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# Towards a performance measurement system for health equity in a local health integration network

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ABSTRACT

While there is a growing literature on building performance measurement systems for health equities, this literature for the most part has not dealt with the challenges of coordinating the various parts of the system, the heterogeneous nature of such systems, or how evaluations and measurement can themselves improve performance. This paper describes the initial steps taken to build a performance measurement system to coordinate health equity across 18 hospitals led by the Toronto Central Local Health Integration Network, which is a regional health authority serving a population of more than 2.5 million residents (near in population to Chicago and Rome) and the most socially diverse urban network in Ontario, Canada. This paper also describes some principles that can help inform a performance measurement system. The innovative aspect of this paper is that these principles were developed through feedback by the hospitals.



## 1. Introduction

Changing a system which consists of multiple different subsystems requires planning that coordinates and aligns the different subsystems as well as a measurement system that not only studies the performance of the individual subsystems but also assists with providing feedback to facilitate subsystem changes. This paper describes the initial steps taken to build a performance measurement system to coordinate health equity across 18 hospitals. This coordination was led by the Toronto Central Local Health Integration Network, which is a regional health authority serving a population of more than 2.5 million residents (near in population to Chicago and Rome) and the most socially diverse urban network in Ontario, Canada.

Some of the key questions that this paper addresses include:

- How can a local coordinating body develop a performance measurement system focused on health equities across multiple organizations?
- How are differences in the various organizations (example, the 18 Toronto hospitals) taken into account in the performance measurement system?

This paper describes some principles that can help inform a performance measurement system. The innovative aspect of this paper is that these principles were developed through feedback by the key stakeholders in the hospitals themselves.

There's a rich and growing literature on building performance measurement systems for health equities (Berger & Branowicki, 2009; Bierman & Clark, 2007; Campbell, Roland, & Buetow, 2000; Kruk & Freedman, 2008; Krzyzanowska et al., 2011; Magistretti, Stewart, & Brown, 2002). While there is a growing literature, this literature for the most part has not dealt with the challenges of coordinating the various parts of the system, the heterogeneous nature of such sub-systems, or how evaluations and measurement can themselves improve performance (Fawcett, Schultz, Watson-Thompson, Fox, & Bremby, 2010; Murray, 1995). This paper raises questions on why performance measurement of health equity initiatives matters. We explore the mechanisms by which performance measurement in itself can impact health equities.

In 2007 the Toronto Central Local Health Integration Network (TC LHIN) began developing a comprehensive strategy and series of initiatives to address health inequities in Toronto. One of the first initiatives was requiring each of the hospitals to develop hospital equity plans. Why start with hospitals? "Hospitals are by far the largest providers of acute healthcare services. It is therefore crucial to ensure that the way in which their services are provided supports overall goals of reducing health disparities and ensuring appropriate high-quality care for even the most disadvantaged and challenging" (Gardner, 2008).

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The TC LHIN strategy was guided by Gardner's (2008) definition of health inequities: "Health disparities or inequities are differences in *health outcomes* that are *avoidable*, *unfair* and *systematically* related to social inequality and disadvantage." (Emphasis added). This definition raises a few questions that are relevant to the approach that a coordinating body might need to take to respond to health inequities: How can coordinated action help enhance health outcomes? How does one know what differences in health outcomes are avoidable – and if so, by what kinds of policy, system, and program actions?

The authors of this paper were commissioned by the TC LHIN to analyze the 18 Toronto hospitals' responses to the equity template. The analysis aimed to help the LHIN direct a systematic approach to addressing health inequities. In their plans, the hospitals discussed a wide range of program and planning initiatives addressing health disparities and the needs of health disadvantaged populations. These activities and strategies were analyzed in terms of a number of key common themes; one of the most important of which was identifying the mechanisms by which a TC LHIN-wide performance measurement system could make a difference to health equities.

This paper is organized as follows: Part 2 describes background for the LHIN; Part 3 discusses how a performance measurement system can help make a difference to health equities based on the literature; Part 4 is an overview of the methods used to analyze the Hospital Health Equity Plans; Part 5 contains the hospital feedback on developing a performance measurement system; Part 6 is a discussion of recommendations for actions to be taken by a coordinating body; Part 7 is our conclusion.

## 2. Background and context

In 2006 the provincial government of Ontario changed the way that their health care system is managed by creating 14 Local Health Integration Networks (LHINs) delineated by geographical areas to coordinate the "collection of services that were often uncoordinated to a true health care system." (Ontario Ministry of Health and Long-Term Care website, 2011) The LHINs would have responsibility for the Health Service Providers within their geographic region. Table 1 below lists the different types and numbers of Health Service Programs that the Toronto Central LHIN oversaw in 2008.

As the most socially diverse urban network, the Toronto Central LHIN determined that Health Equity was a priority area. The City of Toronto is home to 2.5 million people (5.5 million in the Greater Toronto Area) and is one of the most multicultural cities in the world with over 30 percent of Toronto residents speaking languages other than English or French (the official languages of Canada) at home. Here is a snapshot provided by the TC LHIN of its context and diverse population:

> *Income disparity* Our LHIN is a study in contrasts with some of Ontario's lowest income neighborhoods and many of Ontario's high income, high education neighborhoods.
> *First home for recent immigrants and refugees* Residents come from over 200 countries and speak over 160 languages and dialects.
> *Socio-economic need* that includes high rates of lone parent families, low income populations, people with low English language fluency, people with HIV/AIDS, youth unemployment and seniors living alone.
> *High concentration of people who are homeless* including: psychiatric consumer survivors and people with serious mental illness.
> *Daily inflow of commuters*—500,000 people travel in and out of the Toronto Central LHIN every day.

**Table 1**
Health service providers and programs within the Toronto Central Local Health Integration Network (LHIN).

| Health service programs within the Toronto central LHIN mandate 2008/2009 | |
|---|---|
| Community Care Access Centres | 1 |
| Community health centres | 18 |
| Public hospitals | 18 |
| Long term care homes | 38 |
| Community mental health & addictions | 94 |
| Community support services: Assisted living in supportive housing | 98 |
| Total number of funded programs | 259 |
| Distinct health service providers | 196* |

*Some agencies provide multiple programs or have programs in more than one sector

(Toronto Central Local Health Integration Network, 2007)

Two principles underlay the overall equity strategy of the LHIN. The first principle was to use existing institutional levers and mechanisms to build equity into service planning and delivery. Some hospitals already had equity-focused planning experience, many had equity or diversity staff or departments, all had significant planning capacities, and many hospital-based equity initiatives were underway. Therefore, hospitals were a good place to first implement the decision to require equity plans as one means of driving change within provider institutions.

A second principle in the LHINs' equity strategy was to build on existing networks and partnerships. The Hospitals Collaborative on Marginalized Populations had been established several years earlier with an explicit equity mandate. The Collaborative was seen to be the ideal forum to support a coordinated system-wide approach to developing the plans informed by stakeholder feedback. The Collaborative worked with the LHIN to develop the common template that all hospitals would use to develop and report their equity plans. The template was designed to yield what each of the hospitals was doing to address the problem of health inequities, with questions on: access, service gaps and challenges, priority setting and planning, promising practices, policies, procedures and standards, governance, targets and measurement, communications, and potential roles for the Toronto Central LHIN.

The mix of the 18 hospitals consisted of: 7 acute (provides shorter term medical care especially for serious acute disease or trauma); 2 community (similar to acute hospitals in providing general acute care but usually smaller and serving the immediate community); 2 sub-acute (provides longer term care, patients are usually transferred directly from acute care hospitals); 5 complex continuing care (provides longer term care for chronic and complex conditions); and 2 rehab (provides rehabilitative care for disabilities, recovery after injury or illness). Of these hospitals, many are academic teaching hospitals and several are specialty hospitals – specializing in, for example, pediatrics, women's health, mental health and addictions.

## 3. How can a performance measurement system developed by a coordinating body make a difference to health equity?

Changing a massive system such as healthcare to address the many factors, including social factors, that affect equitable health outcomes is a complex challenge (Gardner, 2008). Different types of complexities abound in ensuring a systematic response to equities: ensure individual different needs are being met by the system, ensure coordination between the various health care providers, ensure that the system does not disadvantage some individuals systematically, ensure equity in health outcomes across different population groups.