SUMMARY REPORT
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The Tri-Hospital + TPH Health Equity Data Collection Research Project Report

Toronto Public Health

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The full research project report is available at:

- http:// www.mountsinai.ca
- http://knowledgex.camh.net/health_equity/Pages/default.aspx
- http:// www.stmichaelshospital.com
- http://www.toronto.ca/health

Introduction

Toronto has undergone a massive transformation over the last three decades. From the force of immigration, the demographics of the city have dramatically changed. No less transformative is the concerted community push for greater recognition of all forms of diversity and social exclusion such as disability, sexual orientation and gender. Yet while Toronto has experienced deep-rooted change, it remains unclear whether our health care system has evolved at the same pace. Such a question becomes all the more relevant in light of changes to the Ontario Human Rights Code, the passage of the Excellent Care for All Act (2010), and an evolving health care system that has come to recognize patient-centered care as a pillar of quality care.

Why are socio-demographic data important? Over four decades of research has generated a large and compelling body of literature on socio-demographic differences in health care access, experiences and outcomes. While universal health care has a levelling effect that reduces health inequities for a majority of the population, affordability does not address other barriers in relation to factors such as racialized status and ethnicity, language, gender, and sexual orientation. We know that there is a significant decline in the physical and mental health status of recent immigrants within a two to five year period following settlement (DeMaio 2010; Hyman 2007; Ng, Wilkins, Gendron, & Berthelot, 2005; Pahwa, Karunanayake, McCrosky, & Thorpe, 2012). Studies also tell us social stigma and discrimination affect access and usage of health care services for persons from the lesbian, gay, bi-sexual, transgender and inter-sex populations (Bergeron & Senn, 2003; Coker, Austin, & Schuster, 2010; Jillson, 2002; Kerith, Conron, Mimiaga, & Landers, 2010; Mayer et al., 2008). Yet, while health equity research has pushed out the boundaries for health system action, there has not been a parallel expansion in the type of data that is routinely collected and used to improve health care.

Currently in Canada, most information on health equity is derived from population level data such as the Canadian Community Health Survey and/or linked databases, which can signal important variations in health outcomes. While that data can provide insight into diverse social and geographic population groups, characteristics such as sexual orientation or gender identity are often missed.

Population health survey data are not routinely linked to specific health care organizations, limiting their capacity to assess their own performance improvements in relation to the observed risk and prevalence of differences in health.

As the old saying goes, "you cannot manage what you don't measure". Administrative records have traditionally focused on limited patient factors such as age and geographic location and medical measures like diagnosis and length of stay. All critical information, yet insufficient when viewed against the new imperatives of health care management. In sum, the lack of socio-demographic information hinders the growth of patient-centred care that captures diversity in multiple forms, and presents a barrier to investigating whether past and on-going change initiatives have produced positive outcomes.

The following report provides an overview of a four year process among four organizations: Mount Sinai Hospital (MSH), St. Michael's Hospital (SMH), the Centre for Addiction and Mental Health (CAMH) and Toronto Public Health (TPH). Through the development and pilot project trial of a socio-demographic questionnaire with a participation rate of over 80%, a set of eight questions and three optional questions is being recommended for wide-scale implementation. Research on the equity of health and health care compels action on the collection of socio-demographic data. The results of the Tri-Hospital + TPH Health Equity Data Collection Project provide evidence that it is 'doable'.

Getting Started

In 2009, a group of equity practitioners from MSH, SMH and CAMH convened a meeting to establish a partnership to further equity in health through the collection of socio-demographic data. All participants had deep experience in the theory and practice of health equity principles, yet recognized that the current system of health data collection did not capture variables (e.g., income) recognized in research as important influences on health care access, experience and outcomes. At a later point, TPH asked to join the process, providing a population health perspective as well as another unique pilot project setting.

The project objectives of the partnership were decided to be:

- Develop and pilot test evidence-based data collection methods and a survey tool
- Analyze patient responses and feedback from data collectors to improve the methodology and tool
- Explore the relation between demographic variables and self-rated health
- Ensure knowledge exchange with other institutions in the Toronto Central LHIN around the findings of the project.

The definition of 'mission critical' was acquiring the best evidence on a range of questions and employing the appropriate expertise - policy researchers, data experts, information technology specialists - at each stage of development. The research questions to be explored were: 1) What socio-demographic variables should be collected? 2) Who is best suited to ask patients for sensitive personal information? 3) What formats maximize response rates? and, 4) How best to inform staff and patients about socio-demographic data collection?

Moving Along the Learning Curve

From the Literature – Commitment, Standardization and Consolidation

In response to the expanding recognition of the social determinants of health and growing push towards health equity, a number of jurisdictions have set a regulatory requirement that health care organizations collect socio-demographic data, most often on racialized status or ethnicity. In England and Wales, government policy for hospitals to collect race/ethnicity data was a story of weak commitment (Fulton, 2010; Iqbal et al., 2009). While all hospitals collected the data as required, the number of responses marked 'not known' or 'not stated' was nearly 90% until a concerted policy push to improve compliance.

For the U.S., acknowledged by most as the international leader, the issue appears to be too much data collection and mandatory requirements marked by too little standardization (Escarce, Carreon, Veselovsky, & Lawson, 2011; Institute of Medicine [IOM], 2009). The process of socio-demographic data collection might be described as a "smorgasboard" of different standards, policies and requirements,mirroring the highly fragmented character of the U.S. health care system and government. Moreover, given the early days of such pioneering work, much of the data collection implemented what might be described as "bad practices". Methods including staff visually scrutinizing patients to determine race or categorizing ethnicity on the basis of last names has resulted in misclassifcation rates of up to 50% (Andrews, 2011; Escarce et al.). Emerging from the fragmentation are signs of consolidation as well as pushing out the parameters of socio-demographic factors. In Massachusetts, the Department of Public Health and Division of Health Care Finance and Policy are working toward a coordinated approach for standardization of data collection (Hawkins, Torres, Simpson, & Cohen, 2011). Through a process of development, a set of socio-demographic questions were identified and then tested and refined through pilot projects.

While previously focused on collecting race, ethnicity, and language (REaL data), US hospitals have now started expanding the list of demographic paramters due to the recognition that more data collection is required for a comprehensive picture on health equity. The Affordable Care Act requires the mandatory collection of data on disability status (Office of Minority Health [OMH], 2011). More recently, the U.S. Department of Health and Human Services (HSS) stated that it would begin a plan to collect data on lesbian, gay, bisexual & transgender populations (LGBT) (OMH).

Public Perception on the Collection of Socio-Demographic Data – The 'Gradient of Comfort'

The collection of socio-demographic data carries with it ethical implications and, for some individuals, a threat or intrusion in their personal lives. A number of studies in the U.S. and Canada have explored whether the general public are accepting of the idea of being asked about race/ethnicity, sexual orientation and other sensitive topics (Baker et al., 2005; Baker, Hasnain-Wynia, Kandula, Thompson, & Brown, 2007; Varcoe, Browne, & Wong, 2009). Findings from these studies are generally positive with responses hovering in the area of 80% and above (e.g., Quan, Wong, & Johnson, 2006), with the exception of one national study in Canada suggesting a much lower level of support at 50% (Lofters, Shankardass, Kirst, & Quinonez, 2011). This study stands in contrast to an earlier Calgary study in which the findings were similar to earlier U.S. work over 80% (Quan et al.).

What is consistent across the studies is that there is a 'gradient of comfort' – people are most open to questions about language, while they are less receptive to questions regarding their income. Similarly, there is a 'gradient' in relation to who is asking for the data, with physicians ranked as the most trusted and greater reluctance about administrative staff.

While the implications of the national survey were of concern, the development and pilot testing process was designed to target and influence the 'gradient of comfort' through various strategies. In relation to the sensitivity of questions, the ordering of questions would move from least sensitive (language) to most discomforting (income). This would both enable the capture of most of the data while also allowing the respondent to ease into a sense of trust. It was important to ensure all data collectors were well trained in understanding the purpose of the data for quality care, and had a natural confidence in establishing a sense of trust with the respondents.

What Socio-Demographic Factors to Measure – Follow the Evidence

The socio-demographic factors most consistently collected by health organizations are race or ethnicity. The rationale for this focus is easy to explain: there is a vast body of international and Canadian research indicating that race and ethnicity play a pivotal role in one's health status, healthcare experience and satisfaction, quality of care received and outcomes (IOM, 2009; Nestel, 2012; Tjepkema, Wilkins, Senécal, Guimond, & Penney, 2009; Tjepkema, Wilkins, Senécal, Guimond, & Penney, 2010; Wray, & Hyman, 2013).

And yet, while race and ethnicity are significant influences on quality and outcomes, there is an equally robust body of evidence on the effects of low income (Phipps, 2003; Ross et al., 2006). Similarly, the effects of social exclusion and marginalization on patients and the provision of health care are now being examined in relation to factors such as:

- immigration status (e.g., DeMaio, 2010; Hyman, 2007)
- sexual orientation (e.g., IOM, 1999; IOM, 2011; Mayer et al., 2008)
- gender (e.g., Bierman, 2012)
- language (e.g., Bowen, 2001)
- disability (e.g., Lezzoni, 2011; Sullivan, Heng, & Cameron, 2006; Veltman, Stewart, Gaetan, Tardif, & Branigan, 2001), and
- homelessness (e.g., Frankish, Hwang, & Quantz, 2005; Hwang, 2000; Hwang, 2001; Hwang, & Henderson 2010).

An emerging research base is empirically validating what has long been known - social marginalization is often mirrored by health inequities. In some countries, legislation and regulation is at last following the evidence.

In many respects, Canada is a laggard in the collection of socio-demographic data. While equity in health has long been a goal of advocates, academics and policy makers, there has been a systematic failure to generate the data necessary to ask 'is it working?' and 'how can we do better?'. Despite rich and compelling evidence, action on standardized socio-demographic health data collection is not following the evidence. For this process, literature reviews were implemented to identify evidence-based key questions for the systematic collection of data; collecting data on those questions will consequently support evidence-based quality care improvements in Toronto. These questions are language, race/ethnicity, born in Canada, disability, sexual orientation, gender, housing, age, religion and income.

Environmental Scan – Don't Reinvent the Wheel

While Canada might be behind in terms of the standardized collection of socio-demographic data for healthcare at the national, provincial and local levels, there are many organizations in various sectors (including health) that have recognized the need and independently moved forward. Having gone through the process of testing and tweaking the questions for real world application, many of those organizations had valuable input on what works and what doesn't in the development of socio-demographic questions. Accordingly, the Tri-Hospital + TPH environmental scan was comprised of key informant interviews in addition to compiling materials on promotion, education and training in data collection. This material included tested tools that can be used to inform and engage patients, as well as prepare data collectors. A total of eleven local human service organizations were scanned ranging from the Toronto District School Board to the South Riverdale Community Health Centre as well as the Disparities Solution Centre in Boston. The combination of learned experience and hard copy information was used to shape the socio-demographic questions and categories, and the strategy of implementation.

Gearing Up

When tasked with reporting data on patients from diverse populations, McKenzie and Cowcroft (1996) suggest adopting a popular learning strategy from medical school: "if you do not know the right name for something then describe it" (p. 1054). There are few words that are more complex and less subject to single definitions than race and ethnicity. Race, as is well accepted by most experts, is not a scientific construct. It is a social construct with diverse interpretations (Krieger, 2003; Williams, 2012). In turn, ethnicity can be measured along a variety of dimensions and associations such as origin, ancestry or identity (Statistics Canada, 2003). Nor is there always accepted language for sexual orientations, with familiar variations such as gay or lesbian or the Aboriginal term two-spirited. Lastly, the potential categorizations for religious affiliations, while not infinite, are large (with estimates up to 4,200).

The process of survey question development was one of creating questions and categorizations that are both useful for the purposes of collection, aggregation and analysis, while meaningful for survey respondents.

Just as a "describe it" process guided question development for data collection purposes, it was essential that people "see themselves" in the descriptions. Although sociological research suggests that the preferred method is open ended categories in which the person self-identifies, it is also acknowledged this process generates information that cannot be easily aggregated (if at all), nor is the data analysis able to distinguish on what basis the individual self-identified (Brunsma, 2005; Brunsma, 2006; Khanna, 2012). Therefore, the development of questions was guided by a middle point approach of using groupings that reflect the demographics of Toronto that can be aggregated (e.g., Black, Asian) and disaggregated (e.g. Black – Caribbean, Asian - South), and uses examples of source countries so that people can recognize and place themselves within the description.

There were a total of 23 iterations of the survey questions developed via existing data collection tools, adjusted after consultations with informed experts and final revisions drawn from the pilot project findings. The primary source of questions and descriptions for race/ethnicity, language and religion was the Toronto District School Board census survey, a survey instrument that has been successfully implemented and validated on repeated occasions. For disability, the question and categories were drawn from Ontario's Human Rights legislation. Questions regarding sexual orientation and gender were created in consultation with the lesbian, gay, bisexual and trans (LGBT) communities.

Drawing from the environmental scan, the next step was to create a survey protocol, recruitment script, data collection training handbook and promotional materials building upon materials developed by NHS Scotland (2009).

Since the health care system is not a singular system and, indeed, hospitals are comprised of a wide variety of programs, settings, patient populations, another focus was to identify a diverse number of pilot sites. The process was a blend of selection and internal hospital championing, negotiation and agreement.

The sites represent a diverse number of settings: outpatient, inpatient, family practice and home visits. Similarly, the patient populations varied from persons with serious mental illness, frail elderly with varying degrees of cognitive competency, socially excluded women with a high risk of pregnancy, patients with complex co-morbidities, and individuals using primary health care. Along with a mix of settings, various methods of administering the surveys were utilized.

Table 1

List of sites for demographic data collection

LOCATION	METHOD	ADMINISTRATION
MSH – General Internal Medicine – bedside	Paper	Volunteers (internationally educated health professionals)
MSH – Gravonsky Gluskin Family Medicine Centre – waiting room	Paper	Self with assistance of volunteers (internationally educated health professionals)
SMH – Family Practice Outpatient Clinic - waiting room	Tablet	Self with assistance of two multi-lingual post-graduate students
CAMH – Outpatient Schizophrenia Program	Paper	Volunteers, research staff and health care providers
TPH – Healthiest Babies Possible Program – 2nd visit	Paper	Health providers

What We Found – The Pilot Project

A total of 2,242 patients were approached in five pilot sites during the summer of 2012. Of these, 86.6% of patients (n = 1,942) answered the survey and 13.4% (n = 300) declined to answer. In other words, the first finding was that patients were willing to share their information[1].

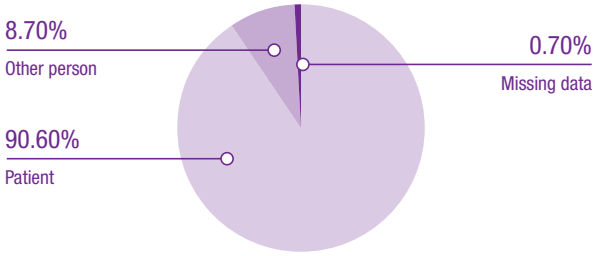
Summary of Data Collection Methods

The techniques and processes used to collect data across the six sites were examined, including where the survey was administered, who provided and who collected the information, and how the data was captured. The pie charts below provide a summary of the findings.

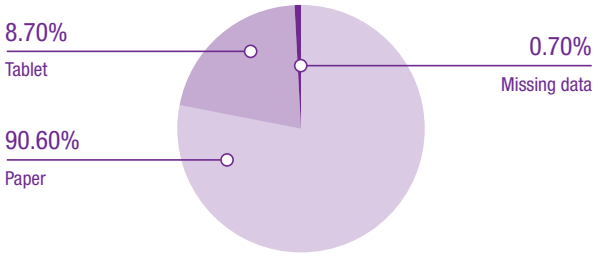
Analysis of the Survey Results

Response validity was calculated for each question by looking at the proportion of "valid" responses. A response was considered to be valid if the respondent selected any one of the available response options (responses of "don't know" and "prefer not to answer" are considered valid).

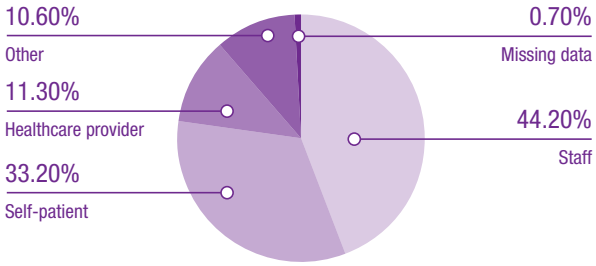
Who provided the information?



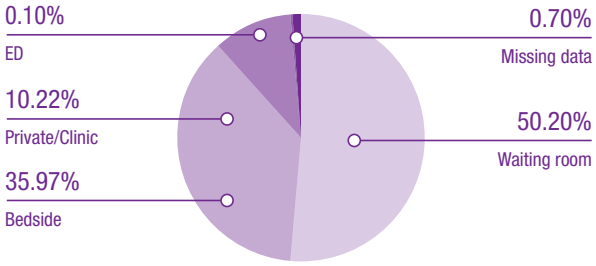
What survey format was used?



Who collected the information?



Where was the survey administered?



[1] *Please note that one of the sites didn't report the number of refusals. The revised participation rate excluding that site is 82.5%*

Table 2

Percentage of valid responses per survey question

QUESTION	VALID RESPONSES
In what language would you feel most comfortable speaking in with your healthcare provider? (n = 1942)	97.6%
How would you rate your ability to speak and understand English? (n = 1942)	98.3%
In what language would you prefer to read healthcare information? (n = 1942)	97.3%
Were you born in Canada (n = 1942)	98.6%
*If not born in Canada, what year did you arrive? (n = 876)	85.5%
Which of the following best describes your race? (n = 1942)	97.6%
What is your religious or spiritual affiliation? (n = 1727)[i]	94.6%
What is your gender? (n = 1942)	97.9%
What is your sexual orientation? (n = 1942)	97.1%
What was your total family income before taxes last year? (n = 1942)	96.4%
*How many people does this income support? (n = 1942)	84.6%
What type of housing do you live in? (n = 1942)	97.2%
In what year were you born? (n = 1232)[ii]	96.1%
Do you have any of the following disabilities? (n = 1942)	94.2%

* *Follow up item*

[ii] *Note: the sample size is smaller because some respondents were asked this question as two separate questions. These individuals could not be grouped appropriately with the other respondents.*

[iii] *Note: the sample size is smaller because for some respondents their date of birth was taken from their health record, not as it was reported on the survey.*

Self-rated health (SRH) was used as an indicator of subjective health. Respondents were asked to rate their health as excellent, very good, good, fair, or poor.

The survey findings show that:

- A greater proportion of individuals who rated their ability to speak and understand English as "Not Well" or "Not at All" reported "Poor" perceived health (29.7%) compared to those who said they spoke and understood English "Very Well" Or "Well" (11.1%)
- The average length of residency in Canada was significantly longer for immigrants who rated their health as "Poor" (38.76 ± 19.46 years) compared to immigrants who rated it as "Excellent" (19.34 ± 20.149 years), "Very Good" (21.17 ± 18.97 years), or "Good" (24.68 ± 19.39 years)
- A greater proportion of the Aboriginal and Racialized group (17.6%) rated their health as "Excellent" than the "White" group (13.7%), and a lower proportion rated their health as "Poor" (9.7%) compared to the "White" population (14.4%)
- A greater proportion of males (35.6%) reported their health as "Fair" or "Poor" compared to females (26.7%)

Follow-up: Feedback from Data Collectors

Discussions with data collectors revealed that the reception of patients to the survey questions was positive and most people were willing to provide the requested information. The general conclusion of data collectors was that the training was of high quality and helpful in a way that made the process of collection relatively easy.

What We Learned – Looking to the Future

The success of the Tri-Hospital + TPH project is now moving from a small collaborative initiative to a system wide application. The TC LHIN identified the collection of socio-demographic as a key pillar in its health equity strategy. The questions and categorizations were assessed to work well, and a final set of 8 core questions with three optional – but recommended – questions has been adopted as the preferred survey approach for wide scale implementation as directed by the TC LHIN (See Appendix A).

Following are the lessons learned from the Tri-Hospital + TPH project:

Lesson #1: With a participation rate of over 80%, the pilot project demonstrated that the collection of socio-demographic data from patients/clients is 'doable.'

Lesson #2: A strong commitment by senior leadership to the value and importance of socio-demographic data collection is necessary.

Lesson #3: The training of data collectors is the key step in successful implementation. Education on health equity (the 'big picture') is important in moving attitudes and acceptance toward buy-in and interest.

Lesson #4: The use of technology is challenging for some patients. For certain populations such as the elderly or people with some disabilities, there is the potential for a steeper learning curve.

Lesson #5: When introducing a demographic data collection model and coordinating data collection across multiple sites, it is essential to continually monitor progress and engage staff and management around that progress. This can include monitoring participation rates for data quality and addressing issues that arise early on.

Lesson #6: All hospitals should implement their own process of learning and adaptation to align the data collection method with technology, setting, and program population. While standardizing definitions, categories of the questions, and self-reporting is necessary to ensure quality data, the method of data collection for each setting can be flexible.

The Tri-Hospital + TPH project was able to meet its objectives after years of discussions, consultations, and research. The extensive work leading up to those objectives makes it easy to forget that demographic data collection is only a means to a bolder end: equity in health, represented in "the absence of systematic disparities in health between groups with different levels of underlying social advantage/ disadvantage- that is, wealth, power, or prestige" (Braveman & Gruskin, 2003, p. 254). The lessons laid out in this report are key to the ambitious work ahead of us, and provide much-needed direction on the long journey to providing equitable health care.

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Appendix A

8 Final Core Questions

1. What language would you feel most comfortable speaking in with your healthcare provider? **CHECK ONE ONLY.**

❍ Amharic	❍ Hindi	❍ Somali
❍ Arabic	❍ Hungarian	❍ Spanish
❍ ASL	❍ Italian	❍ Tagalog
❍ Bengali	❍ Karen	❍ Tamil
❍ Chinese (Cantonese)	❍ Korean	❍ Tigrinya
❍ Chinese (Mandarin)	❍ Nepali	❍ Turkish
❍ Czech	❍ Polish	❍ Twi
❍ Dari	❍ Portuguese	❍ Ukrainian
❍ English	❍ Punjabi	❍ Urdu
❍ Farsi	❍ Russian	❍ Vietnamese
❍ French	❍ Serbian	❍ Prefer not to answer
❍ Greek	❍ Slovak	❍ Do not know
❍ Other (Please specify) _____		

2. Were you born in Canada?

❍ Yes	❍ No	❍ Prefer not to answer	❍ Do not know
❍ If **no**, what year did you arrive in Canada? _____			

3. Which of the following best describes your racial or ethnic group? **CHECK ONE ONLY.**

❍ Asian - East (e.g., Chinese, Japanese, Korean)	❍ Latin American (e.g., Argentinean, Chilean, Salvadorian)
❍ Asian - South (e.g., Indian, Pakistani, Sri Lankan)	❍ Métis
❍ Asian - South East (e.g., Malaysian, Filipino, Vietnamese)	❍ Middle Eastern (e.g., Egyptian, Iranian, Lebanese)
❍ Black - African (e.g., Ghanaian, Kenyan, Somali)	❍ White - European (e.g., English, Italian, Portuguese, Russian)
❍ Black - Caribbean (e.g., Barbadian, Jamaican)	❍ White - North American (e.g., Canadian, American)
❍ Black - North American (e.g., Canadian, American)	❍ Mixed heritage (e.g., Black- African and White-North American) (Please specify) _____
❍ First Nations	
❍ Indian - Caribbean (e.g., Guyanese with origins in India)	❍ Other (Please specify) _____
❍ Indigenous/Aboriginal not included elsewhere	❍ Prefer not to answer
❍ Inuit	❍ Do not know

4. Do you have any of the following disabilities? **CHECK ALL THAT APPLY.**

❍ No disabilities	❍ Physical disability
❍ Chronic illness	❍ Sensory disability (i.e. hearing or vision loss)
❍ Developmental disability	❍ Other (Please specify) _____
❍ Drug or alcohol dependence	
❍ Learning disability	❍ Prefer not to answer
❍ Mental illness	❍ Do not know

5. What is your gender? **CHECK ONE ONLY.**

❍ Female	❍ Intersex	❍ Male	❍ Trans- Female to Male
❍ Trans-Male to Female	❍ Other (Please specify) _____	❍ Prefer not to answer	❍ Do not know

6. What is your sexual orientation? **CHECK ONE ONLY.**

❍ Bisexual	❍ Two-Spirit
❍ Gay	❍ Other (Please specify) _____
❍ Heterosexual (“straight”)	
❍ Lesbian	❍ Prefer not to answer
❍ Queer	❍ Do not know

7. What was your total family income before taxes last year? **CHECK ONE ONLY.**

❍ $0 to $29,999	❍ $120,000 to $149,999
❍ $30,000 to $59,999	❍ $150,000 or more
❍ $60,000 to $89,999	❍ Prefer not to answer
❍ $90,000 to $119,999	❍ Do not know

8. How many people does this income support? _____

❍ Prefer not to answer	❍ Do not know

Optional Questions

(Recommended but not required by the TC LHIN)

1. In what language would you prefer to read healthcare information? **CHECK ONE ONLY.**

❍ Amharic	❍ Hindi	❍ Somali
❍ Arabic	❍ Hungarian	❍ Spanish
❍ Bengali	❍ Italian	❍ Tagalog
❍ Braille	❍ Karen	❍ Tamil
❍ Chinese (Simplified)	❍ Korean	❍ Tigrinya
❍ Chinese (Traditional)	❍ Nepali	❍ Turkish
❍ Czech	❍ Polish	❍ Twi
❍ Dari	❍ Portuguese	❍ Ukrainian
❍ Farsi	❍ Punjabi	❍ Urdu
❍ English	❍ Russian	❍ Vietnamese
❍ French	❍ Serbian	❍ Prefer not to answer
❍ Greek	❍ Slovak	❍ Do not know
❍ Other (Please specify) _____		

2. What is your religious or spiritual affiliation? **CHECK ONE ONLY.**

❍ I do not have a religious or spiritual affiliation	❍ Jainism	❍ Sikhism
❍ Animism or Shamanism	❍ Jehovah's Witnesses	❍ Spiritual
❍ Atheism	❍ Judaism	❍ Unitarianism
❍ Baha'i Faith	❍ Islam	❍ Zoroastrianism
❍ Buddhism	❍ Native Spirituality	❍ Other (Please specify) _____
❍ Christian, not included elsewhere on this list	❍ Pagan	
❍ Christian Orthodox	❍ Protestant	❍ Prefer not to answer
❍ Confucianism	❍ Rastafarianism	❍ Do not know
❍ Hinduism	❍ Roman Catholic	

3. What type of housing do you live in? **CHECK ONE ONLY.**

❍ Boarding Home	❍ Homeless/on street	❍ Shelter/Hostel	❍ Prefer not to answer
❍ Correctional Facility	❍ Own home	❍ Supportive Housing	❍ Do not know
❍ Group Home	❍ Renting	❍ Other (Please specify) _____	

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Mount Sinai Hospital
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