RISE
Rapid-Improvement Support and Exchange

RISE population-health management webinar:

Applying an equity lens when caring for your population

June 17, 2021

Hosts

Mike Hindmarsh,
RISE PHM Coach

Dr. Rob Reid,
RISE Co-Lead

Presenters

Cynthia Damba,
Ontario Health, Health Analytics Manager

Sophia Ikura,
Health Commons Solutions Lab, Executive Director

Zawar Patel,
Health Commons Solutions Lab, Senior Lead

Betty-Lou Kristy,
Minister's Patient and Family Advisory Council (PFAC), Chair

This session helps support OHTs in achieving the following OHT TPA milestones:

- Re-designing care for patients in your priority population(s)
- Helping every patient in your priority population(s) to experience coordinated transitions between providers

RISE
Rapid-Improvement Support and Exchange

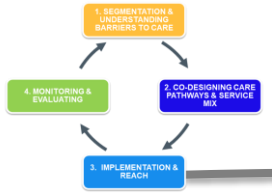
Land acknowledgement

“As we meet here today, we are in solidarity with Indigenous Peoples of Turtle Island and would like to begin by acknowledging that the land on which we gather is part of the Treaty Lands and Territory of the Mississaugas of the Credit, and before, the traditional territory of the Haudenosaunee, Huron and Wendat. We also acknowledge the many First Nations, Inuit, Métis and other global Indigenous Peoples who now call this area their home. We are grateful for the opportunity to be working on this land”.

RISE
Rapid-Improvement Support and Exchange

Today's journey

Learn about the importance of applying an **equity lens to your PHM work**



Ontario Health Toronto

Through examples learn approaches to **understand inequities in care** for your populations using data

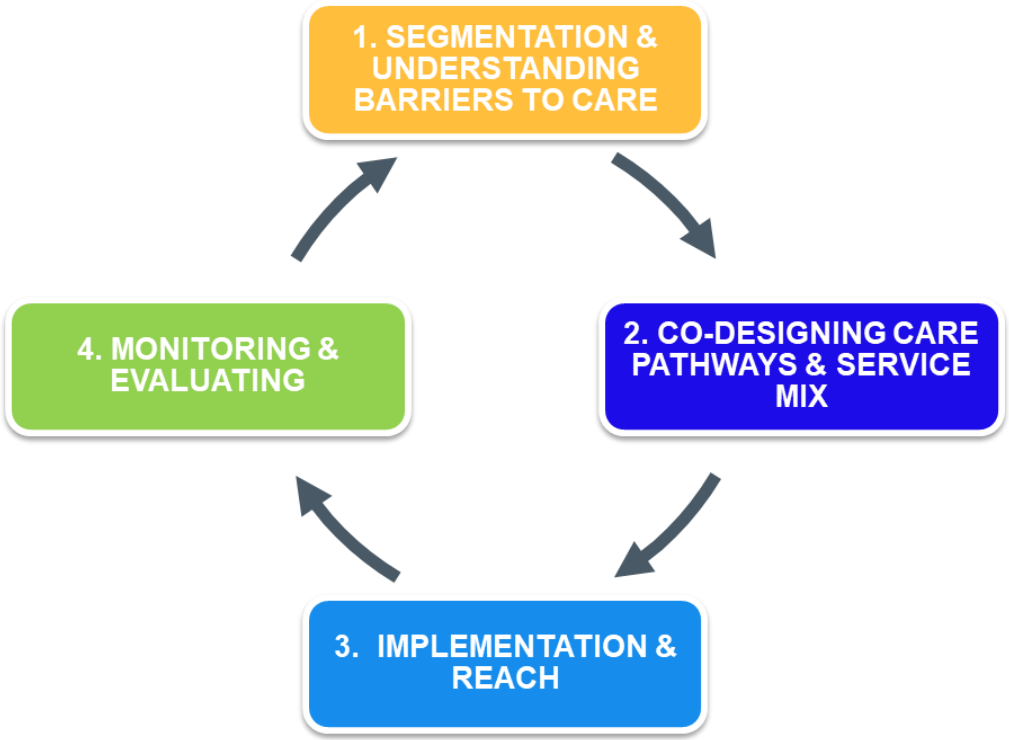
HEALTH COMMONS SOLUTIONS LAB

Understand how to **leverage community resources** to map your resources and learn more about marginalized communities

Ontario

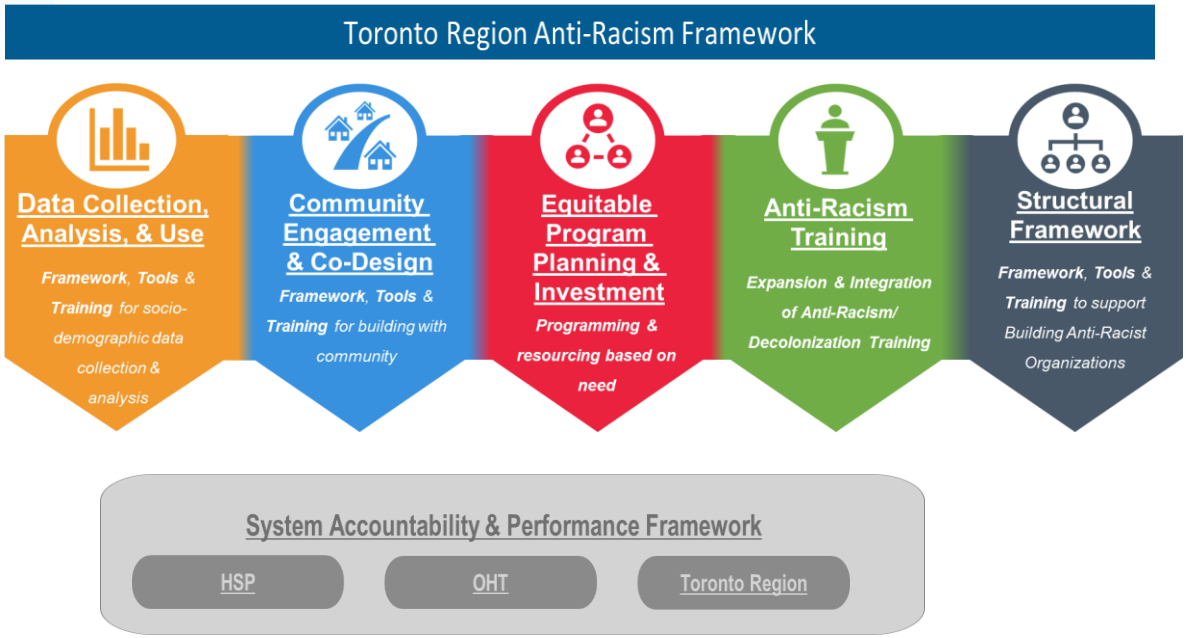
Understand the importance of **patient engagement across the equity spectrum**

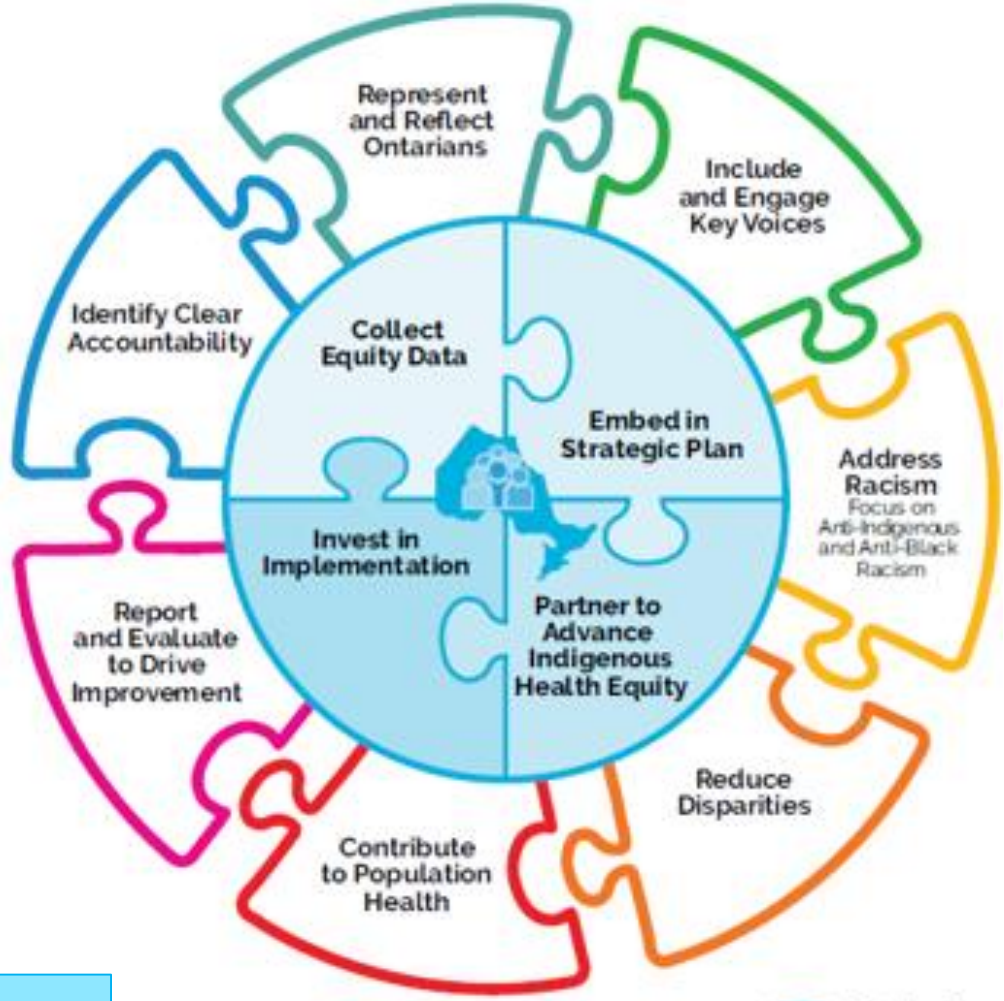
An equity lens needs to be applied to each step of population-health management



Source: Adapted from Population Health Alliance, 2012

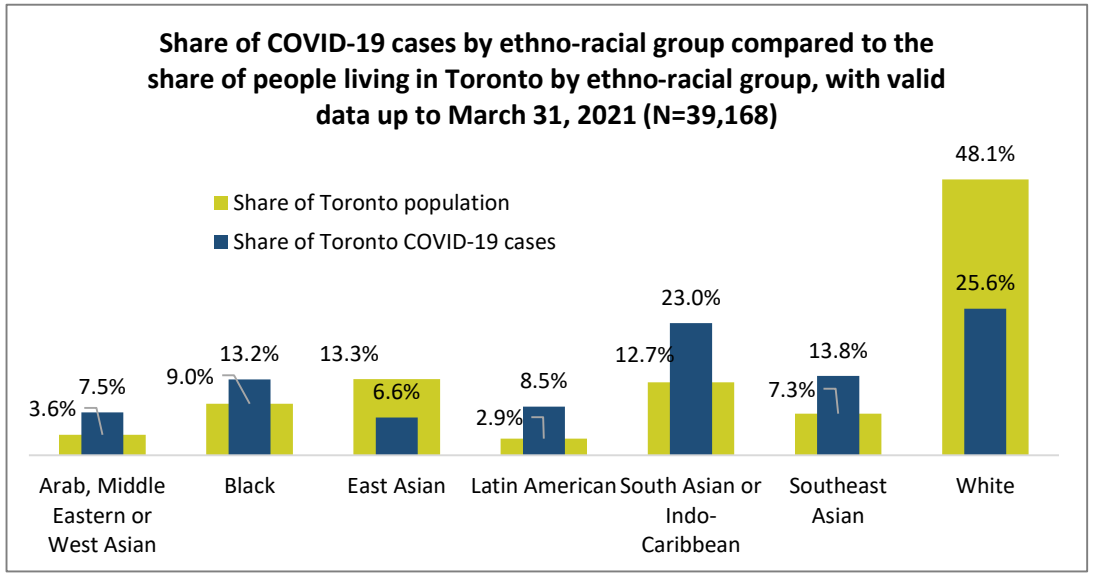
Health Equity is a Priority for Ontario Health

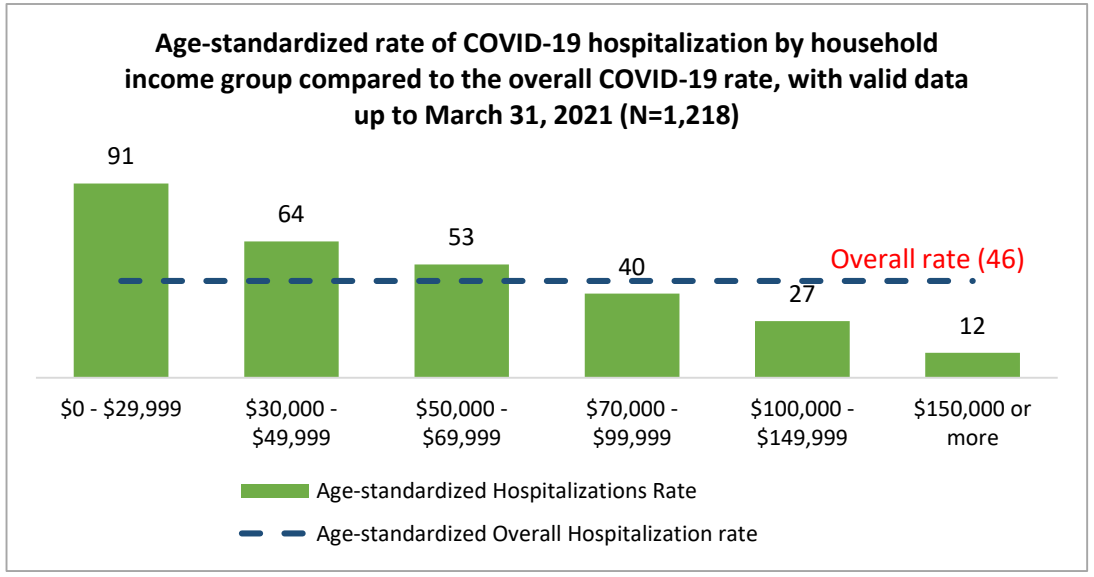




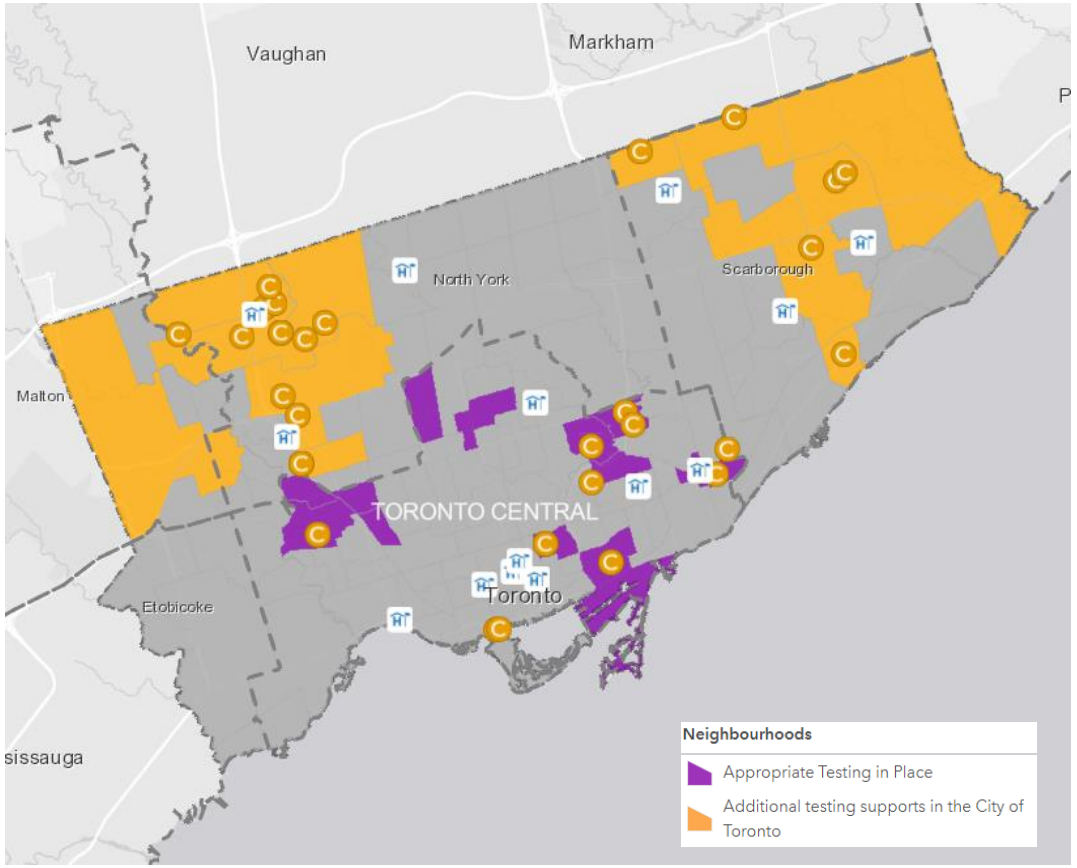
Black Health Plan

COVID-19 has Highlighted the Importance of Equity and Socio-demographic data





Regional Targeted Neighbourhood COVID-19 Testing in Toronto



Source: https://www.toronto.ca/home/covid-19/covid-19-latest-city-of-toronto-news/covid-19-pandemic-data/covid-19-ethno-racial-group-income-infection-data/

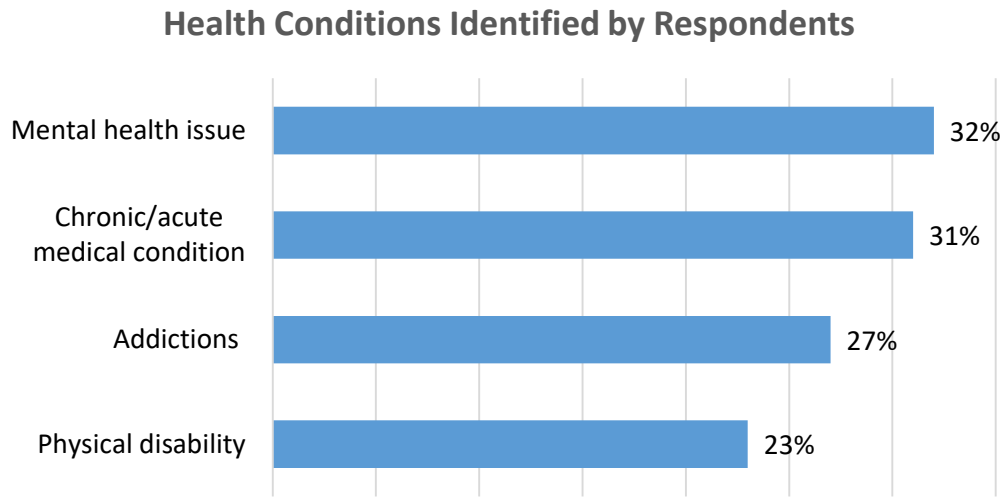
Health Disparities for Homeless Population in Toronto

Who is affected?
~ 8,715 estimated homeless population

- Due to **migration, inability to pay for housing and eviction**
- **94%** of people were staying in **indoor sites**
- **40%** of those staying in city-administered shelters were **refugee/asylum claimants**
- Overrepresented groups included: **Indigenous** (38% of the outdoor population); **Racialized groups, particularly Blacks; LGBTQ**, especially **youth**; **veterans**
- **Youth** and **seniors** contributed 10% each

Access and health issues

- **>50**% of people reported **at least one type of health condition**
- **38%** visited a**n emergency room**
- **27%** have been **hospitalized**
- Challenges accessing health care



Source: *City of Toronto, 2018; Street Needs Assessment Report:* https://www.toronto.ca/wp-content/uploads/2018/11/99be-2018-SNA-Results-Report.pdf

Types of Socio-demographic (Equity) Data and Sources

Primary sources

- **Localized institution/agency** collection (e.g. Toronto Region Hospital and CHC data collection; DATIS)
- **Specific marginalized populations** like Indigenous population, those experiencing homelessness, living in subsidized housing

Secondary sources

- **Population Surveys** (e.g. CCHS, OPOC, Hospital Patient Experience Surveys)
- **Census:** individual characteristics (e.g. income, visible minority), Ontario Marginalization Index
- **Administrative data sources** (e.g. Immigration (CIC-IRCC Permanent Residents database)

Equity data analysis lens

- **Person level:** stratifying indicators by SES characteristics, Linkage to administrative data sources
- **Geographic/Area-level:** analysis using socio-demographic information aggregated by geographic areas such as neighbourhoods or FSAs
- **Intersectionality:** examining multiple sociodemographic characteristics to understand impact of multiple and overlapping identities that individuals have (e.g. race and age group; income and gender; homeless, sexual orientation & age)

Equity Data Collection in Toronto Region Hospitals and CHCs, 2019/20

http://torontohealthequity.ca/

8 Standardized Questions:

1) Preferred language (speaking); 2) Immigration; 3) Race-ethnicity; 4) Chronic conditions/disability; 5) Gender; 6) Sexual orientation; 7) Household Income; 8) # of people supported by Income

4 Optional Questions:

1) Preferred language (reading); 2) Religious Affiliation; 3) Type of Housing

	15 Hospitals	16 Community Health Centres (CHCs)
Areas of data collection	Emergency departments, inpatient units (acute, rehab, complex care, mental health, palliative), specialized units, Family Health Teams, outpatient clinics, operating rooms, medical imaging	At Registration New and active clients, group clients
Total Participants	**~350,000**	**54,427**
Participation rates: Range across organizations	**25% (4% to 100%)**	**77% (53% to 92%)**

Will be enhanced through the Toronto Anti-Racism Strategy Implementation Phase by Early Adopters

Uses of Equity Data

Measuring Health Equity allows us to improve patient care at several levels of health service delivery and planning:

1. **Informing clinical care delivery**– allows providers to quickly flag patient characteristics that may impact care delivery and planning
   - ✓ Language/interpretation; cultural sensitivity; income supports
2. **Quality Improvement**– to flag emerging needs or populations that may require additional or customized support in their care delivery
   - ✓ Analyze/profile who is being served
   - ✓ Stratify key indicators
   - ✓ Build into Quality Improvement Plans (QIPs)
3. **Care model planning and design**– to illuminate gaps in service specific to certain population segments, local regions or smaller areas (which may not be a challenge across the broader population), or link patient population characteristics to utilization in new ways, and measure disparities in service outcomes across different groups
4. **Evaluation/Research**
   - ✓ Confirm whether interventions are reducing disparities
   - ✓ Accountability

Engagement, Governance, Access, and Protection (EGAP) Framework

- Data Governance Framework for Race-based Health Data Collected from Black Communities
  - **Engagement**— Genuine, cyclical, accessible consultation with communities regarding data collection management, analysis, and use.
  - **Governance**— Community decision-making about engagement processes and data collection, analysis, use, and management, achieved through the establishment of a Community Governance Table
  - **Access**— The right of communities to access their collective data and to determine who else can access it
  - **Protection**—The safeguarding of all individual rights and types of data, including identifiable, de-identified, and anonymized data.

Source: https://blackhealthequity.ca/wp-content/uploads/2021/03/Report_EGAP_framework.pdf

HEALTH COMMONS SOLUTIONS LAB

ASSET MAPPING – EQUITY IN PRACTICE

HEALTH COMMONS SOLUTIONS LAB

Founded in 2017 with core support from the Toronto Central LHIN, the Ministry Of Health, Sinai Health, and the University of Toronto

Mission
Create workable solutions to complex health challenges

Vision
All people living with dignity and health

More information
Visit our website for more details on what we do and to access free to use resources and tools

If you have specific questions please contact us

HOW WE WORK

- Values-based, health equity perspective committed to enabling **cost-effective healthcare**
- **Strong ground game**, based on a deep commitment to understanding end-users
- Scalable, transparent, **non-proprietary** solutions
- Trusted, neutral partner; **bridging and brokering** between institutions
- **Plugged-in** to research, data and technology partners (e.g. ICES, WHIV, Dalla Lana)
- **Flexible delivery model,** drawing on in-house and external subject-matter-experts
- Diverse and experienced team that spans **epidemiology, health policy** and **service design**

USING DATA AND LIVED EXPERIENCE TO IMPROVE SERVICE PLANNING AND DESIGN

Equity data

+

People's lived experience

=

Deeper understanding of population needs

=

Insights to plan and design equitable care

ASSET MAPPING & POPULATION HEALTH PLANNING

Different Approaches to Asset Mapping

System - oriented → *Human -centred*

INVENTORY	DIRECTORY	NAVIGATION	USER RESEARCH	ENGAGEMENT
Collect information about assets like location and service volume (usually done to inform system planning).	Collect and share information about assets in a way that tells you where to go and what you will receive there.	Map connections between assets to better understand the patient/client/ caregiver journey.	Develop a deeper understanding of your patients/clients/ providers by mapping assets from their perspective.	Bring together patients/clients/ providers to co-design an asset map where the process for getting there is as important as the product (output).

Undertake asset mapping to develop greater insight into priority populations

Use outputs of asset mapping to improve service planning and design

BRINGING CLIENTS AND PROVIDERS TOGETHER

Case Study Of Asset Mapping As Engagement

What we did

Facilitated engagement with 19 youth and 28 providers to identify, collect information about, and **visualize assets** in East Toronto that foster mental health and wellness.

What we learned

- Providers loved the chance to hear from youth about where they go to feel well in the community. Youth appreciated the chance to share their expertise!
- Youth operate in a 'hyper local' manner. They want to be able to see what's near them and are looking for things near school, work or home.

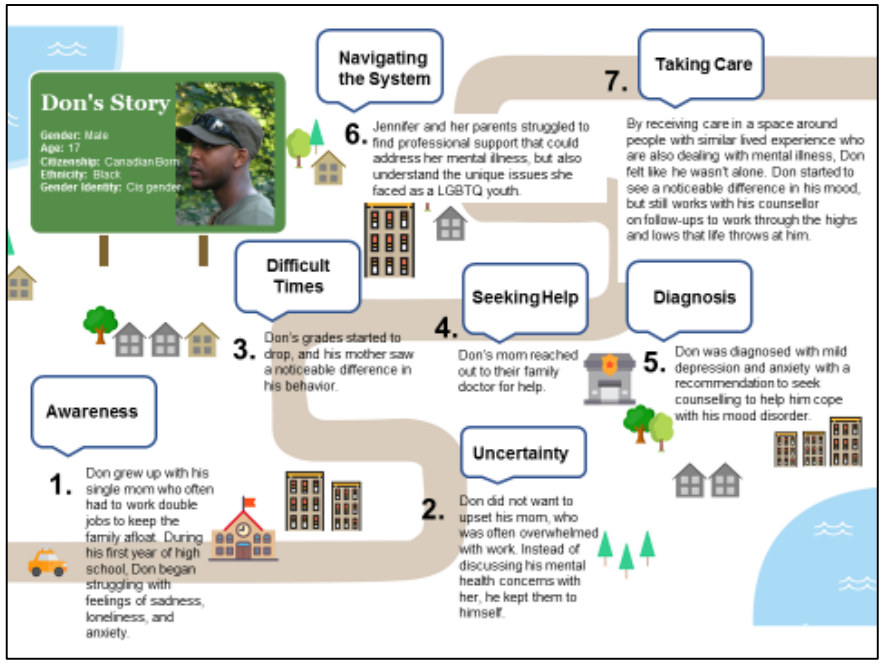
"I liked having our voices heard and getting an opinion on something meaningful."

— Youth participant

BRINGING CLIENTS AND PROVIDERS TOGETHER

Youth Wellness *Journey Canvas* To Map System Navigation

We developed this tool to ground discussions in the diverse experiences of youth as they navigate through the health and social service system. The journeys highlighted the varying levels of ease and success youth experienced while navigating.



What assets exist in the community to support Don at different points in his story?

BRINGING CLIENTS AND PROVIDERS TOGETHER

Final Product - Annotated Map

Woodgreen- Youth @ Wor...

Name
Woodgreen- Youth @ Work Queen St

Address
1080 Queen St E, Toronto, ON M4M 3M4

Website
woodgreen.org

Phone
416-645-6000 Ext. 2133

Social Media
Facebook, Twitter, Instagram, LinkedIn

Description
WoodGreen Community Services supports young people who are searching for a job.

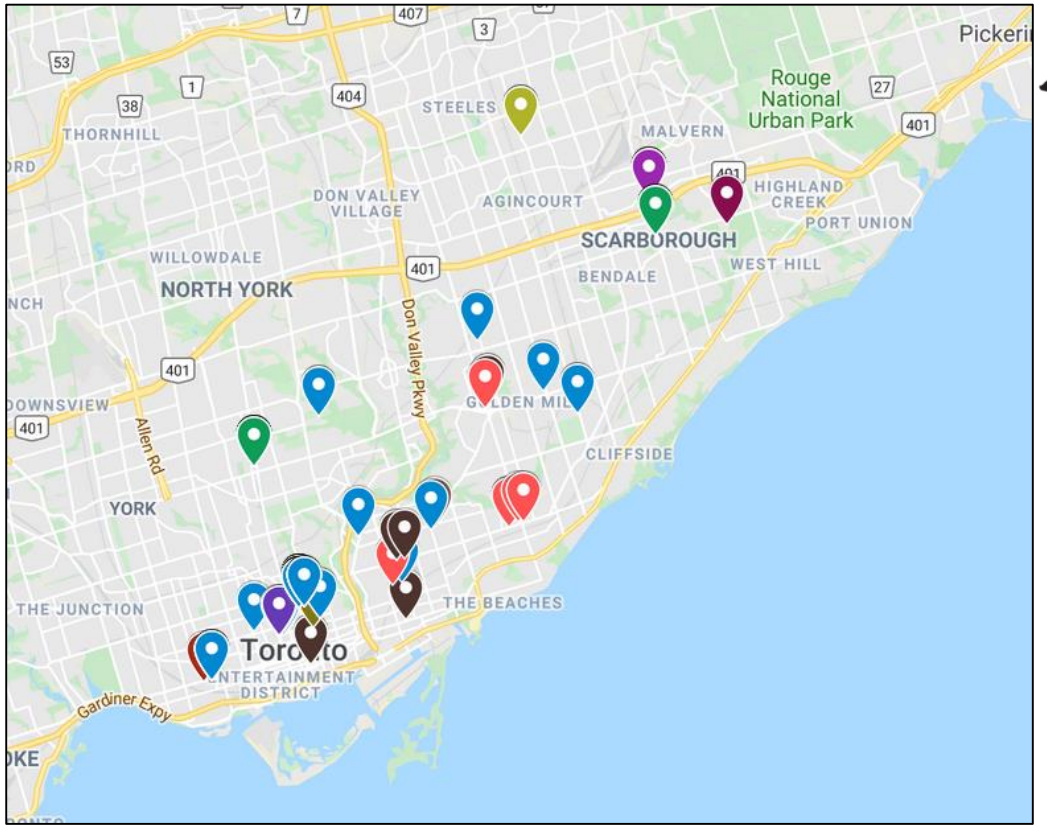
Type of Service
Vocational/Employment

Service Target
None

Referral Needed
No

We asked youth – what would you want to know about this asset before accessing it?

Data collected was visualized to help the OHT sift through what is out there (and what the gaps are).



BRINGING CLIENTS AND PROVIDERS TOGETHER

Identifying Features Of Services That People Value

TOOL

Community Resource Attributes

HEALTH COMMONS SOLUTIONS LAB

Tell us what you want to know about our service. Rank the most information from 1 to 5.
Pick from our list or add your own!

FEATURES

- Hours
- Location(s)
- Social Media
- WiFi availability
- Diversity of staff
- Flexible hours
- Description of what to expect
- Permanent Residency Card or Health Card requirements
- Catchment area
- Reviews of other clients
- TTC tokens provided
- Age range of typical client
- Privacy + confidentiality
- Cost
- Waitlist
- Appointment required or drop-in
- Peer mentoring availability
- Opportunities for volunteering

Here are some of the features I care about the most...

1. _____
2. _____
3. _____
4. _____
5. _____

BRINGING CLIENTS AND PROVIDERS TOGETHER

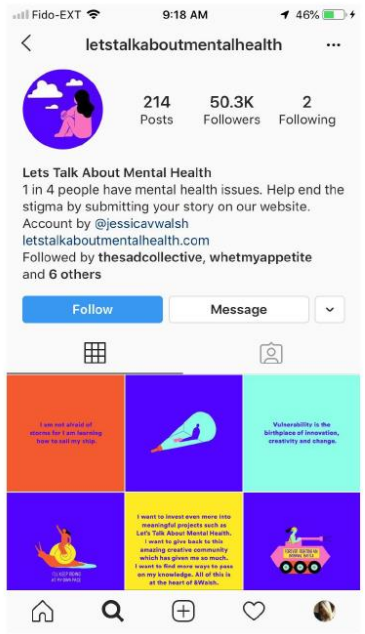
Ideas For Future Development

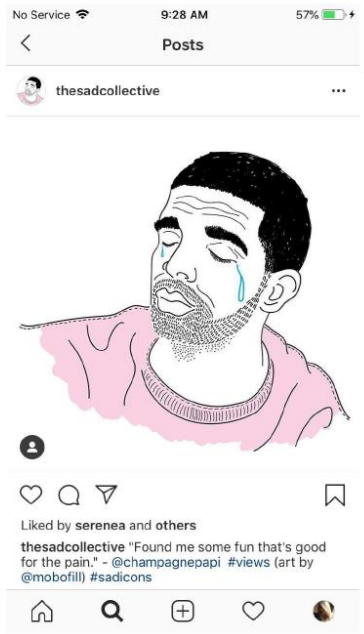
Leveraging the Power of Social

Connecting and/or pushing content about wellness on existing platforms like Instagram and Snapchat.

Benefits:

- Meets youth on the platforms they are currently using
- Content could be generated by youth
- Provides feedback loop for service providers





We processed the workshop data generated and identified future opportunity areas for the OHT to consider.

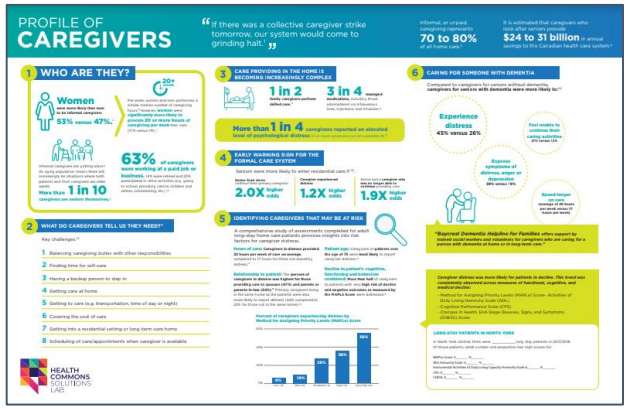
HOW TO GET STARTED WITH ASSET MAPPING

Step 1

Have a look at the overview

Step 2

Explore examples of asset mapping including resources & tools on our website. Click on the images below for additional examples.



Step 3

Adapt and use the resources & tools

Step 4

Get in touch for advice and support

RISE
Rapid-Improvement Support and Exchange

Questions and Answers

- Just looking at graph shown (slide 9), can we get a bit more explanation how the chart showing % of population by ethnic grouping shows that there is an inequity in the % of the population that was affected by COVID?
  - **Answers:**
    - CYNTHIA DAMBA *"The graph shows that for certain groups (e.g., Arab, Black, Latin American, South and Southeast Asian) that the % of cases is greater than the proportion of residence in those groups in Toronto thereby, indicating a disproportionate infection rate. Below is the graph information in chart format.*

Ethno-Racial group	Share of Toronto population	Share of Toronto COVID-19 cases
Arab, Middle Eastern or West Asian	3.6%	7.5%
Black	9.0%	13.2%
Latin American	2.9%	8.5%
South Asian or Indo-Caribbean	12.7%	23.0%
Southeast Asian	7.3%	13.8%
East Asian	13.3%	6.6%
Total Visible Minorities	48.8%	72.6%
White	48.1%	25.6%
Note about the data: Those identifying as mixed race or another ethno-racial identity (2%) are excluded from this graph		

For example, looking at the first column- total visible minorities represent 48.8% of Toronto's total population whereas, this same group represents a larger proportion (72.6%) of Toronto's total COVID-19 cases. The opposite is true when looking at the white population which represents 48.1% of Toronto's total population versus 25.6% of total COVID-19 cases.

Questions and Answers

- I can understand the need for collecting data, but I'm beginning to realize that the absence of collecting data (due to infrastructure limitations, etc.) can become quite convenient in allowing no real change to health equity (HE). Any advice from the panel would be appreciated.

  - **Answers:**
    - CYNTHIA DAMBA – *"an important statement and we encourage everyone to look at different methods of using data. Perhaps, your organization might not be collecting data but there are other ways to understand health equity. For example, looking at sociodemographic characteristics by neighbourhood and engaging different groups in your community (e.g. service providers, community providers, community organizations beyond health) who service those populations. By working with these groups you can understand the population's needs. Sophia provided an example of one way to do this."*
    - SOPHIA IKURA – *" like any complex problem, you need multiple ways to do this. There might be fears of what the it will reveal, logistical challenges, it might be seen as not as important. However, we can't afford not to respond to the needs and there are many leaders who would be responsive to it. A top down and then bottom up approach can be taken. We are also in a moment where we can start collecting this information through the people coming in for COVID vaccines through COVAX system."*
    - ROB REID – *" you won't know about inequities unless you look, meaning you need data. It takes courage and commitment to gather the data. Cynthia's example shows how it is possible. Sophia's example demonstrated that we can't apply a one size fits all approach, we need to take a user centered approach to address the inequities."*

Questions and Answers

- It would be interesting to understand the informal vs. the formal type of supports that folks use. how we can maximize/ optimize those informal supports. helps build the networking and system capacity to support.
  - **Answer:**
    - SOPHIA IKURA – *"ask people to map what they use. We often use patient journeys, they can fill in the rest on the formal side and informal side of what they're accessing. Then, you can see what patterns of access are repeated which might highlight a partnership you don't have in place. This map is also important to inform the end user of what is available in their community. "*
- Has there been any determination of a standardized HE data collection tool that would be adapted across sectors and across OHTs? We are in the process of exploring the feasibility of having providers in our OHT collect the same HE data but we would like to align this work with any emerging provincial HE data collection efforts/priorities.
  - **Answers:**
    - CYNTHIA DAMBA – *"there is a discussion and work happening at Ontario Health to look at a standardized way of rolling out equity data collection. More information will be coming to the regions. Teams are encouraged to continue collecting data. In the Toronto region, there is a measuring health equity project for hospitals and CHCs (*see Cynthia's example on slide 12*) and it will be rolled out with tools once the pilot is completed. "*
    - SOPHIA IKURA – *" Health Commons Solutions will also have a resource in the future for rolling out data collection for COVID."*

Questions and Answers

- How are folks doing this kind of engagement given COVID and in some places, less than optimal internet services.
  - **Answers:**
    - ZAWAR PATEL *"start where you can, including working with partners to see where there are already outreach and engagement activities and how you could use or adapt those. Local circumstances will also determine your approach, so what works in the city may not be the most effective approach in a more rural area. Flexibility is key and also being innovative in using available resources and people effectively."*
- If the target population is identified as frail elderly, how can they be reached if we focus primarily on technology (social media sites)?
  - **Answer:**
    - SOPHIA IKURA *"with Seniors it is very much a ground game. Working with local partners, you can create a basic map of services and design it in a way that encourages their feedback"*

Questions and Answers

- How do you promote equity questions in primary care especially from family Doctors? Many medical trainings avoid this line.

  .– **Answer:**
  - SOPHIA IKURA *"Audit and feedback on who is accessing services and who is not is an important place to start"*

- Agree collecting health equity (HE) for vaccination is a great opportunity...however how can we access these data from COVAX for current planning/QI for vaccination equity. We have not been able to access these data.)?

  – **Answer:**
  - SOPHIA IKURA *" at this point you are correct, we cannot access the equity data from COVAX now, however consent is being obtained at the collection point so that we can link the data set to OHIP and then to health planning data sets."*

Betty-Lou Kristy

Chair, Minister’s Patient and Family Advisory Council (PFAC)

Importance of co-designing care with patients, families and caregivers

Co-design with Patients, Families/Caregivers focuses on building relationships and linkages to provincial expertise; and system governance, policy and planning that create/impact the healthcare eco-system for the authentic engagement of lived/family experience

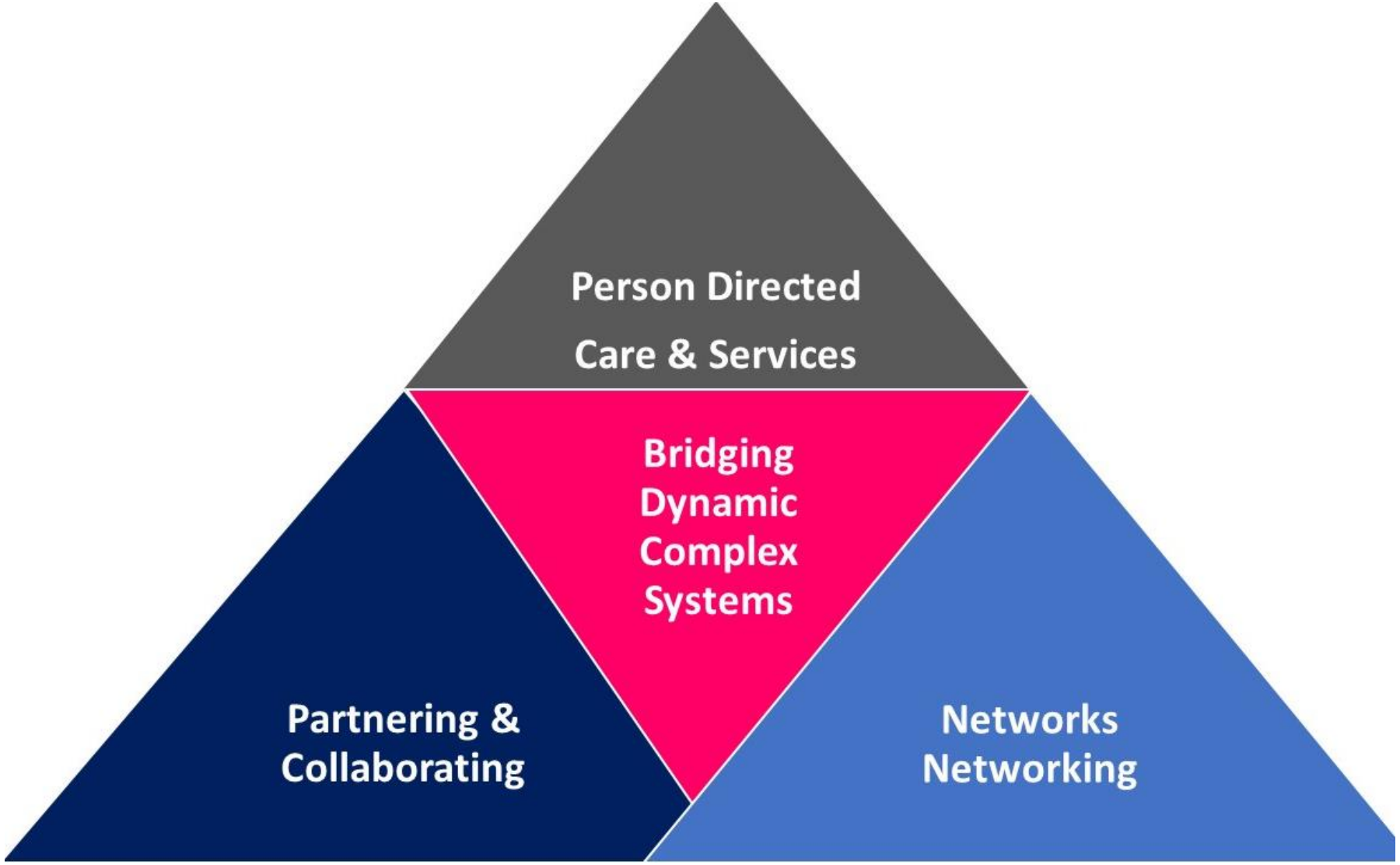
Why?

1. This reduces duplications, inefficiencies, barriers and silos.
2. It creates opportunities to share (upload and download) knowledge, expertise & evidence.
3. It is foundational to co-creation, humanizing and equity.
4. Solidifies the partnerships & infrastructure needed for sustainability
5. Promotes the recognition and integration of **Patients, Families/Caregivers** as a viable and valued part of person-directed healthcare.

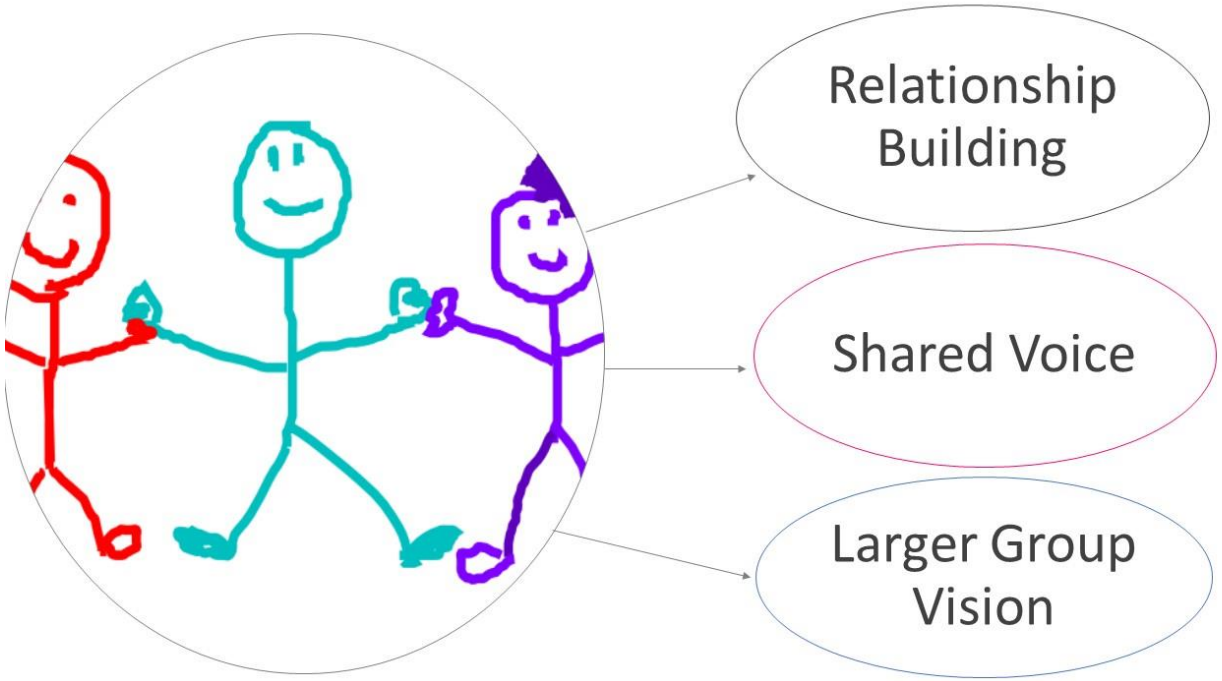
Clinical/medical models for data collection, outcome measurements, work plans and project charters are not necessarily an ideal fit with the true organic nature, values base and intention of engaging people using services, and what truly matters to them

In order to be responsive to existing system needs, the entire approach to codesign has to be about bridging.

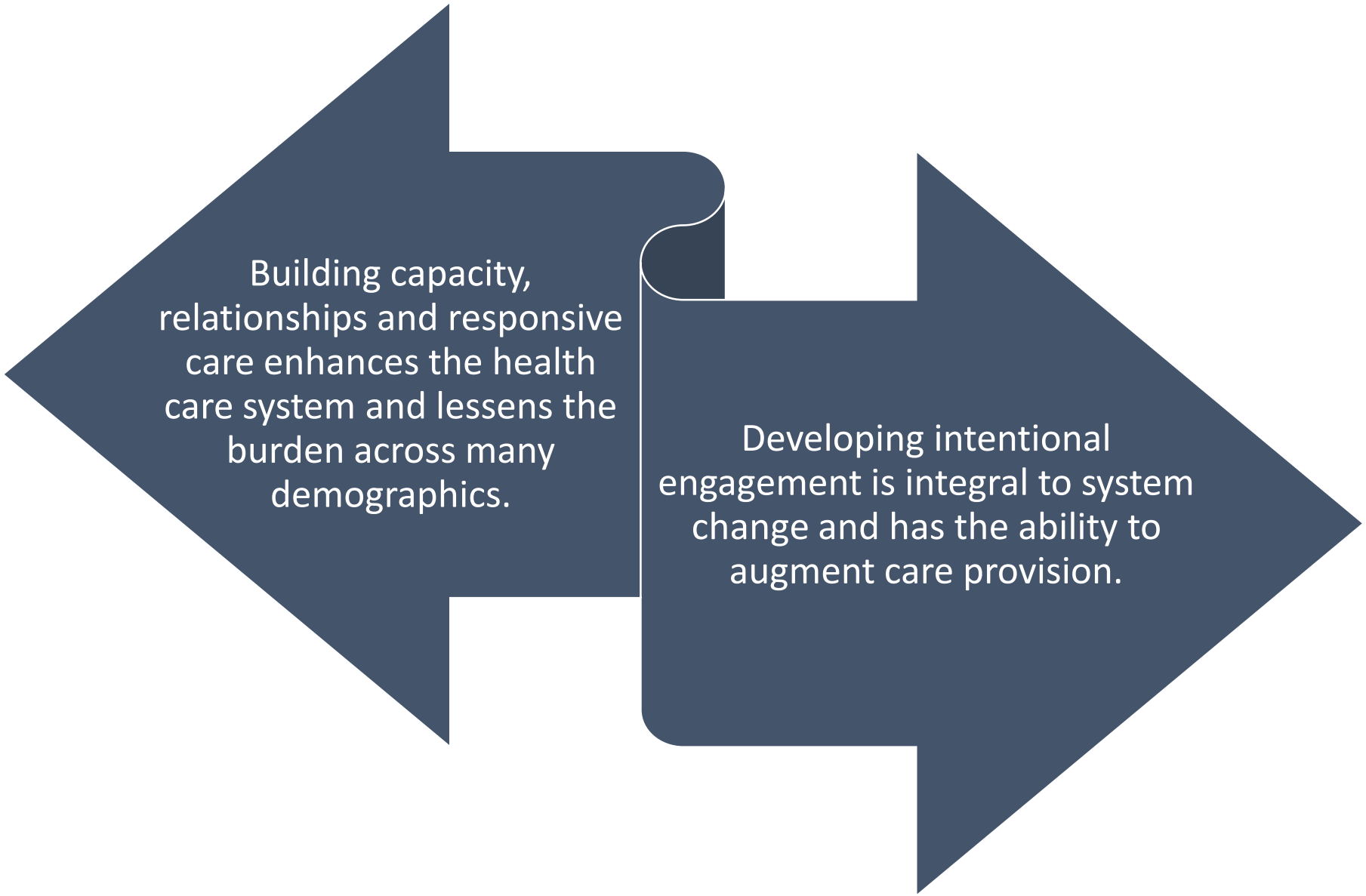
Co-designing care is part of a larger system



Co-designing care includes a focus on relationships and shared voice



Transformation of the health care system is complex and dynamic



The value of beginning with values

Values are the core essence of the work. Translating values into actions has provided a basis for training, evaluation, QI and a common language to communicate how to stay authentic.

Knowing that human connection is the most important part of “treatment and support”, being able to translate and hold people accountable to the actual values in actions in interactions with individual is vital.

Importance of Values-Based Work

- Honours the individual as a person, holistically
- Honours the person as an expert in their own lived experience
- Empowers the person to achieve their wellness goals
- Reminds the person they have innate, unwavering worth
- Creates a space where safety and self-exploration may occur

Priorities of Patient, Family and Caregiver Partnership within OHTs

- Within the Ontario Health Team (OHT) model, teams are to uphold the principles of patient partnership, community engagement, and system co-design, and meaningfully engage and partner with patients, families, caregivers, and communities.

- OHTs are asked to design care in ways that best meet the needs of the populations they serve in the planning, design, delivery and evaluation of services.

- Approved OHTs have been asked to create a Patient, Family and Caregiver Partnership and Engagement Strategy and a Patient Declaration of Values (based on the provincial Declaration of Values).

- Both of these foundational documents will guide OHT work based on values and principles, with co-design at the centre and an equity lens considered throughout.

- For example, through guidance released by the ministry in March 2021, the following were set out as suggested principles to align with:
  - **Partnership and Co-design, Learning, Empowerment, Transparency, Responsiveness, and Respect**

- The guidance also identified a number of key enablers that OHTs can leverage to ensure meaningful partnership and co-design with patients, families and caregivers from their diverse local populations, these include:
  - **Commitment to Diversity, Inclusion, Health Equity and Cultural Competence; Minimizing Barriers, etc.**

- To learn more about these documents, visit:
  - Patient Declaration of Values for Ontario
  - Ontario Health Teams – Patient, Family and Caregiver Partnership and Engagement Strategy: Guidance Document

Ontario

“When allowed full and equitable political and social power with meaningful involvement in healthcare governance, policy development, planning, delivery and evaluation, people with lived experience, family/caregivers and peers can provide unique and relevant context upon which to work with, and base decisions on. The lived experience of people, families/caregivers and peer support is shaping the cultural shift from ‘storytelling’ to evidence. It provides a road-map to affirmative change”-Betty-Lou Kristy

Our Personal Journeys = Living Expertise = Experiential Evidence

Key Messaging

- It’s about all of us working together across our diverse populations.
- We all want the best care possible for those we love and ourselves
- Our system is always growing.

RISE population-health management upcoming events

A place for OHTs to exchange learnings and share examples of their work with one another.

Collaboratives
(Cohort 1 and 2 OHTs)

<u>Applying an equity lens</u> (July 15, 11:30-1pm):

will help OHTs think about how to understand inequities in care in their populations. **OHTs can work with experts from the June 17th webinar to apply an equity lens** to their populations. OHT working group leads who attend are encourage to invite their patients partners to this session.

<u>Person-centred design</u> (August 19, 11:30-1pm):

will help OHTs learn **effective approaches for engaging and partnering with patients/families/caregivers in care model design**. OHTs will be able to work with Betty-Lou Kristy (Ontario Minister's PHAC chair), Dr. Kerry Kuluski (Dr. Mathias Gysler Research Chair in Patient and Family-Centered Care) and other experts. **OHT working group leads who attend are encourage to invite their patients partners to this session.**

If you are a priority population working group or population-health management lead and would like to attend a collaborative, please contact Leslie McGeoch (Leslie.McGeoch@thp.ca) or your coach.

Webinars

<u>Creating safer environments for Indigenous Peoples</u> (Sept/Oct 2021 TBA, noon-1pm):

will help OHTs as they implement population-health management to think about how to **provide care models which are inclusive of Indigenous cultures and create culturally safe environments for Indigenous Peoples**. The event will be posted once a date is confirmed on our events page (https://www.mcmasterforum.org/rise/join-events)

Coaching
(Cohort 1 and 2 OHTs)

If you are a cohort 1 or 2 OHT priority population working group or population-health management lead and do not have a population-health management coach but would like one, please contact Leslie McGeoch (Leslie.McGeoch@thp.ca)

RISE
Rapid-Improvement Support and Exchange

Population-health management (PHM) equity resources
(please also see the appendices)

All or most topics

- **Health Commons Solutions Lab** has many helpful resources and examples of applying an equity lens https://www.healthcommons.ca/
  - Health Commons Solutions Lab increased socio-economic data collection during vaccine clinics. This document provides a summary of their learnings Socio demographic data collection - Google Slides
- **Ontario health's equity, inclusion, diversity and anti-racism framework**: https://www.ontariohealth.ca/sites/ontariohealth/files/2020-12/Equity%20Framework.pdf
- **Indigenous primary health care council (IPHCC**) has helpful toolkits and resources for OHTs: https://www.iphcc.ca/about/resources/

Data

- http://torontohealthequity.ca/ for info on equity demographic data being collected across the TC-LHIN hospitals and CHCs
- A group that can help with neighbourhood and community level data in Toronto is the Ontario Community Health Profiles Partnership. http://www.ontariohealthprofiles.ca/index.php. They are moving into other regions as well and are actively working on using an OHT lens to their data.
- For those focused on older adults with frailty as priority population, here is link to frailty estimates by Ontario Health Region and which drills down to census division and neighborhood levels: https://rgps.on.ca/resources/frailty-estimates-by-census-division-and-ontario-health-region/

RISE
Rapid-Improvement Support and Exchange

Resources shared in the chat box by community members!

- "*An excellent foundational resource for health equity*" https://nccdh.ca/resources/entry/health-equity
- *"The asset based approach to community development will be very useful for asset mapping"* http://www.deepeningcommunity.org/abcd-canada-home
- *"A great resource that addresses the fact that people who have been marginalized by systems need trauma and violence-informed approaches"* https://equiphealthcare.ca/
- *"Here's a nice article that touches on a number of these concepts including community assets, partnership, equity, health literacy, access, community trust, and more"* https://www.washingtonpost.com/health/2021/05/30/barbershop-coronavirus-vaccines/
- https://www.culturallyconnected.ca/

RISE
Rapid-Improvement Support and Exchange

THANK YOU!

APPENDICES

- Additional resources
- Additional examples and information

Additional resources

1. Measuring Health Equity: Demographic Data Collection and Use in Toronto Central LHIN Hospitals and Community Health Centres. http://torontohealthequity.ca/wp-content/uploads/2013/02/Measuring-Health-Equity-Demographic-Data-Collection-Use-in-TC-LHIN-Hospitals-and-CHCs-2017.pdf

2. Ontario Community Health Profile Partnership website: http://www.ontariohealthprofiles.ca/

3. Centre for Studies in Aging and Health (CSAH) & Seniors Health Knowledge Network, https://sagelink.ca/

4. Providing Services for LGBT2SQ Seniors; https://sagelink.ca/providing-services-for-lgbt2sq-seniors/

5. Our Health Counts Toronto: http://www.welllivinghouse.com/what-we-do/projects/our-health-counts-toronto/

6. Our Health Counts Thunder Bay: http://www.welllivinghouse.com/wp-content/uploads/

7. City of Toronto, 2018; Street Needs Assessment Report, City of Toronto, 2018: https://www.toronto.ca/wp-content/uploads/2018/11/99be-2018-SNA-Results-Report.pdf

8. Black Health Equity Working Group. (2021). Engagement, Governance, Access, and Protection (EGAP): A Data Governance Framework for Health Data Collected from Black Communities in Ontario: https://blackhealthequity.ca/wp-content/uploads/2021/03/Report_EGAP_framework.pdf

9. CAMH's Dismantling Anti-Black Racism strategy http://www.camh.ca/-/media/files/camh-dismantling-anti-black-racism-pdf.pdf

Additional resources

10. Ontario Marginalization Index (ON-Marg). http://www.ontariohealthprofiles.ca/onmargON.php

11. Measuring Health Inequalities: A Toolkit — Glossary of Terms. April 2020. https://www.cihi.ca/sites/default/files/document/cphi-toolkit-glossary-of-terms-en.pdf

12. Measuring Health Inequalities: A Toolkit. Toolkit Area-Level Equity Stratifiers Using PCCF and PCCF+. CIHI. https://www.cihi.ca/sites/default/files/document/cphi-toolkit-area-level-measurement-pccf-2018-en-web.pdf

13. Key Health Inequalities in Canada. A National Portrait. PHAC 2018. https://www.canada.ca/content/dam/phac-aspc/documents/services/publications/science-research/key-health-inequalities-canada-national-portrait-executive-summary/key_health_inequalities_full_report-eng.pdf

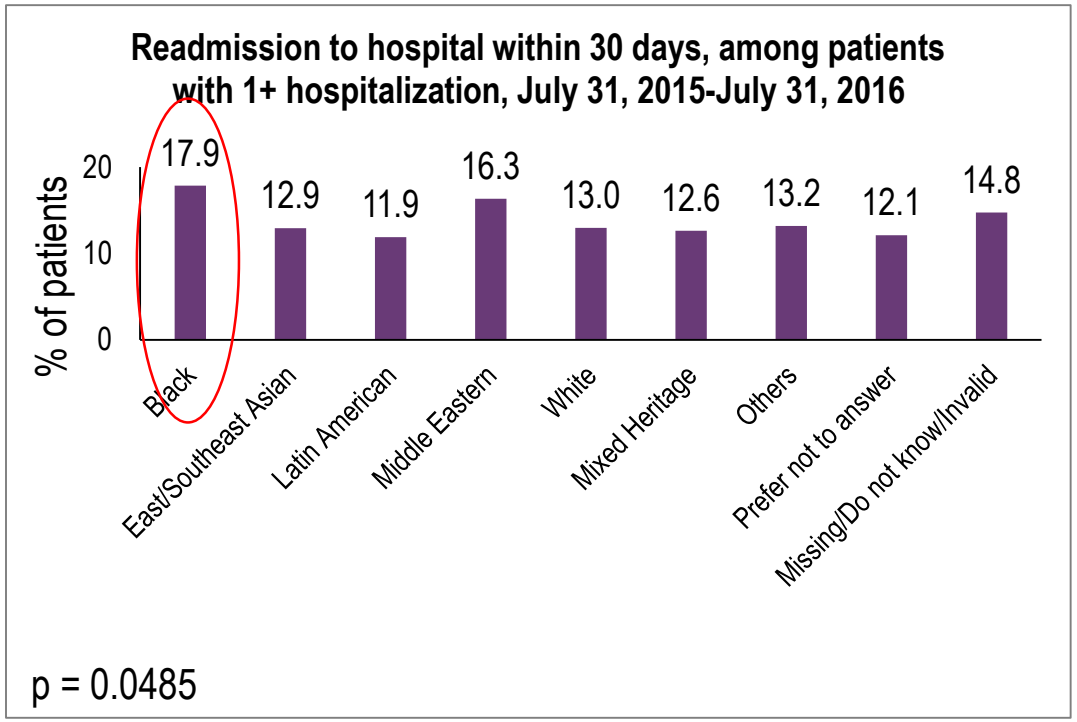
14. Trends in Income-Related Health. Technical Report. July 2016. https://secure.cihi.ca/free_products/trends_in_income_related_inequalities_in_canada_2015_en.pdf

15. Trends in Income-Related Health Inequalities in Canada. Summary Report. November 2015. https://www.cihi.ca/sites/default/files/document/summary_report_inequalities_2015_en.pdf

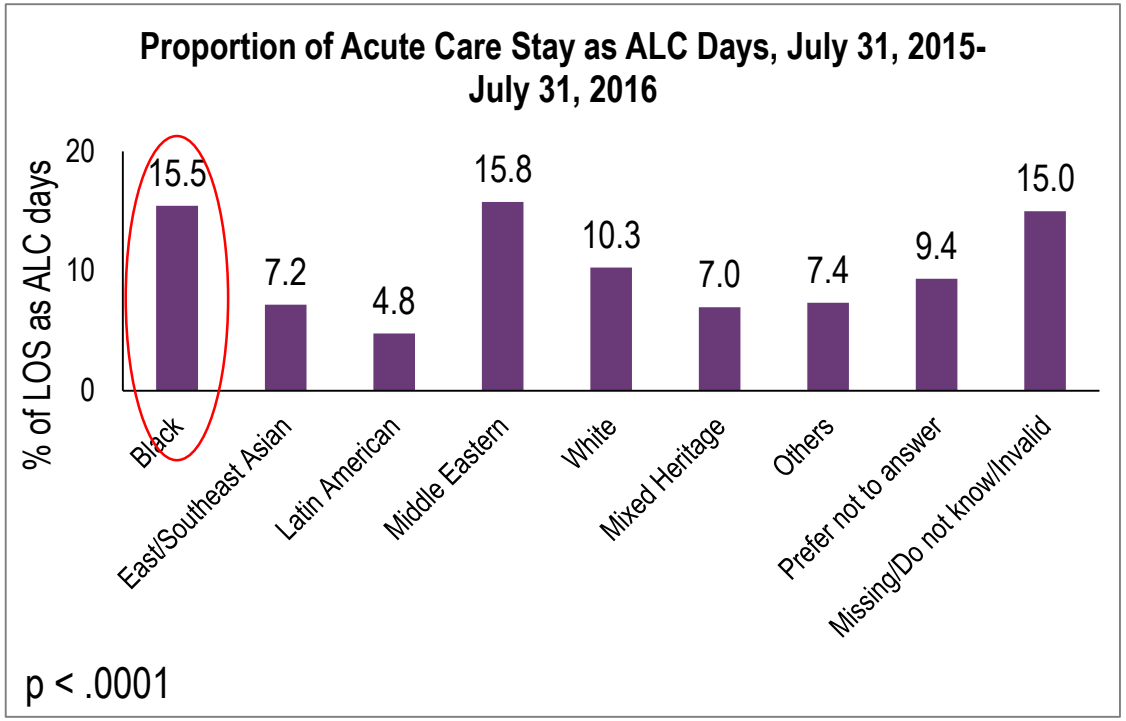
16. Health Inequalities Interactive Tool. CIHI. https://www.cihi.ca/en/health-inequalities-interactive-tool

Health Disparities in Service Use by Race/Ethnic Group

Black patients had the highest rate of readmissions (17.9%)



Black patients had the second highest proportion of ALC days (15.5%)



Study results informed the establishment of the Black Health Plan Table

Health Disparities Among Urban Indigenous Population in Toronto

Socio-demographics & Social Determinants of Health

- 87% of Indigenous adults in Toronto were below the before-tax Low-Income Cut-Off (LICO)
- 63% of those aged 15+, were unemployed
- ~25% indigenous adults indicated they sometimes or often did not have enough to eat

Health Outcomes

- Health conditions: 11X rate of general population: Learning disability, Hepatitis C; 3x higher: Asthma, HPB, Stroke, COPD; 1.5 – 2X higher: Diabetes, Arthritis
- 18% used prescription opiates without a prescription or out of keeping with how they were prescribed in the past year
- Higher prevalence of mental health conditions than the overall adult population in Ontario; Anxiety Disorders (24%) and Major Depression (23%)

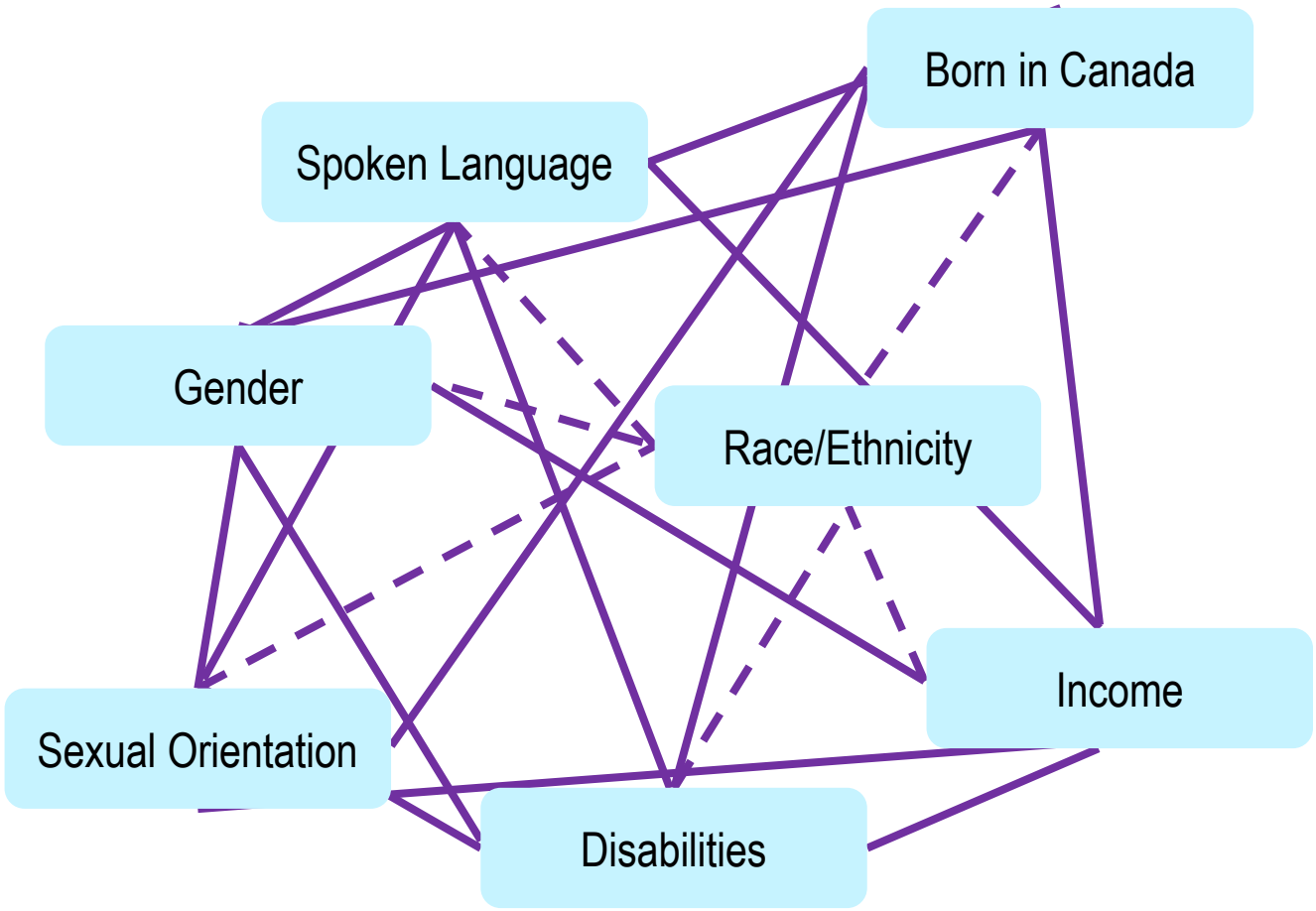
Access to Health Services

- 66% had a regular family doctor vs 90% of gen population
- 28% had unmet health care needs (due to transportation, lack of trust)
- 28% (over 1 in 4) experienced discrimination in health care system because of emotional or mental health problems, of which 58% reported this delayed or prevented them from getting care

Source: Our Health Counts Toronto, 2018 – Well Living House

Also see Our Health Counts Thunder Bay: http://www.welllivinghouse.com/wp-content/uploads/2020/11/Final_OHC-TB-Factsheet-Demographics.pdf

Exploring Intersectionality



- Intersectionality refers to the multiple and overlapping identities that each individual has
- These lead to unique experiences, opportunities, and challenges for different groups
- Anti-Black racism is experienced differently depending on gender, immigration status, sexual orientation, age, disability, ethnicity, and more.

https://blackhealthequity.ca/wp-content/uploads/2021/03/Report_EGAP_framework.pdf

Magnitude and Economic Impact of Health Disparities in Canada

Health disparities are pervasive and damaging. People with **low income compared to those with high income:**

- X **Lower life expectancy** – 5.3 years for men and 3.1 for women
- X **Lower health adjusted life expectancy** – 12.9 years for men and 10.8 for women.
- X 12.2% report **lower self rated mental health status** vs 3.0% high income
- X **Higher rate of chronic conditions**:
  - X 9.7% have Diabetes vs 4.9%
  - X 21.2% have Arthritis vs 14.2%
- X **Higher food insecurity**: 24¼ vs 0.7%

Differences by Age group, Cultural/Racial background, Indigenous identify, Immigration status, Education, Urban/Rural, Sexual orientation, Employment status and occupation are also available.

Source: Key Health Inequalities in Canada. A National Portrait. PHAC 2018.
https://www.canada.ca/content/dam/phac-aspc/documents/services/publications/science-research/key-health-inequalities-canada-national-portrait-executive-summary/key_health_inequalities_full_report-eng.pdf

Current State
- Inequities in service delivery and health outcomes
- Increasing unnecessary costs

Future State
- All residents have equitable, quality-driven care while maintaining a focus on a sustainable healthcare system.

Condition (2012)	Estimated annual cost of hospitalization/condition in Canada	Trends in inequality lowest income vs highest income level	Hospitalizations that could have been avoided if all income levels had same rate as those in the highest income level
COPD hospitalization rates (less than 75)	• $8,000 per hospitalization • Total = ~$314.6M	• 3.1 times • 150 more hospitalizations for every 100,000 adults	• 45.3% • ~18,700 hospitalizations
Mental Illness (selected MH & SA) Hospitalization rate per 100,000	• $11,700 per hospitalization • Total = ~$6.3 billion	• 2.08 times greater	• 26.8% • ~40,300 hospitalizations
Alcohol-Attributable* Hospitalization indicator per 100,000(15+)	• $7,500 per hospitalization • High direct and indirect costs	• 2.42 times greater • 93 more hospitalizations for every 100,000 adults	• 31.6% • ~ 9,000 hospitalizations
Hospitalized Heart Attack Rate per 100,000	• $11,800/hospitalization • $853.7M	• 1.35 times greater • 85 more hospitalizations for every 100,000 adults	• 14.6% • ~11,000 hospitalized
Diabetes prevalence Rate per 100	• $13.5 billion	• 2 times greater • 5.1 more cases of diabetes for every 100 adults	• 32.1% • ~ 673,700 fewer people with diabetes

List of Abbreviations

- **ALC** – Alternative Level of Care
- **CCHS** – Canadian Community Health Survey
- **CHC** – Community Health Centre
- **CIC – IRCC** – Citizen and Immigration Canada – Immigration, Refugee and Citizenship Canada Database
- **DATIS** – Drug and Addictions Treatment Information System
- **FSA** – Forward Sortation Area
- **OPOC** – Ontario Perception of Care Survey (for community mental health and substance use agencies)
- **SES** – Socio-Economic Status