

## Health equity in the 2016/17 Quality Improvement Plans:

A snapshot on how Ontario's health care organizations are working to ensure better health for all Ontarians



# About Us

Health Quality Ontario is the provincial advisor on the quality of health care. We are motivated by a single-minded purpose: **Better health for all Ontarians.**

## Who We Are.

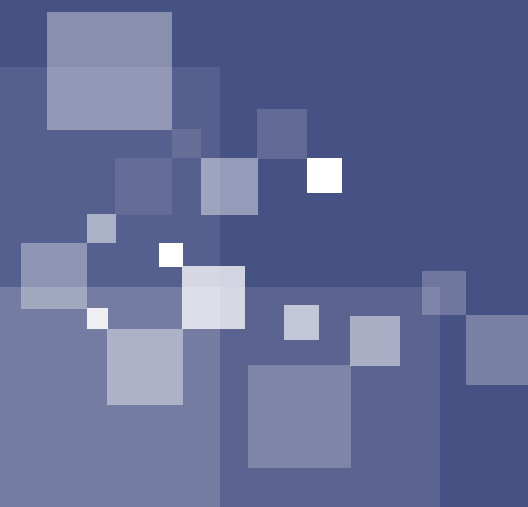
We are a scientifically rigorous group with diverse areas of expertise. We strive for complete objectivity, and look at things from a vantage point that allows us to see the forest and the trees. We work in partnership with health care providers and organizations across the system, and engage with patients themselves, to help initiate substantial and sustainable change to the province's complex health system.

## What We Do.

We define the meaning of quality as it pertains to health care, and provide strategic advice so all the parts of the system can improve. We also analyze virtually all aspects of Ontario's health care. This includes looking at the overall health of Ontarians, how well different areas of the system are working together, and most importantly, patient experience. We then produce comprehensive, objective reports based on data, facts and the voice of patients, caregivers and those who work each day in the health system. As well, we make recommendations on how to improve care using the best evidence. Finally, we support large scale quality improvements by working with our partners to facilitate ways for health care providers to learn from each other and share innovative approaches.

## Why It Matters.

We recognize that, as a system, we have much to be proud of, but also that we often fall short of being the best we can be. Truth be told, there are instances where it's hard to evaluate the quality of the care and times when we don't know what the best care looks like. Last but not least, certain vulnerable segments of the population are not receiving acceptable levels of attention. Our intent is to continuously improve the quality of health care in this province regardless of who you are or where you live. We are driven by the desire to make the system better, and by the inarguable fact that better... has no limit.





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## Introduction

Imagine if all people were able to reach their full health potential and receive high-quality health care that is fair and appropriate to them, no matter where they live, who they are, or what they have.

This describes the ideal state of health equity. In Ontario, we are not yet living in a state of health equity. But this is a goal we strive for as we work to improve the quality of care provided in this province, and we are beginning to make strides to get there.

Health inequity is not simply a consequence of an inequitable health care system. A number of other factors also affect whether people are able to reach their full health potential. These factors are known as the *determinants of health*, and include income and income distribution, food insecurity, housing, Aboriginal status, and gender, among others.<sup>1,2</sup> Although the health care system is just one of many

### What is equity?

**Health equity** is the ideal state in which all people are able to reach their full health potential and receive high-quality care that is fair and appropriate from each person's perspective, no matter where they live, who they are or what they have.

**Health care equity** is the aspect of health equity that focuses on the health system's ability to provide equitable health care services.<sup>7</sup>

factors affecting health, a system that provides equitable, high-quality care can help to mitigate the negative impacts of the other determinants of health.<sup>3,4</sup>



To further our goal of health equity in Ontario, Health Quality Ontario released a [Health Equity Plan](#) in 2016. This Plan embeds health equity into our own work and advises providers, system leaders, and planners to make it prominent in their thinking, discussions, and planning, bringing emphasis to an important dimension of quality as we work together to build a system that is safe, effective, patient-centred, efficient, timely, and equitable.<sup>5,6</sup>

In 2015, to bring an emphasis to equity in quality improvement efforts, Health Quality Ontario asked organizations to describe what they are working on to address health equity in their 2016/17 Quality Improvement Plans (QIPs). The purpose of this snapshot is to summarize and share examples of what organizations are currently doing to improve health equity in Ontario, as reported in their 2016/17 QIPs. We hope that health care organizations will be inspired by these examples, and will incorporate some of the insights shared in this snapshot into their own practice.

## Health Equity in the 2016/17 QIPs

The data used in this report were generated from the 2016/17 QIPs submitted by more than 1,000 health care organizations in Ontario. The QIPs are an opportunity for organizations to commit to a set of quality improvement objectives, formalize their improvement activities, and describe precisely how they will achieve these goals. Currently, organizations from four sectors of the health care system (hospitals, interprofessional team-based primary care organizations, community care access centres, and long-term care homes) are required to submit a QIP to Health Quality Ontario annually.

2016/17 marked the first year that a section relating to health equity was added to the QIP template. We did not provide specific guidance regarding recommended indicators or approaches; instead, we encouraged organizations to share what they are currently doing so that we could learn from this to inform how equity might be integrated into the QIPs in the future.

## Key observations

There is variation among organizations regarding the type of work they are doing related to equity. This variation is expected, because of the unique factors that affect every organization and the population that they serve.

Organizations are also at different stages with regard to their work on equity. Some organizations are collecting and analyzing data to identify groups of patients with poor outcomes relative to the rest of their population, and some organizations have already identified populations and are designing and testing initiatives that address their specific needs.

The responses we received fell into three broad categories:

- Organizations that included custom indicators related to health equity;
- Organizations that included comments describing their current or planned work related to health equity; and
- Organizations that included comments indicating that they were in the early stages of addressing equity or were not prepared to share their work on equity in their QIP.

In this snapshot, we focus on the first two categories of responses. By sharing the indicators and activities/change ideas that organizations are currently using to address health equity, we hope to facilitate the spread of such ideas across the province, supporting our goal of better health for every Ontarian.

# Custom indicators related to health equity



Indicators (or measures) are used in quality improvement science to enable identification of opportunities for improvement and track progress to improvement targets. Indicators need to be relevant, reliable, and valid. In the Workplan section of the QIP, organizations are asked to complete a Measures section for each indicator, including a description of the indicator, the unit/population, data source, current performance, and target performance.

Although Health Quality Ontario did not provide a definition of an indicator related to health equity for the 2016/17 QIPs, some organizations included custom indicators related to their own efforts to address health equity. There was considerable variation among organizations in their interpretation of what constitutes an indicator related to health equity. Twenty-two organizations submitted health equity indicators, defined as indicators for which all components of the indicator measures template in the QIP Workplan were completed, which described specific, measurable concepts and were relevant to equity. One of these organizations (a primary care organization)

## Methodology

The data in this report are derived from the 2016/17 QIPs. A team of quality improvement specialists at Health Quality Ontario used a mixed-methods approach to analyze all of the submitted QIPs for content related to equity in the Workplan section only. The Workplan section is where organizations describe their planned quality improvement initiatives for the coming year.

First, the number of organizations that did not choose to include an indicator or a comment were counted and removed from further analysis. Then, the number of organizations that stated that they were working on equity in each sector were counted. A manual (case-by-case) thematic analysis was conducted to count the number of organizations that included indicators that measured aspects of equity. We included indicators for which all components of the indicator measures template in the QIP Workplan were completed, which described specific, measurable concepts and were relevant to equity.

An inductive qualitative analysis was conducted to organize and sort the data according to themes. The examples showcased in this report were selected in a way that reflected a wide range of initiatives across the province and within each of the four sectors.

submitted two health equity indicators. Of these indicators, 19 were submitted by primary care organizations, 2 were submitted by hospitals, and 2 were submitted by long-term care homes. Even within these 23 indicators, organizations did not consistently describe how the population of interest was identified, and sometimes included fairly general concepts when creating custom indicators. However, organizations did describe many improvement strategies and change ideas related to these indicators.

These indicators and associated improvement strategies typically related to measuring and improving population health outcomes, ensuring equitable access to services and programs, and ensuring people are served in their preferred language. Many were also related to creating the structures needed to provide equitable care. Most of the indicators were process measures as opposed to outcome measures. Five examples are presented in Table 1.

Table 1. Examples of indicators reported under the Equitable dimension in the 2016/17 QIPs.

Organization	Objective	Measure / Indicator	Unit / Population	Source / Period	Current Performance	Target Performance	Target Justification
Queen's Family Health Team (primary care)	Ensure that people with intellectual and developmental disabilities (I/DD) receive an annual physical.	Percent of I/DD group home patients who have an I/DD Health Check within the last 18 months.	Adults with an I/DD who reside in group homes who have not refused an annual health exam	Electronic medical record retrospective chart review April 2015-March 2016	Collecting baseline	90% of patients with an I/DD to have received an I/DD Health Check (i.e., physical examination) within the last 18 months	Most recent evidence shows that 25% of people with I/DD have had an annual physical in the past year.  Data from the health team on people with I/DD who do not live in a group home indicated that 80% received a Health Check in the past 18 months.
Niagara Falls Community Health Centre (primary care)	Equitable cervical screening for eligible clients with low income	Percent of eligible clients with low income that have had cervical screening within past 3 years	% / primary care organization population eligible for screening	Electronic medical record/ chart review / 3 year period per screening guidelines	Collecting baseline	70%	We aim to have the same performance across all levels of income. Our Multi-Sector Service Accountability Agreement is 70% of eligible clients are screened therefore we aim to have this same performance for our clients with low income.

Continued on page 6

Continued from page 5: Table 1. Examples of indicators reported under the Equitable dimension in the 2016/17 QIPs

Organization	Objective	Measure / Indicator	Unit / Population	Source / Period	Current Performance	Target Performance	Target Justification
<b>Parkdale Community Health Centre</b> <i>(primary care)</i>	Improve breast cancer screening for vulnerable populations.	Number of trans inclusive women facing barriers who access screening.	Number of primary care organizations' population eligible for screening	In-house survey / 2016-17	7.00	10.00	Increase current year's outreach.
<b>The O'Neill Centre</b> <i>(long-term care)</i>	To ensure equitable opportunity and enjoyment of recreational programmings	Average % of residents with severe cognitive impairment (CPS=5 or 6) and/or who are confined to their bed/room who receive recreational programming across all 5 domains per Quarter.	% / Residents	Activity Pro, MDS Outcome Summary Report / Sept 1, 2015 - Feb 29, 2016	25.6	38.00	Realistic given residents status. Encourages improvement
<b>Grey Bruce Health Services</b> <i>(hospital)</i>	Reduce re-admissions	Substance abuse emergency department visits readmitted to any Grey Bruce Health Services emergency department within 30 days	Days / Mental health patients	CIHI DAD / October 2014 to September 2015	17.70	15.00	Stretch target



# Change ideas and activities described for the custom indicators related to health equity

For each of the 23 indicators, organizations also described what they plan to do to improve their performance to meet their targets – referred to as their change ideas/activities. The examples below describe the change ideas/activities that organizations described to improve their performance on their indicators related to health equity.

## Collection and analysis of data, particularly surveys

The most commonly reported activities were related to collecting data, particularly demographic data. The collection of data allows organizations to understand who their patients are and what unique needs they may have. Collecting data is an important step; however, ideally organizations will also go further by indicating how they are using it or plan to use it to improve the care that they provide.

Organizations described using different tools to collect data. Some organizations described using surveys to collect demographic data:

All hospitals and community health centres in the Toronto Central LHIN participate in collecting equity data using [a standardized survey tool to collect demographic data](#). Many of these organizations described initiatives related to this practice in



their QIPs. For example, **St Michael's Hospital** aims to increase the percentage of their patients that complete this survey. This effort to collect these data for first day surgery patients, direct-admit patients, and patients at the family health team, ambulatory clinic, and emergency department will result in better information to guide programming. The target is that 90% of patients approached will complete the equity survey. A summary of the opportunities and results of this work will be created by March 2017.

Some organizations used standardized, validated, clinically relevant tools:

**Brighton Quinte West Family Health Team** used the [Patient Health Questionnaire-9](#) (PHQ-9), a widely used instrument for screening, diagnosing, monitoring, and measuring the severity of depression. They want to understand the specific needs of their population of patients with depression in order to plan for equity-based improvements to program delivery.

Other data collection was related to specific areas of focus:

**Tyndall Nursing Home** will incorporate a new survey question into their resident satisfaction survey that will assess whether residents feel they are treated “fairly and equitably”. In addition to survey distribution, residents will also be approached to gather more information. The target is to determine the baseline percent of respondents who respond positively to the question.

The **Four Villages Community Health Centre** will be assessing their cancer screening data using an equity lens. They plan to analyze the data and explore practices to improve screening rates for vulnerable populations, such as patients who may experience barriers travelling to receive care. Once identified, they plan to look at process changes to address any identified barriers (for instance, linking people to subsidized travel).

### Cultural competency training

Many organizations reported that they are working to improve cultural competence among their staff. Some organizations mentioned collaboration with the LHINs to provide this training; other organizations mentioned developing the training themselves or in partnerships with other groups or organizations.

**West Haldimand General Hospital** plans to employ cultural sensitivity/competency training for 100% of the emergency department staff.

**North Bay Nurse Practitioner-Led Clinic** aims to improve patient experience for Indigenous clients by providing cultural competency training to their staff. They are partnering with their local Indigenous Friendship Centre to provide training in local communities' culture and customs, and also encourage their staff to attend the San'yas Indigenous Cultural Competency Training, which is available through the BC Provincial Health Services Authority.

**Weeneebayko Area Health Authority** is developing their own cultural competency training incorporating historical knowledge about people from the James and Hudson Bay region, exploring the current health status of those residing in the region, and coaching on effective ways of communicating with people from the region. Baseline data will be collected to set future targets.

### Key Terms

**Cultural competence** has been defined as “a set of values, behaviours, attitudes, and practices within a system, organization, program or among individuals that enables them to work effectively cross-culturally”.<sup>8</sup>

**Cultural safety** refers to “a doctor-patient encounter in which the patient feels respected and empowered, and that their culture and knowledge has been acknowledged”.<sup>9</sup>

Essentially, “cultural safety refers to the patient’s feelings in the health care encounter, while cultural competence refers to the skills required by a practitioner to ensure that the patient feels safe”.<sup>9,10</sup>

**Pine Meadow Nursing Home** also plans to educate staff regarding cultural competency, focusing on Indigenous cultural competency training.

### Adding an equity lens to program planning

Many organizations are adopting or adapting the Ministry of Health and Long-Term Care’s tool, the [Health Equity Impact Assessment Tool](#). This tool is intended to help organizations identify and address potential unintended health impacts (positive or negative) of a policy, program, or initiative on specific population groups. Use of this tool also incorporates data collection, as this is one of the first steps when using the Health Equity Impact Assessment Tool.

**South Riverdale Community Health Centre** plans to incorporate the sociodemographic information they are collecting into their use of the Health Equity Impact Assessment Tool to investigate populations who may be receiving inequitable care.

**Manitoulin Central Family Health Team** plans to review their current programming using the Health Equity Impact Assessment Tool to identify and reduce inequities in access to these programs.

## Access to care

Access to health care can be affected by a number of barriers. Many organizations focused on these barriers to measure and address issues related to access to care.

**Scarborough Centre for Healthy Communities** is focusing on ensuring that their cancer screening services are reaching all patients who need them. They will be monitoring cancer screening indicators according to age and ethnicity groups to explore whether access to colorectal and cervical cancer screening is impacted by these determinants of health.

**South-East Ottawa Community Health Centre** aims to improve health equity in target populations. Specifically, they are interested in improving health outcomes and management for patients with diabetes who are new immigrants and refugees from Somalia, Nepal, or Syria.

**Brock Community Health Centre** is focusing on improving usage of primary care services among clients 13–19 years of age. They will work with high schools to explore how to better use primary care wellness services, use feedback from students and staff, and provide staff training on youth rights and responsibilities, and youth mental health and sensitivity.

## POVERTY

Several primary care organizations referenced the use of a poverty tool to assess whether this determinant of health is impacting access to care among their patient populations.

**Loyalist Family Health Team** described their use of the Upstream Poverty Screening Tool as a screening tool for their programs. The impetus has been their partnership in the Kingston Health Links initiative in the South East LHIN. Building relationships with community and social services and using the screening data they are collecting will inform service planning and will be a useful tool to refer patients with identified barriers to Health Links and community and social services.

**Taddle Creek Family Health Team** plan to explore data collection related to the determinants of health, including poverty. A key component of their change ideas is working with other family health teams to explore how they are using this data. They also plan to partner with programs such as [Telemedicine Impact Plus](#) to improve access to interprofessional teams for complex patients in the community.

## HOMELESSNESS

The **Inner City Family Health Team** (formerly Seaton House) aims to address the needs of patients with developmental delays who are chronically homeless and have mental health and addictions issues. They aim to connect these people to primary care services. The cohort is a little-known subpopulation of street-involved communities that are high users of emergency services. Sixty men and twenty women from the shelters will be assessed to identify the barriers they experience to participate in their health care. Partner agencies will work together to develop relevant health treatment plans.

## RURAL/NORTHERN COMMUNITIES

Travel and travel wait lists are an issue in rural/northern communities.

The **City of Lakes Family Health Team** aims to increase access to primary care in a particular community around Chelmsford. They plan to open a fourth satellite location in Chelmsford as patients in and around this area have very limited access to health services.



## Comments describing current or planned work related to health equity

A total of 305 organizations included comments related to health equity. The most common theme reported in the comments was language, followed by cultural competency. The next most frequent themes were gender, Aboriginal/Indigenous populations, accessibility, program planning, poverty, rurality, French language services, refugees, and mental health and addictions. Many organizations that did not include a health equity indicator reported that they are collecting data about their patient populations, or are linking available data to patient care and outcomes.

Fifty-six percent (n=171) of the organizations that included comments were long-term care homes. Of these homes, about 60% (n=101) described providing language supports such as translation and attention to health literacy. Some homes also described efforts to collect data regarding their residents' religious, cultural, and ethnic backgrounds to inform care.

Eleven of the 14 CCACs in Ontario included comments describing their work on health equity. These comments most frequently

described providing training related to cultural competency, and providing surveys or services in different languages. The Central West CCAC mentioned a Health Equity Plan in their comment:

**Central West CCAC** has a multi-year Health Equity Plan that incorporates key tools such as the [National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care](#) and the Health Equity Impact Assessment Tool. They plan to determine diversity characteristics and social determinants of health of patient populations accessing their services.

### Language

Comments most commonly described activities aimed at improving equitable care related to language of service and translation (reported by 44% of organizations). Language interpretation services to aid health care patients who are not adept in a country's official language(s) are critical to improve health equity across diverse populations, and achieve clinical safety and quality for both patients and providers.<sup>11-15</sup>



Many long-term care homes included similar comments in which they described addressing equity by offering their Resident and Family Satisfaction survey in multiple languages (up to 15 different languages). Some of these homes were within a larger corporation (e.g., Extendicare), while others were not. This demonstrates that these homes may have worked together in completing their QIPs.

### Cultural competency training

**North York General Hospital** offers a basic four-session workshop for all staff, physicians, and volunteers, and enhanced workshops to engage professional leaders and experts of different communities to share their in-depth knowledge of and experiences with diversity staff, physicians, and volunteers.

An example of the full text of a comments section from **Plantagenet Family Health Team** shows the range of initiatives described in the Comments section:

*“Even though we do not have an equity plan, Plantagenet FHT strives to be equitable to its community. Plantagenet FHT is a rural community where 82% of its patients are francophone and 7.6% can only speak French. All physicians are bilingual, services, programs, documentations are in bilingual format. Patient experience surveys are available in both languages. The Prescott-Russell community has been identified as low income. In order to help, Plantagenet FHT offered OTN service to its patients but also to the local community in order to alleviate loss of income/time efficiency for travelling to the nearest city (63 km). Since our region has one of the highest rates of Diabetes and Cardiovascular disease compared to the Province, Plantagenet FHT has two well established programs to serve its patients. Since 22.5% of the population are daily smokers compared to 15.8% for Ontario, Plantagenet FHT offers STOP with FHT and Ottawa Model Smoking Cessation not only to its patients but to the community as well.”*

## Moving forward

Our introduction of health equity as an element of the QIP process for the 2016/17 QIPs has provided valuable information on what organizations across the province are currently doing to address health equity. In this section, we will summarize what organizations are currently doing and what steps they should consider taking in the future.

Our analysis reveals that organizations are at different stages of developing indicators and reporting their activities to provide equitable health care to Ontarians. A small number of organizations submitted true indicators related to equity, while more organizations submitted free-text comments describing their efforts to address health equity (without including a measurement plan).

### Want more information?

To read more examples from the 2016/17 QIPs, use our search tool, Query QIPs, to perform a text query for ‘equity’ in the workplans of QIPs submitted in 2016/17.

Some of the comments featured in this report that are not associated with an indicator are not publicly visible on QIP Navigator. If you would like more information on these comments, please contact [QIP@hqontario.ca](mailto:QIP@hqontario.ca).

Read our Health Equity Plan to find out how we plan to bring health equity to the forefront and inspire action in the Ontario health care system.



## Collecting demographic data and identifying opportunities for improvement

Collecting demographic data is essential in order to understand the barriers faced by the patient population, identify existing gaps, and develop improvement strategies and goals for the delivery of equitable health care. Collecting baseline data is a good place for organizations to start as they begin to address health equity. Organizations should collect these data with an eye to how they will use it to identify groups with poor outcomes and plan initiatives to improve their care. Consider using business intelligence tools to mine demographic data, clinical outcomes, and process data to identify opportunities for improvement that target groups of patients with the poorest health outcomes. When setting goals for improvement, the performance of the group of patients with the best health outcomes should inform goals for improving care for populations with poorer outcomes.

## Designing approaches to address health equity

Addressing health equity can seem overwhelming, considering how many factors are interacting to lead to the current state of inequity. When designing approaches to address health equity, it is reasonable to start small and focus on addressing the issues most heavily affecting your patient population. Organizations across the province will likely end up developing different approaches to addressing health equity because their populations may be facing very different barriers to optimal health. Because of the wide variation in populations and the barriers that they face, there is no ‘one size fits all’ indicator to address health equity, and it will likely be necessary to develop custom indicators to track your organization’s progress on the initiative(s) you have designed.

## Working together to make progress

Consider how you can work with leaders, providers, stakeholders, and patients to break down barriers such that all of the population receives great care and optimal outcomes. Partnerships across organizations

are also important to providing equitable health care. By working together, organizations can collaborate on developing programs, share tools and resources, learn, and easily spread any successful initiatives they have developed within their own organization. Health Quality Ontario will also continue to bring focus to equity and, where possible, ensure that promising practices are shared.

## Conclusion

The variety of examples and topics presented in this snapshot reflect the diversity of approaches and areas of work that can help tackle inequities. We acknowledge that organizations have, and will develop, different trajectories in their work on equity. And yet, we encourage all organizations, at whatever stage they are, to make an additional effort and take the challenge to plan and think about how to move their work on equity forward. For example: once an organization identifies a sub-population that has difficulties accessing services, it sounds reasonable to take a step further and explore the options to take a proactive action (design an intervention) that will help this group to overcome the existing barriers. For other organizations, the concept of “equity” may be diffuse or confusing. For them, the challenge becomes to build and consolidate a stronger “equity culture” among their staff and health care providers that, in the future, will lead them to undertake the necessary practices and projects to provide more equitable services to their clients.

At Health Quality Ontario, we aim to support organizations as they incorporate an equity lens into their efforts to improve the care that they provide, and plan to adjust our guidance moving forward to identify ways to address equity through measurement in the QIPs. The data included in this snapshot illustrate how health care organizations are working to ensure all of their patients receive high-quality care, no matter where they live, who they are or what they have.

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## Acknowledgments

This report was developed by a team of staff at Health Quality Ontario, who wrote, reviewed, or approved versions of the report: Andrea Bracaglia, Felicia Dong, Laurie Dunn, Lee Fairclough, Jorge Ginieniewicz, Emily Hayes, Sudha Kutty, Martin Lees, Danyal Martin, Margaret Millward, Gouthami Munukuntla, Maria Papadimitriou, Bhavana Patel, Teresa Petch, Shusmita Rahman, and Jeffrey Turnbull.

This report could not have been produced without the help of Health Quality Ontario's partners: the Association of Family Health Teams of Ontario, the Association of Ontario Health Centres, the Ontario Association of Community Care Access Centres, the Ontario Hospital Association, the Ontario Long-Term Care Association, the Ontario Association of Non-Profit Homes & Services for Seniors, the Ministry of Health and Long-Term Care, and Health Quality Ontario's Cross-Sector QIP Advisory Committee. The members of the QIP Advisory Group are Lee Fairclough, Dr. Richard McLean, Dr. G. Ross Baker, Dr. Cathy Faulds, Kelly Gillis, Sonja Glass, Joanne Iacono, Nicole Lafreniere-Davis, Susan Leach, Peter McKenna, Daile Moffat, Jillian Paul, Fredrika Scarth, and Anne Wojtak.

We would also like to acknowledge the more than 1000 organizations across Ontario that submitted QIPs in 2016/17. Thank you for sharing your efforts to improve the quality of care that you provide.

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© Queen's Printer for Ontario, 2017

ISBN 978-1-4606-9470-1 (Print)  
ISSN 2369-9116 (Print)  
ISBN 978-1-4606-9471-8 (PDF)  
ISSN 2369-9124 (Online)

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