HSPN Health System Performance Network

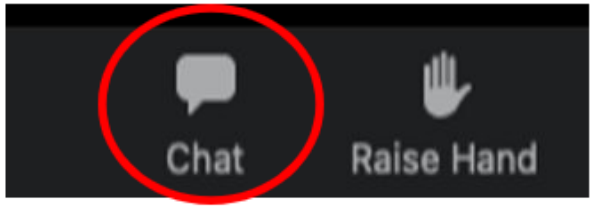
Measuring Health Equity to Address Inequities in Ontario Health Teams

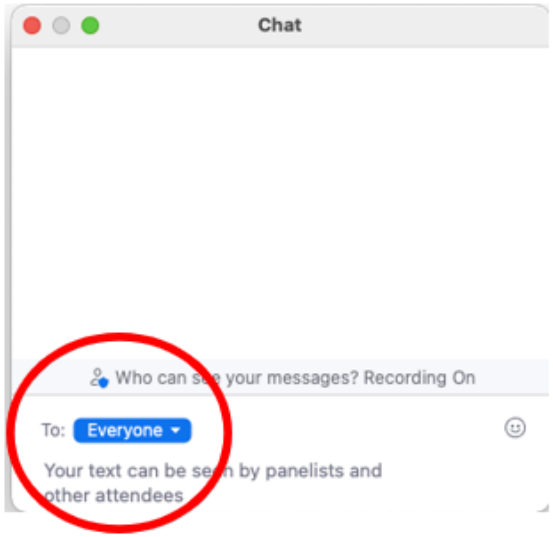
HSPN Monthly Webinar

January 27, 2026

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

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

139/139 (100%) answered

Yes. I have participated previously.	(71/139) 51%
No. This is my first event.	(68/139) 49%

HSPN Health System Performance Network

Today's event
Measuring Health Equity to Address Inequities

Host

Dr. Walter Wodchis
Principal Investigator
HSPN

Presenters

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Research Officer
HSPN

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Ontario Health

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Mississauga OHT

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Decision Support Lead
Ottawa OHT/ÉSO d'Ottawa

HSPN Monthly Webinar

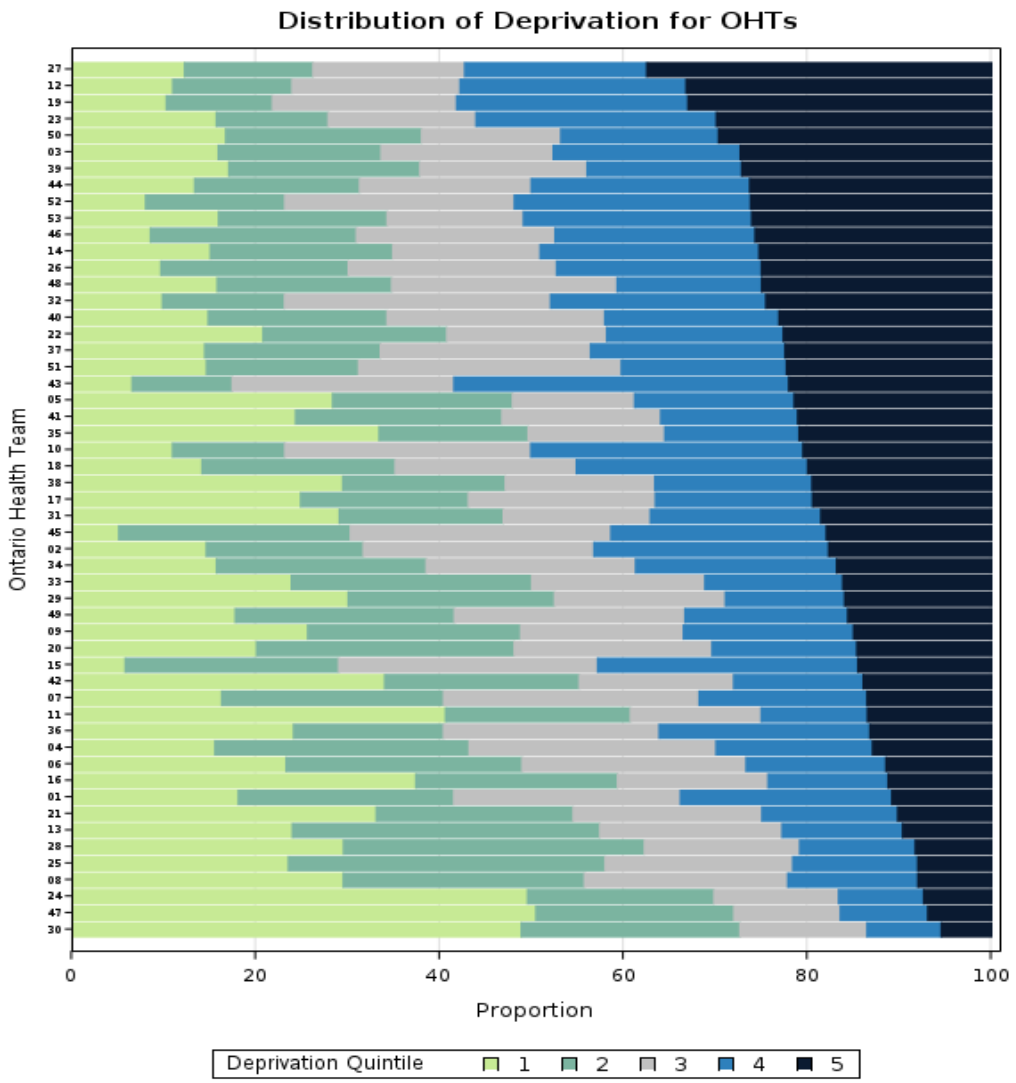
January 27, 2026

AGENDA

1. Why and how is health equity measured?
2. HSPN measurement and reporting of health inequity
   - V1.0: OHT relative distributions of Material Deprivation
   - V2.0: Stratification by Material Deprivation
   - V3.0: Indicator associations with Slope Index of Material Deprivation
3. Ontario Health Dashboard Slope Index of Material Deprivation
4. Ontario Health Team Approaches
   - Mississauga Ontario Health Team
   - Ottawa Ontario Health Team -Équipe Santé Ontario

Why and How ?

Material Deprivation Quintile



We use the Material Deprivation Score from the Ontario Marginalization Index to assess equity in OHT indicators across socioeconomic status.

Indicators

- Proportion of the population aged 25 to 64 without a high-school diploma
- Proportion of families who are lone parent families
- Proportion of total income from government transfer payments for population aged 15+
- Proportion of the population aged 15+ who are unemployed
- Proportion of the population considered low-income
- Proportion of households living in dwellings that are in need of major repair

Proportion of OHT population according to Neighbourhood Material Deprivation

Ontario Health Teams. OHT Attributable Populations

Why is Health Equity Measured?

1. There are strong socio-economic and health system equity factors that lead toward lower health outcomes including knowledge, time, and resources that affect people's ability to access the right health services at the right time. These include pre-occupation with income security, housing security, food security, transportation and primary care attachment, etc.
2. Understanding where medical access and quality are important and where other socio-economic factors are important can direct OHT action toward partnerships and intervention.

How is Health Equity Measured? You Need:

1. Indicator:
   - ACSC Hospitalizations, Cancer Screening, etc.

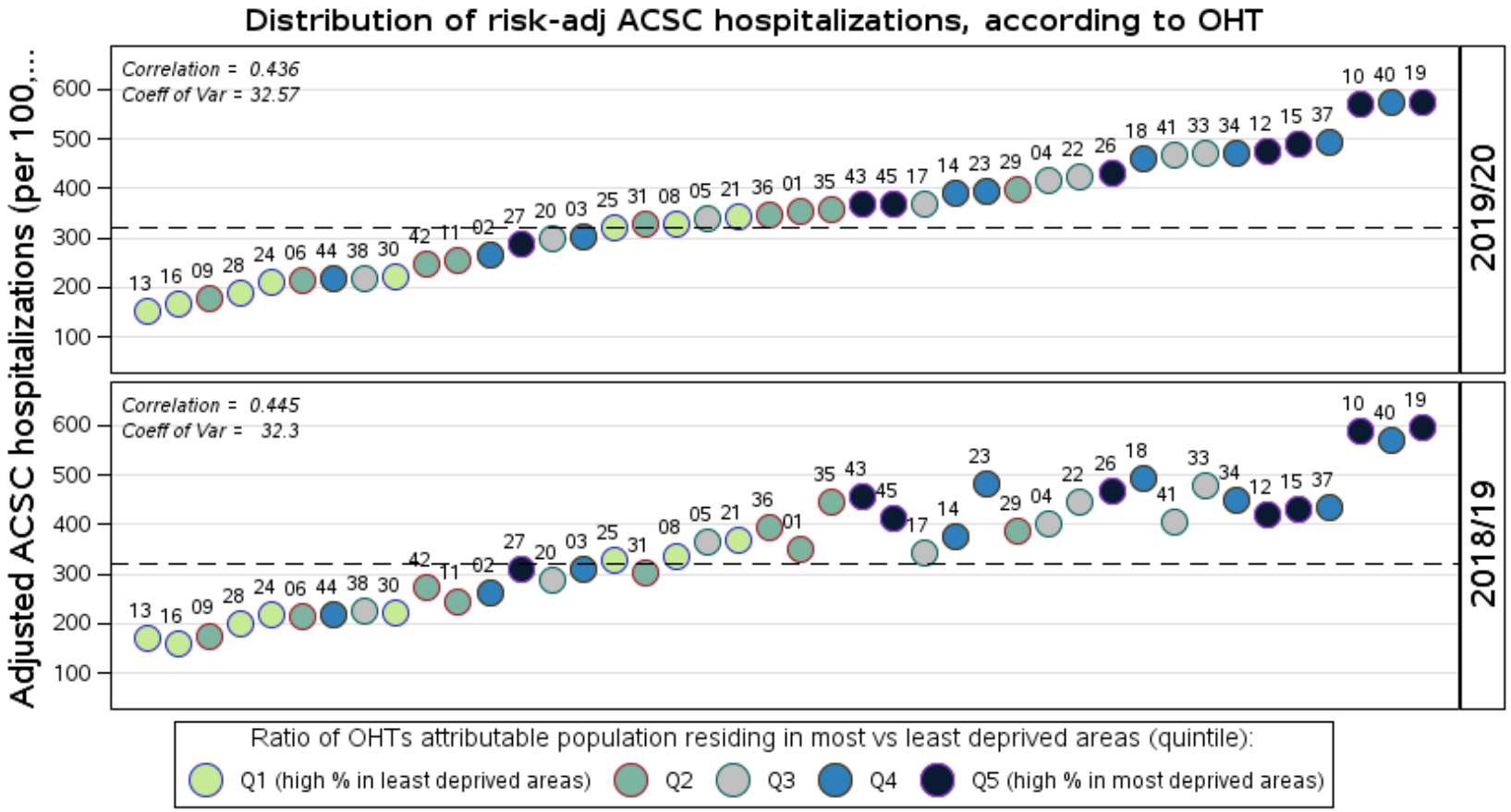
2. Stratifier:
   - Material Deprivation, Income, Education, Immigration, Race, Primary Care Models

3. Analysis/Measurement:
   - Stratified analysis, Ratio of highest to lowest, Slope Index of Inequality (RII), Relative Index of Inequality (RII)

HSPN Measures of Equity

V1.0 : Descriptive

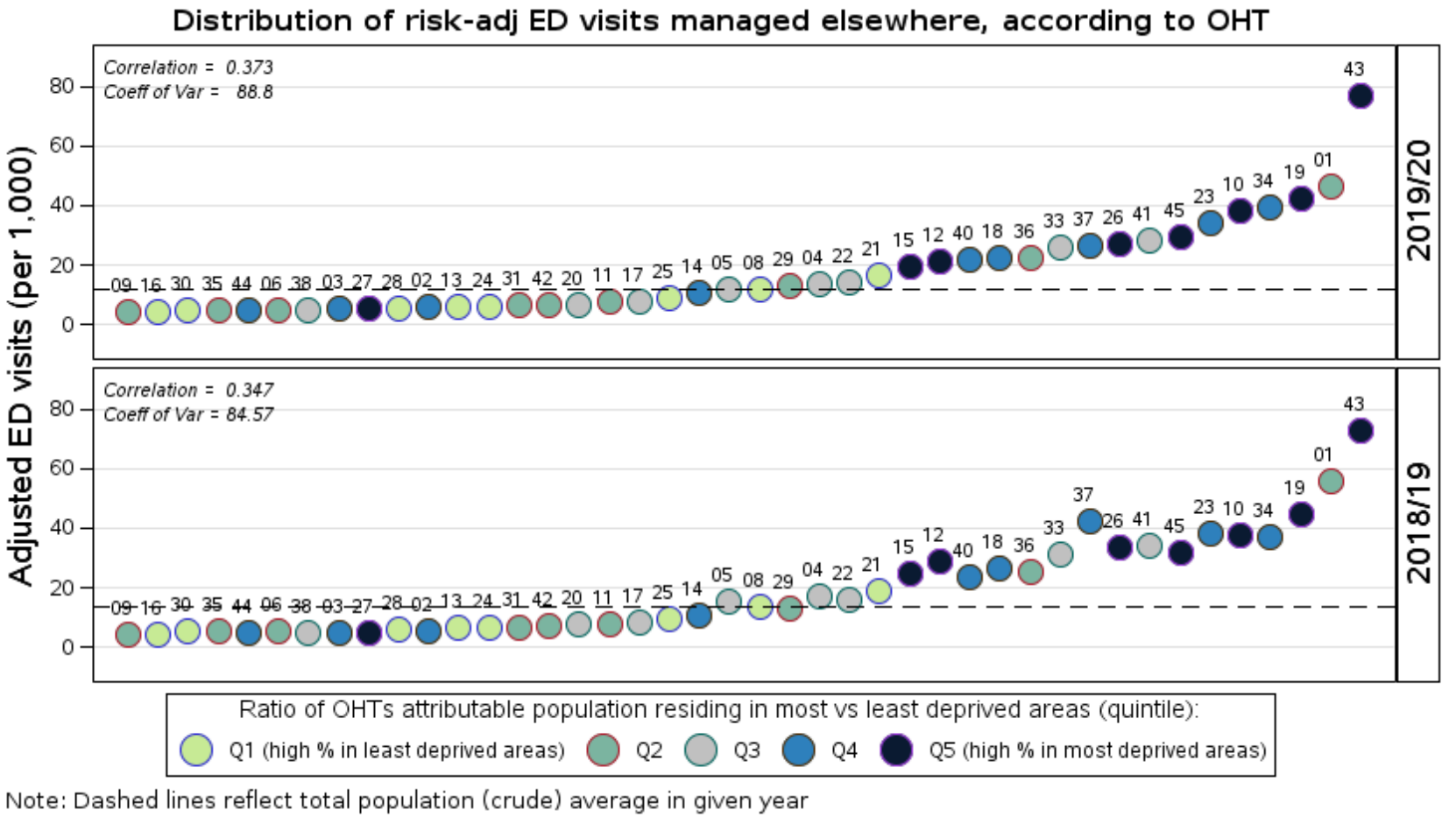
Hospitalizations for Ambulatory Care Sensitive Conditions



Note: Dashed lines reflect total population (crude) average in given year

Correlation with deprivation	Variability across OHTs (same year)
Moderate ($tau_{2019/20}$=0.436)	High ($CV_{2019/20}$=32.6)

ED visits best managed elsewhere



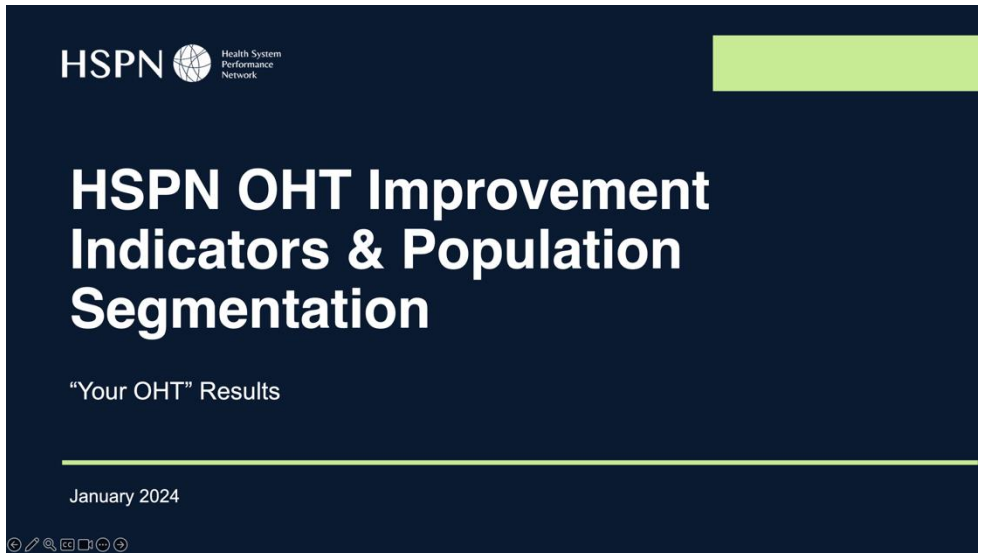
Note: Dashed lines reflect total population (crude) average in given year

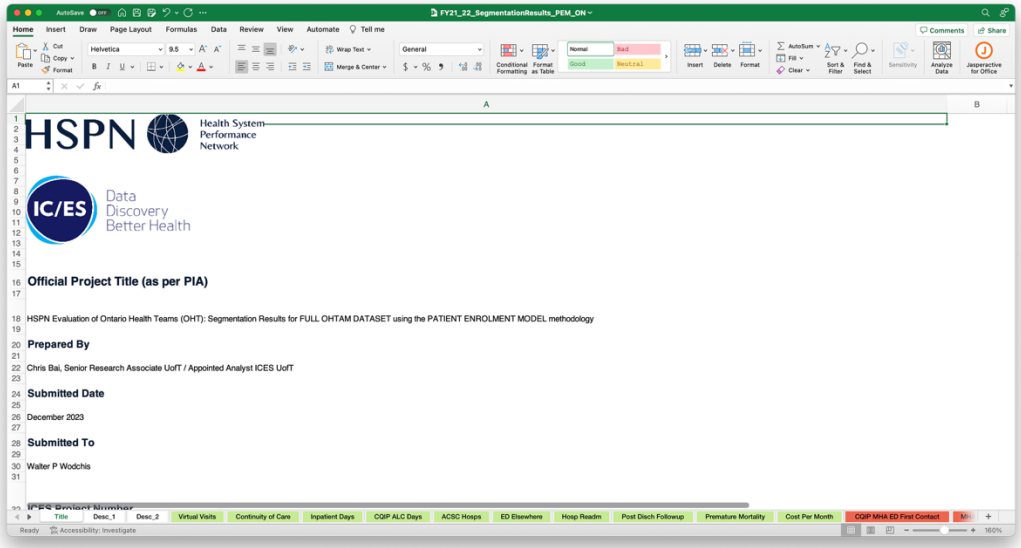
Correlation with deprivation	Variability across OHTs (same year)
Fair/Moderate ($tau_{2019/20}$=0.373)	Very high ($CV_{2019/20}$=88.8)

HSPN Measures of Equity

V2.0 : Stratified

1 Powerpoint Presentation & 3 Excel Spreadsheets





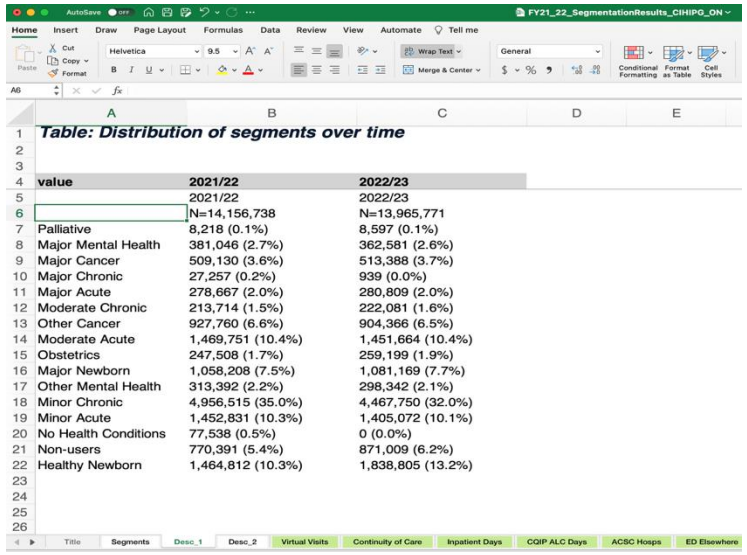
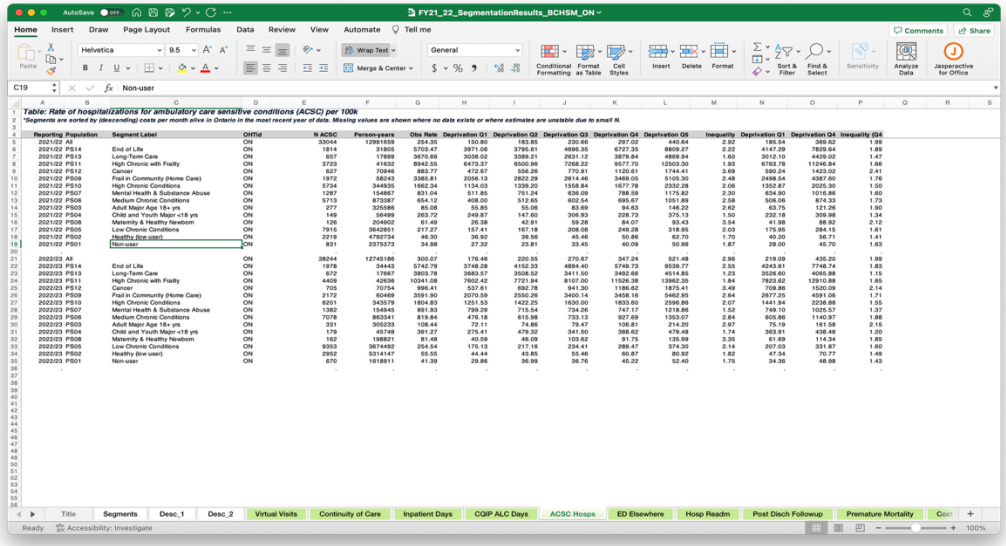


Table: Distribution of segments over time

value	2021/22	2022/23
	2021/22	2022/23
	N=14,156,738	N=13,965,771
Palliative	8,218 (0.1%)	8,597 (0.1%)
Major Mental Health	381,046 (2.7%)	362,581 (2.6%)
Major Cancer	509,130 (3.6%)	513,388 (3.7%)
Major Chronic	27,257 (0.2%)	939 (0.0%)
Major Acute	278,667 (2.0%)	280,809 (2.0%)
Moderate Chronic	213,714 (1.5%)	222,081 (1.6%)
Other Cancer	927,760 (6.6%)	904,366 (6.5%)
Moderate Acute	1,469,751 (10.4%)	1,451,664 (10.4%)
Obstetrics	247,508 (1.7%)	259,199 (1.9%)
Major Newborn	1,058,208 (7.5%)	1,081,169 (7.7%)
Other Mental Health	313,392 (2.2%)	298,342 (2.1%)
Minor Chronic	4,956,515 (35.0%)	4,467,750 (32.0%)
Minor Acute	1,452,831 (10.3%)	1,405,072 (10.1%)
No Health Conditions	77,538 (0.5%)	0 (0.0%)
Non-users	770,391 (5.4%)	871,009 (6.2%)
Healthy Newborn	1,464,812 (10.3%)	1,838,805 (13.2%)

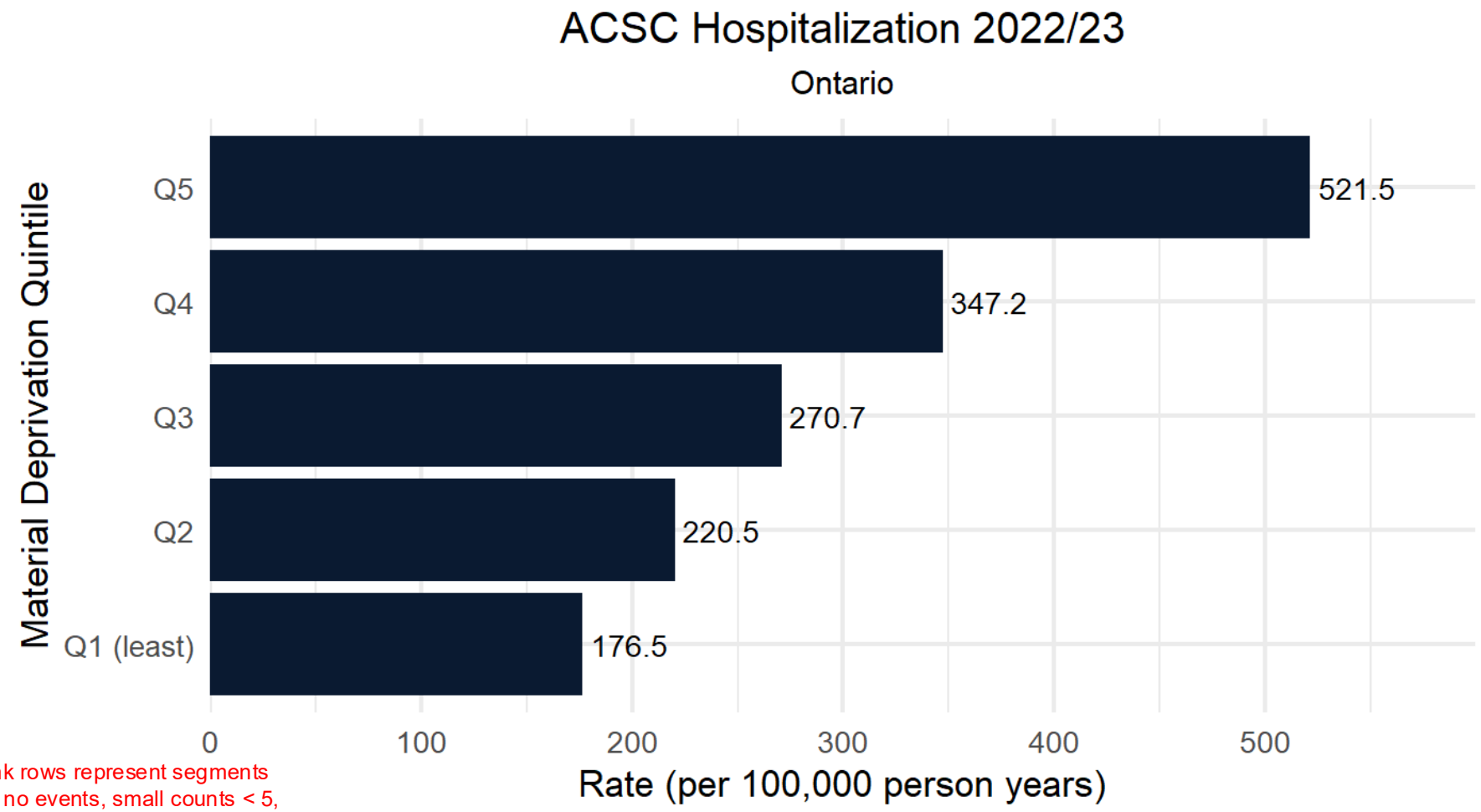


Stratification / Segmentation

- For the top chosen indicators, we report on the OHT-specific results by four Stratifications or four ways to Segment the population:

1. Neighbourhood Material Deprivation Quintile
2. Primary Care Patient Enrolment Model
3. CIHI Pop Grouper Health Profile Categories (HPCs)
4. BC Health System Matrix Segments

2022/23 Rate of hospitalization for ambulatory care sensitive conditions (ACSC) per 100k by Material Deprivation Quintile



Blank rows represent segments with no events, small counts < 5, or with < 30 patients in denominator.

Notes:
*Rate of ACSC hospitalization per 100,000 person years is shown at the end of the bar.
*Data are suppressed for segments with small counts.
*Overall rate per 100,000 person years in Ontario = 300.1.

Horizontal axis presents rate of hospitalization for ambulatory care sensitive condition per 100k:

- Ontario average indicated in figure footnote.

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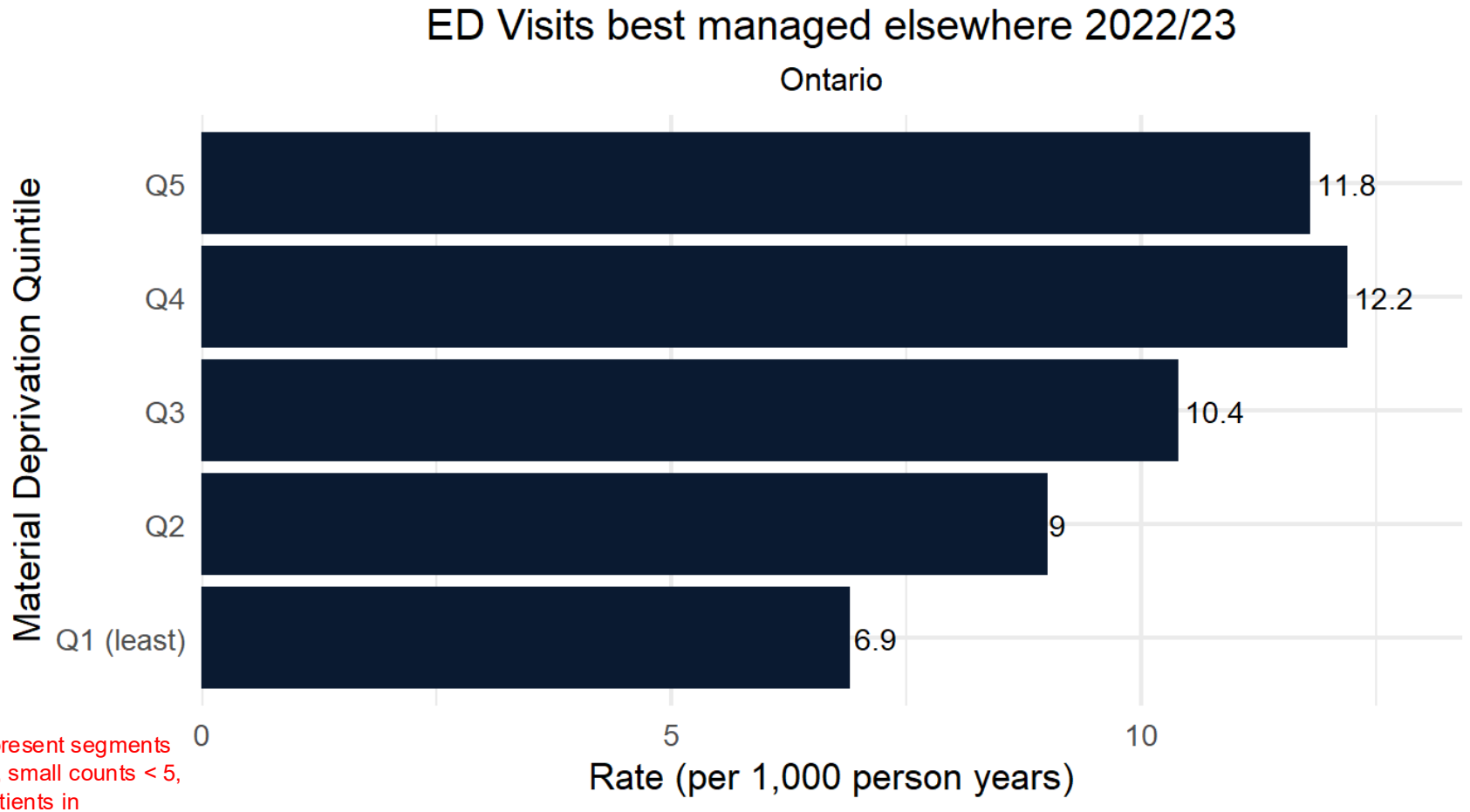
IC/ES

2022/23 Rate of ED Visits best managed elsewhere by Material Deprivation Quintile



Blank rows represent segments with no events, small counts < 5, or with < 30 patients in denominator.

Notes:
*Rate of ED visits per 1000 person years is shown at the end of the bar.
*Data are suppressed for segments with small counts.
*Overall rate per 1000 person years in Ontario = 10.1.

Horizontal axis presents rate of ED visits per 1000 person years that could be treated in alternative primary care setting.

- Ontario average indicated in figure footnote.

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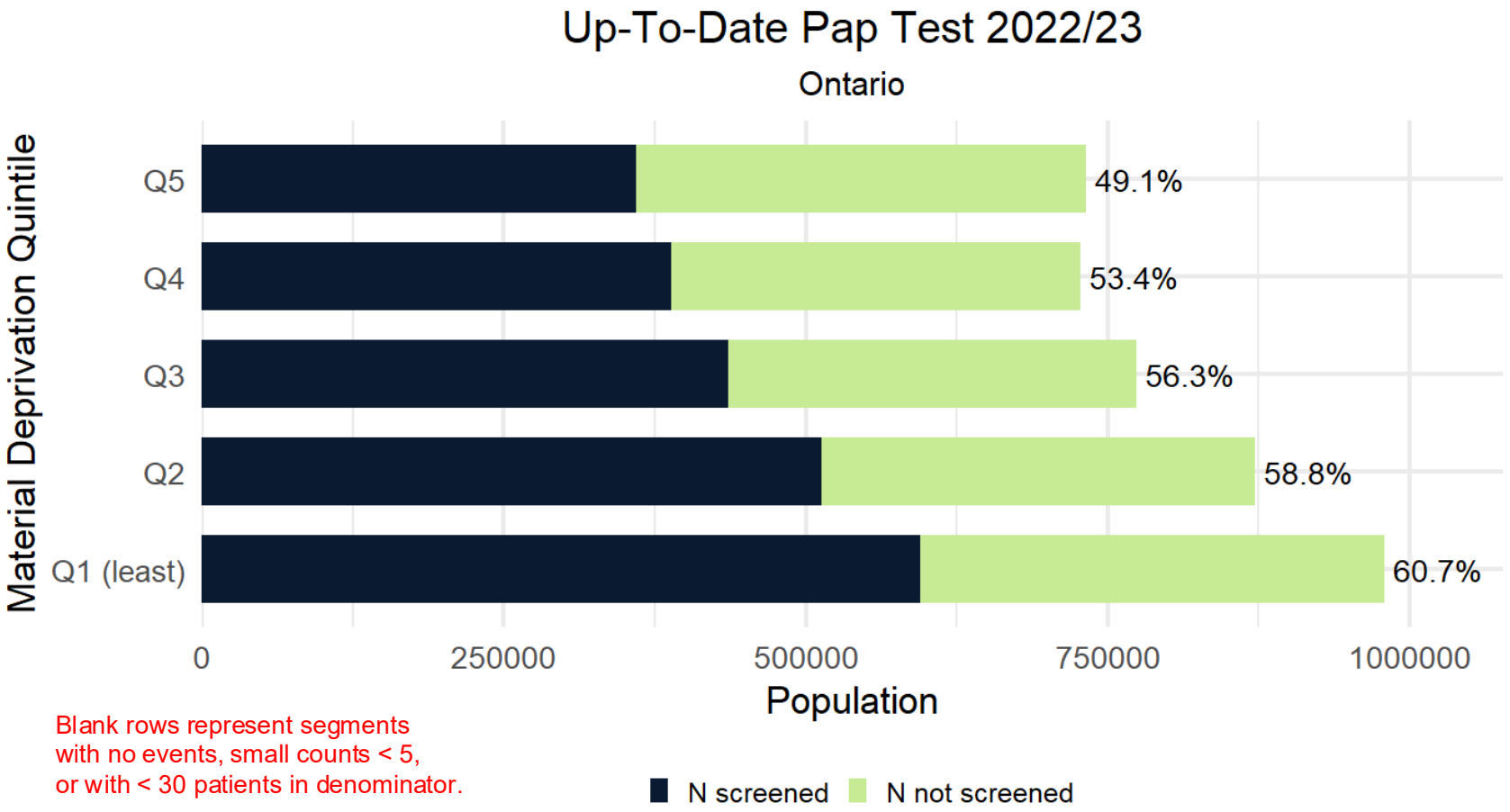
Percentage of screen-eligible patients (women 23-69 yrs of age) up to date with Papanicolaou (Pap) tests on March 31, 2023 by Material Deprivation Quintile



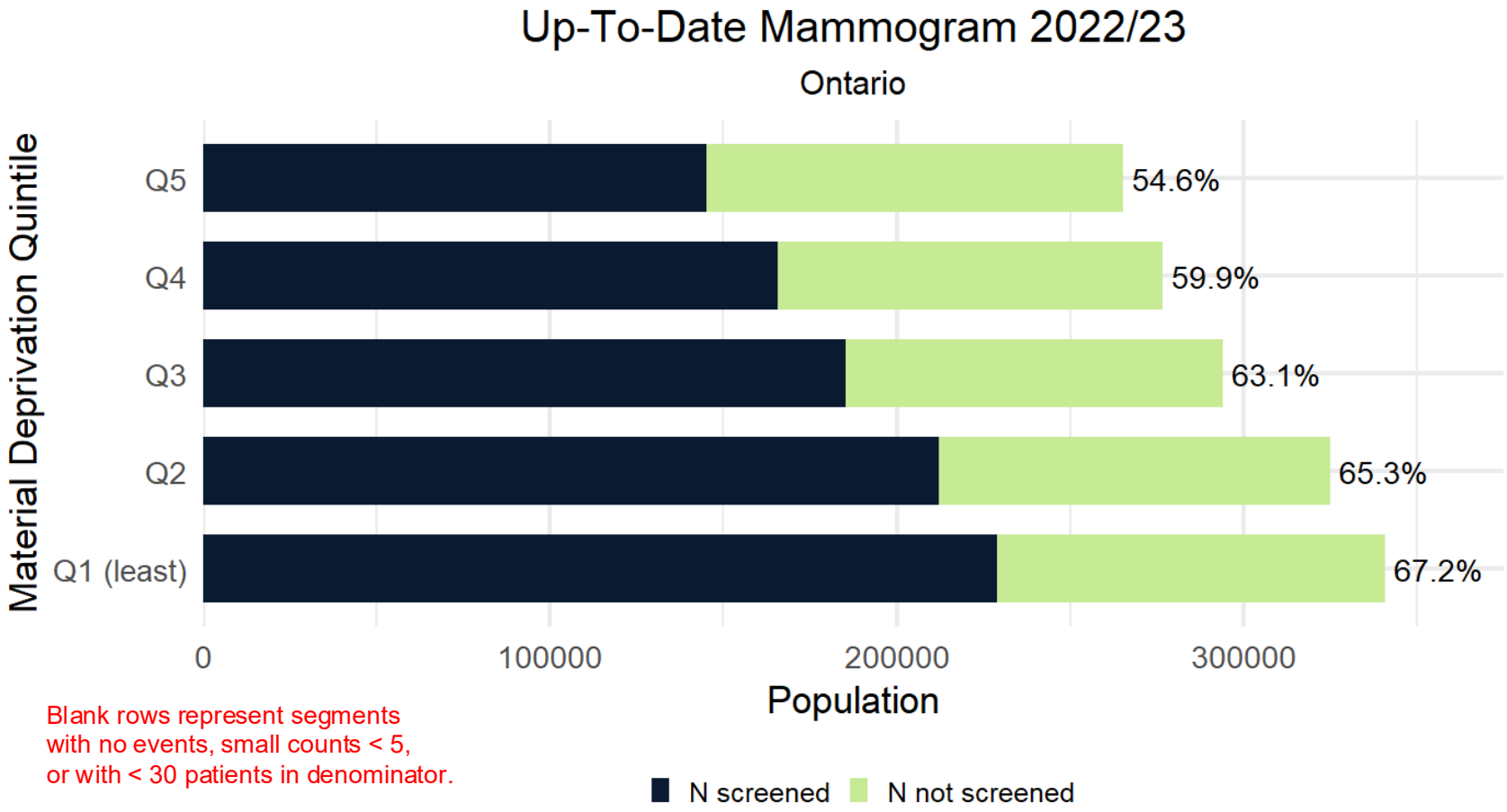
Blank rows represent segments with no events, small counts < 5, or with < 30 patients in denominator.

Notes:
*Proportion of segment screened is shown at the end of the bar.
*Data are suppressed for segments with small counts.
*Overall proportion screened in Ontario = 56.0%.

Horizontal axis shows the number of women 23-69 years

- Bright green indicates number of women not screened;
- Dark blue represents number of women screened;
- Percentage to the right is the proportion of each segment screened.
- Ontario average indicated in figure footnote.

Percentage of screen-eligible patients (women 52-69 years of age) up to date with a Mammogram on March 31, 2023 by Material Deprivation Quintile



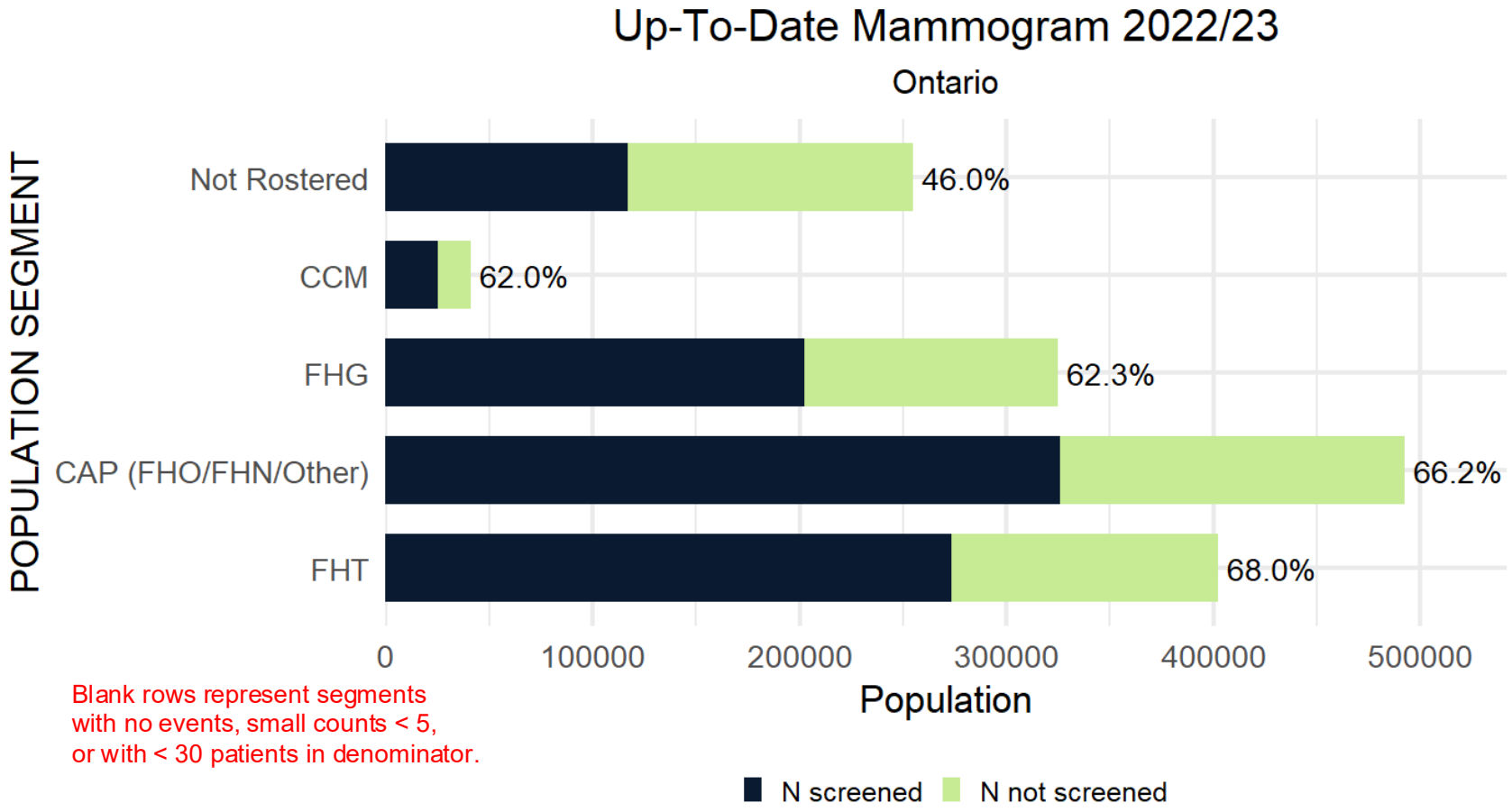
Blank rows represent segments with no events, small counts < 5, or with < 30 patients in denominator.

Notes:
*Proportion of segment screened is shown at the end of the bar.
*Data are suppressed for segments with small counts.
*Overall proportion screened in Ontario = 56.0%.

Horizontal axis shows the number of women 52-69 years:

- Bright green indicates number of women not screened;
- Dark blue represents number of women screened;
- Percentage to the right is the proportion of each segment screened.
- Ontario average indicated in figure footnote.

Percentage of screen-eligible patients (women 52-69 years of age) up to date with a Mammogram on March 31, 2023 by Primary Care Model



Blank rows represent segments with no events, small counts < 5, or with < 30 patients in denominator.

Notes:
*Proportion of segment screened is shown at the end of the bar.
*Data are suppressed for segments with small counts.
*Overall proportion screened in Ontario = 62.3%.

Horizontal axis shows the number of women 52-69 years:

- Bright green indicates number of women not screened;
- Dark blue represents number of women screened;
- Percentage to the right is the proportion of each segment screened.
- Ontario average indicated in figure footnote.

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IC/ES

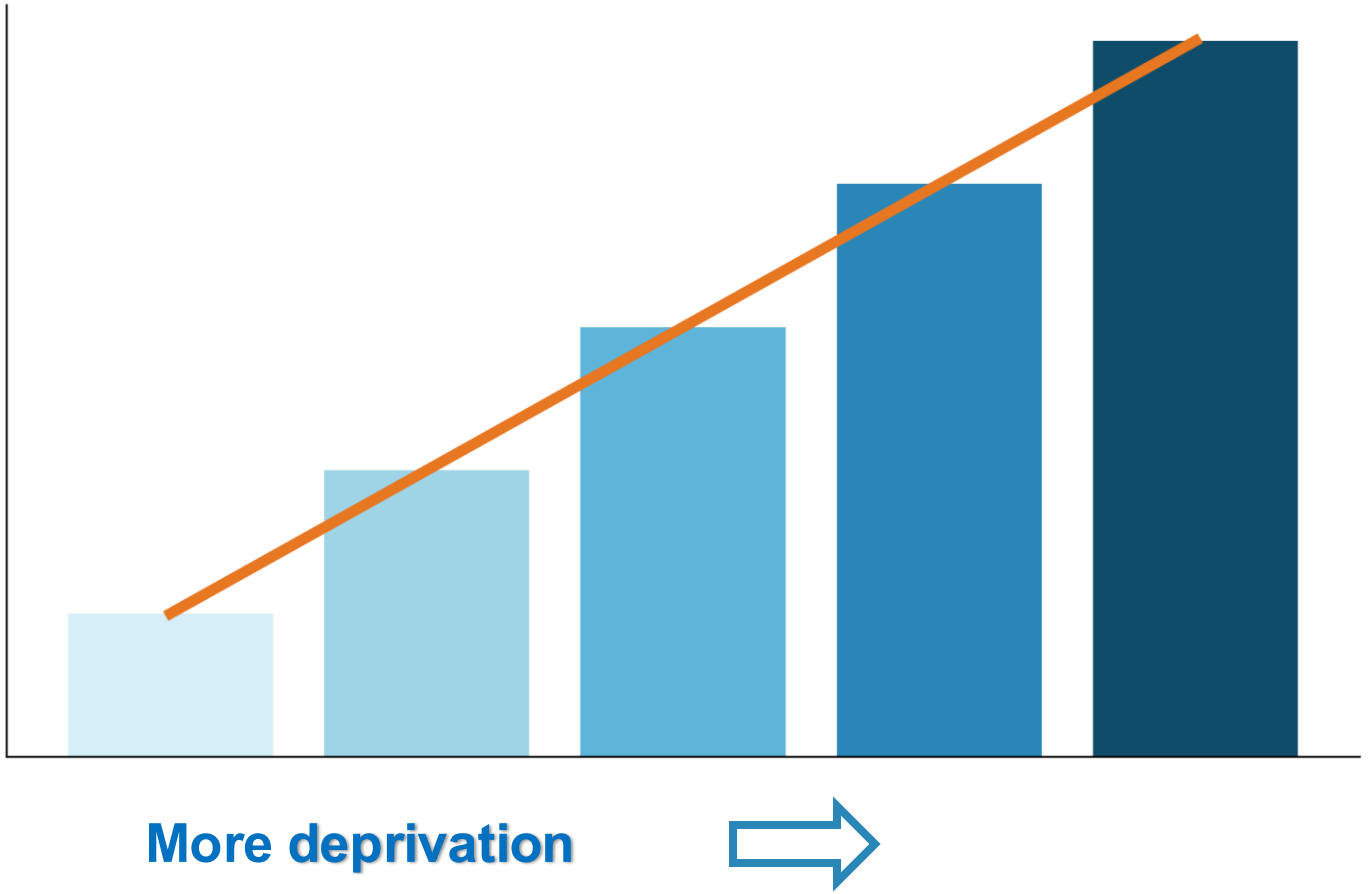
HSPN Measures of Equity

V3.0 : Cross-Analyzed

Slope Index of Inequality

- The Slope Index of Inequality (SII) is an absolute measure of inequality that summarizes the difference in a health outcome between the **most** and **least deprived** populations within an area.
- Captures the entire socioeconomic gradient. Population subgroups (OHT-ADAs) are ranked from least deprived (0) to most deprived (1) based on the equity stratifier (Material Resources).
- The SII is estimated as the slope of a population-weighted linear regression, where the outcome is regressed on the deprivation rank.
- Units are the same as the outcome, making the results easy to interpret (e.g., ED visits per 1000 person years).

Slope Index of Inequality (HSPN)



Adapted from: https://www.scotpho.org.uk/methods-and-data/measuring-health-inequalities/

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Slope Index of Inequality

The direction of the indicator and the stratifier determines the interpretation of the Slope Index.

		SII Interpretation	
Indicator (y-axis)	**Stratifier (x-axis)**	**Positive & Significant**	**Negative & Significant**
Higher-positive (e.g. screening)	Higher means more resources	Anti-Equity (pro-"rich")	Pro-equity (pro-"poor")
	Higher means less resources	Pro-equity (pro-"poor")	Anti-Equity (pro-"rich")
Higher-negative (e.g. hospitalization)	Higher means more resources	Pro-equity (pro-"poor")	Anti-Equity (pro-"rich")
	Higher means less resources	Anti-Equity (pro-"rich")	Pro-equity (pro-"poor")

Slope Index of Inequality

SII = 0 → No inequity across deprivation levels

Larger absolute SII → Greater inequity

Negative SII → Higher rates in less deprived areas

Positive SII → Higher rates in more deprived areas

Higher rates may be **better** or **worse depending** on outcome

Relative Index of Inequality

- The Relative Index of Inequality (RII) is the relative complement to the SII and is calculated using the same regression equation as the SII.
- Instead of the slope, it is calculated by taking the ratio between the incremental advantage of the most advantaged group in the population and the least advantaged.
- RII is reported as a standardized unit-free metric, comparable across indicators.
  - **RII = 1** → no inequity
  - **RII > 1** → higher rates in more deprived areas
  - **RII < 1** → higher rates in less deprived areas

Methods

Study Population

- Included all residents of Ontario alive and eligible for health insurance as of April 1, 2023 or April 1, 2024 depending on indicator.
- Analyses were restricted to indicator specific eligible populations:
  - ACSC Hospitalizations / ED Visits: Patients <75 years
  - Cervical cancer screening: Screen-eligible women aged 23–69
  - Breast cancer screening: Screen-eligible women aged 52–69
  - Colorectal cancer screening: Screen-eligible adults aged 52–74

Equity Stratifier

- The factor scores for the Material Resources dimension of the 2021 Ontario Marginalization Index.

Methods

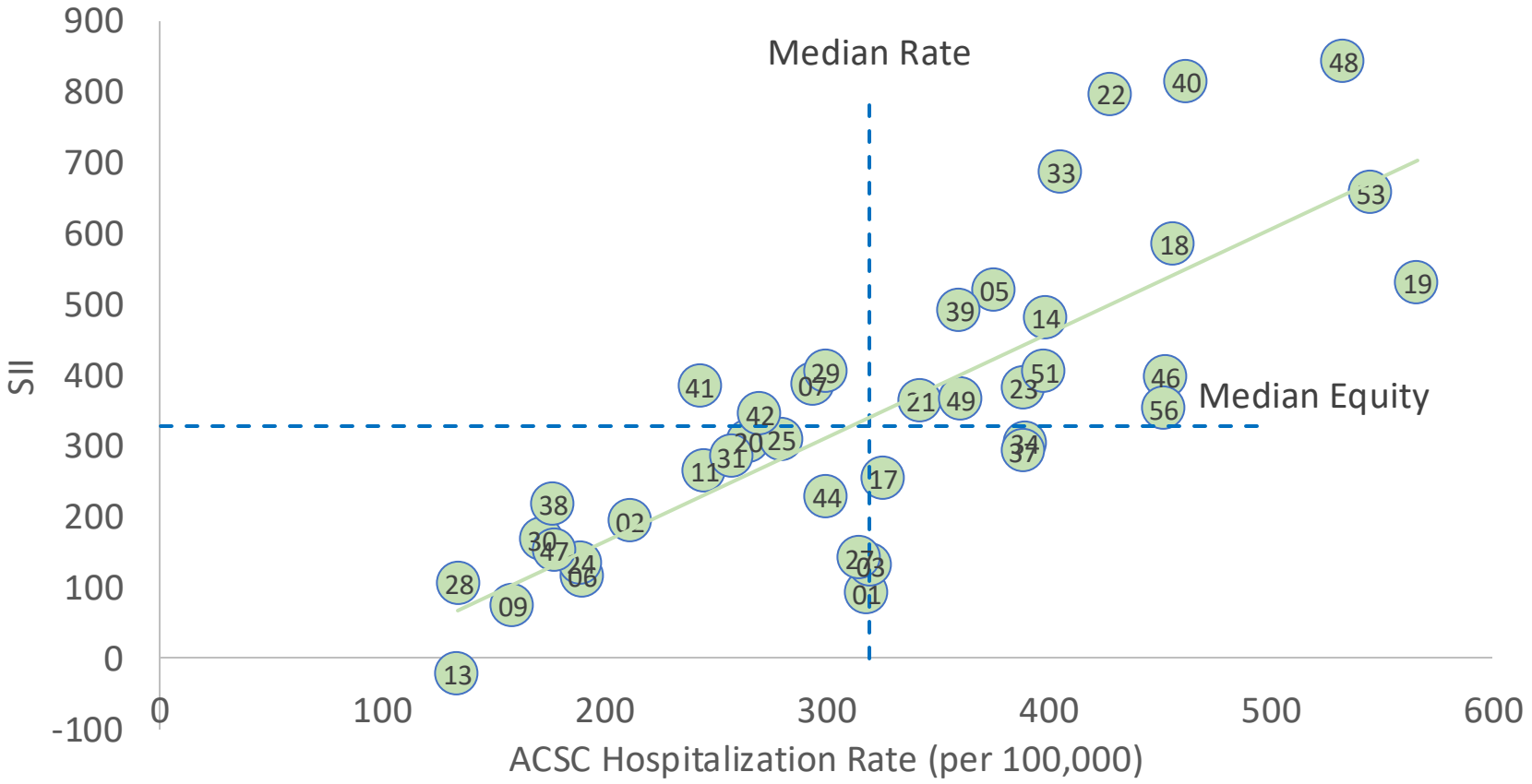
Geographic Exclusions

- OHT-ADAs were selected as the geographic unit of analysis.
- OHT-ADAs with populations below the minimum threshold to yield ≥20 expected events were excluded.
- OHT's that have containing fewer than 10 ADA's were excluded.

Adjustments

- All Rates were adjusted for Age; ACSC Hospitalization, ED Visit, Colorectal cancer screening, and % Not rostered additionally adjusted for Sex.

ACSC Hospitalization

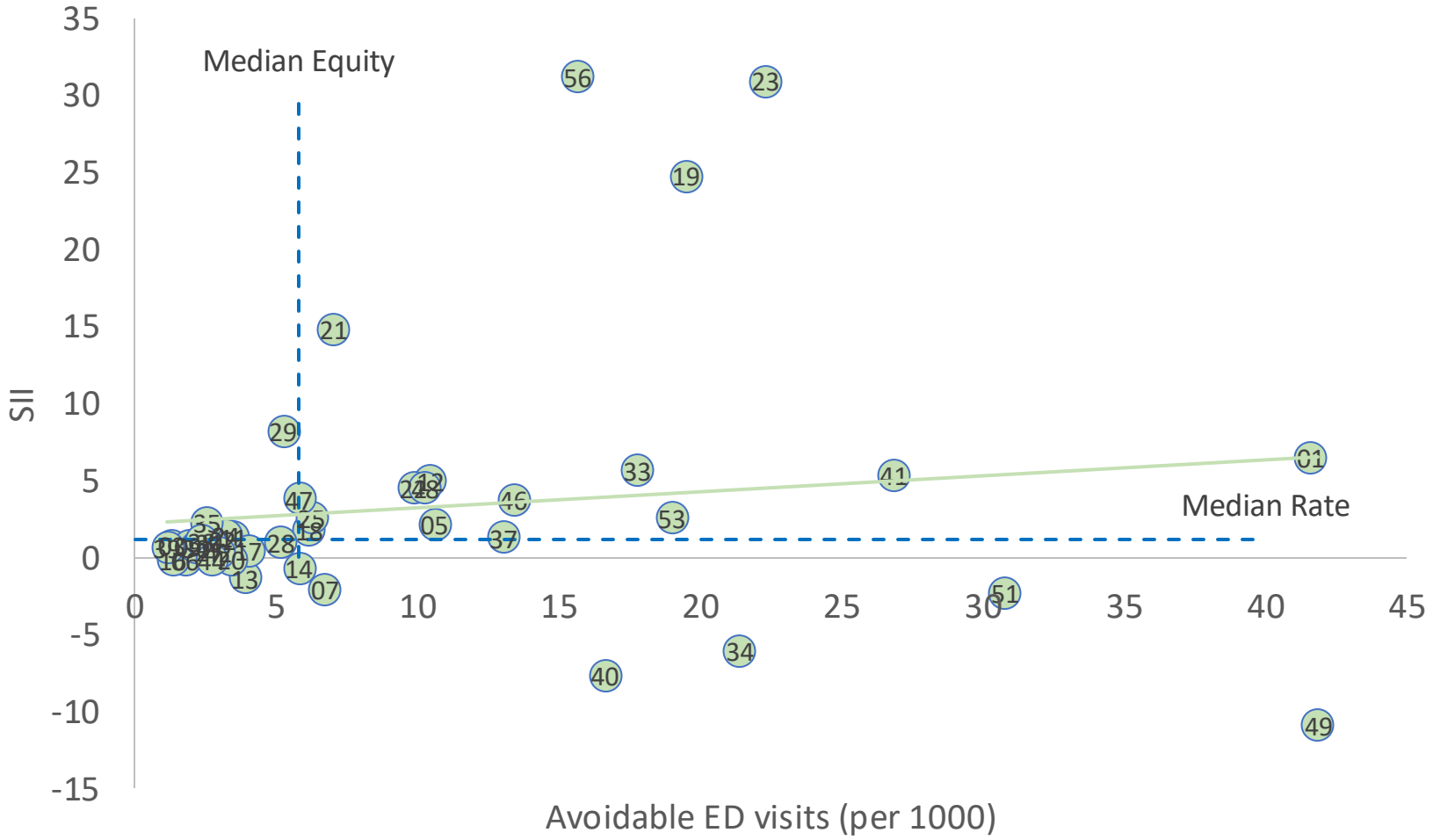


Pearsons Corr: 0.80

Higher ACSC rates were associated with greater deprivation-related inequity (SII r = 0.80).

Nearly all OHTs showed higher hospitalization rates in more deprived ADAs.

Avoidable ED visits



Pearsons Corr: 0.13

Most OHTs cluster at low ED visit rates and low inequity, with a small number of OHTs driving higher inequities and a few OHTs with high ED rates.

The overall association between ED visits and gradient of inequity is positive but weak.

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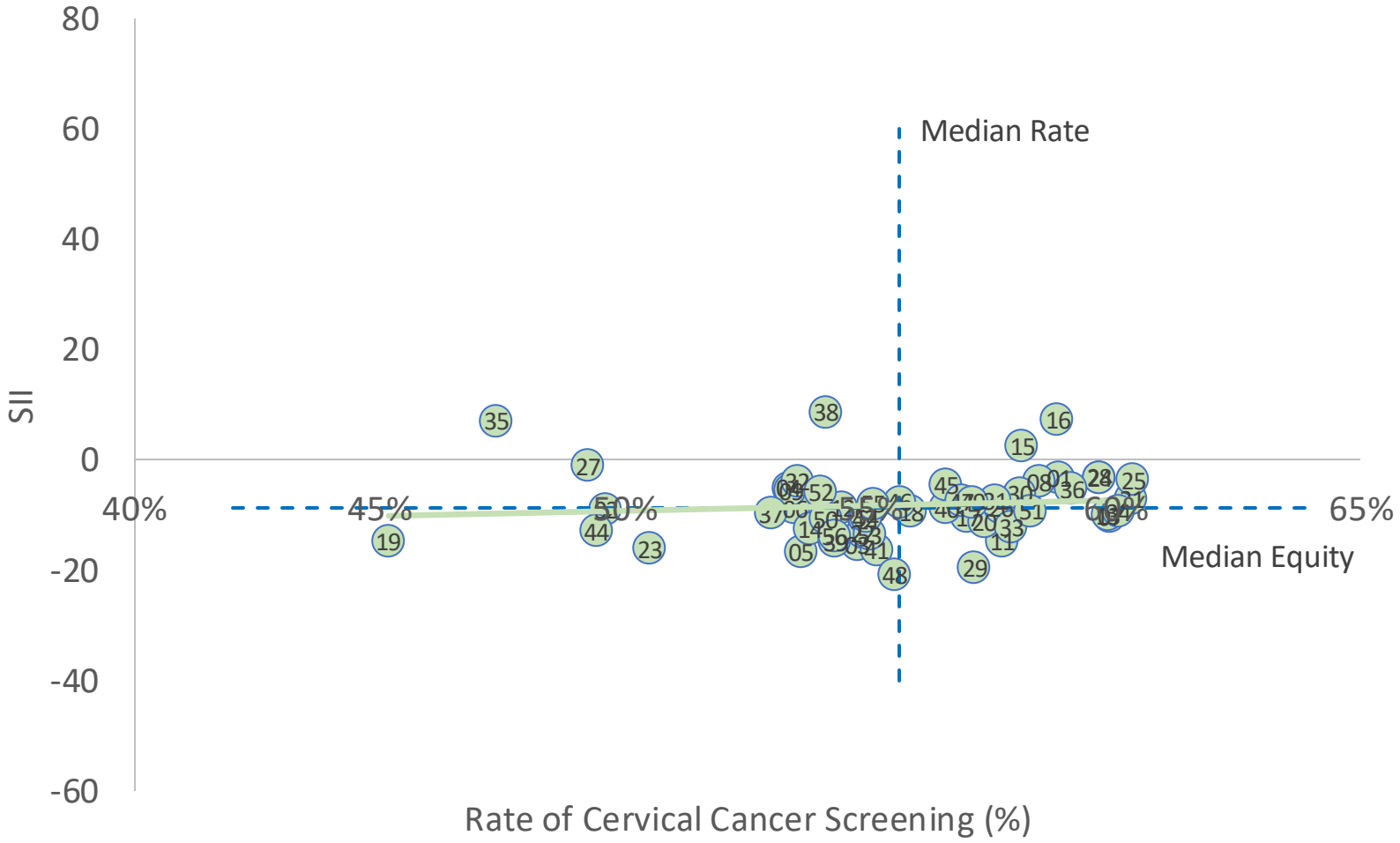
Cervical Cancer Screening



Pearsons Corr: 0.08

The median equity below zero reflects a small gradient with lower screening in more deprived areas.

The flat trendline shows little relationship between overall screening rates and deprivation-related inequity.

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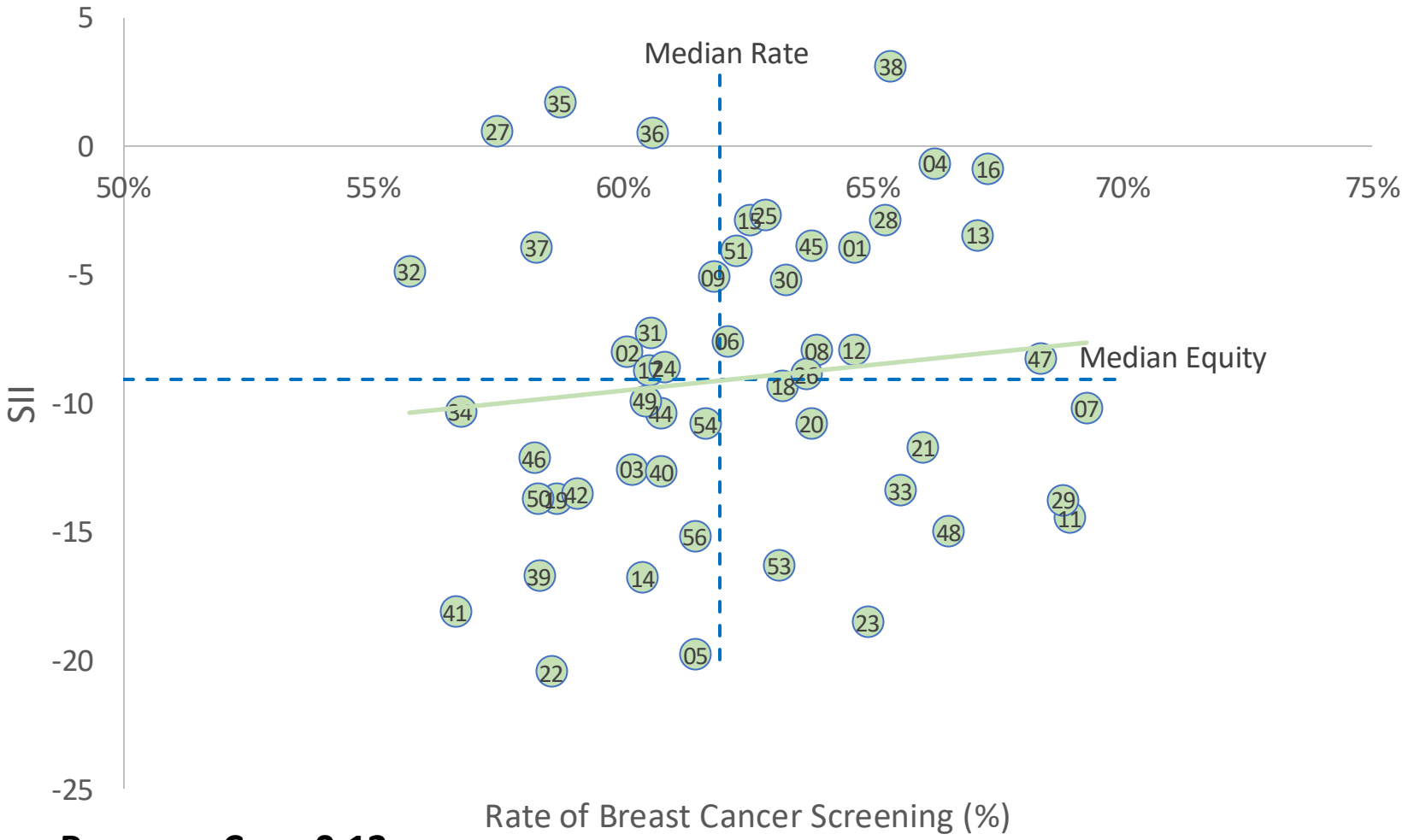
Breast Cancer Screening



Pearsons Corr: 0.12

Screening rates vary across OHTs, with a median SII below zero.

Shallow trendline shows modest association between overall screening levels and inequity (SII r = 0.12).

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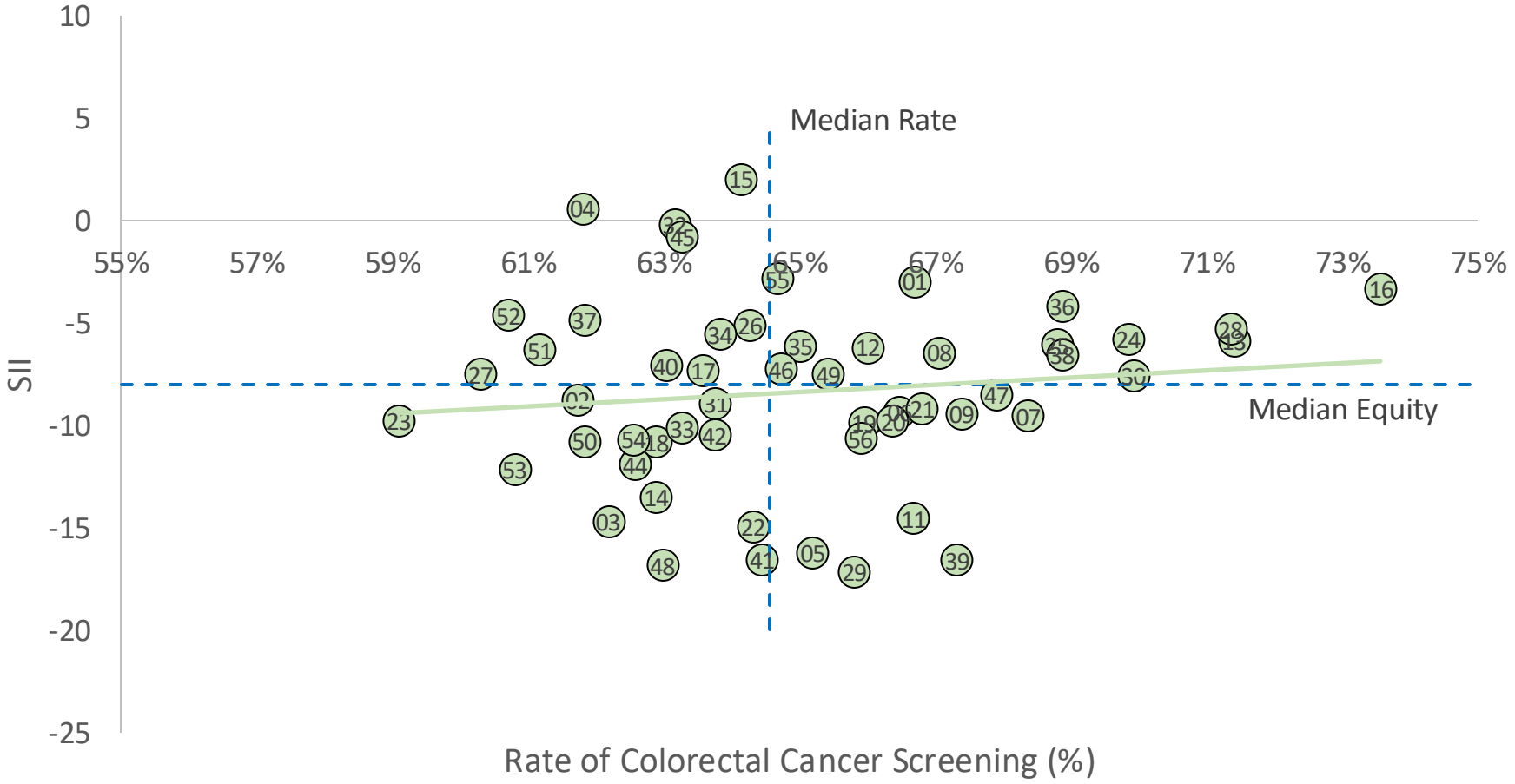
Colorectal Cancer Screening



Pearsons Corr: 0.12

Screening rates vary across OHTs.

Median Equity is below 0 reflecting lower screening in more deprived areas.

Flat to shallow trendline shows little association between overall screening levels and inequity

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% Not Rostered

Pearsons Corr: 0.23

OHTs with a higher percentage of patients not rostered have slightly higher inequity, though most cluster near the median.

The overall association between attachment and gradient of inequity is positive and modest.

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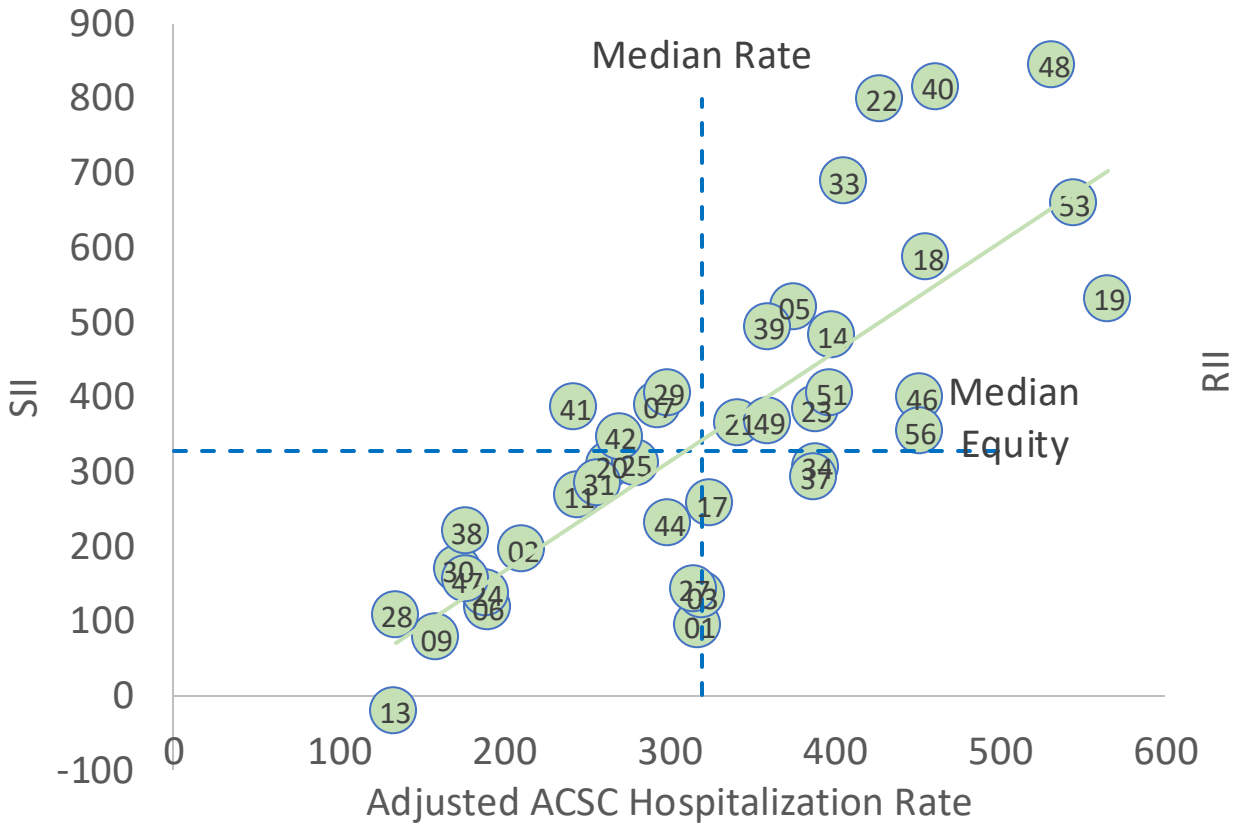
RII and SII


900
800
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SII
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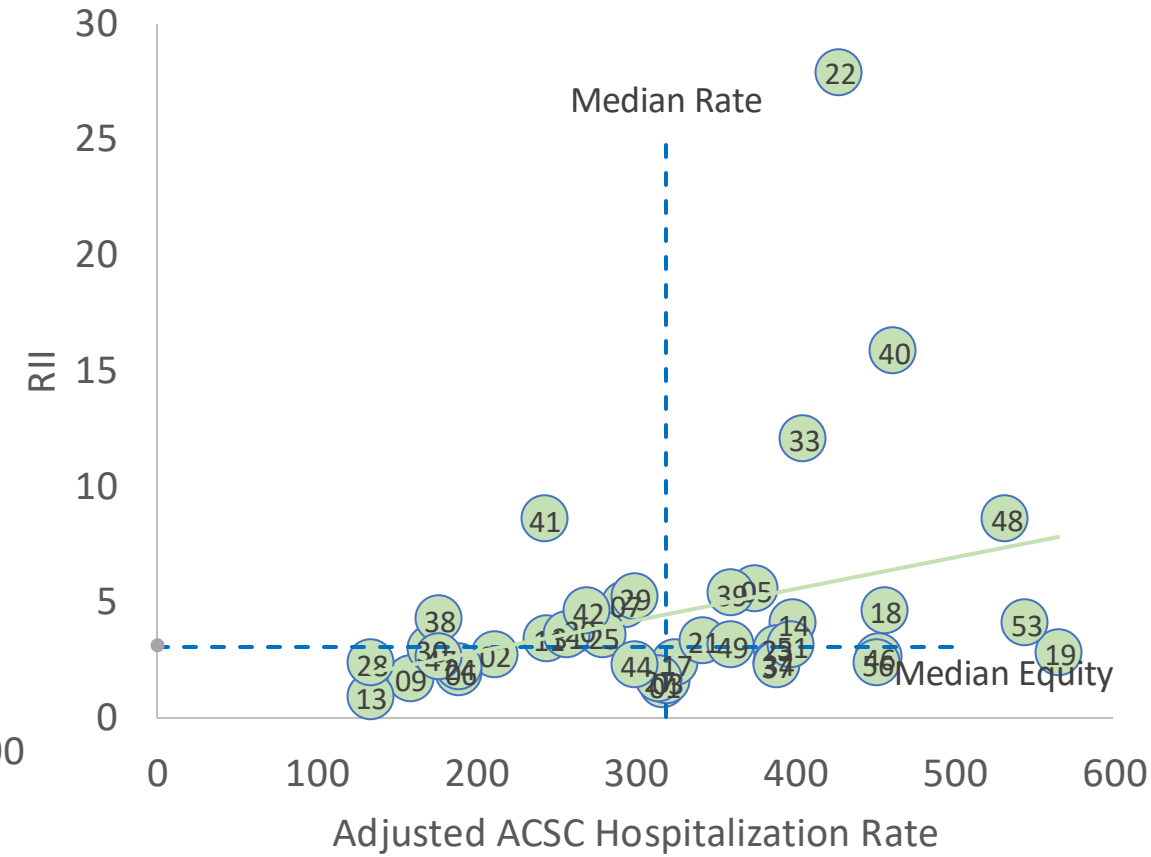
100
200
300
400
500
600
Adjusted ACSC Hospitalization Rate
Median Rate
Median Equity


30
25
20
15
10
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RII
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300
400
500
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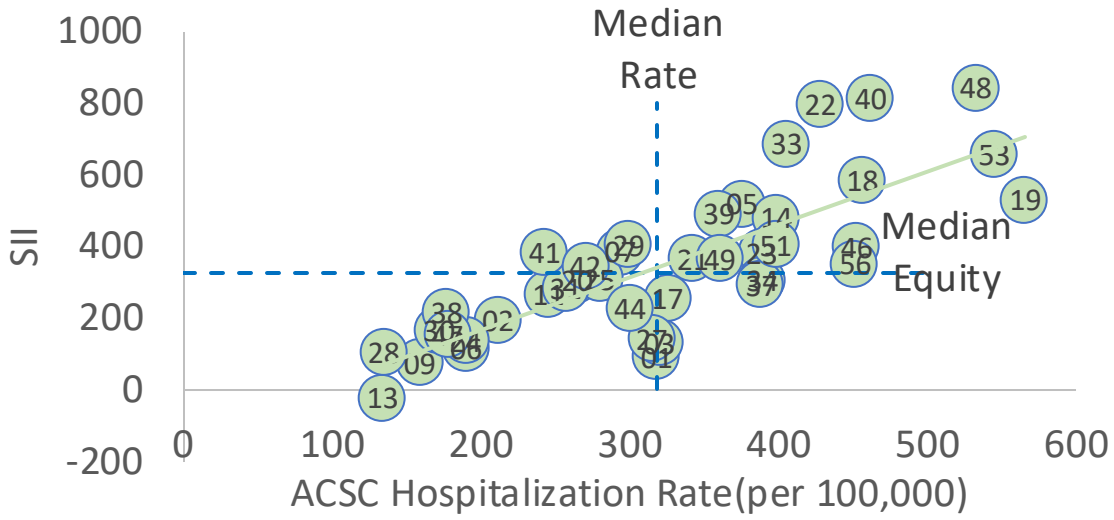
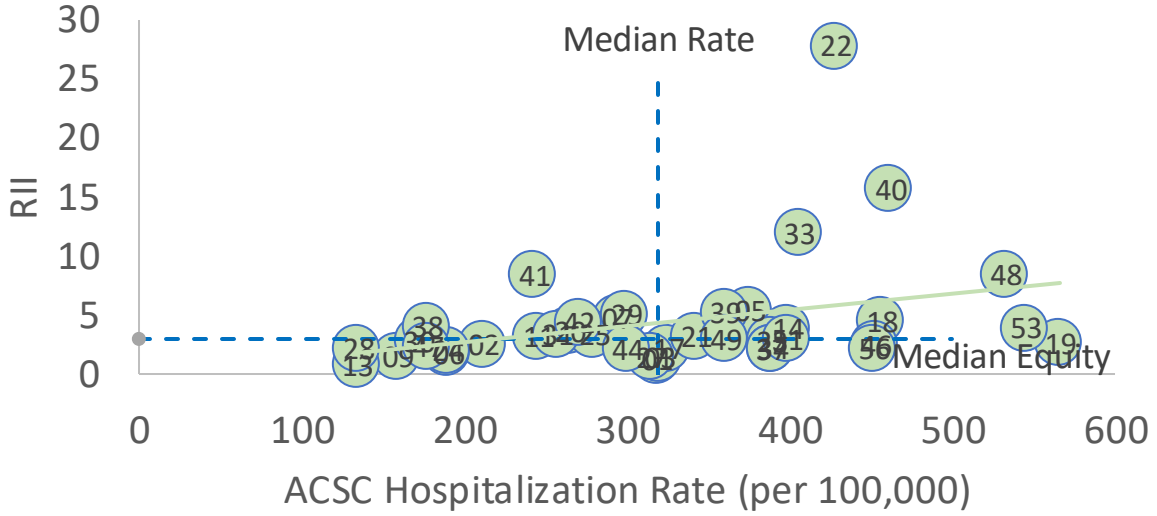
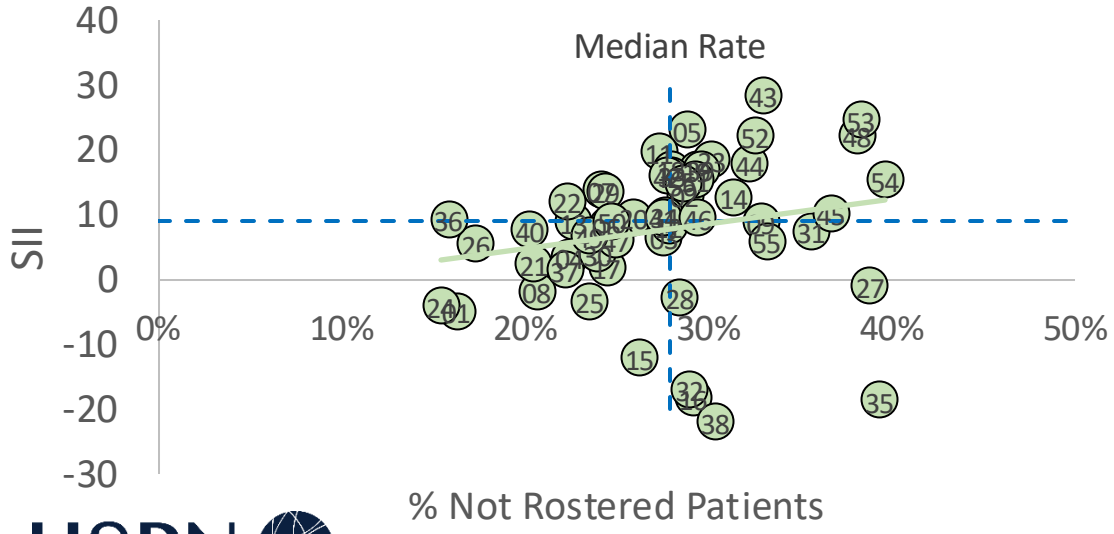
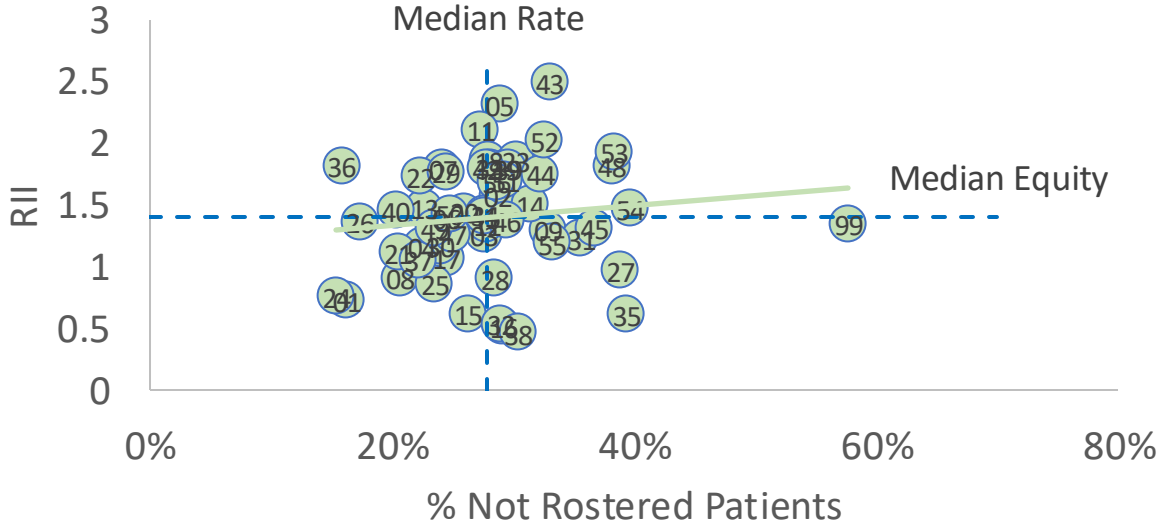
Adjusted ACSC Hospitalization Rate
Median Rate
Median Equity

RII and SII









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Interpretation

Strong Associations

- ACSC hospitalizations and not being rostered to primary care rosters showed a strong relationship with Material Deprivation (both are higher in more deprived neighbourhoods).

Weak Associations

- Cancer Screening had a range across OHTs where some OHTs had equity gaps, others were equity-positive (lower SES had higher achievement); ED visits best managed elsewhere are rare and only a few OHTs have inequities.

Ontario Health

HSPN Webinar

January 27th, 2026

Ontario Health

OHT Performance and Improvement Program

Standardized Performance Measures

Note: Some measures are considered "developmental" and require additional time to test and validate.

- ✓ System-Level Measures
- ✓ Patient and Provider Experience
- ✓ Process Measures (locally collected)

Enabling Processes

Structured reporting and collaborative reviews transform data into insights that guide decisions.

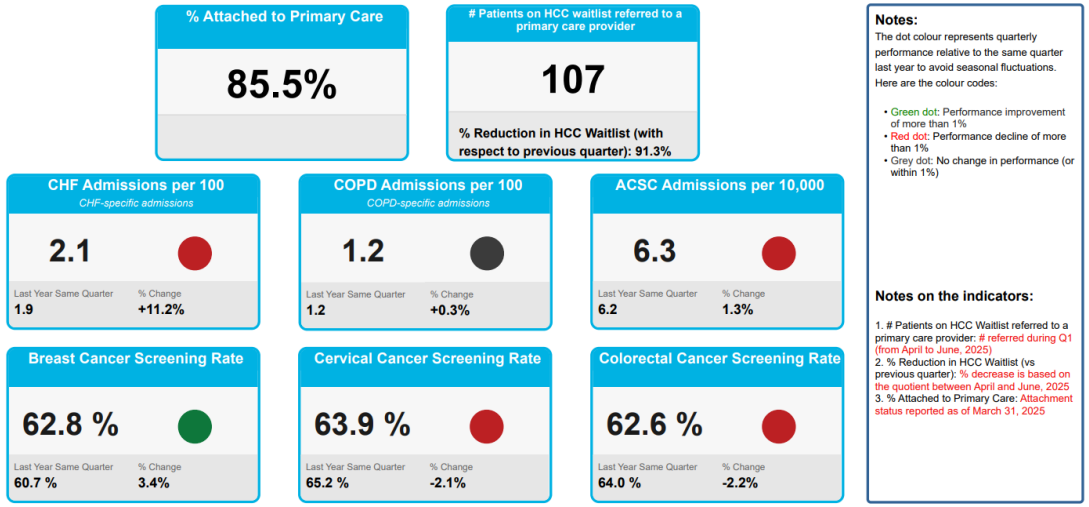
- ✓ Quarterly OHT level Performance Reports
  OHT-specific performance for OHT, PCN and PFAC Leads, OHT Staff and OHT Leadership Council
- ✓ Quarterly Performance Review (QPR)
  Meetings led by Regions to discuss quarterly OHT reports and performance quality improvement.
- ✓ Quality Improvement Plans
  Quality improvement planning and support fully aligned to performance program

The OHT Performance and Improvement Program combines standardized measures with enabling processes to support continuous performance improvement

Overview of OHT Performance Reports

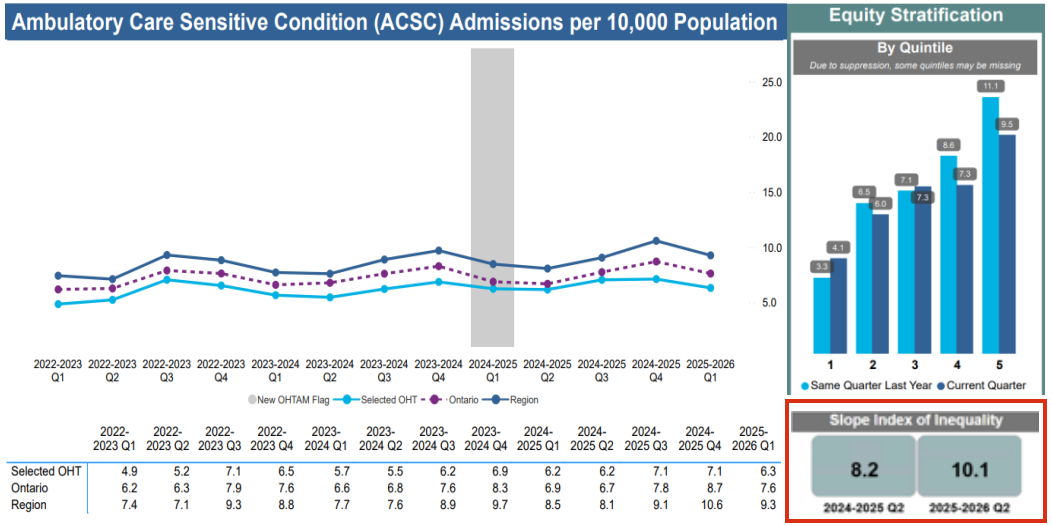
A. Summary Scorecard

Provides the latest quarter performance overview with a % change related to the same quarter in the previous fiscal year



B. Historical Trends and Equity

Provides the last 3 years performance trends along with comparison with regional and provincial averages and **equity stratified data**



	2022-2023 Q1	2022-2023 Q2	2022-2023 Q3	2022-2023 Q4	2023-2024 Q1	2023-2024 Q2	2023-2024 Q3	2023-2024 Q4	2024-2025 Q1	2024-2025 Q2	2024-2025 Q3	2024-2025 Q4	2025-2026 Q1
Selected OHT	4.9	5.2	7.1	6.5	5.7	5.5	6.2	6.9	6.2	6.2	7.1	7.1	6.3
Ontario	6.2	6.3	7.9	7.6	6.6	6.8	7.6	8.3	6.9	6.7	7.8	8.7	7.6
Region	7.4	7.1	9.3	8.8	7.7	7.6	8.9	9.7	8.5	8.1	9.1	10.6	9.3

Validated Indicators

Primary Care Attachment

% Attached to Primary Care

HCC Waitlist Indicators

Patients on HCC waitlist referred to a Primary Care provider

% Reduction in HCC Waitlist (with respect to previous quarter)

Chronic Disease Management Indicators

CHF Admissions per 100 patients (#)

COPD Admissions per 100 patients (#)

ASCS Admissions per 10,000 patients (#)

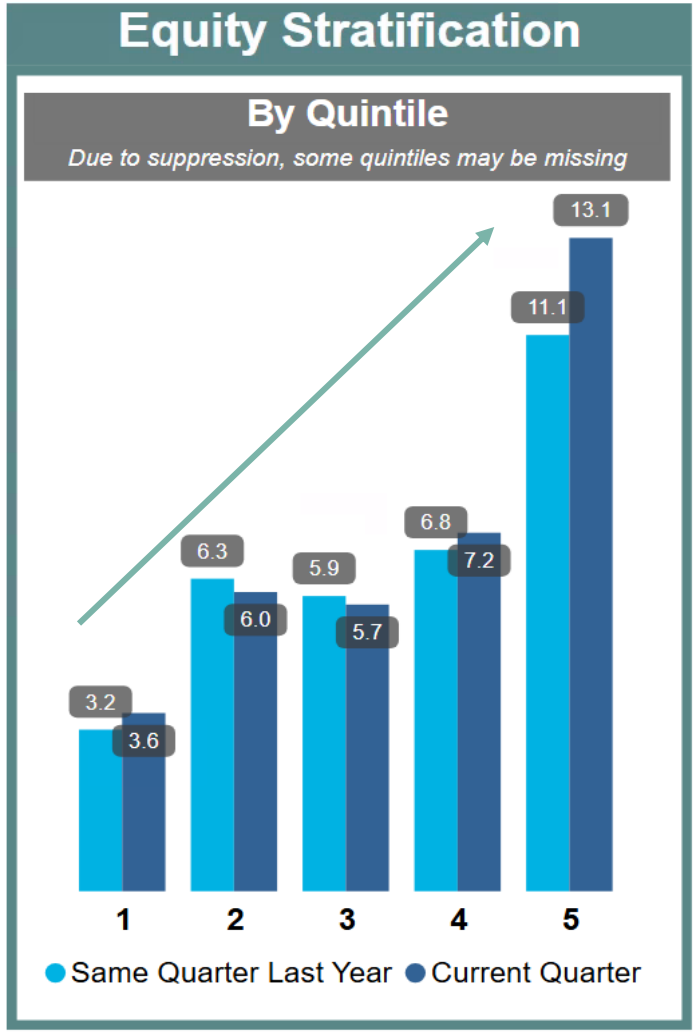
Cancer Screening Indicators

Breast Cancer Screening (%)

Cervical Cancer Screening (%)

Colorectal Cancer Screening (%)

Equity Stratification on the Performance Reports
Health Equity Quintiles



Equity-stratified data has been introduced for the OHT-level performance reports. The equity variable used is **ON-Marg material resource quintiles**, an area-based measure derived from Canadian Census data. Quintiles are assigned at the dissemination area (DA) level.

- Material Resources (previously material deprivation) include factors related to access and attainment of basic material needs, such as % unemployed, % without a high school degree within a geographic area
- **ON-Marg** assigns deprivation quintiles based on the proportion of the population within a geographic area, which have fewer material resources. Q1 represents the least marginalized areas, while Q5 represents the most marginalized.

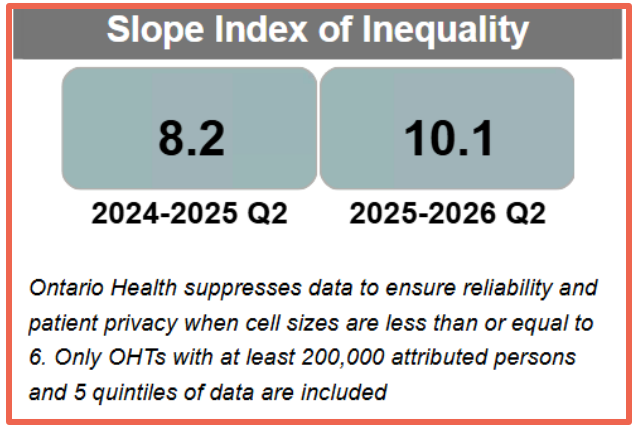
Example: The graph on left shows an OHT where the number of ambulatory care sensitive conditions (ACSC) are greatest in the most marginalized group (Q5) compared to the other 4 quintiles. In the addition, the level of inequality has increased relative to the same quarter in the previous.

How to interpret it?

- OHTs should aim for an even distribution across quintiles.
- OHTs can use the performance reports to identify clinical priorities with the most uneven distribution across quintiles as performance improvement opportunities and consider targeted interventions within areas with lower material resources.

Equity Stratification on the Performance Reports

Slope Index of Inequality (SII) *Starting on FY25/26 Q2 report*



This example shows that inequities have increased for ACSC from Q2 last fiscal year to Q2 this fiscal year (i.e., the SII is further from 0).

How to interpret it?:

- Current interventions may not be reaching the populations with the greatest need.
- Resources and efforts may need to be redistributed or better targeted.
- Barriers to primary care access may be growing for specific groups.

- The Slope Index of Inequality (SII) provides an additional tool to measure an OHT's progress at improving health equity.
- SII quantifies the social gradient of the indicator, showing the difference in indicator values across sub-groups at each quintile of material resources. It **captures the entire socioeconomic gradient rather than focusing on extremes** (e.g., rate difference).
- SII offers a robust, comprehensive, and policy-relevant measure of equity, making it ideal for monitoring trends and guiding targeted interventions.
- It provides a single value for the two references periods. A **higher magnitude** (regardless of sign) **means worse inequality** (the gap between groups is larger). **A value of 0 means perfect equality** (no difference across the socioeconomic gradient).
  - **A negative SII** indicates the indicator is higher among the most marginalized sub-group
  - **A positive SII** indicates the indicator is higher among the least marginalized sub-group
- To ensure reliability, Ontario Health will only include an SII value if the OHT has 5/5 ON-Marg quintiles present, and an attributed population of 200,000 persons or more.

Mississauga Ontario Health Team

Inequality & Performance

Mississauga Health's Approach to Utilizing the Relative Index of Inequality for Performance Measurement

Trillium Health Partners

Mississauga Health
Ontario Health Team
Partnering for your health

Who we Serve

Mississauga Health
Ontario Health Team
Partnering for your health

Anne

is facing challenges while coordinating her father's care and managing his medical needs

Sita

is managing her diabetes, handles household chores, and plays an active role in caring for her family

Hassan

Is living alone in Mississauga and was recently found wandering and confused

900,000+

People seeking services in Mississauga

1 in 10

Do Not Have a Family Doctor

50% +

Residents born outside Canada with 130 languages spoken

Current State

Performance and Equity Measurement at MOHT

- **Background**
  - Current data sources available (OH dashboard, OH performance summaries, IntelliHealth) provide limited granularity.
  - Cannot create sub-indicators or conduct intersectional analysis (e.g., geography, equity, condition-specific)
  - Limits nuanced reporting for internal performance and meeting evolving MOH/OH priorities (e.g., unattached patients, chronic condition tracking)
- **Current Status at MOHT**
  - No automated process to extract/transform/load data for OHT-specific indicators
  - Reporting capacity constrained by lack of customizable, regularly refreshed datasets
  - OH to release limited new data (e.g., unattached patient counts), but major platform enhancements are not expected.

Problem: MOHT needed more **timely** data **tailored to local needs** and priority populations so we can make better informed decisions (e.g., primary care team expansion)

Solution

Mississauga Health OHT Scorecard

Objective:

- The OHT Performance Scorecard is designed to enable comparability with other OHTs, track trends over time, and **monitor health equity**
- Intended for application in annual reports, proposals, and planning, while minimizing duplication across partners

Advancing OHT Strategic Priorities:

1. **Alignment with OH**: Balances OH's required measures with local OHT priorities
2. **Enhanced Insight**: Enables more frequent updates and flexible, OHT-tailored indicators
3. **Equity & Customization**: Incorporates equity measures (RII)
4. **Performance Monitoring:** Monitors progress against key indicators compared to peer performance
5. **Integrated Care Support:** Prepares OHT to evolve with upcoming requirements

Mississauga Health is committed to achieving an equitable system of health and wellness across each community by;

- Understanding the needs of diverse communities;
- Reducing the barriers to care;
- Supporting the development of diverse, inclusive, and anti-discriminatory organizations;
- And advocating on the social determinants of health.

Comparison between MOHT and OH selected measures

Metric Selection & Data Collection

12 metrics total, selected in consultation with M-OHT & subject matter experts

Clinical Category	MOHT Measures	OH Performance Measures
Patient Flow & Chronic Disease Pathways	• Rate of ED Visits for Potentially Avoidable Causes per 10,000 population • CHF admissions per 100 individuals • COPD admissions per 100 individuals • ACSC Hospitalizations per 10,000 population • Percent of ALC Days	• CHF-specific admissions per 100 individuals • COPD-specific admissions per 100 individuals • ACSC admissions per 10,000
Preventative Care	• Breast Cancer Screening Rate (%) • Cervical Cancer Screening Rate (%) • Colorectal Cancer Screening Rate (%)	• Breast cancer screening rate (%) • Cervical cancer screening rate (%) • Colorectal cancer screening rate (%)
Priority Populations	• ED as First Contact for MHA Care • Repeat (2+) Fall-Related ED Visits Among those Identified as Frail Older Adults • Decedents with 2+ ED Visits in the last 30 Days of Life	N/A
Primary Care Access & Attachment	• % Not Rostered (to team-based care)	• % Patients Attached to Primary Care • # Patients on the HCC waitlist referred to a primary care provider • % Reduction in HCC waitlist

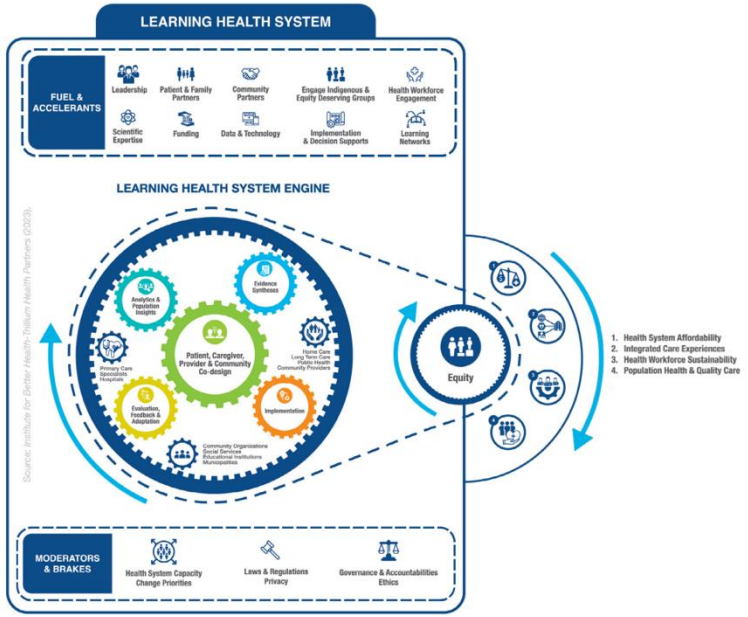
Goal:

Remain flexible to changing priorities and definitions while offering additional insights into MOHT priority areas

& **integrate equity into every measure**

Measuring Inequity

What is RII?	RII is the relative index of inequality. It measures relative risk of one group to another. In our reporting, we assess risk using material deprivation derived from **ON-Marg index**. In other words, it tells us how much better or worse a particular group is based on health outcomes
Why RII?	• It is **unitless** and allows us to investigate the differences among the groups – insight into **where we should prioritize** • RII is a well-established measure used for health system performance – aligned to THP's *Learning Health System* approach • RII is used for corporate reporting at THP (e.g., OBSP) – understood by both THP and MOHT leadership
What are we measuring?	THP in partnership with the MOHT is leveraging the RII metric to understand how healthcare is utilized by different groups. Access results in positive health outcomes, and therefore we want to understand how access varies among those from low deprived areas versus high deprived areas.
What is ON-Marg?	**ON-Marg is an index created based on census data.** The ON-Marginalization Index is a tool used to measure and understand the degree of disadvantage an or exclusion that different communities may face.



Data Pipeline

- Identify available data sources housed at ICES: DAD, NACRS, OHIP, RPDB
- THP IBH Biostatistician runs indicator results using available admin data
- MOHT, Peers, and Provincial results included
- THP Performance Analytics built MOHT scorecard
- Scorecard distributed to THP and MOHT leadership

- Through MOHT's partnership with THP and the Institute for Better Health, we have a unique opportunity to build this scorecard **from the ground up using foundational health administrative data** grounded in evidence-based key performance indicators.
- Designed with maximum flexibility to evolve alongside shifting priorities and emerging program initiatives.

OHT Performance Summary - Mississauga Health

Patient Flow & Chronic Disease Pathways | Preventative Care | Priority Populations | Primary Care Access & Attachment

Rate of Emergency Department Visits for Potentially Avoidable Causes per 10K People

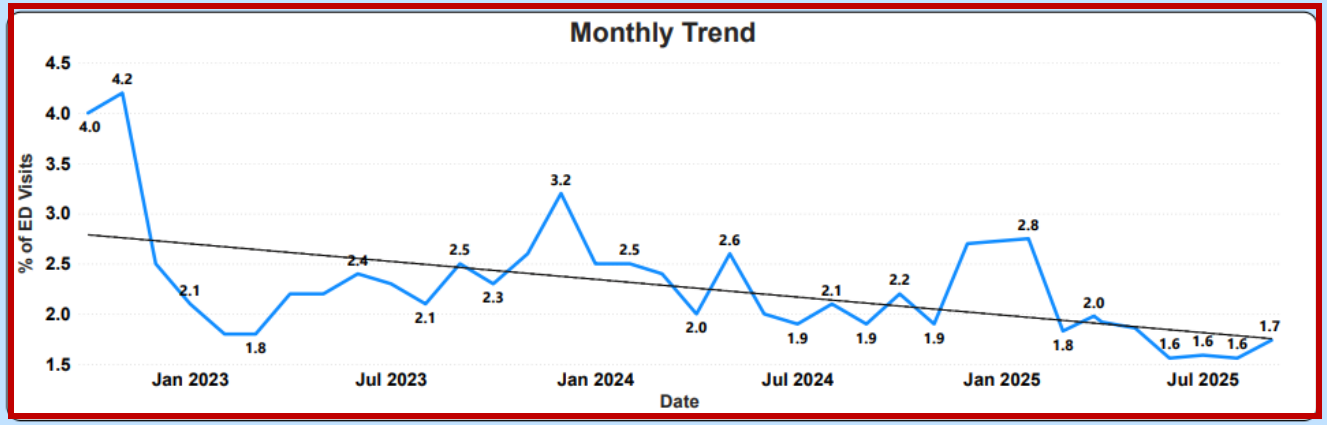
Rate of Emergency Department Visits for Potentially Avoidable Causes per 10K People

Number of unscheduled visits to the emergency department for conditions that could be managed in primary care (e.g., family doctor, nurse practitioner, or other community healthcare provider) in the community, divided by the total number of unscheduled emergency department visits in the observation period

Decreasing values are preferred

YTD

10.2



PYTD

28.0

% ED Visits for Potentially Avoidable Causes

RII Rolling 12 Month Average	Mississauga Health Most Recent Fiscal Quarter	Initial 12 OHTs Most Recent Fiscal Quarter	Province Most Recent Fiscal Quarter
1.61	4.9	14.3	17.1

MOHT Scorecard Results

Data Trends

Metric	Trend	RII
Percent of ED Visits for Potentially Avoidable Causes	**Decreasing**	1.61
CHF Admission Rate per 100 CHF Patients	**Decreasing**	1.19
COPD Admission Rate per 100 COPD Patients	**Decreasing**	1.04
ACSC Hospitalizations per 10K Population	**Increasing**	4.54
Percent of ALC Days	**Neutral**	1.61
Breast Cancer Screening	**Neutral**	1.26
Cervical Cancer Screening	**Neutral**	1.23
Colorectal Cancer Screening	**Neutral**	1.28
ED as First Contact for MHA	**Decreasing**	0.87
Not Rostered Individuals	**Decreasing**	1.34

- ACSC exhibits **high inequity** and an **increasing utilization** trend
- M-OHT ranks well relative to others OHTs in terms of ACSC hospitalizations
  - Despite this, we see a strong equity gradient among this patient cohort
- Presents an **opportunity for tailored interventions** to better support the vulnerable population

Conclusion

Summary

- A need for data tailored to our population, accessible at a frequent cadence to better inform decision making and track trends over time

- Sought to integrate equity as an inherent aspect of each metric to better understand support our diverse population
  - You can't drive performance improvement without equity

- Many of our metrics exhibited some level of equity gradient, but strong gradients were seen in ACSC, ALC, and Avoidable ED Visits

Next Steps

- Identify existing OHT initiatives that may be able to "move the needle" on our metrics
- Develop target setting methodology to track changes in metric values

Ottawa OHT/ÉSO d’Ottawa

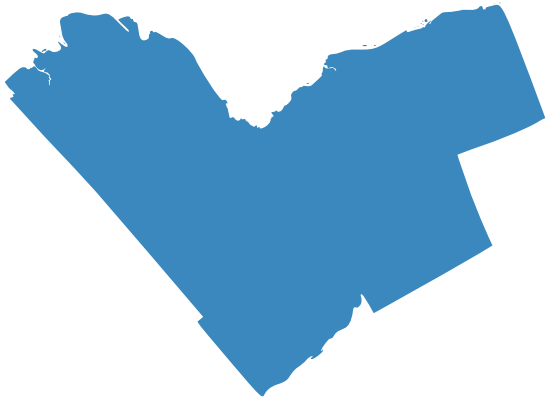
Ottawa OHT-ÉSO

HEALTH EQUITY DATA IN DECISION MAKING

January 27, 2026

Prepared by Shelley Horrocks

Place-Based Data



- In Ottawa, there are rich, local, place-based resources to support equity-informed planning are available

ONS SQO

OCHPP
Ontario Community Health Profiles Partnership

Open Ottawa

NEIGHBOURHOOD EQUITY INDEX

By using one place-based system (Neighbourhoods) across OHTs and community partners, we can;

1. Understand our City's unique communities and their needs
2. Use the same, simple language in collaborative planning
3. Integrate health outcome, system usage, population health, and social determinant data from multiple sources

Statistics Canada Statistique Canada

INSPIRE-PHC

HSPN Health System Performance Network

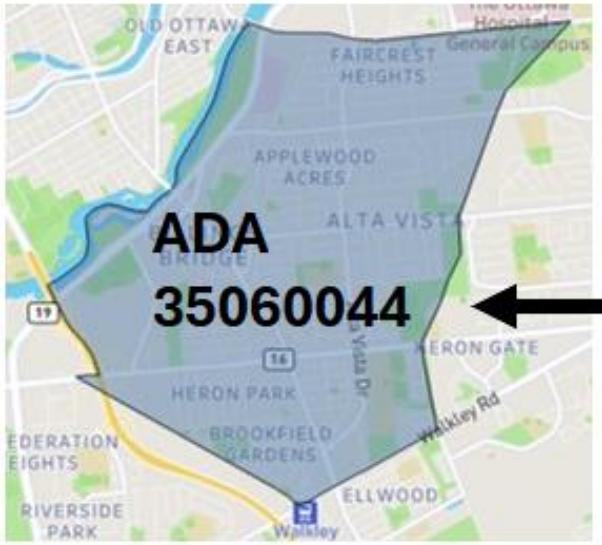
Epic
with the patient at the heart

ÉQUIPE SANTÉ ONTARIO
Ottawa
ONTARIO HEALTH TEAM

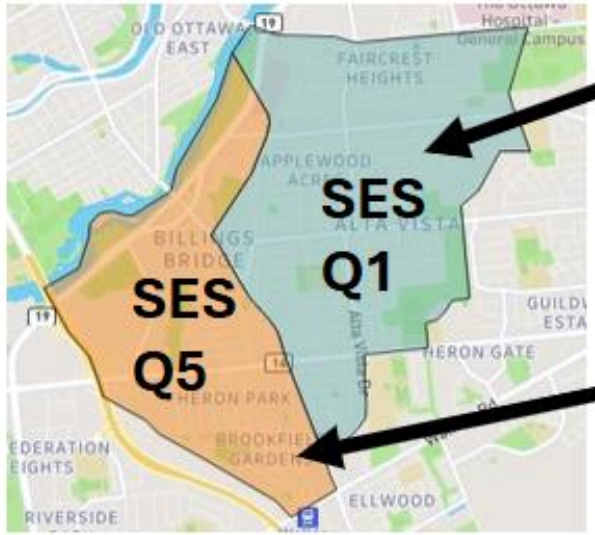
Natural Neighbourhoods

Ottawa Neighbourhood Study's 'natural neighbourhoods'

Standard 'stats' shapes often **hide equity and health disparities**



Aggregated dissemination area (ADA)
Standard Census-based geography



Alta Vista
higher income, older population

Billings Bridge–Heron Park
lower income, younger population

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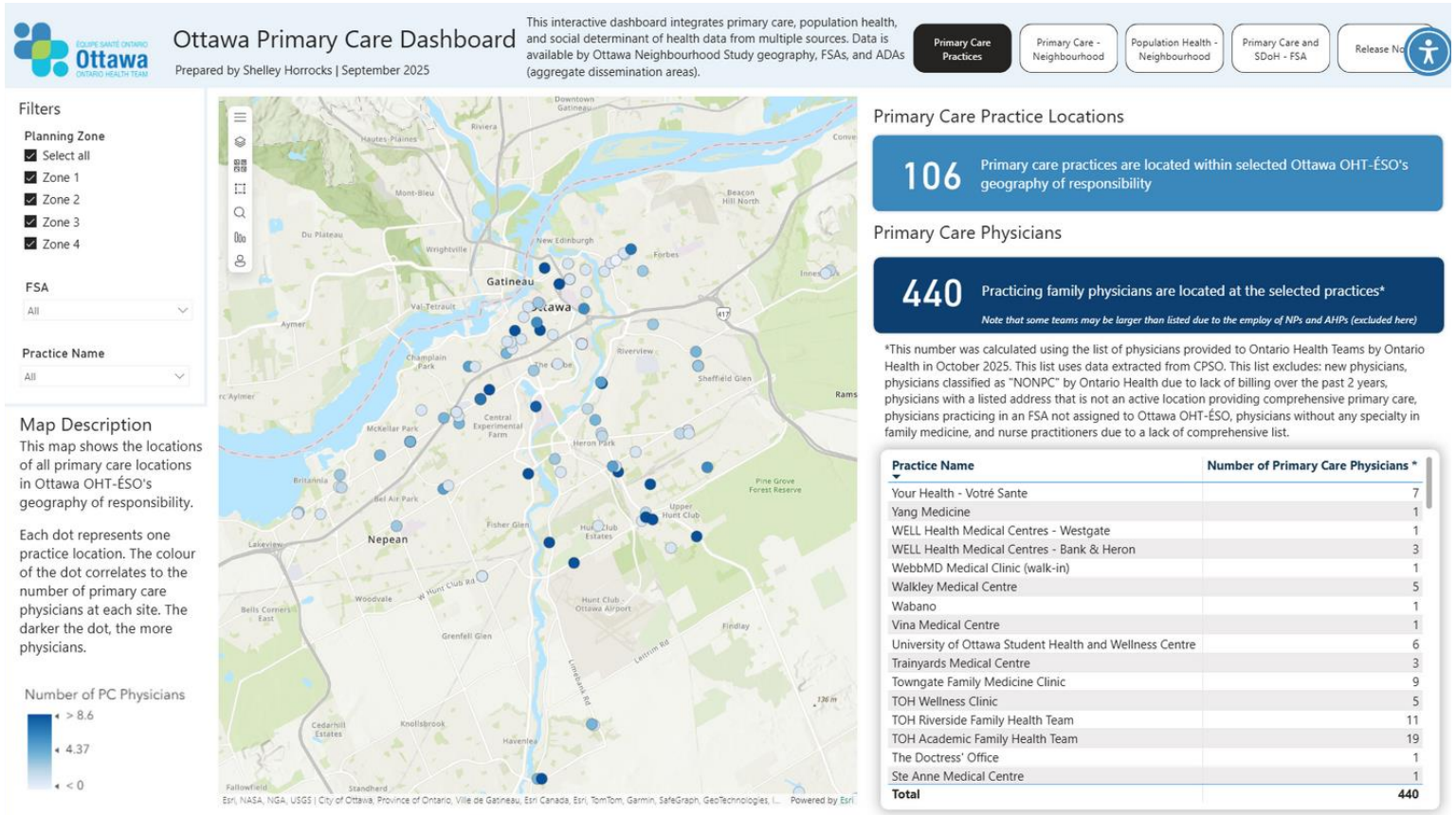
Ottawa
ONTARIO HEALTH TEAM

Equity Data in Planning

To support Interprofessional Primary Care Team expansion/creation planning, we developed a Primary Care Dashboard for our OHT's primary care geography integrating;

Primary Care Data



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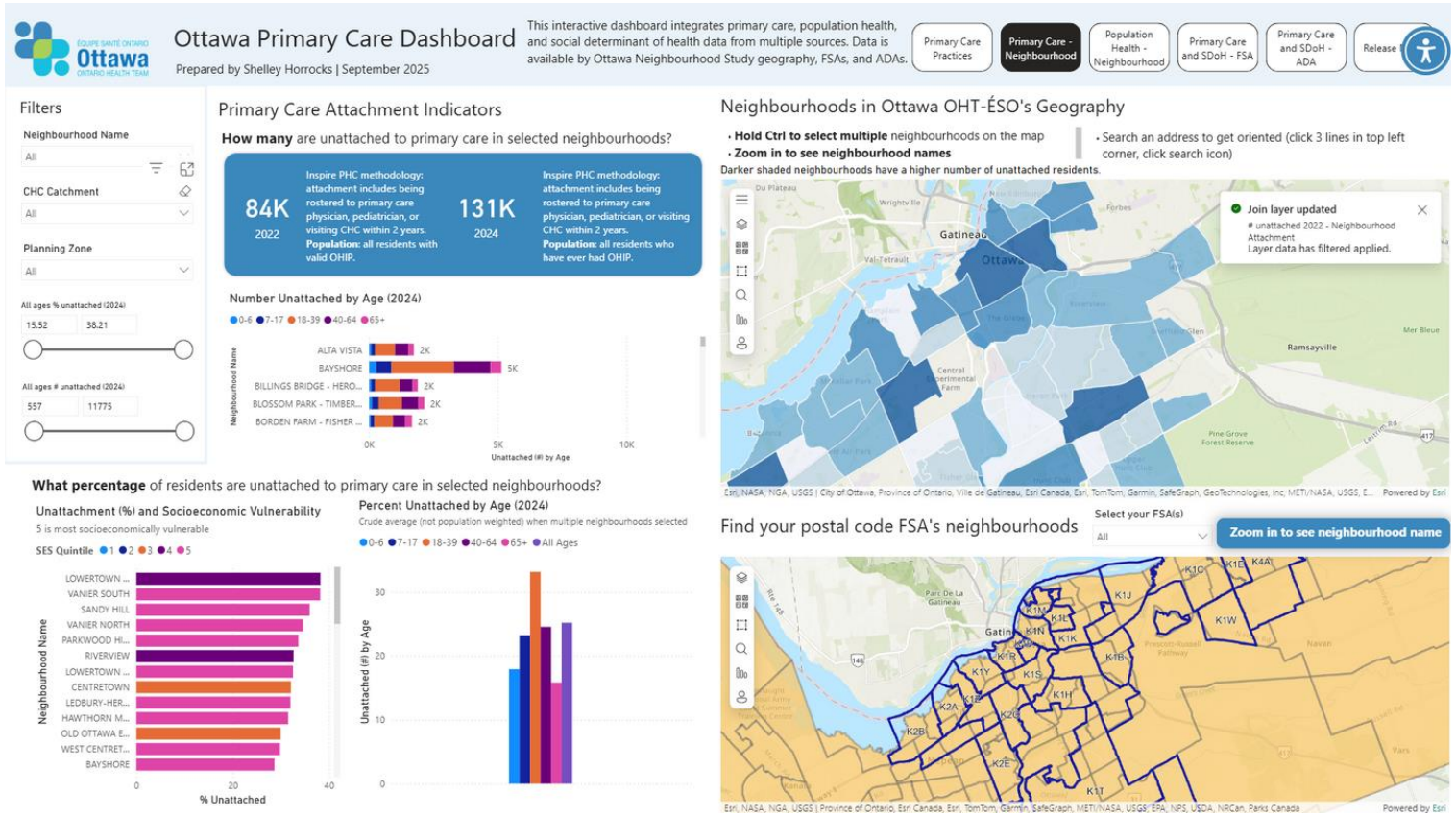

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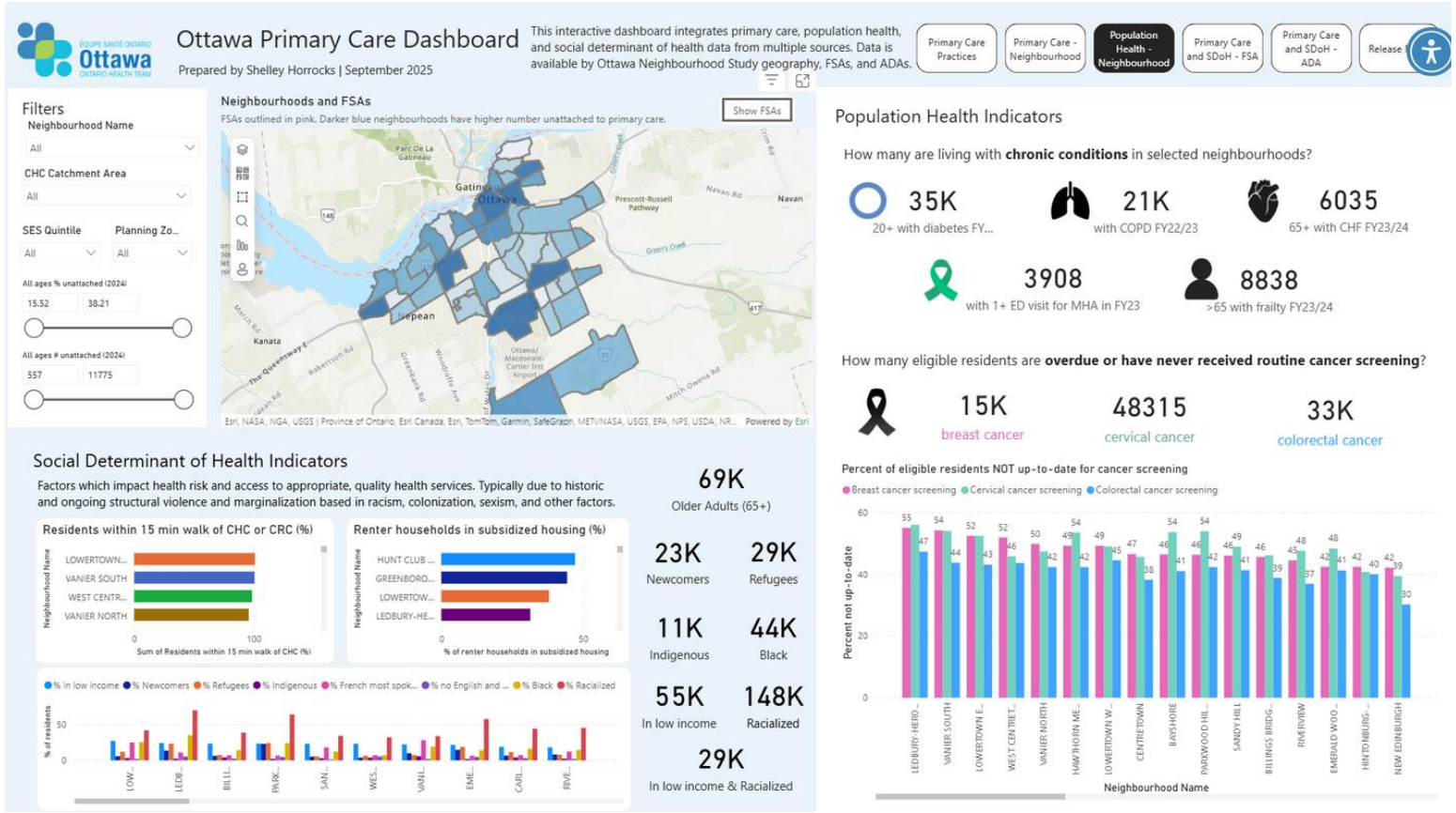
Population Health, SDD, & SDoH



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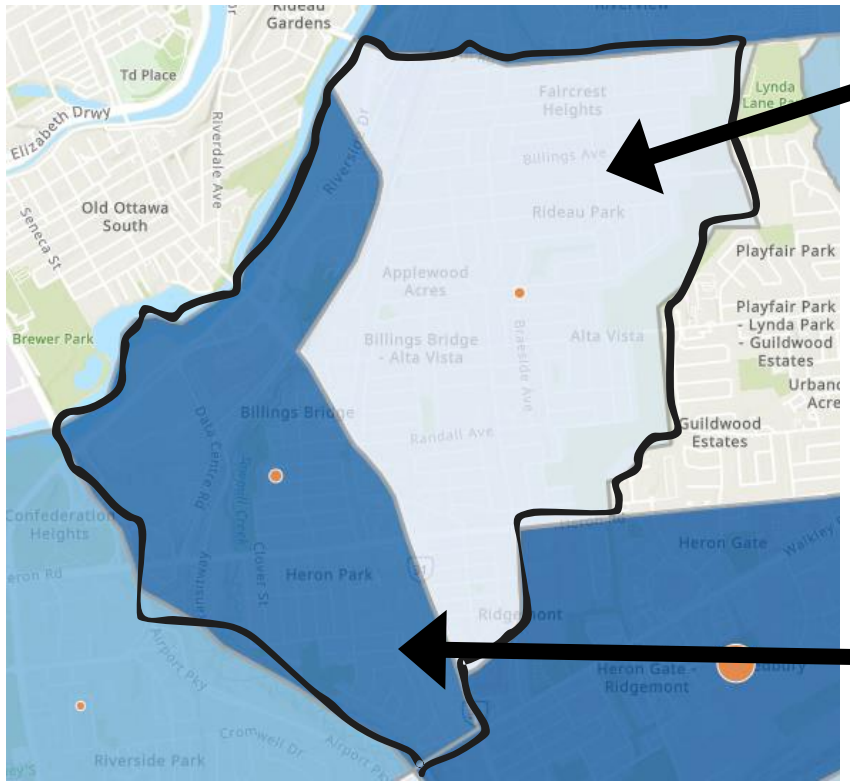
Identifying Disparities

Ottawa Neighbourhood Study's 'natural neighbourhoods'

Standard shapes often **hide equity and health disparities**

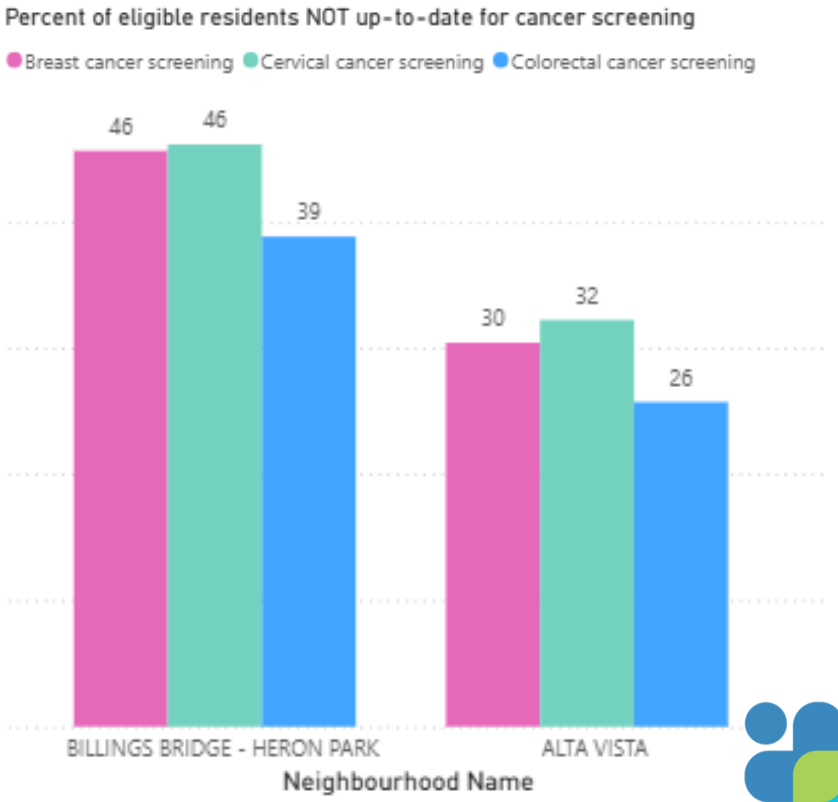


Alta Vista
13.7% unattached
(N=1,034)

ADA (combined)
16% unattached
**different data year*

Billings Bridge-Heron Park
22.5% unattached
(N=1,220)

shading= % uncertainly attached to primary care (2022)
dot= N uncertainly attached to primary care (2022)



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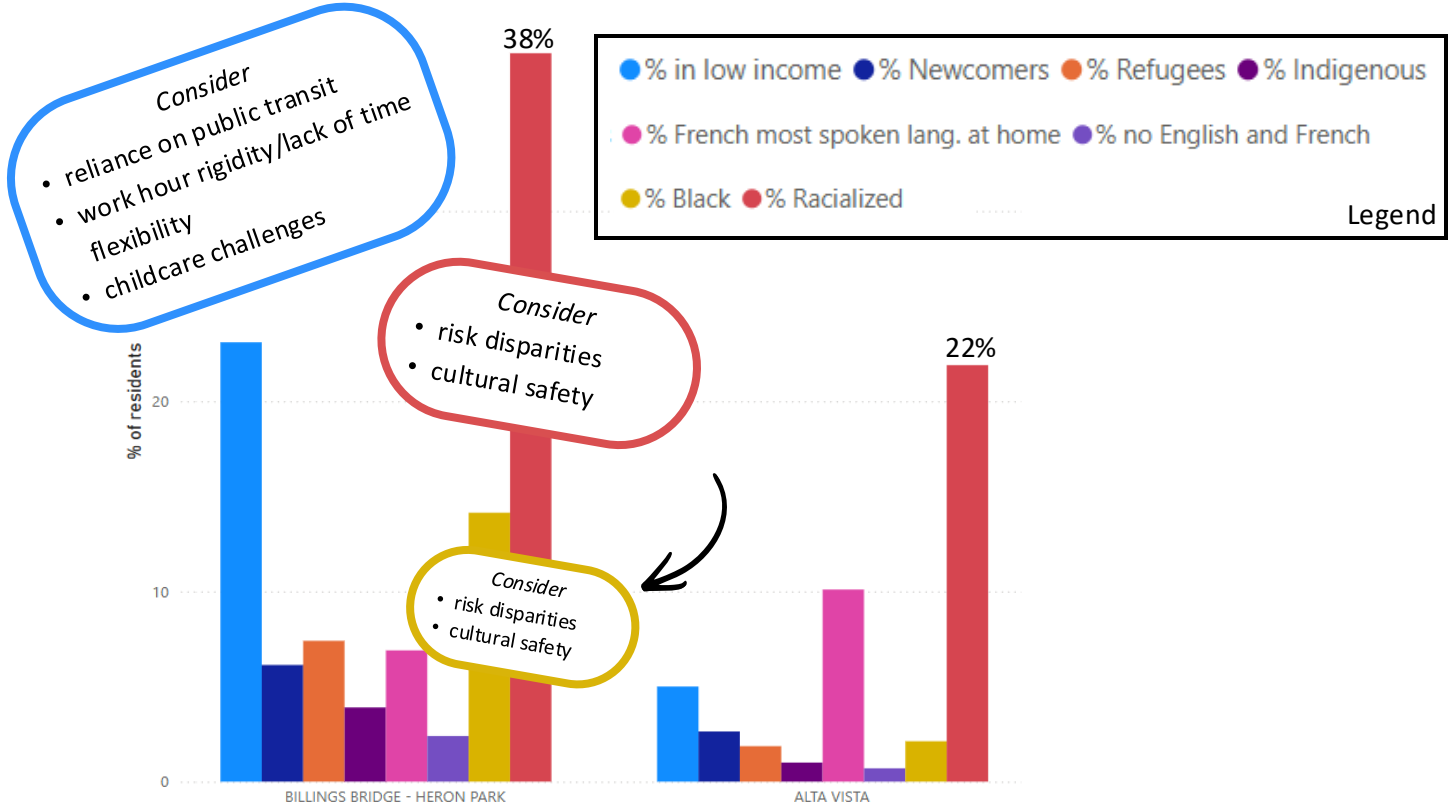
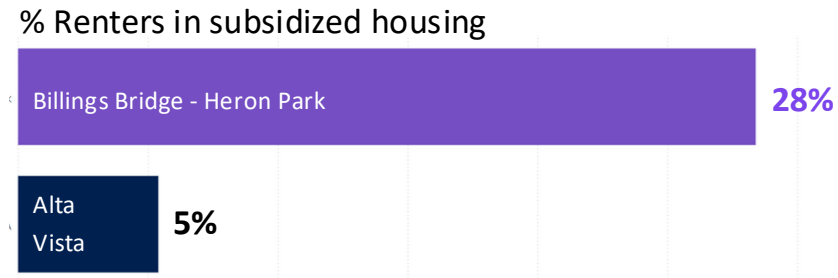
Grounding Planning

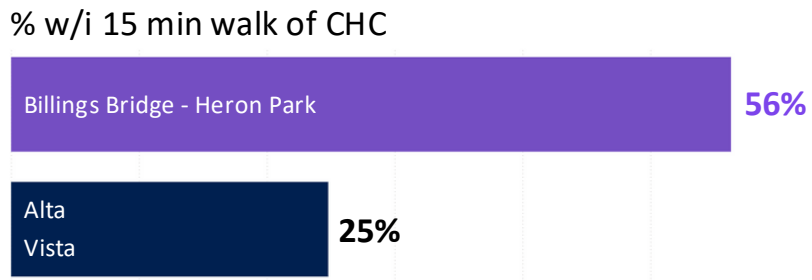
Once disparities are identified, we can use sociodemographic and social determinant of health data to explore targeted interventions.

Neighbourhood Sociodemographic Factors



Barriers and Enablers





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THANK YOU!

Any questions?

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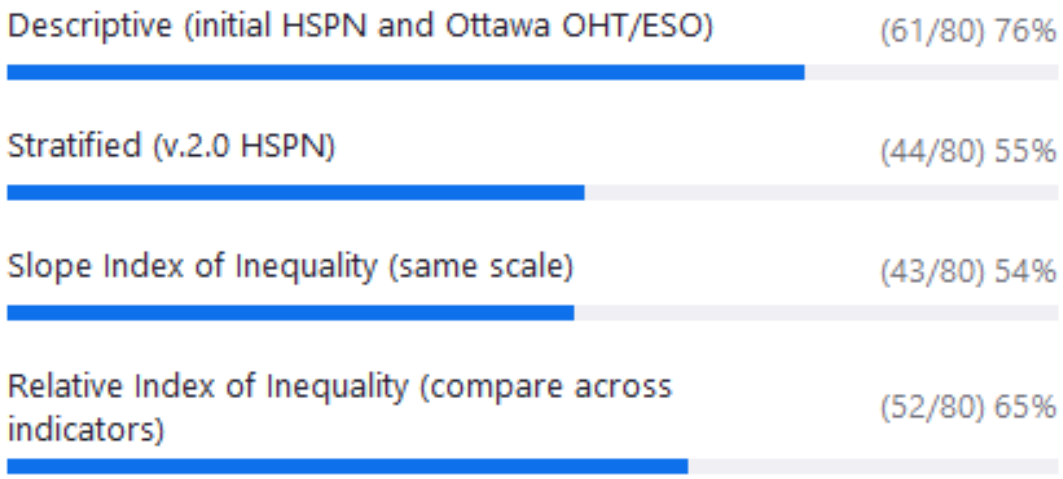
Poll 3

1. Of the measurement approaches used today, which do you think are useful for OHTs?
(select any/all that are useful) (Multiple choice)

80/80 (100%) answered



Discussion

What forms of supports over and above the reports and data available through Ontario Health would be useful to you?

Up Next

- HSPN webinar series
  - 4th Tuesday of the Month: 12:00 – 1:30 pm
  - February 24th, 2026
    - …stay tuned !

THANK YOU!

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The Health System Performance Network

hspn.ca