Central East **LHIN**

Appendix 6:

Detailed Recommendations

The Culture, Diversity and Equity Project

Ontario
Local Health Integration Network

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The Project Charter Committee approved this document on January 19, 2010.

Introduction

This appendix to the Culture, Diversity and Equity Project (CDE Project) details the ten recommendations put forward in the project's Final Report. Implementation of the priority actions outlined in the recommendations would result in direct and significant improvement in health equity throughout the Central East LHIN.

The goals, purpose, and rationale of each recommendation are explained using, whenever possible, evidence from the other appendices of the report:

- The Literature Review (Appendix 1);
- The Environmental Scan (Appendix 2);
- The community member and health service provider Focus Groups (Appendix 3); and
- The Community Consultation Process (Appendix 4).

Process of Development

These recommendations were developed using multiple approaches. The CDE Project carried out:

- A comprehensive literature review addressing issues of health equity;
- An environmental scan of culturally competent services and services for uninsured individuals;
- Focus groups with 174 diverse participants, either community members or health and social service providers; and
- A public consultation with 63 community forum participants and 175 online participants in order to appraise a first draft of the recommendations.

Community members and health and social service providers provided us with valuable feedback from the earliest stages of the project. We believe we have identified the most essential actions for the successful implementation of each recommendation.

Recommendation #1: Central East LHIN Leadership

Recommendation Statement

The Central East LHIN will define a clear strategic vision for health equity, and will engage community members in the process.

Recommendation Activities

Priority Actions	Deliverable	Lead
Provide the Central East LHIN board with comprehensive training on power, oppression and health inequity.	Training session	Board
Develop a Health Equity Health Interest Network (HEHIN)[1] that comprises 50%+ marginalized community members, Central East LHIN board members, and health service providers.	Health Equity Health Interest Network	Board, LHIN office, Collaboratives, CDE Project Charter Committee
Develop and adopt a health equity vision statement and guiding principles related to health equity, in collaboration with the Health Equity Health Interest Network.	Health equity vision statement and guiding principles related to health equity	Board, HEHIN, LHIN office
Set ten-year goals with clear leadership roles, targets, milestones, and outcomes and develop a three-year Health Equity and Evaluation Plan.	Ten-year health equity goals and a three-year Health Equity and Evaluation Plan.	Board, HEHIN, LHIN office
Commit resources to organizational development, service enhancements, a client navigation system, an information and knowledge transfer system, health equity research, and the Health Equity Office (see later recommendations)	Resource commitment	Board, LHIN office
Develop an intra-LHIN Health Equity Committee.	Internal Central East LHIN Health Equity Committee	Board, LHIN office

[1] The role of the Health Equity Health Interest Network is the same as that of other health interest networks (e.g., Seamless Care for Seniors): they are expert committees that advise the Central East LHIN directly on its priority initiatives and activities.

Priority Actions	Deliverable	Lead
Develop and adopt internal health equity guiding principles for requests for proposals, assessing proposals, research, contracts, etc.	Health equity guiding principles as part of various internal activities	Board, HEHIN, LHIN office
Incorporate health equity into the performance management of all Central East LHIN office staff.	Health equity part of performance management of all staff	Board, HEHIN, LHIN office

Goals and Purpose

Goals

The implementation of recommendation #1 will:

- Represent the necessary first step toward the creation of a framework for minimizing or eliminating socially/institutionally structured health inequalities that lead to differential health outcomes;
- Make the Central East LHIN a national and international health equity leader;
- Engage the Central East LHIN in critical self-reflection, therefore increasing learning opportunities;
- Communicate a commitment to health equity to all stakeholders;
- Build a common understanding of health equity across the Central East LHIN; and
- Provide clear directions across organizations funded by the Central East LHIN on health equity definitions.

Purpose

The most important purpose of recommendation #1 is to create and demonstrate leadership in the Central East LHIN around health equity. Other purposes are to:

- Provide a health equity standard that the Central East LHIN can both achieve and be accountable to;
- Help develop and sustain a health care system within the Central East LHIN that is committed to health equity, one that provides direction for programs, services and resource allocation;
- Champion health equity in keeping with various legislations, initiatives and institutions; for example:
  - The Canadian Charter of Rights and Freedoms;
  - The Ontario Human Rights Code;
  - The Federal-Provincial-Territorial Advisory Committee on Population Health's establishment of a Health Disparities Task Group;
  - The ten-year plan to strengthen health care adopted at the 2004 First Ministers' Meeting on the Future of Health Care;
  - The OPS Diversity Office in the Ministry of Government Services;
  - The Ontario Ministry of Health and Long-Term Care ten-year plan for Ontario's health care system;
  - The Ontario Health Quality Council's equity framework;
  - Various LHINs; and
  - Greater Toronto Area Diversity and LHINs Working Group, specifically addressing diversity and equity issues in the LHIN context.

Rationale for Recommendation

Literature

Equity policies should be adopted at every level of the Central East LHIN, as an integral component of strategic goals, vision, and mandate. This will ensure compliance throughout the system (Beal, 2004; Department of Health, 2007a; WHO, 2008). Moreover, governance of equity policies should extend to the highest levels of the Central East LHIN, with ultimate responsibility resting unambiguously with the most senior manager/s including the board. This will help ensure coherent integration of health equity concerns across all policy, program, service/function areas and effective coordination across the system (Rachlis, 2007b; Gardner, 2008a; GTA Diversity and LHINs Working Group, 2008a).

Justification: The Central East LHIN should state in its health equity policies the reasons for addressing health inequities:

- Health inequalities contradict values of fairness and justice; and
- Reducing health inequalities leads to better average health outcomes for the population as a whole.

Objectives: The Central East LHIN should clearly state that the objectives of its health equity policy are to:

- Reduce health inequalities, either absolutely (often through universal initiatives) or relatively (often through targeting the most disadvantaged); and
- Reduce health inequities (rooted in determinants of health) or health care inequities (inequities within the health care system).

Ideally, the health equity policy should address both universal and relative reduction as well as health status and health care disparities.

Scope: The Central East LHIN should consider the breadth of marginalized groups (e.g., racial and ethnic minorities, class, gender, etc.), and of organizational domains (leadership, governance, service and service delivery, research and education, human resources, contracting and procurement, and communications).

Health equity policy should ideally include all disadvantaged populations across all organizational domains.

Evidence: The Central East LHIN should prioritize health equity interventions on the basis of their evidence-based effectiveness in potentially reducing health inequalities.

Strategic Options and Priorities: When developing their health equity policies, the Central East LHIN should consider their strategic intervention options in terms of upstream or downstream entry points. Health care interventions are downstream while determinants of health interventions are upstream (adapted from Mackenbach et al., 2002b).

As a large funding body, the Central East LHIN has the opportunity to address midstream interventions as well, both within the Central East LHIN and beyond (e.g., it can lobby government and other bodies for more upstream interventions).

When determining midstream and/or downstream priorities, the Central East LHIN must consider whether they want to use universalist approaches (targeting all individuals) and/or selectivist approaches (targeting services and benefits to specific populations, depending on need).

Community Member Focus Groups

During focus groups, community members were asked to comment on how they believe equity visions, guiding principles, etc. as envisaged under recommendation #1 should be developed and what components should be included. Community members made the following suggestions:

- Include front-line staff and management (from the bottom up);
- Include marginalized individuals;
- Make policies feasible and action-oriented;
- Ensure that language is accessible for staff;
- Use policies as a tool to support staff rather than threaten them (policies can create a climate of fear);
- Review, revise and update on an on-going basis;
- Include more equity requirements than the minimum demanded by accreditation bodies and the Ministry; and
- Include health equity in human rights and all other broader policies and procedures.

Recommended components of the policy:

- A newly created Code of Conduct;
- Zero tolerance for abuse;
- Respect, equality and sensitivity;
- Pro-active outreach;
- Mandatory and ongoing training;
- Joint service planning with the community;
- Human resources policies; and
- Diverse boards;
- Policies for implementing health equity;
- Client Bill of Rights; and
- Clients' right to professional interpreters.

Health Service Provider Focus Group

Though health service providers were not asked for policy recommendations specific to the Central East LHIN, they did identify the Central East LHIN as having a useful role in monitoring health equity within organizations, since funding should be tied to an organization's health equity performance.

Speaking of health equity policies in general, they made the following suggestions, which are clearly applicable to the Central East LHIN:

- Make social justice the justification for health equity policies;
- Acknowledge the impact of the broader determinants of health on health equity;
- Broaden the scope of what constitutes marginalized populations to include people with mental health/addiction issues;
- Involve communities in the development of policies;
- Hire and retain diverse staff; and
- Make clients aware of complaints processes.

Suggested components:

- A Client Bill of Rights;
- Recognition of the importance of social justice values and principles;

- Anti-discrimination/anti-stereotyping/anti-stigma;
- Initial training and re-training;
- Provision of culturally appropriate services;
- Mandatory accommodations for clients based on language, visual impairment, culturally deaf, religion, culture, socioeconomic status.

Environmental Scan

The following elements were not mentioned directly, but can nonetheless be used to suggest possible policy components:

- Access to interpreters;
- Increased cultural competence (including recognition of diverse explanatory models of illness).

Community Consultation

Amongst community members, **76% felt that recommendation #1 was essential to advancing health equity**. They ranked it **fourth (49% of participants) out of the ten recommendations**, and offered the following comments and concerns:

- Though it is commendable for the Central East LHIN to initiate this process, it is the Ministry of Health and Long-Term Care that holds the power to create real change;
- There may be a lack of long-term commitment to this issue due to too many competing interests within the Central East LHIN;
- Although adopting health equity as a strategic vision and commitment is necessary, it must go beyond a simple statement to include real action;
- The focus should be on implementation over development;
- Community members and other key stakeholders need to be engaged in this recommendation;
- Members should be chosen based on a set of criteria related to representation and affiliations with other groups/coalitions/networks; and
- Achieving health equity in such a diverse LHIN, whose population has such varying needs, will be a challenge.

Strategic Alignment

Political will and a favorable policy/political environment are critical to the advancement of health equity policies. This recommendation is strategically aligned with the following local and national offices, policies and policy drivers:

- The Central East LHIN's 2010-2013 Integrated Health Service Plan (IHSP) states that an equitable health system that allows everyone the same quality of care regardless of who they are and where they live is one of the attributes of a high performing health system;
- The Canadian Charter of Rights and Freedoms and the Ontario Human Rights Code;
- The 2002 and 2003 First Ministers' Health Accords, which make national commitments to reducing disparities through the adoption and promotion of a national Healthy Living Strategy;
- The Federal-Provincial-Territorial Advisory Committee on Population Health's 2002 establishment of a Health Disparities Task Group with the mandate of providing advice on the role of the health sector in addressing health disparities;
- The "Ten-year plan to strengthen health care" adopted and promoted at the 2004 First Ministers' Meeting on the Future of Health Care;
- The OPS Diversity Office in the Ministry of Government Services and development and promotion of an "OPS Diversity Three Year Strategic Plan";

- The ten-year strategic vision and plan being developed for Ontario's health care system by the Ontario Ministry of Health and Long-Term Care (MOHLTC), which is expected to feature equity as a prominent direction;
- The Ontario Health Quality Council's consistent advocacy for Ontario's governmental bodies (MOHLTC, LHINs) to adopt the Ontario Health Quality Council's equity framework;
- The Toronto Central LHIN's insertion of health equity and diversity performance indicators into the CEO's Annual Performance Plan and its requirement that all 18 hospitals in the Toronto Central LHIN provide action plans; and
- The GTA Diversity and LHINs Working Group, specifically addressing diversity and equity issues in the LHIN context.

Recommendation #2: Central East LHIN Health Equity Office/Staff

Recommendation Statement

The Central East LHIN will develop health equity tools to investigate the viability of a Health Equity Office; or, alternatively, hire designated Health Equity staff to monitor and evaluate Health Equity initiatives in the Central East LHIN.

Recommendation Activities

Priority Actions	Deliverables	Lead
Develop a Health Equity Office or, alternatively, hire designated Health Equity staff.	Health Equity Office or Health Equity staff	Central East LHIN and HEHIN
Develop an accessibility plan for community members who need to file a complaint; receive, investigate, and monitor client and staff complaints about discrimination.	Accessibility plan	Health Equity Office/Staff and HEHIN
Develop a Health Equity Planning and Implementation Framework for Central East LHIN-funded health care organizations.	Health Equity Planning and Implementation Framework	Health Equity Office/Staff and HEHIN
Develop a health equity monitoring and accountability system.	Monitoring and accountability system	Health Equity Office/Staff and HEHIN
Develop a Health Equity Education Framework for the Central East LHIN.	Health Equity Education Framework	Health Equity Office/Staff and HEHIN
Develop Health Equity indicators and evaluation standards.	Indicators and evaluation standards	Health Equity Office/Staff and HEHIN
Develop a communication plan and report overall health equity work and monitoring to community and other stakeholders.	Communication plan	Health Equity Office/Staff, HEHIN and Central East LHIN

Goals and Purpose

Goals

The implementation of recommendation #2 will:

- Monitor and assess health in(equity);
- Provide a clear process to community members for health equity complaints;
- Ensure systematic investigation of complaints;
- Assist organizations in developing and implementing health equity policies;
- Assist organizations in developing and reviewing health equity standards;
- Assist organizations in developing health equity training;
- Ensure that the Central East LHIN office receives relevant advice; and
- Ensure that the Central East LHIN community is informed of health equity advances.

Purpose

The literature review and Central East LHIN community members and health service providers clearly identify the need for an external or neutral internal body that will monitor organizations and investigate client complaints related to health equity. This body should also be active in advancing health equity, by providing assistance to the Central East LHIN office.

Rationale for Recommendation

Literature

Clear leadership is critical to enforcing compliance with health equity mandates. This involves governance of health equity strategy across all policy program and service/function areas along with effective performance management.

The literature shows the advantages of the following actions:

- Mainstream accountability measures for health equity policies and strategies into existing performance management systems;
- Use health equity impact assessments (across the whole system), as they are a particularly good tool for accountability measures (versus silo-ing responsibility for health equity plans to specialists only); they also ensure that all policy/program areas take into account how their interventions affect various diversity groups; and
- Establish an oversight body at the corporate level to monitor progress and coordinate efforts for eliminating disparities.

Among the major 'levers' for managing performance currently available to the LHINs are their:

- Funding and allocation powers;
- Local health system planning and contracting role (e.g. Integrated Health Service Plans; LHIN-Provider service accountability agreements etc.); and
- Oversight role (potential) in monitoring progress and compliance with health equity policy objectives reflected and articulated in service plan agreements.

Requiring ongoing measurement, evaluation, target-setting and reporting on progress made is critical to establishing accountability and quality assurance of health equity policy objectives. As part of service agreements, the LHINs could require organizations to:

- Set annual targets related to health equity policy goals and objectives;

- Introduce performance measurement, evaluation and monitoring against these targets; and
- Provide regular reporting not only to the LHINs, but to the wider public on progress (e.g. annual report cards) made against such targets.

Compliance with health equity policies presupposes sufficient capacity to do so. In this respect, the LHINs can play a critical support and capacity building role. They can, for instance:

- Provide or support training initiatives;
- Developing health equity/cultural competence guidelines and standards for care; and
- Establish or collaborate with existing health equity researchers and/or research units to assist in the intelligence gathering and an exchange process (critical to ensuring effective implementation and accountability).

While potentially beyond the direct control of the LHINs, licensing and accreditation agencies within the health care system can also play a quality assurance role by requiring health care providers to meet standards of health equity/cultural competence as a condition of licensing and/or accreditation (Exworthy et al., 2006; Betancourt et al., 2002; Office of Minority Health, 2001).

Community Member Focus Group

Most participants in this focus group recommended a complaints body to deal specifically with issues of culture, diversity and equity. It could be external or internal to the Central East LHIN office and act as client advocate, ombudsman, regulating officers (e.g., accreditation), and/or monitor of organizations' accessibility plans.

Health Service Provider Focus Group

Front-line workers in this focus group pointed out that internal monitoring lacks rigour and consistency, and that diversity committees tend not to concentrate on action. In the long-term care system, for example, Ministry inspections do not address culture, diversity and equity. Moreover, in current accreditation systems, such as Building Healthier Organizations (BHO) for example, diversity is a token or add-on rather than a focused issue. Finally, the fact that many organizations hire accreditation services appears to many staff as a conflict of interest. Among the suggestions put forth:

- Report monitoring to external bodies rather than internal ones;
- Create an external system modeled on Workplace Hazardous Materials Information System (WHMIS) systems that includes an internal and external diversity complaints system (e.g., ombudsman) that can respond in a timely manner and tie funding to Central East LHIN benchmarks.

Community Consultation

Among community members **60% felt that recommendation #2 was essential to advancing health equity**. They ranked it **seventh (28% of participants) out of the ten recommendations**, and offered the following considerations and concerns:

- Some of the activities in this recommendation should be done at a provincial level rather than a local level; this would be more effective since many of these issues go beyond the Central East LHIN;
- Some of this work needs to be done across all the LHINs;
- Synergy with other LHINs is needed to achieve this work;
- This recommendation will take up a lot of time and resources;
- A high level of community member involvement is required; and
- This is a positive step towards increasing accountability.

Strategic Alignment

This recommendation aligns itself strategically with the following:

- The health equity and diversity performance indicators that the Toronto Central LHIN has inserted into the CEO's Annual Performance Plan, requiring all 18 hospitals in the Toronto Central LHIN to provide action plans;
- The GTA Diversity and LHINs Working Group that specifically addresses diversity and equity issues in the LHIN context.

Recommendation #3: Organizational Policies

Recommendation Statement

All Central East LHIN-funded agencies will make health equity a clear strategic vision and commitment.

Recommendation Activities

Priority Actions	Deliverables	Lead
Develop a Health Equity Committee (HEC) including 50%+ local marginalized community members, board members, and health and community service providers.	Health Equity Committees (HEC)	Board and management
Adopt the health equity guiding principles created by the Central East LHIN.	Health equity guiding principles	Board, HEC, and Organization
Develop and adopt an organizational health equity vision statement.	Health equity vision statement	Board, HEC, and organization
Review and enhance all organizational policies to reflect the organizational vision and the Central East LHIN principles of health equity.	Policies that include health equity	Board, HEC, and Organization
Develop a three-year Health Equity Plan that incorporates the Central East LHIN ten-year goals.	Health equity plans	Board, HEC, Organization, and Health Equity Office/Staff
Commit/shift internal resources to implement Health Equity Plans.	Resources for health equity plans	Board, HEC, Organization, and CE LHIN

Goals and Purpose

Goals

The implementation of recommendation #3 will:

- Provide all Central East LHIN-funded agencies with a health equity vision and policies that address health equity;
- Engage Central East LHIN-funded agencies in critical self-reflection, therefore increasing learning opportunities;
- Initiate a process in which all Central East LHIN-funded agencies review their existing policies and diversity work; and
- Create consistency among the considerations and components of policies across the Central East LHIN.

Purpose

With the rapid demographic changes in the Central East LHIN, health equity is growing area of concern. Central East LHIN-funded agencies require assistance in their efforts to increase health equity within the communities they serve. The purpose of this recommendation is to establish a certain level of standardization and consistency in these efforts.

Rationale for Recommendation #3

Literature (this is the same rationale as recommendation #1)

The most comprehensive approaches to policy combine and incorporate the following:

- Health equity and health care equity policy objectives;
- Upstream, midstream and downstream ('all stream') policy interventions; and
- Universalist and selectivist approaches that have proven most effective.

Political will and a favorable policy/political environment are critical to the advancement of health equity policies. Health equity policies should strategically align themselves, wherever possible, with national and local policy contexts and drivers to gain traction.

The ways in which health equity policies and strategies are formulated can greatly influence whether they are put into practice, and whether they establish accountability. Critical to any action plan are:

- Clear and realistic articulations of health equity policy goals and objectives in terms that can be measured and operationalized;
- Concrete action plans in relation to policy goals and objectives, with guidelines on how these deadlines will be met and by whom, and how success will be measured; and
- Diverse stakeholders (including community stakeholders) input in the policy development process.

For organizations, key considerations in the development and application of health equity policy include (adapted from Mackenbach et al., 2002b):

Justification: Organizations should state in their health equity policies the reasons for addressing health inequities:

- Health inequalities contradict values of fairness and justice;
- Reducing health inequalities leads to better average health outcomes for the population as a whole.

Scope: Organizations should consider the breadth of marginalized groups taken into account (e.g., racial and ethnic minorities, class, gender, etc.) and of organizational domains (leadership, governance, service and service delivery, research and education, human resources, contracting and procurement, and communications).

Organizations should ideally include all disadvantaged populations across all health organizational domains.

Evidence: Organizations should base their proposed policies and strategies upon evidence to achieve the highest possible effectiveness.

Intervention: Organizations should also decide whether their health equity policies use universalist approaches (targeting all individuals) and/or selectivist approaches (targeting services and benefits to specific populations according to need).

Community Member Focus Group

During focus groups, community members were asked to comment on how recommendation #3 should be developed and what components should be included. They made the following suggestions:

- Include marginalized individuals;
- Make policies feasible and action-oriented;
- Ensure that language is accessible for staff;
- Use policies as a tool to support staff rather than threaten them (policies can create a climate of fear);
- Review, revise and update on an on-going basis;
- Include more equity requirements than the minimum demanded by accreditation bodies and the Ministry; and
- Include health equity in human rights and all other broader policies and procedures.

Recommended components of the policy:

- A newly created Code of Conduct;
- Zero tolerance for abuse;
- Respect, equality and sensitivity;
- Pro-active outreach;
- Mandatory and ongoing training;
- Joint service planning with the community;
- Human resources policies; and
- Diverse boards;
- Policies for implementing health equity;
- Client Bill of Rights; and
- Clients' right to professional interpreters.

Health Service Provider Focus Group

Speaking of health equity policies in general, health service providers made the following suggestions, equally applicable to the Central East LHIN:

- Make social justice the justification for health equity policies;
- Acknowledge the impact of the broader determinants of health on health equity;
- Broaden the scope of what constitutes marginalized populations to include people with mental health/addiction issues;
- Involve communities in the development of policies;
- Hire and retain diverse staff; and
- Make clients aware of complaints processes.

Suggested components:

- A Client Bill of Rights;
- Recognition of the importance of social justice values and principles;
- Anti-discrimination/anti-stereotyping/anti-stigma;
- Initial training and re-training;
- Provision of culturally appropriate services; and
- Mandatory accommodations for clients based on language, visual impairment, culturally deaf, religion, culture, socioeconomic status.

Environmental Scan

The following elements were not mentioned explicitly, but can nonetheless be used to suggest possible policy components:

- Access to interpreters;
- Increased cultural competence (including recognition of diverse explanatory models of illness).

Community Consultation

Among community members, **69% felt that recommendation #3 was essential to advancing health equity**. They ranked it **third (50% of participants) out of the ten recommendations**, and offered the following comments and concerns:

- Large organizations should start this process first to serve as a model and basis for smaller organizations to follow;
- Engaging community members on all these Health Equity Committees may be a challenge;
- Effective outreach is necessary to engage community members and various methods need to be utilized;
- Increased accessibility provisions such as orientation to work, child care, evening meetings, etc., will allow community members to participate fully in these committees;
- Why is the Health Equity Plan for three years; and
- It would be useful to look at other sectors working on equity issues.

Strategic Alignment

This recommendation aligns itself strategically with the following:

- The Canadian Charter of Rights and Freedoms and the Ontario Human Rights Code;
- The 2002 and 2003 First Ministers' Health Accords which make national commitments to reducing disparities through the adoption and promotion of a national Healthy Living Strategy;
- The 2002 Health Disparities Task Group established by the Federal-Provincial-Territorial Advisory Committee on Population Health, with its mandate of providing advice on the role of the health sector in addressing health disparities;
- The "ten-year plan to strengthen health care" adopted and promoted at the 2004 First Ministers' Meeting on the Future of Health Care;
- OPS Diversity Office in the Ministry of Government Services and development and promotion of an "OPS Diversity Three Year Strategic Plan";
- The ten-year strategic vision and plan for Ontario's health care system being developed by the Ontario Ministry of Health and Long-Term Care, which is expected to feature equity as a prominent direction;
- The Ontario Health Quality Council's ongoing advocacy for Ontario's governmental bodies (MOHLTC, LHINs) to adopt the Ontario Health Quality Council's equity framework;
- The policy developments and strategic commitments of various LHINs;
- The Toronto Central LHIN's insertion of health equity and diversity performance indicators into the CEO's Annual Performance Plan, and requirement of all 18 hospitals in the Toronto Central LHIN to provide action plans; and
- GTA Diversity and LHINs Working Group, specifically addressing diversity and equity issues in the LHIN context.

Considerations for Implementation

Additional actions to consider when implementing policy actions:

- Establish a shared definition of health equity and its effects on clients;

- Link health equity to the mission, vision, mandate, and values of the organizations;
- Encourage organization-wide support for health equity work;
- Link to other work done within the organization;
- Seek community support;
- Ensure accountability;
- Develop partnerships with a diversity of organizations and groups;
- Incorporate diversity into organizational decision-making, priority-setting activities, visioning, strategic planning and budgeting;
- Include diversity in human resources policies and practices, organizational planning, budgeting, research, ethics, training, clinical work, strategic planning, site redevelopment planning, health promotion, marketing and communication; and
- Deliver ongoing information, training and resource support to help all staff, volunteers, students and board members develop capacity in diversity and to understand their rights and responsibilities.

Recommendation #4: Organizational Monitoring

Recommendation Statement

The Central East LHIN Office will monitor health equity data through performance management systems.

Recommendation Activities

Priority Actions	Deliverables	Lead
Guide a process to identify relevant health equity data and collection methods[2] with stakeholders including epidemiologists and information technologists (coordinating with other LHINs; e.g., Toronto Central LHIN).	Relevant health equity data and collection methods	Health Equity Office/ Staff
Require the monitoring of health equity data through the different accountability agreements (e.g., HSAA, LSAA and MSAA).	Monitoring of health equity data included in the different accountability agreements	LHIN Office/Staff
Monitor the compliance of organizations regarding their health equity policies, work plans, client satisfaction, and data.	Monitoring of organizational compliance	Health Equity Office/Staff and LHIN Office
Allocate funding to organizations based on organizational health equity plans.	Funding of organizations linked to health equity plans	LHIN Office

Goals and Purpose

Goals

The implementation of recommendation #4 will:

- Ensure health equity leadership;
- Ensure the application of standards of health equity and performance measures;
- Enable intra-organization health equity monitoring through performance measures; and
- Ensure that funded organizations are in compliance with health equity standards.

[2] See recommendation by Bob Gardner and the Toronto Central LHIN

Purpose

To ensure high standards of health equity and compliance across all Central East LHIN organizations.

Rationale for Recommendation

Literature

The most critical method of ensuring accountability for and compliance with health equity policy and strategy is to:

- Embed and monitor health equity goals/outcomes in performance management systems;
- Ensure the availability of specialist staff dedicated to health equity issues; and
- Ensure that responsibility and accountability are established throughout the entire organization.

Among the major levers for managing performance currently available to the LHINs are their:

- Funding and allocation powers;
- Local health planning role; and
- The LHIN-provider service accountability agreements.

These levers can be used to:

- Effect compliance with health equity strategic priorities using funding criteria that are based on performance (e.g., demonstrated improvement of service delivery for marginalized communities, according to specific performance targets, standards, and/or benchmarks) (GTA Diversity and LHINs Working Group, 2008a); and
- Establish health equity plans that reflect analyses of relevant health equity issues in local catchment areas, and that embed accountability in contractual agreements and obligations (between the LHIN and health service providers) (GTA Diversity and LHINs Working Group, 2008a; Gardner, 2008a).

The LHIN can also play an important role in capacity building by providing funding and oversight, to:

- Develop data systems and performance/outcome measures;
- Research into partnership, collaboration and establishing health equity research units;
- Develop firm performance targets as well as process and outcome measures; and
- Provide ongoing monitoring and assessment.

Such approaches would advance the Central East LHINs' health equity strategic goals; for example, establishing a comprehensive equity plan for hospitals and Community Health Centres that clearly articulates alignment with the LHIN's overall equity vision.

Community Member Focus Groups

Community members stated that the important means of monitoring organizations' adherence to culture, diversity and equity policies include:

- Complaints monitoring and handling;
- Service delivery, observations, investigations (e.g., sensory and physical space);
- Monitoring accessibility plans; and
- The role of the community, i.e., its inclusion on diversity committees; the number of community consultations/focus groups; and the use of client feedback (e.g., online polling, surveys, evaluation forms, focus groups, suggestion boxes, and telephone surveys).

Health Service Provider Focus Groups

Participants agreed that, generally:

- There is a lack of monitoring of culture, diversity, and equity policies;
- Issues are often swept under the carpet;
- Clients do not know how to complain; and
- Commitment is often due to accreditation and politics, rather than from a social justice perspective.

From a monitoring perspective, front-line workers addressed issues related to internal monitoring, Ministry inspections, and accreditation. Participants observed that internal monitoring is not rigorous or consistent, and most diversity committees do not focus on action. In the long-term care system, for example, Ministry inspections do not address culture, diversity, and equity. In current accreditation systems such as Building Healthier Organizations (BHO), diversity is merely a token. It has never been raised as an issue, and is an add-on, not a focus. There is a general problem with accreditation, because many organizations hire accreditation services which, to many staff, are a conflict of interest.

Participants said to include all organizational levels in internal monitoring and work directed towards implementing organizational policies. Leadership suggested that clients be included in the process. Front-line workers suggested strong regularity, including monthly check-ups and yearly reports on activities.

Participants argued that the approach should:

- Address actual workplace issues;
- Be rigorous and consistent;
- Include community partners;
- Compare policies with practice; and
- Make use of a standardized system of statistics (e.g., diversity of staff, board, clients; language; referrals; family and client feedback; partnerships; translated materials).

Many participants suggested that monitoring reports should be sent to external bodies rather than internal ones. Some suggested an external system modeled on Workplace Hazardous Materials Information System (WHMIS) that includes an internal and external diversity complaints system (e.g., ombudsman) and responds in a timely manner, linking funding to Central East LHIN benchmarks. Leadership made the following suggestions:

- Use a transparent and systematic approach that includes the development of clear indicators and standards across the Central East LHIN;
- Involve both staff and communities in the monitoring process; and
- Use an internet-based complaint system.

Community Consultation

Among community members, **73% felt that recommendation #4 was essential to advancing health equity**. They ranked it **ninth (19% of participants) of the ten recommendations**, and they offered the following comments and concerns:

- Data must be consistently defined, measured and reported;
- There may be more diversity in some parts of the Central East LHIN, which will affect the amount of work and funding required;
- How will equity orientation will be measured differentially between mainstream organizations seeking to be more inclusive, and population/issue specific organizations (e.g. ethno-culture focused agencies); and
- Not all organizations have the technology skills needed.

Strategic Alignment

This recommendation aligns itself strategically with the Central East LHIN's commitment to accountability and the development of standards across the LHIN, and its requirement that funded organizations be accountable for delivery to standards (thereby facilitating the accountability of those organizations). The Integrated Health Service Plan includes accountability and system monitoring as core components.

The Ministry and all LHINs have a strong focus on accountability and monitoring of LHIN-funded organizations.

Recommendation #5: Organizational Education

Recommendation Statement

All Central East LHIN-funded agencies will educate their staff in health equity, diversity and anti-discrimination.

Recommendation Activities

Priority Actions	Deliverables	Lead
Assess current levels of health equity, diversity and anti-discrimination awareness, knowledge, and skills among staff, board and volunteers using a toolkit developed by the Health Equity Office.	Organizational assessments	Board, HEC, and Organization
Set educational health equity, diversity and anti-discrimination goals.	Organizational goals	Board, HEC, and Organization
Develop and implement an educational plan for the organization.	Organizational educational plans	Board, HEC, and Organization
Evaluate the outcomes against organizational goals.	Evaluation	Board, HEC, and Organization
Report results to the Central East LHIN.	Report to Central East LHIN	Board, HEC, and Organization
Develop plans for ongoing health equity, diversity and anti-discrimination education.	On-going health equity education plan	Board, HEC, and Organization

Goals and Purposes

Goals

The implementation of recommendation #5 will:

- Foster leadership in health equity;
- Increase knowledge and awareness of health equity;

- Result in well-informed, well trained board members, health service providers and volunteers in the Central East LHIN;
- Provide organizations with standards of health equity and performance measures;
- Set performance measures to monitor health equity within; and
- Ensure that funded organizations are in compliance with health equity standards.

Purpose

To ensure high standards of health equity throughout organizations as a result of well-trained individuals who work or volunteer at different levels of an organization.

Rationale for Recommendation

Literature

For health care professionals, cultural competence training outside of post-secondary educational contexts remains "haphazard and varying in quality." This in no small part due to the lack of agreed-upon standards and evaluative criteria by which to assess cultural competence training in such contexts (California Endowment, 2003).

Among the limitations identified in the literature are:

- A lack of evidence-based, quality evaluation (Curtis et al., 2007; Anderson et al., 2003);
- An over-emphasis in cultural competence training on awareness building/attitude changing over skill-focused training (Curtis et al., 2007; Engerbretso et al., 2008);
- The persistence of teaching strategies that depict groups in static, homogenous, stereotypical ways (Betancourt et al., 2005; Engerbretso et al., 2008); and
- The lack of standards and criteria for assessment (California Endowment, 2003).

Cultural competence training offered to individual staff is insufficient for improving the overall cultural/linguistic appropriateness and accessibility of programs and services, despite the existence of evaluative tools of cultural competence borrowed from post-secondary educational curricula (such as the Tool for Assessment of Cultural Competence Training or TACCT) (see http://www.aamc.org/meded/tacct/start.htm).

The literature offers a number of best practice recommendations in this regard:

- Evaluate and design properly (Gozu et al., 2007; Curtis et al., 2007);
- Evaluate training programs (Gozu et al., 2007; Curtis et al., 2007);
- Develop greater consensus on training standards and evaluative criteria (OMH, 2001; Betancourt, 2005);
- Focus on skills versus solely attitudes and knowledge training modules (Engerbretso et al., 2008);
- Take a systems approach to cultural competence training (Curtis et al., 2007);
- Train health care policy-makers and practitioners in conducting health equity impact assessments (WHO, 2008); and
- Provide ongoing education and training in culturally and linguistically appropriate service delivery (OMH, 2001).

Community Member Focus Groups

Community members indicated that cultural competence training should include initial training as well as several re-trainings. Other issues raised:

- Lack of competence related to culture, diversity and health equity in the areas of awareness, skill, knowledge and power;

- Lack of sensitivity in processes like intake and service delivery (awareness);
- Incorrect assessments;
- Lack of accommodations provided;
- Lack of awareness, skill and knowledge included pathologizing cultural differences (e.g., deafness), and denying different cultural explanatory models of illness;
- Disregard of different methods of communication (e.g., email, interpretation services, ASL interpreters);
- Not understanding or addressing broader determinants of health (e.g., immigration and poverty); and
- Experiences of stereotyping, heterosexism, racism, ableism, etc. due to a lack of understanding of the basic power distribution related to diversity and the health care system.

Health Service Provider Focus Groups

Health service providers identify a clear lack of training offered by organizations, leading to inconsistent levels of knowledge and skills among staff. Front-line workers state that there are few opportunities to share knowledge and expertise with staff or outside organizations (e.g., First Nations organizations). Participants offered the following concerns and suggestions:

- Inability to serve clients who do not speak English;
- A lack of clinical training and education in the areas of culture, diversity and equity;
- Lack of self-awareness around social location, power and privilege;
- Need for basic core knowledge and approaches to avoid clinical errors;
- During *intake*, poor knowledge of existing culturally appropriate services, which can lead to inappropriate service delivery;
- During *clinical assessments*, the need to understand culture and be informed by the clients (onus should be on the service providers to ask), to include family as a source of information (e.g., cultural and religious needs) and not simply consider medical history;
- During *planning and treatment*, the need for culture matching (e.g., physician from the same culture) to accept non-traditional and family-centred treatment approaches, and the need to reconsider treatment plans when cultural issues arise; and
- During *referrals*, the general lack of culturally competent services and the time it takes to find appropriate services; mostly social workers (e.g., in hospitals) refer clients, and therefore most of the knowledge of services remains within a small group of staff; and
- Cultural dimensions are often not shared during referrals.

Suggestions:

- Offer cultural competence training during staff orientations;
- Focus clinical training on how to ask questions rather than cultural profiling (suggested by front-line workers);
- Approach health more holistically;
- Overcome stigma by developing outreach strategies to communities; and
- Revise assessment tools.

Leadership participants suggested reaching and partnering with communities and organizations to increase cultural competence, the use of cultural brokers and community volunteers, and identifying cultural competence as a core competence.

Environmental Scan

Some participants replied that they ask organizations if they receive cultural competence training as a part of the decision-making they do before referring a client to a particular service.

Community Consultation

Among community members, **88% felt that recommendation #5 was essential to advancing health equity**. They ranked it second **(69% of participants) out of ten recommendations,** and offered the following comments:

- Training is central to moving health equity forward;
- Provision of training is relevant and correlated with good equity practice, but should not be the only predictor of equitable organizational practice;
- The trainings need to be customized for the organizations and delivered locally;
- Funding needs to be made available for training to occur; and
- Adequate staff time is needed for training.

Strategic Alignment

This recommendation aligns itself strategically with the following:

- The Central East Local Health Integration's 2006 Network Technical Report (2006) where it is stated that "Equity is a key component of an effective health care system, and without understanding how these factors influence health status in our society, the chances of improving the overall health of the population is near impossible";
- Knowledge and awareness are identified as a key factor in improving health equity, which includes provider training as being important. As well, cultural competency is a theme that was identified within each priority in this Plan; and
- The Toronto Central LHIN's document "Health Equity Discussion Paper", in which training and capacity building is identified as one of the key components of how system transformation and innovation can be equity-driven, by the Toronto Central LHIN and other LHINs.

Recommendation #6: Service Enhancement

Recommendation Statement

The Central East LHIN will invest in system and service enhancements to increase access to health care for marginalized populations.

Recommendation Activities

Priority Actions	Deliverables	Lead
Invest in developing a LHIN-wide diversity accommodation system encompassing language, visual impairment, physical mobility, etc.	Accommodation system	LHIN Office
Identify regional health equity priority populations and their respective health care gaps, using community consultation (community members and health service providers).	Identification of regional health equity priority populations and respective health care gaps	Health Equity Office/Staff, Planning Partners, Community members
Invest in a minimum of three regional pilot projects aimed at the selected priority populations (e.g., to enhance existing services/projects)	Three regional pilot projects	LHIN Office
Review regional health equity priority populations after a three-year period based on community demographics, and emerging research/data.	Review of regional health equity priority populations	Health Equity Office/Staff
Review the regional pilot projects through external evaluations.	External project evaluations	LHIN Office
Reserve the right, based on community consultation and evaluations, to discontinue pilot projects (if negative outcomes and/or community needs met) extend them (if unclear outcomes, and/or continued community needs), or transform any of them into a program (if positive outcomes and/or if there is a continued long-term community need).	Adjustments to projects, including transformation into programs	LHIN Office
Continue the expansion and improvement of primary health care.	Improved Primary Health Care	LHIN Office

Goals and Purpose

Goals

The implementation of recommendation #6 will:

- Increase access to health services, especially for communities that experience greater health inequities;
- Address specific health inequities;
- Increase diversity accommodation; and
- Evaluate the effectiveness of projects that focus on specific populations.

Purpose

The main purposes of recommendation #6 are to:

- Identify population groups who experience health inequities within the Central East LHIN
- Ensure that those inequities are adequately addressed
- Address other issues of health inequity based on what is learned from Central East LHIN pilot projects; and
- Ensure that a diversity accommodation system increases health equity, and removes barriers for marginalized communities.

Rationale for Recommendation

Literature

Canada has hardly any policies that require systematic cultural sensitivity in health care services among provinces. It is mostly hospitals that have started this, but in isolation. Despite this limitation, current best patient care and services practices in hospitals could have broader application in the Central East LHIN, that is, to (Wilson-Stronks et al., 2008):

- Build a foundation of policies and procedures to systematically support cultural competence, including integration of cultural and language considerations;
- Collect and use data to improve services for a diverse population with practices that facilitate the monitoring, measurement, and evaluation of cultural and language services; and
- Apply practices to the needs of specific populations to ensure safe, quality care, and decreasing health disparities including the targeting of accommodations to the evolving needs of those populations.

Further, to ensure that organizations meet changing staff and patient needs, the development of services and activities tailored for specific populations should be a continuous process. While the practices show progress toward delivery of culturally appropriate care, they also indicate the complicated reality of a long road ahead. Although knowledge, field experience, and technology have improved the delivery of culture and language services, hospitals need to consider the balance between convenience, cost, patient safety, and quality.

Finally, establishing collaborative practices brings together multiple departments, organizations, providers, and individuals to achieve objectives related to culturally and linguistically appropriate care. Collaboration, whether internal or external, may provide new avenues for cultural competence initiatives.

Community Member Focus Groups

The need for better accommodations came up repeatedly in the community members focus groups. This need was often compounded by marginalization (e.g., finding a family physician as a culturally deaf person, a person with mental health or addictions issues, or as a newcomer).

Participants identified three negative experiences with the health care system, each one closely linked with the other: 1) discrimination, stereotyping, and stigma; 2) lack of accommodation; and 3) negative treatment experiences.

Negative experiences of accommodation include:

- Lack and denial of interpretation (including ASL);
- Inappropriate use of family members for interpretation;
- Lack of transportation (particularly for the visually impaired and seniors);
- Inaccessible facilities (lack of signage and audible elevators); and
- A lack of diverse ways of communication (e.g., culturally deaf re hearing when name called).

Participants identified four areas for possible enhancements: 1) staff; 2) services; 3) information/communication; and 4) systemic.

In all of these areas, better accommodations were suggested, or more specifically, a systemic change which would allow accommodations within the system such as:

- Mandatory accommodation provisions;
- Greater gender-balance of interpreters; and
- Interpretation available on evenings and weekends.

Health Service Provider Focus Groups

All front-line worker participants agreed that marginalized communities suffer a disproportionate burden of illness, and that this needs to be addressed (e.g., immigrants with TB). Leadership participants went further, calling health equity a civic duty and social justice issue that is about providing the best possible client-centred care, better and more effective services and, therefore, better clinical outcomes.

At the organizational level, participants identified the following systemic challenges:

- Lack of commitment to reach out to diverse populations;
- Lack of inter-organizational information flow regarding diversity;
- Lack of staff speaking different languages; and
- Lack of culture matching.

Participants also stated that the failure of organizations to ensure culture, diversity, and equity is due to a lack of resources.

Limited interpretation services within the Central East LHIN force family members to take on the role of interpreters; this can compromise the level of care (e.g., crucial information may be censored or inaccurate).

On the other hand, hospitals and other large organizations can offer translation and interpretation between many languages by pooling staff. Front line workers pointed out that the Central East LHIN needs something similar to Access Alliance's interpretation services.

Environmental Scan

Some participants linked the lack of appropriate clients health care services to the unavailability of access and accommodation. Many services are not available locally and/or do not have the necessary accommodations (for example, ASL services or linguistic interpretation).

Community Consultation

Among community members, **75% of felt that recommendation #6 was essential to advancing health equity**. They ranked it **first (71% of participants) out of the ten recommendations**, and offered the following considerations and suggestions:

- A significant resource commitment will be required: where will the resources come from;
- A transparent process is needed for choosing the three regional priority populations and three respective health care gaps;
- Three priority populations is not enough;
- Some highly populated areas may have multiple priority populations;
- Funding should potentially be expanded to existing projects that are addressing the three priority populations;
- Need to involve multiple stakeholders such as community members, politicians, public health and other allied sectors; and
- Evaluation of these projects is very important; therefore, there needs to be a well-planned process for it.

Strategic Alignment

The Ministry of Health and Long-Term Care approach involves identifying priority health issues and directing funds towards those programs and services.

The Central East LHIN 2010-2013 Integrated Health Service Plan recognizes client groups as "Priority Populations" for whom they plan to tailor activities and investments in achieving common outcomes for their population. The Central East LHIN has also been identifying priority health issues within the LHIN and directing funds towards various initiatives. Often these initiatives are disease and/or issue specific. This approach is identified as a best practice.

The Toronto Central LHIN has recommended strategically targeting investments and service interventions for the greatest health equity impact.

Recommendation #7: Social Determinants of Health

Recommendation Statement

The Central East LHIN senior management will commit to a vision of health that includes the broader determinants of health.

Recommendation Activities

Priority Actions	Deliverable	Lead
Promote and ensure the inclusion of the broader determinants of health in Central East LHIN planning partnerships.	Broader determinants of health included in planning partnerships	LHIN Office and Health Equity Office/Staff
Develop and participate in cross-sectoral partnerships and coalitions (e.g., housing, food security).	Cross-sectoral partnerships and coalitions	LHIN Office
Require organizations to develop cross-sectoral partnerships and coalitions.	Broad participation in cross-sectoral partnerships	LHIN Office, Organizations
Advocate at different levels of government to address the link between policies and social and economic inequities.	Advocacy on social determinants of health	LHIN Office

Goals and Purpose

Goals

The implementation of recommendation #7 will:

- Bring awareness of the importance of the broader determinants of health;
- Address the broader determinants of health in a more coordinated and inclusive way; and
- Implement multiple strategies that address the broader determinants of health.

Purpose

Many of the issues of health equity are related and rooted in the broader determinants of health which have been demonstrated to affect individuals' physical health. Therefore, the level of access to the broader determinants of health (and their quality) must be addressed to achieve health equity.

Rationale for Recommendation

Literature

Literature indicates that the health care sector can and should play a lead role in advancing a broad inter-sectoral health equity policy agenda, one that addresses social determinants of health. For example, the United Kingdom has rapidly become a leader in government health equity policy and action aimed at both the health care system and the wider determinants of health and health equity.

In the 1980s, the *Black Report* described how "lowest employment-level groups showed a greater likelihood of suffering from a wide range of diseases and dying prematurely from illnesses or injury at every stage of the life cycle" and concluded "the material conditions under which people life their lives: availability of income, working conditions, and quality of available food and housing etc. were the primary determinants of these findings" (Raphael & Bryant, 2006; see Black & Smith, 1992).

This seminal research played a significant role in shaping UK research and policy developments, central to which is a focus on the social determinants of health. These include a national health strategy, having as one of its two aims "to improve the health of the worst-off in society and to narrow the health gap" addressing not only the social causes of ill-health and inequities but health inequities in particular. The National Health Service Plan listed amongst its goals "to narrow the health gap in childhood and throughout life between social economic groups and between the most deprived areas and the rest of the country" (UK Department of Health, 2000).

Among the major policy initiatives in response to the evidence on UK health determinants was the Department of Health's 1999 *Reducing Health Inequalities: An Action Report* which sets out an action plan for the UK government to officially acknowledge the wide range of social policies influencing health inequalities. For example, the report emphasized the need to tackle "the causes of poverty, social exclusion, not just the symptoms." Corresponding policy initiatives include the following themes: raising living standards and tackling low income; education and early years; employment; transport and mobility; building healthy communities; housing; reducing crime; and public health issues.

Community Member Focus Groups

Community members felt that health service providers lack awareness, skill and knowledge in the broader determinants of health (e.g., immigration and poverty), and that they are neither understood nor addressed.

Community members suggested that in order to encompass the idea of social justice, policies should:

- Advocate equal access and treatment;
- Recognize health as a human right;
- Acknowledge the broader determinants of health through a client bill of rights; and
- Protect individuals suffering from mental health issues.

Health Service Provider Focus Groups

Participants identified the different broader determinants of health as negatively impacting the health of clients.

From the perspective of individual clients, poverty is perceived as the principal systemic barrier to health care services. In HKPR, for example, clients ignore health issues because they cannot pay for transportation to health services, or purchase additional necessary health services.

A systemic challenge for individuals is a mistrust of mainstream service providers, particularly in Scarborough and Durham where diverse clients feel their cultural needs are not respected. Even though some regions have clusters of diverse communities, many clients prefer to travel to Toronto to receive services.

Racism and discrimination is an issue in health care delivery. This impacts treatment outcomes. Health service providers need to develop a more holistic approach to health care.

Community Consultation

Among community members, **78% felt that recommendation #7 was essential to advancing health equity**. They ranked it fifth **(43% of participants) out of the ten recommendations**, and offered the following comments and concerns:

- The broader determinants of health need to be clearly identified;
- The Ministry of Health and Long-Term Care needs to support working with the broader determinants of health;
- Cross-sectoral work with other LHINs and provincial ministries will be required; and
- There needs to be long-term commitment to addressing the broader determinants of health.

Strategic Alignment

The Central East LHIN 2010-2013 Integrated Health Service Plan (IHSP), identifies the need for "*Supportive and sustainable environments that address the social determinants of health and cultural competency"* as a component of the Central East LHIN's vision of achieving healthy communities. Although not a part of the Central East LHIN mandate, its vision speaks to health promotion as well as disease prevention and management. The Central East LHIN also recognizes that in order to achieve the vision, it is important to form active partnerships with other health care and non-health care sectors

The Central East LHIN Integrated Health Service Plan (IHSP) Technical Report (2006) outlines opportunities for the LHIN to focus on the continuum of care for the "whole person." The report also notes that success goes beyond accountability relationships between the Central East LHIN and health service providers. The Plan details upstream strategies and partnerships to be developed that would address the determinants of health and health promotion and self-management to prevent unnecessary use of limited health care services downstream.

The Toronto Central LHIN's 2008 Health Equity Discussion Paper also recommends that the broader determinants of health must be addressed through cross-sectoral collaborations in order to build equity into system transformation. It cites the large body of research that suggests that the roots of health disparities stem from social and economic inequality and exclusion.

Finally, Health Canada lists as one of its objectives: "*Integrate renewal of the health care system with longer term plans in the areas of prevention, health promotion and protection.*"

Recommendation #8: Client Navigation System

Recommendation Statement

The Central East LHIN will create a navigation system for clients.

Recommendation Activities

Priority Actions	Deliverable	Lead
Develop components for creating a navigation system in partnership with the HEHIN.	Components of a navigation system	LHIN Office and HEHIN
Fund the development of a navigation system for clients (including a web site)	Development funding for navigation system	LHIN Office
Assess the applicability of providing a multilingual (including French) navigation system.	Access options re languages	LHIN Office and HEHIN
Develop a communication plan for the navigation system.	Communication plan	LHIN Office and HEHIN
Provide navigation system training to community members and health service providers.	User training	LHIN Office and HEHIN

Goals and Purpose

Goals

The implementation of recommendation #8 will:

- Provide awareness of and access to available services to community members;
- Make important health information available in different languages; and
- Provide health information access to marginalized community members.

Purpose

Community members in the Central East LHIN often have difficulty finding out about and accessing services, as well as understanding how the health system works. This creates barriers to achieving good health. This recommendation will work towards removing those barriers while increasing access.

Rationale for Recommendation

Literature

The complexity of the health system makes navigation difficult for people from every sector of the population. The system is a patchwork of doctors' offices, hospitals, community health centres, and long-term care facilities.

The difficulties of navigating are most acutely felt by marginalized groups (e.g., newcomers, and ethno-racial and ethno-cultural minorities). Among the reasons cited within the literature for why such groups do not seek health services are:

- Barriers to access and services' use;
- Lack of information about availability of certain health services;
- The use of alternative health providers; and
- A general lack of culturally sensitive or acceptable health services (Zanchetta and Poureslami, 2006).

Researchers advise that addressing the unique and joint impacts of these factors will enable both policy makers and health care providers to develop a culturally appropriate health care system that meets the needs of these populations (Zanchetta and Poureslami, 2006).

Cultural Competence: One of the most widely cited cultural competence intervention frameworks is contained in a report for the Commonwealth fund: *Cultural Competence in Health Care: Emerging Frameworks and Practical Approaches* (Betancourt, Green & Carrillo, 2002). Various models of cultural competent care are identified and ultimately aimed at improving the quality of health care for all.

According to the framework, empowering patients to be more active partners in the medical encounter is the key aspect of developing clinical cultural competence. Organizations can do this through programs that educate patients on health care system navigation and how to become an active participant in their own care (Betancourt et al., 2002).

Community Member Focus Groups

Participants made the following suggestions related to service enhancements:

- Assist clients in finding specific services (e.g., gender transitioning);
- Increase the availability of translators and interpreters; and
- Use various ways of gathering client information (e.g., sending out forms prior to appointment).

In order to improve information sharing and communication, participants suggested the:

- Use of web sites, information booklets, service directories, local hotlines, local hubs of information, and email;
- Use of videos, flyers, pamphlets, and community workshops that also address stigma; and
- Education of newcomers on the health system and its services.

Health Service Provider Focus Groups

Participants offered the following general suggestions:

- Develop brochures in different languages; and
- Offer orientation to refugees at their time of immigration.

In order to deal with systemic issues, they also suggested that service users should be educated in the long-term care system to avoid client-to-client and client-to-staff discrimination, and to help clients to better understand the health care system.

Environmental Scan

Health service providers identified interpreter system navigation as an issue for clients. Many clients do not connect to services because they do not know how to and because they lack information about existing services.

Community Consultation

Among community members, **64% of felt that recommendation #8 was essential to advancing health equity**. They ranked it **sixth (34% of participants) out of the ten recommendations,** and offered the following comments and concerns:

- How to enable web site access for non-computer literate people, those living in rural areas, the disabled, and people who do not speak English;
- Community members need web site training;
- There need to be non-technological methods of disseminating the information that is on the web site;
- Flyers will have be translated into more than five languages;
- The web site should be linked to other web sites;
- A community consultation in the web site process is needed; and
- Web sites require a long-term commitment to resources that keep web sites maintained and relevant.

Strategic Alignment

The Central East LHIN 2010-2013 Integrated Health Service Plan highlights many different projects and initiatives that aim to increase client access to health and service information.

One of the key objectives of the Central East LHIN's 2006 Framework for Community Engagement is "To provide the community with balanced and objective information to assist them in understanding the role and mandate of Central East LHIN and the responsibilities and expectations of all stakeholders." Suggested methods to achieve this include fact/information sheets, newsletters/brochures, web sites, open forums and meetings, public service announcements, paid advertising and media publicity.

The Toronto Central LHIN Health 2008 Equity Discussion Paper states that one way to achieve the greatest equity impact is to reduce linguistic, navigation and additional barriers.

One of Health Canada objectives is relevant: "*Provide health information to help Canadians make informed choices.*"

Recommendation #9: Information and Knowledge Transfer

Recommendation Statement

The Central East LHIN will develop an online health equity information and knowledge transfer[3] system for service providers.

Recommendation Activities

Priority Actions	Deliverable	Lead
Promote health equity knowledge transfer in the planning partnerships.	Promotion of health equity knowledge transfer	LHIN office
Organize, coordinate, and promote events that facilitate knowledge transfer among health service providers.	Knowledge transfer events	LHIN office
Fund the development and maintenance of a web site for health service providers to share information (e.g., resources, definitions, best practices, literature, links, tools) and to facilitate interactive dialogue (e.g., chat room, opportunities to ask questions).	Web site	LHIN office
Offer training in using the knowledge transfer system.	Web site training	LHIN office
Develop a communication plan to promote the knowledge transfer system.	Communication plan	LHIN Office & Health Equity Office/Staff

Goals and Purpose

Goals

The implementation of recommendation #9 will:

- Increase knowledge transfer in the Central East LHIN;
- Effect sharing of information using virtual technology;
- Increase the health equity knowledge of health and other service providers in the Central East LHIN; and
- Increase awareness of health equity issues, services and events.

[3] Not linked to client health records

Purpose

Health and other service providers of the Central East LHIN require a health equity and knowledge system to assist them in the planning, implementation, delivery and evaluation of service to community members. The resulting virtual central hub of information will allow for better and more effective flow of information and increased shared learning.

Rationale for Recommendation

Literature

Knowledge development and exchange regarding health in/equity and its indicators, through partnerships and (community-government-academic) collaboration, is critical to putting health equity on the policy agenda and to advancing health equity policy.

According to the Health Disparities Task Group (HDTG) of the Federal/Provincial/Territorial Advisory Committee on Population Health and Health Security for the Public Health Agency, Canada has "few comprehensive, integrated efforts to address known health disparities and the factors and conditions that lead to them" (2004). The HDTG document divides Canadian interventions around health equity into four main categories (HDTG 2004:16):

1. **Leadership and policy development:** Development of the Healthy Living Initiative, establishing population health units in Health Ministries, wellness and health promotion programs, strategic plans that include disparity reduction priorities, primary health care innovations, etc. In Quebec, the Health Ministry is required by law to examine the health impact of policies across the government.

2. **Inter-sectoral collaboration and partnerships**: Child health initiatives, nutrition programs, prevention and harm reduction strategies, intra-governmental awareness-raising task groups, targeted programs for high-risk groups, etc.

3. **Building community capacity**: Community development activities at the regional health authority level, primary health care outreach, staff training within a population, core area rehabilitation initiatives in cities, comprehensive school health programs, etc.

4. **Knowledge development and exchange**: Widely publicized health status reports, detailed community profiles, health atlases, workshops for staff, health status indicators, specific research support programs, etc. (HDTG 2004:16)

Increasing public awareness of health equity issues through public involvement, consultation, advocacy and knowledge exchange also helps to ensure that health equity remains on governmental policy agendas, by helping to cultivate sufficient "push from below" around health equity issues, also essential to sustaining such policies (Rachlis 2007; Gardner, 2008a; WHO, 2008).

Knowledge exchange is also an area of focus to ensure organizational cultural competence, specifically through the exchange of information between organization/providers and the client/population, and internally among staff (HRSA, 2002).

Community Member Focus Groups

Community members identified an overall lack of awareness and knowledge amongst health service providers when dealing with marginalized community members.

Participants also noted a lack of sensitivity in various processes, such as intake and service delivery (awareness). Improper assessments and poor accommodation (awareness, skills, and knowledge) are also problems.

In order to improve information sharing and communication, participants suggested the use of web sites, information booklets, service directories, local hotlines, local hubs of information, and email.

Health Service Provider Focus Groups

Health Service Providers identified a variety of knowledge transfer challenges and needs. At the *organizational level*, there is a lack of inter-organizational information flow regarding diversity. Front-line workers (several members from Durham and HKPR) suggested that the Central East LHIN should avoid reinventing the wheel, i.e., that it should learn from the experiences of other areas like Toronto.

Leadership participants made the following suggestions:

- Create partnerships to break up current silos;
- Change initial education for services providers; and
- Acknowledge the existence of racism and discrimination.

Several issues related to the continuum of care were identified:

- During *intake*, a lack of knowledge of existing culturally appropriate practices can lead to inappropriate service delivery (e.g., in the case of drop-ins);
- During *clinical assessments*, cultural and religious needs are not met even if medical history is taken into account. This is due to a combination of poor cultural understanding and inadequate information obtained from clients and their families. Related factors include: limited information flow from assessments to clinical staff, questions not asked by the service providers, sometimes purposefully, and a lack of time and resources to do comprehensive cultural assessments.

In terms of structural suggestions, participants identified a need for a system like the Workplace Hazardous Materials Information System (WHMIS).

HKPR raised the added challenge of how technology, when tied to service delivery creates barriers for seniors and other individuals (e.g., use of web sites for information) and for service delivery (e.g., email systems for volunteers).

Environmental Scan

In finding appropriate services, some service providers do not use any web site, directory or database and often information they rely on comes from each other. Other service providers use a variety of web sites, directories and databases; however, there is no one major web site, directory or database.

Participants also noted that there is/are:

- Limited resources for identifying clinical services within the community, e.g., finding service for the homeless or uninsured;
- No system such as 211Toronto in the Central East LHIN;
- No clear path for newcomers to follow when accessing health services;
- Insufficient awareness, by service providers and clients, of what services are available and that many things are unclear regarding service provision in hospital/health settings and in the community.

Community Consultation

Among community members**, 67% felt that recommendation #9 was essential to advancing health equity**. They ranked it **eighth (21% of participants) out of the ten recommendations**, and offered the following comments and concerns:

- Resources would be required to keep the web site relevant;
- Health service providers would need web site training;
- The amount of time that use of the web site will demand of health service providers and their ability to find that time;
- The web site could be used to reveal client information (i.e., like E-health); and
- The inclusion of educational institutes and other professional associations.

Strategic Alignment

The Central East LHIN 2010-2013 Integrated Health Service Plan, states that part of the Central East LHIN's role is to be an integrator of the health care system, i.e., to:

- Create learning opportunities;
- Facilitate knowledge transfer across sectors and regions through community engagement, planning partners, working groups and project teams;
- Support initiatives with evidence-based data and information;
- Build coalitions among organizations on different levels (governance, management and front-line care);
- Support the uptake of project management skills by health service providers by training and distributing tools (distributed through the Central East LHIN Project Management Office); and
- Support activities that encourage integration through service and financial planning, integration toolkits and expertise.

The Toronto Central LHIN's 2008 Health Equity Discussion Paper discusses the importance of building equity into system transformation. One of the proposed methods of doing this is by "driving continuous service and system-level innovation through an equity lens – developing better sources of equity data, relying on solid local research, enabling front-line innovation, and creating forums to share lessons learned."

Recommendation #10: Health Equity Research / Evaluation

Recommendation Statement

The Central East LHIN will coordinate systematic research on health inequities throughout the Central East LHIN and evaluate pilot projects.

Recommendation Activities

Priority Actions	Deliverable	Lead
Guide a process with stakeholders, including an epidemiologist and information technology experts, to identify relevant health equity data and methods for collection (coordination with other LHINs).	Health equity data (existing and missing) and collection methods	LHIN Office
Develop an ongoing and systematic method and action plan for the evaluation of health equity within the Central East LHIN (e.g., access, treatment, health outcomes).	Systematic evaluation method and action plan	LHIN Office
Central East LHIN-funded organizations collect the data needed to measure health equity.	Data collection	Organizations
Provide funding to external organizations to evaluate the projects (e.g., universities).	Project outcomes evaluation	LHIN Office
Share all findings with relevant stakeholders.	Dissemination of findings	Health Equity Office

Goals and Purpose

Goals

The implementation of recommendation #10 will:

- Identify and collect relevant health equity data;
- Evaluate funded projects; and
- Ensure future health equity planning.

Purpose

The recommendation helps to further understanding of health equity in the Central East LHIN. By bridging the current information gap, planning for programs and services and planning and funding allocation can be improved.

Rationale for Recommendation

Literature

In laying down foundations for longer term change within the Ontario health care system, a first priority is for the LHINs and their funded service providers to begin to integrate disaggregated measures of disadvantage (race, ethnicity, language, gender, sexual orientation, socio-economic status, Aboriginal status, etc.) into existing data collection systems within the health care system.

This will enable better accounting for potential differences in health status and health care treatment/outcome among different population groupings (WHO, 2008; Gardner, 2008; GTA Diversity and LHINs Working Group, 2008a; Lettner, 2008c). New data collection systems will be needed where existing information systems fail to capture potential differential service needs and inequities.

Developing performance indicators and outcome measures in relation to health equity strategic goals and objectives is particularly important in establishing accountability for the reduction of health inequity by stakeholders in the LHIN health care system (see Betancourt et al., 2005). Such performance measurements are essential because they "provide the data by which incentives (to reward progress or penalize the lack of it) are implemented" (Exworthy et al., 2006).

Health equity and diversity-related measures should not only be incorporated into the performance evaluation systems set up for policies, programs and services – through such means as internal audits, client satisfaction assessments, quality assurance data, and outcomes-based evaluations – but they should also inform the professional performance evaluations of individual staff members (e.g., through staff performance development plans and evaluations) (GTA Diversity and LHINs Working Group, 2008a). It is particularly important that senior managers and board directors overseeing the development and implementation of strategic priorities around health equity are rendered individually and professionally accountable for the success of such policies, in their individual performance contracts and evaluations (ibid.).

Furthermore, ongoing evaluation and assessment of policy initiatives, programs and services, for their health equity impact, are particularly critical to ensuring effective, efficient and equitable programs and services, and accountability.

Finally, the collection and use of community- and patient-level data is essential to developing and improving services in health care. These include services to meet the needs of diverse patient populations. Instituting practices to systematically collect data makes it possible to monitor, measure, and evaluate the effectiveness of culture and language services. Services can then be designed to meet the specific needs of the organization.

Community Member Focus Groups

Community members identified a lack of planning. One of their recommended changes in the system involves performing an analysis of existing services and usage patterns.

Health Service Provider Focus Groups

Leadership noted the importance of measuring quality of care, analyzing trends, and conducting internal performance reviews (including competence).

Health service providers felt that limited resources lead to a deficiency in local research studies that would otherwise address these challenges.

Community Consultation

Among community members, **63% felt that recommendation #10 was essential to advancing health equity**. They ranked it as the **least important of the ten recommendations**. They stated that evaluations should lead to valid processes that provide health care, and that this would require strong leadership and commitment.

Strategic Alignment

The Central East LHIN has four strategic directions, one of which is Health Service and System Integration: "Create an integrated system of care that is easily accessed, sustainable and achieves good outcomes."

The Central East LHIN 2010-2013 Integrated Health Service Plan details the attributes of a High Performing Health System. Such attributes include, for example:

- An e*ffective* health system where people receive care that works and is based on the best available scientific information;
- A commitment is made, by the integrator of the health care system, to support health service providers and other organizations' initiatives with evidence-based data and information.

The Toronto Central LHIN 2008 Health Equity Discussion Paper states that:

- The Toronto Central LHIN, and all the other components of the health care system, should be focusing their planning and delivery on the best available evidence;
- Currently there are significant gaps in the data that is available;
- There is insufficient data to enable disaggregation to the local level; and
- These gaps should be a continuous priority not only for the Toronto Central LHIN but for other LHINs as well.

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