

CHC·GT

Community Health Centres
of Greater Toronto

Community Health Centres of Greater Toronto Health Equity Plan

Building on Potential / Driving Action

DECEMBER, 2011

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Executive Summary

Community Health Centres (CHCs) are uniquely positioned to lead equity-driven reform in health care. Our work in addressing health disparities and serving marginalized populations across Greater Toronto provides us with a foundation upon which to build and serves as a platform for thinking about health equity in broad and strategic terms. New requirements by Toronto and other Local Health Integration Networks to develop equity plans therefore presented an opportunity for Toronto's CHCs to demonstrate leadership by creating a sector-wide plan that leverages the potential of equity initiatives already underway, identifies common challenges and maximizes synergies.

Building on Potential/Driving Action was developed using data gathered through a survey of CHCs and an exploratory session with CHC leadership on existing equity initiatives, desired outcomes, measurement tools and unmet needs, and prepared for CHC-GT by the Wellesley Institute. The plan is based on a shared goal: CHCs are committed to advancing health equity by providing the highest quality care to all and by addressing the roots of health inequalities through a community development approach. We will achieve this by working together at three levels: through the development of a powerful common strategy, by adapting this framework to the specific needs of the communities we serve, and by working collaboratively on solutions to pressing common challenges.

ALIGNING EQUITY EFFORTS: A COMMON SECTOR STRATEGY

In the face of competing priorities and in the context of fiscal restraint, the challenge for CHCs moving forward will be to maintain momentum on health equity. To do so, CHCs will need to integrate an equity approach within existing and emerging processes and initiatives. Specifically, GT CHCs will:

1. Build equity into priority setting and service planning: A more explicit planning framework – incorporating community engagement, a common equity lens, and the use of the Health Equity Impact Assessment tool – will ensure equity is embedded in routine planning within each CHC.
2. Align equity with system drivers and priorities: CHCs will highlight the role health equity plays in contributing to a number of current system priorities, including quality improvement, chronic disease prevention and management, Alternative Levels of Care (ALCs), wait times and sustainability.
3. Embed equity in performance measurement and management: CHCs will build on extensive international, provincial and local efforts to develop and measure explicit equity targets. Specifically, CHCs will develop and implement a sector-wide performance measurement and management strategy that embeds equity and uses common equity indicators.
4. Target for equity impact: Within their strategic and operational plans, CHCs will target key access barriers and priority populations, based on evidence and analysis of local health care issues and community involvement in planning and priority setting.
5. Build equity into health promotion: Health promotion activities that reach only the well informed or most connected run the risk of widening health disparities. CHCs will lead in employing a strategy of “targeted universalism” to ensure health promotion campaigns reach those communities who need them most and address the impacts of poverty and unemployment, enable community development and civic engagement, and build resilient communities.

6. Build in social determinants: CHCs will position the client-centred care agenda as an opportunity to reach well beyond health care and empower communities to address inequities caused by social and economic policy and underlying structures.
7. Drive equity through innovation: CHCs will continue to address equity in collaboration with mental health, ethno-cultural and other community-based providers and to share and build upon successes. The emerging model of the CHC as a multi-service hub in high-need areas will be carefully evaluated for its potential in reducing inequities.

DRILLING DOWN: ADAPTING IN INDIVIDUAL CHCS

Implementation of the seven sectoral strategic directions outlined above will take place at the organizational level and within a context of each community's needs, priority populations and identified access barriers. Key to the success of implementation efforts at this level is to build in objectives of learning and accountability. To achieve this, each CHC will prepare an annual performance report on the activities and impact of the equity directions and objectives as adapted to their specific context, and present this report, as well as key lessons learned on promising practices and front line innovations, to an equity symposium organized annually by the CHC-GT forum.

BUILDING ACROSS AND TOGETHER: ADDRESSING COMMON CHALLENGES

Consultations with CHC leadership revealed three issues best addressed through by working collaboratively across the sector. To advance health equity over the next three years, Toronto CHCs will:

1. Share interpretation resources and capacities: Language remains a crucial barrier to equitable access to health care in Toronto. Toronto CHCs will develop, in 2012, a concrete plan to streamline access to interpretation services, share training guides and other resources, and develop common standards and processes to ensure consistent high quality and access.
2. Build equity into performance measurement and management: Leveraging our experience in addressing health care inequities, CHCs will play a leadership role in incorporating equity into comprehensive quality improvement strategies and mechanisms at the provincial level. By 2013, CHCs will devise a set of performance indicators that measure not just access and quality of health care services, but equity-focused health promotion and enabling community engagement and social participation.
3. Develop a systematic strategy for non-insured populations: CHCs will build on work done to date for this highly vulnerable population to identify service gaps and develop consistent policies and procedures for assessing and supporting people without insurance, including sector-wide arrangements with hospitals, common data collection, and resource sharing mechanisms. This project will be implemented in the first and second years of this plan, through 2012 and 2013.

Operationalization and development of this plan will be a dynamic and iterative process. It is intended to build on a variety of initiatives in planning, measurement and service delivery already underway in the health care sector. As these initiatives are implemented and evolve, CHCs will demonstrate their continued leadership in this area by communicating the impact of these changes on Greater Toronto's most vulnerable populations, and by extending our reach even further to better meet the needs of the communities we serve.

Introduction

CONTEXT

Toronto Central and other LHINs have required their provider partners to develop equity plans. Toronto Central began with hospitals, which have recently completed their second iteration, refreshing the plans originally developed in 2009. The intention always was to have providers in other sectors also develop equity plans.

AN EQUITY ACTION PLAN FOR TORONTO CHCS

Community Health Centres (CHCs) are in a unique situation to drive an equity agenda: addressing health disparities and serving marginalized populations have long been fundamental priorities. Arguably, their strategic and operational plans already are, in effect, equity plans. Recognizing this, Community Health Centres of Greater Toronto (CHC-GT) saw this LHIN requirement as an opportunity to think more broadly.

They will not develop individual Centre equity plans, but a sector-wide plan. This will provide an opportunity to:

- assess the breadth and focus of promising equity initiatives currently underway ⇒ in order to build on this potential;
- identify common challenges in embedding equity concretely in service planning and delivery ⇒ to address these challenges in coherent and coordinated ways;
- maximize potential synergies from coordinating programs, sharing lessons learned, joint planning and a coherent overall strategy.

Developing an effective sector-wide plan will not only meet LHIN accountability requirements, but will enrich Toronto Central's overall equity strategy and improve CHCs' ability to deliver on their equity mandates and priorities. However, the plan also has a wider focus, involving CHCs from across Toronto. The goal is to build on the excellent work already being done – to develop an effective and achievable equity action plan that will be far more than the sum of the individual CHC parts and make a major contribution to enhancing health equity in Toronto.

SCOPE

This plan is meant to be part of a dynamic and iterative process, not a one-time document. Through the accountability and learning mechanisms set out below, and through ongoing experience in meeting community health needs, the principles and directions set out here will continually be elaborated and adapted. This plan covers a three-year horizon, with a series of dovetailed initiatives and projects across the period and annual reporting to keep the overall plan on track and dynamic.

ENVIRONMENT: OPPORTUNITIES AND CHALLENGES

To understand the context for this plan, the GT CHCs commissioned a survey of member CHC equity initiatives and perspectives. The survey asked respondent CHCs to describe three specific equity initiatives, their desired outcome, evidence that the outcome is being achieved, and direct resources used; identify three to five client needs not yet addressed; and provide other highlights about health equity work at their CHC. Responses to the survey highlighted that all CHCs see equity embedded in

everything they do. In fact, key elements of the CHC model of care can be seen as vital success conditions for delivering on equity:

- a funding model based upon salaried professionals that enables practitioners to spend the time needed to properly address the particularly complex needs of many of their most disadvantaged clients;
- multi-disciplinary and team-based programming that wraps around client needs in a holistic and integrated way;
- a model that integrates chronic condition prevention and management and health promotion into comprehensive primary care;
- focussing on communities and populations not well served elsewhere in the health system;
- community engagement and community development initiatives that begin to address the poverty, income inequality, racism and other social determinants that underlie health inequities.

Key types of equity initiatives are common across the GT CHCs:

- targeted engagement and services, e.g., to specific populations, determinant(s) of health, priority health strategies or public policies, intensity/priority of need;
- community-based outreach and support, e.g., through peer workers, dedicated staff, inter-agency or inter-sectoral partnerships;
- coordinated or “wrap-around” case management;
- “non-traditional” support, e.g., TTC, childcare, low cost drugs, diagnostics and specialist services, off-site nursing, shower and laundry facilities, good food boxes, interpreters.

There are also common desired equity outcomes:

- improve access to quality care;
- reduce isolation and social exclusion;
- empower clients and educate providers;
- build civic engagement and community capacities;
- better health outcomes and quality of life.

GT CHCs report using common evidence or equity measurement tools:

- utilization rates, including by priority populations;
- community-based advocacy, social capital;
- experiential outcomes from client satisfaction surveys.

They also identified unmet needs they work to address:

- access to care for non-insured clients;
- recognizing the effect of social determinants of health, specifically housing and food (in)security and other outcomes of poverty, on client and population health, as well as the impact of intersecting or “multiple determinants” or inequities;
- access barriers such as affordable medication and availability of interpretation and translation services;
- providing care for populations with complex needs and challenging circumstances, e.g., youth, LBGT, homeless, mental health consumer/survivors, physical-developmentally disabled;
- ensuring timely and equitable access to all needed services in the full context of people lives, rather than solely focusing on specific targets in isolation (e.g. hips and knees).

An exploratory planning session was then held with EDs and senior program managers from all CHCs. Key further themes raised were:

- potential equity initiatives, including addressing :
 - gaps in CHC catchment areas;

- resource shortages among CHCs;
- other social determinants issues not directly highlighted by the survey such as poverty, substance use connected to populations with complex needs, food security and gun violence;
- the importance of including stakeholders and community members in each step of the equity planning and evaluation process;
- the need to build internal momentum for integrating equity into organizational culture and values;
- the challenge of thinking about the full range of social determinants of health and the communities being served to ensure that the services provided are appropriate and comprehensive.

Opportunities within the wider health system include:

- equity and population health are enshrined as essential principles of a high-performing health system in the new *Excellent Care for All* act. While the ten year strategy has not been released, equity is a central priority for the Ministry of Health and Long-Term Care;
- equity is a key priority of the Toronto Central LHIN (as well as other GTA LHINs and beyond);
- increasing evidence is emerging on the scale and nature of systemic health inequities.

In the most fundamental way, addressing health disparities and providing care and support for those populations that face systemic barriers to access to health care is the reason CHCs exist. CHCs are well placed to drive — in fact, to lead — equity-driven reform. Challenges moving forward will be aligning equity with key system trends and drivers:

- embedding equity within the emerging quality improvement and client-centred agendas;
- demonstrating that priorities such as sustainability and cost-effectiveness, preventing and managing chronic conditions, and reducing wait times and ALCs cannot be achieved without incorporating equity into planning and delivery;
- achieving the ECFAA commitment of excellent care for all by enhancing seamless and coordinated continuums of care for all populations, including the most vulnerable and isolated that CHCs have long served.

While CHCs will continue their commitment to equity and pursue this plan, they will consider challenges such as:

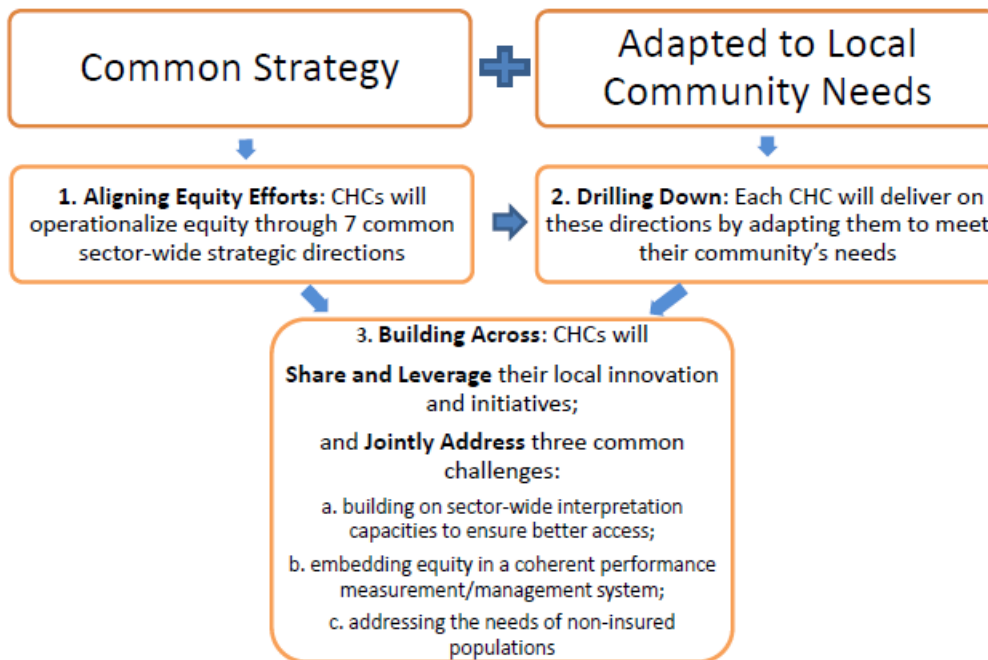
- while TC LHIN is solidly committed to equity, a new provincial government could change LHINs' mandates and priorities;
- fiscal restraint will constrain health care spending for the immediate future;
- while CHCs focus on priority populations, they balance this with serving a wide range of individuals in their communities;
- even within broad general or formal support for equity, there is always a danger that competing priorities can push equity out as governments and providers default to more comfortable clinical and quantifiable objectives;
- different levels of government could downplay or challenge equity as a health and public policy goal.

Equity Action Plan Overview

The plan will provide common overall strategic directions to align equity initiatives within the sector. At the same time, each CHC will drill down to adapt implementation to their unique community needs and context.

It will establish a framework to share and leverage the potential of equity initiatives and innovation underway at Centres across the city. And it will focus on three key issues of concern to all CHCs and

CHCs are committed to advancing health equity by providing the highest quality care to all and by addressing the roots of health inequalities in their communities through



the communities they serve.

COMMON SECTOR STRATEGY

This plan begins from a shared goal:

CHCs are committed to advancing health equity by providing the highest quality care to all and by addressing the roots of health inequalities through a community development approach. They will achieve this by working within a powerful common strategy, adapting this framework to the specific needs of the communities they serve, and by focussing their collective energy and resources on pressing common challenges.

This action plan is based on a multi-pronged and well-coordinated set of strategic directions for acting on health equity within the CHC sector:

1. Building equity into priority setting and service planning;
2. Aligning equity initiatives with system drivers such as quality and chronic disease prevention and management and LHIN priorities;
3. Embedding equity into performance measurement and management;
4. Targeting programs to address priority populations or key access barriers;
5. Building equity into health promotion programming;
6. Tackling the underlying roots of health inequality in the wider social determinants of health through community development and cross-sectoral collaborations;

7. Building on the potential of existing equity-orientated innovations through sharing lessons learned and promising practices.

These directions are filled out below; each would also be adapted to meet the unique needs of each CHC.

1: Building equity into priority setting and service planning

This doesn't mean all programs are all about equity. Rather, all CHCs always see equity as fundamental in planning services and outreach.

BEGIN FROM CLEAR STRATEGIC PRIORITIES

Many Centres responded to the recent survey that equity is a fundamental priority. And there is no question that equity is fundamental to the CHC model and ethos. But what this commitment concretely means in practice has varied.

Implementing equity strategy will be based upon each CHC:

- identifying how these common equity directions will be incorporated and/or adapted within their strategic plans;
- prioritizing particular populations or access/quality barriers in their plans;
- setting specific targets and objectives relating to these populations or barriers or other defined equity-related priorities to which they will be accountable;
- regularly reporting to their Board on progress towards these equity priorities.

There would also be further advantages from a sector point of view of being explicit: setting out priority equity populations and barriers would allow synergies to be assessed across the sector. Are key populations being missed? Identifying which CHCs are addressing specific equity populations or barriers would also allow effective practice and delivery to be shared for these specific purposes.

START FROM THE COMMUNITY

If the goal is to reduce health disparities and meet the needs of the most vulnerable communities, who will define these communities, their needs and what is needed to meet them?

- can't just be "experts," planners or professionals;
- community voices and interests must be built into planning and priority setting;
- not as occasional community engagement, but to identify equity needs and priorities, evaluate how we are doing and build relationships.

Like so many other issues identified here, this is not news to CHCs: all engage their communities and many innovative and effective mechanisms and processes have been developed to ensure that CHCs remain grounded in their local communities.

But again, practice across the GT CHC sector can vary. It will be important to consistently integrate community engagement into overall planning, for example:

- is community engagement always part of the environmental scans and SWOT analyses that CHCs undertake for strategic planning?
- where and how can CHCs learn from each other's practices and experiences? Are there areas where common insight and intelligence can be shared?
- could standardized community engagement processes be developed?
- how can CHC practice inform and be effectively coordinated with the development of hospital and LHIN community engagement guidelines?

EQUITY-FOCUSED PLANNING

The goal here is to embed equity in routine planning: not that all programs are all geared to particular disadvantaged populations or addressing access barriers, but that all programs ensure equity is always considered in planning, priority setting and organizational processes such as human resources.

One tool that is being promoted within Ontario and starting to be extensively used within TC LHIN is Health Equity Impact Assessment.

GT CHCs will:

- consistently use a common equity lens as a scoping mechanism to identify areas where more detailed equity analysis is necessary;
- each CHC will commit to applying the MOHLTC Health Equity Impact Assessment tool (HEIA) to at least one issue or program a year;
- explicitly incorporate equity as a key factor within existing planning mechanisms.

SIMPLE EQUITY LENS

Could this program have a differential or inequitable impact on access or quality for some groups served?

How will this program affect priority populations or equity barriers?

2: Aligning Equity With System Drivers and Priorities

QUALITY

Under the ECFA Act providers have to develop Quality Improvement Plans. Implementation began with hospitals and they reported their first QIPs this April 1. While equity was not one of the required elements in the first template, hospitals could include equity as one of the dimensions added to their reports and equity may be more explicitly required in subsequent years.

CHCs are anticipating that they and other providers will also be required to develop Quality Improvement Plans in the immediate future. CHCs are uniquely placed to be system leaders here as well, and will develop QIPs that embed equity. They are developing reliable and effective equity indicators that will be built into their overall quality improvement processes and planning. This integration of equity and quality will build upon earlier provincial work undertaken with the Ontario Health Quality Council (now Health Quality Ontario).

CHRONIC DISEASE PREVENTION AND MANAGEMENT

CHCs have been much involved in LHIN, provincial and local network planning around diabetes, mental health and other key chronic conditions. The challenge is to be strategic here. As well as enhancing service delivery coordination, CHCs can use these planning forums to advance:

- the kind of comprehensive inter-professional care they practice — care that can best meet the complex needs of populations facing barriers to good health;
- explicitly show how CDPM has to be analyzed and planned through an equity lens — and how this can be done;
- highlighting that failure to take an equity approach will severely limit the impact of CDPM programs: e.g. diabetes is so affected by the social conditions in which people live that failing to take these determinants and barriers into account will mean that the most severely impacted will not benefit from programs and, as a result, overall population level targets cannot be achieved.

UPSTREAM SOLUTIONS FOR DOWNSTREAM SYSTEM PRESSURES AND PRIORITIES

Alternative Levels of Care (ALCs), wait times and sustainability are major provincial and LHIN priorities. Providing high-quality primary care and health promotion programs can contribute to reducing pressures at the acute level. Most importantly, the focus of upstream planning is to keep people well so they do not need to access the acute care system.

CHCs will continue to contribute to LHIN and other planning initiatives in these and other priority areas.

3: Embed Equity in Performance Measurement and Management

Extensive international experience and research highlights that a critical way in which equity is driven into action within the health care system is through explicit equity targets and incentives. This needs to be part of a coherent strategy of cascading expectations through the system — from the Province ⇒ LHINs ⇒ providers, and then within each CHC ⇒ into specific programs and services.

CHCs have all been working on developing performance and impact indicators appropriate to their populations' needs and their strategic objectives. At the same time, the provincial Executive Directors network and the Association of Ontario Health Centres (AOHC) have been working on a performance measurement strategy and system. The goal will be to most effectively build on and coordinate the work already underway to create a coherent performance measurement/management strategy that reflects the specific dynamics and populations served and contributes to sector learning and continuous service quality improvement.

GT CHCs will achieve this by developing a sector-wide performance measurement and management strategy that embeds equity and uses common equity indicators, and that all CHCs will implement. This plan identifies this as one of three joint projects among GT CHCs (details follow below).

4: Targeting For Equity Impact

CHCs have long focussed their efforts on populations facing the harshest disparities or most in need of specific services, and/or on addressing critical barriers to equitable access to high-quality services. This will now be explicitly built into their strategic and operational planning, and CHCs will detail how their program mix and service delivery reflect this prioritization.

Targeting requires sophisticated analyses of the bases of disparities, for example:

- what is the main problem, e.g. lack of coordination among providers; sheer lack of services in particular neighbourhoods; precarious employment, language barriers, discrimination and other social determinant challenges faced by immigrants;
- what is the evidence, e.g. the literature indicates that community-based research has great potential to provide rich local needs assessments and evaluation data;
- what is the involvement of local communities and stakeholders in planning and priority setting, critical to understanding the real local problems.

Again, this highlights the potential of systematically sharing research, community intelligence and advice, and other local data and experience across CHCs.

5: Building Equity Into Health Promotion

Equity will be built into health promotion strategies and programs by;

- addressing the adverse impact of poverty and unemployment on opportunities for good health;
- enabling community development and civic engagement that contributes to healthy individuals and connected and resilient communities;
- targeting health promotion services and programs to those populations most at risk.

CHCs may be the sector within the LHIN system that has the clearest mandate for health promotion. More specifically, current health policy research and literature emphasizes a contradiction of universal or general health promotion campaigns: if the well-informed or well-connected disproportionately take up and benefit from health promotion messages or services, then health disparities can widen. CHCs work to ensure that health promotion is available for populations most affected by social and economic inequality and who need it the most. Many experts call for the kind of “targeted universalism” the CHCs have long practiced.

Most fundamentally, CHCs take a broad view of health promotion: not just delivering excellent programs or education, but addressing the underlying determinants of health through community building and collaboration, and advocating for the policy changes necessary to reduce the adverse health impact of poverty and inequality. This means addressing the exclusion and disengagement facing disadvantaged communities.

The goal, here as well, is to keep people well and prevent the need for acute care. This work also necessarily extends beyond the acute and LHIN sectors. CHCs will continue to contribute to healthy community partnerships and other such planning initiatives to advance health promotion.

6: Building In Social Determinants

The goal is to work well beyond health care to tackle the underlying roots of health inequality in poverty and the wider social determinants of health through:

- community-based capacity building and development;
- cross-sectoral collaborations and innovative hub and other integrated service delivery;
- building community and public policy mobilization to drive the fundamental social and policy change needed to tackle inequality.

The CHC model of care is explicitly geared to supporting people from poor and marginalized communities within a social determinants perspective by:

- providing comprehensive multi-disciplinary services across a full range of needs;
- integrating determinants of health into program design looking beyond vulnerable individuals to the communities in which they live;
- providing and/or partnering for related services/support such as settlement, language, child care, literacy, employment training, youth support, etc. that address clients’ social conditions and needs as a whole;
- supporting involvement in cross-sectoral planning efforts such as healthy community partnerships and neighbourhood-based initiatives.
- bringing this broader, determinants-based focus to community development and poverty reduction.

LOOPING BACK TO QUALITY: EQUITY-DRIVEN SERVICES

One of the core principles of the emerging quality agenda is client-centred care, and that means taking the full range of people's mental, spiritual and physical health needs into account. Social context and living conditions are part of this: when people face adverse social determinants of health, it can increase their risk of mental and physical health challenges and illness. And when people have fewer resources to cope (from supportive formal and informal social networks, to good food and being able to afford medication) their recovery from illness or capacity to deal with chronic conditions will be worse. Providers and programs need to know this to customize and adapt care to needs and contexts, e.g., through more intensive case management, referral planning, service mix and fostering community connections.

AND BACK TO COMMUNITY: BUILDING MOMENTUM AND MOBILIZING FOR EQUITY

Sophisticated strategy, solid equity-focused research, planning and innovation, and well-targeted investments and services are key. But in the long run, fundamental changes in over-arching public policy, specifically social and economic policy, as well as in underlying structures that contribute to inequality are needed. These kinds of huge changes come about primarily through widespread community mobilization and public pressure.

One key to equity-driven reform is empowering communities to imagine their own alternative vision of different health futures and to organize to achieve them. As noted earlier, CHCs' community engagement, partnerships and community development efforts support this goal.

7: Driving Equity Through Innovation

There are a huge number of community and front-line initiatives already addressing equity across the sector and GT CHCs, as well as mental health, ethno-cultural and other community-based providers, have developed a range of effective and innovative programs. For example, many CHCs and other community providers have established train-the-trainer programs and 'peer health ambassadors' to provide system navigation, outreach and health promotion services to particular communities. This progressive service delivery is a beacon of inspiration for other sectors and a constant living demonstration that action is possible.

However, the potential of this front-line innovation is not being fully realized: ideas and experience are not always systemically shared or built upon. Developing forums and mechanisms to ensure this can be done is addressed later.

One immediate promising direction to build upon is the hub-style multi-service centres being developed within some new satellite CHCs in designated high-need areas. The equity impact of CHCs delivering primary and preventive care and other agencies providing a range of employment, child care, language, literacy, training and social services out of single 'one stop' locations will need to be carefully evaluated.

Drilling Down: Adapting in Individual CHCs

Each CHC will adapt these seven strategic directions to the specific needs of their community and context, identifying priority populations or access barriers by analyzing available local health profiles, needs assessments, program and other data.

Each CHC will then analyze and report on:

- how the overall framework was adapted to meet their particular client needs and situation;
- how their own primary care, health promotion, community initiatives and other programs were adapted to meet the specific equity populations/barriers identified;

- how overall sector-wide priorities, programs, initiatives or strategies – e.g. better interpretation, serving non-insured people, equity indicators and performance measurement – were adapted to local needs;
- how local cross-sectoral collaborations, community development and other efforts addressed social determinants;
- sharable successes and other lessons learned from equity initiatives and innovations.

Two mechanisms will drive these broad principles into consistent action, ensure accountability of the sector, and build on the collective potential of all this activity. Each CHC will:

- prepare an annual performance report along the lines above on activities and impact of the agreed equity directions and objectives as adapted to their specific situation;
- present this report, as well as key lessons learned on promising practices and front-line innovations, to an equity symposium organized annually by the CHC-GT forum.

There are two complementary objectives to this model: learning and accountability.

First of all, this process will become an indispensable component of the sector's overall learning and innovation strategy. Sharing information on equity initiatives through these annual reports and creating a forum to discuss and elaborate the lessons learned moving forward will contribute to continuous service improvement and program development. Individual CHCs and the sector as a whole will build this learning into their working practices and culture.

Secondly, sharing the annual performance reports within the sector is also a vital means of CHCs being accountable for their activities and impact to each other. This particular accountability mechanism is also part of a broader strategy:

- the reports can be planned and developed in such a way as to also be adaptable for CHC annual reporting on their MSAAs;
- as experience is built through several years of annual reports, the CHCs can elaborate the deliverables and targets that could be built into the next generation of the MSAAs to be negotiated for 2014;
- as the model evolves, the sector could consider submitting highlights from the annual conference and the individual reports to the LHIN as part of its ongoing dialogue.

Building Across and Together: Addressing Common Challenges

CHCs have worked within a shared commitment to providing the best possible services to disadvantaged communities, in ways that reflect and can help to ameliorate the broader inequalities, constraints and realities of their clients' lives and social circumstances. CHCs work within a shared understanding of:

- the systemic structures of inequality and exclusion that shape the health and well-being of their clients;
- the complex, intersecting, and dynamic nature of the social determinants of health;
- the need to work beyond the bounds of health care to address these underlying roots of health disparities and to build on the capacity, reliance and potential of the communities they serve.

But key challenges have been identified moving forward, specifically, how to:

- leverage the collective capacity and energy of the CHCs, their staff and communities;
- build synergy across the sector to enhance and realize these individual capacities and shared deep commitment;
- create coherence across the sector, including enhancing coverage for at-risk communities;

- systematically address critical common challenges.

LEVERAGING COLLECTIVE POTENTIAL

CHCs are driving a huge amount of front-line innovation and community-based initiatives addressing equity. One of the key directions in the overall strategy is to create forums and mechanisms that harness and build upon all this innovation to enhance synergy, coordination and impact across the sector.

Experience indicates that to drive equity-focused innovation and effective interventions, GT CHCs need to be able to:

- collate and analyze all the useful intelligence gained from equity-focused planning;
- capture and share information on local initiatives, and build on local front-line insights;
- share the resulting knowledge across the sector and beyond;
- assess the most promising initiatives or directions rigorously;
- adapt and spread promising initiatives across the province where appropriate.

Creating an effective annual and ongoing forum to which individual CHCs report their equity-driven innovation and where cross-sectoral coordination and synergies can be identified, enabled and sustained is the key mechanism to realize this goal.

Thinking in system terms, equity innovations should be shared not just within CHCs but across the health system:

- Toronto Central, at best partnering with other LHINs to ensure GTA coverage, could fund a web-based innovation knowledge management database and infrastructure;
- there could be significant advantages in establishing such an infrastructure very broadly and the Ministry of Health and Long-Term Care could consider supporting such a province wide initiative with the AOHC.

Three Common Projects

These projects address three crucial equity issues identified during the planning day and survey:

1. interpretation and translation: to bring shared sector resources to bear on the vital access barrier of language;
2. quality: to lay a solid foundation for quality improvement that embeds equity and complements provincial and LHIN mandates and initiatives;
3. non-insured clients: to develop coherent and well-coordinated policies and practice — sector-wide and with other partners — to better meet the needs of this particularly vulnerable population.

1: SHARING INTERPRETATION RESOURCES AND CAPACITIES

Language has been highlighted as a crucial barrier to equitable access and high-quality care in an increasingly diverse city and society. The need to provide appropriate and effective interpretation and translation services has been demonstrated consistently in the wider research literature, identified as a key issue through several years of hospital equity plans within Toronto and is major priority for Toronto Central LHIN. Important research and development groundwork has been done on the potential of providing more centralized and coordinated interpretation resources.

This project is about effectively building on existing capacities and sharing resources across the sector to address a common and crucial access barrier. It will be implemented during the first year of

this plan, through fiscal 2012-13.

A work plan is being developed and will include:

- streamlining access to interpretation services;
- sharing training guides and other resources;
- developing common standards and processes to ensure consistent high quality and access.

2. BUILDING EQUITY INTO PERFORMANCE MEASUREMENT AND MANAGEMENT

This project aligns with the emerging quality agenda and the coming requirements under ECFA. CHCs have long emphasized quality improvement and have worked provincially with Health Quality Ontario and its antecedent organizations on primary care Quality Improvement initiatives. The sector wants to effectively anticipate these broader quality trends and demands. More broadly, CHCs recognize that they have an opportunity to build on their unique mandate and experience to play a leadership role on how equity can be incorporated into comprehensive QI strategies and mechanisms.

This project is underway and will result in equity being integrated into a revised performance management system by 2013. A multi-disciplinary work group is developing a plan that will include:

- developing a cascading series of indicators that will support the needs of LHINs, CHCs and specific programs;
- these will be aligned with LHIN, Health Quality Ontario and other provincial priorities, and other sectors of the health system;
- developing systematic processes to collect the necessary data – building on the work of the CHC Data Alliance and linking with LHIN and provincial developments;
- towards incorporating equity into a comprehensive performance measurement and management system.

The indicators to be developed will include not just measures of access and quality of health care services delivered and health outcomes, but indicators for equity-focused health promotion and for enabling community engagement and social participation.

3: SYSTEMATIC STRATEGY FOR NON-INSURED POPULATIONS

This project addresses the unmet needs of a vulnerable and under-served population. The adverse impact of limited and inequitable access for people without health insurance has been well documented by the 2010 research conference organized by the Women's College Network on Uninsured Clients and partners and by the practice experience shared within this and other networks. The issue has been prioritized by the Hospitals Collaborative on Marginalized Populations and the Toronto Central LHIN. GT CHCs have done considerable research on the existing situation and will now build towards more systematic policy, procedures and allocation of resources across the sector to better provide vital health care services to non-insured people. Systematizing this issue will:

- reduce avoidable and excessive administrative complications within the sector and with partners who may not share the CHCs' mandate to serve this population;
- streamline and improve access and consequently reduce the adverse health burden on a very vulnerable population.

This project will be implemented through the first and second years of this plan, through calendar years 2012 and 2013. Phase I of the research project has been completed on identifying the scale of non-insured clients, their needs, gaps in existing services and resources, and system alignment. The work plan moving forward will include:

- further research on service gaps, including access to home and community care through CCACs,

- and their impact on quality of care and health outcomes for CHC non-insured clients;
- developing consistent policies and procedures for assessing and supporting people without insurance, including developing common sector-wide arrangements with hospitals;
- common data collection — on services provided and the care trajectory of these clients through the system, challenges they face (e.g. demands for payment, differential quality of care, treatment outcomes);
- developing policies and procedures to more systematically share resources effectively across the sector (i.e. using available funds as a sector-wide pool.)

Conclusions: Building Momentum for Equity

This equity plan builds on and complements other strategic and operational planning underway within the sector, such as programs for seniors and coordinating with CCACs and other partners to ensure equitable access and smooth transitions to home and community-based support services.

While there is a great deal of equity-focused and community-driven innovation across the CHCs, the extent and nature of these initiatives may not be well known. It will be important for the sector to develop an “impact narrative”: telling the story of how all these initiatives separately and together make an important contribution to meeting the needs of the most vulnerable populations and overall health equity.

ENHANCING COVERAGE

A vital challenge is ensuring that as many people in health-disadvantaged circumstances and communities can access CHC services.

Each GT CHC will have identified priority populations and barriers and built that into their own plans and programs. The system challenge is to roll together all these individual CHC actions at sector and LHIN level to build on successes and address access challenges.

This will also allow more complex ‘reach’ questions to be addressed: individual CHCs know who is accessing services, but do not know as well who is not coming in the door. Critical equity questions are how to reach those who need services the most; how to create and adapt services to meet their often more complex needs, and how to ensure that those most in need are retained within programs? Standard programming evaluation standards of number of clients served or cost per client cannot capture these complex equity considerations.

There are neighbourhoods or particular disadvantaged communities that do not fall within existing CHC catchment areas. Toronto Central and/or MOHLTC could consider filling in the gaps of existing catchment areas as an equity priority.

Similarly at the system level: are there gaps not being filled by CHCs or other providers adequately, for example:

- CHCs and other community-based organizations provide mental health. Are overall services comprehensive enough? Are all sub-populations’ needs being met?
- CHCs, hospital and midwives all provide reproductive care to disadvantaged communities. Are there inefficient overlaps or gaps in which particular communities are not well served at all by any providers?

Toronto Central LHIN can again play an enabling and integrative role here by linking up the equity planning underway in the CHC, hospital and other sectors.

This is not meant to be a one-time only plan. Rather this will be an iterative process in which CHCs continue to elaborate and enhance their plans to better meet the needs of their clients and advance equity across the health-care system.

The Wellesley Institute was commissioned to facilitate and draft this plan. For further information on Wellesley's work on health equity contact:

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