HSPN Health System Performance Network

Interventions to Address Inequities in Ontario Health Teams

HSPN Monthly Webinar

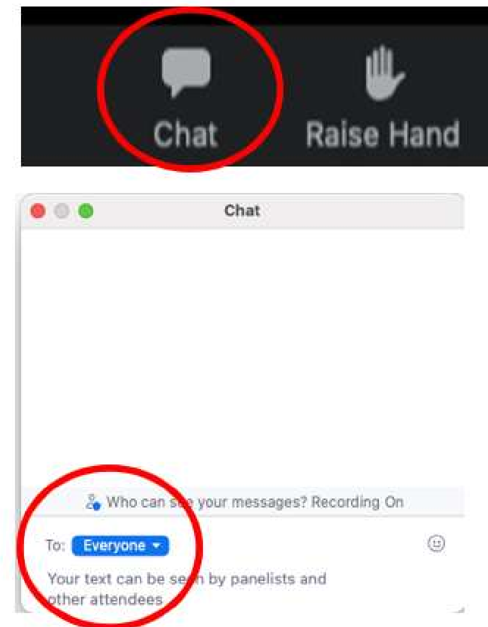
September 26, 2023

Welcome & thank you for joining us!

Please let us know who you are by introducing yourself (name & OHT or other org)

- Open Chat

- Set response to everyone in the chat box



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Land Acknowledgement

We wish to acknowledge this land on which the University of Toronto operates. For thousands of years it has been the traditional land of the Huron-Wendat, the Seneca, and the Mississaugas of the Credit. Today, this meeting place is still the home to many Indigenous people from across Turtle Island and we are grateful to have the opportunity to work on this land.

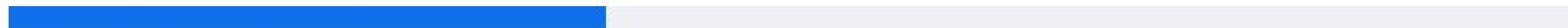
Poll 1

1. Have you joined us for an HSPN webinar previously ? (Single Choice)
*

107/107 (100%) answered

Yes (66/107) 62%

No, this is not my first event (41/107) 38%



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HSPN Health System Performance Network

Today's event
Equity Interventions

Co-Hosts

Dr. Paul Wankah-Nji
Post-Doctoral Fellow
UofT and HSPN

Dr. Walter Wodchis
Principal Investigator
HSPN

Presenters

Dr. Sarah Sowden
Advanced Clinical Academic Fellow
Newcastle University

Melissa McCallum
Executive Director: GHHN

Christopher Maragh
Director of Integrated Health Systems and Partnerships: HRH

Fatah Awil
Health System Planner: NWT OHT

Ashnoor Rahim
Executive Director: KW4 OHT

Kimberley Floyd
CEO WellFort Community Health Services

Terrence Rodriguez
CW OHT

Poll 2

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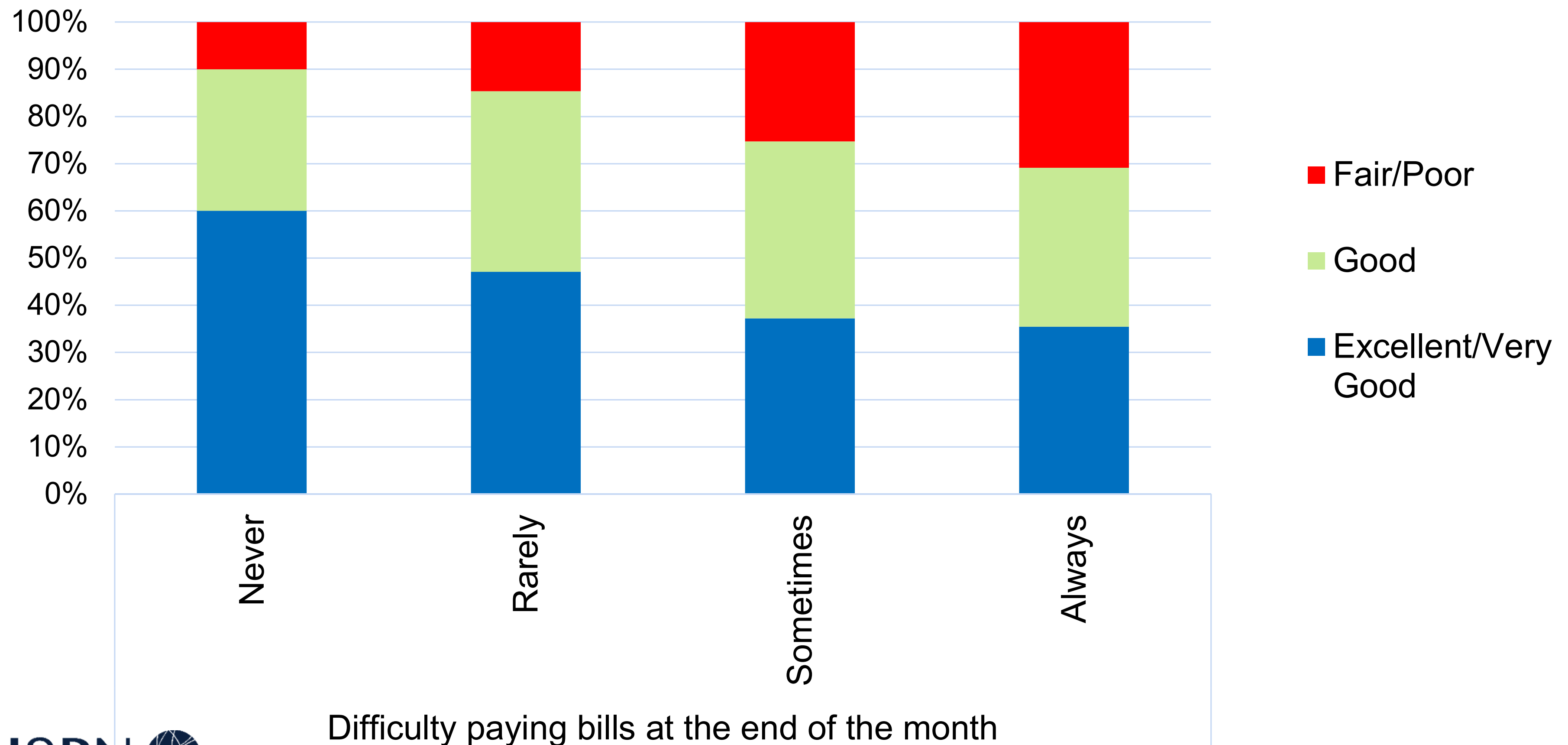
Acting to improve equity in health and health care

Dr Paul Wankah

Background

- **Health inequities**: systematic, unjust and avoidable differences in health between advantaged and disadvantaged social groups
  - Inequitable distribution of health outcomes, resources, and opportunities to be healthy
- **Disadvantaged social groups**
  - Race/ethnicity
  - Income
  - Education
  - Geography (rural/remote areas)
  - Disability
  - Immigrants/refugees
  - Sex and gender

Overall health status of OHT members is much worse amongst those who have difficulty paying bills at the end of the month



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Acting to improve equity

- Levels of interventions
  - Upstream (System level)
  - Midstream (Organisational level)
  - Downstream (Clinical level)
- Scope of interventions
  - Universalism
  - Targeted
  - Proportionate Universalism

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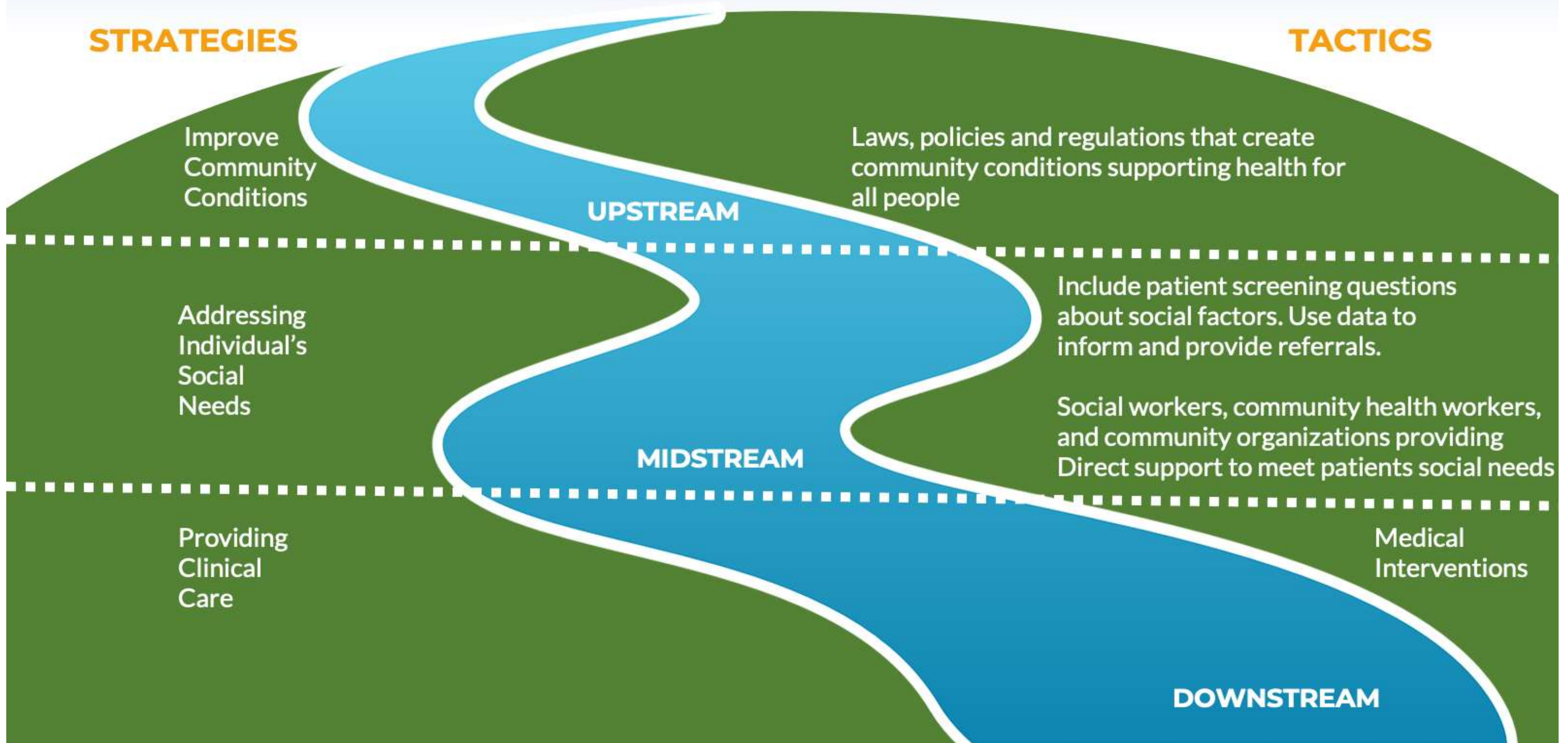

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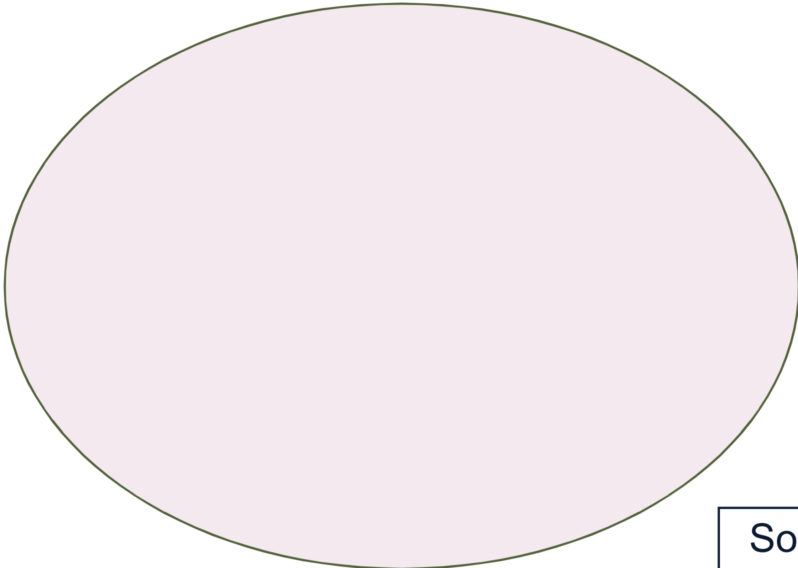
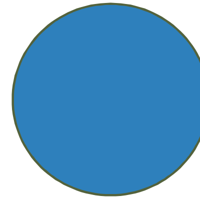
https://www.linkedin.com/pulse/time-look-upstream-stijn-coolbrandt/

Universalism



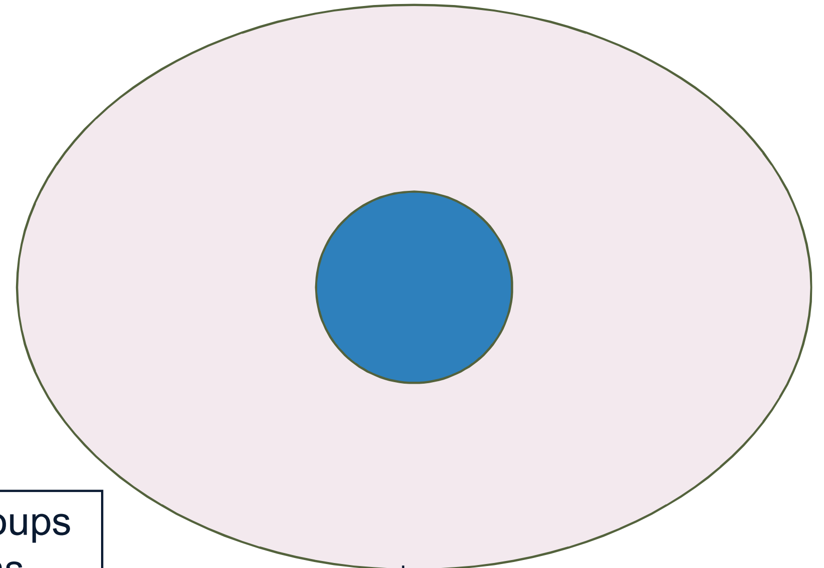
Everyone has access to programs

Targeted



Socially disadvantaged groups have access to programs

Proportionate universalism



Everyone has access to programs, and specific interventions are implemented to enhance access for socially disadvantaged groups

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Marmot, 2010; Carey et al. 2015

“What works?”
How can we address inequalities and improve health and care equity?

Dr Sarah Sowden sarah.sowden@ncl.ac.uk @SarahLSowden

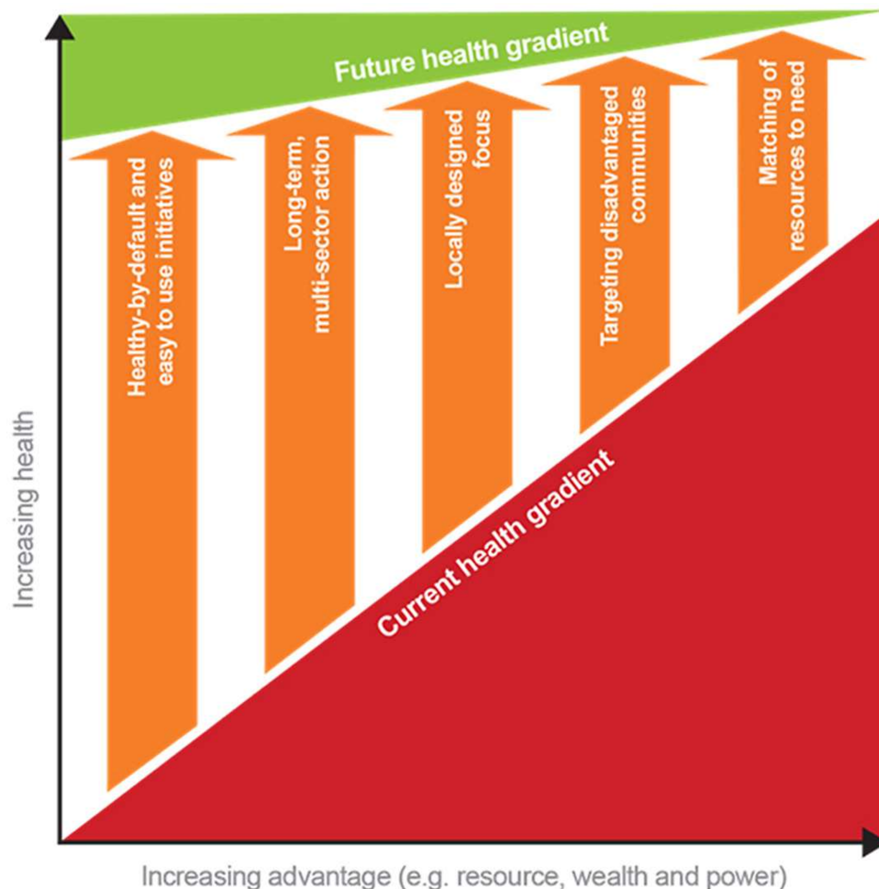
Advanced Clinical Academic Fellow and hon Consultant in Public Health

Newcastle University, Newcastle Upon Tyne, UK

Roadmap for our next 15 minutes together

- Evidence-based guiding principles for addressing inequalities
- Examples of activity in England (Deep End and UNFAIR research programmes)
- Where to find out more

“Progress on closing the gap is possible”….

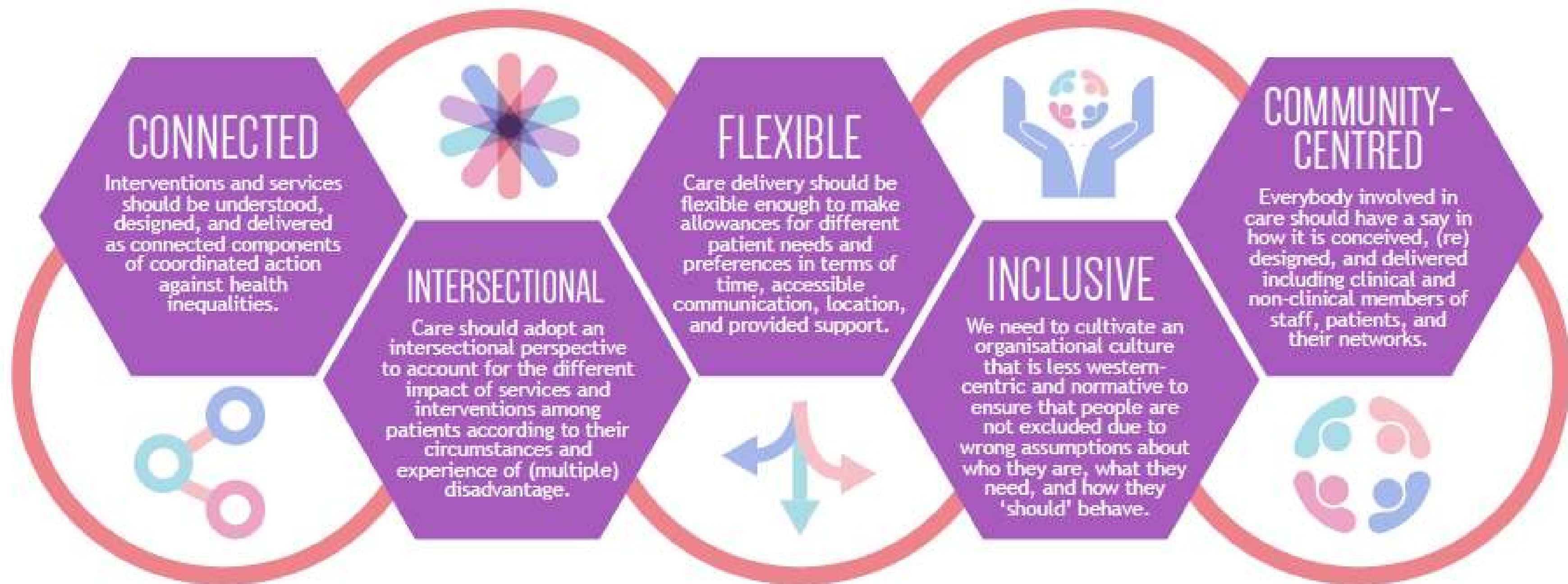


“Here we present a practical, evidence-based framework of guiding principles to help level up health…The principles are designed to collectively inform national, regional, and local policy and services.”

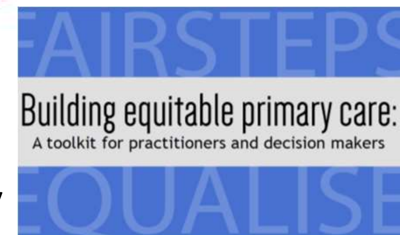
“**The literature on inequalities remains imbalanced on describing the problem of inequalities rather than finding solutions.** More detailed research is needed on specific programme and policy impacts and via what mechanisms they reduce inequalities. Future research should collect more robust data assessing how intervention impact is distributed across different levels and types of disadvantage.”

Davey F, McGowan V, Birch J, Khun I, Lahiri A, Gkiouleka A, Arora A, Sowden S, Bambra C, Ford J. Levelling Up Health: A practical, evidence-based framework for reducing health inequalities. *Public Health in Practice*, 2022, 4, 100322. https://doi.org/10.1016/j.puhip.2022.100322

Focusing on the common qualities of reviewed interventions in EQUALISE, we identified 5 Key Principles of Equitable Care that should inform services, interventions and initiatives

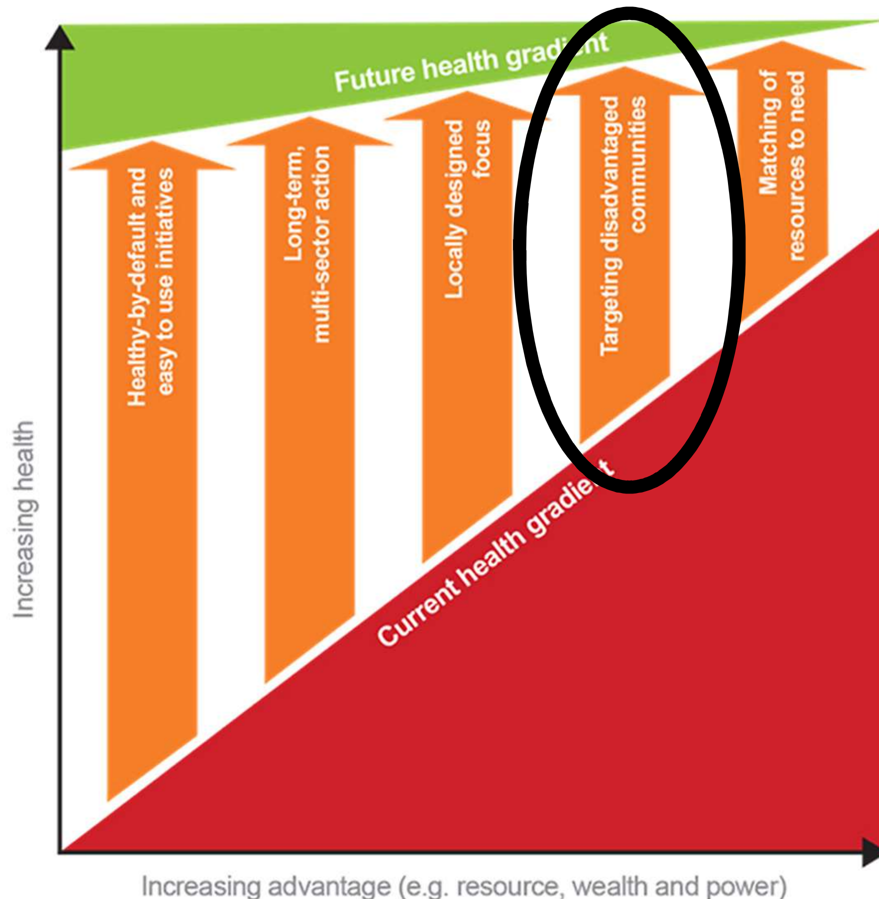


Gkiouleka A, Wong G, Sowden S, Bambra C, Siersbaek R, Manji S, Moseley A, Harmston R, Khun I, Ford J Reducing health inequalities through general practice: a realist review and action framework, Lancet Public Health, 2023 https://doi.org/10.1016/S2468-2667(23)00093-2



Access toolkit based on this research here: https://www.qmul.ac.uk/ceg/research/health-inequalities/building-equitable-primary-care/

“Progress on closing the gap is possible”….



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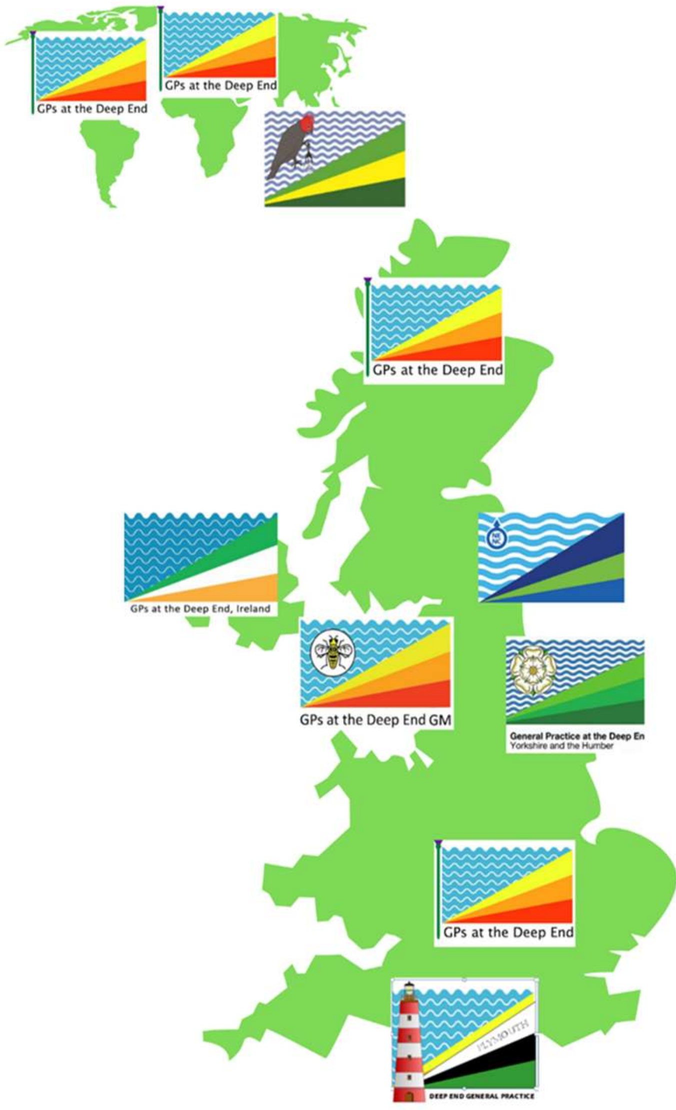
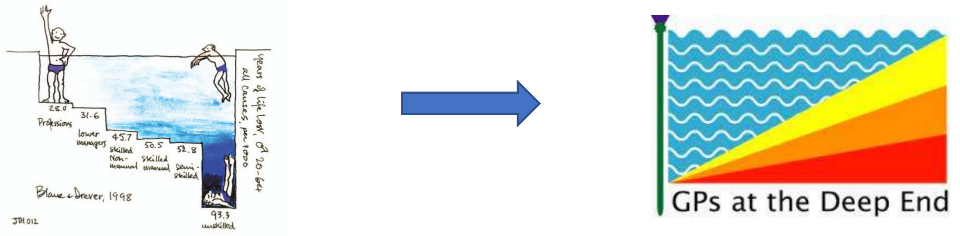


Deep End General Practice Networks

The Deep End movement started in Glasgow over a decade ago, bringing together GPs serving the most deprived communities to share learning and ideas, and to address the **inverse care law**

Professor Graham Watt spoke about treading water – likening GPs working in areas of blanket deprivation as being in the Deep End.
British Journal of General Practice 2011; 61 (582): 66-67 https://doi.org/10.3399/bjgp11X549090



Aim to change the way primary care is delivered and advocate for wider systemic change in healthcare funding

What is the Deep End Network NENC?

The North East & North Cumbria (NENC) region of England Deep End Network was established in 2020.

The network is a partnership between:

- Local general practices (family practices)
- Public Health Consultants working in local government
- Newcastle University (regional Applied Research Collaboration)
- NHS England
- Financial and data support from the regional NHS Integrated Care System

Network aim → To bring together GPs serving the most deprived communities to share learning /ideas and to work collaboratively to change the way primary care is delivered, to create positive change for practices, patients and communities.

Co-design Research aims

Generate an in depth understanding of the challenges of delivering primary care in areas of severe socioeconomic deprivation, including experiences through the Covid-19 pandemic

Co-create with primary care practitioners a Deep End network for the North East and North Cumbria region to ensure it serves their needs.

Wildman JM, Sowden S & Norman C."A change in the narrative, a change in consensus": the role of Deep End networks in supporting primary care practitioners serving areas of blanket socioeconomic deprivation, *Critical Public Health*, 2023, https://doi.org/10.1080/09581596.2023.2205569

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Newcastle University

iCS Integrated Care System North East & North Cumbria

Our patients present later [with cancer] than the national average. I think a lot of that must have to do with deprivation...[they're] worried about where the next meal is going to come from...they're not going to worry quite so much if there's a little bit of blood in their cough.

We see this all the time, patients who end up on an absolute cocktail of pain meds and psychiatric meds, and all the rest of it, for really quite shaky indications. And my fear is we end up doing them harm by trying to help ... If we get beyond with the patient, the idea that a pill might help, there isn't much else around that's accessible and that's acceptable to offer as an alternative.

<u>Volume</u> of complex patient need

Mental health was a huge issue

Recruitment and retention challenges

Wider healthcare system fails to recognise challenges

Wildman JM, Sowden S & Norman C."A change in the narrative, a change in consensus": the role of Deep End networks in supporting primary care practitioners serving areas of blanket socioeconomic deprivation, *Critical Public Health*, 2023, https://doi.org/10.1080/09581596.2023.2205569

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Research impact

Providing supportive community for practices working in the Deep End by a series of webinars "by the Deep End for the Deep End" Events Archive - GPs at the Deep End NENC GPs at the Deep End NENC and newsletters

Research led to the creation of pilot projects focused on addressing key challenges identified through the co-design work including:

- Embedded clinical psychology Making a difference to mental health care in areas of blanket deprivation - ARC (nihr.ac.uk)
- Opioid prescribing reduction Projects - GPs at the Deep End NENC GPs at the Deep End NENC
- Early Career Trailblazer Fellowship scheme and the TrainDEEP pilot
- Immunisation 'catch up' pilot
- Social determinants of health pilot

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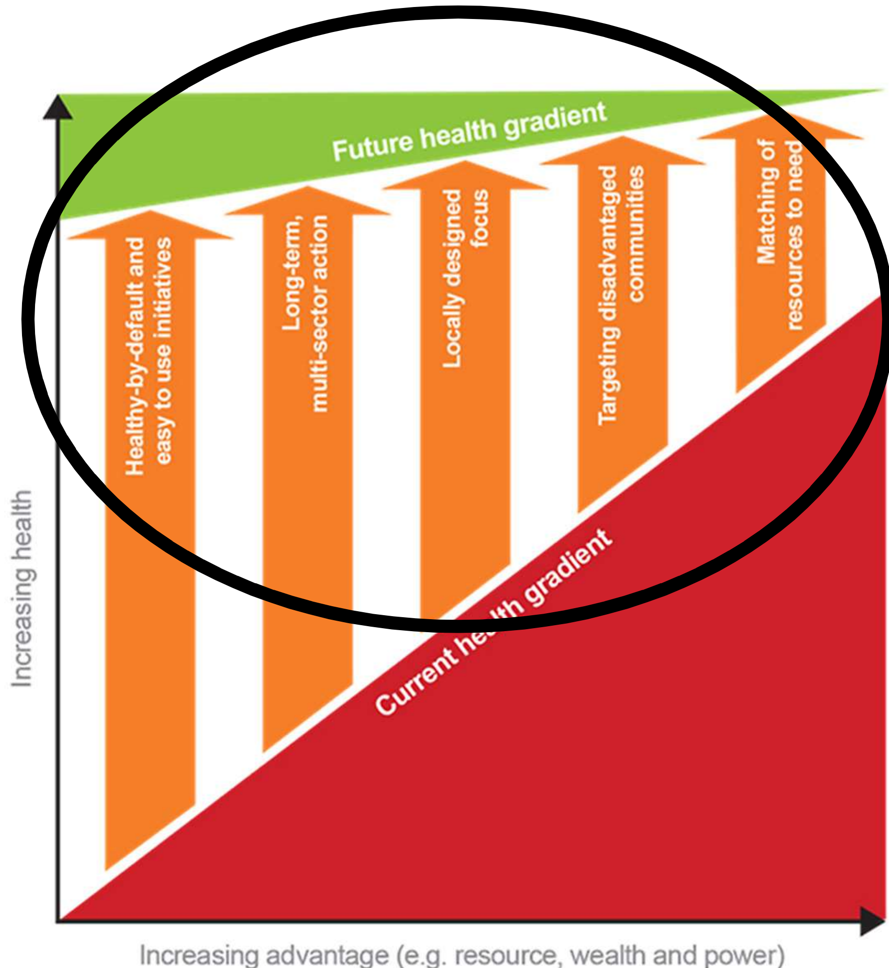

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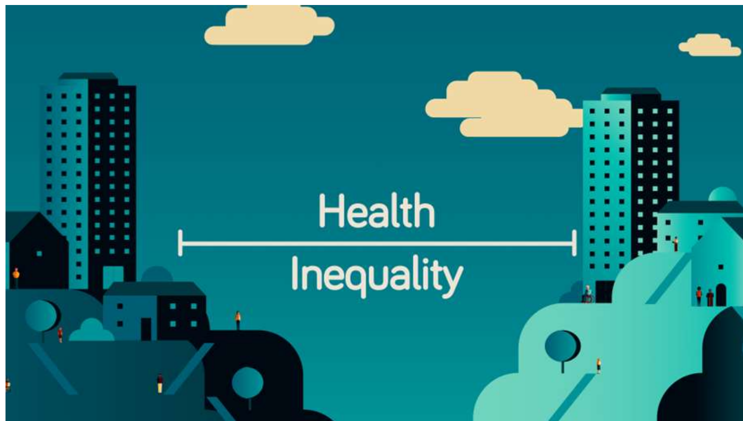
UNFAIR https://bit.ly/UNFAIRstudy

How can we reduce socioeconomic inequalities in avoidable hospital admissions?



This image was co-produced with members of the public, researchers and a local filmmaking company Kaleidoscope CFA as part of the UNFAIR research programme. Everyone is welcome to use and share the image, please acknowledge source (https://bit.ly/UNFAIRstudy) when doing so.

- Five year (2019-2024) applied mixed methods research
- Partnership with NHS, OHID, local councils, patients, public, voluntary and community sector organisations

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- What interventions work to reduce socioeconomic inequalities in avoidable hospitalisations?

UNFAIR

Evidence review

Local Case Studies

- How are local areas addressing health inequalities with a focus on avoidable hospital admissions?

Patient and public involvement

Quantitative data analysis

- What do the public think and feel about health inequalities and what do they say needs to change to address them?

Link to the animation: https://bit.ly/animationUNFAIR

https//bit.ly/UNFAIRstudy

- How are socioeconomic inequalities in avoidable emergency hospitalisations within and between local areas changing over time and what factors explain these changes?

- What interventions work to reduce socioeconomic inequalities in avoidable hospitalisations?

- How are local areas addressing health inequalities with a focus on avoidable hospital admissions?

UNFAIR

Evidence review

Local Case Studies

Patient and public involvement

Quantitative data analysis

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Methods

Systematic Review

We searched MEDLINE, Embase, CINAHL, Cochrane CENTRAL and the Web of Knowledge platforms for studies published between Jan 1 2000 and Feb 23 2022

Interventions of interest

- Carried out within healthcare or social care settings e.g., hospital at home initiatives

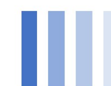
Health and Social Care

- Interventions implemented across both healthcare and at least one other public policy sector e.g., social prescribing

Integrative

- Policy level changes to change health behaviours e.g., sugar taxation

Population Health and Cross-sectoral Policy



Risk of Bias

Sowden S, Nezafat Maldonado B, Wildman J, Cookson R, Thomson R, Lambert M, Beyer F, Bambra C. Interventions to reduce inequalities in avoidable hospital admissions: explanatory framework and systematic review protocol. *BMJ Open* 2020, **10**, e035429.
http://dx.doi.org/10.1136/bmjopen-2019-035429

Key messages from UNFAIR evidence review

- Research studies infrequently evaluate equity impacts.

  Equity evaluation of interventions must become the default.

- Evidence of interventions that exacerbate, maintain or reduce inequalities in hospitalisations and/or readmissions.

  Well-meaning interventions have the potential for harm as well as good.

- Effective interventions for reducing inequalities in hospitalisations and/or readmissions were found across all domains of activity.

  Whole systems action, not healthcare interventions alone, are required to address inequalities in healthcare outcomes.

- Effective interventions were characterised as either placing limited self-agency requirements on the part of an individual for behaviour change, or were person-centred and supportive in design.

  Patients and the public must be at the centre of everything we do.

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Roadmap for our next 15 minutes together

- Evidence-based guiding principles for addressing inequalities
- Examples of activity in England (Deep End and UNFAIR research programmes)
- Where to find out more

Where can I find out more?

NENC Deep End Network activity www.deependnenc.org @deependNENC

NENC Deep End research activity www.deependnenc.org/research

- https://arc-nenc.nihr.ac.uk/projects/deepend-nenc/
- Watch presentation https://www.youtube.com/watch?v=hZ4fQN_cg1Q
- Watch 2 min Video https://arc-nenc.nihr.ac.uk/arc-impacts/
- https://arc-nenc.nihr.ac.uk/projects/mental-health-in-the-deep-end-minded-pilot-evaluation/
- Wildman JM, Sowden S & Norman C."A change in the narrative, a change in consensus": the role of Deep End networks in supporting primary care practitioners serving areas of blanket socioeconomic deprivation, *Critical Public Health*, 2023, https://doi.org/10.1080/09581596.2023.2205569
- Norman C, Wildman JM, Sowden S. COVID-19 at the Deep End: A Qualitative Interview Study of Primary Care Staff Woking in the Most Deprived Areas of England during the COVID-19 Pandemic, *International Journal of Environmental Research and Public Health* 2021, 18(16), 8689. https://doi.org/10.3390/ijerph18168689

UNFAIR research activity https://bit.ly/UNFAIRstudy

- Sowden S, Nezafat Maldonado B, Wildman J, Cookson R, Thomson R, Lambert M, Beyer F, Bambra C. Interventions to reduce inequlties in avoidable hospital admissions: explanatory framework and systematic review protocol, *BMJ Open* 2020, 10, e035429. http://dx.doi.org/10.1136/bmjopen-2019-035429
- Parbery-Clark C, Nicholls R, McSweeney L, Sowden S, Lally J. Coproduction of a resource sharing public views of health inequalities: An example of inclusive public and patient involvement and engagement, Health Expectations, 2023 http://doi.org/10.1111/hex.13860

Further health and care inequalities research https://www.ncl.ac.uk/medical-sciences/people/profile/sarahsowden.html

- Davey F, McGowan V, Birch J, Khun I, Lahiri A, Gkiouleka A, Arora A, Sowden S, Bambra C, Ford J. Levelling Up Health: A practical, evidence-based framework for reducing health inequalities. *Public Health in Practice*, 2022, 4, 100322. https://doi.org/10.1016/j.puhip.2022.100322
- Ford J, Sowden S, Olivera J, Bambra C, Gimson A, Aldridge R, Brayne C. Transforming health systems to reduce health inequalities. *Future Healthcare Journal* 2021, **8**(2), e204-e209. https://doi.org/10.7861/fhj.2021-0018
- Olivera JN, Ford J, Sowden S, Bambra C. Conceptualisation of health inequalities by local healthcare systems: A document analysis. *Health and Social Care in the Community* 2022, 00, 1-8. DOI:10.1111/hsc.13791 https://doi.org/10.1111/hsc.13791
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- Tanner LM, Stonuite A, Wildman JM, Still M, Bernard K, Green R, Eastaugh C, Thomson KH, Sowden S. Which non-pharmaceutical primary care interventions reduce inequalities in mental ill-health: systematic review, *BJGP* 2023 DOI: https://doi.org/10.3399/BJGP.2022.0343

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Poll 3

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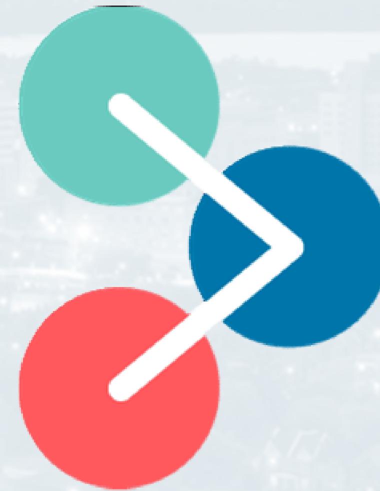
Greater Hamilton Health Network



Building Community Health Together

HSPN OHT Webinar: Interventions to Address Inequities in Ontario Health Teams

September 2023

Health Equity

The starting point

"Do justice to our voices and showcase our experiences that usually get dismissed."

Health Equity Inputs

- Community voices
- Lived experience
- Historical reports
- GHHN Health Equity Framework
- GHHN Health Equity Supplementary Report
- SDOH data, heat maps, healthcare outcome data

***being mindful that these are stories that have been told over and over again with no action!!**

GHHN Examples of Equity Driven Initiatives

- **The Concern:** women were presenting to shelter in high numbers, increased rates of homeless women being turned away, medical and social needs were complex, increased rate of pregnant homeless women, known inequities in funding and bed counts for women already exist in the system
- **The Intervention:** Women's Homeless Health Drop In Days
- Low barrier, free, health and social care delivered where women are served (shelters, day space): primary care, STI testing, cancer screening, MHA care, newcomer services, naloxone training, social activities, food, gift cards, menstrual products and more! No appointments.
- Bring together as many providers as we can in one space
- Co-locate the co-designed services, "one-stop shopping" but also think about the social!
- **Results:** over 500 women have been seen, STI's identified, access to housing and healthcare started, wound care, first ever GHHN abortion care pathway created, race based and SDOH data collected to inform the next clinic days, TRUST!
- **Next steps:** expanded homeless health days to men this month for the first time! Saw 142 men in two afternoons in a shelter/church parking lot, women's health days continue every season

GHHN Examples of Equity Driven Initiatives

- **The Concern:** low-income housing units being decanted and deemed not livable during the pandemic, revealed countless other issues in the vulnerable housing sector
- **The Intervention:** Residential Care Facility Integrated Care Initiative
- Wrap a comprehensive primary and social care team around vulnerable housing environments that serve low-income individuals
- Chose 4 homes in the core with high rates of hospital and EMS utilization – these homes are disconnected from the system yet house some of the most complex individuals in the city (MHA, chronic disease, poverty)
- **Results:** primary care being delivered to the person's home for the first time, onsite care management, advocacy for issues like pests, appointments and safety, community connectors to bridge health and social care, cancer screening, dental care, cultural safety, "these people are put on the map", completed research on understanding the care need of tenants
- **Next steps:** this work is being used to inform a redesign of the entire RCF system in Hamilton, was awarded a 1.2 million grant from the Juravinksi Research Institute: Improving equitable access to integrated primary care in residential care facilities

Key Takeaways from the GHHN Experience

- **“Treat data as neutral, not as a weapon”**
- **JUST GO** – too much time is spent in analysis, this further erodes trust, start using collective muscles together and adapt
- Every single partner has a place in this work – we will not be successful if you do not include social and community assess (churches, small charities, food banks, not for profits, educations, volunteer organizations)
- There is power in equity **advocacy** as an OHT
- Organize partners to apply for funding ahead of time – be ready for this
- Recognize organizations/communities already do equity work very well, they have just never been fully recognized in the system
- **LISTEN** to communities, this cannot be a checkbox exercise

Central West

Click to add text

ONTARIO HEALTH TEAM

SERVING BRAMPTON, NORTH ETOBICOKE, WEST WOODBRIDGE, MALTON AND BRAMALEA

Equity Interventions at CW OHT

Kimberley Floyd
Terrence Rodriguez

HSPN- September 26, 2023

Addressing Health Inequities In Action

Kimberley Floyd, CEO WellFort Community Health Services

Executive Sponsor of Central West OHT Collaborative Quality Improvement Plan on Cervical Screening

HSPN- September 26, 2023

cQIP
The Problem

Central West
ONTARIO HEALTH TEAM

OHT cQIP

Increasing overall access to preventative care

% o screening-eligible patients up to date with:
- Pap tests

Cervical cancer screening decreased during the pandemic

1. incidence cervical cancer
2. CW-OHT has the lowest cancer screening rates in the province
3. **54.33** %(FY 19/20) **to 46.73%** (FY 20/21) of screened eligible pts
4. barriers under screened: structural access, cultural, religious, & socioeconomic

Central West
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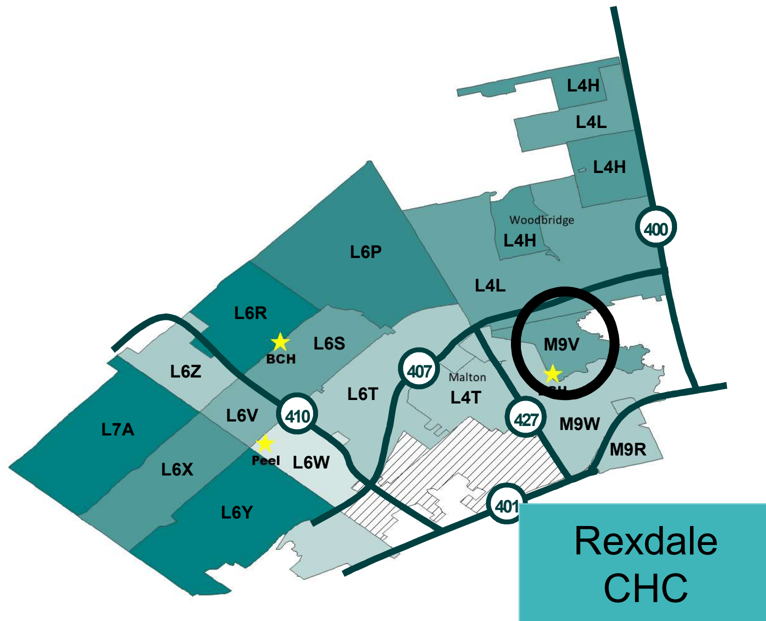
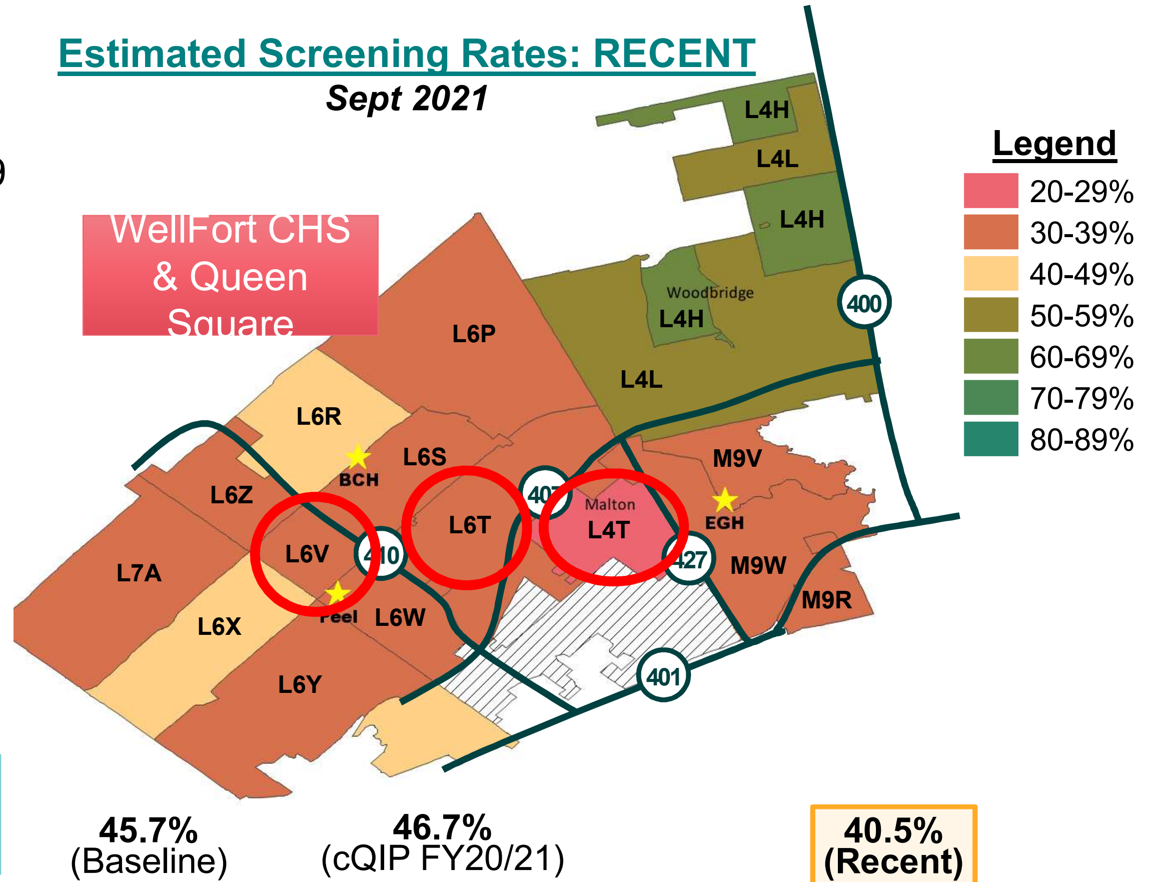
Pap Tests: Eligible Population Distribution & Screening Rates

Total Estimated Eligible Population: 312,039





Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2020												2021											

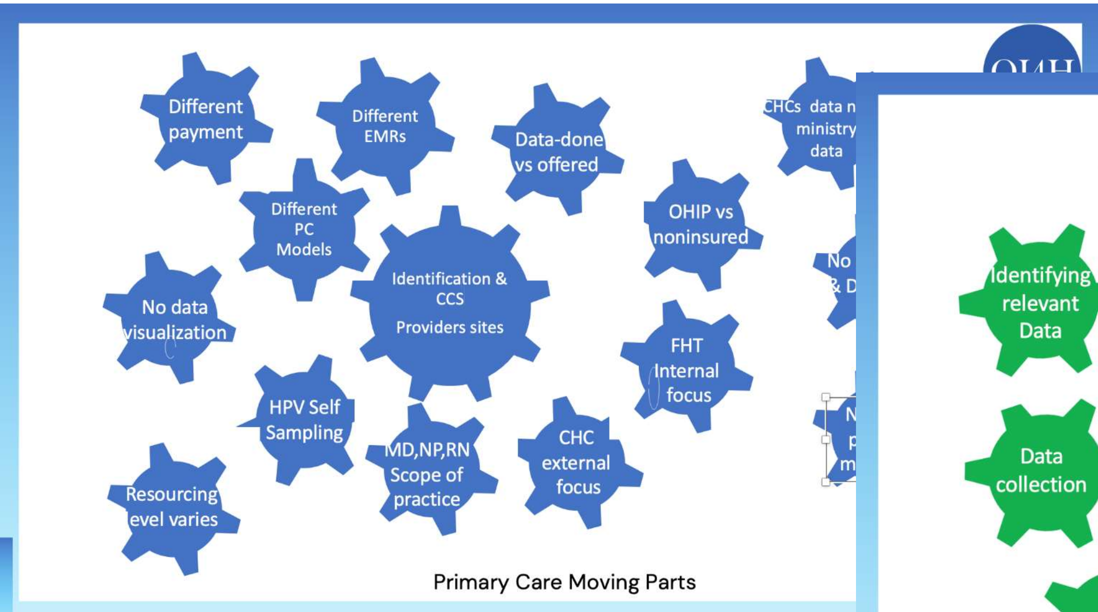
Sources:

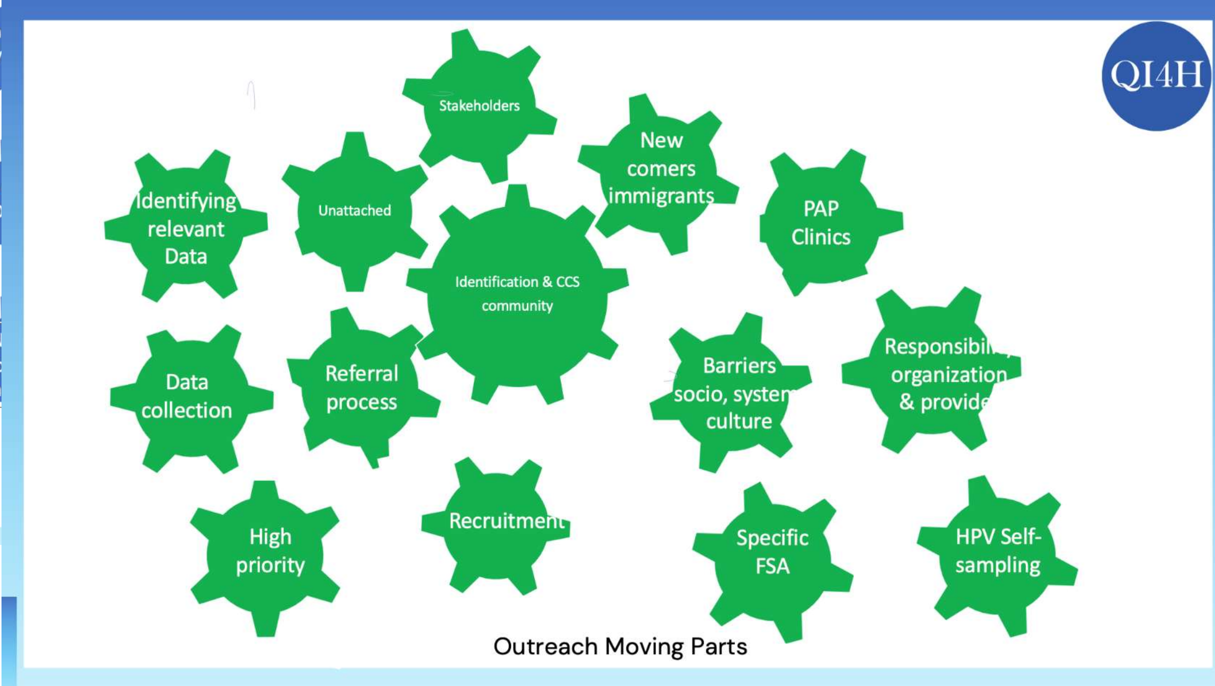
- Population size by FSA and age decile based on MOH 2020 Registered Persons Database population projections (using 2017 as baseline year)
- Baseline & recent rates estimated using monthly test volumes by FSA in OH's Health System Recovery Dashboard (Nov 2021)
- cQIP rate from OH cQIP data package (FY 20/21)

cQIP Aim Statement

Increase cervical cancer screening rate by 8% of eligible clients living in FSA-L4T, L6T, & L6V, M9V by March 2024

Preventative Cancer Screening: Dual Focus





Central West
ONTARIO HEALTH TEAM

Future State

Strategic Business Goals-Future State

Measure cervical CS rates the same way across all providers

Break down structural access, cultural, religious, & socioeconomic cervical screening barriers for high priority population

Standardize cervical CS process

Reliable CCS system of care to support all results patient care management

Central West
ONTARIO HEALTH TEAM

Data Collection to Better Understand Needs and Inequities

QI4H QUALITY IMPROVEMENT FOR HEALTH CARE INC. www.qi4h.com

Community Cervical Cancer Screening Data Tracking Sheet

Have you ever been sexually active?	Did you have any of these surger	Are you prepared to do your pap today?	May I ask why you said no?	Are you currently or have been a WellFort client in the past?	Name	Address	Which FSA do you live in?	Phone Number	E-mail address	Access to primary care	Doctor Name & contact info	Have you had a pap test?	When was your last pap test?	Was the pap test done in Canada?	Age	Gender	Sexual Orientation	Income	How many people is this income supporting?	What educational level have you completed?	Language	Language - Other (please sp	Racial/Ethnic Description	Born in Canada	Country of origin	When did you arrive in Canada? (Please tell the year yyyy)	Years in Canada	Insurance status	Screened	Ded
es o refer not to answer	Partial hysterectomy - cervix is in Total hysterectomy - removal of (Gender reassignment surgery	Yes No		Yes No			L4T L6T L6S L6R L6P			Have a primary care provider Go to a walk in clinic Do not have a primary care provider		Yes No	Less than 1 year 1 year 2 years 3 years Greater than 3 years	Yes No		1. Female 2. Intersex 3. Male 4. Trans - Female t 5. Trans - Male to I 6. Two-Spirit (ate 7. Other (Please sc 8. Do not know 9. Prefer not to a	1. Bisexual 2. Gay 3. Heterosexual 4. Lesbian 5. Queer (a term 6. Two-Spirit (at 7. Other (Pleases 8. Do not know 9. Prefer not to	1. $0-14,999 2. $15-19,999 3. $20-24,999 4. $25-29,999 5. $30-34,999 6. $35-39,999 7. $40-59,999 8. >60,000 9. Missing Data 10. Do not know 11. Prefer not to answer MD for missing data DNK for Do Not Know PNA for Prefer Not to Answer	1 2 3 4 5 6 7 >7 I prefer not to answer Not sure	1. primary or equivalent (2. secondary or equivalent 3. post-secondary or equ 4. I prefer not to answer 5. too young to have com 6. no fo1mal education 7. other (specify) 8. not sure	1. Amharic 2. Arabic 3. ASL 4. Bengali 5. Chinese (Cantonese) 6. Chinese (Mandarin) 7. Czech 8. Dari 9. English 10. Farsi 11. French 12. Greek 13. Hindi 14. Hungarian 15. Italian 16. Karen 17. Korean 18. Nepali 19. Polish 20. Punjabi 21. Russian 22. Serbian 23. Slovak 24. Somali 25. Spanish 26. Tagalog 27. Tamil 28. Tigrinya 29. Turkish 30. Twi 31. Ukrainian 32. Urdu 33. Vietnamese 34. Other (please specify specify): 35. Do not know 36. Prefer not to answer		1. Asian - East (e.g. Chinese, Japanese, Korean) 2. Asian - South (e.g. Indian, Pakistani, Sri Lankan) 3. Asian - South East (e.g. Malaysian, Filipino, Vietnamese) 4. Black - African (e.g. Ghanaian, Kenyan, Somali) 5. Black - Caribbean (e.g. Barbadian, Jamaican) 6. Black - North American (e.g. Canadian) 7. First Nations 8. Indian - Caribbean (e.g. Guyanese with origins in) 9. Indigenous/Aboriginal - *not included elsewhere* 10. Inuit 11. Latin American (e.g. Argentinean, Chilean) 12. Metis 13. Middle Eastern (e.g. Egyptian, Iranian, Lebanese) 14. White - European (e.g. English, Italian, Portughese, Russian) 15. White - North American (e.g. Canadian, American) 16. Mixed heritage (e.g. Black - African & White - North American) 17. Other(s): Please specify: 18. Do not know 19. Prefer not to answer	Yes No Do not know Prefer not to answer				Insured OHIP OHIP Eligible but no c Non-Insured IFH Private 3rd Party	Yes No	Yes No

Central West
ONTARIO HEALTH TEAM

Key Themes- Cervical Cancer Focus Group Discussions

Black, African, Carribean Group

- *Facilitators:* Social networks encourage regular cancer screening, having a friendly/warm HCP with appropriate body language.
- *Barriers:* Limited office hours, finding childcare, transportation issues and getting time off of work, finances.
- *Recommendations:* PAP smear reminders, Step-by-step videos or pamphlets going over the steps in a PAP smear, clinics in apartment buildings, transportation services.
- *Suggestions for Information dissemination:* Social media, Awareness campaign, TV, Radio, Q&A Session with professionals.

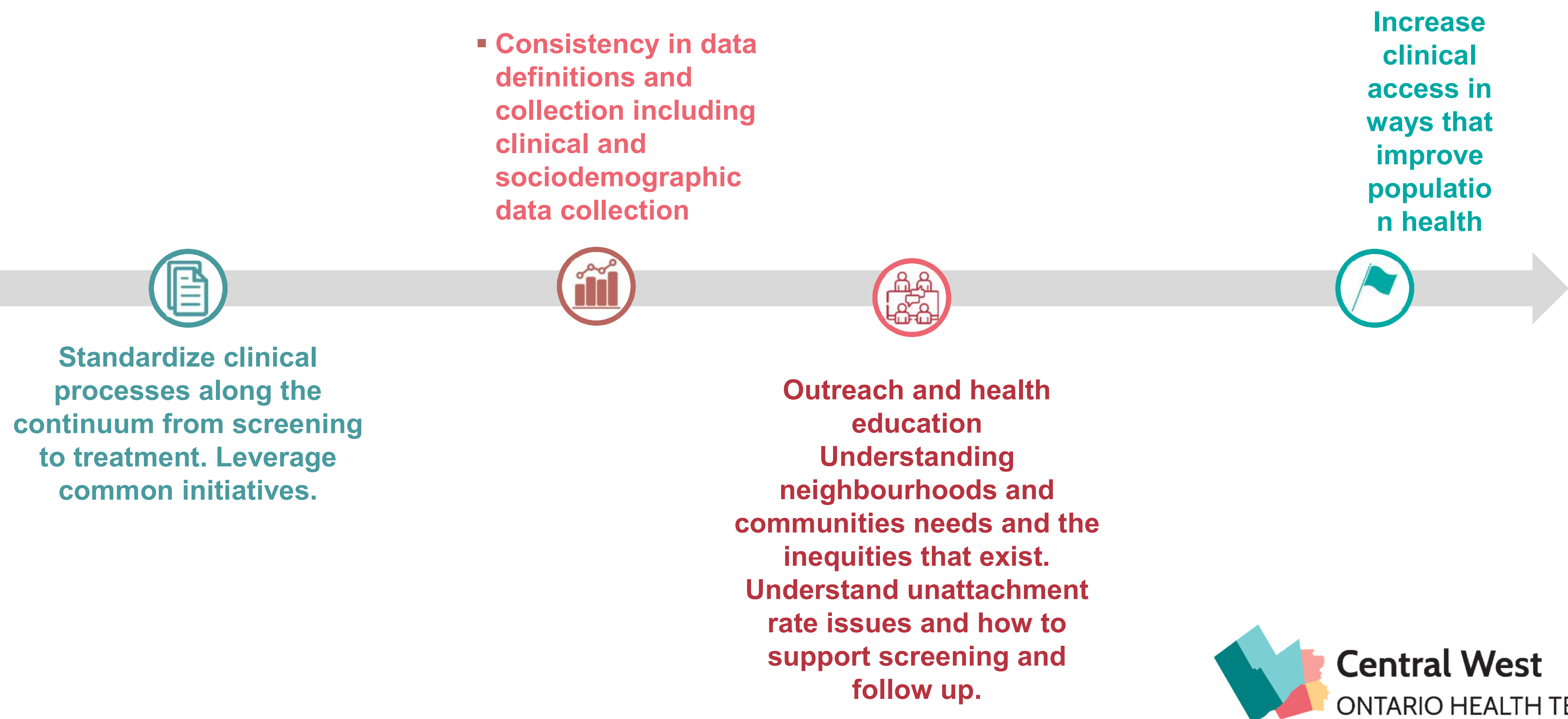
South Asian Group

- *Facilitators:* Having friends/family accompanying when going for screening, supportive HCP, having a provider of the same ethnicity.
- *Barriers:* Limited office hours, issues with booking appointments, transportation, childcare and getting time off, taboos to discuss health and changes in health, finances.
- *Recommendations:* Holistic approach (Interventions that include prescribed meds and natural remedies), care available in different settings i.e.community centres, reduce costs of services (PAP smears and HPV vaccine).
  Suggestions for Information dissemination: Educational campaigns, workshops, social media, newspaper.

roots community services
Inspiration. Empowerment. Action.

WellFort

OHT Cervical Screening-Lessons so far



Thank You

For more information

Kimberley.floyd@wellfort.ca

Central West
ONTARIO HEALTH TEAM

CENTRE DE SANTÉ COMMUNAUTAIRE

REXDALE

COMMUNITY HEALTH CENTRE

Rexdale-Osler Breast Screening Collaboration

Breast cancer affects people of all races, but Black women often get diagnosed later and have higher mortality rates. The High Priority Community strategies (HPCS) program places significant emphasis on cancer screening which includes Mammogram.

The Breast screening initiative started February 21, 2023.

The main objective of this collaboration with the Osler Breast Screening Program is to work together to help improve screening, reduce barriers, and enhance early detection in the African, Caribbean and Black communities.

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REXDALE
COMMUNITY HEALTH CENTRE

Here are some of the Myths

- Only women can develop breast cancer
- Mammograms are always painful
- A mammogram can cause breast cancer
- If you have no Family history of breast cancer, you can't get breast cancer
- Breast cancer can only happen to middle-aged and older women

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REXDALE
COMMUNITY HEALTH CENTRE

Who is Eligible?

- Must be from the African, Caribbean and Black community living in Rexdale/North Etobicoke
- Patient between the age of 50-74 years old
- Last mammogram was 2 years ago
- No previous Breast Cancer
- No implants
- OHIP
- No OHIP/Health Insurance(Rexdale covers the cost for uninsured clients-NO VISITORS/TOURIST)

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REXDALE
COMMUNITY HEALTH CENTRE

Client are enrolled through Local Physicians that RCHC have partnered with, community outreach, partners and agencies,events, etc.

→ HPC Nurse Practitioner screen for eligibility

→ Clients are informed and prepared for the screening

→ Requisitions with client's information are faxed to booking office 4 days before the appointment

→ Three appointment slots are set aside for RCHC Clients every Tuesday

→ RCHC staff accompany clients to ensure a smooth registration and appointment process

→ Results are handled by HPC NP at RCHC and community physicians

→ Abnormal test results are followed up by Osler team

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Number of clients screened from February 21,2023-September 12,2023

119 Screened

127 up to date

3 Abnormal Results

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REXDALE
COMMUNITY HEALTH CENTRE

Offers social support by accompanying clients to their Appointments

Offers a $25 food card as a screening incentive

Offer Transportation and Translation help for clients in need

Connects unattached Clients to Primary care services and programs

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REXDALE
COMMUNITY HEALTH CENTRE

Testimonials

 # 48146

- **I was really scared because I did not know how the test was performed. The technician was professional and explained every step of the procedure before it was done. They took pictures at every angle and the procedure did not hurt at all. I was surprised when it was done because it was done quickly. I did not have pain afterwards. I am glad I did it and encourage others who have not done it also. The gift card at the end was a good surprise. Thank You.**

CENTRE DE SANTÉ COMMUNAUTAIRE
REXDALE
COMMUNITY HEALTH CENTRE

#38197

- **The HPC staff was provided transportation to the appointment and back home which was very convenient for me. There was an intern who was training, and they asked my permission for her to be present which I did not mind. They were cracking jokes which calmed me down during the procedure. It was a bit painful because of all the tagging and pulling but I tolerated it well because I was doing it for my health. Overall, the experience was very good. The HPC staff was very friendly, and I was happy to receive a gift card at the end. I would recommend it to my family and friends.**

CENTRE DE SANTÉ COMMUNAUTAIRE
REXDALE
COMMUNITY HEALTH CENTRE

#8422

- **It was time for me to do mammogram and I was glad that the HPC staff called and booked an appointment. The experience was very good, and the test went well. There was no wait time, and it went by quickly. The staff was very friendly and being provided transportation was very convenient. I have been with Rexdale CHC since 2005 and have had a very good experience. A lot of people do not know how many resources Rexdale CHC offers. I have follow-up appointments after the mammogram, and I am hoping the HPC staff will continue to support.**

CENTRE DE SANTÉ COMMUNAUTAIRE
REXDALE
COMMUNITY HEALTH CENTRE

Thank you

CENTRE DE SANTÉ COMMUNAUTAIRE
REXDALE
COMMUNITY HEALTH CENTRE

Questions?

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REXDALE
COMMUNITY HEALTH CENTRE

NORTH WESTERN TORONTO

Ontario Health Team

Health Equity in Action

Fatah Awil, OHT System Planner

Chris Marah, OHT Lead

About the North Western Toronto Ontario Health Team

Our Team
- In 2019, North Western Toronto Ontario Health Team was one of the first OHTs selected to implement a new model of care that is more connected and accessible.

Our Population
- The population that resides in the North York West sub-region
- Patients and clients served by our NWT OHT partner organizations
- The attributed population (414,000 people) - naturally occurring "networks" between patients, physicians and hospitals

Our Priorities
- Improving population health
- Health Concerns: Acute, respiratory, chronic and mental health conditions -chronic obstructive pulmonary disease, cancer, schizophrenia, psychosis, dementia, etc.
- Reducing health disparities and leverage the strength from the community

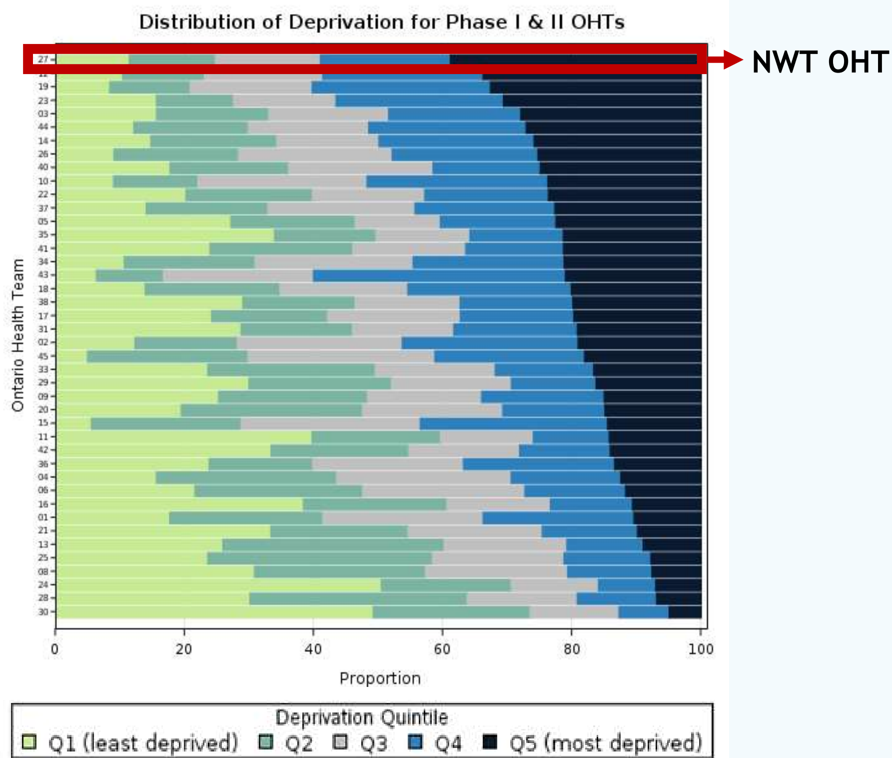
Opportunities
- Developing an enabling environment to support integrated care (governance, project management, digital health, change management, etc.)
- Expanding OHT membership
- Developing a multi-year strategy for the NWT OHT

Current Partners

Attributed Population Health Data

Proportion of OHT population according to Neighbourhood Material Deprivation

Deprivation: Lower Access to basic material needs i.e unemployment and/or without a high school degree



Our Community

Although our community has many strengths there are challenges which include but is not limited to:

There is a low number of physicians surrounded by high primary care need (Source: IC/ES, 2018).

Greater prevalence of chronic conditions compared to Ontario (Source: Toronto Community Health Profiles Partnership, 2019).

Our community ranks in the lowest level of mental health providers in comparison to a very high level of mental health disorders (Source: Toronto Community Health Profiles Partnership, 2019).

Our community experiences housing instability and challenges with attaining basic needs (59%) (Source: Ontario Marginalization Index).

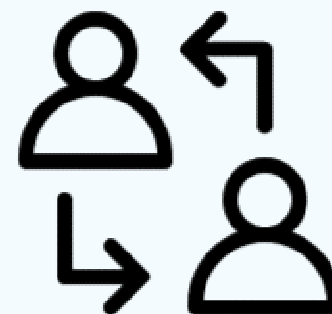
Health Equity Strategy Development

The NWT OHT Health Equity Committee has approached the development of the health equity strategy for the NWT OHT in consultation with our Institute for Healthcare Improvement (IHI) coach, OHT partners and a review of existing Health Equity (HE) strategies.

Our Process

Environmental Scan of Local Best Practices

Literature Reviews

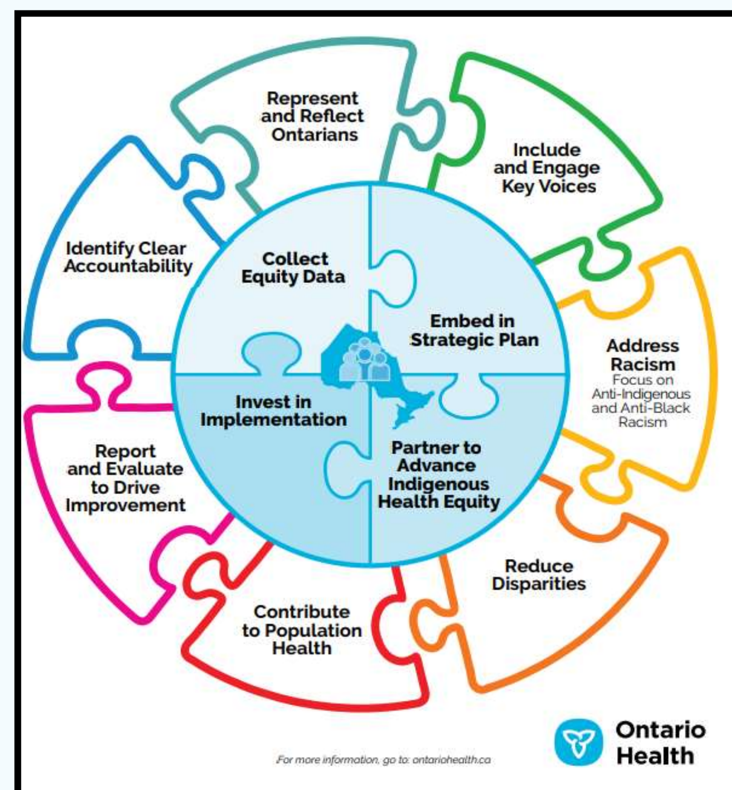


Community Engagement

Health Equity Strategy Development

How was the strategy developed?

- The original Health Equity Strategy consisted of 11 domains, each of which corresponded to the 11 areas of action identified in Ontario Health's Equity, Inclusion, Diversity, and Anti-Racism (EIDAR) Framework
- Each domain consisted of strategies and sub-strategies with level of implementation, time frame, and metrics for each sub-strategy defined
- Due to the framing and size of strategy we made our strategy more community facing.



DRAFT

Health Equity House

Ontario Health

Multi-Year Strategy

Aligned with Ontario Health's Equity, Diversity, Inclusion and Anti-Racism Framework

5 Health Equity Strategy Domains

What we need to do within the OHT and within community

Foundation Principles

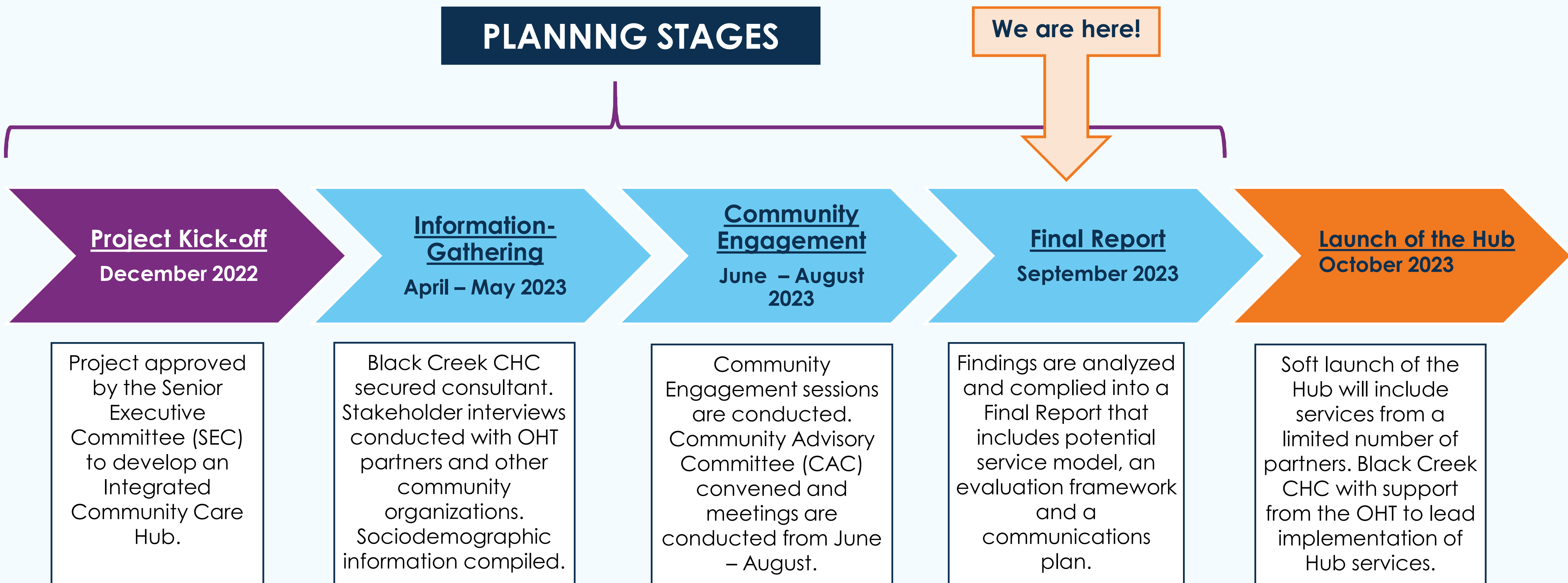
What principles will guide our actions?

Implementing our Strategy: Community Care Hub

To implement our health equity strategy, we leveraged existing partner resources to conceive the concept of a community care hub.

- The Community Care Hub will be located within the Northwestern Toronto community - **2115 Finch Avenue West, North York, ON M3N 1N1**.
- The space of the hub was provided by in-kind by Humber River Health and Black Creek Community Health Centre's Cheryl Prescod (Executive Director) was our Executive Sponsor
- **The Hub** will leverage a **community health service integration approach** and will include partners from both the health and social services sectors to reduce the disparities of health
- **Key features of the Hub:**
  - No referral required and flexible operating hours, easy accessibility and services that reflect the needs of the community (co-design).
  - Services at the Hub reflect an alignment of priorities between the Community, Ontario Health Teams and Ontario Health.

Implementing our Strategy: Community Care Hub



Implementing our Strategy: Community Care Hub

Our OHT held Community Engagement Sessions and developed a Community Advisory Committee made up of frontline staff and community residents to inform the development of the hub.

Key Findings
• The community would like to see the following services provided at the hub, mental health and addictions, housing/legal services, dental services, employment services, and senior/youth services • Increased access to both social and recreation activities for seniors • Community members want improved access and timely care • More BIPOC representation among staff and service providers

NWT OHT's community engagement session on June 15, 2023 at Black Creek Community Health Centre (Sheridan Mall location).

Next Steps

Task	Deliverables	Timeline
Receive approval from the Senior Executive Committee on final report, evaluation framework and communications plan	• Consolidate community and community advisory committee feedback into a final report • Finalize evaluation and communication plans	September
OHT to operationalize Community Care Hub Model	• Draft programming schedule • Establish an Operational "Community Advisory Committee" • Develop a MOU or service agreement template for potential service providers • Develop client booking and intake processes • Develop community resource databank + referral processes	September – October
Launch of the Hub	• Launch pilot program • Evaluate community utilization and adjust service offerings as needed	October – November

NORTH WESTERN TORONTO

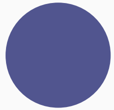
Ontario Health Team

Questions?

NORTH WESTERN TORONTO

Ontario Health Team

Thank You



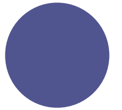
KW4
ONTARIO HEALTH TEAM

Interventions to Address Inequities in Ontario Health Teams

Ashnoor Rahim, Executive Director, KW4 Ontario Health Team

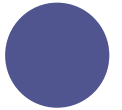
September 26, 2023

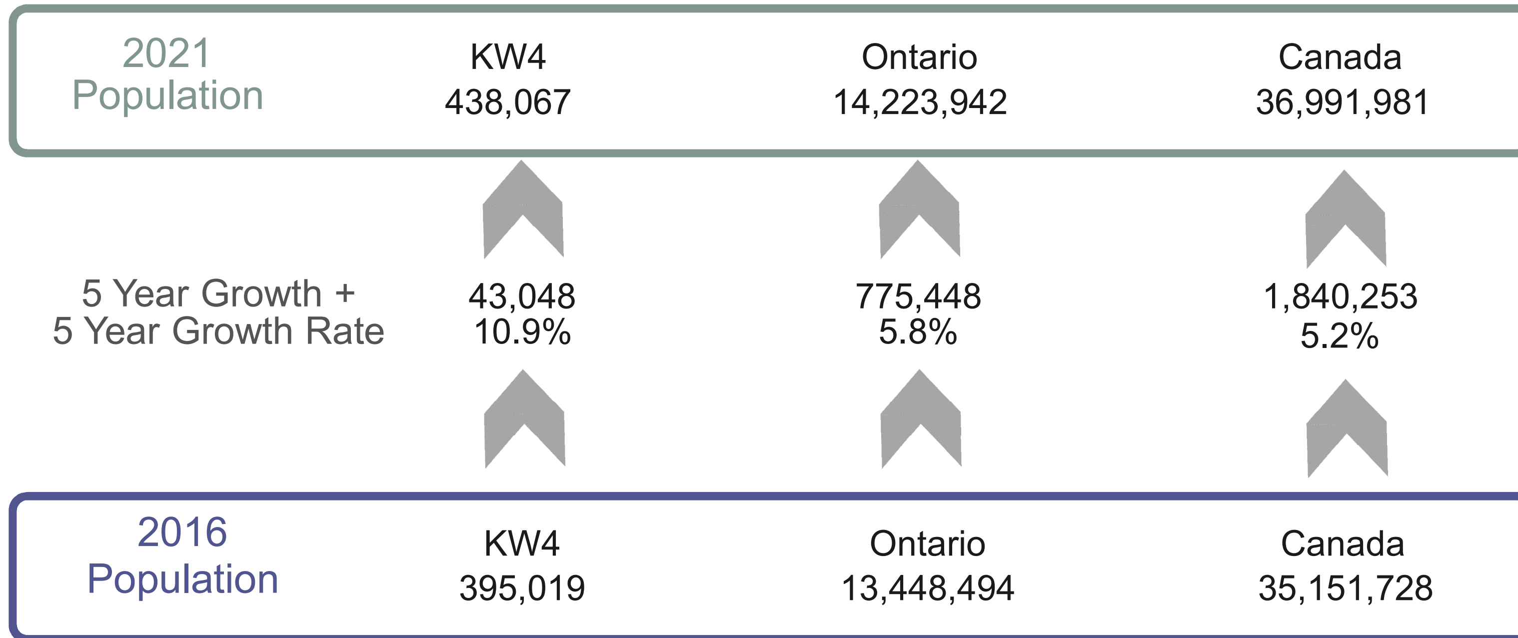
Today's Agenda



- Health Equity work in KW4 OHT
- Data and Priority Neighbourhoods
- Neighbourhood Integrated Care Team Project
- Lessons Learned
- Appendix

Population Growth & Rate

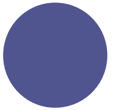




The KW4 region is growing much faster than Ontario and Canada.

Source: Statistic Canada

Census Data- Newcomers



43,048

Newcomers
(recent immigrants)

55% of KW4's Growth

Between 2016 to 2021

Immigrants accounted for the total population

2021

Recent immigrants

2021

Immigrants accounted for just over a quarter of the population in KW4 in 2021

From a growth perspective, recent immigrants made up a large proportion of the KW4's population growth

Source: Statistic Canada

KW4
ONTARIO HEALTH TEAM

Journey Mapping in Support of Co-design

The Newcomer Journey to Health & Wellness in KW4

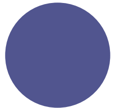
0-4 WEEKS

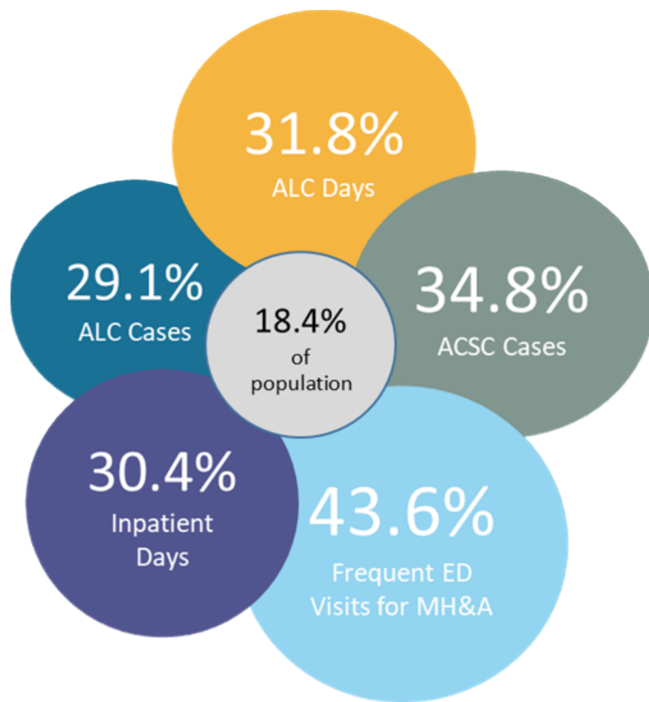
NEEDS	Finding immediate and safe housing and staying with your family	Getting children back to school and initiating immigration processes	Finding seasonally appropriate clothing	Undersatanding how to and findings ways to get around in all weather conditions
TOUCHPOINTS	Having a friend, a family member or a sponsor here enables access to primary care	Being aware of community organizations that serve newcomers enables access to primary care	Being aware of what type of services are covered based on, and regardless of, your immigration status having help with accessing healthcare	Focusing on immediate physical health needs are mainly why people seek healthcare
CHALLENGES	Finding housing and a family doctor are major issues	Not knowing where to go nor how to ask for help affect people's arriving journey	Not having a working knowledge of English or someone who can translate impacts people's independence and isolation	Not being aware of one's own and other's trauma, or not knowing what trauma is, can lead to further issues
EMOTIONS	I feel happy	I feel lost	I feel broken	I feel disappointed
POSSIBLE SOLUTIONS	Create an orientation tool that will inform people of what services are available out in the community per service type)	Work with universities to share student residences to provide temporary shelter for newcomers	Create free primary care based screening program for newcomers (1st month)	Provide educational opportunities on trauma and intergenerational trauma to newcomers and providers

This project continues to help us implement people- centered and evidence-informed system change beyond the healthcare system realm in KW4.

Outcomes from this project have informed our strategic (2022-2024) priorities and population health management efforts.

Priority Neighbourhoods (N2C, N2G, N2H, N2M)





KW4 OHT's current 4 priority neighbourhoods account for only 18.4% of the population in FSAs attributed with KW4.

The lowest cancer screening rates and 14-17% below screening rates of the best-performing neighbourhoods in KW4.

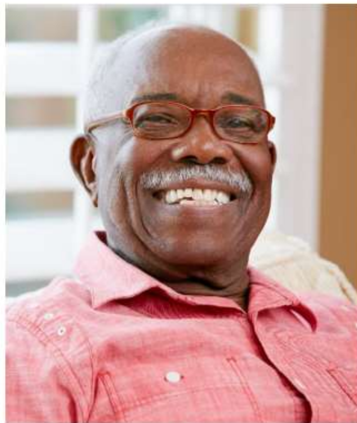
A higher rate of representation (30%) of patients registered with Health Care Connect in hopes of finding a Primary Care Provider.

Source: Hospital Data – FY 2022/23
Healthcare Connect data – June 1, 2023

KW4 ONTARIO HEALTH TEAM

Neighbourhood Integrated Care Team Project

Karl



Persona Profile:
Senior

Objective:
To improve overall access to care for seniors in the most appropriate setting.

Jeffrey

Persona Profile:
Person with Mental Health and Addictions Challenges

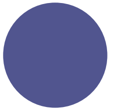
Objective:
To improve access to community services for adults with mental health and addictions challenges.

Nadia

Persona Profile:
Newcomer

Objective:
To improve the health and wellness of newcomers within the first two years of their arrival in KW4.

Lessons Learned



1

Achieving results involves adopting a population health perspective.

2

Desired outcomes require the involvement of all tiers of government.

3

The measurement and evaluation of progress is complex.

4

Achieving health and wellness goals requires a longitudinal perspective.

CONTACT US

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Visit

www.kw4oht.com

Follow @KW4OHT

info@kw4oht.com

Key questions for our discussion

- How are you intervening to address inequities in health and health care in your OHT?
- Who is involved in developing and implementing interventions to improve equity in your OHT?
- What resources do you have to support the development and implementation of interventions to improve equity in your OHT?

Poll 4

How knowledgeable are you about interventions to address health inequities ?

1 – Not knowledgeable at all
2
3
4
5 – somewhat knowledgeable
6
7
8
9
10 – Very Knowledgeable

HSPN

Up Next

- HSPN webinar series
  - 4th Tuesday of the Month: 12:00 – 1:30 pm

Upcoming

- October 24 – Patient engagement In collaboration with IFIC Canada
- November 28 – OHT Digital Health Initiatives

Can you share some feedback? Scan here! (or click link in chat)

HSPN

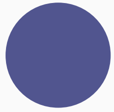
THANK YOU!

@infohspn

hspn@utoronto.ca

The Health System Performance Network

hspn.ca



Appendix

Newcomer with Diabetes: Integrated Care Pathways

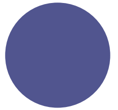
KW4 ONTARIO HEALTH TEAM

KW4 ONTARIO HEALTH TEAM

Newcomer with Diabetes

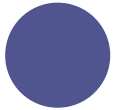
The following slides depict the co-designed integrated care pathway developed with the KW4 community. This pathway is intended to be an 'ideal future state' pathway. It is a starting point for continued Integrated Care Pathway development for KW4 OHT moving forward.

Newcomer with Diabetes: Goals and Services



	Newcomer with Diabetes
Goals	• Increase knowledge of resources and services available in the KW4 region • Provide strong system navigation • Reduce unnecessary duplication of efforts between providers • Provide a multidisciplinary, team-based approach to care • Establish a clear point of contact for the patient • Provide culturally-sensitive care • Improve chronic disease management in the community • Reduce barriers to accessing care
Services that may integrate with this pathway in the future (this is not an exhaustive list)	• Diabetes Central Intake (Regional Coordination Centre) • Diabetes Program (Community Healthcaring Kitchener-Waterloo) • Refugee Health Integrated Care Program (Centre for Family Medicine) • Primary Health Care, Refugee Health, Community Health and Wellness (Community Healthcaring Kitchener-Waterloo) • Adult Diabetes Education Centre (Grand River Hospital)

Newcomer with Diabetes: Intake and Triage



1 Person presents with diabetes and/or symptoms:

- Primary Care
- Hospital
- Pharmacy
- Settlement Services
- Community Organization
- Self-referral (Waterloo Wellington Diabetes website self-referral form or Newcomer App – once created)

Note: Care provider in this case is refers to anyone with a billing number.

2 Care provider addresses immediate care needs (and introduces Newcomer App)

3a Care provider completes referral to Diabetes Central Intake and, if required, completes a referral to specialist care

3b Person completes self-referral form. Referral form accessibility options:

1. Newcomer App with direct link to Waterloo Wellington Diabetes self-referral form;
2. Waterloo Wellington Diabetes website self-referral form
3. Paper form printable through Waterloo Wellington Diabetes website

Self-referral form offered in a variety of languages for referral to care and/or to education

Note: Opportunities to provide education to pharmacy, settlement services, community organizations to support a newcomer to compete a self-referral/access additional resources. Opportunities to flag the newcomer's insurance status early when the referral is submitted.

4 Central Intake Team processes the referral and collects relevant information

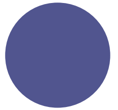
Note: Self-Referral forms completed online are supported by OCEAN eReferral and are seen by Central Intake referral clerk immediately (during normal business hours)

5 Central Intake Team triages the person based on level of urgency for care or requirements for education

There are three sub-groups:

- **Urgent** (standard wait time 1-2 days)
- **Semi-Urgent** (standard wait time 7-14 days)
- **Non-Urgent** (standard wait time 14-28 days)

Newcomer with Diabetes: Assessment



6 Central Intake Team flow the referral to the most appropriate Diabetes Education Program (DEP) based on their needs and insurance status

→ **7** The respective Diabetes Education Program (Hospital Diabetes Education Program or Community Diabetes Education Program) conducts a full assessment

→ **8** Based on the assessment, the relevant Diabetes Education Program provides education

→ **9a** If the person has an existing PCP, the Diabetes Education Program will make recommendations to the PCP for further care. If a specialist is recommended, the PCP will submit a referral

9b If person is not attached to a primary care provider, attempts will be made to link the patient to a provider who will continue to collaborate with the Diabetes Education Program to provide care

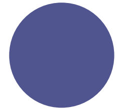
→ **10** Primary Care Provider completes assessments, reviews recommendations from the Diabetes Education Program and develops an individualized care plan in collaboration with the person and the Diabetes Education Program

Newcomers' insurance status may limit access to services:

- Short-term visa
- Long-term visa
- Government-assisted refugee
- Self-sponsored

Note: In order to see a specialist, a referral from primary care provider, emergency (hospital) or urgent care is required. Typically specialists involved in care include but are not limited to: endocrinologists, ophthalmologists, nephrologists, chiropodists.

Newcomer with Diabetes: Care Planning and Care Delivery



Potential providers to include in the care team, for example:

Registered Dietitian	Pharmacist	Counselling
Endocrinologist	Diabetes Educator	Transportation Supports
Multicultural Care Provider	Behavioural Change Specialist	Recreational Therapy
Language/Translation	Podiatrist	Peer Supports
	Wound Care	

Note: Opportunities for additional education to be provided to various service providers about culturally competent resources for newcomers with diabetes and various service options dependant on insurance status.
Opportunities to share additional information about the Waterloo Wellington regional self-management program.
Also, opportunity for translation services at each point of interaction.