HSPN Health System Performance Network

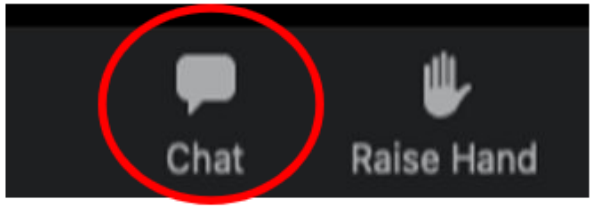
Furthering our Understanding of Equity in the Ontario Health System

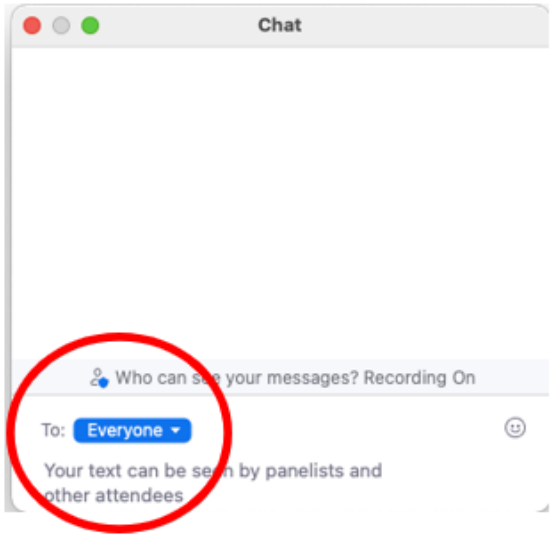
HSPN Monthly Webinar

March 26, 2024

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

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

HSPN Poll 1: First time ?

Poll | 1 question | 115 of 146 (78%) participated

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

115/115 (100%) answered

Yes, I have participated previously (61/115) 53%

No, this is my first event (54/115) 47%

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Today's event
Equity in Ontario's Health System

Host

Dr. Walter Wodchis
Principal Investigator
HSPN

Presenters

Jessica Morgan
Master's Student
HSPN

Iryna Pshonyak
Master's Student
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PhD Student
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Priyanka Gayen

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Vijay Kunaratnam

Emily Charron

Victor Rentes

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Understanding of Equity in the Ontario Health System

A review of HSPN 2023 equity-related webinars

March 26, 2024

HSPN Webinars
2023 Equity Series

May 2023: Building Capacity for Equity

October 2023: Equity Interventions

April 2023: A Primer

June 2023: Measuring Equity

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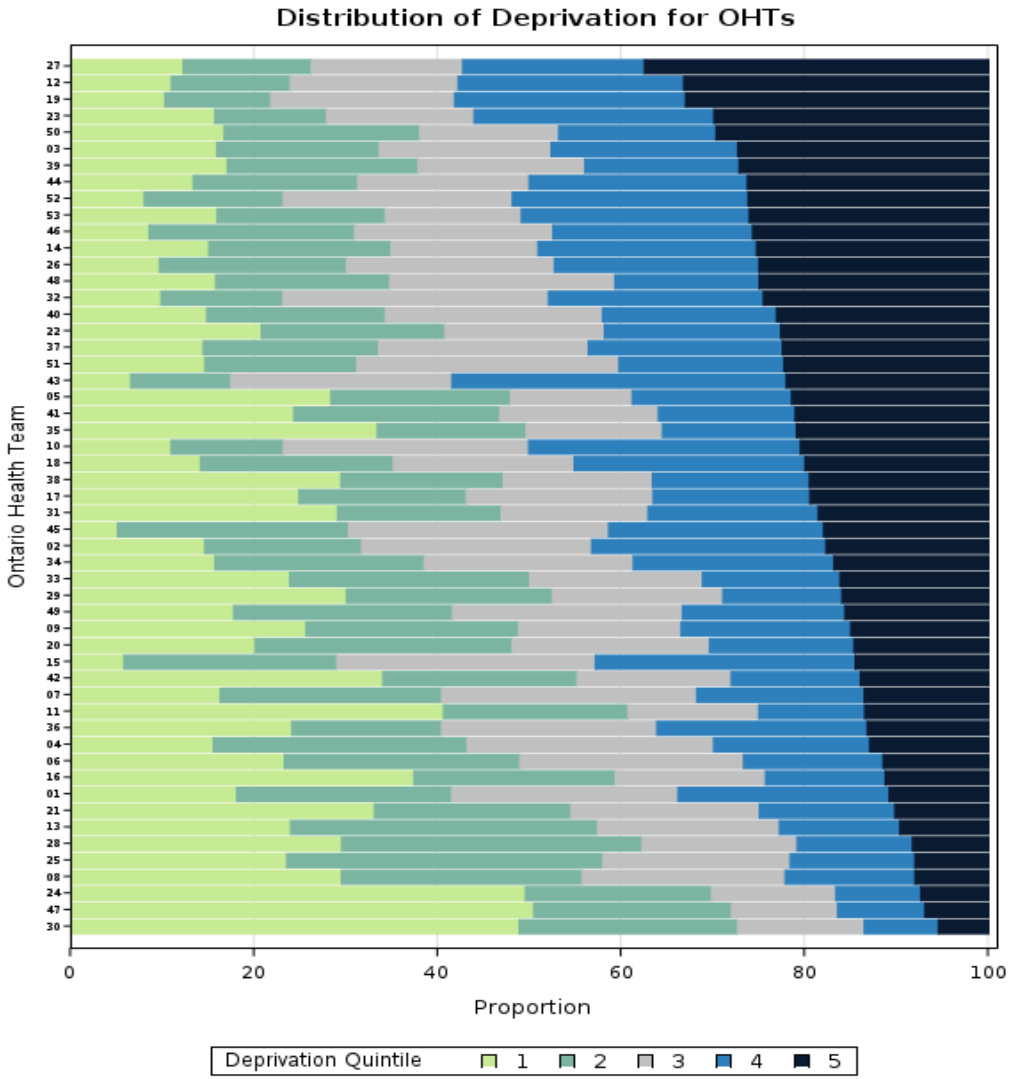
Key Takeaways:

- Considerable variation across OHTs in the distribution of their attributable population residing in areas of low to high material deprivation.
- Measures of health outcomes have larger associations with area-level deprivation as compared to process measures such as access.
- Quadruple aim measures of Patient and Provider experience have varying strength in associations with socio-demographic factors.

Proportion of OHT population according to Neighbourhood Material Deprivation
Ontario Health Teams. OHT Attributable Populations:



Ideas:

- Measure current state, e.g. using Anti-Black Racism Organizational Self-Assessment Survey.
- Offer one-on-one support to organizations in creating and implementing Anti-Black Racism action plans.
- Create an ABR Learning Network across Organizations and OHTs.

- Recognize Equity, Diversity and Inclusion (EDI) as a priority in the OHT.
- Use an OHT EDI Framework in planning, decision-making and OHT projects and initiatives.
- Ensuring the membership of decision-making structures and committees in the OHT is representative of diverse populations.
- Identify opportunities to advance equity, diversity and inclusion in every practice/organization.

Interventions:

Elements of designing and implementing interventions:

- Evidence review of interventions that affect priority action areas.
- Local case studies to understand what actions individuals have shown to be feasible.
- Engage with patients and public to understand patient stories and gauge areas of priority.
- Measure effects quantitatively and qualitatively.

- Leverage resources including Health Equity Frameworks and Community voices and Lived experience.
- Just go! Start somewhere. (and Listen !)
- Partner with community agencies and outreach organizations.
- Consider social supports, food gift cards, transportation and related needs.
- Consider new initiatives such as community hub with services co-inspired with community members.

Measurement Implications:

- All data presented by socio-economic status and ethnicity as part of routine reporting.
- Use short (access), medium (integration) and long term (outcomes) metrics.
- Incorporat key metrics into routine performance reports
- Generate consensus on equity priorities.

- Integrate quantitative and qualitative evidence.
- Undertake analysis at the level of action.
- Link data with evidence-based actions.
- Enable peer support and learning with clear organisational responsibilities.
- Embed measurement in equity-focused quality improvement.

HSPN Equity Series: 5 Reports

- How should we measure health equity for performance reporting?
- Are there inequities in use of virtual care in Ontario?
- What are the barriers and facilitators in access to diabetes care for Black and South Asian populations?
- How can we collect socio-demographic data for community-based action?
- What are international examples for governance and accountability for equity in integrated care?

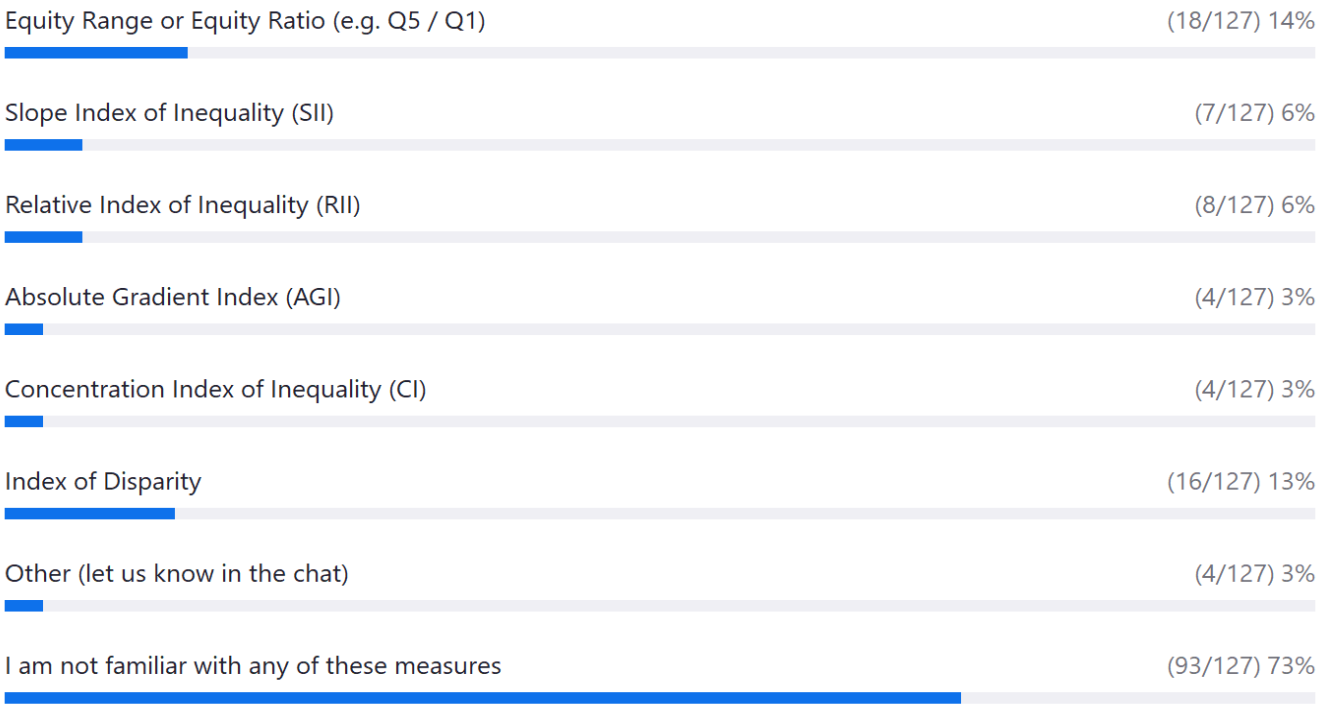
Poll 2

HSPN Equity Poll 2: Which measurement is known?

Poll | 1 question | 127 of 189 (67%) participated

1. Which statistical approach to measuring equity are you familiar with (check all that apply) (Multiple Choice)

127/127 (100%) answered



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How to Measure Health Equity

Jessica Morgan, Marissa Bird, and Paul Wankah

March 26, 2024

Objective:

Identify and describe how health inequities can be quantified into a single measure for the purpose of evaluating health system performance.

Definition of health inequity used to guide work:

Differences in health that are linked to social, economic, or environmental disadvantage/under-resourcing.[1]

1. Braveman PA. Monitoring Equity in Health and Healthcare: A Conceptual Framework. *J Health Popul Nutr*. 2003;21(3):181-192.

1. Equity Stratifier

Definition of health inequity used to guide work:

Differences in health that are **linked to social, economic, or environmental disadvantage/under-resourcing.**[1]

- Identify different subgroups in the population according to economic, social, or environmental factors.[2] E.g., Race, ethnicity, sex, income etc.
- Sources of equity stratifiers: Census and surveys.
- What differentiates health equity measurement from measures of average health.

1. Braveman PA. Monitoring Equity in Health and Healthcare: A Conceptual Framework. *J Health Popul Nutr*. 2003;21(3):181-192.
2. Canadian Institute for Health Information. In Pursuit of Health Equity: Defining Stratifiers for Measuring Health Inequality — A Focus on Age, Sex, Gender, Income, Education and Geographic Location.; 2018.

2. Health System Performance Indicator

Definition of health inequity used to guide work:

Differences **in health** that are linked to social, economic, or environmental disadvantage/under-resourcing.[1]

- Have directionality, are comparable (e.g., risk-adjusted), and are used to monitor health system performance.[3] E.g., Cancer screening rates.

1. Braveman PA. Monitoring Equity in Health and Healthcare: A Conceptual Framework. *J Health Popul Nutr*. 2003;21(3):181-192.
3. Canadian Institute for Health Information. What is an Indicator? https://www.cihi.ca/en/access-data-and-reports/health-system-performance-measurement/what-is-an-indicator#_What_are_the_Differences

3. Statistical Approach

Definition of health inequity used to guide work:

Differences in health that are linked to social, economic, or environmental disadvantage/under-resourcing.[1]

- Quantify the relationship between an equity stratifier and a HSPI.

- Approaches identified:
  - Rate range
  - Rate ratio
  - Slope index of inequality
  - Absolute gradient index
  - Relative index of inequality
  - Concentration index of inequality
  - Index of disparity

1. Braveman PA. Monitoring Equity in Health and Healthcare: A Conceptual Framework. *J Health Popul Nutr*. 2003;21(3):181-192.

- Rate range
- Rate ratio
- Slope index of inequality
- Absolute gradient index
- Relative index of inequality
- Concentration index of inequality
- Index of disparity

Simple measures

- May overlook important differences in the population.[4]
- Appropriate when aim is to improve the health of a specific group relative to another or serve as a starting point for more complex measures.[4]

Complex measures

- Capture inequalities across the entire population.[4]
- More difficult to interpret, more computationally intensive.

4. Wagstaff A, Paci P, van Doorslaer E. On the measurement of inequalities in health. Soc Sci Med. 1991;33(5):545-557. doi:10.1016/0277-9536(91)90212-U

- Rate range
- Rate ratio
- Slope index of inequality
- Absolute gradient index
- Relative index of inequality
- Concentration index of inequality
- Index of disparity

Absolute measures

- Provide more context than relative measures.
- Not comparable across different indicators.

Relative measures

- Dimensionless; comparable across different indicators.[5]
- Could lead to an overestimation of magnitude of health inequalities for HSPIs with low event rates.[5]

5. King NB, Harper S, Young ME. Use of relative and absolute effect measures in reporting health inequalities: structured review. BMJ. 2012;345(sep03 1):e5774-e5774.

Key Takeaways

1. To measure health performance inequities:
    1. Equity stratifier,
    2. Health system performance indicator
    3. Statistical approach

2. Consider each component thoroughly – choice affects results and interpretation

3. Best approach depends on aim

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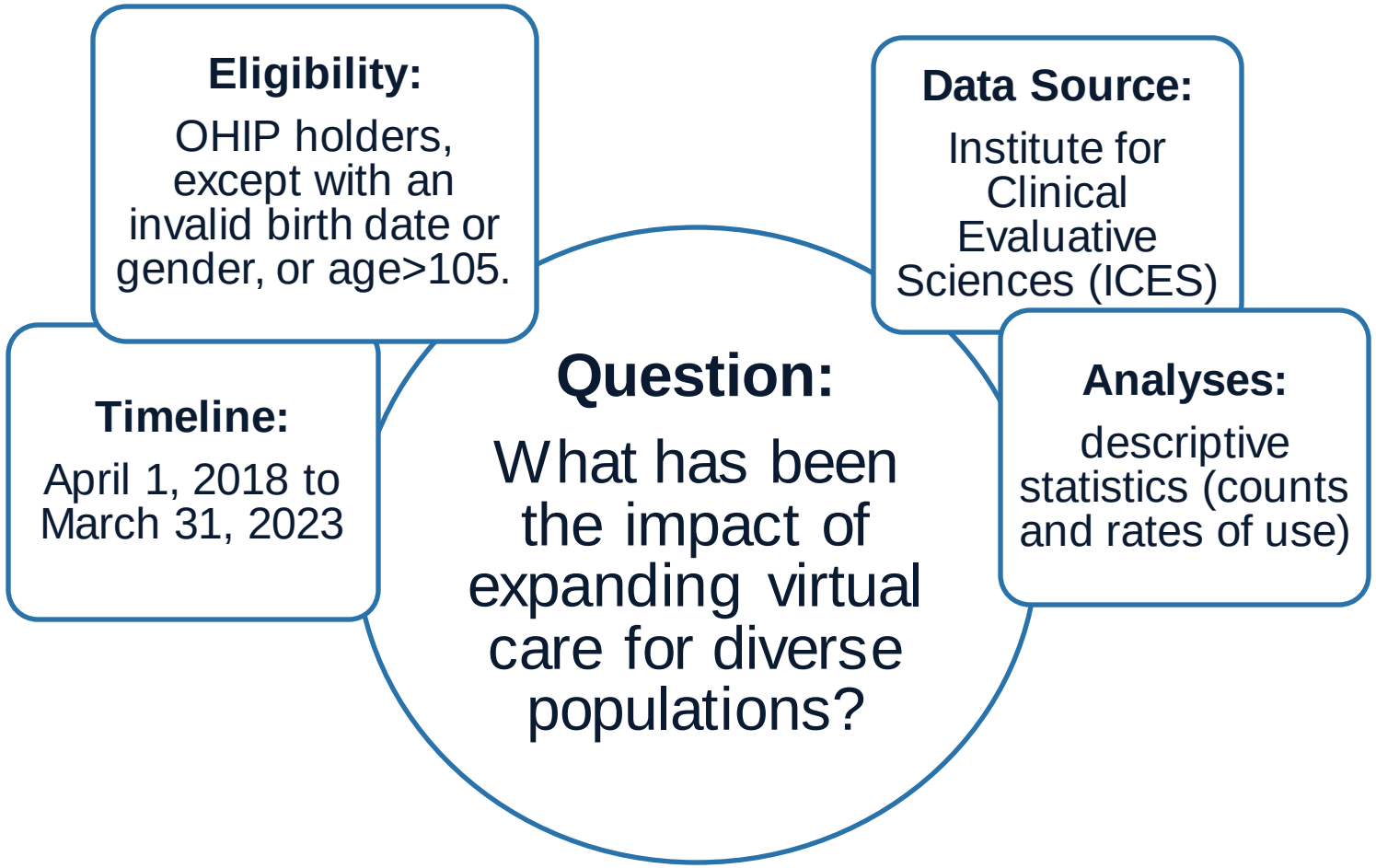
Virtual Healthcare and Equity in Ontario

Iryna Pshonyak, Emily Charron, Ruiyue Ma, & HSPN Team

March 26th, 2024

Methods



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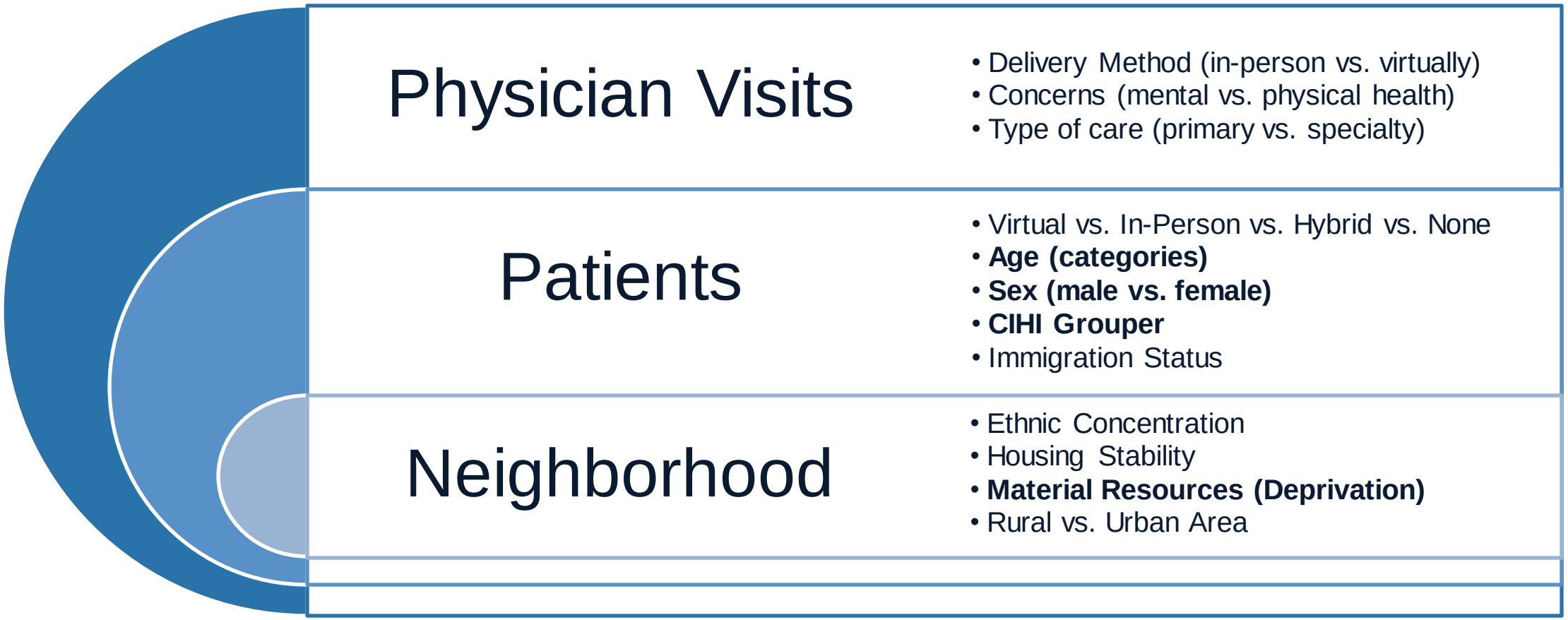
Equity Stratifiers and Other Variables



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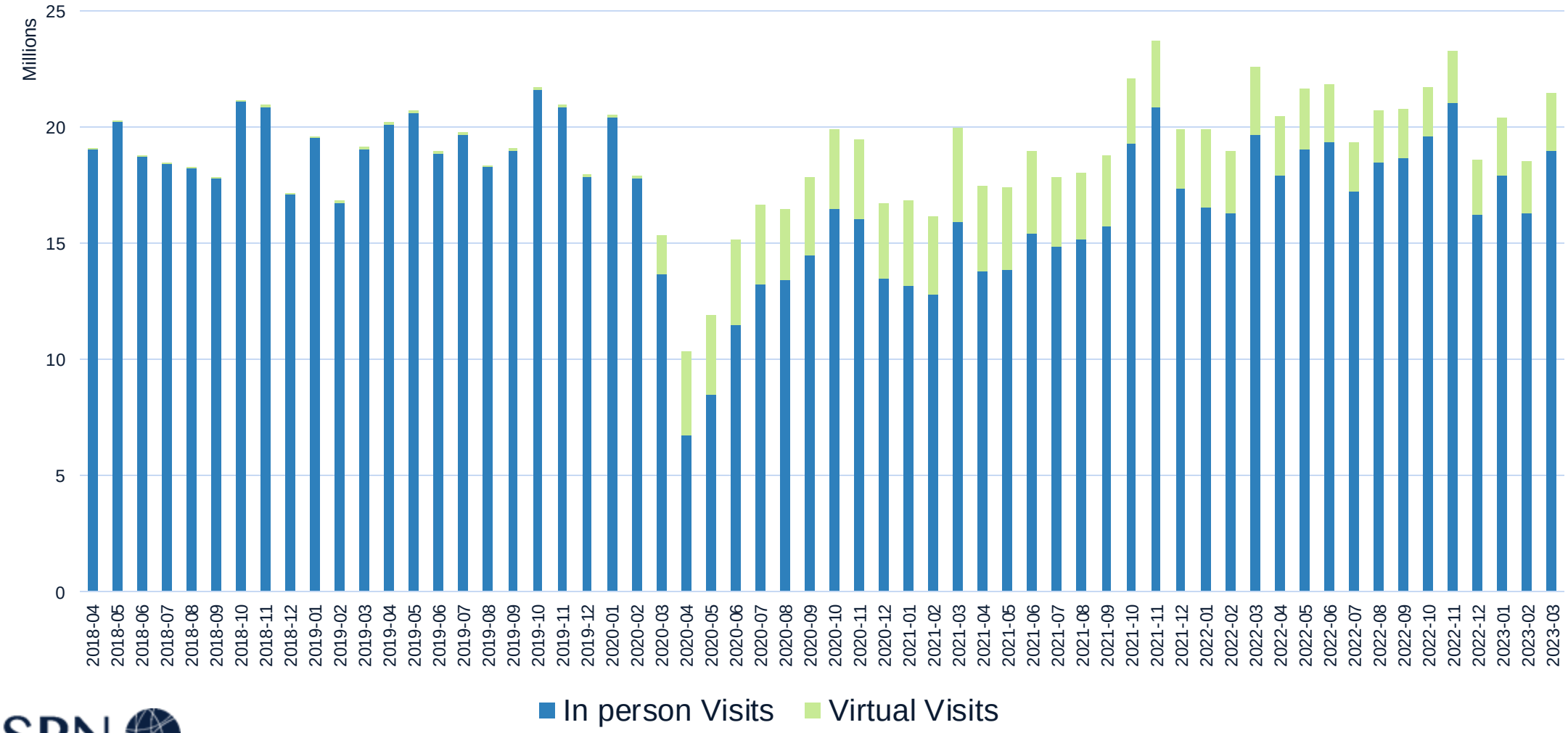
Total Monthly In-Person and Virtual Visits in Ontario from April 2018 to March 2023



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Virtual Visits Trends

Pre-Pandemic

majority of virtual appointments were for **primary care**

virtual appointments being used equally for **mental and physical concerns**

Post-Pandemic

majority of virtual appointments were for **primary care**

75% of virtual visits treated **physical concerns**

more mental health appointments per month and more occur virtually

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Patients of Virtual Care

- Ontarians of age **65 and above** had more appointments than any other age group
- **Women** are more frequent users of healthcare and used virtual care more in conjunction with in-person care
- **Patients with 5 or more health conditions** are responsible for more appointments in-person and virtually
- As the time passes, more patients return to in-person care

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Total Annual Healthcare Use by Age

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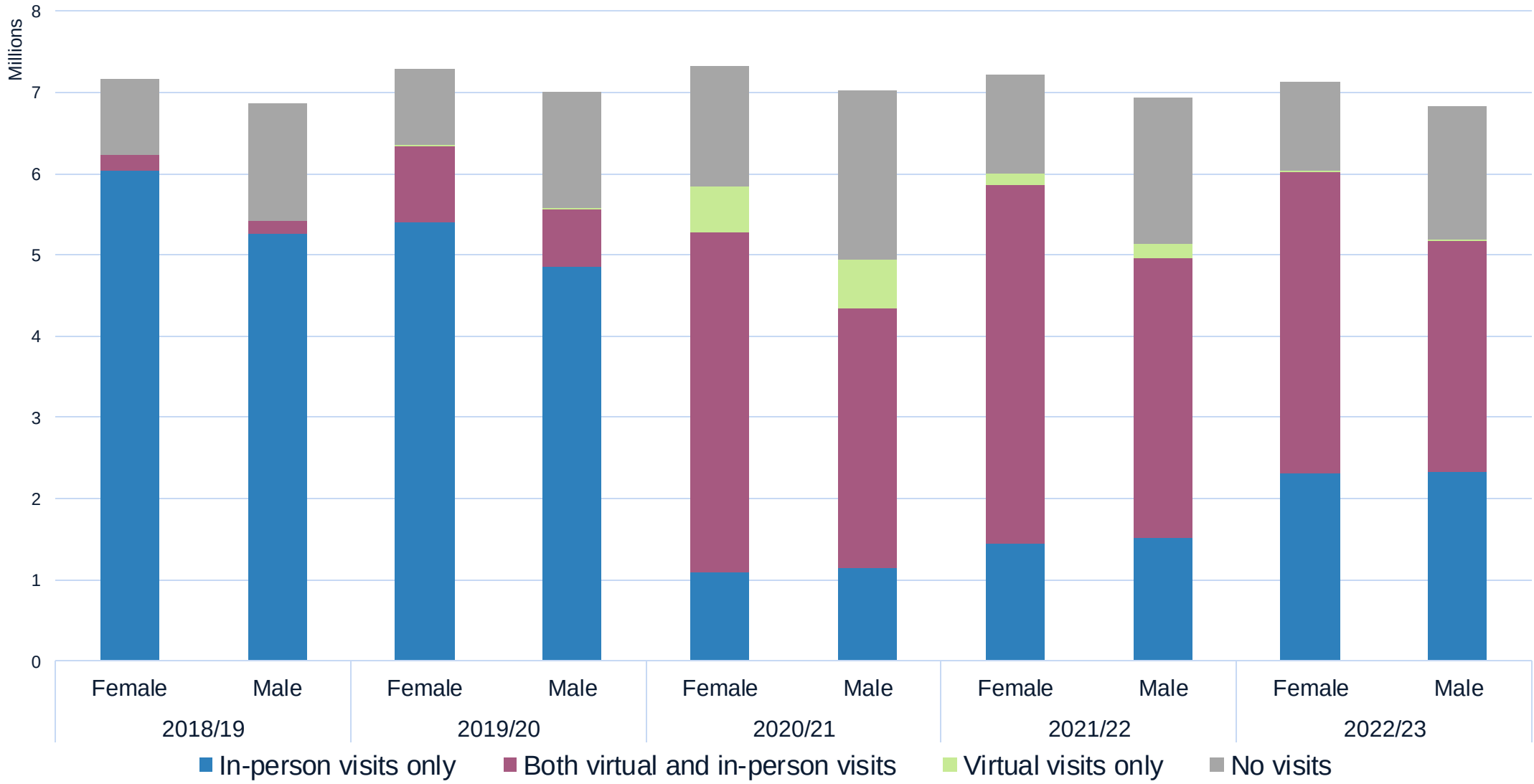
Total Annual Healthcare Use by Sex



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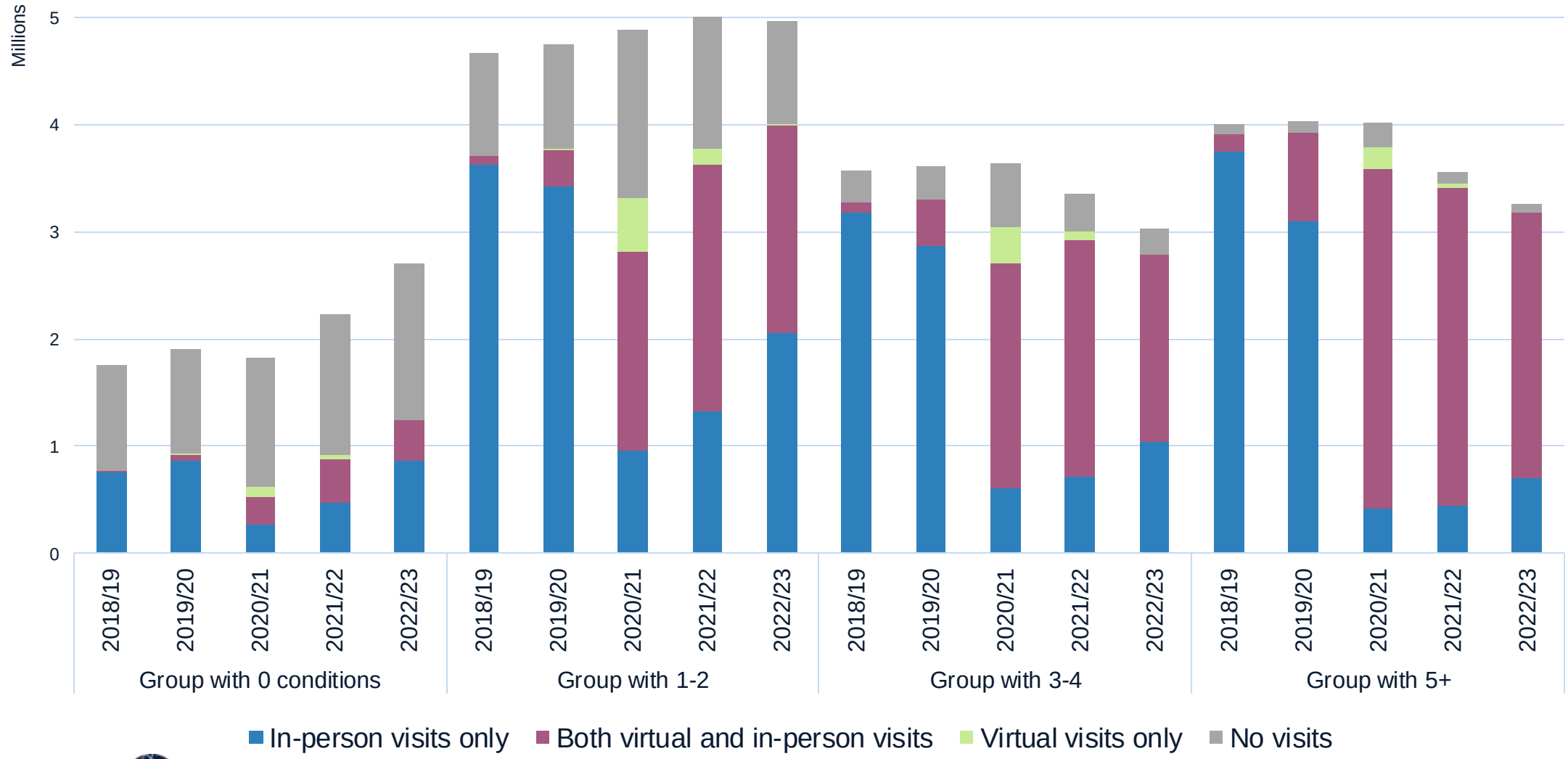
Total Annual Healthcare Use by CIHI POP Group



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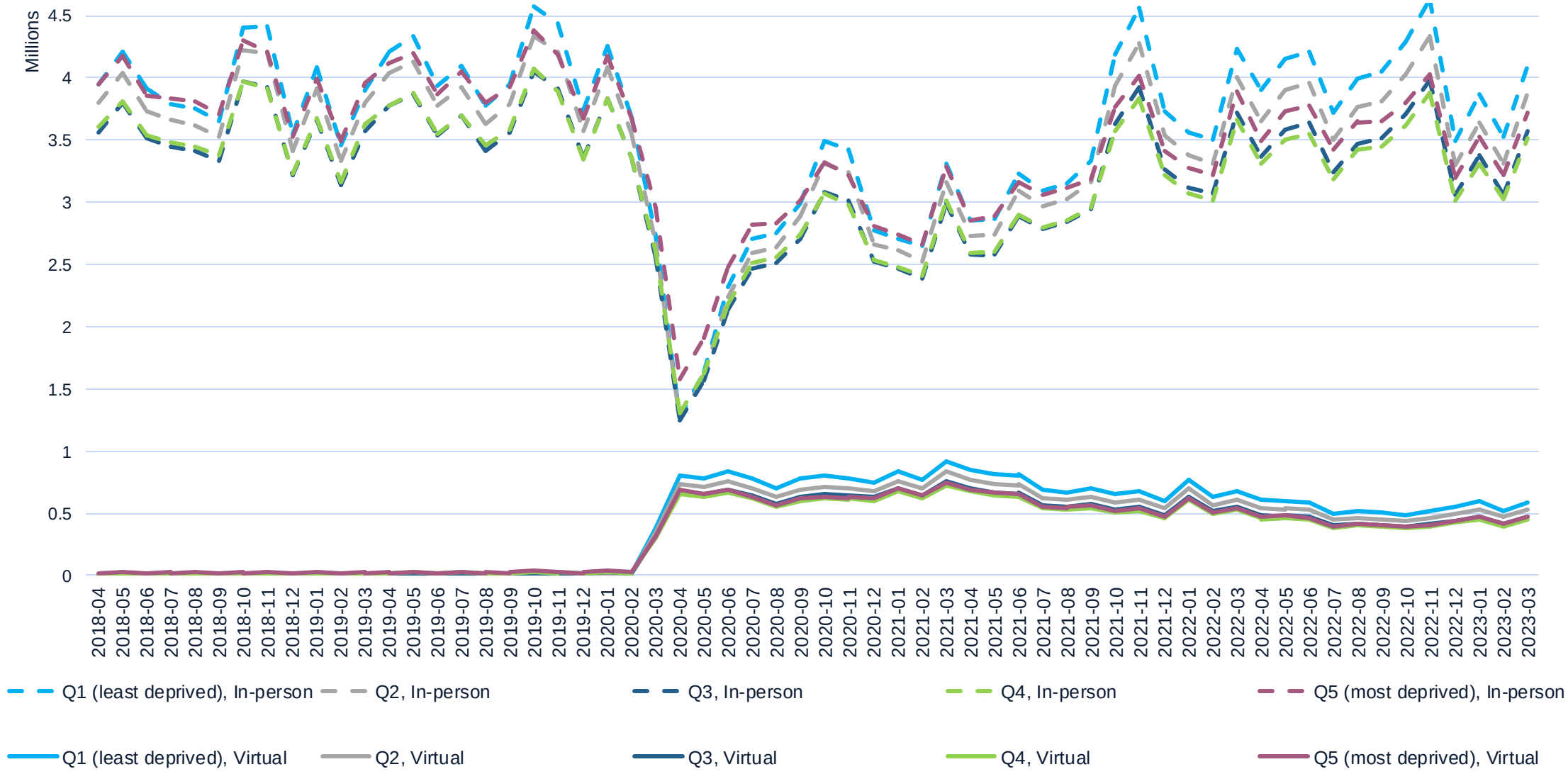
Equity Stratifiers by Residency

- Overall individuals in least deprived neighbourhoods have a slightly larger population and contribute more total visits both virtual and in-person.
- Individuals in neighbourhoods with higher deprivation have more in-person visits per person per year. Post-pandemic this is a slightly weaker relationship.
- Pre-pandemic, individuals in higher deprived neighbourhoods had slightly higher virtual care visit per person per year; post-pandemic, virtual care is now the same across material deprivation groups.

Total Monthly Visits by Material Deprivation



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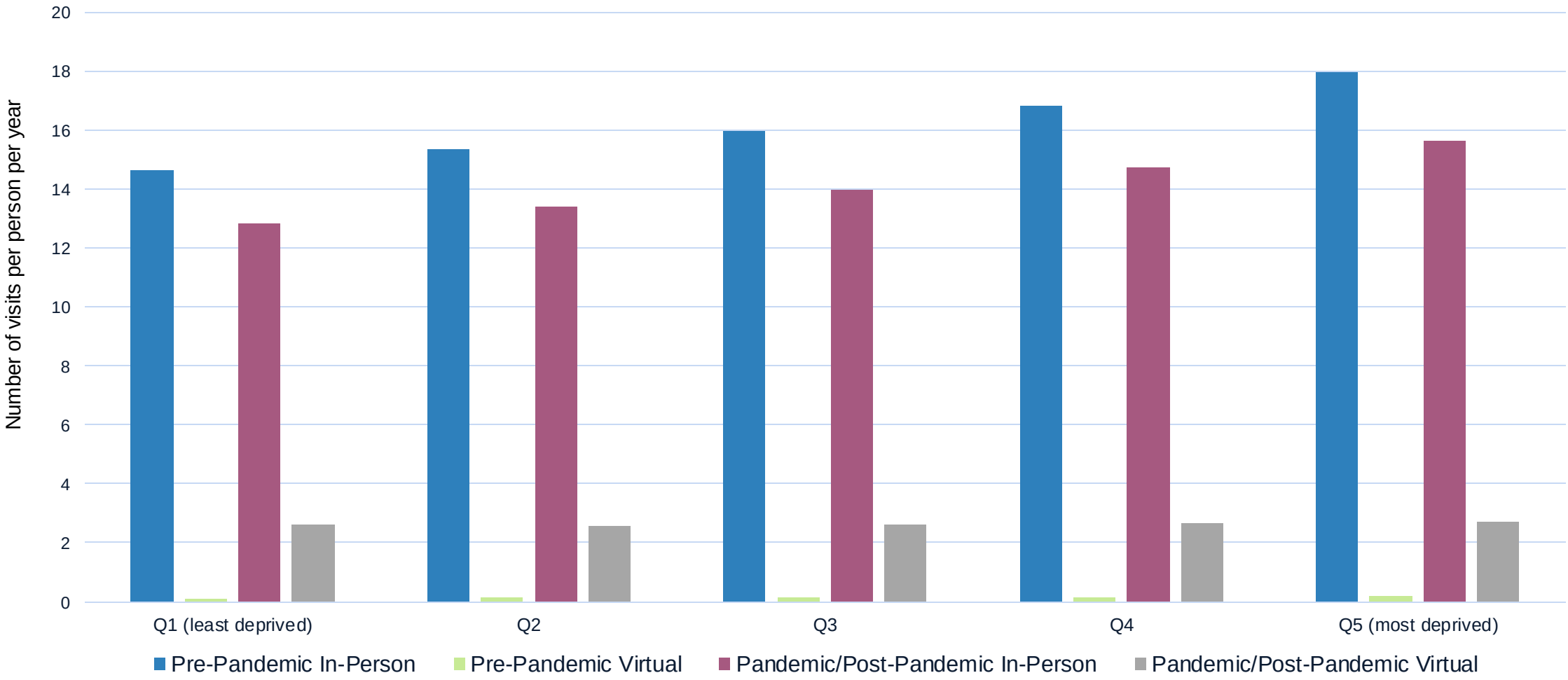
Rate of Healthcare Use by Material Deprivation



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Key Takeaways

- The amount of virtual care increased overnight with the advent of the COVID 19 pandemic. Virtual care has declined slowly, but is still far more prominent that prior to the pandemic.

- Most individuals with virtual care also seek care in-person.

- Individuals with higher deprivation have more in-person visits per person per year. Post-pandemic this is a slightly weaker relationship.

- Overall it appears post-pandemic that people in higher deprivation neighbourhoods may have lower access to care as compared to those in areas with lower deprivation.

Poll 3

HSPN Equity Poll 3: Virtual Care 1

Poll | 1 question | 116 of 190 (61%) participated

1. Poll 3: Do you expect virtual care for physician services to increase or decline in your OHT ? (Single Choice)

116/116 (100%) answered

I expect it will increase	(55/116) 47%
I expect it will decline	(10/116) 9%
I expect it will stabilize and stay about how it is now	(51/116) 44%

Poll 4

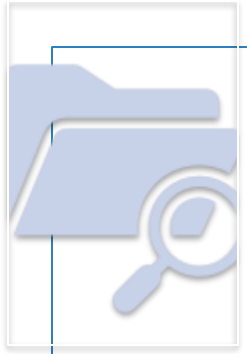
HSPN Equity Poll 4: Equity and Virtual Care

Poll | 1 question | 118 of 189 (62%) participated

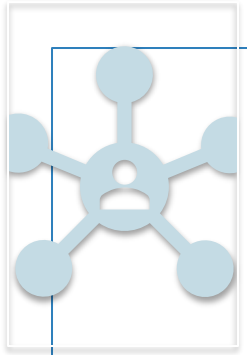
1. Do you believe that Virtual Care is reducing inequities in access to healthcare ? (Single Choice)

118/118 (100%) answered

SOME LIMITATIONS



Data



Complex interaction between equity stratifiers

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Barriers and facilitators in accessing diabetes care for South Asian and Black populations living in Ontario

Laleh Rashidian, Lauren Cadel, Chris Bai, Walter Wodchis

26th March 2024

Overview of Research Project

- What are the barriers and facilitators in accessing diabetes care for South Asian and Black populations living in Ontario?

- Two main components:
  - 1) A quantitative report; measuring diabetes access to care and outcomes across **South Asian** populations in Ontario
  - 2) A qualitative report; exploring barriers and facilitators to diabetes care across **Black** populations in Ontario

Overview of Quantitative Methods

Population

South Asian patients included in the Ontario Diabetes Database

- South Asian patients identified using Surname Algorithm
  - OHIP
  - Type I or Type II Diabetes Mellitus
  - 1 Hospital Discharge Abstract or 2 Physician Service Claims within 2 years showing DM

Selected Indicators

1- HbA1c screening

2- Retinal screening

3-Statins dispensed

4- Hospitalization for long-term diabetes related complications

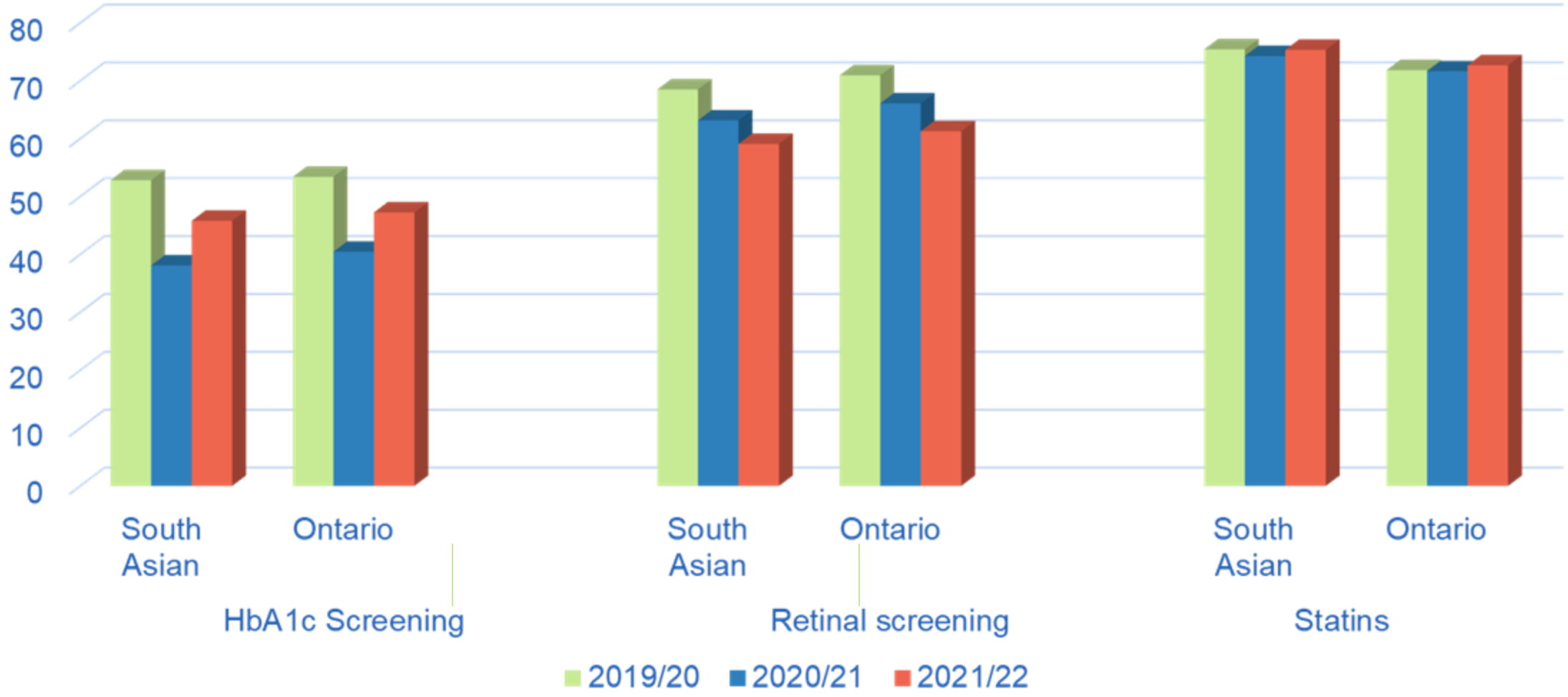
5-Poor Glycemic Control

Sources of data

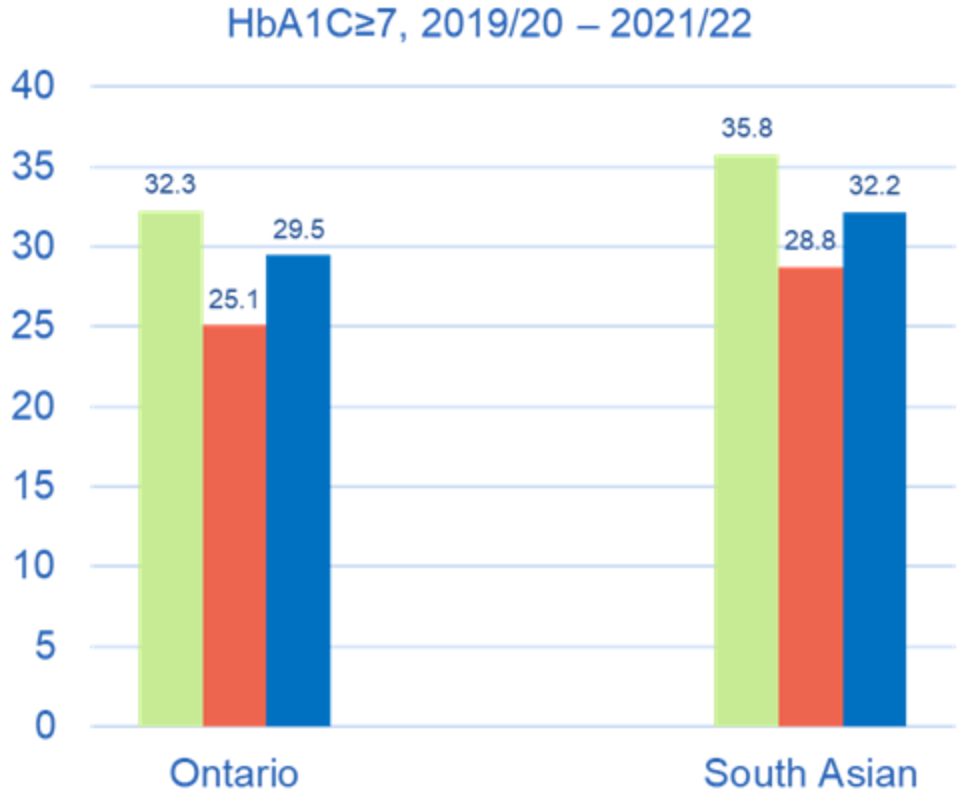
Administrative data available through ICES:

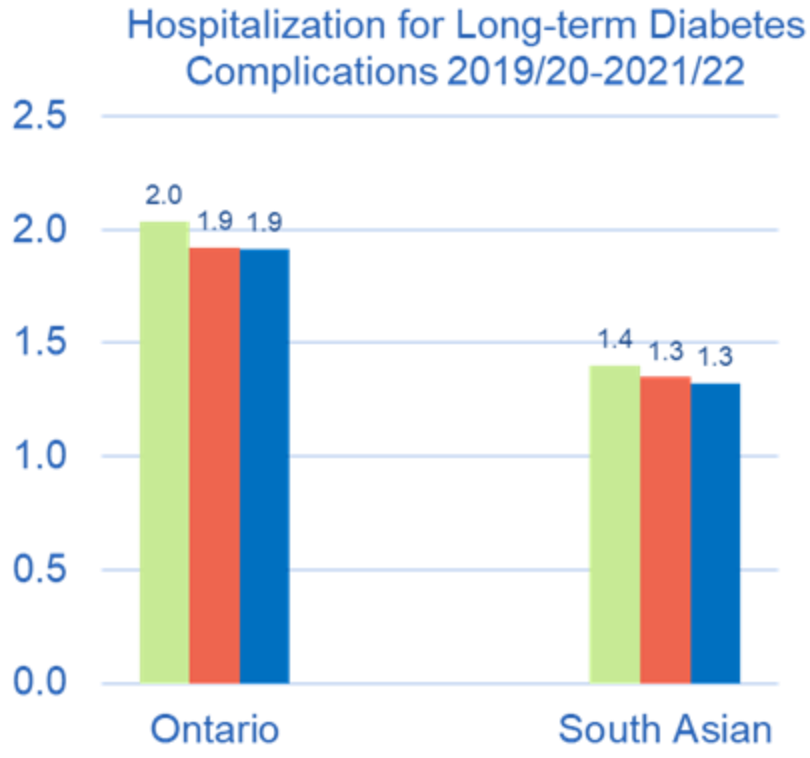
a) OHIP
b) Registered Persons Database
c) Ontario Diabetes Database
d) Ontario Drug Benefit
e) National Ambulatory Care Reporting System
f) Discharge Abstract Database
g) Ontario Laboratory Information System
h) Continuing Care Reporting System

Preliminary findings:
Indicators measuring diabetes access to care: 2019/20 – 2021/22



Indicators related to adverse Diabetes outcomes: 2019/20 - 2021/22



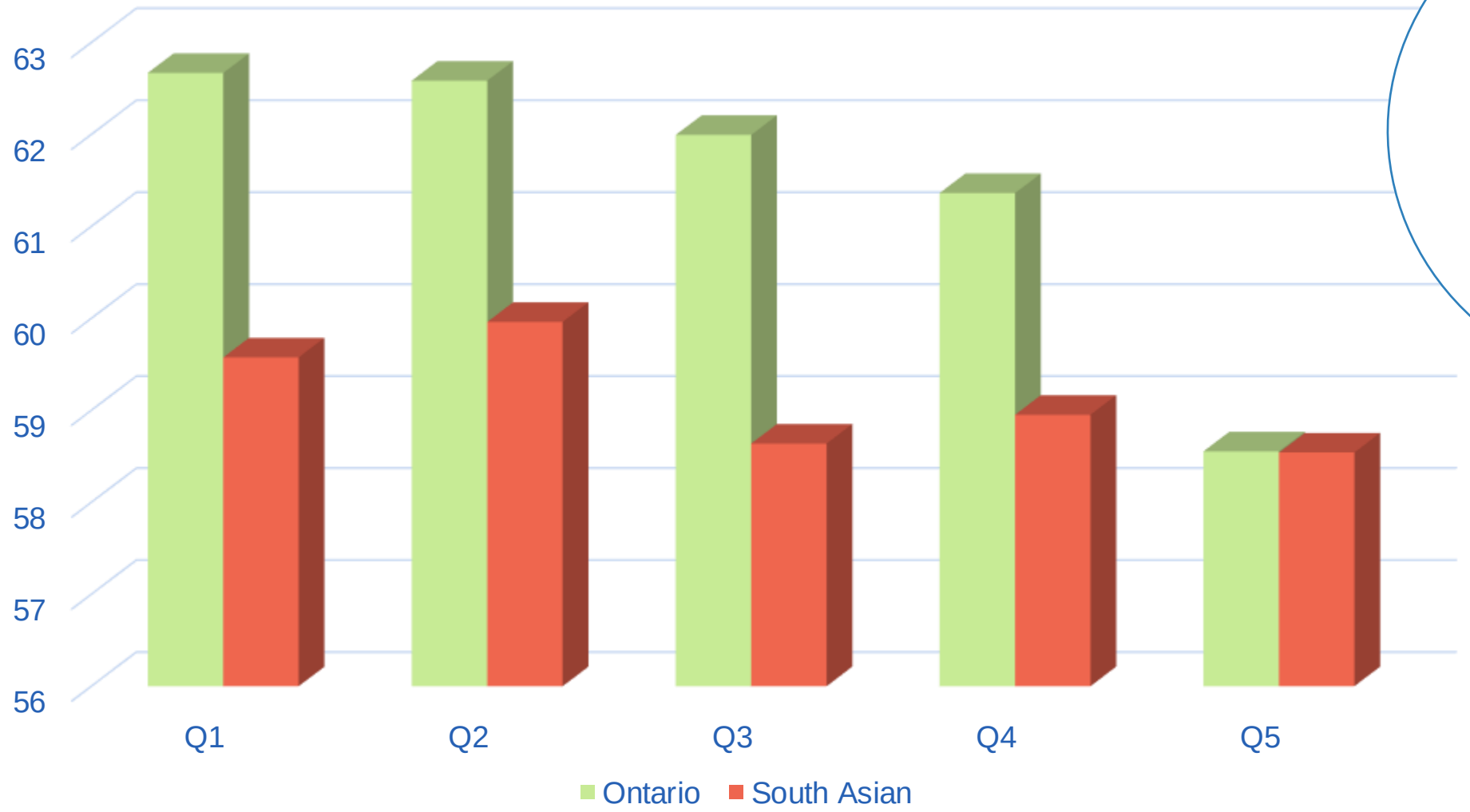


2019/20 2020/21 2021/22

HbA1c screening across Material Deprivation Quintiles 2021/22

- ✓ Higher rates of HbA1c screening are better
- ❑ HbA1c screening **lower** among SA pop compared to ON
- ❑ No distinctive SES gradient observed

Retinal screening across Material Deprivation Quintiles, 2021/22

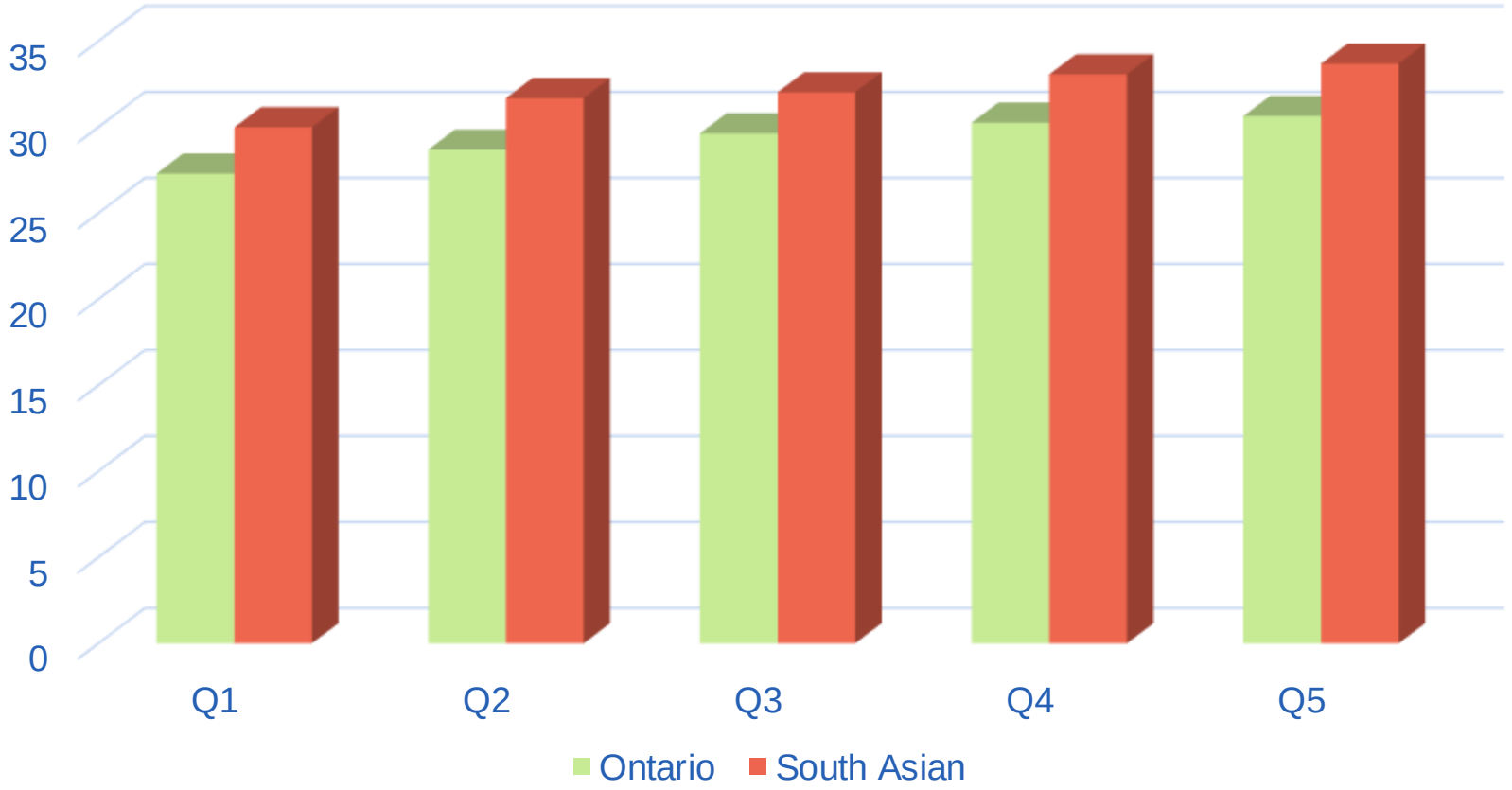


- ✓ Higher rates of retinal screening are better
- ❑ Retinal screening **lower** among SA pop compared to ON

Statins dispensed across Material Deprivation Quintiles – 2021/22

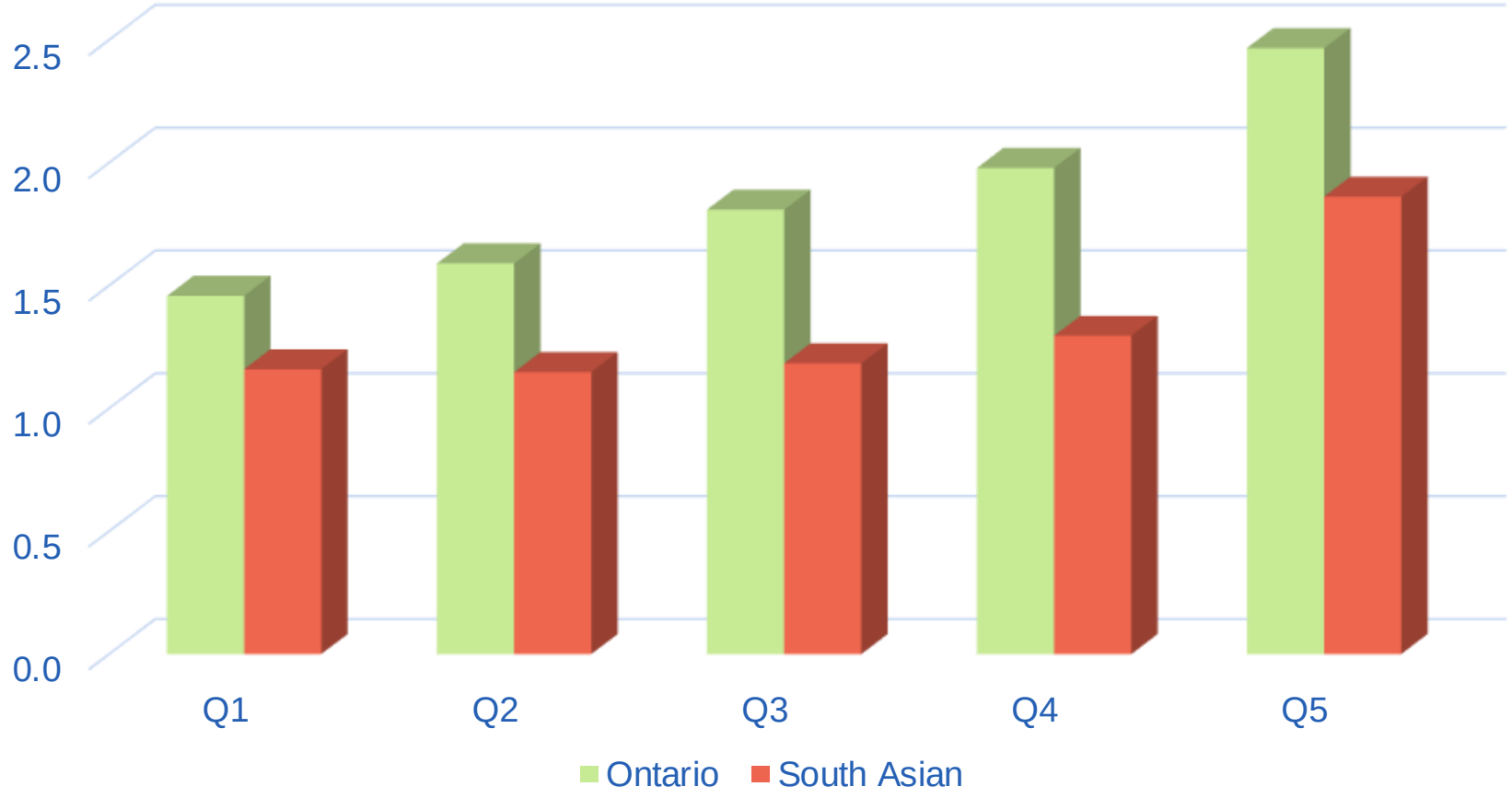
- ✓ Higher rates of statins dispensed is better
- ❑ Proportion of patients with statins dispensed **higher** among SA pop compared to ON
- ❑ No distinctive SES gradient observed

Patients with poor glycemic control (HbA1c ≥7) across Material Deprivation Quintiles – 2021/22



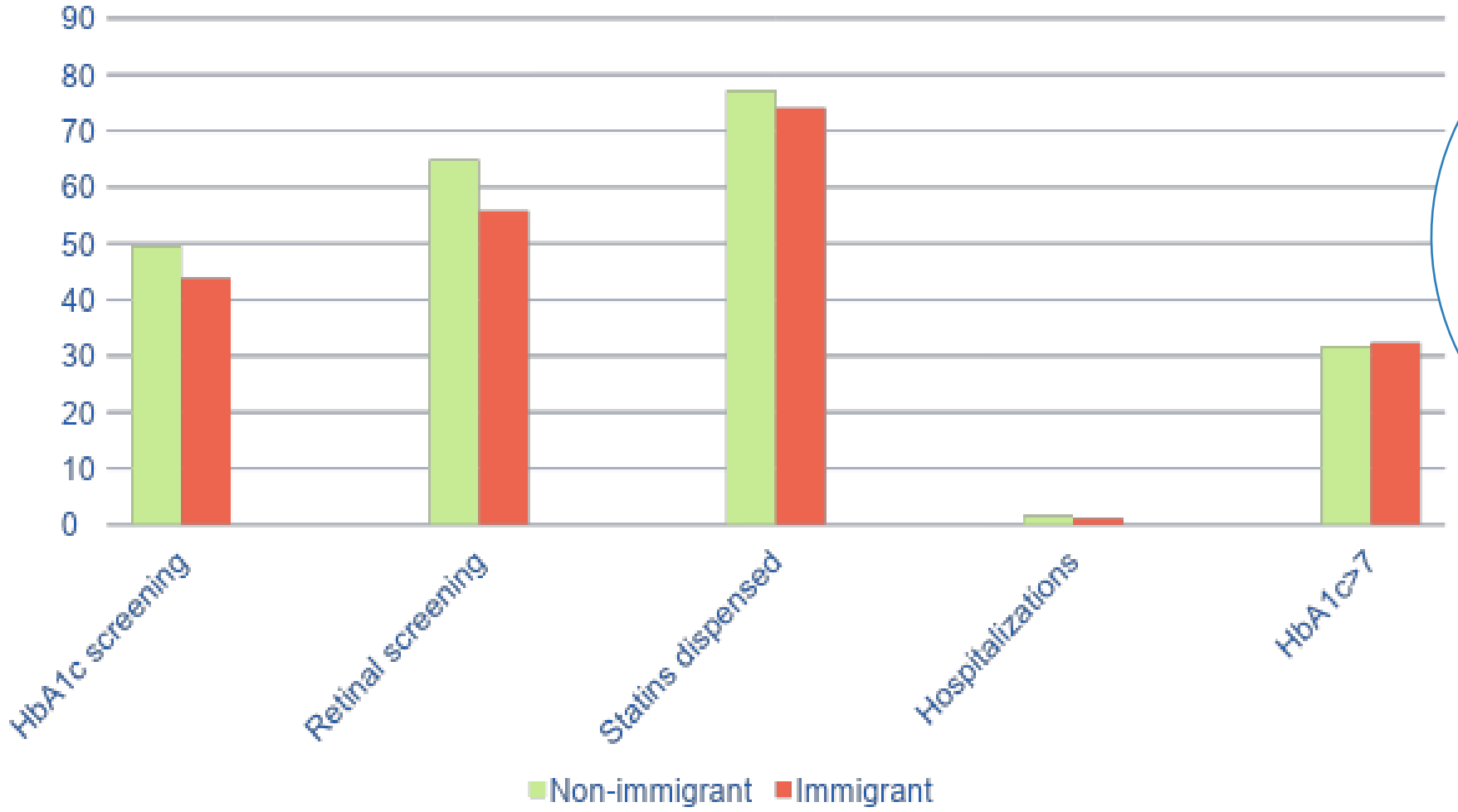
- ✓ Lower rates of HbA1c≥7 are better
- ❑ Poor control **higher** among SA pop compared to ON
- ❑ Poor control is more common among most deprived subgroup

Hospitalization for Long-term Diabetes Related Complications across Material Deprivation Quintiles – 2021/22



- ✓ Lower rates of Hospitalizations are better
- ❑ Hospitalization rates **lower** among SA pop compared to ON
- ❑ Higher rates among most deprived population subgroup

Diabetes Indicators among South Asian Immigrants vs South Asian Non-immigrants- 2021/22



- Immigrants include
  - Sponsored families
  - Economic caregivers,
  - Supported refugees,
  - Economic immigrants and
  - Other immigrants/refugees

Key Takeaways

- Access to screening services (HbA1c screening, retinal screening) lower across South Asian population compared to provincial average

- South Asian populations living in Ontario had higher rates of statins dispensed across all quintiles

- While patients are more likely to be in poor control of diabetes across South Asian populations,

surprisingly*, *hospitalization rates as a result of long-term diabetes related complications are lower than provincial average

- **What do we want to know?**
- What are the barriers and facilitators to accessing diabetes care for Black populations living in Ontario?

- **Why are we doing this project?**
- To identify current challenges in order to improve access to diabetes care for Black populations across Ontario

- **What is involved?**
- 1-on-1 interview (telephone, zoom, in-person) lasting approximately 30 minutes

- **Who can participate?**
- 18+ years of age, self-identify as Black, have diabetes, live in Ontario

- **Compensation**
- $35 gift card for participating in the interview

- **Contact information:**
- Lauren Cadel - lauren.cadel@utoronto.ca - 437-247-3997
- Laleh Rashidian - laleh.rashidian@mail.utoronto.ca

HSPN Health System Performance Network

Collecting Community-Based Sociodemographic and Equity Data

Presenter: Xiaomeng Ma

Contributors: Xiaomeng Ma, Priyanka Gayen, Farah Tahsin, Julianna Hill, Walter Wodchis

26th March 2024

RATIONALE OF COLLECTING SOCIO-DEMOGRAPHIC DATA

Patients:

- Strengthen patient-care team member relationships
- Respond to identified needs through shared decision-making and priority setting
- For immediate care improvements

Health organizations:

- Plan and tailor services
- Demonstrate need to funders and partners, and hire and train staff to meet clients' needs
- Provide equitable care through targeted interventions
- Improve integration of cross-sector partnerships
- Support organizational efforts to drive care transformation and quality improvement

Providers:

- Guide and tailor client care

Community and Payers:

- Highlight/identify systemic inequality and racism at the local, state and national level
- Enhance community collaboration and planning
- Empower health organizations to advocate for policies supporting equity and social justice in their communities
- Inform care delivery redesign and payment reform

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RATIONALE OF COLLECTING COMMUNITY HEALTH NEED DATA

- Better understand the wellbeing needs and strengths of the clients and communities served
- Measure and improve practice of the Model of Health and Wellbeing, and have evidence to demonstrate impact
- Measure and improve health equity and upstream practices based on determinants of health and grounded in a community development approach
- Build shared measurement for collective impact on challenges facing the communities served such as food security, social inclusion, recreation or transportation

RATIONALE OF COLLECTING WELL-BEING DATA

- Understand the challenges faced by community residents
- Better prepare to take action that helps everyone, especially those most marginalized, to thrive
- For evidence-based decision-making
- For collaborative action with community

SOCIO-DEMOGRAPHIC DATA COLLECTION TOOLS

Data collection tool	Author	Type of data collected
A. Sociodemographic data collection and use in Ontario CHCs- Report	Alliance for Healthier Communities (Canada, 2022)	9 questions that significantly impact patient and client health outcomes: - **Language, Born in Canada, Race/ethnicity, Gender, Sex, Sexual orientation, Disability, Income, Number of people income supports**
B. Measuring Health Equity Demographic Data Collection and Use in Toronto Central LHIN Hospitals and Community Health Centres	Sinai Health System (Canada, 2017)	Same as the previous one, except 'Sex' - Language, Born in Canada, Race/ethnicity, Gender, Sexual orientation, Disability, Income, Number of people income supports
C. Toronto Public Health Equity Data Collection Research Project	Upstream Lab (Canada, 2012)	10 domains of questions: - Language, Immigration status, Age, Race, Religion, Disability, Gender, Sexual orientation, Income, **Housing status**
D. Upstream Risks Screening Tool and Guide	Kaiser Permanente (US, 2015)	5 domains of questions: - Economic stability, Education, Social & community context, Neighborhood & physical environment, Food
E. Protocol for Responding to & Assessing Patients' Assets, Risks & Experience (PRAPARE)	National Association of Community Health Centers (US, 2023 [latest])	4 domains of questions: - Personal characteristics, Family and home, Money and resources, Social and emotional health

The final demographic data collection tool list was determined based on: (1) the feasibility of gathering a specific type of information from hospital clients and community residents and (2) whether the tool's design was intended to support a health intervention initiative.

THE WOMEN's HEALTH HOMELESS DAYS' DATA COLLECTION QUESTIONNAIRE

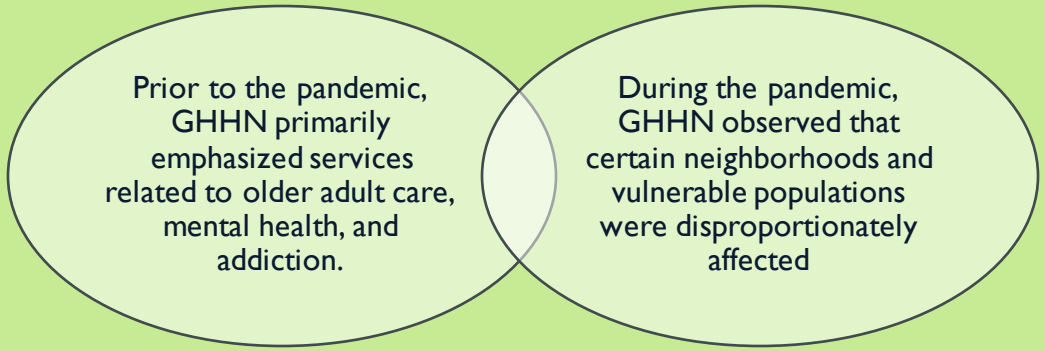
• Age • Language • Gender identity • Sexual orientation • Country of birth • Indigenous identity • Ethnic/cultural background • Possession of a health card • Access to a family physician	• Disability status • Education level • Employment status • Personal and family income • Household type

COMMUNITY NEED AND WELL-BEING

Project	Author	Questions
Community Need Assessment		
A. Community Health Needs Assessment: Taylor-Massey Neighborhood, Toronto	Access Alliance (Canada 2017)	Questions on: - Demographic information - Length of Time Spent Living in the Community - Number of Relatives and Close Friends - Sense of Belonging - Sense of Trust - Inclusion and Discrimination - Civic & Democratic Engagement - Health and Wellbeing (Self-rated physical and self-reported mental health) - Income and Food Security - Education and Everyday Task Completion - Concerns in the TMN - Service Needs in the TMN
Community Well-being Assessment		
B. A Profile of Wellbeing in Rural Ontario	University of Waterloo (Canada, 2022)	Questions on: - Demographics, including living standards - Community vitality - Democratic engagement - Education - Environment - Healthy population - Leisure and culture - Living standards - Time use - Overall life satisfaction

CASE STUDY - RESIDENTS IN CONGREGATE SETTINGS IN THE GREATER HAMILTON AREA

Demographics and Geography of the Greater Hamilton Area



*"…there's a **21-year life expectancy** difference between those who live in the core of Hamilton to those who live in the mountains within the same city … there are **newcomers**, **refugees**, those living in poverty, the **homeless**, and racialized populations."*

Sociodemographic and Health Need Data Collection

Affiliated CHCs within the OHT have been collecting race-based and sociodemographic data, revealing a fragmented care landscape, economic hardships, a predominantly racialized population, and elevated mental health and addiction rates in the neighborhood.

GHHN has introduced race-based and sociodemographic data collection into various projects like the Lower Limb Program and Women's Health Days. This data has been instrumental in understanding event attendees' demographics.

HSPN

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Tailoring Services Using Collected Data

A. The care team decided to appoint a house physician to act as the primary care provider for the entire household. Two out of the four Residential Care Facilities have successfully established connections to primary care services. But there is currently no formal admissions process in place.

B. The care team typically brought a cancer screening bus to conduct mammograms and Pap tests for women, along with Fit testing for everyone.

C. The care team introduced domestic violence and sexual assault teams to engage with them after trust built with women in Residential Care Facilities.

HSPN

Learnings from the Project

Data standardization, align the goals and build trust

"... we found that it's much longer and harder for bigger institutions to get started. So we've started more grassroots community organizations."

"It is important to listen to communities and then go in."

"we started by setting a level for the whole group and then chunking it off into small projects."

Thank you for your attention.

Standardizing data

Address recognized social determinants of health

Aligning objectives with partners

Building trust

HSPN

HSPN Health System Performance Network

Advancing Equity in Integrated Health Systems

Presenter: Paul Wankah

Contributors: Stefanie Tan, Julie Farmer, Sara Allin, Walter Wodchis

26th March 2024

Policy priority

What are international examples for governance and accountability for equity in integrated care?

- Equity in health and healthcare is a policy priority of integrated care systems.
  - Providing care to an attributable population while addressing the unique needs of socially disadvantaged groups (e.g., low-income, Race and ethnicity, disability)
  - Organizing and distributing resources in a way that supports care delivery to socially disadvantaged groups

Great variability in equity promoting initiatives

Country	Integrated care models	Equity promoting initiatives
England	Integrated Care Systems	Some local examples: • Focus on frail, isolated older adults in more rural or remote areas • Focus on Black and Minority Ethnic groups in socially deprived urban areas
Netherlands	Neighborhood Care Teams	• Monitoring and planning at the local level • **The Hague**: Interventions in a couple of socially and materially deprived neighborhoods. Mainly comprised of investing more in neighborhoods that need more supports.
Germany	• Gesundes Kinzigtal model • Hamburg Health Kiosks	• Monitoring and planning at the local level • **Hamburg**: Adapting design of integrated care system to cultural characteristics of their locality. This consisted of improving access to physicians for a local population with high-levels of immigration, don't speak German, high unemployment with low-income levels.

Lessons learnt

- Successes were related to local or neighborhood level initiatives addressing equity: developing capacity for equity work at the local level

- Although each country had different priority groups for equity initiatives, common features include a focus on;
  - Socio-economic depravation,
  - Older frail adults' groups,
  - BIOPC communities and recent immigrants.

- Access of data for planning and evaluation of initiatives around equity was important – e.g., to identify target populations for neighborhood care teams.

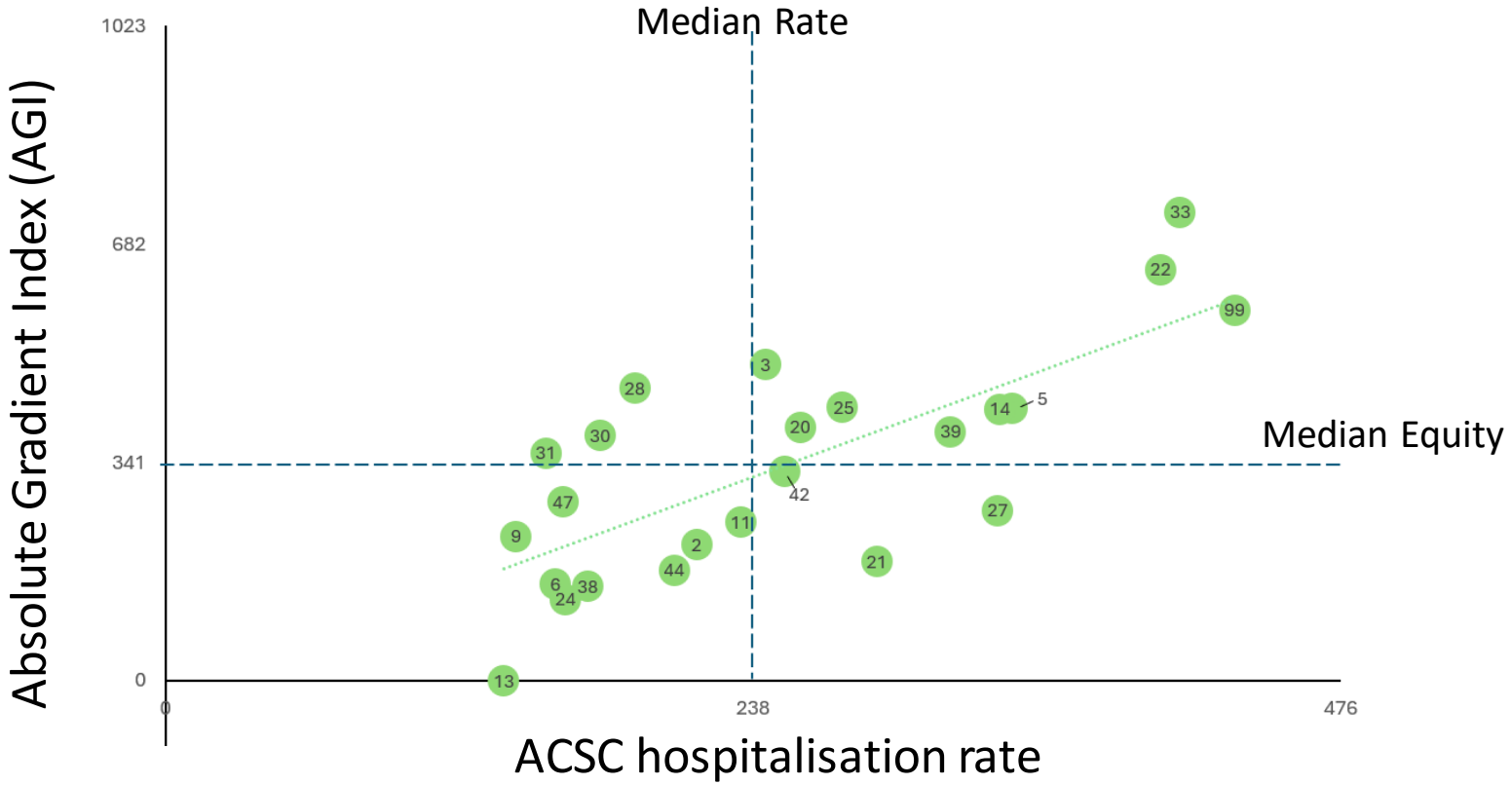
- Governance can set priorities, initiatives still lacking accountability.

Discussion Question

What are some opportunities that you see for Ontario Health Teams to address equity in governance and accountability mechanisms ?

So after all of this … will it change anything?

- YES ! Get ready for a new form of reporting indicators and equity:



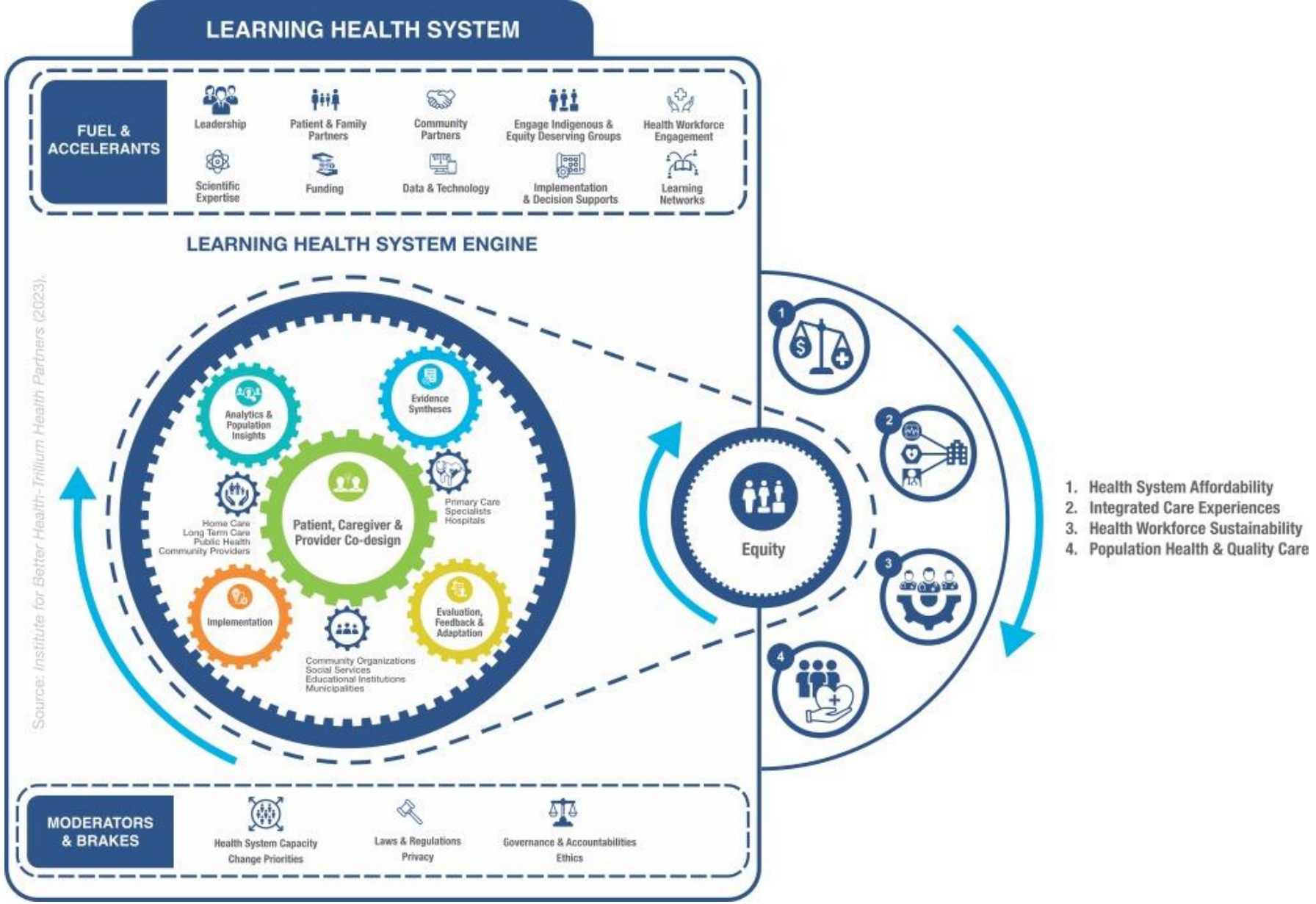
Up Next

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

Upcoming April to October 2024:

Advancing the Learning Health System in Ontario

LEARNING HEALTH SYSTEM ACTION FRAMEWORK



SOURCE*: Institute for Better Health-Trillium Health Partners* (2023).

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

THANK YOU!

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