PREAMBLE

The St. Michael’s approach to equity, diversity and inclusion has always been one of integration, continuously changing the culture of the organization. Following are examples of equity-specific projects as well as other initiatives that demonstrate how principles of health equity are being incorporated into daily operations.

This document was submitted to the Toronto Central Local Health Integration Network (LHIN) in September 2010 and serves as a refresh of the 2009 St. Michael’s Hospital Report also entitled “Quality Healthcare for All.” As a result, these reports should be reviewed in tandem.
QUESTIONS AND ANSWERS

1. **One of the key benefits from the first equity plans was extensive and broad discussion within the hospitals. Please report specifically on:**

   **A. How the first report was discussed at Board and/or senior management tables and specific commitments undertaken as a result?**

   The 2009 Report was presented to and approved by the Board of Directors and Senior Management Team. Meetings were coordinated with the Chair of the Board and the President and CEO to review, edit and approve it. It was also presented and endorsed by the Community Advisory Committee of the Board (CAC).

**Specific commitments as result of the 2009 report include:**

1. Equity has been expressly incorporated into our Corporate Quality Improvement model adapted from the US Institute of Medicine (2001). Using the acronym, **SOAPEE**, quality at St. Michael’s comprises 6 dimensions: Safety, Outcomes, Access, Patient experience, Equity, and Efficiency. The quality innovation agenda is being championed by the President and CEO. Although “Equity” is specifically identified within the model, equity principles are being incorporated into all Quality dimensions. Equity Indicators are being developed and incorporated into the Quality Balanced Scorecard Report to the Senior Management and Board Quality Committee. As such, all programs and services are expected to engage in this Quality Improvement Project.

2. **Internationally Educated Professionals** mentorship project, as highlighted in our current Strategic Plan, has become an essential part of Human Resources and is currently underway as a key recruitment and retention strategy; this initiative was reinforced by the work described in the 2009 report. In addition, paid interns identified through our partnership with Career Bridge (www.careerbridge.ca) are currently placed throughout the hospital.

   **B. if and how the September 2009 Report Analysis of the Hospital Health Equity Plans by Sridharan et al was discussed within the hospital, what conclusions were drawn?**

   This Sridharan Report was developed by the Centre for Research on Inner City Health, a key research unit within St. Michael’s. Dr. Sridharan presented his findings to the entire SMH Management Group and a President’s Advisory Council Meeting, thereby increasing awareness of our Equity Agenda. In addition, it was reviewed in detail by staff of the Inner City Health Program and the Community Advisory Panels.

   The recommendations regarding equity data collection, coordinating interpretation and translation services, as well as enhancing balanced scorecards were immediately incorporated into the work of various community partnerships that St. Michael’s serves in a leadership capacity, specifically the Hospital Collaborative on Marginalized and Vulnerable Populations and the South East Toronto Organization. In addition, all of the recommendations continue to influence our relationships with our community partners and the Toronto Central LHIN.
### Strategic Planning

As an organization we embark on a strategic planning exercise every 3-4 years. We are currently in the middle of our strategic plan (2009-12). In our current plan, we emphasize the importance of equity through our continued investment in our Inner City Health Program and into services to ensure capacity building for others to develop programs that foster equitable care. For example, strategic direction 6 states: “St. Michael's Hospital will strengthen its commitment as a key system resource in addressing health services needs for marginalized inner city populations by developing a well-defined academic curriculum, in collaboration with our academic partners, that will build system knowledge, expertise and capacity in this area.” We have in fact committed to ensuring that this direction is complete by the end of fiscal 2010-11, as articulated by our corporate objectives for 2010. In addition, Elder Care is a central theme throughout our current Strategic Plan.

A new Family Practice Centre has been established at 80 Bond Street in order to expand access to primary care for our local communities, many of whom are members of diverse, marginalized or vulnerable populations.

A corporate objective in the 2009-12 strategic plan is to establish a new Patient and Family Learning Centre. The Patient and Family Learning Centre will house consumer health information that patients and families can easily access. In addition, staff and volunteers will be available to conduct tailored information searches for patients who need assistance. The Learning Centre collection will be developed according to the results of a needs assessment that is being done to survey SMH patients and their families about their information needs and how they would like to access it. Key to this initiative is a plan to ensure that patients from marginalized inner city populations are able to access health information and understand it. All staff and volunteers in the Centre will have training on equity and knowledge of the barriers to health literacy so that they can serve the population according to their needs.

In July 2010, the Honourable Deb Matthews, Minister of Health and Long-Term Care, recognized St. Michael's Hospital for our exceptional progress in reducing emergency department (ED) wait times. St. Michael's Hospital has gone from having overall wait times that were more than 25 hours to having wait times that are less than 10 hours. Minister Matthews said, “You’re a model for hospitals across the province.” This was due in large part to a strategic effort to partner with long term care facilities, community partners and efforts by staff to continually assess care in a compassionate manner. This is also an example of increased access for equity seeking populations.

### Operational Planning

St. Michael's continues to support its emphasis on Inner City Health and approximately one-third of all patient care activity is related to caring for the disadvantaged. As an organization, this activity continues to be prioritized and balances the hospital’s focus on highly acute and complex tertiary care, such as trauma and critical care.

With regard to the 2009 submission, we continue to support particularly identified programs. Of note, we received significant external recognition for the “My Baby and Me Passport Incentive Program” which was the recipient of an Innovation Award for “meeting community need through integrated care” from Ontario’s Minister of Health and Long Term Care, Deb Matthews.

The St. Michael's Social Work department has organized a very well attended conference in September 2010 on caring for the most vulnerable, entitled, “Passport to Urban Parenting.” In addition, the Inner City Health Program plays an active role on the planning committees for the Healthy Connections and the Ontario Hospital Association conferences on health equity.
Service Delivery

Some recent examples of how equity has been incorporated into Service delivery include:

A. Creation of a new Aboriginal Health Community Advisory Panel (CAP) and Aboriginal Health Strategy. Please see description under Question 4.

B. Both the Patient Education Committee (see response to Question 3) and the Compassionate Care Committee (access for those without OHIP cards) have incorporated equity principles into their planning, deliberations and decision making.

C. Course and workshops are being provided to build staff teaching competencies including being able to identify barriers to patient learning and respond accordingly. Training clinical staff to ensure patient education is accessible and usable to all patients and families includes: the development of active listening skills and teach back technique to determine the needs of patients and their families, knowledge of health literacy and plain language communication, using graphic illustrations, adhering to a grade 6 literacy level for all written materials, vetting materials for usability by patients and families.

D. Cultural Sensitivity Training, Multi-Faith Spiritual Care, cultural and religious Patient Menu’s, and free patient access to Face-to-Face or Telephone Language Interpretation continues to be provided and are always available to all staff in order to better serve their patients.

E. Joint translation project with Sick Kids and the resulting 10 shared documents are being incorporated into patient education. Please see further details under Question 4.

F. The Community Support Worker in the Emergency is self-identified as Aboriginal with significant years of lived experience with homelessness. His role has been to assist patients in the ED who are homeless or under housed to better navigate use of internal services and those of community partners.

G. The plans for the physical environment of the new Patient and Family Learning Centre include consideration of the upcoming recommendations for the built environment standard of the Accessibility for Ontarians with Disabilities Act. These include an ergonomic mouse for people with limited motor abilities, large font keyboard for those with vision impairment, a designated computer for wheelchair access and adequate space for persons in wheelchairs to access the shelves and collection.

H. The Virtual Ward is a demonstration project that integrates community care, primary care and hospital care for high-risk patients of being re-admitted after discharge. Patients are admitted for 2-8 weeks on average and are monitored by a multi-disciplinary team of health professionals. Currently, 60-90 patients participate in this project. It is in direct alignment with many of the MOHLTC priorities including Aging at Home, ED wait times (reducing post-discharge ED visits), reducing ALC days and reduced readmissions. If successful, this will serve as a replicable model for the Toronto Central LHIN and the Province.

I. The Centre for Research on Inner City Health (CRICH) published 121 research studies on health equity issues in 2009, and is currently conducting 59 research projects related to health equity. Their annual report on health equity impact projects is available here http://www.stmichaelshospital.com/crich/

J. Development of a Multimedia Informational Tool for Breast Cancer Patients with Low-Health Literacy. St. Michael’s was recently awarded a small pilot grant from the Canadian Breast Cancer Research Alliance to develop a multimedia information tool for low-health literacy breast cancer patients, which will improve understanding of breast cancer and its treatments and help in managing distress. The tool will be designed to increase patient understanding of breast cancer and its treatments and enhance self-management (i.e. active patient participation in treatment to minimize impact of cancer of physical and psychological distress).

K. Cervical Cancer Screening by Region of Origin among Ontario’s Urban Immigrants. This project will compare the prevalence of appropriate cervical cancer screening among immigrant women from all major geographic regions of the world and native-born women. It will determine the proportion of women who were screened at least once during the three years: 2006, 2007 and 2008. The study population consists of the 2.9 million screening-eligible women living in Ontario's urban centres. Analysis will be adjusted for numerous variables including age, neighbourhood income, and prenatal care during the study period. The ultimate goal of this project is to determine on whom efforts to reduce screening disparities should be focused.
2. **Measurement and monitoring of health equity outcomes are necessary to gauge health equity progress.** What has the hospital done since its 2009 plan to embed equity measurement and monitoring into mechanisms such as its Balanced Scorecard, routine data collection, program quality and service indicators etc.?

A. “**SOAPEE**, or the strategic and operational prioritization of quality improvement**, described in the response to question 1 will include specific equity indicators that the President and CEO will be engaging to identify and reach targets;

B. The **Homeless Balanced Scorecard** has now completed 1.5 years of gathering data and is currently being fine tuned by an internal working group made up of Researchers, Decision Support, Patient Affairs and Inner City Health staff as well as community representatives. Once the tool has been finalized and targets have been identified, this unique monitoring item will be shared with hospitals across the Toronto Central LHIN;

C. The Centre for Research on Inner City Health (CRICH) has completed the recruitment of a **Director of Evaluation**. Dr. Sanjeev Shridharan is an internationally renowned equity researcher and has played a key role in summarizing the recommendations contained in the 18 Hospital Health Equity Reports (2009) for the Toronto Central LHIN.

D. **CRICH produced a user guide for the Hospital Collaborative on Marginalized Populations to measure equity of care in hospitals.** It is available at [www.stmichaelshospital.com/crich/measuring_equity.php](http://www.stmichaelshospital.com/crich/measuring_equity.php)

The Report developed equity indicators based on a review of 362 academic and grey publications and recommends a total of 10 indicators for use in TC LHIN hospitals. It provides information about appropriate data sources, use in other jurisdictions, and implementation. Recommended indicators related to age, ethnicity, income, sexual orientation and gender identity (among others) have already been adopted for pilot use by the St. Michael's Family Practice Electronic Medical Record as well as departments within the Toronto Western Hospital and the Toronto Grace Hospital.

E. Staff of St. Michael’s Hospital has **freely shared our Equity Leadership** including the CRICH Health Equity Indicators Project (2009), along with the collaborative experience of key partnerships including our Community Advisory Panel Model, South East Toronto Organization and the Hospital Collaborative on Vulnerable and Marginalized Populations with others through meetings and conferences locally and internationally. These include the Toronto Central LHIN, Healthy Connections Conference, Ontario Hospital Association in Canada and the World Health Organization’s Health Promoting Hospitals Conference in the United Kingdom.

3. **Tell us more about one initiative directed towards addressing a crucial access barrier or improving services and quality for a particular disadvantaged population that has been especially effective and/or innovative, and that may have wider implications for other hospitals. In other words, look for initiatives that could be particularly useful to pass on to other hospitals – that can ‘travel well’.

According to the Canadian Council of Learning, sixty percent of Canadians have basic to low health literacy skills. This poses a challenge to the healthcare system since patient and family involvement in their care is often critical to successful health outcomes. A particular challenge to Health Care Providers (HCPs) is distilling their specialized health knowledge into quality patient education resources that respond to patients with low health literacy. The “3Ws and an H” tool, developed collaboratively by Patient Education Programs at St. Michael’s Hospital and Princess Margaret Hospital provides a framework through which HCPs can condense their clinical knowledge into specific actionable information for patients and families in plain language. The title of the tool refers to Who (are you writing for?), Why (should they read it?), What (do they have to do?) and How (is it written?). This tool allows developers to look at their audience more closely and address specific needs, including font size, literacy level, plain language, translation, pictures, use of white space, etc., making it a good demonstration of how equity principles can be incorporated into daily operations.
4. **What new equity-focused programs or significant service or organizational changes have been undertaken as a result of challenges or opportunities identified in the 2009 plan?** This could be about issues identified across the hospitals such as language, data and uninsured, or it could be specific to your hospital.

**New Initiatives include:**

A. **The Sick Kids Translation Project** - a joint initiative to translate generic patient education documents into 9 languages that could be used by all 18 Toronto Central LHIN Hospitals. St. Michael's Hospital submitted and shared 5 generic documents through this process and shared the results freely. In addition, a Spiritual Care services document was put forward for translation with the intention to inform patients and their family members who may not speak English that a chaplain is a spiritual care professional and member of their health care team. The document explains the role of spiritual care and how a chaplain may be of assistance in hospital.

B. **The Compassionate Care Committee** is a new cross-Hospital initiative that brings together Clinical, Finance, Admitting, Mission and Values and Inner City Health staff, to discuss how best to provide necessary care to people without OHIP cards while maintaining fiscal responsibility.

C. Mount Sinai Hospital, St. Michael's Hospital/CRICH and the Centre for Addiction and Mental Health (CAMH) have agreed to partner on a **health equity data collection action pilot project** in a response to the Toronto Central LHIN’s health equity initiatives which require data to build equity into all planning and service delivery and to target specific investments and programs to disadvantaged populations and critical access and quality barriers. While hospitals are currently collecting some demographic data, it is often incomplete and inconsistent and can only be used to infer some characteristics of our patient population.

The initial pilot project proposed will provide invaluable information to the province and the Toronto Central LHIN. The overall goal is to develop a model for hospitals to gather patient demographic data resulting in an increased quality of care and patient outcomes.

The objectives of the project are:

1. To determine the key demographic characteristics of the patients we are serving
2. To have better data to measure patient health outcomes and health inequities
3. To develop and pilot an effective data collection methodology to address the issues surrounding personal data collection
4. To evaluate health equity outcomes based on clinical indicators
5. To ensure knowledge exchange of successful piloted methodologies to other institutions in the TCLHIN

Secondary benefits may include opportunities for integration, shared and consistent hospital polices and assisting the provincial priorities of reducing ED wait times and Alternate Level of Care days.

D. **Aboriginal Health Community Advisory Panel (CAP)** - The purpose of the Interim Aboriginal CAP is to increase and continue the dialogue towards a welcoming, respectful and culturally appropriate centre of care for all clients, including members of First Nations, Inuit and Métis communities. Our first meeting was held on June 28, 2010.

This interim CAP consists of Aboriginal community agency representatives and community members, as well as senior and clinical managers, students, volunteers and physicians from a variety of departments across the hospital. Together, CAP members guide the development of a **Aboriginal Health Strategy**, provide recommendations for broader community consultation and identify potential opportunities in the areas of service provision, clinical education and staff recruitment, among others.
E. St. Michael’s Hospital continues to play a leadership role at the **Hospital Collaborative for Vulnerable and Marginalized Populations**. One of the priority areas has become a systematic and integrated response to **serving non-insured clients**. Members have agreed to advocate or otherwise influence public policy to remove the 3-month OHIP waiting period for new or returning Ontario citizens and permanent residents. In cooperation with other Hospitals and our CHC partners, we are also developing a standardized hospital-CHC draft agreement.

F. A recently developed **Chinese Outreach Pilot Program** for Cantonese- and Mandarin-speaking patients and their families is currently being led by an internal group of Chinese professionals from departments across St. Michael’s Hospital. Based on the experience of sister hospitals, specifically Mt. Sinai Hospital and the University Health Network, who maintain similar programs for the Chinese community, the pilot will assist to create a more welcoming atmosphere, ease access to care and act as a measuring platform for patient satisfaction and outcomes. The internal group also plans to recruit interested volunteers from the Chinese community to create linkages to other available diverse resources for our patients. The results will help us better serve all ethnically diverse populations that come to St. Michael’s.

G. St. Michael’s Hospital is partnering with Toronto Public Health to provide a **Dental Clinic for disadvantaged children and youth** in our new Family Practice location at 80 Bond Street. This service is expected to be operational in January 2011.

5. **Please apply the Health Equity Impact Assessment Tool to at least one significant initiative: for example, in a central priority such as ALC, reducing wait times for identified priority services, or addressing an identified access barrier? If you have already applied the tool to an initiative; please describe the outcome.**

**Corporate Patient Flow Performance**, reporting to the Executive Vice-President and Chief Medical Officer, was established in August 2008 as a change management team to catalyze results-based access and flow improvements based on fundamental principles of quality improvement, organizational learning and performance management. Starting off with 6.2 FTEs, it is now a team of 8.2 FTEs and a budget of $1.2M, 40% of which is allocated to corporate initiatives such as organizational capacity building. The team’s mandate translates into five streams of programming intended to reduce wait times for patients accessing our inpatient beds and in so doing, also impact all dimensions of quality as defined earlier. The five streams of programming include:

1. Corporate level activity through a senior clinical and administrative governance structure
   A. Includes corporate policy and guideline development, balanced measurement framework and corporate-wide tools and improvement feedback processes

2. Daily operational monitoring and unit-based facilitation/coaching of developed policies, tools and enablers

3. Local rapid process improvement action groups focused on inter-service and intra-service coordination and process improvements

4. Organizational capacity building such as a Quality Improvement Fellowship in Access and Flow development

5. External partnerships and knowledge translation activities

The Health Equity Impact Assessment Tool was applied to the Corporate Patient Flow (CPFP) Program. The CPFP program aims to implement systemic process improvements through a data-driven approach to ensure that barriers to accessing timely care throughout the hospital are removed. At this level, the CPFP program objectives align most strongly with the concept of equal access to service for the entire community we serve. In this sense, it was initially challenging to apply the Equity Impact tool in a rigid fashion. However, given the multiple levels of activity of the CPFP program, a realization was made that Equity concepts are strongly addressed at the Local Process Improvement Level, in which teams of staff and physicians focus on initiatives that improve potential disparities in care access at clinical program or unit levels. Concrete examples include: translation of patient discharge preparation letter in different languages, investment in care models that aim to improve care to those at high risk of readmissions, and exploring improvement opportunities in better optimizing capacity for our mental health patients.
6. Include an organizational chart to show how equity is embedded within your hospital and how accountability for equity is addressed organizationally. Describe the process undertaken by your organization to complete the plan and how it reflects equity principles.

St. Michael’s has an integrated, intersectional, pro-active and on-going approach to equity fully based in our Mission and Values. Equity principles have become part of everyone’s responsibility within St. Michael’s. However, the President and CEO ensures these are implemented throughout the organization. This is done in cooperation with key staff within Mission and Values, Human Resources, Patient Affairs and Risk Management and the Inner City Health Program among others. For a complete list, please consult page 20 of the 2009 report.

The process for completing was led largely by the Diversity & Special Projects Coordinator, Inner City Health Program. This was done in consultation with Program Directors, Public Relations, Patient Affairs and Risk Management, Corporate Administration and the Patient Flow Initiative. The initial draft was provided to the Senior Management Team, Program Directors and the Community Advisory Committee of the Board that includes the Board Chair, President and CEO, and the Chairs of the Community Advisory Panels, for their input and revisions. This final version was reviewed and signed by the President & CEO and the Chair of the Board in September 2010.
Special thanks to the following key contributors:

Aisha Lofters, Family Physician & Researcher
Anthony Mohamed, Diversity & Special Projects Coordinator
Bill McCormick & the Printing Team
Christina (Tina) Papadakos, Patient Education Specialist
Clarence Yue, Director, Major Gifts, Foundation
Dana Dumouchelle, Medical Media
Dermot Covel, Medical Media
Jim O’Neill, Executive Director, Community and Health Service Partnerships & Director, Inner City Health Program
Joan McLaughlin, Director, Supply Chain & Support Services, Logistics/Support Service
Kelly Murphy, Director, Knowledge Transfer
Marcelo Silles, Medical Media
Melanie Kohn, Director, Corporate Strategic Projects
Miin Alikhan, Director, Corporate Patient Flow Performance
Pat McKernan, Director, Patient Affairs and Risk Management
Sarah Baker, Chief Communications Officer & Director of Public Relations
Susan Blacker, Director, Cancer Services Planning & Performance Administration
Tareq Ali, Manager, Marketing and External Communications
CONTACT AND AUTHORIZATION

Dr. Robert (Bob) Howard,
President and Chief Executive Officer
St. Michael's Hospital
30 Bond Street
Toronto, ON M5B 1W8 Canada
T 416.864.5600
E howardr@smh.ca

Signature: [Signature] Date: September 30th, 2010

Bill Morneau,
Chair, Board of Directors
T 416-383-6451
E bmorneau@morneausobeco.com

Signature: [Signature] Date: September 30th, 2010

Further enquiries regarding equity at St. Michael's should be directed to:

Anthony Mohamed
Diversity & Special Projects, Inner City Health Program
St. Michael's Hospital
30 Bond Street
Toronto, ON M5B 1W8 Canada
T 416.864.5087
E mohameda@smh.ca