Sinai Health System

Ontario
Toronto Central Local Health Integration Network

Measuring Health Equity in the Toronto Central LHIN

2019 Environmental Scan Report

Sinai Health System
Health Equity Office

March 5, 2019
(Final Toronto Central LHIN approval: March 25, 2019)

Purpose

The Toronto Central Local Health Integration Network (LHIN) mandated demographic data collection initiative is now on its sixth year. Given this, Sinai Health System's Health Equity team conducted environmental scan calls with health equity leads at hospitals and community health centres (CHC) across the Toronto Central LHIN. The purpose of these calls were to:

a. document CHCs and hospitals' experiences with collecting, using, and promoting patient/client demographic data collection;
b. highlight innovative and best practices around data collection and use;
c. share knowledge between hospitals and CHCs ; and
d. inform the Learning Exchange Event to be held on March 28th, 2019.

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Methodology

Currently, 16 hospitals and 16 CHCs are collecting demographic data. Of these 32 organizations, 19 accepted to participate in Sinai Health's environmental scan. 9 of these were hospitals and the remaining 10 were CHCs.

The environmental scans were conducted through phone interviews which lasted between 20 and 45 minutes. All calls were conducted between January 15th and February 21st, 2019. All organizations were provided with the interview questions beforehand. The questions were separated in 2 main sections concerning demographic data collection and data use.

Data Collection: Hospitals

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Data Collection Areas

Admitting	Surgery (Day, Inpatient)	Imaging	Emergency Department
ECG/ECHO	Primary Care	Women and Infants	Gynecology
Diabetes Clinic	Cancer Centre	Chiropody Clinic	Outpatient Clinics
	Transplant Clinic		

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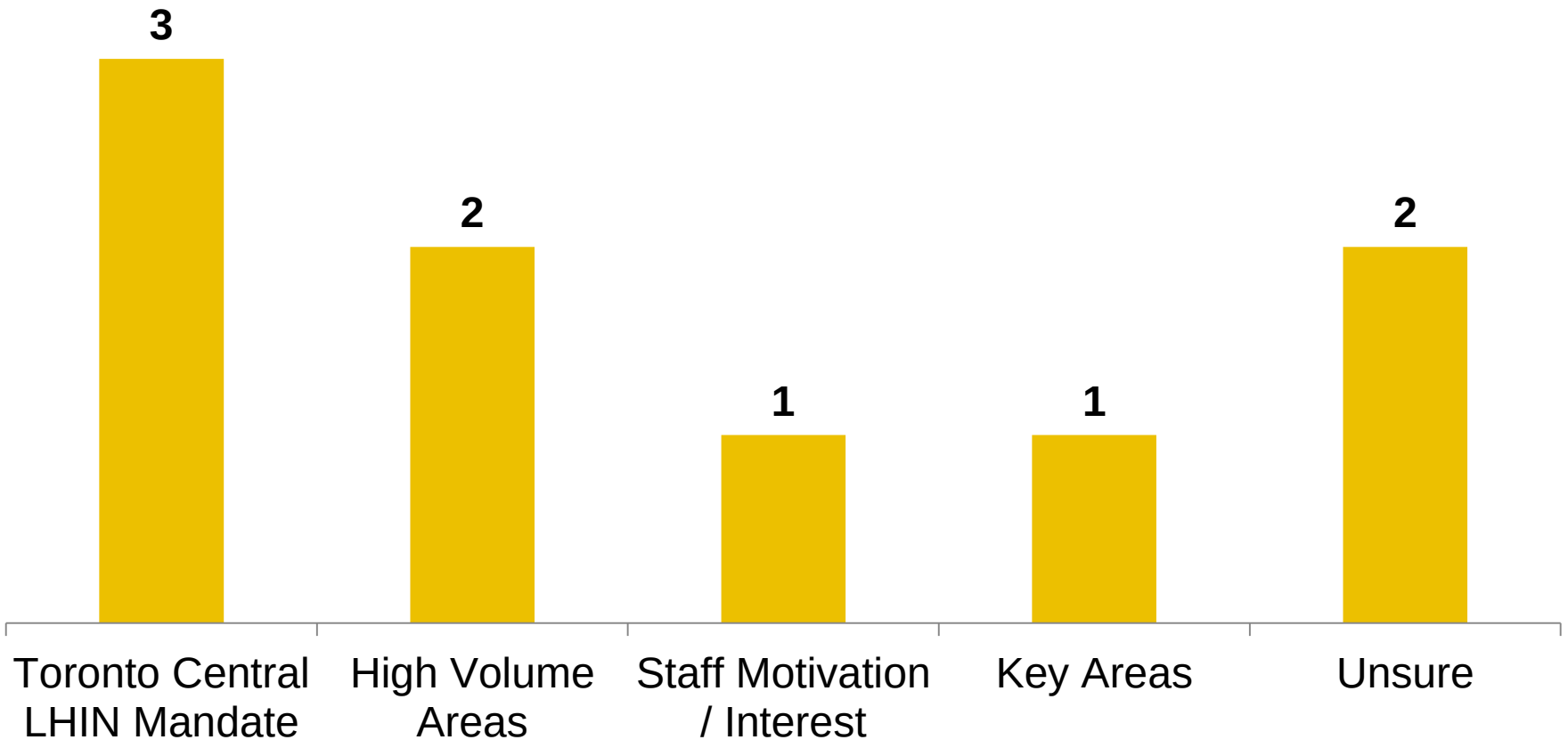
Data Collection Areas
Why were these areas chosen?



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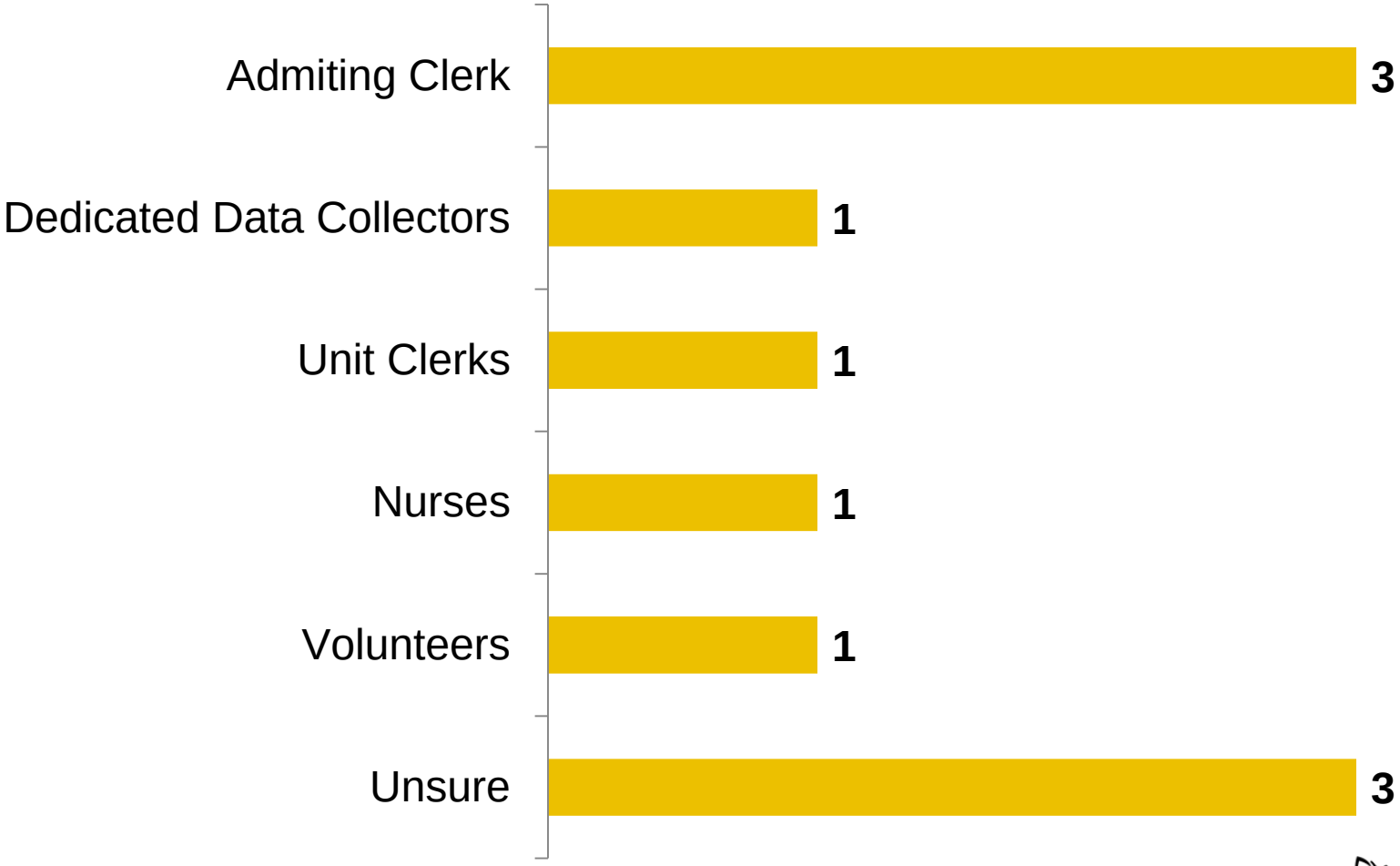
Who is collecting data?

(reflects multiple responses per hospital)



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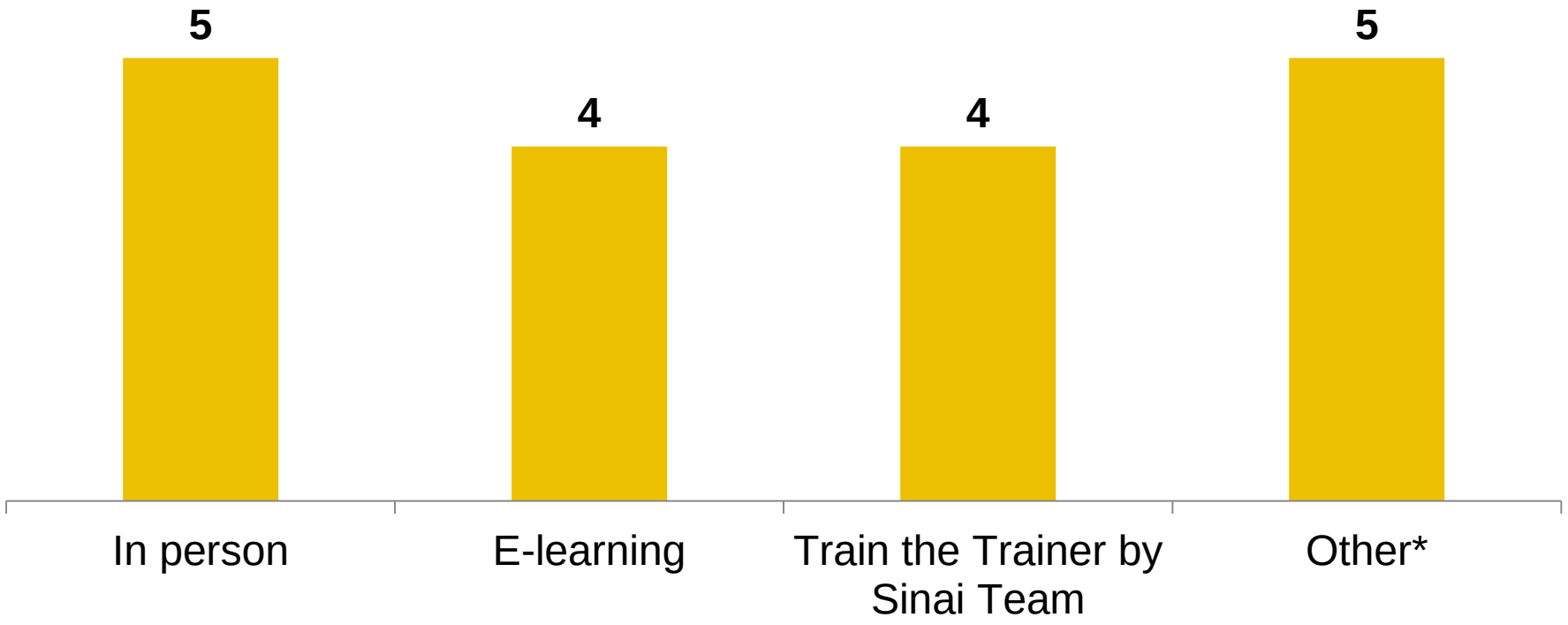
Staff training

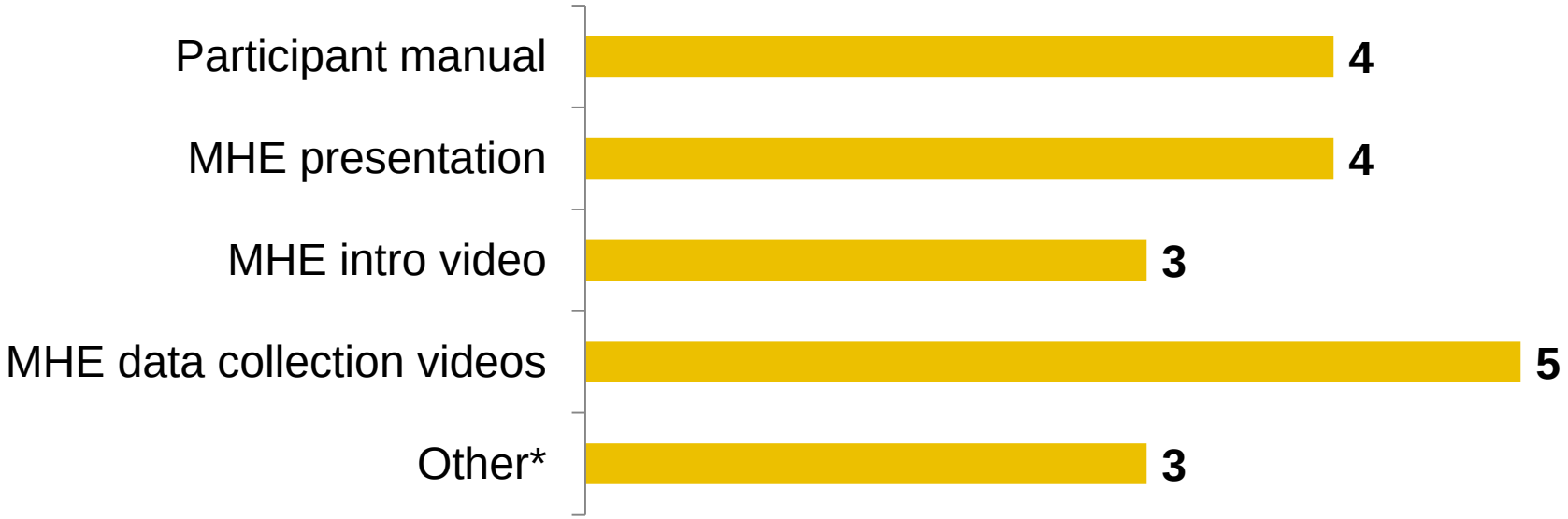
All 9 hospitals interviewed provided staff training. Five organizations used more than one training method which is reflected in the graph below:



*Other: included creating own training materials including scripts and training binder and using a train the trainer model by internal staff.

Staff training

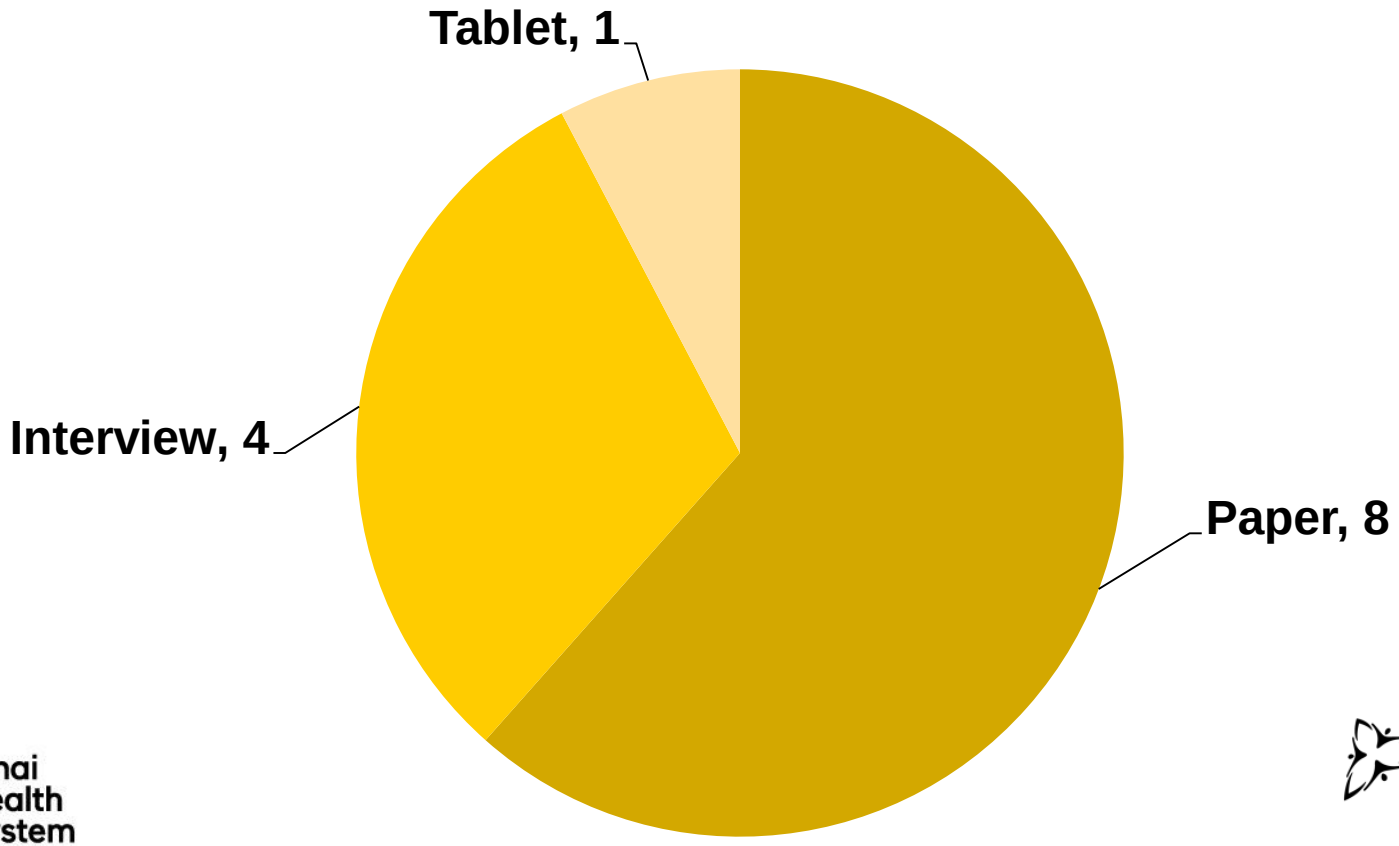
Of the 9 hospitals interviewed, 7 use at least one of the available Measuring Health Equity (MHE) training materials with 4 of these using more than one. The most used material is the MHE data collection videos.



*Other: included modified staff scripts, adapted participants manuals, and data entering guidelines.

Data Collection Method

Of the 9 hospitals interviewed, 4 hospitals use more than one collection method and 6 only use one. The most used collection method is paper form collection.



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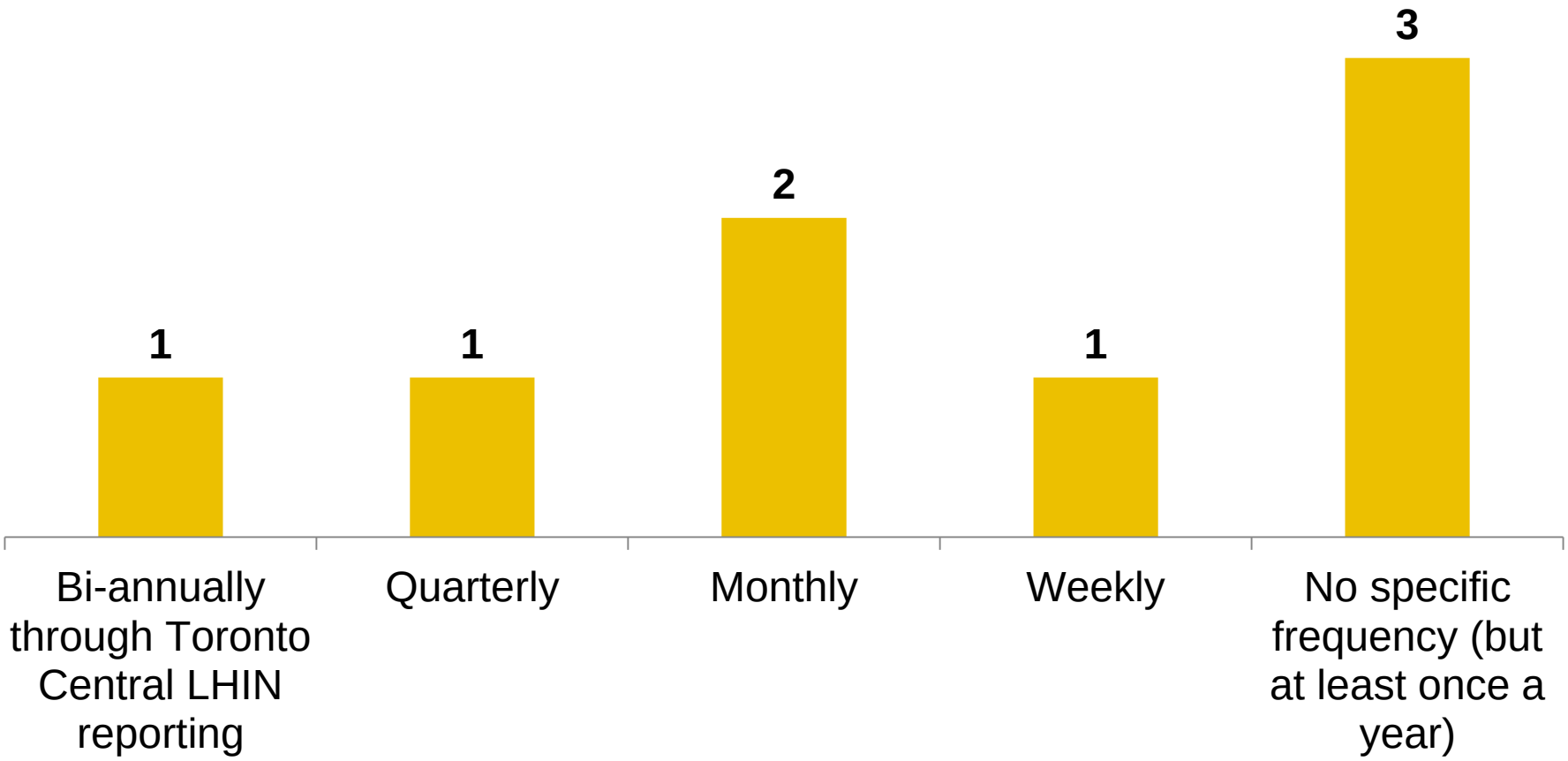
Data Collection Tools

Of the 9 hospitals interviewed, 8 use at least 1 of the 11 data collection tools available. Six hospitals use more than 1 available data collection tool. The most used tools are the MHE brochures and poster.

Data Collection Tools	# of Hospitals using tool
Translated demographic questions	3
Cheat Sheet	2
Cue Cards	0
Guidelines for Collecting from children & youth	0
Scripts	2
Glossary in English	1
Glossary in French	0
Patient Brochure	4
Translated Patient Brochures	2
Poster	4
French Poster	0

Data Audit

Of the 9 hospitals interviewed, all but one audit their data quality. The frequency of these audits vary as seen below:



Data Collection: CHCs

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Data Collection Areas

Of the 10 CHCs interviewed, 4 collect data from only new clients and 6 collect from all clients. All interviewed CHCs' data was collected by registration clerks in various areas:

- **Intake Appointments**
- **At Point of Registration**
- **Primary Health**
- **Settlement Program**
- **Crisis Intervention**
- **Diabetes Education Program**
- **Group Sessions**

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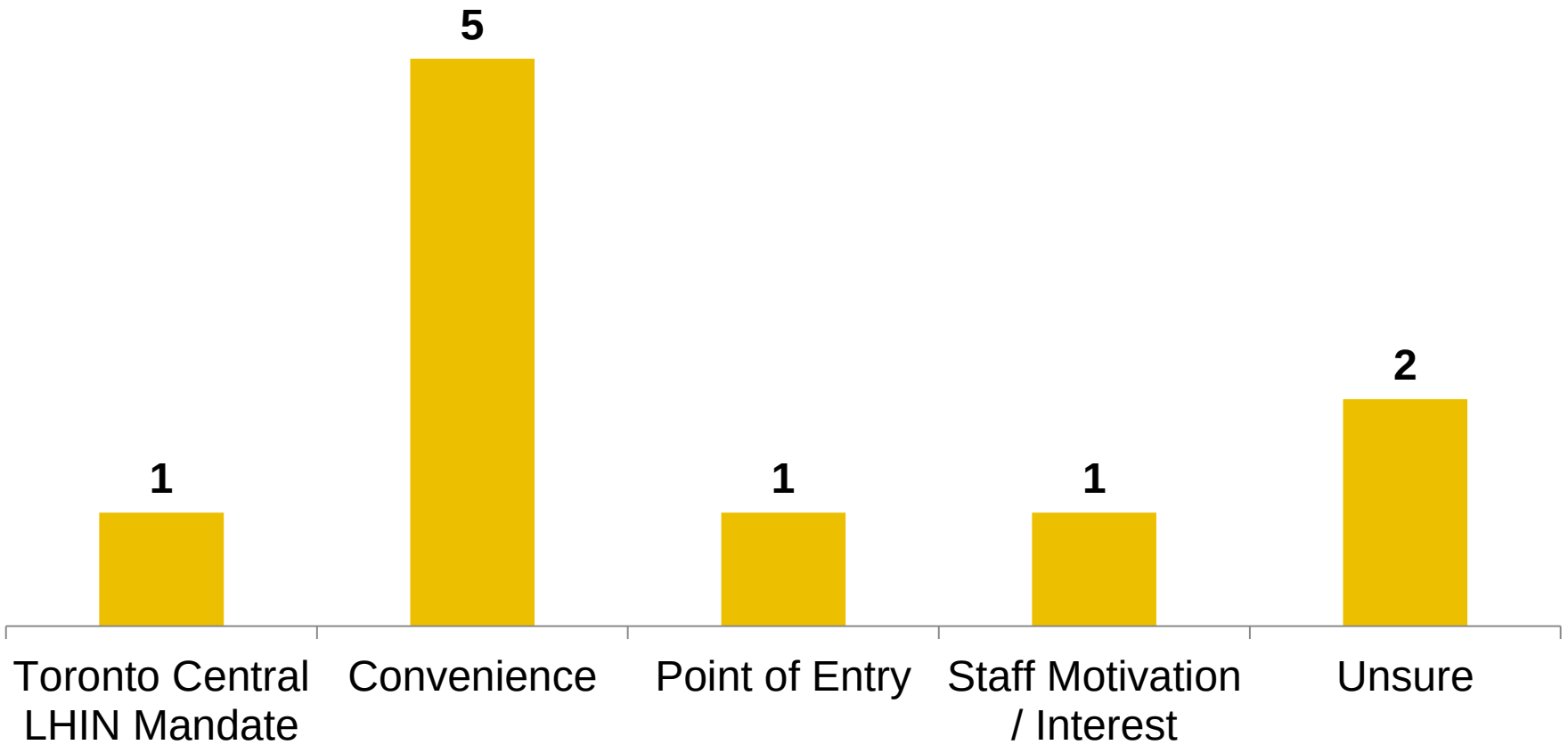
Data Collection Areas
Why were these areas chosen?



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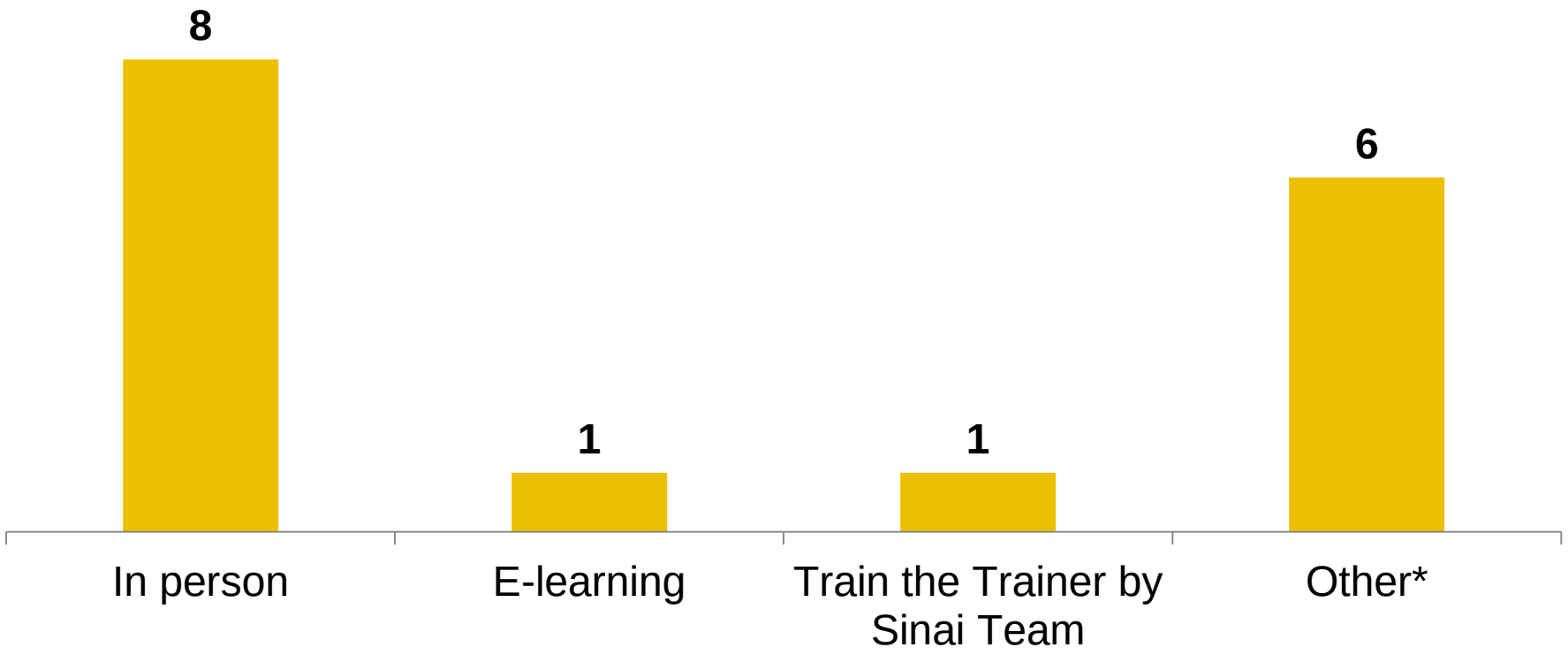
Staff training

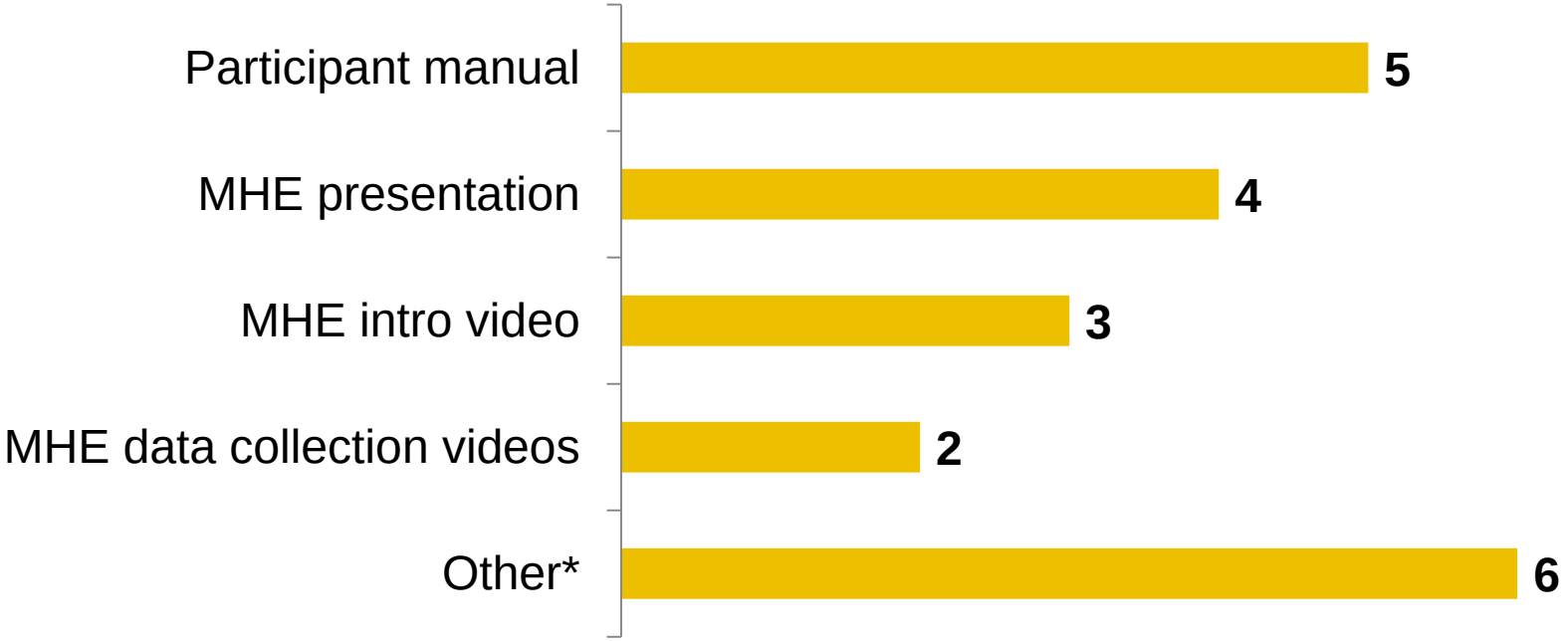
All 10 CHCs interviewed provided staff training. Four organizations used more than one training method which is reflected in the graph below:



*Other: included creating own training materials and using a train the trainer model by internal staff.

Staff training

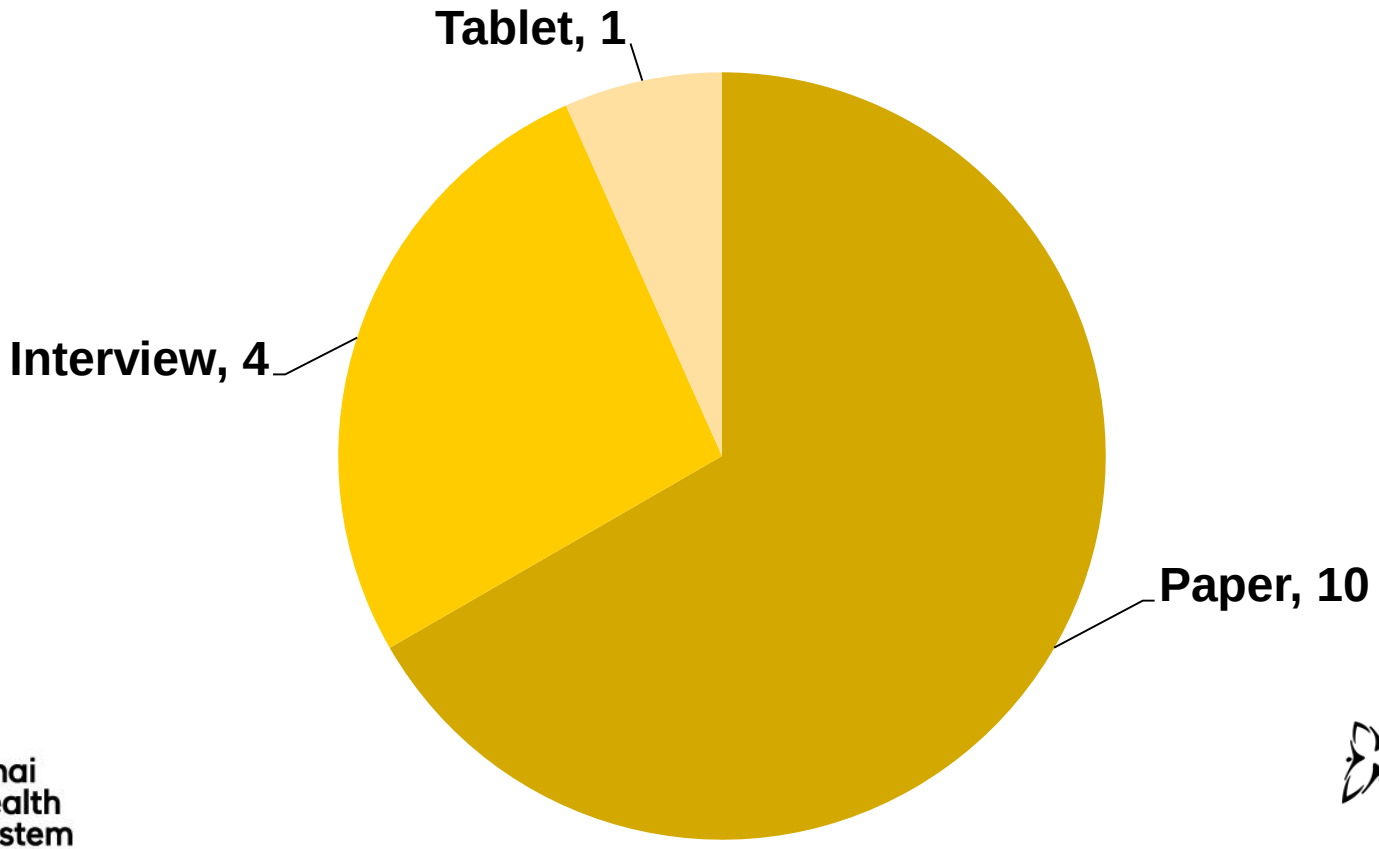
Of the 10 CHCs interviewed, 6 use at least one of the available Measuring Health Equity (MHE) training materials with 4 of these using more than one. The most used material is the participant manual.



*Other: included modified staff scripts , training resources and data entering guidelines.

CHCs: Data Collection Method

Of the 10 CHCs interviewed, 4 CHCs use more than one collection method and 5 only use one. The most used collection method is paper form collection.



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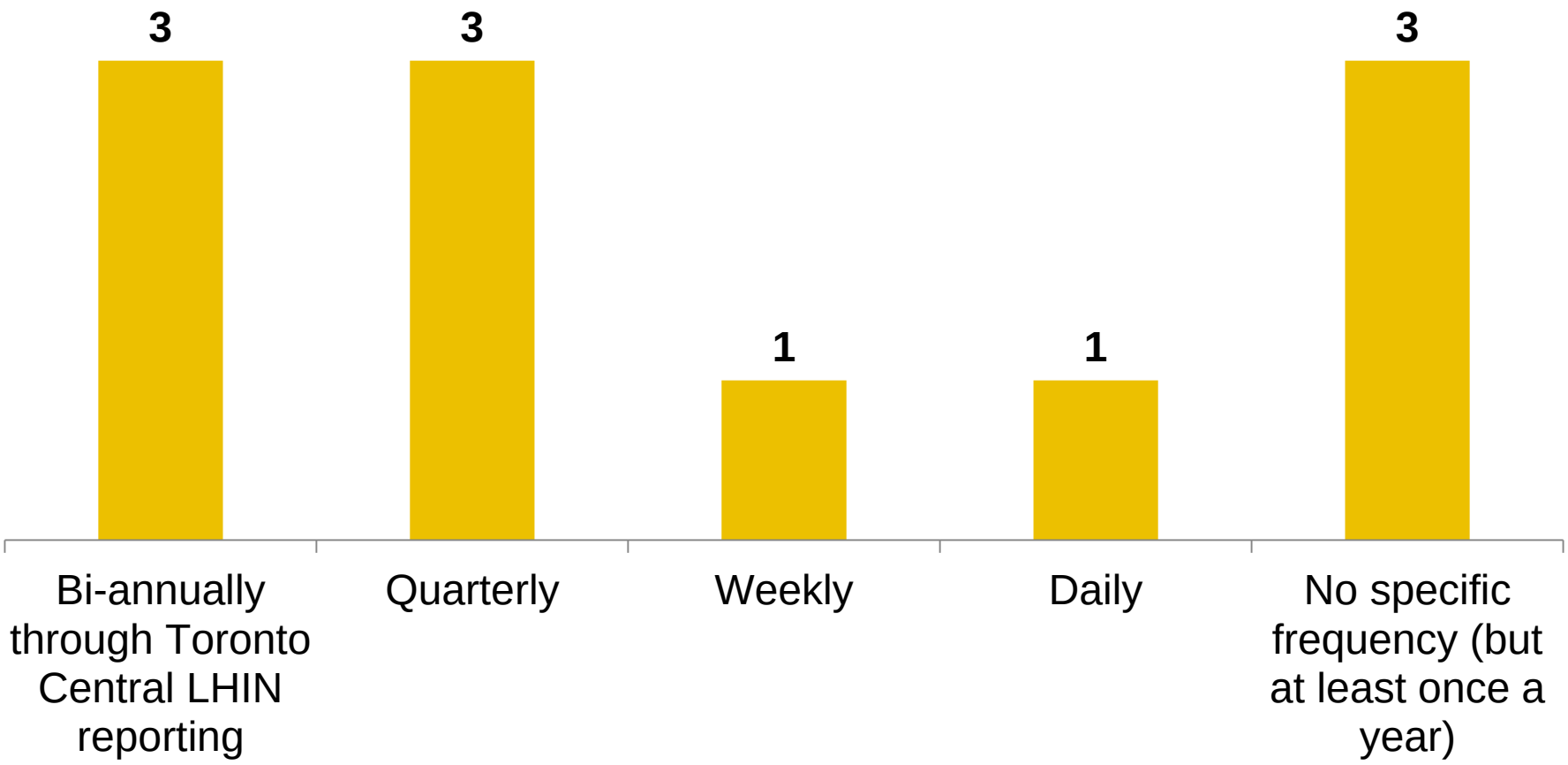
CHCs: Data Collection Tools

Nine CHCs reported using at least 1 of the 11 available MHE collection tools. Seven CHCs use more than 1 available tool.

Data Collection Tools	# of Hospitals using tool
Translated demographic questions	7
Cheat Sheet	2
Cue Cards	1
Guidelines for Collecting from children & youth	3
Scripts	3
Glossary in English	3
Glossary in French	0
Patient Brochure	4
Translated Patient Brochures	3
Poster	6
French Poster	1
Other (youth guideline and patient information board)	2

CHCs: Data Audit

Of the 10 CHCs interviewed, all but one audit their data quality. The frequency of these audits vary as seen below:



Data Use: Hospitals

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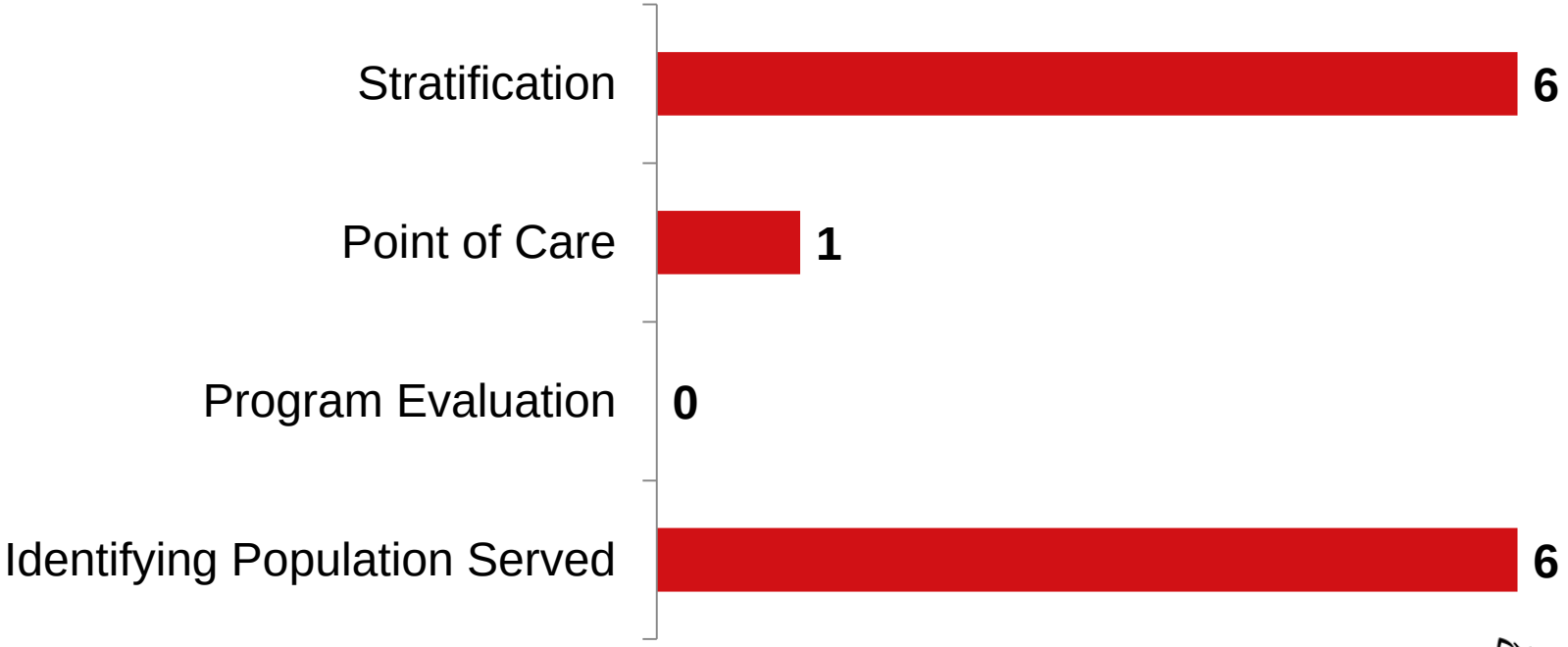
Overview

Of the 9 hospitals interviewed, 8 use their data. The most frequent use was for the Toronto Central LHIN annual stratification report and identifying the population served. Three hospitals used their data in more than one way.



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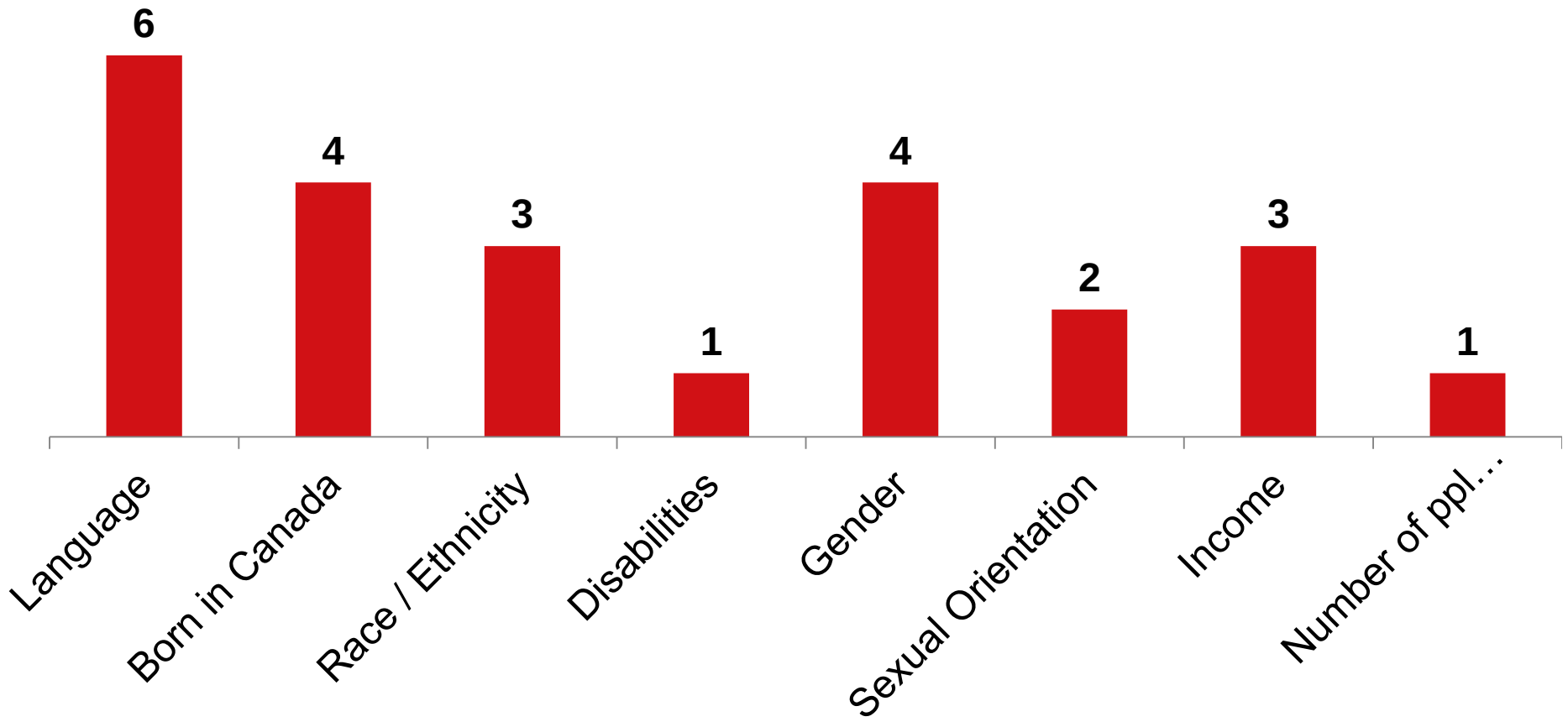
Stratification

Of the 8 demographic variables, ‘language’ was the variable most used for stratification with ‘born in Canada’ and ‘gender’ being the second most used variables.



Stratification

Of the 6 hospitals that stratified their data, length of stay (LOS) was the most used clinical indicator.

- **Length of Stay**
- **Alternative Level of Care Designation**
- **Missed Care Opportunities**
- **Discharge Destination**
- **Diabetes Screening**
- **Need for Interpreter Services**
- **OR Cancellations**

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Stratification

- Information performance teams, data quality managers, data quality department staff, nursing director, health equity specialists, and data analyst were identified as the key people who conducted the stratification and analyzed the data.
- Four organizations found a significant effect between their selected indicators and demographic variables, 1 organization did not find any significant effects, and the remaining 2 hospitals were unaware if any effects were found from their stratification.

Stratification

Of the 4 hospitals that stratified their data and found an effect, 3 used their findings to drive change.

Organization	How findings were used?
Holland Bloorview Kids Rehabilitation Hospital	Found significant effect between race/ ethnicity and missed opportunities of care. Hospital implemented transportation program in certain areas to reduce missed care opportunities.
Providence Health Centre	Found significant effect between income and ALC and Inpatient rehabilitation length of stay efficiency. Used results to inform business cases through community resource worker.
Sinai Health System	Found significant effect between Chinese speaking patients and LOS in stroke rehab. Hospital used data to apply for CFHI grant (which was awarded) to implement strategies to help transition/ discharge process of this population.

Point of Care

- Only 1 hospital believed data was being used at point of care in some programs. However, they were not able to expand how this data was being used. It was noted that the use of demographic data at point of care was very limited as the data was stored in an area of the EMR that most staff would not know how to access. Two organizations expressed similar reasons of why data was not being used at point of care.

Identifying Population Served

- Six hospitals used their data to identify the population they are serving. However, only 4 hospitals implemented changes based on these patient profiles (see next slide for a summary of these).
- Three out of the 6 organizations presented/shared their patient population profiles. Those that did, shared/presented these findings to: steering committees, quality committees, V.P. of risk, director of quality and patient experience, management team, and pockets of clinical staff who are using the data.
- Three out of the 6 organizations used the ‘Demographic Data Summary Tools’ that allows each organization to compare their patient population to the 2016 Census Data.

Identifying Population Served

Organization	How findings were used or planned to be used?
Providence Health Centre	Used data to inform automated follow up call service. Used demographic data to identify the top four languages in which patients feel most comfortable speaking in and translated the automated call into these languages.
Runnymede Health Centre	Used language data to identify top languages to translate patient and family brochures.
St. Michael's Hospital	Used data to see if hospital was meeting mandated targets and to improve how projects are being created.
Sunnybrook Health Centre	Used language data to identify top languages to translate materials in. Also used data to cross-reference with other demographic data that hospital collects as well as cross-reference with census data.

Data Use: CHCs

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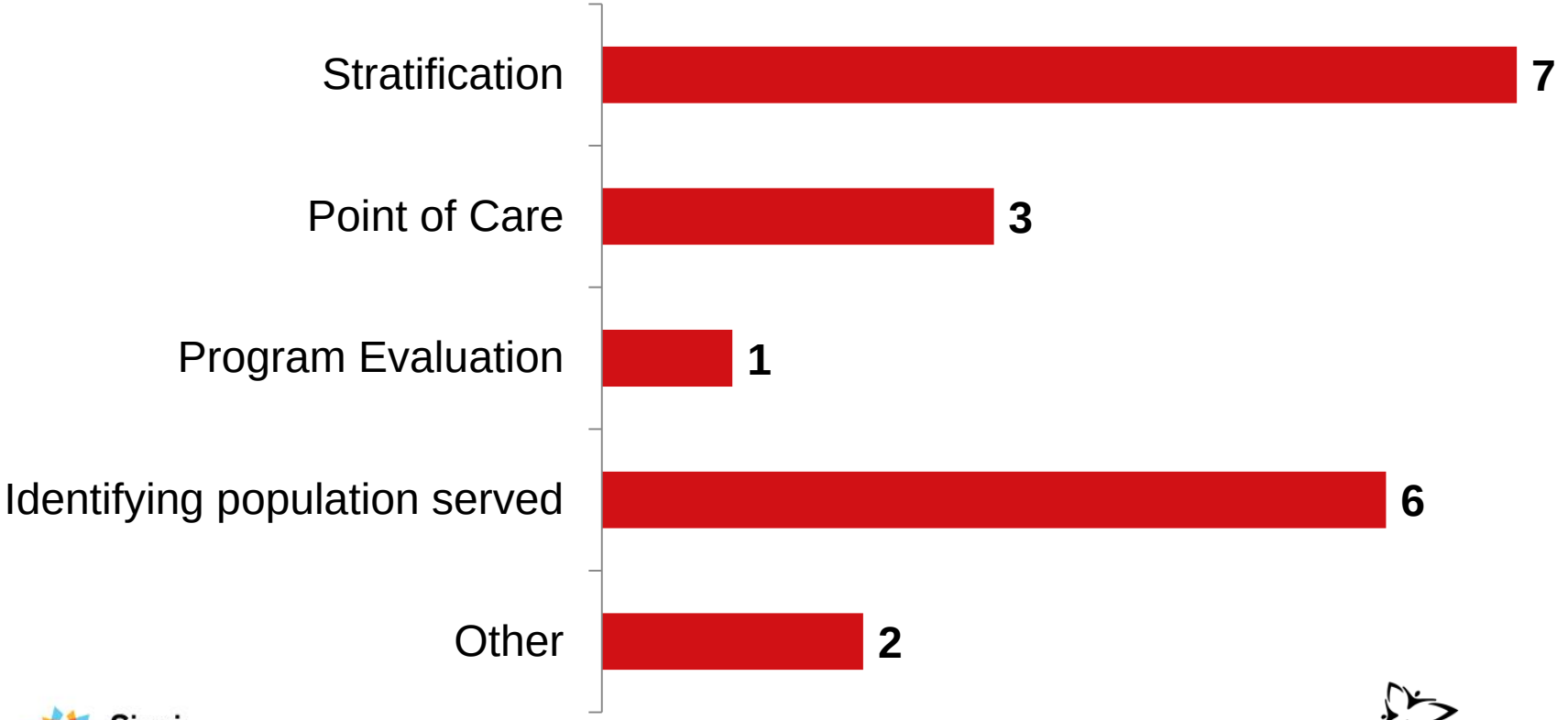
Overview

Of the 10 CHCs interviewed, all but one are using their data. The most frequent use was for the Toronto Central LHIN annual stratification report. Four CHCs used their data in more than one way.



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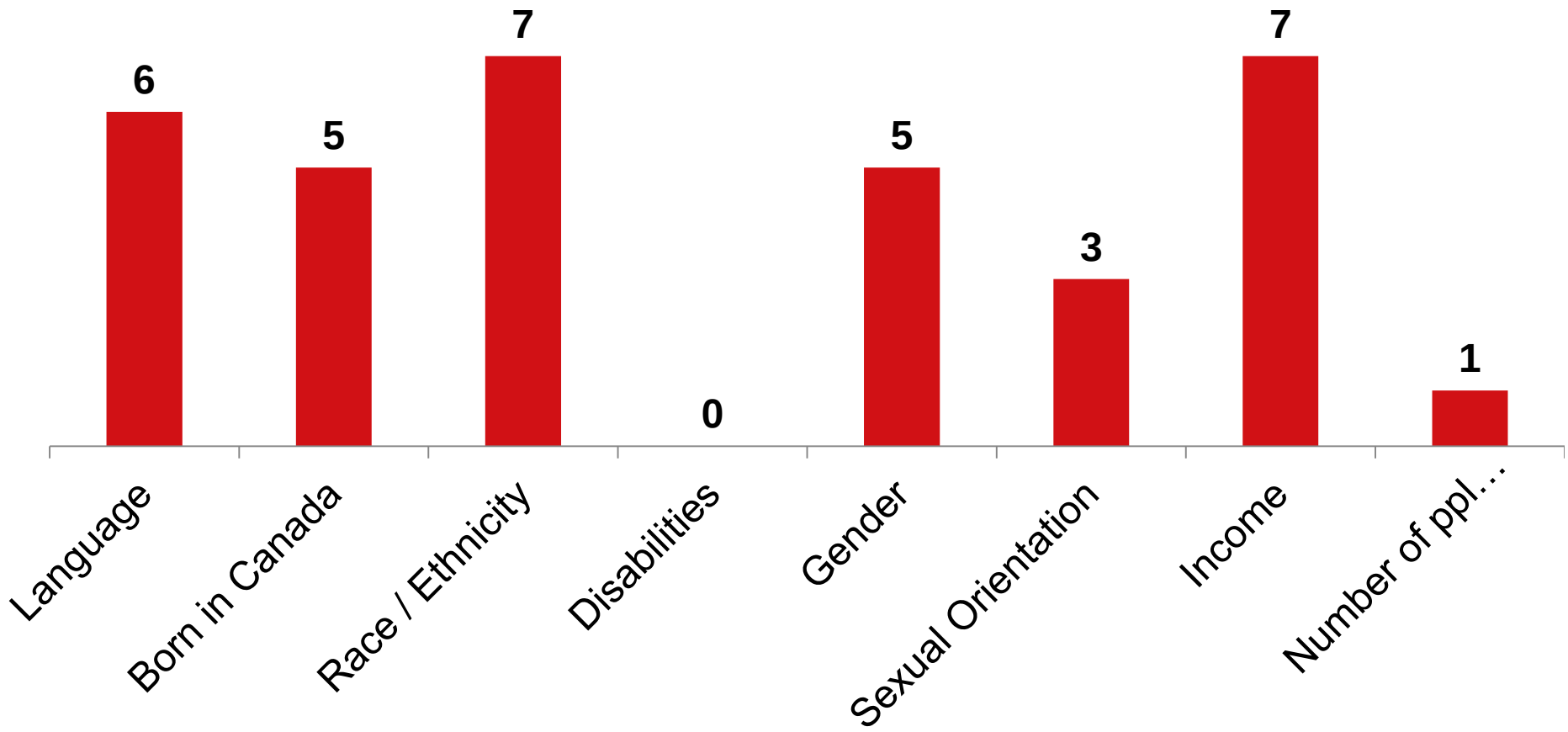
Stratification

Of the 8 demographic variables, ‘race / ethnicity’ and ‘income’ were the variables most used for stratification.



Stratification

- Of the 7 CHCs that stratified their data, breast, cervical and colorectal cancer screening were the most used clinical indicators. Other clinical indicators that were looked at were flu shot rates, eye screening, missed opportunities of care, and diabetes screening.
- Data management coordinators, manager of health promotions, clinical teams, managers of quality, social workers, and external consultants were identified as the key people who conducted the stratification and analyzed the data.
- Two organizations found a significant effect between their selected indicators and demographic variables, 3 organization did not find any significant effects, and the remaining 2 CHCs were unaware if any effects were found from their stratification.

Stratification

Of the 7 CHCs that stratified their data, 2 used their finding to drive change.

Organization	How findings were used?
Davenport Perth Neighbourhood Community Health Centre	Collaboration was initiated with four other CHCs: Unison, Parkdale Queen West, Access Alliance, and The Four Villages (the 'West End QI Collaboration') to establish uniform data protocols and improve validity of data stratification. Data across the CHCs was analyzed, identifying trends of lower cancer screening rates among certain populations. DPNCHC's clinical team was then consulted with to modify screening processes.
Unison Health & Community Services	Found statistical significance for: - cervical cancer and income and - colorectal cancer screening and both gender and income. Shared analysis with primary care team to develop change ideas with a view to being able to implement strategies that would improve screening rates.

CHC: Stratification Feedback

- Income categories do not capture big families for CHCs making stratification difficult at times. Recommend revising and increasing income brackets.
- Low participation rates for certain demographic questions make it difficult to stratify. Thus, aggregating data from two years often provided better results in highlighted health disparities.

Point of Care

Three CHCs used the demographic data at Point of Care.

Organization	How findings were used?
Access Alliance Multicultural Health and Community Services	All service providers including clinical staff are advised to review demographic data prior to initial appointment to contextualize intervention.
Davenport Perth Neighbourhood Community Health Centre	At intake, Medical Secretaries input client demographic data, which is then accessible to clinicians for first appointment with clients. Socio-demographic data is used to inform clinical care.
South Riverdale Community Health Centre	Demographic data integrated in client charts and accessible by all providers working with client. Data used to inform clinical assessments and clinical judgement.

Program Evaluation

Three CHCs used the demographic data to evaluate their program/services.

Organization	How findings were used?
Access Alliance Multicultural Health and Community Services	Used data to evaluate settlement program. Identified who is accessing services. This helped contextualize findings from evaluation in order to assess indicators such as access (e.g. mapping language needs against interpretation provided).
Davenport Perth Neighbourhood Community Health Centre	Developed individual practice profiles (for the clinical team) that included socio-demographic data, which were used to inform practice improvements. This process was carried out across the WEQI Collaboration.

Identifying Population Served

- Six CHCs used their data to identify the population they are serving. A description on how each organization used the data is found on the following slide.
- Three CHCs confirmed presenting/sharing their patient population profiles. Those that did, shared/presented these findings to their health care team. One organization presented it to their Board Quality Committee and another organization had plans of making their finding available online.
- Although no CHC used the ‘Demographic Data Summary Tools’, 1 CHC created their own version of the tool.

Identifying Population Served

Organization	How findings were used?
Access Alliance Multicultural Health and Community Services	Continuously use patient profiles to identify populations served, used by teams for evidence-informed program and service improvements/changes. Also, clients based on target profile are pulled for tailored outreach for programming. Additionally, routinely use top preferred languages to inform translations of Client Experience Surveys and other materials.
Davenport Perth Neighbourhood Community Health Centre	Used DPNCHC client data in Community Needs Assessment (which informs new organizational Strategic directives) to compare to catchment area demographics.
LAMP Community Health Centre	Use demographic data to create client profile summaries for various service areas. Based on these, target areas that need improvement to create organizational strategies

Identifying Population Served

Organization	How findings were used?
Planned Parenthood	Use demographic data client profile summaries to assess whether own annual population survey mirrors demographic data. Also use client profile summaries when making a case for something such as a grant.
Regent Park Community Health Centre	Refer to client profile summaries as part of client analysis.
South Riverdale Community Health Centre	Used demographic data for mapping in neighborhood strategies. Additionally, client profile summaries increased the understanding in complexity of individuals being served at organization.
Unison Health & Community Services	Annual demographic client summaries shared with Board Quality Committee and staff.

Other Data Use

Organization	How findings were used?
Access Alliance Multicultural Health and Community Services	Using data to build evidence for research and advocacy. For instance, used data for pilot project with Women's College regarding HPV screening.

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Contact Information

For more information on the support available from Sinai Health System, please contact:

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