to services and service without discrimination

Examples of hospital-based equity data collection-research

- CAP Surveys, CAMH
- Hospital Census of People who are Homeless
- Chart Review using surnames to identify ethnicity
- Outcome study – Assertive Community Treatment
- Patient Questionnaires – Cancer
- Telephone follow-up –Acute MI
- Canadian Pediatric Surveillance Program
- Electronic Pt. Information System-Language/LOS

Dianne Patychuk, Steps to Equity

Toronto-Peel Community Assessment Project (CAP)

Collected information on:

- What is your preferred language?
- Are you currently working for pay?
- What is your main source of income?
- Do you have any other sources of income?
- Canadians come from many cultural and racial backgrounds. Please identify the racial/cultural group that best describes you? White, Aboriginal, Southeast Asian, Black, South Asian, Chinese, Filipino, Latin/Hispanic, Arab/West Asian, Other, Don't Know, Refused

Dianne Patychuk, Steps to Equity

Toronto-Peel Community Assessment Project (CAP)

- People of White/European ancestry are a greater proportion of those in mental health services (73%-83%) than their share in population;
- Underrepresented in mental health services overall, the African/Caribbean population make up a greater proportion of those in court services (20%) than their share in population (racial profiling?);
- South Asians and Chinese population are also underrepresented in mental health services.

Koegel, et al 2004, Durban et al, 2002 Health Systems Research and Consulting Unit CAMH

Dianne Patychuk, Steps to Equity

Hospital Census/Survey April 15- Homelessness

- Hospital census or survey to report number of inpatients and people with Emergency Department visits between 6 pm and 12 a.m. who are homeless or No Fixed Address
- Part of the Street Needs Assessment
- 12 hospitals participated in 2006: 275 people out of 5052 homeless people counted were in health care or treatment facilities.
- Letter sent to President and CEOs – please participate in 2009

Dianne Patychuk, Steps to Equity

Chart Reviews- 2 GTA Hospitals

- William Osler and Centenary, Rouge Valley
- Used surname, first names and self-reported ethnicity (where available) to identify and match South Asians with control group
- Time from MI to admission, risk factors, treatment, in-hospital outcomes, discharge medications, mortality
- Important differences in risk factors- South Asians did not have the typical risk profile. They had lower BMI, lower smoking, lower hyperlipidemia
- Observed treatment differences were not statistically different (sample size).

Gupta et al. CMAJ 19, 2002: 166(6)

Assertive Community Treatment Outcome Study

- 66 consecutively admitted clients
- Mount Sinai/Hong Fook ACT
- Age, marital status, race/ethnicity, primary language, familiarity with English, education, living status, acculturation
- 80% immigrants, 32% illiterate in English (unable to set up telephone service or bank account); 2/3 had to use language other than English to communicate with care providers

Yang et al. Psychiatric Services 56.9. Sept 2005

Patient Questionnaires – Quality of Life, cancer understanding

- 202 Clinic clients, Princess Margaret Hospital
- Questionnaires in Chinese, Italian, Spanish, Portuguese
- Age when they left school, further education, if working, type of work, income bracket, living arrangements, Country of birth, age at immigration, first and second languages, religion
- Differences between limited English patients and English speaking patients; patients not served in own language or using a family member as an interpreter – less realistic expectation of cure & poorer quality of life

Tchenn, Tannock et al. Brit J of Cancer 2003 (9), 641-647

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Telephone follow-up Acute MI

- Prospective longitudinal study post MI Ontario
- SES & Acute Myocardial Infarction (SESAMI) study
- 13 item patient questionnaire includes 5-income categories (94% answered), 3 education categories (98% answered) and ethnicity/racial (13 categories)
- 3335 consecutively admitted patients
- Excluded limited English fluency patients
- Higher income better/educated had preferential access to cardiac specialty services

Alter et al. JAMA. 2004-Vol 291, No 9. 1100-1107

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Canadian Pediatric Surveillance Program

- Collect data on all new diagnosis of non-type 1 diabetes in 0-18 yr olds
- Ethnicity - 13 categories
- Hospital for Sick Children retrospective chart review to review clinical experience over 8 years – 41 patients
- Overrepresentation of children from South Asian and African Canadian groups compared to percent in the population (higher incidence Type 2 diabetes)
- Need for ethnically-sensitive strategies

Zdravokovic et al. 2004 Diabetic Medicine 21, 1144-1148

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Electronic Patient Information System - Language and LOS

- Consecutive hospital admissions, (59,547 records), Toronto Western, Toronto General, Princess Margaret
- UHN electronic patient information system containing language information (assessed by admission clerk)
- English proficiency validated by direct interviews of 280 patients (88% agreement with admission records)
- Limited English Proficiency patients had 6% longer length of stay (LOS), greater for stroke (3.6 days) and diabetes (1.8 days).

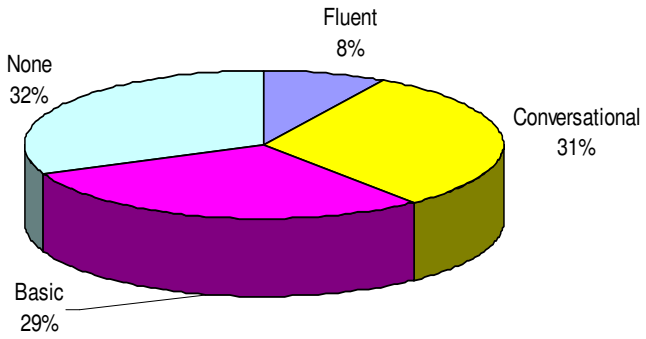
John-Baptiste et al. J Gen Intern Med. 2004:19:221-228

Wellness Centre Clients

A satellite program of Mount Sinai, mental health in Ethnocultural communities (collects client information on level of skill in English)

English Skill

(n=146)



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In Conclusion:

- While the best solution may be to require ethnicity, country of birth, year of immigration *at OHIP registration*, other opportunities exist based on experience to date: Disease Surveillance Programs/Disease Registries; electronic health records, Preferred language at patient registration, and exisiting hospital and community health centres examples.

Dianne Patychuk, Steps to Equity

What do you think?

- Collect preferred language on all admissions
- Add ethnicity/racial group and country of birth to OHIP registration
- Socio-demographic data on disease registries, electronic health records
- What about including client socio-demographic, language and ethnicity data on patient satisfaction surveys?
- Annual Client One-day Census?

Dianne Patychuk, Steps to Equity

University Health Network
Toronto General Hospital Toronto Western Hospital Princess Margaret Hospital

Medical Interpreters: The Business Case

Elizabeth Abraham, M.A., M.Sc., C.Trans.
Interpretation and Translation Services
Healthcare Interpretation Network & UHN

"Without language, we lose the most…

…effective tool for establishing a meaningful relationship with patients and the opportunity to address individual worries and fears. Ultimately, professional medical interpreters have the unique ability to assist clinicians in establishing the healing connections that form the foundation of ethical and culturally sensitive care."

Schapira L *et al.* "Lost in Translation: Integrating Medical Interpreters into the Multidisciplinary Team" (2008) *Oncologist* 13(5): 586-592.

Elizabeth Abraham, HIN, UHN

Effective communication necessary for

- Patient-centred care
- Patient safety
- Risk management
- Cost control
- To meet the needs of a diverse patient population

Elizabeth Abraham, HIN, UHN

Language access ≈ the cost of an x-ray

Excellent Resource:
MGH Disparities Solution Center: A Guide for Hospital Leaders **www.mghdisparitiessolutions.org**

Elizabeth Abraham, HIN, UHN

- Shorter inpatient stays
- Fewer readmissions
- Fewer emergency visits
- Fewer diagnostic tests
- More accurate diagnoses
- More likely to attend follow-up appointments
- Better adherence to treatment plans

↑ trained interpreters = ↓ costs

Elizabeth Abraham, HIN, UHN

Cost-benefit analysis of providing interpreter services at healthcare settings (Nazneen, K)

Relationship between IS as an input in healthcare services and net social benefit

LEP patient → **Clinical Decision** (Rational Decision Theory)

- a1. No interpreter
- a2. Untrained interpreter
- a3. Trained interpreter

(Production Function)

Inputs **L*i* – *interpretation services***
K – capital
\+ L – labour

Outcome Y

- b1. ↑ morbidity/mortality, poorer outcomes
- b2. Moderate morbidity/mortality
- b3. ↓ morbidity/mortality, improved outcomes

Elizabeth Abraham, HIN, UHN

Nazneen: Mortality rates, service utilization

- Compared mortality rates for English-speaking and LEP patients for chronic, manageable diseases:
  - Diabetes
  - Asthma
  - Asthma with bronchitis
  - Hypertension
- Compared proportions of admissions, emergency visits, outpatients visits
- Estimated cost of physician time

Elizabeth Abraham, HIN, UHN

Nazneen (cont): Conclusions

Integration of interpretation services resulted in

- Reduction of disparities in mortality rates between English and LEP patients for specific diagnoses
- Shift in utilization services from IP and emergency services to OP clinics and primary care
- Reduction in diagnosis codes per LEP patient
- **Reduced overall health care costs**

Elizabeth Abraham, HIN, UHN

Risk management: informed consent

To treat a patient without their consent is battery.

Family or bilingual staff are not acceptable substitutes for medical interpreters when obtaining a patient's informed consent, or discussing a negative diagnosis, home care or medication instructions.

Elizabeth Abraham, HIN, UHN

Measuring Equity of Care in Hospital Settings: From Concepts to Indicators

Gilbert Gallaher (Ph.D.), Sophie Kim (B.A.), Maritt Kirst (Ph.D.), Aisha Lofters (M.D.), Kelly Murphy (M.Ed.), Patricia O'Campo (Ph.D.), Carlos Quiñonez (D.D.S., Ph.D.), Nicole Schaefer-McDaniel (Ph.D.), Ketan Shankardass (Ph.D.) Centre for Research on Inner City Health, St. Michael's Hospital

Slides not available: abstract of presentation given by Carlos Quiñonez follows.

In 2009, the Toronto Central Local Health Integration Network (TCLHIN) required hospitals to begin reporting on equity initiatives. This project directly responds to these policy priorities. In collaboration with the TCLHIN Hospital Collaborative on Marginalized Populations, we reviewed scholarly and grey literature to identify equity measures for in-hospital use. Our review identified 706 possible equity indicators, which we 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).

Carlos Quiñonez, CRICH

First Steps
Resources and Tools

April 6, 2009
Dianne Patychuk, Steps to Equity
Katherine Smith, Toronto Central LHIN

Contents

- Equity Analysis
- Intellihealth
- Community Social Data Strategy
- City Neighbourhood Profiles, Social Atlas, Demographics
- Toronto Community Health Profiles
- PHAC-GIS
- ICES In-Tool and Power Study
- CIHI-Statistics Canada, Census Profiles, Health Indicators
- Longitudinal Health & Administrative Data Initiative (LHAD)
- Equity Tool Kit
- Equity Lens

Equity Analysis: Principles

- Analyzing health status and health utilization data by population groups can identify health service inequities and provide a way to track trends over time as strategies to reduce health disparities are implemented.
- Socio-economic and ethnicity data is not collected on health datasets.
- Census and survey data provide information that can be used to disaggregate the population and user statistics into population subgroups for comparative analysis
- A common unit of analysis (e.g. census tracts), for both utilization data and population data enables linkage, and comparative analysis in the absence of individual equity data collection.

Patychuk, Steps to Equity; Katherine Smith, TC LHIN

Equity Analysis: Steps

- From client user statistics, hospital user data or “intellihealth”, pull off desired health data (e.g. number of Emergency department visits). Be sure to include the 6-digit postal code for each visit or record.
- Geocode the 6 digit postal code to a census tract and sum the visits for each census tract so that the result is the number of ED visits per census tract.
- Socio-demographic data at the census tract level (not in intellihealth) can now be compared to health data in various ways to create two to five different population groups so that their ED visits (or other health care experiences) can be compared (e.g. readmissions, wait times, diagnostic tests, differential treatment, etc.).

Patychuk, Steps to Equity; Katherine Smith, TC LHIN

Key Challenges

- Access to health data
- Access to method of geocoding
- Limitations of ecological methods (using census are characteristics to create populations comparison groups in the absence of individual level variables)
- Access to census data for linking to geocoded health data

Patychuk, Steps to Equity; Katherine Smith, TC LHIN

Intellihealth

Access to health data & geocoding to census tracts

- Ministry of Health and Long-Term Care
- Hospital data (DAD, NACRS, NRS, CCRS) Home Care, Vital Stats
- Geocoding of 6-digit postal codes to census tracts (smaller geographic units - DAs - not available)
- Several hospitals already on board
- intellihealthontario@ontario.ca
- Training time, accountability for quality control, understanding and reporting data

Patychuk, Steps to Equity; Katherine Smith, TC LHIN

Community Social Data Strategy

Access to census data to create population groups

- City of Toronto leads group of 25 human service agencies to access Statistics Canada data: cost of $200 per year, over four years.
- All geographies – Dissemination Areas, Census Tracts, Forward Sortation Areas, Neighbourhoods, and 14 other municipalities
- Hospitals can apply to join, subject to Statistics Canada approval. Hospitals with access to census data through universities may be ineligible.
- Contact Harvey Low hlow@toronto.ca

Patychuk, Steps to Equity; Katherine Smith, TC LHIN

City of Toronto

Neighbourhood socio-demographic data

- Neighbourhood profiles for 140 city neighbourhoods. City of Toronto neighbourhoods are aggregations of census tracts. http://www.toronto.ca/demographics/neighbourhoods.htm
- Neighbourhood socio-demographic profiles available at: http://www.toronto.ca/demographics/profiles_map_and_index.htm
- A Social atlas has over 300 2006 maps http://www.toronto.ca/demographics/atlas.htm
- Other 2006 census profiles, demographic reports, analysis: http://www.toronto.ca/demographics/reports.htm

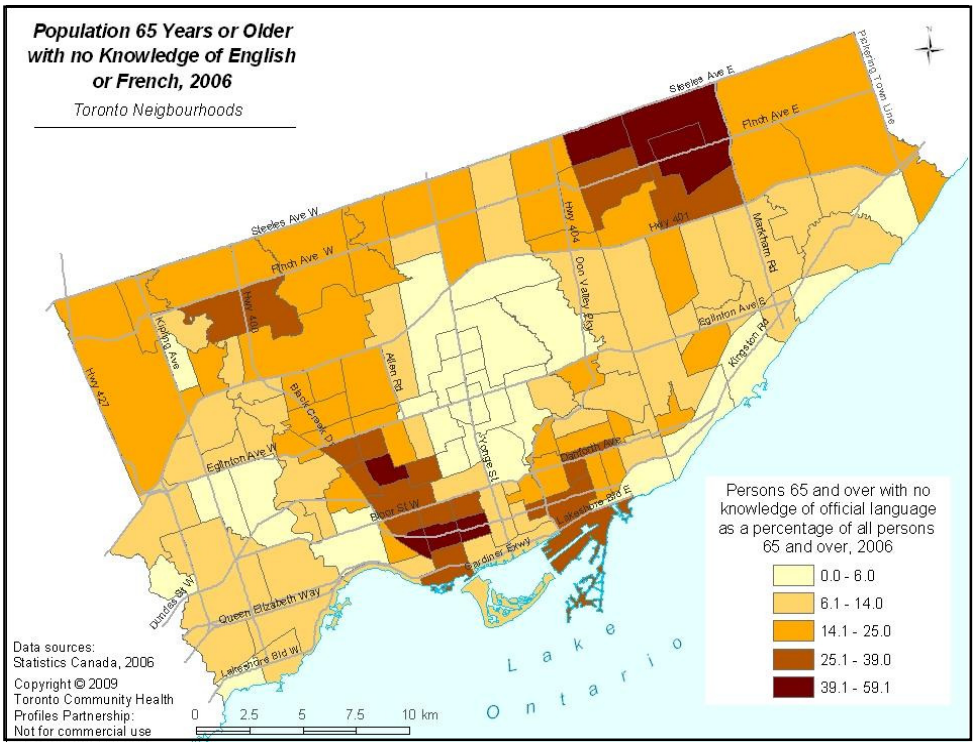
Patychuk, Steps to Equity; Katherine Smith, TC LHIN

Toronto Community Health Profiles Partnership

Neighbourhood and sub-LHIN population and health data

- Information on wide range of community health status and health care utilization, and indices
- Website is being updated with new data (mothers and babies, future will include self-rated heath, ED visits at the neighbourhood and sub-LHIN levels) and equity analysis
- Thematic maps, profiles, resources tab links to other tools and websites; link to interactive mapping tool under development
- Workshops and tools; as the map that follows shows, ***at least*** 25% of seniors living in the two darker shaded areas will require service in a language other than English or French.
- www.torontohealthprofiles.ca

Patychuk, Steps to Equity; Katherine Smith, TC LHIN



Public Health Agency of Canada: GIS Map Generator

- For health professionals in government, universities and NGOs (excepting those in the private sector), previously offered free access to GIS resources, including PCCF and PCCF+ (geocoding) and mapping. www.phac-aspc.gc.ca/php-psp/gis_e.html
- Currently undergoing restructuring but may re-open this service in the future. Geocoding is an essential requirement for equity analysis that this service has provided.

Patychuk, Steps to Equity; Katherine Smith, TC LHIN

ICES

- ICES-In-Tool: Income Quintile, age and gender rates for chronic diseases and specialty health services, hospitalization for diabetes complications.
- Graphs and tables for LHIN income quintiles and sublhins are best available local evidence of magnitude of health service inequalities
- In-tool will host power study
- Investigative Reports
- Atlases
- http://intool.ices.on.ca/

Patychuk, Steps to Equity; Katherine Smith, TC LHIN

power

- Project for an Ontario Women's Health Evidence-Based Report Card (POWER)
- health indicators differ by gender, age, income, education, ethnicity, language, and immigration
- Interactive data being readied for access on ICES-in-Tool
- PI: Bierman AS. Co-Applicants: Abramson B, Angus J, Anderson G, Bayoumi A, Booth G, Dunn J, Dunn S, Dusek J, Ferris L, Glazier R, Hawker G, Jaakkimainen L, Khanlou N, Krzyzanowski M, Lin E, McDonald L, Manuel D, Moineddin R, Rabineck L, Rhodes A, Rochon P, Stewart DE, Stukel T.
  For more information please visit www.powerstudy.ca

Patychuk, Steps to Equity; Katherine Smith, TC LHIN

CIHI and Statistics Canada

- The Canadian Institute for Health Information (CIHI) and Statistics Canada are moving to report health status and health service indicators by income quintiles and in the longer term, where possible by other equity variables (Aboriginal, education, period of immigration, ethno-racial group) as recommended by the WHO Commission of the Social Determinant of Health and many Canadian organizations.
- Free Internet Publications http://cansim2.statcan.gc.ca/cgi-win/cnsmcgi.pgm?Lang=E&ResultTemplate=/Stu-Etu/Stu-Etu3&ChunkSize=25&AS_Theme=2966&ChunkStart=1&AS_Date=.&AS_Ser=.&AS_Auth=.&AS_Srch=&AS_SORT=0&AS_UNIV=3&Version=2&AS_Mode=2

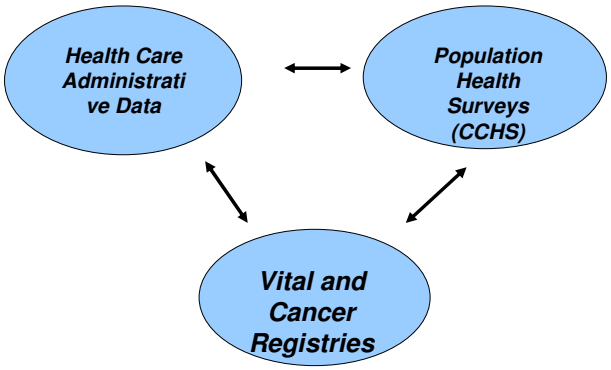
Patychuk, Steps to Equity; Katherine Smith, TC LHIN

LHIN and other Census Profiles

- Go to www.statcan.ca/census
- Click on 2006 Community Profiles (Right column)
- Type in place name – e.g. Toronto; to access data for a LHIN type in LHIN name (minus the word "local: eg Central Health Integration Network.
- Census tract profiles are also available "one CT at a time".

Patychuk, Steps to Equity; Katherine Smith, TC LHIN

Longitudinal Health & Administrative Data Initiative



- Record linkage of social demographic characteristics (from surveys) with health service use, cancer, vital statistics

MOU with provinces/territories (Ont. &Man. on board)

Availability: University-based Research Data Centres (RDCs) For info see: Health Reports Vol. 20.No 1 March 2009

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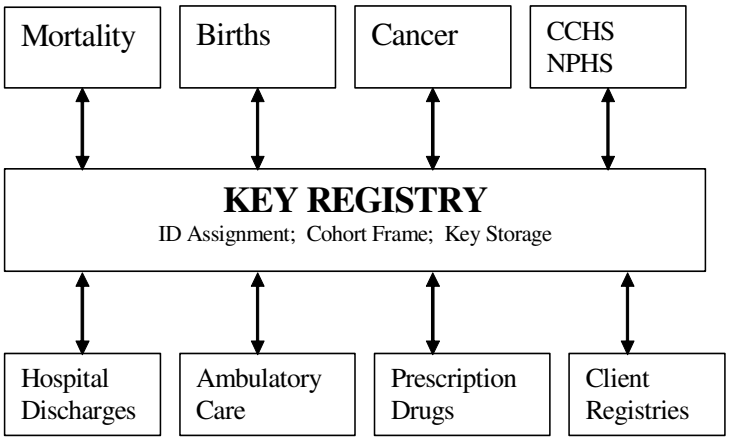
LHAD Data Model

HSD DATA



ADMINISTRATIVE DATA

LHAD can help describe

- Different health care treatment of people with and without mental illness
- Ethnicity, SES, period of immigration, language, education, etc. of hospitalizations for specific conditions
- Different end-of-life care for different population groups

(Over 90% of CCHS participants say yes to having their health number linked)

Patychuk, Steps to Equity; Katherine Smith, TC LHIN

Health Equity Council (HEC)

- Broad-based collaborative of community health and social service organizations, institutions and concerned individuals whose mandate is to engage in education, research, organizational change, capacity building, community partnerships as well as advocacy to enhance access, equity and inclusion in all facets of individual and community health and well-being in Ontario
- To join the HEC communication network (listserv), send an email request including your full name to: mkanee@mtsinai.on.ca
- If you are interested in joining the Health Equity Council, email - healthequitycouncil@gmail.com
- HEC website, and People's Charter of Health Equity and Diversity: :www.healthequitycouncil.ca

Patychuk, Steps to Equity; Katherine Smith, TC LHIN

Health Equity Toolkit

- The Health Equity & Community Engagement Toolkit is a web-based resource that is currently being developed to guide the planning, implementation and evaluation of equity related organizational change.
- Partnership of Scadding Court Community Centre and the Centre for Addiction & Mental Health (CAMH).
- Advisory Committee with representatives from the Health Equity Council, the Centre for Research on Inner City Health (CRICH) at St. Michael's Hospital, Mount Sinai, the Wellesley Institute, the Ontario Council for Agencies Serving Immigrants, other community based agencies,
- The Toolkit will be live after August 2009. Blog is alive now.
- http://www.scaddingcourt.org/Health_Equity/index.html#

Patychuk, Steps to Equity; Katherine Smith, TC LHIN

Health Equity Lens (example)

The City of Toronto "equity lens" utilizes these questions:

1. How did you identify the barriers faced by diverse groups and assess the impact of the policy/program on them? What diverse groups are impacted by the identified barriers?

   (Examples of identifying barriers and assessing impact – consultation, research, collection of data on gender, race and other characteristics, outreach, field work, etc.)

2. How did you reduce or remove the barriers? ..changes made to the policy/program to benefit diverse groups; targeted human and budgetary resources allocated?

   (Examples of barrier reduction and proactive strategies – language translation, accessible location, diversity training, hiring and retention of diverse staff, designated accessibility planner, integrating community input into policy/program, special program, advocacy, etc.)

3. How do you measure the results of the policy/program to see if it works to benefit diverse groups?

   (Examples: statistics on distribution of resources, analysis of disaggregate data, improvement in specific areas, satisfaction with policy/program results, etc.)

Next Steps

- Discussion/Evaluation/Next Steps

  integrate equity, expand access to tools and resources

Acknowledgements...

- Thank you to our sponsors, speakers, and host
- Thank you to the individuals who planned and organized and delivered this event:

  Dianne Patychuk, Bob Gardner, Elaine Amoine, Rosalie Steinberg, Connie Kim, Katherine Smith, Ted McNeill, Linda Gardner, Anthony Mohamed, Rick Edwards, and Susan Himel.