Toronto Central LHIN

Black Experiences in Health Care: Why Race Based Data Matters

Detailed Report

Prepared for the *Black Experiences in Health Care Symposium* held on January 30th, 2020

Ontario

Acknowledgements

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The authors wish to acknowledge and specially thank:

Toronto Region hospitals and Community Health Centres (CHCs) that collect, analyze and use standardized demographic data, as well as Sinai Health System that played a key role in supporting the implementation of the Measuring Health Equity Project.

ICES for conducting the linkage of the hospital equity data to its databases and analysis through the Applied Health Research Question (AHRQ) Project 2016 0900 839 000. Thanks to the ICES researchers: Erin Graves, Lindsay Favotto, Elisa Candido, and Aisha Lofters who have worked on this project.

Toronto Region community mental health and addiction (CMHA) agencies that collect client experience data through the Ontario Perception of Care (OPOC) tool, and the Drug and Addiction Treatment Information System (DATIS) that hosts these data.

Our thanks to the patients and clients across the Toronto Region who saw the value of this work and shared their personal information.

Acknowledgements

Additional thanks to the following individuals for the guidance, support, and review of the report:

Ryan Hinds, Victoria Williams, Suzanne Dugard, Aaron Slater and other OH (Toronto Region) colleagues

Gideon Quaison (Health Commons Solutions Lab)

Camille Orridge (Wellesley Institute)

Frank Sirotich (Canadian Mental Health Association)

Rachel Solomon (Hospital for Sick Children)

Chris Sullivan, Derek Chechak, and Karen MacCon (CAMH Provincial System Support Program)

The authors would like thank the Black Health Alliance, Health Commons Solutions Lab, and Sinai Health for organizing and hosting the January 30th 2020 Black Experiences in Health Care Symposium. Finally, the symposium experience would not have been as rich without the attendees who participated to create the energizing and informative event it was. We thank you for allowing us to continue to support this work.

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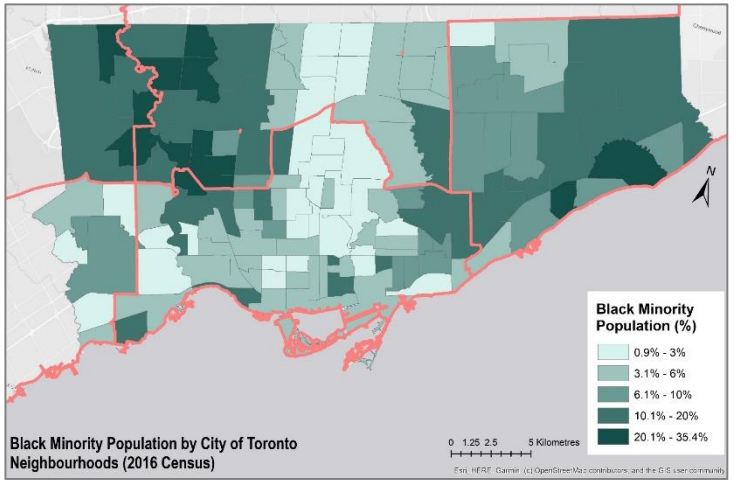
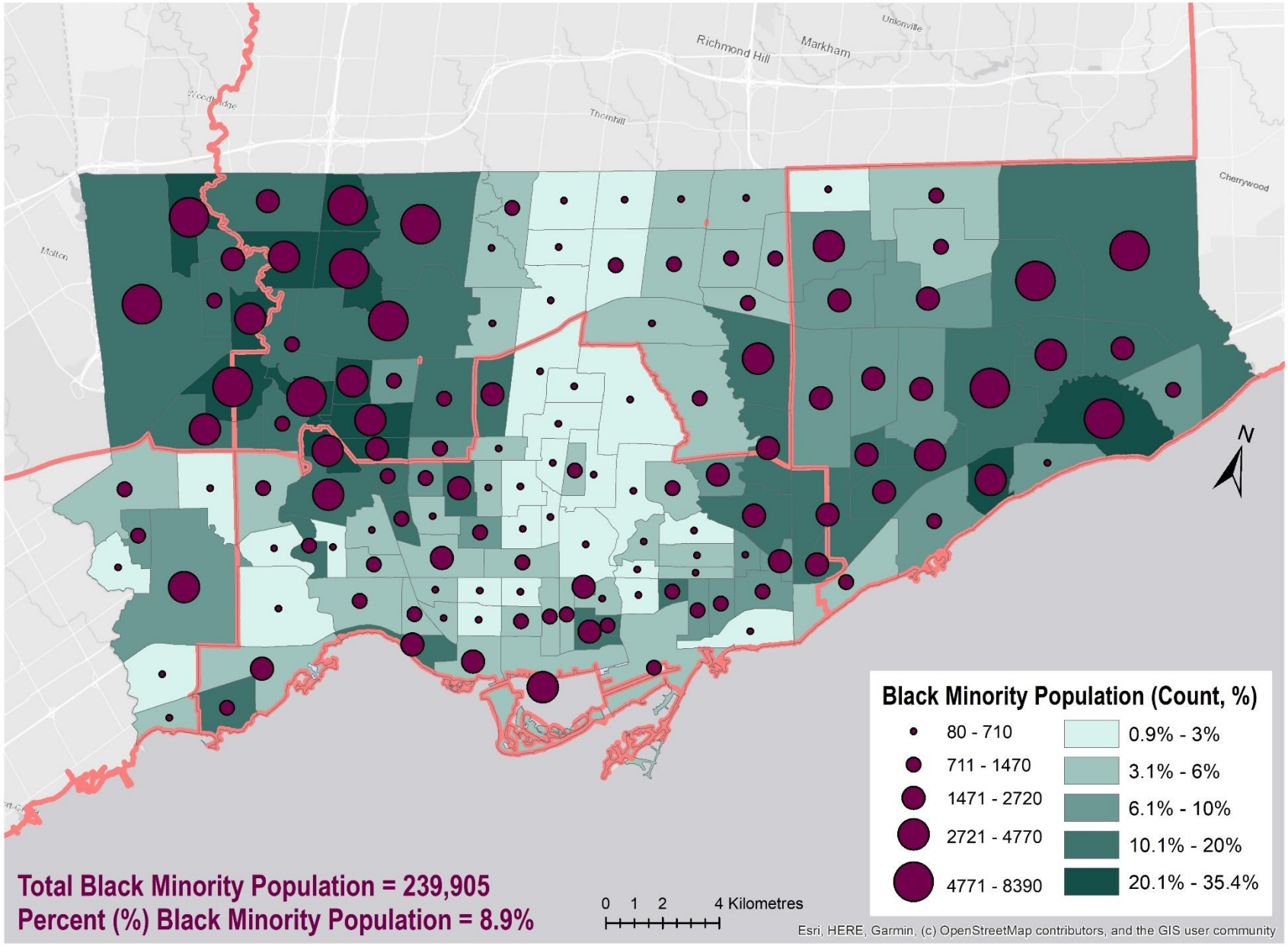
Background on Measuring Health Equity in Toronto Central LHIN

The Need for Health Equity in Toronto Central LHIN: Our Unique Population

- Population of ~ 1.4 million (2019) in 73 neighbourhoods (4.7% identified as Black in 2016)
- Most diverse patient population in the province
  - Age, gender, income, immigrants, languages, race/ethnicity, chronic conditions, sexual orientation, homeless, uninsured
- High population growth in some areas
- Over 170 health service providers (HSPs), ~ 200 programs
- High inflow of patients from neighbouring regions and province



Black Minority Population by City of Toronto Neighbourhoods (2016 Census)



Patient Declaration of Values for Ontario

Ontario

Equity and Engagement

1. We expect equal and fair access to the health care system and services for all regardless of language, place of origin, background, age, gender identity, sexual orientation, ability, marital or family status, education, **ethnicity, race,** religion, socioeconomic status or location within Ontario.

2. We expect that we will have opportunities to be included in health care policy development and program design at local, regional and provincial levels of the health care system.

Minister's Patient and Family Advisory Council in consultation with Ontarians, February 19, 2019
https://www.ontario.ca/page/patient-declaration-values-ontario?_ga=2.106473987.1001127571.1552841289-740680260.1503348529

A Better Way Forward
Ontario's 3-Year Anti-racism Strategic Plan (2017):

Policy, Research & Evaluation

/ Disaggregated Race Data Collection Framework and Guidelines
to strengthen and standardize race-based data collection, analysis and public reporting of disaggregated data by government and institutions.

TORONTO POLICE SERVICE
RACE-BASED DATA COLLECTION STRATEGY

Police Services Act, R.S.O. 1990, c.P.15, as amended, s. 31(1)(c)

Ontario *Human Rights Code,* R.S.O. 1990, c. H.19

Anti-Racism Act, 2017, 2017, S.O. 2017, c. 15 and the *Data Standards for the Identification and Monitoring of Systemic Racism* made under s. 6(1) of this *Act*

Standardized Equity Data Collection in Toronto Central LHIN

Community Health Centres and Hospitals

- Measuring Health Equity project – Since 2012
- First in Canada
- 8 Questions: preferred language, whether born in Canada, racial/ethnic group, disabilities, gender, sexual orientation, income, and number of people supported by income
- Target: 75% of patients/clients

http://torontohealthequity.ca/

Community Mental Health & Addictions

- **O**ntario **P**erception **O**f **C**are (OPOC) survey – tool recommended by the province
- **O**ntario **C**ommon **A**ssessment of **N**eed (OCAN)
- The Access Point referral data for mental health and addictions supportive housing, case management and Assertive Community Treatment (ACT) teams
- Select client socio-demographic data

City of Toronto, United Way, Toronto Central LHIN

- Social Identity Data Project – 2019/20
- Standardized data collection for multi-funded agencies
- Pilot project with 15 programs in 11 multi-sectoral agencies

Research Studies

- **S**creening for **P**overty **A**nd **R**elated social determinants and intervening to improve **K**nowledge of and links to resources (SPARK) Study
- Primary care focused
- Review of questions
- Randomized controlled trial

Note: patient participation in all questionnaires/surveys is voluntary

How does Measuring Health Equity impact care and planning?

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

At the point of access: Asking these eight socio-demographic questions allows the provider to quickly flag patient characteristics that may impact care delivery and planning (e.g., self-identified gender)

At a health service provider level: Aggregated to the provider level, socio-demographic data may flag unrecognized and emerging needs or populations that may require additional or customized support in their care delivery

At a system level: Looking at results across a geography, this data may illuminate gaps in service specific to local regions or smaller areas (which may not be a challenge across the broader LHIN), or link patient population characteristics to utilization in new ways and measure disparities in service outcomes across equity seeking groups

Current State of Equity Data Collection Across Toronto Central LHIN Hospitals and Community Health Centres (CHCs)

2018/19

Equity Data Collection Participation Rates and Challenges for Hospitals and Community Health Centres, 2018/19

	15 Hospitals Emergency departments, inpatient units (acute, rehab, complex care, mental health, palliative), specialized units, Family Health Teams, outpatient clinics, operating rooms, medical imaging	**16 Community Health Centres (CHCs)** New and active clients, group patients
Total participants	**345,516**	**48,276**
Participation rates*		
Range across organizations	2.2% to 100%	37.6% to 90.0%
75% and over	2	9
50% - 75%	5	6
Below 50%	8	1

* Percentage of eligible patients who were approached to fill out the demographic (health equity) questions and provided their information.

- CHCs and hospitals have progressively reached increasing number of patients to collect equity data; however, participation rates varied among hospitals and CHCs. The majority of CHCs were collecting data for over 75% of their total client population (above target).

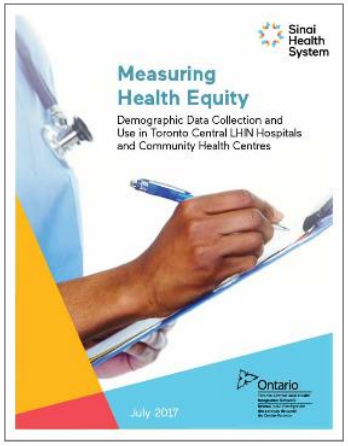
Challenges in Collecting Equity Data

- Entering and extracting data in IT systems
- Expanding collection into high volume/high paced areas and some populations
- Sensitivity around some questions and comfort level asking these questions
- Improving and maintaining data quality (e.g., missing data, “Prefer not to answer”)
- Staff resources and training on collecting and using the data for service planning and quality improvement initiatives
- Organizational cultural change, competing priorities

How Hospitals & Community Health Centres are Using the Equity Data

Examples : http://torontohealthequity.ca/

- Inform clinical care – language needs, dietary preferences, supports to assist low income patients
- Analyze/profile who is being served – demographic dashboards
- Stratify indicators
- Build into Quality Improvement Plans (QIPs)
- Future use by Ontario Health Teams (OHTs)



East Toronto Health Partners

https://www.woodgreen.org/about-us/media/in-the-news/where-health-meets-community-we-are-one-east-toronto/

Equity Data Collection Questionnaire: Race/Ethnicity Question

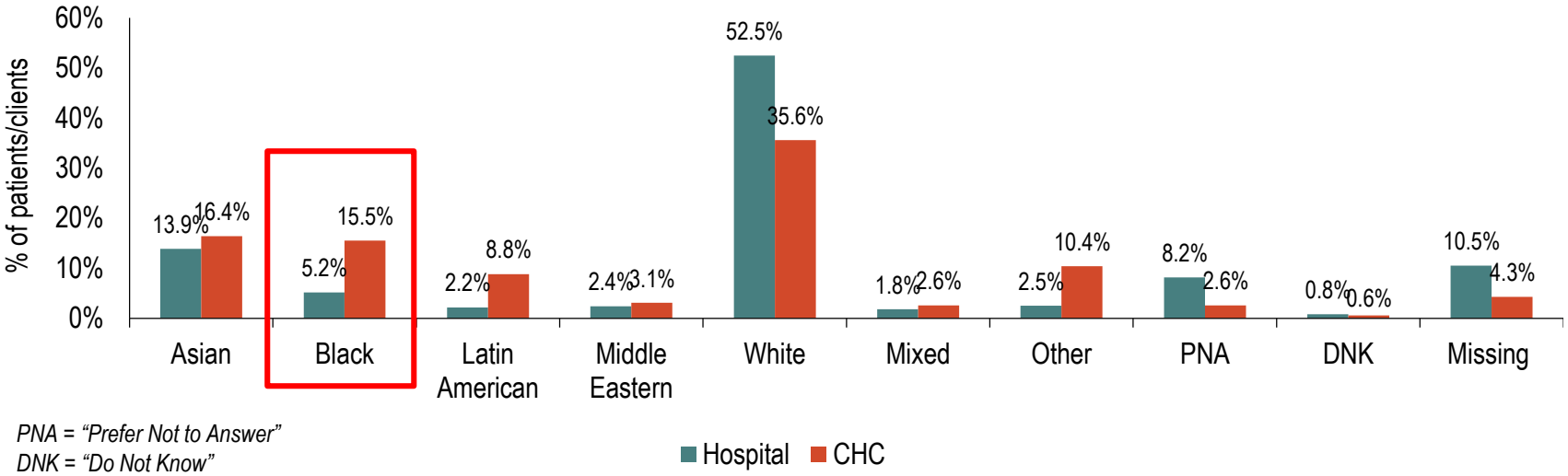
- Black patients/clients are a heterogeneous group captured under 3 main categories, but they can also be included under the “Mixed Heritage”, “Other” and ”Prefer not to answer” categories

Which of the following best describes your racial or ethnic group? Check **ONE** only	
1. Asian – East (e.g., Chinese, Japanese, Korean)	10. Inuit
2. Asian – South (e.g., Indian, Pakistani, Sri Lankan)	11. Latin American (e.g., Argentinean, Chilean, Salvadoran)
3. Asian – South East (e.g., Malaysian, Filipino, Vietnamese)	12. Metis
4. Black – African (e.g., Ghanaian, Kenyan, Somali)	13. Middle Eastern (e.g., Egyptian, Iranian, Lebanese)
5. Black – Caribbean (e.g., Barbadian, Jamaican)	14. White – European (e.g., English, Italian, Portuguese, Russian)
6. Black – North American (e.g., Canadian, American)	15. White – North American (e.g., Canadian, American)
7. First Nations	***16. Mixed heritage (e.g., Black – African & White – North American) Please specify:*** _____
8. Indian – Caribbean (e.g., Guyanese with origins in India)	***17. Other(s): Please specify:*** _____
	88. Prefer not to answer
9. Indigenous/Aboriginal – *not included elsewhere*	99. Do not know

Responses by Race/Ethnicity:

Toronto Central LHIN Hospitals and Community Health Centres (CHCs) - 2018/19

- Higher racial/ethnic diversity among CHC clients than hospital patients
- Black patients represented **15.5% of clients who responded to the questionnaire in CHCs compared to 5.2% of patients in hospitals.** *Black residents represented 8.9% of City of Toronto and 4.7% of Toronto Central LHIN residents in 2016.*
- Proportion of Black patients reported varied considerably among hospitals and CHCs
- Higher proportions of patients who preferred not to answer or had missing information for the race/ethnicity question in hospitals compared to CHCs - these affect the proportions identified in the other categories



PNA = "Prefer Not to Answer"
DNK = "Do Not Know"

Hospitals
N = 117,211*
Black population ranged from 2% to 8%

Community Health Centres (CHCs)
N = 47,447*
Black population ranged from 3% to 53%

Black includes: African, Caribbean, North American
*Data from 4 hospitals and 1 CHC were excluded due to high average missing data rates or "prefer not to answer" rates (above 35% and 50%, respectively)

Health Service Utilization of Toronto Central LHIN Hospitals, by Race/Ethnic Group

Results from ICES AHRQ Project 2016 0900 839 000 – Hospital Equity Data Analysis

This study was supported by ICES, which is funded by the Ontario Ministry of Health (MOH).The opinions, results and conclusions are those of the authors and are independent from the funding source. No endorsement by ICES or the Ontario MOH is intended or should be inferred.

Parts of this material are based on data and information compiled and provided by Canadian Institute for Health Information (CIHI). However, the analyses, conclusions, opinions and statements expressed herein are those of the author, and not necessarily those of CIHI.

Overall ICES Methodology and Participation

- Analysis included patients who visited the 8 participating Toronto Central LHIN hospitals from **April 2013 to July 2015**, completed the 'Adult Socio-demographic Data Questionnaire' and were linkable to ICES data.

  ✓ **First comprehensive analysis of linked system equity data in Ontario**

- Their data were linked to health administrative databases (emergency department, acute inpatient, day surgery, acute inpatient mental health, physician visits/billings, derived disease cohorts) to look at:
  - the quality of data submitted and their responses
  - their health care utilization from **July 31, 2015 to July 31, 2016**
  - their comorbidities

  "Linking" data is the process for which the data provided by the survey participant may be connected to their health record.

- The number of patients contributed by the different hospitals varied considerably, and subsequently, may have affected the results of the indicators as some hospitals, like CAMH, are specialized for specific populations.

Hospital	Linked Records		Unlinked Records		Total Number of Participants
	Number	Percent	Number	Percent	
Centre for Addiction and Mental Health (CAMH)	24,357	99.4	147	0.6	24,504
Providence Healthcare	3,309	99.6	14	0.4	3,323
Runnymede Health Centre	440	99.8	<5		441-446
Sinai Health System	22,273	98.6	305	1.4	22,578
St Michael's Hospital	36,756	97.4	998	2.6	37,754
Sunnybrook Health Sciences Centre	274	2.7	10,061	97.3	10,335
Toronto Grace Health Centre	188	97.9	<5		192-197
University Health Network (UHN)	14,645	99	151	1	14,796
Total Patients	**102,242**	**90%**	**11,682**	**10%**	**113,924**

Source: ICES AHRQ Project 2016 0900 839 000

*After removal of duplicate patients within each hospital

ICES Analyses: Data Quality Considerations

Data Quality Issues Identified

- No date of birth and/or survey date in the equity data submitted/transferred
- Text (character) data provided for numeric fields
- Inconsistent information (e.g., participant indicated they were 'Born in Canada' but also provided a response for 'Number of years in Canada')
- Data other than pick-list values provided in some fields
- Inconsistent spelling or capitalization for some text variables
- Some sites used a smaller list of response options (e.g., only options for gender were male or female)
- Values for missing data, 'Prefer Not to Answer', and 'Do Not Know' were not consistent between sites

Resulting Challenges for ICES

- Different ability from site to site to link survey data to health records
- Very manual processes for data preparation and provision - at hospital sites and at ICES
- Small sample sizes for some groups leading to collapsing of categories

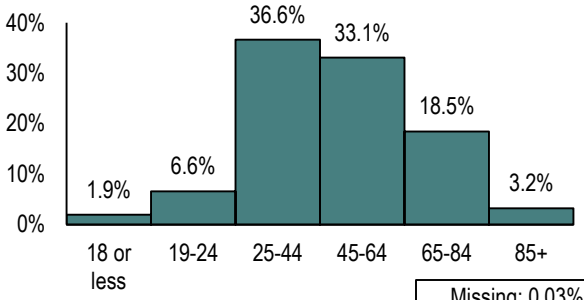
Potential Causes at Hospitals

- Lack of data standardization between hospital sites
  - Data collection
  - Data storage
  - Data identifiability

ICES Analysis: Demographics of Toronto Central LHIN Hospital Patients, April 2013 to July 2015

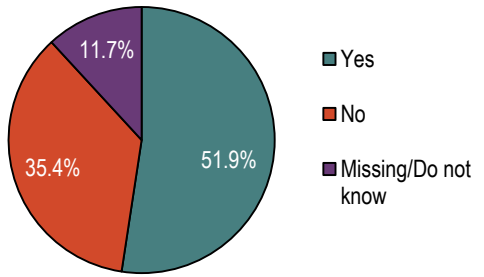
Total Participants = 102,242

Age



Missing: 0.03%

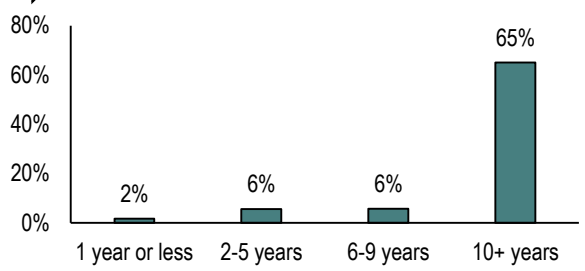
Born in Canada?



Prefer not to answer: 0.1%

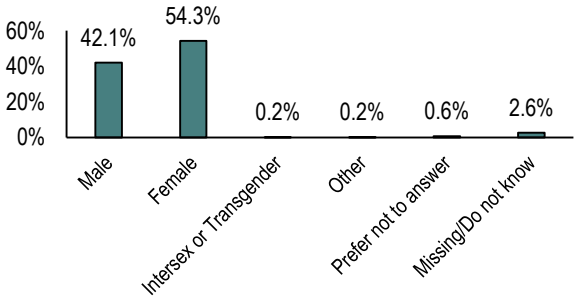
If "No"

Years Living in Canada*



Missing: 21% Invalid: 1%

Gender



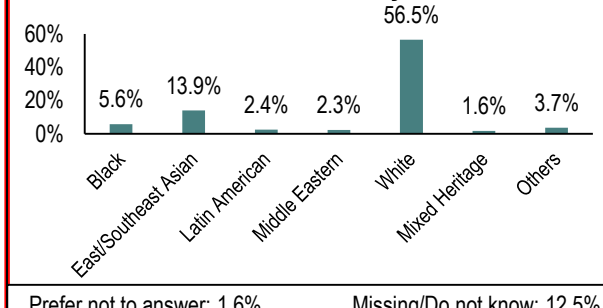
Preferred Languages

1	English	90.8%
2	East/Southeast Asian	2.1%
3	Western European	1.7%
4	South Asian	0.5%
5	Middle Eastern	0.4%
6	French	0.4%
7	Eastern European	0.3%
8	Russian	0.3%
9	Other	1.2%

Prefer not to answer: 4.6%

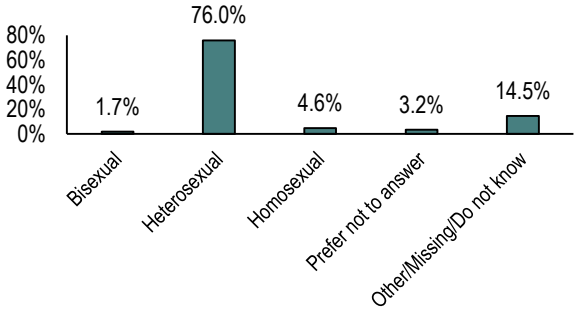
Missing/ Do not know/ Invalid: 1.9%

Race/Ethnicity

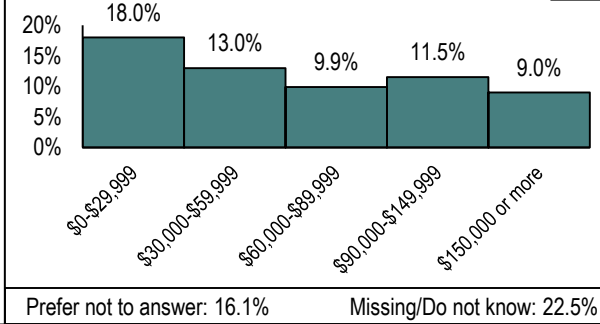


Prefer not to answer: 1.6% Missing/Do not know: 12.5%

Sexual Orientation

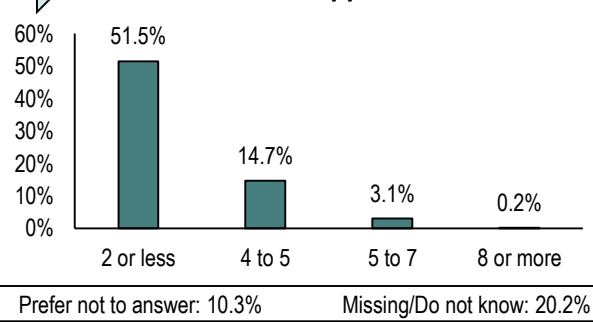


Household Income



Prefer not to answer: 16.1% Missing/Do not know: 22.5%

Income Supports



Prefer not to answer: 10.3% Missing/Do not know: 20.2%

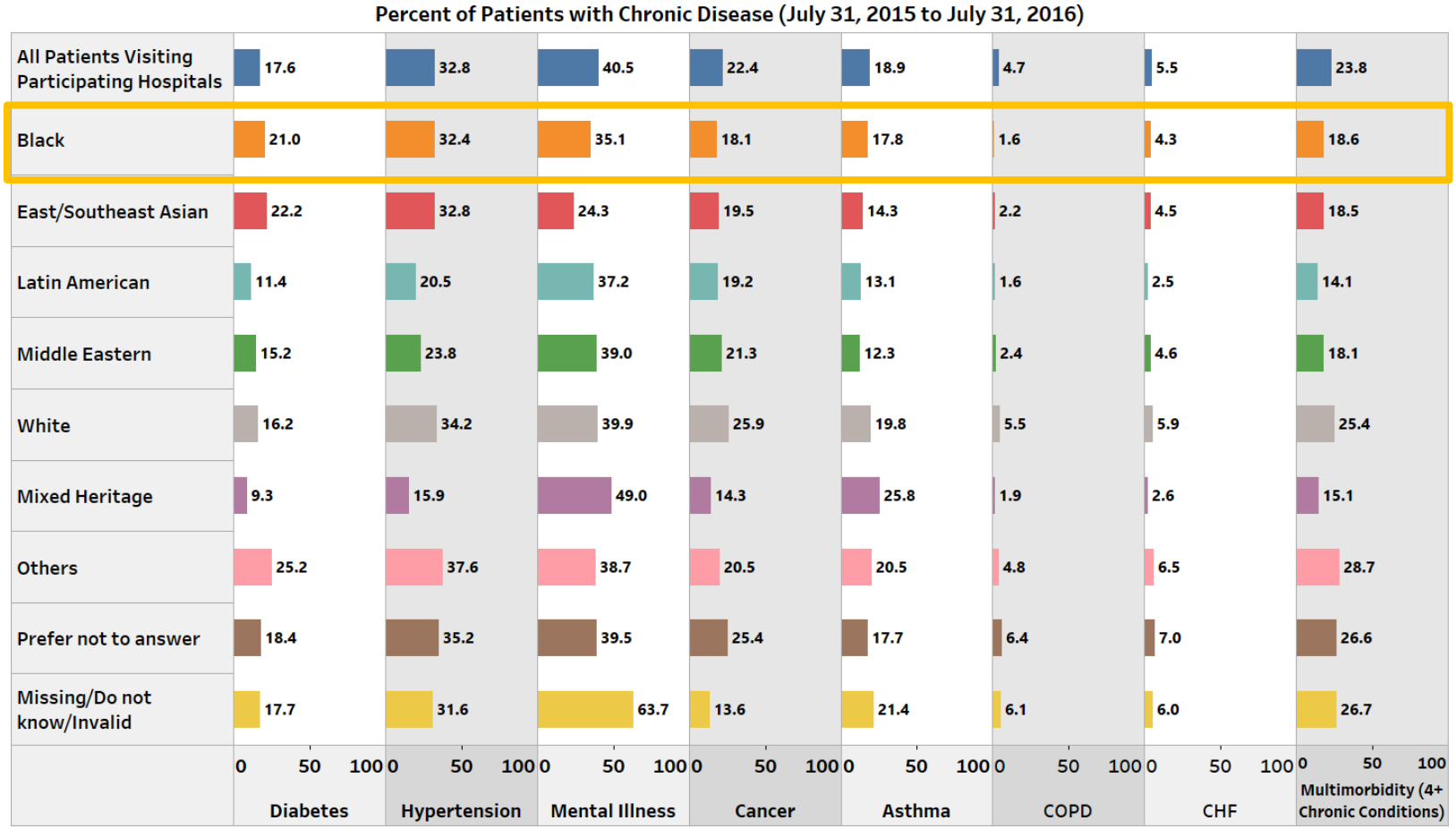
Source: ICES AHRQ Project 2016 0900 839 000

*Only calculated for individuals who reported that they were not born in Canada.

Chronic Disease Prevalence by Race/Ethnic Group

Rates of chronic conditions varied considerably among the racial/ethnic groups.

Compared to other racial/ethnic groups, Black patients had the third highest rate of diabetes. Compared to the overall summary rates for hypertension, mental illness, cancer, asthma and multiple chronic conditions, rates among Black patients were slightly lower.



Data quality considerations: High rates of mental illness may have been due to a high number of patients from CAMH

Chronic condition rates for Black and other groups may be affected by data quality (high rates in the Missing/Do not know and Prefer Not to Answer groups)

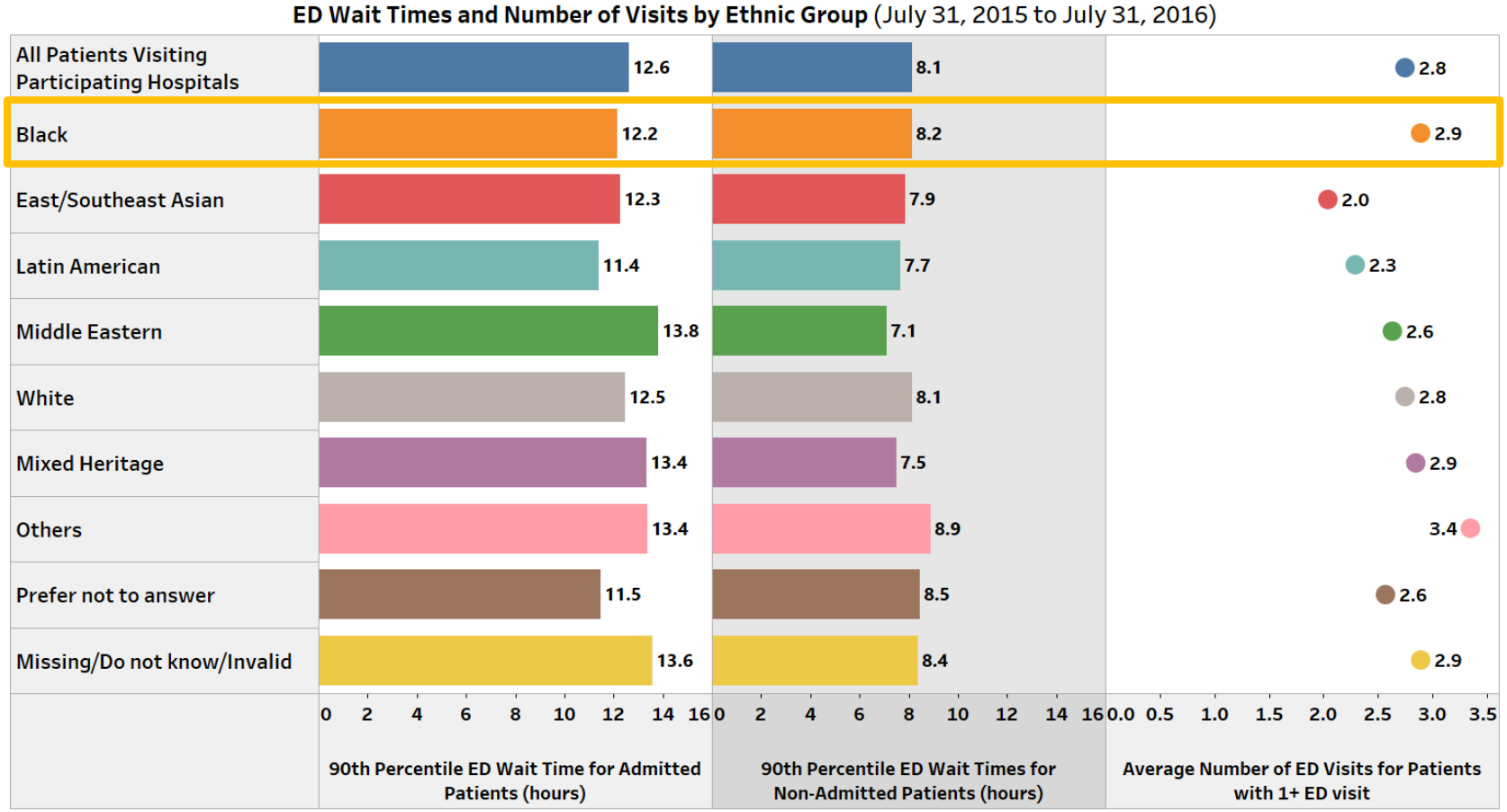
Source: ICES AHRQ Project 2016 0900 839 000

Emergency Department Use by Race/Ethnic Group

There was less variation by race/ethnic group for patients who were not admitted versus those admitted, however, variation within both patient groups was significant.

Length of stay for Black patients was nearly similar to that of all patients combined.

Black patients had the **second highest average number of repeat ED visits (2.9)** (together with the mixed heritage group). Patients who identified as "Others" had the highest number (3.4).

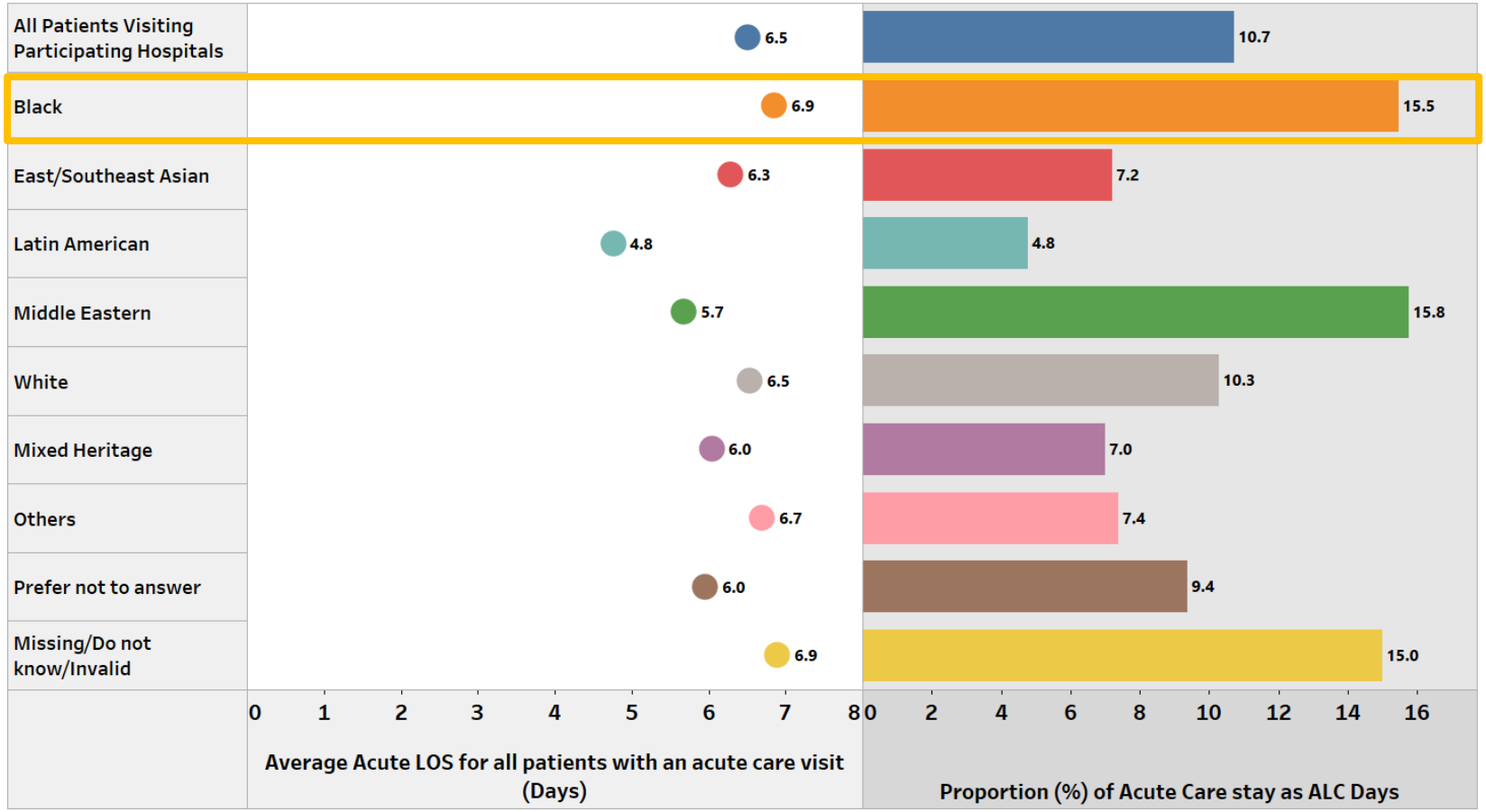


Source: ICES AHRQ Project 2016 0900 839 000

Acute Inpatient Hospitalization by Race/Ethnic Group

There was considerable variation by race/ethnic group for average length of stay in acute care hospitals as well as proportion of days spent in alternative level of care (ALC) (patients occupying a hospital bed, but who do not require the intensity of services provided in that care).
Black patients had the **highest average length of stay (6.9 days) - 1.4 times** that of Latin American patients (4.8 days).
Black patients had the **second highest proportion of ALC days (15.5%) - 3.2 times** that of Latin American patients (4.8%).

LOS in Acute Hospitals and ALC by Ethnic Group (July 31, 2015 to July 31, 2016)

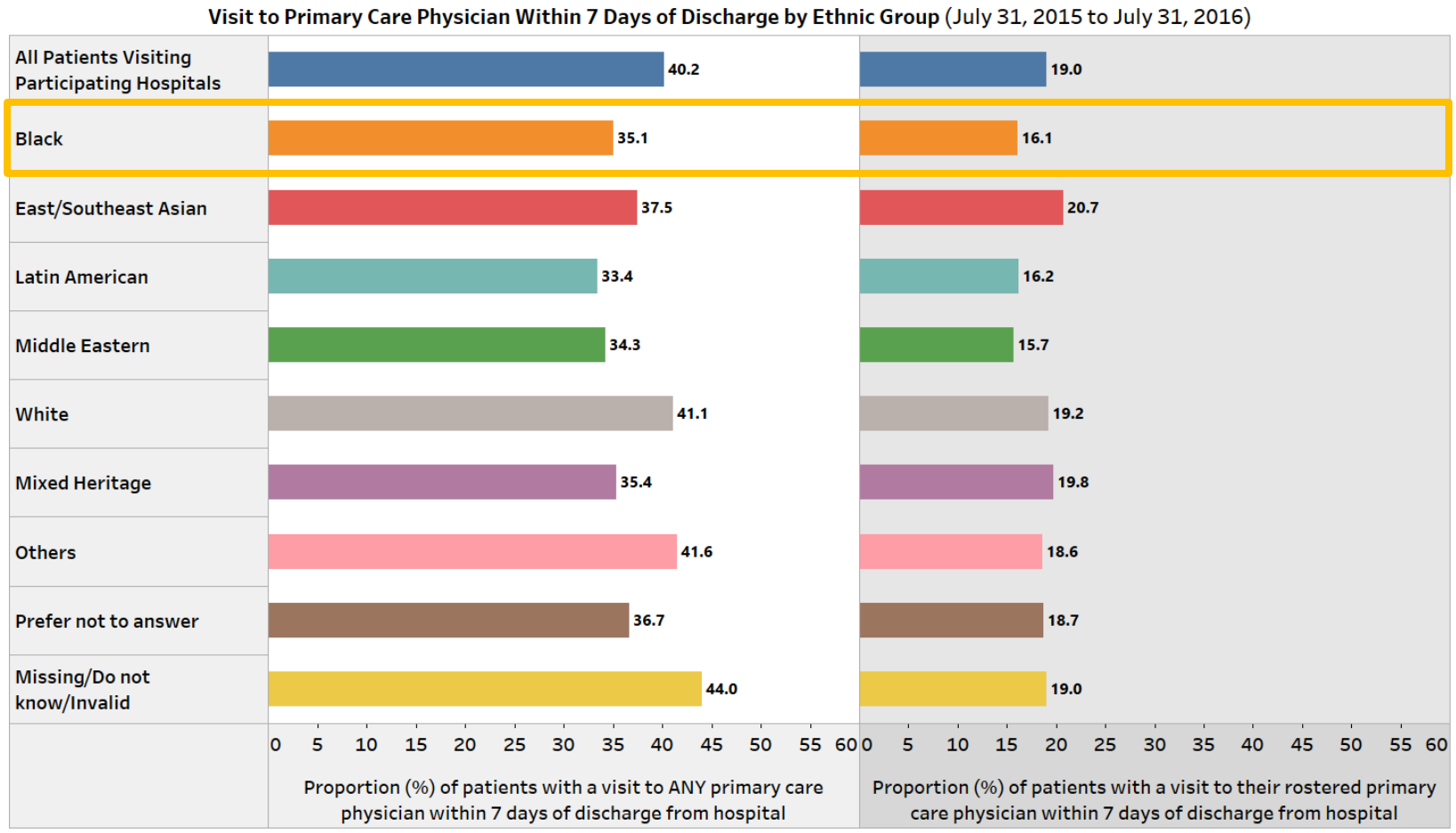


Note: These indicators are not adjusted for comorbidities or severity, which may impact the rates

Source: ICES AHRQ Project 2016 0900 839 000

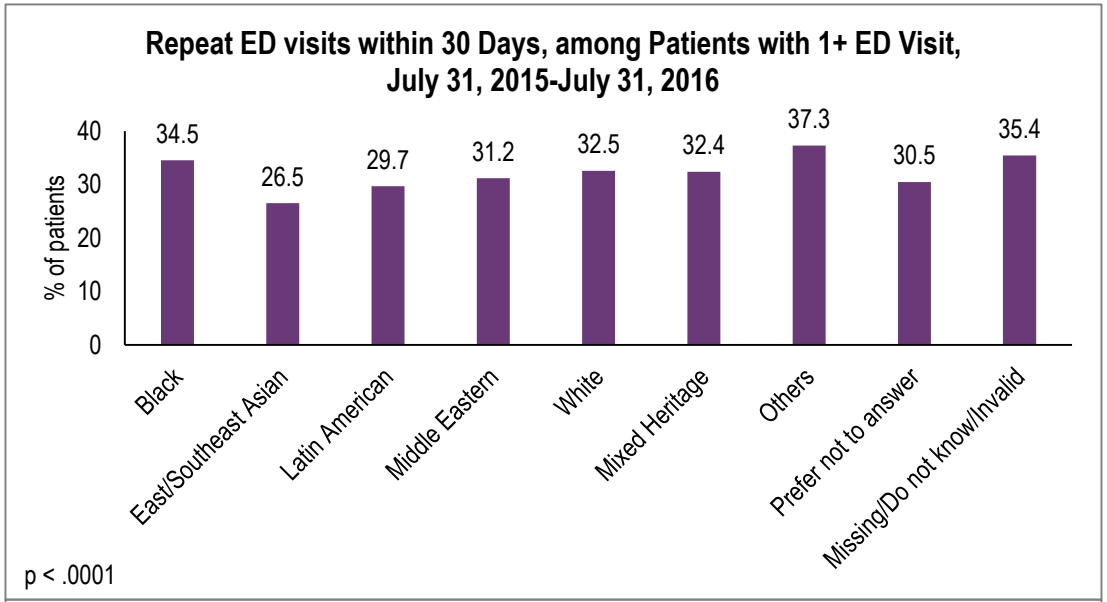
Primary Care Physician Visits Post-Discharge by Race/Ethnic Group

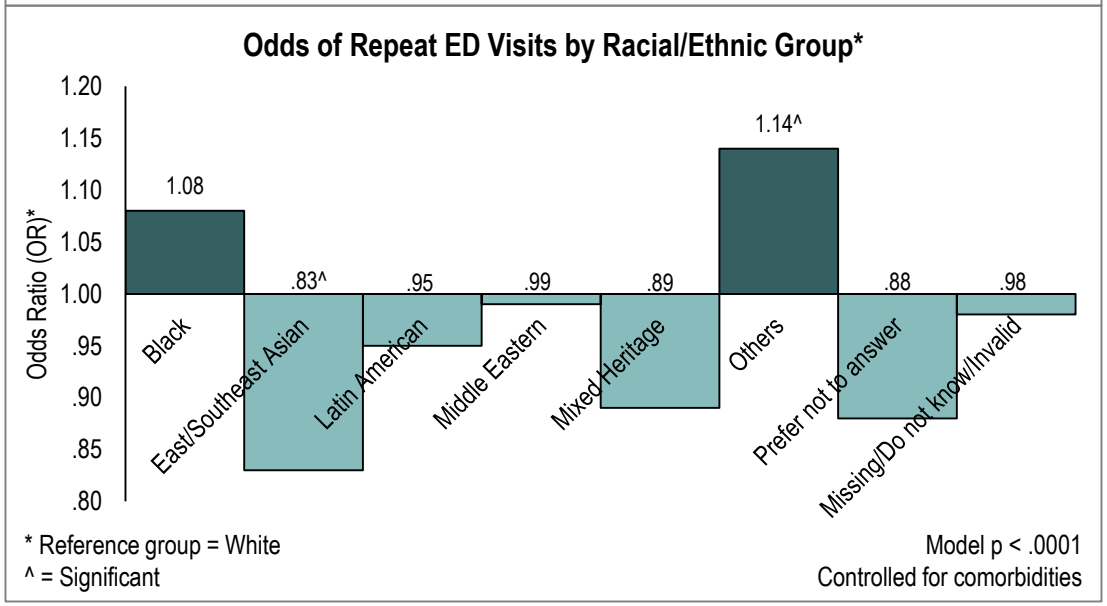
There was considerable variation by race/ethnic group for visits related to primary care after hospital discharge.
Black patients were **among the groups with the lowest rates of follow-up visits to any primary care physician (35.1%).**
Across all groups, patients seemed less likely to see their rostered physician post-discharge. Note: CHC physician attachment was not considered.
Black patients had the **second lowest rate of post-discharge follow up visits to their own primary care provider (16.1%).**



Source: ICES AHRQ Project 2016 0900 839 000

Repeat ED Visits within 30 Days by Race/Ethnic Group





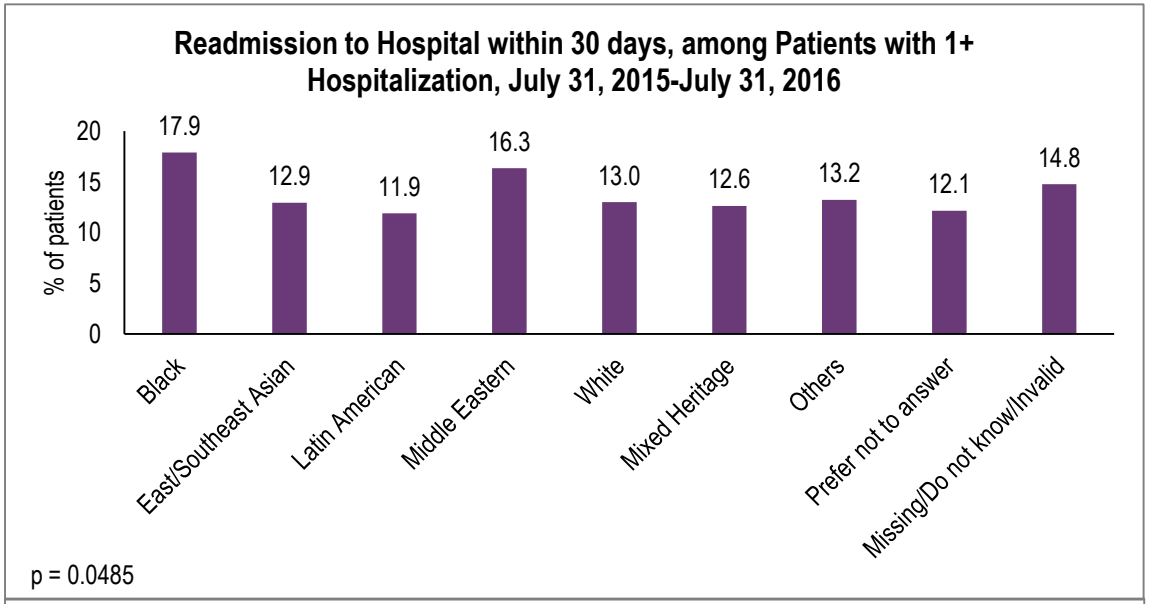
- There was considerable variation by race/ethnic group for repeat emergency department (ED) visits, even after excluding patients from CAMH who would mainly be individuals with mental health and/or addictions
- **Black patients had the second highest rate of repeat ED visits within 30 days (34.5%)** compared to 26.5% for East/Southeast Asian patients
- Compared to patients who are White, Black patients and those who identified as Other were more likely to have repeat ED visits. However, the odds were not statistically significant for the Black patients.
- This may indicate that other socio-demographic factors play a more important role in predicting occurrence of repeat ED visits. **Income, having drug or alcohol dependence and/or mental illness, sexual orientation and younger age groups were statistically significant in this model.**

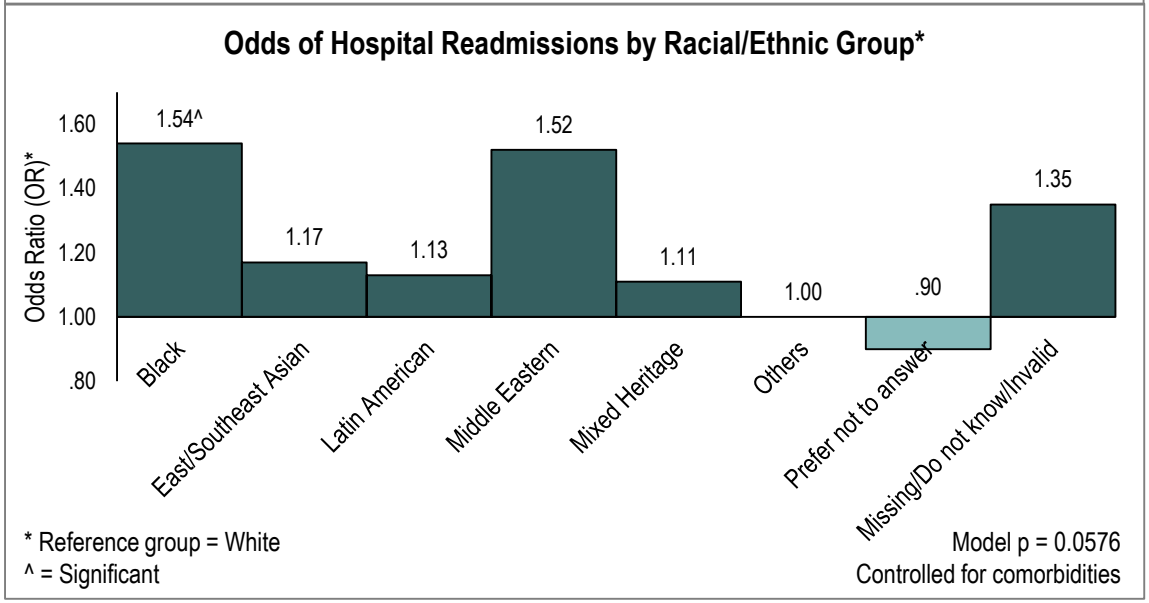
Repeat ED visits within 30 days may indicate inadequate care in hospital, failure of patient to care for themselves after discharge, or failure to get recommended follow-up treatment.

Odd Ratios were determined from logistic regression model based on all socio-demographic questionnaire items, controlling for the Charlson Comorbidity Index

Source: ICES AHRQ Project 2016 0900 839 000

Hospital Readmissions within 30 Days of Discharge by Race/Ethnic Group





- **Black patients had the highest rate of readmissions (17.9%)** compared to 11.9% for Latin American patients
- Compared to patients who are White, patients from all other race/ethnic groups were more likely to have a hospital readmission, with the exception of the group who identified as "Others"
- **Black patients had the highest odds of hospital readmissions – 1.54 greater** than White patients. This was significantly different.

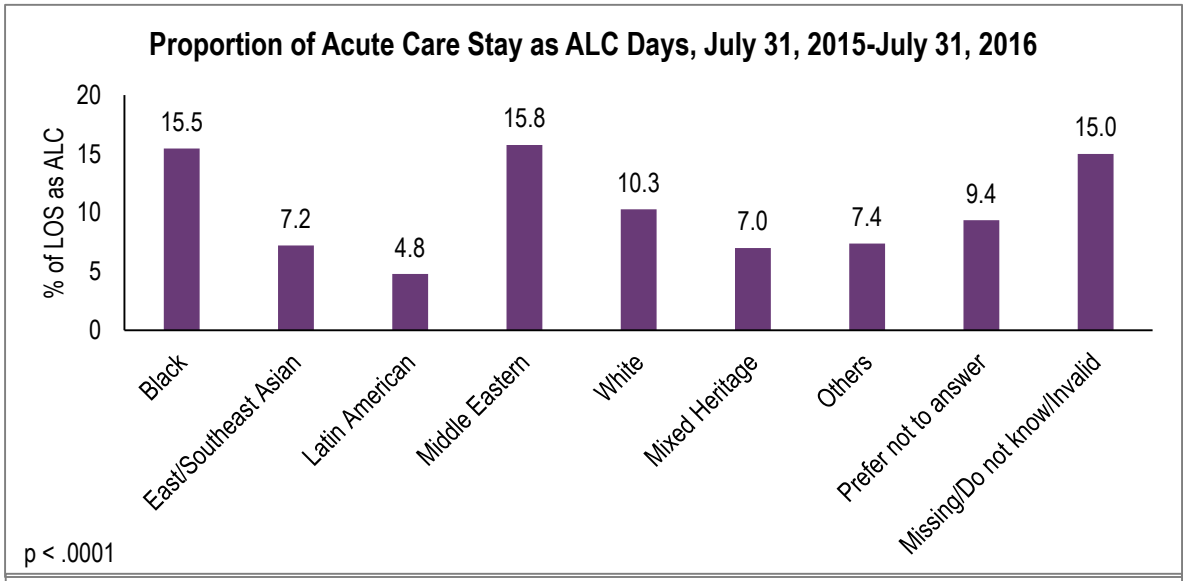
Selected readmissions conditions included: pneumonia, diabetes, stroke, gastrointestinal disease, congestive heart failure, chronic obstructive pulmonary disease, heart attack and other cardiac conditions.

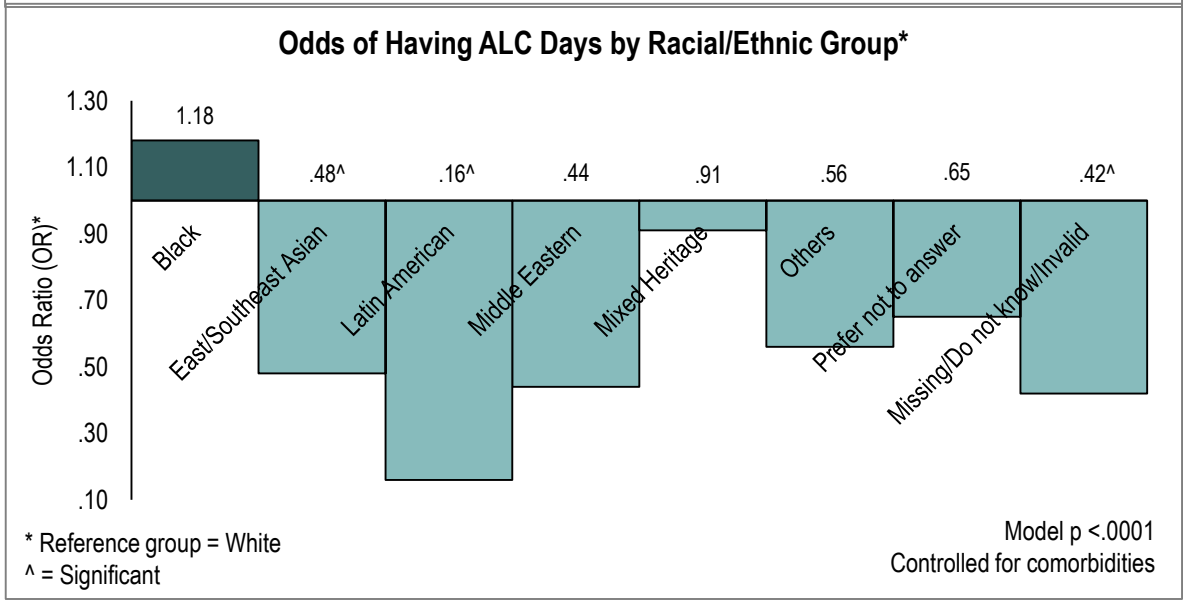
Readmissions may indicate inadequate care in hospital, failure of patient to care for themselves after discharge, or failure to get recommended follow-up treatment.

Odd Ratios were determined from logistic regression model based on all socio-demographic questionnaire items, controlling for the Charlson Comorbidity Index

Source: ICES AHRQ Project 2016 0900 839 000

Having Alternative Level of Care (ALC) Days by Race/Ethnic Group





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

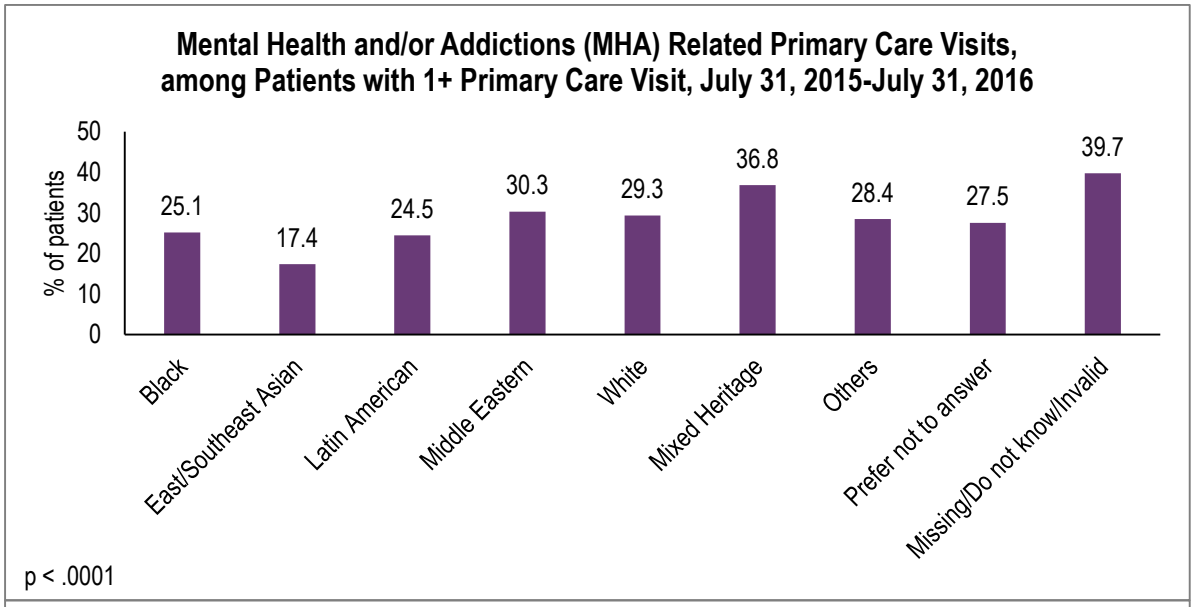
- Compared to patients who are White, patients from all other race/ethnic groups were less likely to have ALC days, with the exception of Black patients
- The odds for Black patients having ALC days was 1.18 times greater than White patients. However, the odds were not statistically significant.
- This may indicate that other socio-demographic factors play a more important role in predicting occurrence of ALC. **Increasing age, lower income, drug and alcohol dependence, and physical, sensory and other disabilities had the highest statistical significance.**

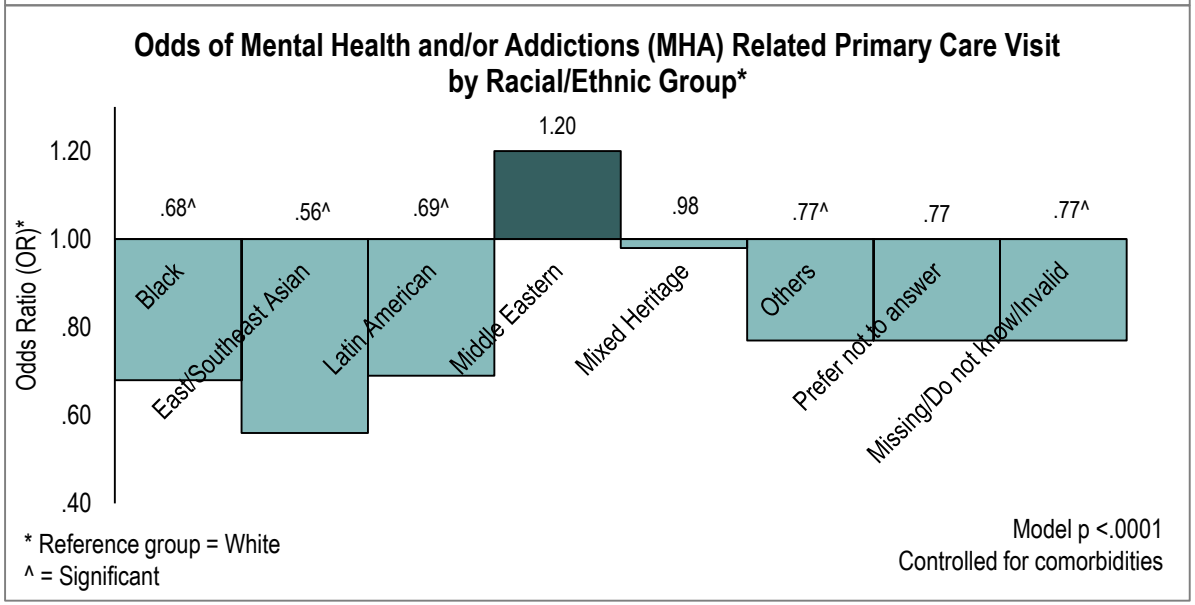
Alternate Level of Care (ALC) refers to those cases where a physician (or designated other) has indicated that a patient occupying an acute care hospital bed has finished the acute care phase of their treatment.

Odd Ratios were determined from negative binomial regression model based on all socio-demographic questionnaire items, controlling for the Charlson Comorbidity Index

Source: ICES AHRQ Project 2016 0900 839 000

MHA Related Primary Care Visits by Race/Ethnic Group





Source: ICES AHRQ Project 2016 0900 839 000

- There was considerable variation by race/ethnic group for mental health and/or addictions (MHA) related primary care visits, even after excluding patients from CAMH who would mainly be individuals with mental health and/or addictions
- **Black patients had the third lowest rate of MHA related primary care visits (25.1%)**

- Compared to patients who are White, patients from all other race/ethnic groups were less likely to visit a primary care physician for a mental health or addiction related concern, with the exception of those identifying with Middle Eastern group
- **Black patients had 32% lower odds of a visit to a primary care physician for a MHA related concern** than White patients. This was statistically significant.
- **Age group, lower income, and sexual orientation had high statistical significance.**

Primary care physicians can serve as the main source of treatment for patients with mental health issues, in addition to psychiatrists. Lower rates of MHA visits may indicate a lower prevalence of MHA and addictions in certain group or lack of access to primary care, or culturally relevant care.

Odd Ratios were determined from logistic regression model based on all socio-demographic questionnaire items, controlling for the Charlson Comorbidity Index

Community Mental Health and Addictions (CMHA) Services Client Experience by Race/Ethnicity

Results from Ontario Perception of Care (OPOC)-MHA, Drug and Alcohol Treatment Information System (DATIS)

Q1-2017/18 to Q2-2019/20

Ontario Perception of Care - MHA Survey Background

Ontario Perception of Care Tool for Mental Health and Addictions (OPOC-MHA):

- Developed at the Centre for Addiction and Mental Health (CAMH) with support from Health Canada's Drug Treatment Funding Program and the Ontario Ministry of Health and Long-Term Care – this has patient-reported experience measures (PREMs)

- Questionnaire surveying:
  1) Registered clients with mental health, substance abuse, addiction and/or gambling-related problems
  2) Registered clients who are a family member/significant other/supporter of a person with mental health, substance abuse, addiction and/or gambling-related problems

- Asks about perceptions of care to help agencies and programs identify areas of strengths and improvement
  - 38 questions categorized into 8 domains: access/entry to services; services provided; participation/rights; therapists, staff and support workers; environment; discharge, program completion, treatment; and overall experience including recovery/outcome and service quality

- *Demographics are collected to help organize the information and* ***identify potential inequities in treatment***

- OPOC-MHA results for Toronto Central LHIN-funded health service providers are reported in the Drug and Alcohol Treatment Information System (DATIS), maintained by CAMH, that tracks service utilization for substance abuse, problem gambling and other programs (e.g., mental health and community services)

- Data for Toronto Central LHIN in DATIS are available beginning Q3-2016/17

Client experience results presented in this report are the aggregate responses of "Agree" and "Strongly Agree"

Ontario Perception of Care - MHA Reporting in DATIS: List of Toronto Central LHIN Health Service Providers

Implementation of the Ontario Perception of Care (OPOC) tool is voluntary for eligible agencies.

Data collection may be performed at varying points in time and frequency (e.g., monthly, quarterly, occasionally, ongoing) depending on the program and unique aspects of the client population.

Reporting period: Q1-2017/18 to Q2-2019/20

The following HSPs had reported OPOC-MHA results into DATIS:

- Breakaway Addiction Services
- Canadian Hearing Society
- CAMH
- Alternatives, East York Mental Health Counselling Services Agency
- Fred Victor Centre
- Gerstein Crisis Centre
- Governing Council of the Salvation Army in Canada
- Jean Tweed Treatment Centre
- Margaret's Housing and Community Support Services
- Mood Disorders Association of Ontario
- Parkdale Activity - Recreation Centre
- Progress Place (Clubhouse)
- Reconnect Community Health Services
- Renascent Fellowship
- Unity Health - St Joseph's Health Centre
- St. Michael's Homes
- Street Haven at the Crossroads
- St. Stephen's Community House
- Transition House
- West Neighbourhood House

Total Participants = 4,197
(with varying sample sizes for agencies and their programs)

Ontario Perception of Care - MHA: Race/Ethnicity Question

- Black clients are captured and further broken down into 3 main categories in the OPOC-MHA questionnaire, but they can also be included under the "Multiple or mixed" category

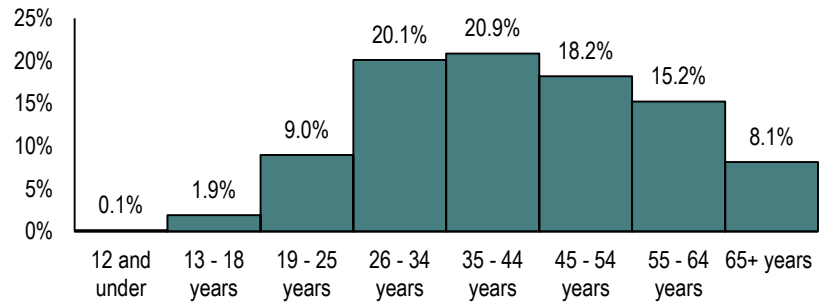
7. Which population group best describes you? (please check one box and then proceed to the more detailed question below that corresponds to your answer)
White → please go to question a below
First Nations, Métis, Inuit → please go to question b below
Asian → please go to question c below
Black → please go to question d below
Middle Eastern → please go to question e below
Latin American → please go to question f below
Multiple or mixed. Please describe. _____

d. If your population group is Black, which of the following best describes your background?
Black African (e.g., Ghanaian, Somali, Kenyan, Ethiopian)
Black Caribbean (e.g., Trinidadian, Jamaican)
Black Canadian/American
Other. Please describe. _____

Ontario Perception of Care - MHA Participant Demographics, Q1-2017/18 to Q2-2019/20

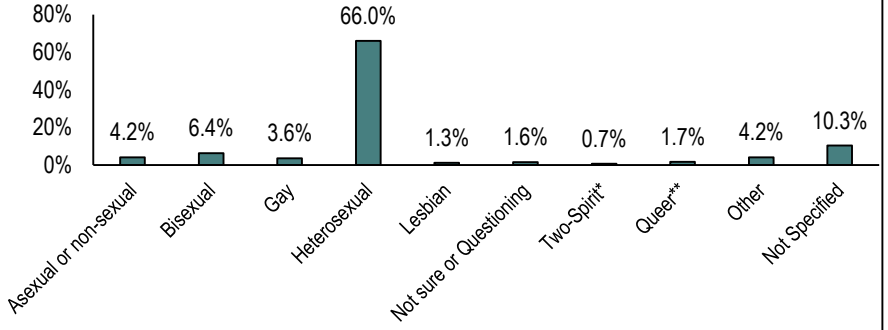
Total Participants = 4,197

Age Group



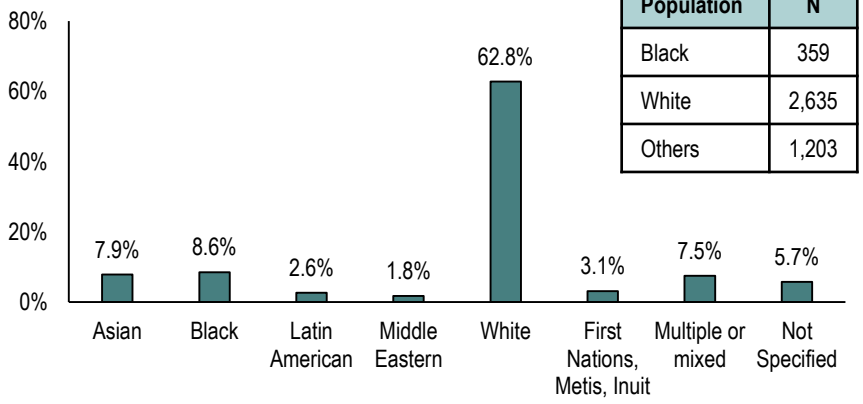
Not Specified: 6.4%

Sexual Orientation



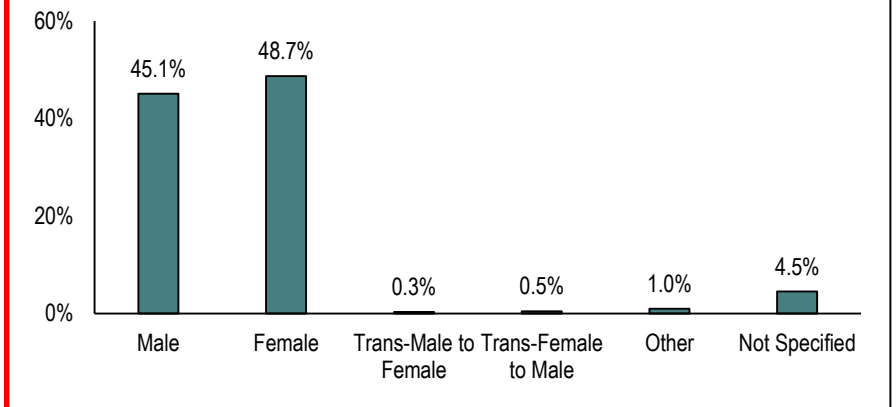
* Two-Spirit = term used by some Indigenous people
** Queer = term used by people who do not follow common sexual

Population Group



Population	N
Black	359
White	2,635
Others	1,203

Gender



Source: OPOC – MHA, DATIS

Considerations for Interpreting OPOC – MHA Results

- **Client experience results presented in this report are the aggregate responses of "Agree" and "Strongly Agree".**

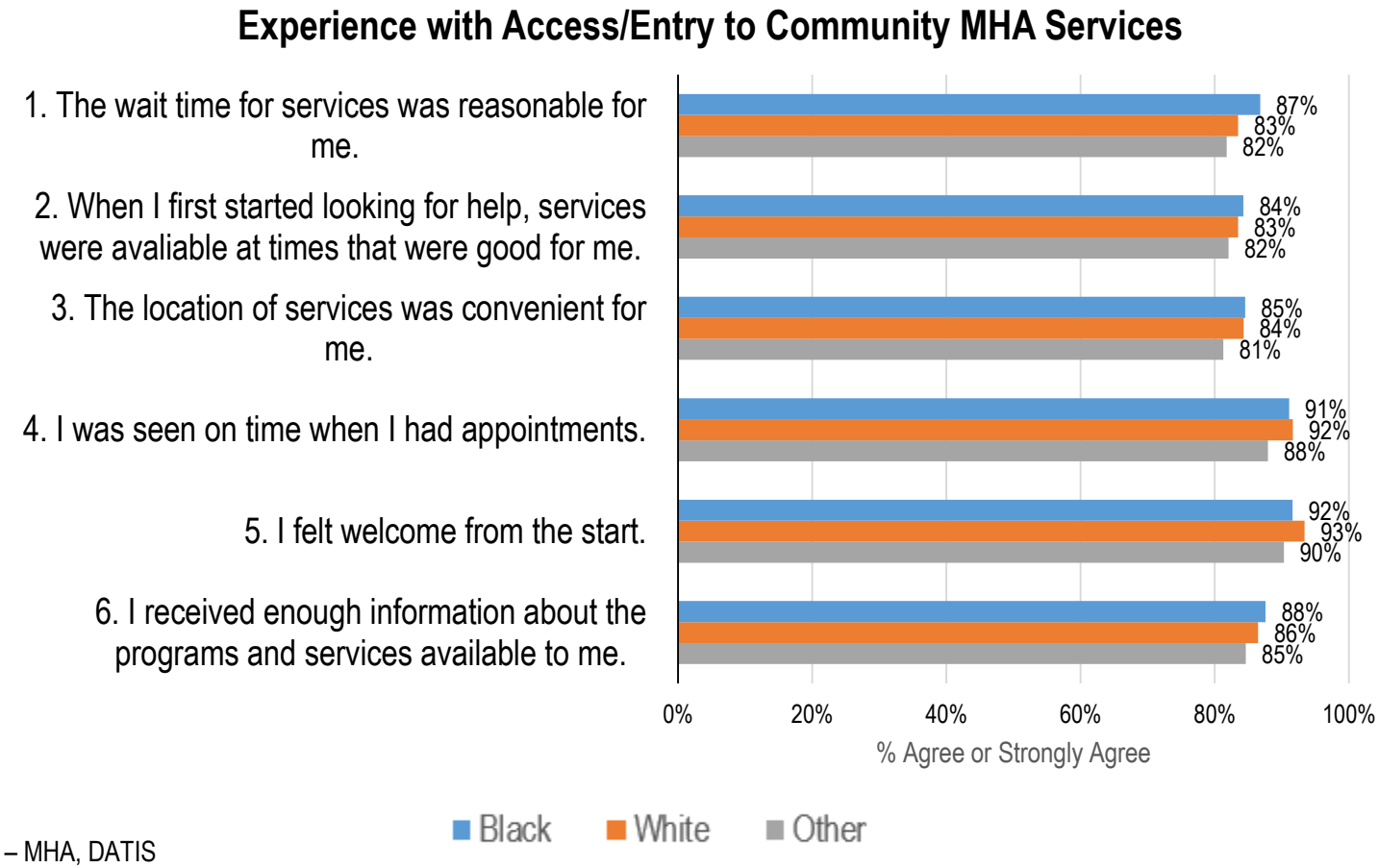
  OPOC items are meant to reflect standards of care rather than the broad construct of satisfaction. As such, results are described as the percentage of clients that agreed (Agreed or Strongly Agreed) that the standard of care described in the questions in the domain were met. There are no standard cut-off scores for high or low experience. The interpretation is that the lower the percentage of agree plus strongly agree, the fewer the clients who received the standard of care.

- It was not possible to determine whether there was proportional representation among service providers for the Black community (or any other sociodemographic variable). Even though the data set had an adequate sample size that approaches statistical significance, we cannot determine if the percentage of Black clients receiving service approximate the percentage served by the Toronto Central LHIN overall. Hence, we cannot conclude if there may be issues of inequitable access to service and/or a lack of awareness about services, as it would not be captured in the survey data.

- MHA organizations can use the additional qualitative comments entered by Black respondents to obtain more information about the care experience that are not captured in the quantitative OPOC data.

Client Experience with Community MHA Services, Q1-2017/18 to Q2-2019/20

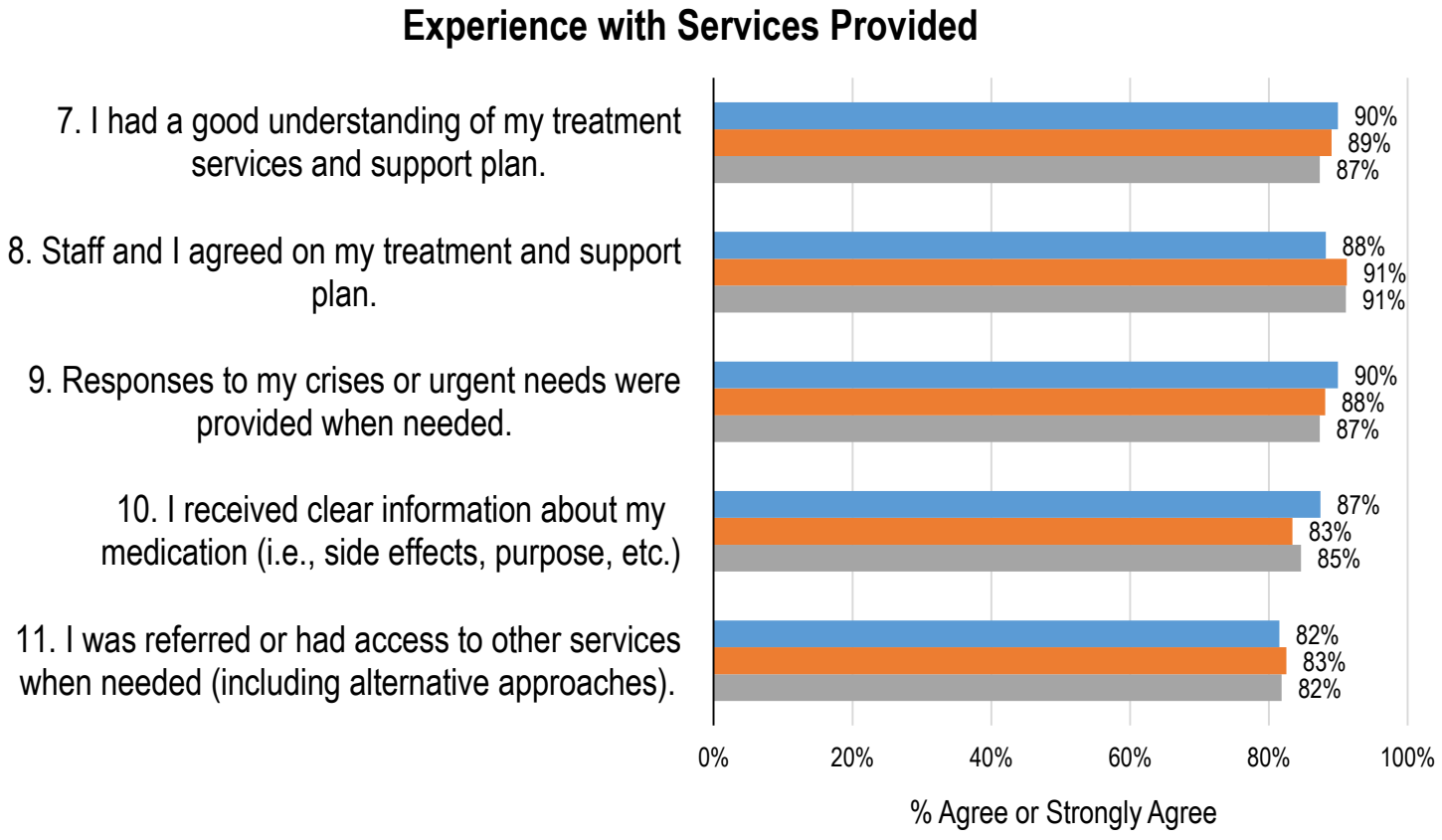
- Overall positive experience - above 80% of clients agreed that access to care standards were met
- **Black clients had slightly better experience compared to White clients and other groups for most aspects**
- There was some difficulty when finding services available at convenient times and locations for all groups



Source: OPOC – MHA, DATIS

Client Experience with Community MHA Services continued, Q1-2017/18 to Q2-2019/20

- 80-90% of clients from the three groups agreed that standards of care were met for services provided
  - Lowest rating was with referrals/transition
- **Black clients had slightly lower ratings for agreement with staff on treatment and support plans**

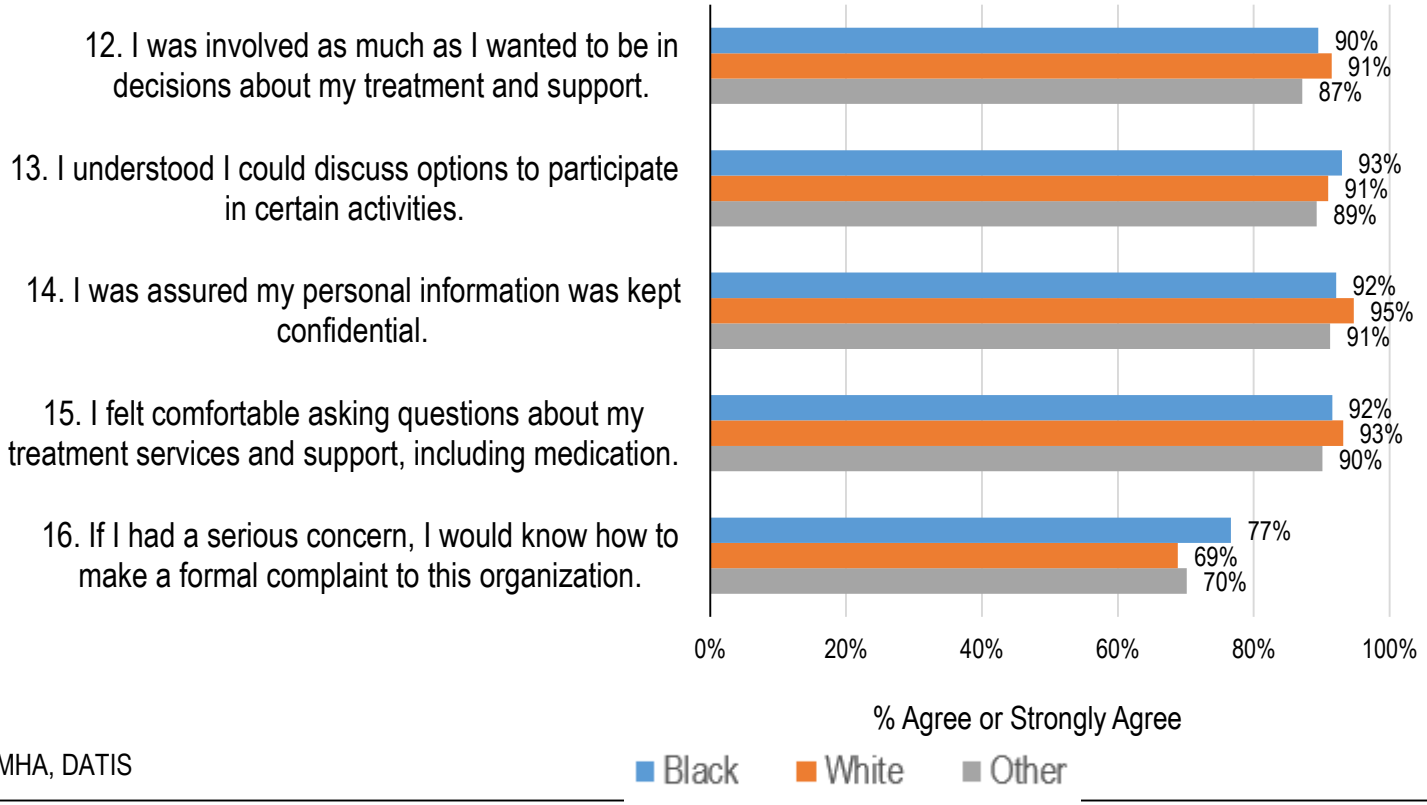


Source: OPOC – MHA, DATIS

Client Experience with Community MHA Services continued, Q1-2017/18 to Q2-2019/20

- Overall positive experience - above 90% of clients agreed that the standards of care for participation and rights were met, with the exception of **knowing how to make formal complaints to organizations**
- Black clients had **slightly higher ratings** compared to White clients and other groups for knowing they could discuss options to participate in certain activities as well as knowing how to make a formal complaint
- **For the other questions, Black clients had slightly lower ratings compared to White clients, but not other groups**

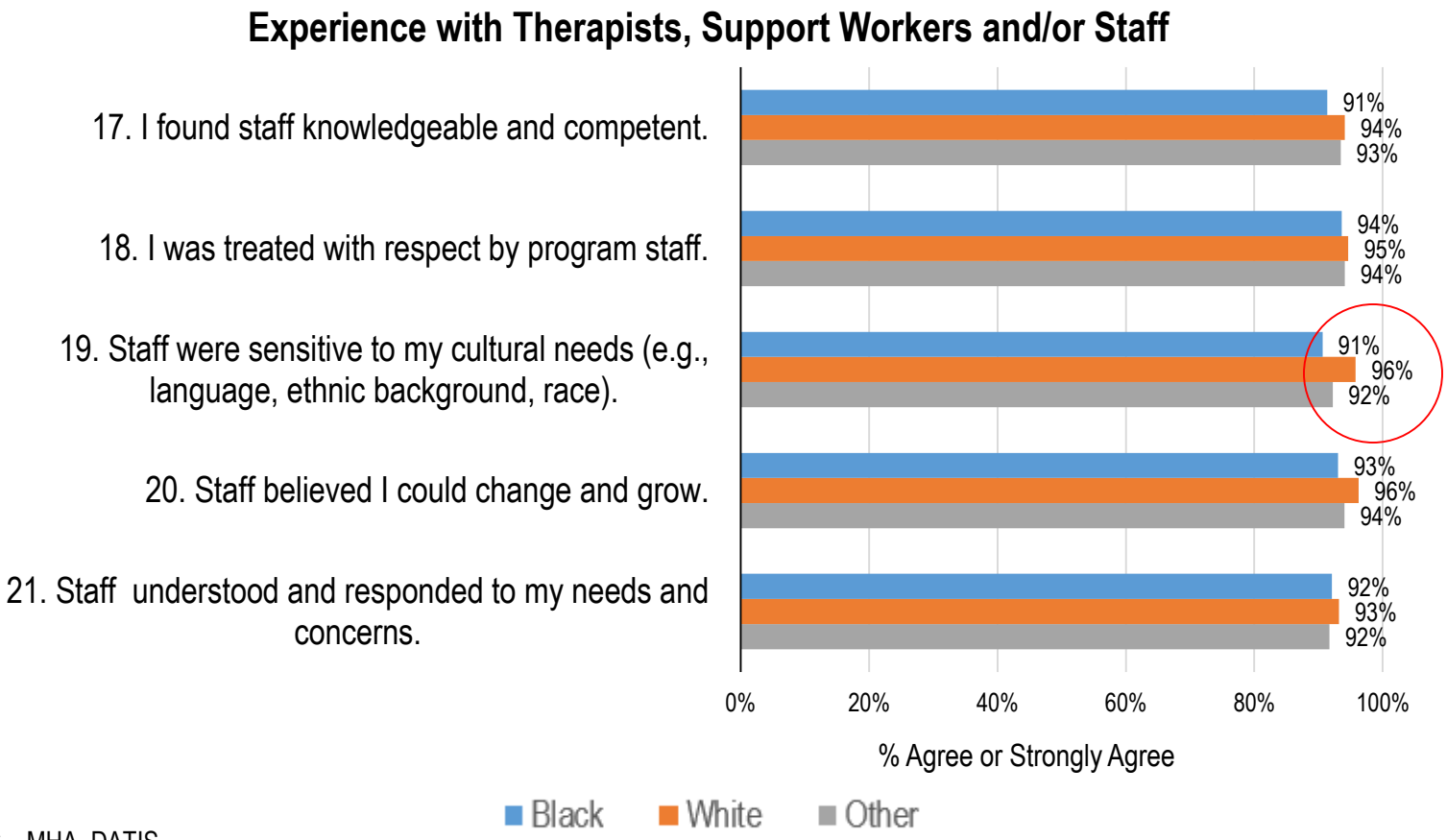
Experience with Participation and Rights



Source: OPOC – MHA, DATIS

Client Experience with Community MHA Services continued, Q1-2017/18 to Q2-2019/20

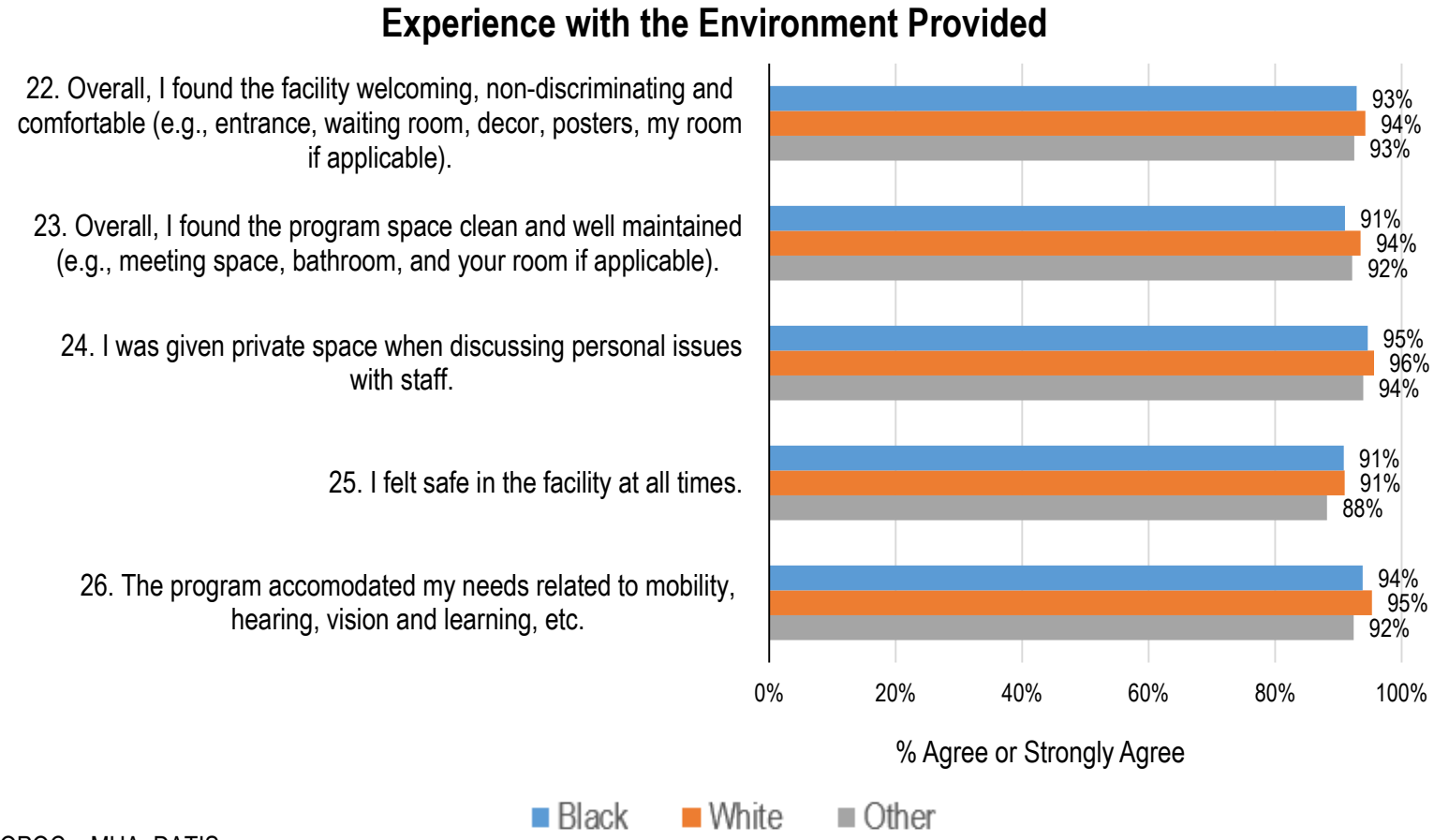
- Overall positive experience – above 90% of clients from the three groups agreed that standards of care with therapists, support workers and staff were met
- **Black clients had lower ratings for all the questions compared to White clients, with the most considerable difference being sensitivity of staff to cultural needs (e.g., language, ethnic background, race)**



Source: OPOC – MHA, DATIS

Client Experience with Community MHA Services continued, Q1-2017/18 to Q2-2019/20

- Overall positive experience - above 90% of clients agreed that environment standards of care were met
  - **Black clients had slightly lower ratings compared to White clients for 4 of the 5 questions**

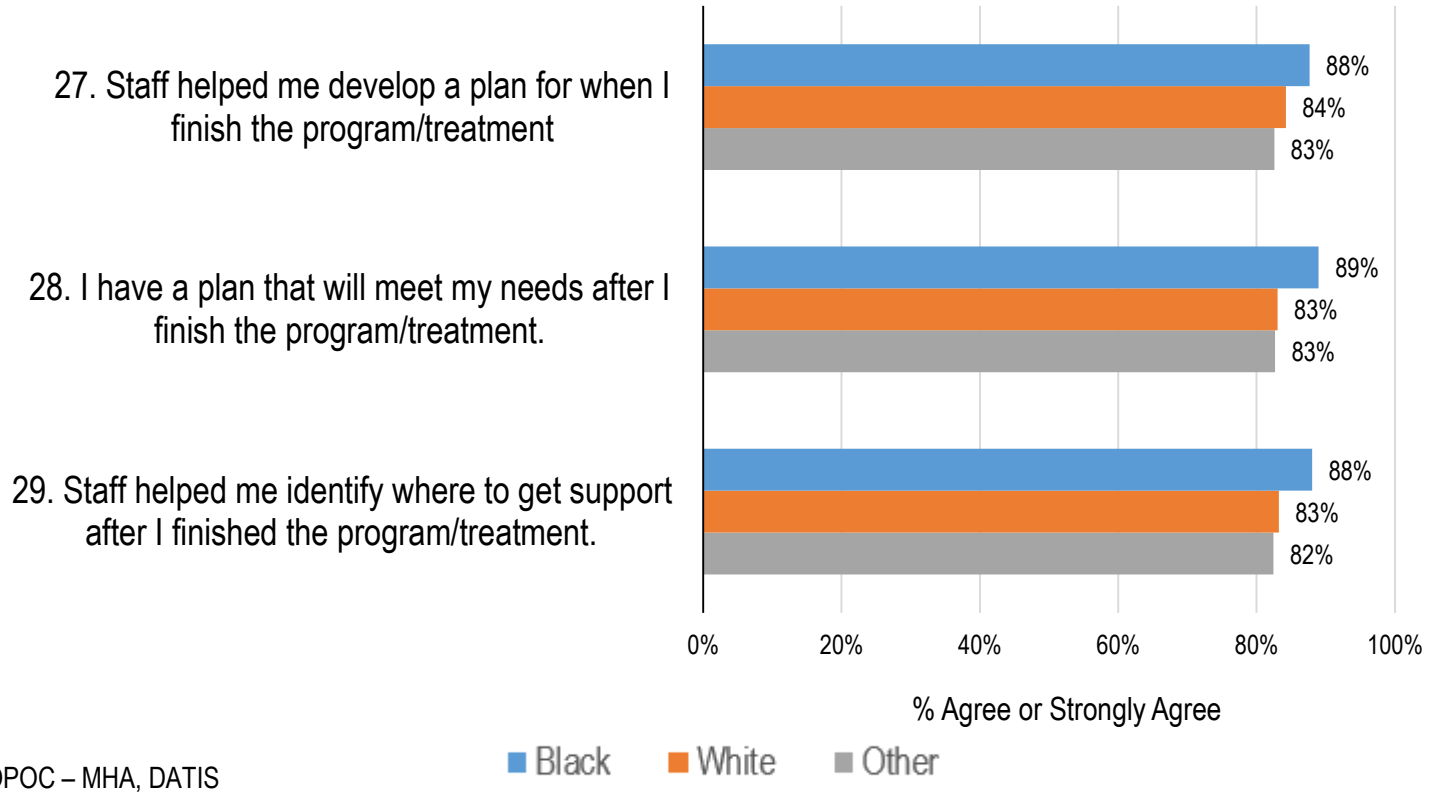


Source: OPOC – MHA, DATIS

Client Experience with Community MHA Services continued, Q1-2017/18 to Q2-2019/20

- Overall moderate experience with discharge or finishing the program or treatment - between 82%-89% clients from the three groups agreed that standards were met
- **Black clients had highest ratings for all three questions compared to White clients and those from other groups**

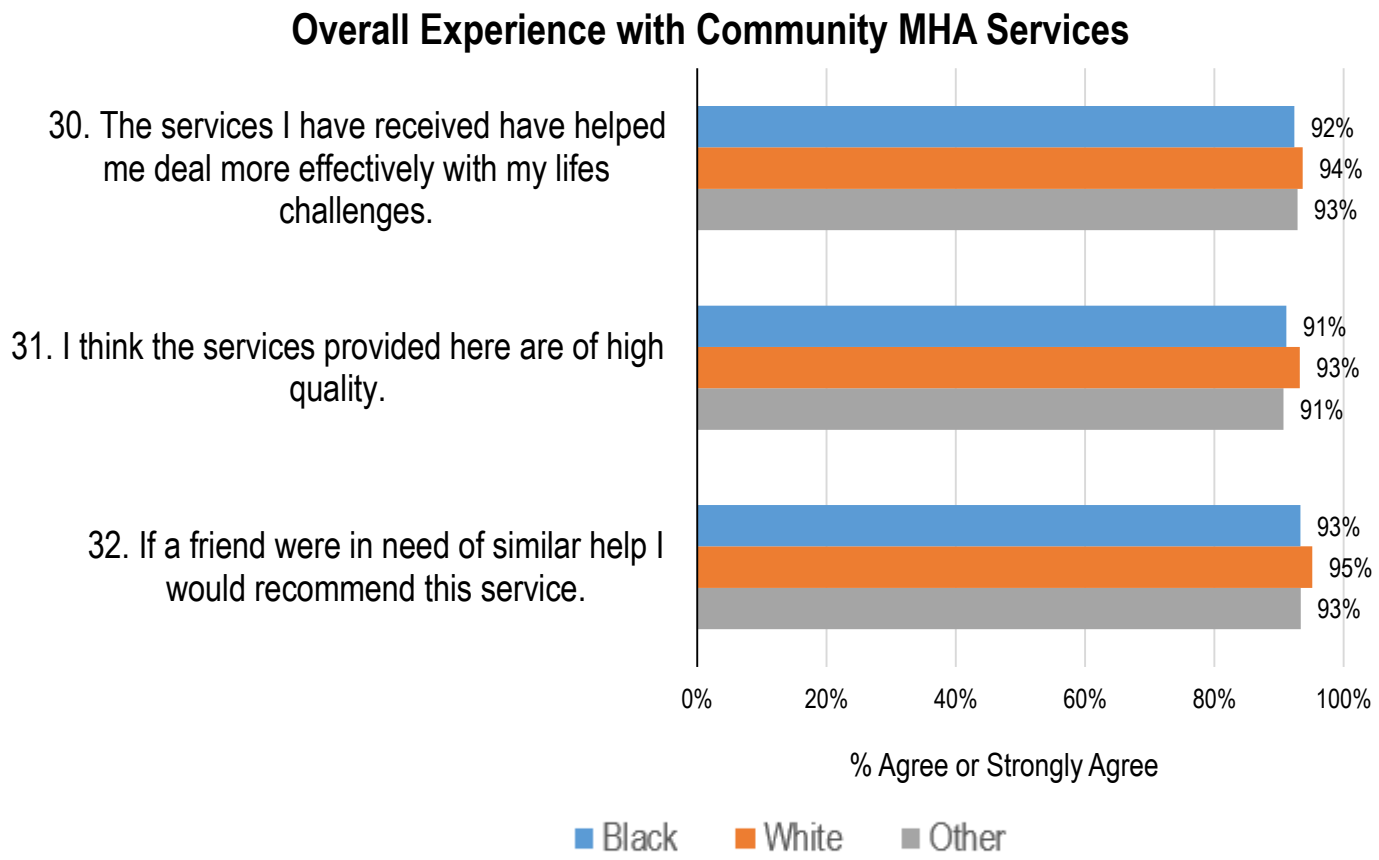
Experience with Discharge or Finishing the Program/Treatment



Source: OPOC – MHA, DATIS

Client Experience with Community MHA Services continued, Q1-2017/18 to Q2-2019/20

- Overall positive experience - above 90% of clients for the 3 groups agreed that standards of care related to overall community mental health and addiction services were met
- **Black clients had slightly lower ratings compared to White clients, but similar to that of other groups for all questions**

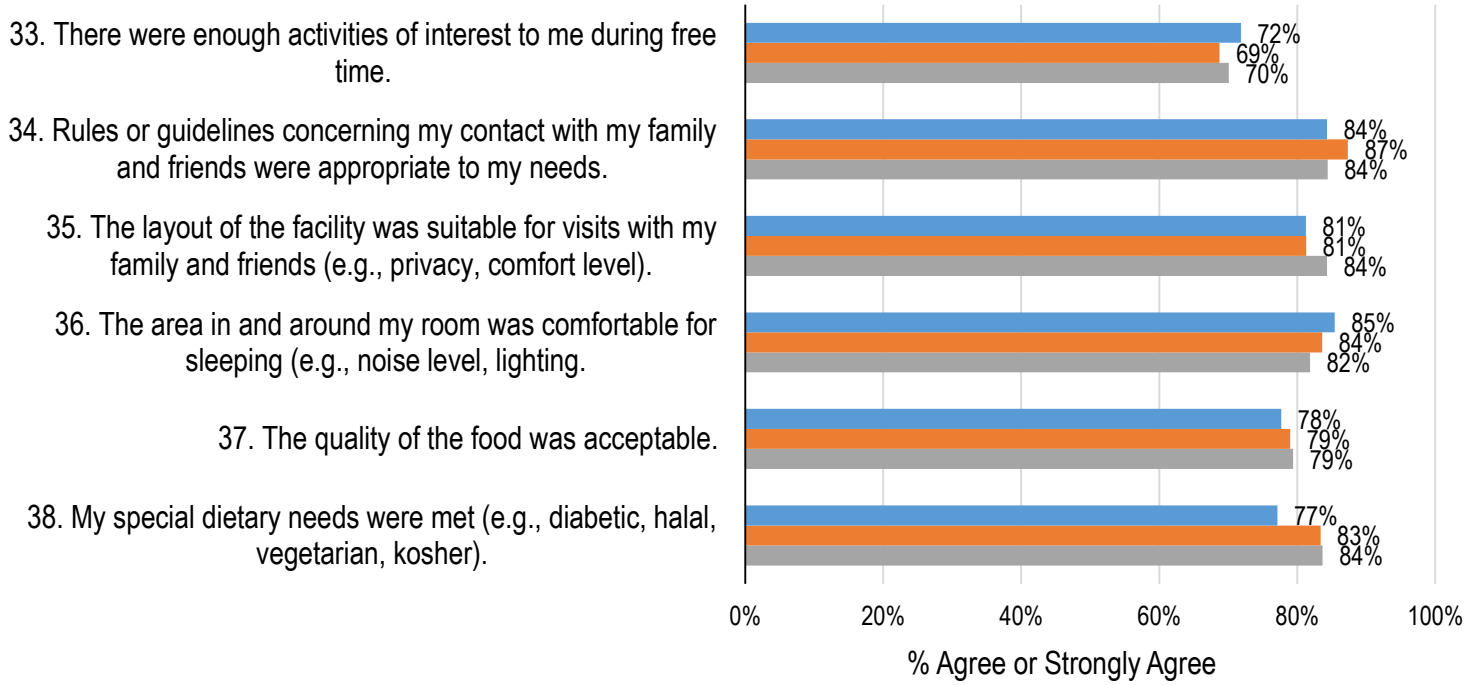


Source: OPOC – MHA, DATIS

Client Experience with Community MHA Services continued, Q1-2017/18 to Q2-2019/20

- For clients in residential or inpatient programs, overall experience was less positive compared to other services (ranging from 70% to 87% agreement that standards of care were met) for the three groups
- Black clients had **slightly higher ratings** for having sufficient activities of interest during free time and comfort of the area in and around their room
- **Black clients had slightly lower ratings for believing that rules or guidelines concerning contact with family and friends were appropriate for their needs (compared to White clients), and meeting of special dietary needs (compared to White and other clients)**

Experience with Residential or Inpatient Programs (if applicable)



Source: OPOC – MHA, DATIS

Planning Implications and Next Steps in the Equity Journey

Reflecting on Findings and Discoveries

- Collection of race/ethnicity data is established in many Toronto Central LHIN community health centres, hospitals and some community mental health and addiction agencies. However, more work is needed to improve data collection rates and quality.

- Data revealed significant differences by race/ethnicity in chronic conditions and comorbidity, emergency department use, inpatient hospitalizations and primary care access that need to be considered when planning for services for the Black population

- There was less variation in client experience (i.e,. agreeing that standards of care were met) by race/ethnicity for clients receiving community mental health and addictions services for Black clients, White clients, and all the other groups; however, Black clients had less positive experiences in some areas

- Differences in race/ethnicity may be masked by looking at the whole groups as homogenous populations (both across other socio-demographic fields but also within the Black race category as there may be variability based on cultural origin). It is important to analyze the intersectionality of correlated socio-demographic variables to identify sub-populations within categories that may be further marginalized.

- Based on the evidence, clients and patients would benefit from health planning informed by demographic/race-based data analysis

Race/Ethnic Disparities: Why? What? How?

Questions to facilitate dialogue about the disparities observed for Black patients related to repeat emergency department visits, low primary care access after hospital discharge, longer stay in acute hospital, high proportion of alternate level of care days, lower mental health primary care visits and satisfaction with some community mental health agency services:

- **Why** are there disparities in service utilization across racialized communities?
  - Baseline health status, services available, cultural norms, family/peer support
- **What** additional factors need to be considered in understanding these disparities?
  - Barriers due to correlated factors (e.g., income, language, birth origin, sexual orientation) that may limit ability to see a doctor, obtain necessary treatments, impact food security, housing security, etc.
  - Barriers related to past experiences of discrimination or lack of trust that can impact accessing services as well as the quality of care received
- **How** can we reduce these disparities? *(see next slide)*

See References in Appendix C

How can we reduce these observed disparities?

- Service providers can implement proactive measures for Black patients seen in the emergency department (ED) or admitted to inpatient care to support smooth transition and continuity of care, e.g., primary care follow-up after discharge
- Need to engage Black population in addressing issues, such as repeat ED visits, readmissions, alternate level of care (ALC) days and satisfaction with some community mental health and addictions services, to identify appropriate solutions
- Establish quality improvement initiatives that focus on understanding the specific sub-groups of Black patients that are affected, barriers which are leading to worse outcomes, and cultural needs and other supports required to improve outcomes
- For experiences with community mental health and addiction (CMHA) services, more detailed analysis and research are required:
    - To better understand what domain(s) could be the focus for intervention to improve the experience of Black communities with CMHA services. For example, satisfaction with therapists, support workers and staff had consistently lower scores (albeit modest) across items.
    - Organizations have access to the qualitative comments provided by clients completing the OPOC-MHA questionnaires. Review of these comments made by Black respondents may provide more information about the care experience that does not appear in the survey data.
    - Ontario Common. However, access to these data were not available for the presentation. Assessment of Need (OCAN) data collected by community mental health agencies could be used as patient reported outcome measures (PROMs) to complement the OPOC data to better understand needs for population sub-groups, as it includes both staff and clients' evaluation of the change in needs over time
- Planning for health services is evolving. Local, regional and provincial leadership should look for opportunities to incorporate the above considerations.

Next Steps in the Equity Journey: Our Shared Responsibilities

Continued expansion of equity data collection and improvements in data quality

- Health service providers should continue building internal capacity to collect equity data and improve quality to ensure comprehensive data
- Encourage adoption of equity data collection among Ontario Health Teams (OHTs) that are going to provide integrated health services to ensure better understanding and addressing of equity disparities in the populations they serve
- Build a culture among service providers around planning based on demographic data by integrating this into regular organizational practices rather than one-off projects to ensure sustainability
- Consider using standardized tools to facilitate quality data collection

Use of the equity information to address equity disparities and monitor progress

- Build capacity on how to analyze and use the equity data to inform quality improvement efforts as well as robust data feedback loops to ensure that data collected are utilized in a meaningful way
- Use of the equity information to identify high-needs populations, and engage these populations in planning and addressing health inequities
- Service providers and health regions should apply an equity lens that stratifies indicators by race/ethnicity and other socio-demographic characteristics. The Health Equity Impact Assessment (HEIA) tool can be used to better understand possible gaps in service.
- Provide training for service providers that addresses unconscious biases and provision of culturally-safe services
- Including equity measures as part of the potential OHT outcome measures could promote greater effort to collect and apply these data. Having common outcome or performance measures (which could be part of a common performance measurement framework) could also support this work.

Next Steps in the Equity Journey: Our Shared Responsibilities

Collaborate with other stakeholders

- Work to standardize the collection and use of race/ethnicity and other equity data beyond the health sector – i.e., other sectors responsible for important social determinants of health such as social services, housing, municipal services, justice system (e.g., the United Way/City of Toronto/Toronto Central LHIN project)

More analysis and research

- More detailed analysis and research are required to inform better understanding of disparities and specific areas to focus on
- Benchmarking across organizations could help identify areas for quality improvement and promising practices used by organizations that could be adapted by others
- Establish standardized process for data linkage to other administrative databases such as those at ICES or CIHI to facilitate broader access to the data by all stakeholders, and allow analysis of the full continuum of care and outcomes for Black and other populations
- Ideally, there would be some capacity to link relevant data across various health and other sectors to inform local, regional and provincial planning. Additionally, promoting data champions within sectors that could undertake robust analyses (e.g., predictive modeling), and report outcomes to providers may further encourage use of these data to inform service planning and development.

Next Steps in the Equity Journey: Our Shared Responsibilities

Sharing best practices in addressing health equity disparities

- Identify best practices, and foster spread and scale of successful local innovations
- Longer term solutions, such as changing hiring practices to encourage diversity in both frontline and leadership positions, so they can better reflect the communities they serve

Guide the collection and use of demographic data at clinical, organizational, regional and provincial levels

- Establish a framework and guidelines to strengthen and standardize race-based and other equity data collection, analysis, and public reporting
- A framework could also ensure proper use and interpretation of race/ethnicity data to prevent further marginalization of sub-groups, as well as include guidelines around framing of equity language for describing groups
- Leverage guidelines from ongoing strategies such as the Ontario Anti-Racism Strategy, Toronto Police Data Collection Strategy, The First Nations Principles of OCAP (ownership, control, access and possession), and others

To achieve a healthy, well population, all sectors need to work together to meet people's individual and collective needs. There are roles for patients/families/communities, and local, regional and provincial levels.

A regional role can be to raise awareness, bring stakeholders together, and drive collective problem solving. The province can play a role in providing stronger and consistent policies and processes for better data collection and use of the data to facilitate addressing equity issues and accelerate solutions.

Thank you

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Ontario

Appendices

Appendix A: List of Abbreviations

- AHRQ – Applied Health Research Question
- ALC – Alternative Level of Care
- CHC – Community Health Centre
- CMHA – Community Mental Health and Addictions
- DATIS – Drug and Alcohol Treatment Information System
- ED – Emergency Department
- HSP – Health Service Provider
- MHA – Mental Health and Addictions
- OCAN – Ontario Common Assessment of Need
- OPOC – Ontario Perception of Care

Appendix B: Standardized Demographic Questions

We Ask Because We Care

We are collecting social information from patients to find out who we serve and what unique needs our patients have. We will also use this information to understand patient experiences and outcomes.

Do I have to answer all the questions?

No. The questions are voluntary and you can choose 'prefer not to answer' to any or all questions. This will not affect your care.

Who will see this information?

This information will be visible only to your health-care team and protected like all your other health information. If used in research, this information will be combined with data from all other patients and no one will be able to identify any of the patients.

1. What language would you feel most comfortable speaking in with your health care provider? Check **ONE** only

☐ 1. Amharic	☐ 9. English	☐ 17. Korean	☐ 25. Somali	☐ 33. Urdu
☐ 2. Arabic	☐ 10. Farsi	☐ 18. Nepali	☐ 26. Spanish	☐ 34. Vietnamese
☐ 3. ASL	☐ 11. French	☐ 19. Polish	☐ 27. Tagalog	☐ 35. Other (please specify): _____
☐ 4. Bengali	☐ 12. Greek	☐ 20. Portuguese	☐ 28. Tamil	
☐ 5. Chinese (Cantonese)	☐ 13. Hindi	☐ 21. Punjabi	☐ 29. Tigrinya	
☐ 6. Chinese (Mandarin)	☐ 14. Hungarian	☐ 22. Russian	☐ 30. Turkish	☐ 88. Prefer not to answer
☐ 7. Czech	☐ 15. Italian	☐ 23. Serbian	☐ 31. Twi	
☐ 8. Dari	☐ 16. Karen	☐ 24. Slovak	☐ 32. Ukrainian	☐ 99. Do not know

2. Were you born in Canada? ☐ 1. Yes ☐ 2. No ☐ 88. Prefer not to Answer ☐ 99. Do not know

If **NO**, what year did you arrive in Canada? _____

3. Which of the following best describes your racial or ethnic group? Check **ONE** only

☐ 1. Asian - East (e.g. Chinese, Japanese, Korean)	☐ 11. Latin American (e.g. Argentinean, Chilean, Salvadoran)
☐ 2. Asian - South (e.g. Indian, Pakistani, Sri Lankan)	☐ 12. Metis
☐ 3. Asian - South East (e.g. Malaysian, Filipino, Vietnamese)	☐ 13. Middle Eastern (e.g. Egyptian, Iranian, Lebanese)
☐ 4. Black - African (e.g. Ghanaian, Kenyan, Somali)	☐ 14. White - European (e.g. English, Italian, Portuguese, Russian)
☐ 5. Black - Caribbean (e.g. Barbadian, Jamaican)	☐ 15. White - North American (e.g. Canadian, American)
☐ 6. Black - North American (e.g. Canadian, American)	☐ 16. Mixed heritage (e.g. Black - African & White – North American) Please specify: _____
☐ 7. First Nations	
☐ 8. Indian - Caribbean (e.g. Guyanese with origins in India)	☐ 17. Other(s): Please specify: _____
☐ 9. Indigenous/Aboriginal - *not included elsewhere*	☐ 88. Prefer not to answer
☐ 10. Inuit	☐ 99. Do not know

TC LHIN Hospitals Demographic Questions – English (visible) 2015/12/18

4. Do you have any of the following? Check **ALL** that apply

☐ 1. Chronic Illness	☐ 9. None
☐ 2. Developmental Disability	☐ 88. Prefer not to answer
☐ 3. Drug or Alcohol Dependence	☐ 99. Do not know
☐ 4. Learning Disability	
☐ 5. Mental Illness	
☐ 6. Physical Disability	
☐ 7. Sensory Disability (i.e. hearing or vision loss)	
☐ 8. Other (Please specify): _____	

5. What is your gender? Check **ONE** only

☐ 1. Female	☐ 6. Other (Please specify): _____
☐ 2. Intersex	☐ 88. Prefer not to answer
☐ 3. Male	☐ 99. Do not know
☐ 4. Trans - Female to Male	
☐ 5. Trans - Male to Female	

6. What is your sexual orientation? Check **ONE** only

☐ 1. Bisexual	☐ 6. Other (Please specify): _____
☐ 2. Gay	☐ 88. Prefer not to answer
☐ 3. Heterosexual	☐ 99. Do not know
☐ 4. Lesbian	
☐ 5. Queer (a term used by people who do not follow common sexual orientations)	
☐ 6. Two-Spirit (a term used by Aboriginal people)	

7. What was your total family income before taxes last year? Check **ONE** only

☐ 1. $0 - $29,999	☐ 88. Prefer not to answer
☐ 2. $30,000 – $59,999	☐ 99. Do not know
☐ 3. $60,000 – $89,999	
☐ 4. $90,000 – $119,999	
☐ 5. $120,000 – $149,999	
☐ 6. $150,000 or more	

8. How many people does this income support?

_____person(s) ☐ 88. Prefer not to answer ☐ 99. Do not know

Appendix C: References

1. Colour Coded Health Care (Wellesley Institute)

   https://www.wellesleyinstitute.com/wp-content/uploads/2012/02/Colour-Coded-Health-Care-Sheryl-Nestel.pdf

2. The Case for Diversity (MHCC, focused on MHA but includes factors that may be applicable for other conditions):

   https://www.mentalhealthcommission.ca/sites/default/files/2016-10/case_for_diversity_oct_2016_eng.pdf

3. Measuring Health Equity: Demographic Data Collection and Use in Toronto Central LHIN Hospitals and Community Health Centres

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