



Healthy Connections 2008
Health Equity: From Challenges to Solutions

Report of Proceedings and Outcomes

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Background and Context

Healthy Connections – Health Equity: From Challenges to Solutions

Purpose and Preparation

Healthy Connections 2008 – Health Equity: From Challenges to Solutions was held on June 5, 2008 at Ryerson University, Toronto, Ontario. The purpose of this one-day Toronto Central Local Health Integration Network (LHIN)-wide conference was to provide a unique opportunity for front line workers, health administrators, policy-makers, and consumer and family networks to come together and learn about the challenges of health inequities, as well as strategies for creating a more equitable health system that responds to the needs of all.

Healthy Connections conference partners:

- Toronto Central Local Health Integration Network (LHIN): <http://www.torontocentrallhin.on.ca>
- Solutions: East Toronto's Health Collaborative: <http://www.solutionshealthcollaborative.ca>
- Canadian Research Network for Care in the Community (CRNCC): <http://www.crncc.ca>
- West End Urban Health Alliance (WEUHA): <http://www.weuha.ca>
- South East Toronto Organization (SETO)

Objectives

The Healthy Connections Planning Committee identified five objectives for the conference:

1. Share the latest thinking regarding health equity internationally, nationally, and locally
2. Create a common and shared understanding of health equity within the Toronto Central LHIN
3. Create an opportunity for cross continuum networking affordable to all
4. Raise awareness of concrete examples of strategies that are working in our communities to address health inequities

5. Communicate lessons learned and best practices to health care providers, consumer and family networks, and policy-makers

Healthy Connections Community Story Slideshow

The Community Story Slideshow was developed by the CRNCC's William Rassenti and Alexandra Williams to illustrate how health service providers are collaborating to address the barriers to health equity in their communities. It is available on the CRNCC website:

<http://www.crncc.ca/events/healthyconnections2008.html>

Proceedings

Opening Remarks

Paul Williams, of the CRNCC and the University of Toronto, welcomed participants to the Healthy Connections conference and acknowledged all of the co-sponsoring organizations. He referred to the conference's title, "Health Equity: From Challenges to Solutions," and stressed that the day was not only about identifying barriers to equity, but also about engaging in action and identifying initiatives to overcome some of the barriers.

Morning Session Highlights and Summary

A summary of each presentation is as follows:

Keynote

- Dr. James Orbinski (St. Michael's Hospital & University of Toronto)
[Bio](#)

Dr. James Orbinski's presentation approached the concept of 'health equity' by considering barriers to health equity at both local and global points of view, and focused on how local health issues are fundamental to global issues and change. He highlighted that the drive for health equity is based within three key fundamentals: dignity, solidarity, and leadership. Dr. Orbinski

illustrated the importance of these fundamentals by providing personal anecdotes of his own experiences from childhood and from working with Médecins Sans Frontières / Doctors Without Borders, particularly his work in Africa with the HIV/AIDS pandemic.

Dr. Orbinski described the importance of solidarity, and how it derives from compassion, warning that individuals often see those suffering around them as separate from themselves, and resort to pity and charity. He explained that solidarity is derived from equity, where one sees another as equal in worth and dignity, and thus works to relieve suffering rather than pity it. Solidarity was defined as a key to provoking change.

One of the key messages that Dr. Orbinski emphasized is that with strong leadership, it is possible to address issues that are seemingly intractable and excessively complex. By rousing public consciousness at a local level, changes can be made which can then push beyond the borders of local scope to approach global issues.

Speakers (in order of presentation)

- Anthony Culyer (University of Toronto & University of York, UK)
[Bio](#) | [Presentation](#)

Anthony Culyer's presentation put a strong emphasis on varying definitions of health equity, and its respective levels of application. Common slogans about equity and health were presented and criticized for their inability to provide clarity and grasp appropriate ethical principles.

- Kerry Bowman (Mount Sinai Hospital & University of Toronto)
[Bio](#) | [Presentation](#)

Kerry Bowman explained that the most vulnerable populations are in the community,

but the appropriate resources are not matched to their demand. He illustrated that the majority of health care money is spent on technology; therefore, there is a lack of equitable resources for the two sectors because community care is not nearly as technology driven as hospital care. He also mentioned that technology allocates resources inequitably within hospital care itself, especially dividing acute and chronic care.

- Dr. Stephen Hwang (St. Michael's Hospital & University of Toronto)
[Bio](#) | [Presentation](#)

Dr. Stephen Hwang's presentation brought a specific focus to the inequities surrounding homelessness, particularly in the Toronto area. Within homelessness, Dr. Hwang identified many subgroups that face further inequities, these groups including homeless women, and those with chronic illnesses. He continued by describing current hopeful and innovative projects in the Toronto area aimed at studying homelessness and engaging in efforts to reduce health inequities accompanying homelessness. Dr. Hwang completed the presentation by outlining general principles aimed at practical solutions to health inequities faced by the homeless.

- Notisha Massaquoi (Women's Health in Women's Hands)
[Bio](#) | [Presentation](#)

Notisha Massaquoi's presentation focused on health equity in relation to racialized women. She noted that the health care system is flawed unless everyone is able to obtain adequate access to services. She described health equity as 'opportunities', and asked what opportunities must be created for all members of society. She illustrated critical issues, including racism, immigration status, and gender; and, outlined the need to expand our points of view and start looking at health care in a broader sense that embraces health, policy, and the ability to

challenge and make change where change is resisted.

- Uzma Shakir (Atkinson Economic Justice Fellow, Atkinson Charitable Foundation) [Bio](#)

Though Uzma Shakir explicitly noted her lack of involvement and professional background in the health care sector, her presentation brought to light a unique perspective on health equity, reaching back to the history and current issues surrounding racism and the South Asian community. She focused on the issue of marginalization, constructed by status, and how it has a bearing on health outcomes.

She expressed that in order to overcome racism (especially within health care), prejudice must be unlearned and structural barriers to health must be deconstructed.

She noted that when the health system was created, the issues surrounding racism were not as obviously significant as they are today; therefore, to think about health in an equitable manner, today's diversity must strongly be taken into account.

Afternoon Working Session Objectives and Summary

Over 200 participants from more than 120 organizations 'rolled up their sleeves' and worked together to name and create concrete solutions for the health inequity challenges that resonate most for their community. Each of the facilitated discussions had a key objective: to identify potential solutions that address the key barriers to equity within the participants' communities. As a way of arriving at some solutions, each group was asked to collectively decide on the three top barriers to health equity and/or three priority areas for reducing inequity.

The aim was to bring a cross-section of health care professionals in a particular community together *and* keep the focus on identifying the levers that can be affected at either the individual, organizational, or community level while productively brainstorming ideas, and sharing knowledge and experiences.

Afternoon Working Session Background Documents

In the afternoon participants were provided with several handouts to assist with setting the context for their afternoon working sessions. This included the **Poverty, Homelessness and Health Access Handout** (Appendix A, page13), which was a compilation of information adapted from three key documents:

1. Poverty by Postal Code, United Way of Toronto, 2004

Poverty by Postal Code is a report written by the United Way of Toronto, which was released in 2004 with the assistance of the Canadian Council on Social Development. For the full report visit:

<http://www.uwgt.org/whoWeHelp/reports/pdf/PovertybyPostalCodeFinal.pdf>

2. Street Health Report, Street Health and the Wellesley Institute, 2007

Street Health conducted the Street Health Report in partnership with the Wellesley Institute in September 2007. For the full report visit:

<http://www.streethealth.ca/Downloads/SHReport2007.pdf>

3. Primer to Action: Social Determinants of Health, Health Nexus and Ontario Chronic Disease Prevention Alliance, 2008

Written by Health Nexus and the Ontario Chronic Disease Prevention Alliance, Primer to Action (2008) provokes thinking around the social determinants of health and chronic disease. This report focuses on six of the twelve determinants of health identified by Health

Canada: income, education, employment, housing, food, and inclusion. For the full report visit:

http://www.healthnexus.ca/projects/PrimertoAction_May30.pdf

Ministry of Health and Long Term Care (MOHLTC) and Toronto Central LHIN Priorities

The Toronto Central LHIN provided participants with a handout that described priorities to improve confidence in Health Care, as well as the priority population groups that the Toronto Central LHIN is focusing on. Appendix B – MOHLTC and Toronto Central LHIN Priorities, page 15.

Toronto Central LHIN Neighbourhood Data Sheets

Toronto Central LHIN Planners compiled a summary of data based on the Toronto Central LHIN Diversity at a Glance analysis. The Planners developed profile sheets for each of the seven neighbourhood areas: West, Northwest, Southwest, North central, Southeast, East, and Northeast. Appendix C – Toronto Central LHIN Diversity Profile, page 16. For more information about the Toronto Central LHIN neighbourhoods visit: <http://www.torontocentrallhin.on.ca/>

Scope of Health Equity Across Toronto

To further set the context for the afternoon sessions, Laura Visser, the Director of Corporate Communications, Planning and Partnerships for Toronto East General Hospital, gave a presentation detailing background information on health statistics provided by the Toronto Central LHIN. Click here to view the full [presentation](#).

In keeping with the mandate of focusing on “identifying the challenges that we have the desire and ability to affect,” Ms. Visser then introduced the following three statements

which participants were to consider in their discussion sessions:

1. Does the neighbourhood data reflect the current realities for the communities your organization serves?
2. Focus on the barriers to care/service and health system inequity that:
 - Are aligned with strategic priorities
 - Have the most impact on health disparities
 - We have the ability to affect
3. List the top 3 barriers or priorities for reducing health system inequity.

Once each room decided on their top 3 barriers or priorities in the first half of the afternoon, Ms. Visser explained that the second half was to be spent with smaller table discussions working on a “solution sheet” for at least one of the identified barriers.

Summary of Working Sessions

East Session #1 – (Facilitator: Susan Himel)

This session identified two barriers to health equity and one priority area for reducing health inequity in their community.

- 1. Lack of affordable and relevant housing**
 - A fundamental issue for the health care community.
 - A component of the broader social determinants of health; determinants could include poverty status, food, income and housing security, or accessibility to transportation.
 - Lack of supportive housing for homeless and those suffering from chronic illness.
- 2. Confronting attitudes and stigma within the system**
 - Address negative attitudes and stigma towards those persons who may be homeless, living in poverty, suffering from mental illness, or struggling with addiction.

- Both health care providers and the broader society must challenge themselves to confront biases and assumptions.

3. Navigation of the health care system

- Overwhelming to patients, clients, providers.
- Care coordination, basic knowledge discrepancies, and lack of information regarding support systems are all challenges.
- Difficult for vulnerable groups, such as elderly and disabled persons or those who might need a language interpreter and/or cultural broker.
- Foreign trained doctors could provide potential assistance with cultural and linguistic challenges.

East Session #2 – (Facilitator: Laura Visser)

This session brainstormed an extensive list of barriers to healthy equity and decided on three barriers to health equity:

1. Lack of social support and corresponding social isolation

- A complex barrier, which includes living alone, perhaps with little or no assistance from family members or friends, living with a physical limitation or disability, and living with a linguistic barrier.
- If someone in need of health care is *also* contending with some of these challenges, they could be very isolated from the community and at risk of not receiving the care that they need.

2. Lack of access to primary care

- Difficulty finding a family doctor or general practitioner who is accepting new patients.
- Family doctors continue to serve as “gatekeepers” for system in terms of patients trying to access specialized care.
- Lack of access to transportation; barrier to receiving primary health care.

3. Lack of affordable and appropriate housing

- Access to adequate housing; factors include affordability, security, and cleanliness, as well as being linguistically and culturally appropriate.
- Example: the importance of being able to access appropriate housing after a hospital visit that does not include a shelter.

Central Session #1 – (Facilitator: Anthony Mohamed)

This session identified one barrier to health equity and three priority areas for reducing inequity in the health care system.

1. Access to the health care system

- A fundamental issue for the health care community.
- The system needs to build in a continuum of services for people, from their home, to their community health centre, to their local hospital.
- Emphasis placed on accessibility of medical services for marginalized populations; for example, mental illness and/or addiction, or disabilities.

2. Information collection and verification

- Lack of a system-wide collection process to identify who is accessing services for what conditions and what the outcomes are for each client.
- Not all health care providers (or clients of health care) speak the same common “health language”.

3. Education within the health care system

- Ongoing educational needs for providers working in the system.
- Focus should be on “upstream” education and training, and physicians and allied professionals should be engaged with serving marginalized populations in the community.

- Emphasis on language and cultural awareness training; could be partly helped by moving more foreign trained professionals into the system (who also might better reflect the diversity of Toronto).
- Lack of training and resources for frontline staff on how to work with diverse populations from an anti-racist and anti-oppression framework.

4. Funding the system

- Equity in funding: a need to re-allocate funds to “where the people are” (in the community) after a comprehensive “gap analysis” at the local level.

Central Session #2 – (Facilitator: Rick Edwards)

Eleven barriers were discussed and this session decided on three main barriers to health equity.

1. Fragmented service and delivery systems

- Service systems that address all of the different social determinants of health are not sufficiently connected, leading to confusion for patients and communication challenges amongst health care professionals.
- Family physicians are not widely accessible.

2. Lack of access to primary care

- Scarcity of family doctors in the community prevents access into the system: i.e. the continued role of the family doctor as the “gatekeeper” to specialized care.
- Waiting lists exist for all forms of treatment.
- Concern around doctors *themselves* not taking on seniors, certain ethnic groups, and patients who smoke, thereby erecting another barrier to access.
- System needs to address the underutilization of foreign-trained professionals.

3. The non-integration of mental health services

- Insufficient tracking of data on mental health.
- Concern around the integration of mental health service providers with other health care providers so that mental health issues do not interfere with general client care.

Central Session #3 – Room D (Facilitator: Krissa Fay)

This session selected three priority areas for reducing inequity in the health care system.

1. Large scale/macro integration of services in health care system

- Lack of genuine power sharing or partnership(s) between hospitals and community organizations of all kinds; barrier to communication and resource sharing, and therefore effective patient care.
- Emphasis should be placed on system navigation; knowledge about basic system navigation needs to be shared widely amongst all health care providers.
- A need to break down jurisdictional barriers or “silos”, potentially creating alternative entry points to primary care beyond just a family doctor and making the system as inclusive as possible.

2. General organization of health care structures

- Critique of the current health care model; services should be organized around a more holistic and grass roots approach.
- Emphasis on the notion of client-based care; i.e. each community would have a true sense of who their clients were and organize their hospital and community partnerships around the needs of those clients.

3. The lack of resources for mental health and addiction and community health centers

- Lack of resources directed to vulnerable members of the community; those challenged by mental health issues and addiction, new immigrants, those living in poverty.
- A more qualitative approach needed to look at the “health” of a community; more resources and stakeholder partnerships could ensure the delivery of key services *before* conditions develop to the point of needing costly medical services.

West Session – (Facilitator: Terrie Russell)

This session identified two major barriers to health equity and one priority area for reducing health inequity in the health care system.

1. Poverty

- Poverty status: community members living in poverty, or living with income and housing insecurity need to have their basic needs addressed first, as this status has a negative impact on health and therefore health equity.
- Questions were raised about the capacity of Local Health Integration Networks, and more broadly the Ontario government, to address some of these fundamental issues and tackle the underlying determinants of health disparities.

2. Access to primary care

- Issues regarding primary care could be an opportunity, rather than a barrier, if the definition of “primary care” became multi-faceted.

3. Interdisciplinary care

- Health care needs to become interdisciplinary and use a “team approach”.
- Hospitals and community-based organizations need to start seeing each

other as equal partners in an interdisciplinary approach to health care.

Key Themes from the Afternoon Session

A cross-section of the ideas that came out of each discussion session reveals the emergence of several key themes from the conference as a whole. These four major themes are by no means an exhaustive or definitive list of the ideas that came out of the conference, but all four of them were tabled in one form or another in each of the six working sessions.

All solution sheets that were generated have been attached (verbatim) in Appendix D - Solutions sheets, page 23.

Navigation

Navigation of our health care system, and the complexities and difficulties of any one individual navigating the system, was unearthed as the number one barrier to health. When a patient is trying to access the health care system, what is their first point of entry: a family doctor; a clinic; an emergency room? Concern was raised around how individuals access basic information and services.

Solutions to the barriers of navigation are far from simple, but a review of the sessions revealed a sweeping conception of navigation. Everyone who touches the health care system, whether they are a community provider, hospital administrator, policy maker, or advocate, has to “navigate” through the system, often on a daily basis. This navigation can be exceedingly difficult, almost impossible, or relatively straightforward, depending on one’s power of agency and base of knowledge. For all stakeholders it is important to ask, what steps can I take that will allow *everyone* to navigate the health care system a little bit more easily?

Solution suggestions:

1. Conceptualize hospitals as a “resource hub” for all agencies and organizations in the community.

This was offered as a solution to the identified barrier that hospital services are frequently separated from community services, and that by not fully integrating these two modes of client care, there is a loss to both client and provider. However, an opportunity can be seized because the hospital is a natural resource platform for training and development, compilation and dissemination of information, information technology support, capacity building, and research evaluation.

2. Provide health services and information in an “outreach mode”. Ask clients what makes them comfortable, go into the community, i.e. “where the people are”.

Organizing health care in an “outreach mode” could take any number of forms, but one example discussed included opening more clinics right in the heart of disadvantaged and marginalized communities, places where people are most in need of quality health care. These clinics should be comprehensive and “barrier free,” offering referrals but also on site access to resources such as primary care physicians, dental care, mental health support, addiction services, and nurse practitioners. They could also serve as teaching and research facilities for all health professionals.

As above, hospitals and community services would have to work together to deliver on such a solution. Support from local residents and simultaneous education and dialogue would be critical in the initial phases and as the project matured. A community advisory board could serve as a possible linkage between clinic and community.

Access to primary care

The second most common theme that arose in each afternoon session was accessibility of primary medical care. For many, seeing a family doctor is their initial contact with the health system for all kinds of issues, from a common cold to an annual physical. If one needs specialized care and has a family doctor, making an appointment to seek a referral seems fairly straightforward. However, what if one does not have access to a primary care physician? It was discussed that often those who are new to Ontario or Canada or who are homeless have an increasingly difficult time finding a family doctor and accessing primary care. The afternoon sessions challenged the status quo around primary care, including the health care system’s “gatekeeper” model in which the family doctor is often the only way to access specialized care. Furthermore, the failure to process the credentials and capitalize on the skills of foreign trained professionals was recognized as a major barrier to moving more doctors and professionals into the system.

Solution suggestion:

1. Encourage doctors to form “doctor collectives”. Encourage more physicians to pursue family medicine.

While this solution may seem daunting, incremental progress can be made at the education level. Encouragement, possibly in the form of incentives (monetary or otherwise) should be given to new medical graduates who want to pursue family medicine or work in community/clinic settings with vulnerable populations. These clinics could have an expanded “scope of practice”, with longer operating hours and support provided by nurse practitioners. These doctors could work for a salary rather than on a fee-for-service basis. A broad range of institutional support would be required for this type of model, even on a pilot project basis.

Housing

The third most common barrier to health care that was discussed was housing – the lack of social and supportive housing for those in greatest need – whether those persons are coping with income and food insecurity, mental illness, or addiction. The theme of housing not only includes those who are homeless, but can encapsulate clients who are new immigrants or refugees, who have recently lost their job, or who are fleeing an abusive relationship. In general, a major theme that emerged from the day was that the system should support a broad range of health and social needs, and a significant component of such a system should be a safe and secure living environment for all to achieve an adequate standard of living.

Solution suggestion:

1. A common front needs to form amongst health care providers – doctors, community and support workers, and advocates – to educate people about the connections between adequate housing and a healthier population.

This solution may or may not be practical or achievable, as with any type of activism that seeks to challenge the status quo and bring greater equity to a system. However, with organization, it could build naturally on previously mentioned reforms, such as more fully integrating hospitals and community organizations and developing strategic partnerships between diverse health care providers. If providers in *all* parts of the system communicated with each other about the benefits of supportive housing, they may start to jointly advocate for longer-term solutions to the problems of homelessness and poverty.

Integration of marginalized communities

A fourth theme to emerge from the sessions was a concern around marginalized and vulnerable groups “slipping through the cracks”

and being inadequately served, or not served at all, by the health care system. Marginalized communities could include, but are not limited to: the homeless, racialized communities, and those coping with mental illness and/or addiction. It was discussed that if there is going to be an increase in the amount of equity in our health system then first priority should be given to those at the highest risk of being unhealthy. Concern was raised around how the health care system can more fully integrate marginalized communities.

Solution suggestion:

1. Focus on education and training *inside* the system to address attitudes towards marginalized communities.

A shift in attitudes must begin at the earliest years of training and education, when medical students and others studying to be health professionals should be exposed to the diverse types of clients that they may be treating and caring for. Furthermore, accountability must be maintained for this type of training as providers work in the system and are confronting mental health patients, those coping with addiction, and visible minorities who may be struggling with cultural and linguistic challenges. Sensitivity and compassion must be treated as *core values* for all health professionals, no matter who the patient is or what he or she may be struggling with.

Closing Remarks

Paul Williams wrapped up the conference by offering some final remarks. He noted that a major theme to emerge from the day was an emphasis on “attitudes, ideas, and values,” and that more attention must be paid to the broader social determinants of health if we are to make progress towards greater equity in health care.

Paul Williams closed the conference by acknowledging all of the CRNCC research assistants that did a tremendous job throughout the conference. This included thanks to:

Johannah Black
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Alvin Ying
Alexandra Williams
Lynn Zhu

Participants were encouraged to provide feedback to conference organizers through the online survey. For evaluation results, see Appendix E - Results of Healthy Connections 2008 Conference Online Evaluations, page 52.

Poverty, Homelessness and Health Access

'Poverty by Postal Code' 2004 Key Findings:

- Substantial rise (6.6%) in poverty in Toronto in last two decades; the national poverty rates have declined slightly over the same period
- One in five families in 2001 were living in poverty
- Families living in poverty are more highly concentrated in some neighbourhoods, with concentration rising from 17.8% in 1981 to 43.2% in 2001
- The number of higher poverty neighbourhoods is almost doubling every 10 years and there are now ~ 120 higher poverty neighbourhoods in the City of Toronto. The inner suburbs are most hard-hit with a rise from 15 to 92 over the last 20 years.
- There has been a profound shift in the resident profile of higher poverty neighbourhoods with visible minority and immigrant families now making up a far larger percentage.

'Street Health 2007' Highlights:

- Homelessness is generally not a short-term crisis
- Poverty is the leading reason people become and remain homeless; generally there are not enough affordable housing options to help offset this outcome.
- Years of declining incomes and cuts to housing have exacerbated the situation
- Mental health diagnoses, depression, emotional crises, suicide attempts, physical and sexual assault are common among people who are homeless
- Homeless people have significantly worse health than the general population. The majority has at least one chronic or ongoing physical health condition.
- Access to health care is difficult, if not impossible. Many lack a stable, comprehensive source of primary health care and people who are homeless have substantially less access to dental and eye care.
- Emergency departments are the most frequently used source of health care.
- Five times as many homeless are hospitalized in a year than the general population
- Preventative measures for mental health concerns (such as advice, screening and medication) are difficult to get. Treatment programs for substance use are also very limited.
- Lack of identification documents such as a health or social insurance card is a key barrier

'Street Health 2007' Action Plan:

- Address the poverty and inequality that underlies homelessness
- Improve access to affordable and appropriate housing
- Improve immediate living conditions for homeless people
- Improve access to health care and support for homeless people

Adapted from 'Poverty by Postal Code' United Way of Toronto 2004 and 'Street Health Report 2007' Street Health and the Wellesley Institute

Summary of Six Key Determinants of Health

“A health care system that truly helps people stay healthy must go beyond health services to include the social determinants of health.”

~ Toronto Central LHIN, Integrated Health Service Plan

Determinant	Working Definition	With It	Without It
Adequate Income	Ability to pay for the essentials in life	Housing Food Clothing Transportation Cultural Activities Recreation Respect In Community	Lack of Essentials Social Isolation
Education	Ability to read and understand the information that has an impact on our lives and the best education possible for our circumstances whether youth, adult or senior	Reach our full potential Cope with Technological Change Better Work Opportunities	Poverty Disadvantage Exclusion
Employment	Access to the workforce with just, favourable and safe working conditions, protection from unemployment, precarious or contingent employment, and a minimum wage	Material Well Being Adequate Income To Live On Social Connections Accomplishment Belonging Satisfaction Fulfillment	Financial Hardships Stress Increased Health Risks Greater Social Isolation Depression Anxiety Panic Increased Substance Abuse
Affordable Housing	Housing that is permanent, affordable, decent and accessible to all	Shelter From The Elements Sense Of Belonging	Homelessness Threat of Eviction Sub-standard Living Environments Exposure to Elements
Food	Access to healthful, affordable, adequate and nutritious food	Academic & Social Success Raised Health Awareness	Obesity Chronic Disease
Inclusion	A society where everyone has both the feeling and the reality of belonging	Caring Cooperation Trust Equity Justice Respect	Social Exclusion Economic Exclusion

Adapted from ‘Poverty by Postal Code’ United Way of Toronto 2004 and ‘Street Health Report 2007’ Street Health and the Wellesley Institute

Ontario Government Priorities to Improve Confidence in Health Care

Reducing wait times in emergency departments and improving access to family health care will be the Ontario Ministry of Health and Long-Term Care's two most important health care priorities over the next four years.

1. The strategy to **reduce emergency department wait times** will include:
 - Reducing the number of visits to emergency rooms
 - A new Aging at Home Strategy that enables seniors to continue living in their homes
 - Better management of chronic diseases, such as diabetes
 - More home care
 - Improved community-based mental health and addiction treatment
2. The strategy to **improve access to family health care** will include:
 - 50 new Family Health Teams
 - 25 nurse practitioner-led clinics
 - 9,000 new nurses

Toronto Central LHIN Priority Population Groups

People with Mental Health and Addictions

- Improve access to coordinated and integrated mental health and addictions services
- Improve coordination and integration of services for people with concurrent disorders

People who require Rehabilitation services

- Improve the transition from hospital and institutional care to independent and supportive community living for groups of individuals who need rehabilitation services

Seniors: People 65 years of age and older

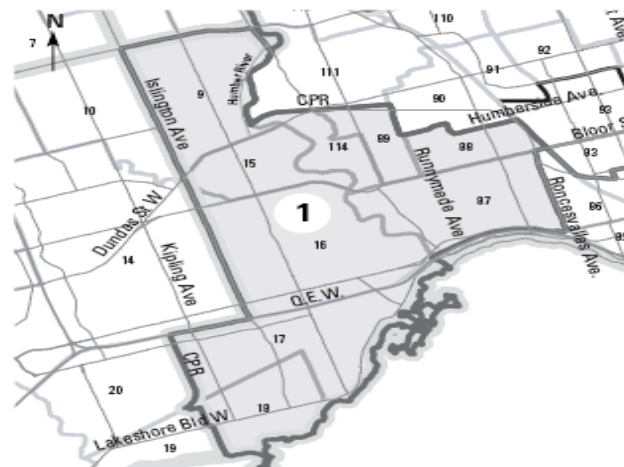
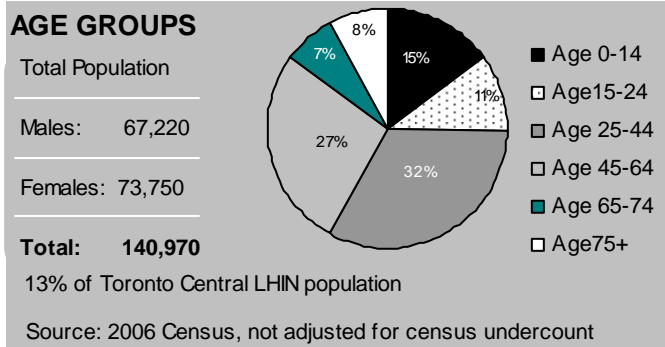
- Provide supports for marginalized and at risk seniors who need to navigate their way through the health system.
- Enable seniors to live independently in the community for as long as possible.

Aging at Home Strategy targets seniors who are dealing with age-related health conditions or age-related disabilities.

- Increase overall supply of services available to seniors including residential options
- Relieve pressures on hospitals/LTC homes by facilitating appropriate placement and avoiding crisis through wellness
- Respect seniors' dignity, independence and choice
- Contribute to a cost-effective and sustainable health care system

Diversity at a Glance

Neighbourhood Area 1 West: Etobicoke/High Park



SENIORS IN THE COMMUNITY	West	Toronto Central LHIN
Age 65+ Living Alone	34%	34%
Age 65+ with Low Income	20%	24%
Age 65+ with No Knowledge of English or French	6%	15%
Age 75+ Living in Institutions*	9%	15%
Age 75+ with Activity Limitation*	66%	66%

HEALTH STATUS	West	Toronto Central LHIN
Chronic Disease (Age 20+)	Rate/100	
Diabetes Mellitus (DM)	7.6	8.9
Osteoarthritis	9.4	8.9
Ischemic Heart Disease	5.9	5.8
Cerebrovascular Disease	2.0	1.8
Chronic Obstructive Pulmonary Disease (COPD) (35+)	2.8	3.3

HEALTH SERVICE USE	West	Toronto Central LHIN
Emergency Department Visits	Rate/100	
Total population	31	29
Children (<15)	33	28
Youth & Adults (15-64)	27	26
Seniors (65+)	47	48
ED Visits that could be managed elsewhere	Rate/1,000	
Total Population	10.5	8.4
Health Procedures (Age 20+)	Rate/100,000	
Cataract Surgery	1,236	1,191

POPULATION CHARACTERISTICS	West	Toronto Central LHIN
Total Immigrants	37%	41%
Recent Immigrants (2001 - 2006)	7%	8%
Francophone Population	2%	2%
No Knowledge of English or French	2%	5%
Aboriginal Population	1%	1%

SOCIOECONOMIC STATUS	West	Toronto Central LHIN
Low Income	17%	24%
Lone-parent families	17%	19%
Age 25+ with No Certificate, Diploma or Degree	12%	16%
Age 25+ with High School Completion	19%	19%
Age 25+ with University Degree	41%	40%

ETHNOCULTURAL COMPOSITION	
Top 5 Communities of Colour	Top 5 Home Languages
Black (3%)	English (77%)
Chinese (3%)	Polish (3%)
South Asian (3%)	Ukrainian (3%)
Latin American (2%)	Russian (2%)
Filipino (2%)	Spanish (1%)
Top 5 Areas of Birth for Recent Immigrants (2001-2006)	
Eastern Europe (39%)	
Eastern Asia (11%)	
Southern Europe (8%)	
South America (7%)	
West & Central Asia and the Middle East (6%)	

Diversity at a Glance

Neighbourhood Area 2 North West: Davenport/Bloor

AGE GROUPS

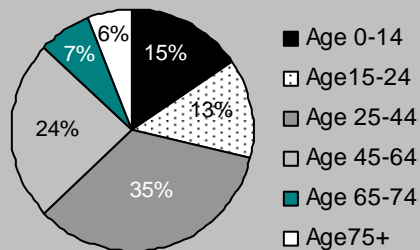
Total Population

Males: 97,125

Females: 101,135

Total: 198,260

18% of Toronto Central LHIN population



Source: 2006 Census, not adjusted for census undercount



SENIORS IN THE COMMUNITY	North West	Toronto Central LHIN
Age 65+ Living Alone	27%	34%
Age 65+ with Low Income	25%	24%
Age 65+ with No Knowledge of English or French	30%	15%
Age 75+ Living in Institutions*	11%	15%
Age 75+ with Activity Limitation*	68%	66%

HEALTH STATUS	North West	Toronto Central LHIN
Chronic Disease (Age 20+)	Rate/100	
Diabetes Mellitus (DM)	11.3	8.9
Osteoarthritis	9.9	8.9
Ischemic Heart Disease	6.1	5.8
Cerebrovascular Disease	1.8	1.8
Chronic Obstructive Pulmonary Disease (COPD) (35+)	3.4	3.3

HEALTH SERVICE USE	North West	Toronto Central LHIN
Emergency Department Visits	Rate/100	
Total population	31	29
Children (<15)	30	28
Youth & Adults (15-64)	28	26
Seniors (65+)	49	48
ED Visits that could be managed elsewhere	Rate/1,000	
Total Population	9.6	8.4
Health Procedures (Age 20+)	Rate/100,000	
Cataract Surgery	1,094	1,191

POPULATION CHARACTERISTICS	North West	Toronto Central LHIN
Total Immigrants	51%	41%
Recent Immigrants (2001 - 2006)	7%	8%
Francophone Population	1%	2%
No Knowledge of English or French	8%	5%
Aboriginal Population	1%	1%

SOCIOECONOMIC STATUS	North West	Toronto Central LHIN
Low Income	25%	24%
Lone-parent families	23%	19%
Age 25+ with No Certificate, Diploma or Degree	31%	16%
Age 25+ with High School Completion	22%	19%
Age 25+ with University Degree	22%	40%

ETHNOCULTURAL COMPOSITION	
Top 5 Communities of Colour	Top 5 Home Languages
Black (10%)	English (61%)
Chinese (6%)	Portuguese (11%)
Latin American (6%)	Italian (4%)
South Asian (5%)	Spanish (4%)
Filipino (3%)	Chinese (4%)
Top 5 Areas of Birth for Recent Immigrants (2001-2006)	
Southeast Asia (13%)	
Eastern Asia (12%)	
South America (13%)	
Southern Europe (11%)	
Africa (10%)	

Diversity at a Glance

Neighbourhood Area South 3 West: West Downtown/Parkdale



AGE GROUPS

Total Population

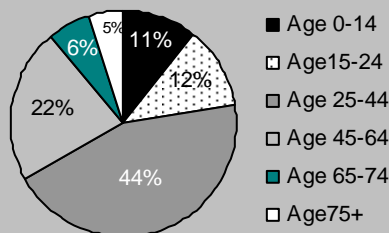
Males: 68,010

Females: 69,380

Total: 137,390

13% of Toronto Central LHN population

Source: 2006 Census, not adjusted for census undercount



SENIORS IN THE COMMUNITY	South West	Toronto Central LHN
Age 65+ Living Alone	33%	34%
Age 65+ with Low Income	34%	24%
Age 65+ with No Knowledge of English or French	32%	15%
Age 75+ Living in Institutions*	19%	15%
Age 75+ with Activity Limitation*	67%	66%

HEALTH STATUS	South West	Toronto Central LHN
Chronic Disease (Age 20+)	Rate/100	
Diabetes Mellitus (DM)	9.9	8.9
Osteoarthritis	8.1	8.9
Ischemic Heart Disease	5.4	5.8
Cerebrovascular Disease	1.8	1.8
Chronic Obstructive Pulmonary Disease (COPD) (35+)	3.3	3.3

HEALTH SERVICE USE	South West	Toronto Central LHN
Emergency Department Visits	Rate/100	
Total population	34	29
Children (<15)	33	28
Youth & Adults (15-64)	23	26
Seniors (65+)	52	48
ED Visits that could be managed elsewhere	Rate/1,000	
Total Population	10.8	8.4
Health Procedures (Age 20+)	Rate/100,000	
Cataract Surgery	1,081	1,191

POPULATION CHARACTERISTICS	South West	Toronto Central LHN
Total Immigrants	45%	41%
Recent Immigrants (2001 - 2006)	10%	8%
Francophone Population	2%	2%
No Knowledge of English or French	8%	5%
Aboriginal Population	1%	1%

SOCIOECONOMIC STATUS	South West	Toronto Central LHN
Low Income	31%	24%
Lone-parent families	21%	19%
Age 25+ with No Certificate, Diploma or Degree	18%	16%
Age 25+ with High School Completion	18%	19%
Age 25+ with University Degree	42%	40%

ETHNOCULTURAL COMPOSITION	
Top 5 Communities of Colour	Top 5 Home Languages
Chinese (16%)	English (67%)
Black (6%)	Chinese (11%)
South Asian (6%)	Portuguese (5%)
Filipino (3%)	Vietnamese (2%)
Southeast Asia (2%)	Polish (1%)
Top 5 Areas of Birth for Recent Immigrants (2001-2006)	
Eastern Asia (35%)	
South Asia (22%)	
Southeast Asia (8%)	
Africa (6%)	
West & Central Asia and the Middle East (6%)	

Diversity at a Glance

Neighbourhood Area 4 North Central: Midtown/Leaside/North Riverdale/Forest Hill



AGE GROUPS

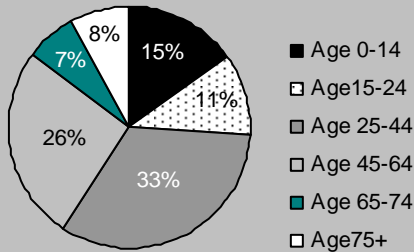
Total Population

Males: 126,025

Females: 145,560

Total: 271,585

25% of Toronto Central LHIN population



Source: 2006 Census, not adjusted for census undercount

SENIORS IN THE COMMUNITY	North Central	Toronto Central LHIN
Age 65+ Living Alone	38%	34%
Age 65+ with Low Income	16%	24%
Age 65+ with No Knowledge of English or French	4%	15%
Age 75+ Living in Institutions*	21%	15%
Age 75+ with Activity Limitation*	64%	66%

HEALTH STATUS	North Central	Toronto Central LHIN
Chronic Disease (Age 20+)	Rate/100	
Diabetes Mellitus (DM)	6.6	8.9
Osteoarthritis	7.8	8.9
Ischemic Heart Disease	5.4	5.8
Cerebrovascular Disease	1.6	1.8
Chronic Obstructive Pulmonary Disease (COPD) (35+)	2.7	3.3

HEALTH SERVICE USE	North Central	Toronto Central LHIN
Emergency Department Visits	Rate/100	
Total population	24	29
Children (<15)	23	28
Youth & Adults (15-64)	20	26
Seniors (65+)	46	48
ED Visits that could be managed elsewhere	Rate/1,000	
Total Population	6.7	8.4
Health Procedures (Age 20+)	Rate/100,000	
Cataract Surgery	1,349	1,191

POPULATION CHARACTERISTICS	North Central	Toronto Central LHIN
Total Immigrants	30%	41%
Recent Immigrants (2001 - 2006)	6%	8%
Francophone Population	2%	2%
No Knowledge of English or French	1%	5%
Aboriginal Population	0.5%	1%

SOCIOECONOMIC STATUS	North Central	Toronto Central LHIN
Low Income	15%	24%
Lone-parent families	14%	19%
Age 25+ with No Certificate, Diploma or Degree	7%	16%
Age 25+ with High School Completion	15%	19%
Age 25+ with University Degree	56%	40%

ETHNOCULTURAL COMPOSITION	
Top 5 Communities of Colour	Top 5 Home Languages
Chinese (4%)	English (86%)
Black (3%)	Chinese (2%)
Filipino (3%)	Russian (1%)
South Asian (2%)	Tagalog (1%)
Latin American (2%)	Spanish (1%)
Top 5 Areas of Birth for Recent Immigrants (2001-2006)	
Eastern Europe (18%)	
Southeast Asia (15%)	
West & Central Asia and the Middle East (13%)	
Eastern Asia (12%)	
South America (8%)	

Diversity at a Glance

Neighbourhood Area 5 South East: East Downtown/South Riverdale



AGE GROUPS

Total Population

Males: 66,370

Females: 58,985

Total: 125,355

12% of Toronto Central LHIN population



Source: 2006 Census, not adjusted for census undercount

SENIORS IN THE COMMUNITY	South East	Toronto Central LHIN
Age 65+ Living Alone	40%	34%
Age 65+ with Low Income	36%	24%
Age 65+ with No Knowledge of English or French	23%	15%
Age 75+ Living in Institutions*	24%	15%
Age 75+ with Activity Limitation*	66%	66%

HEALTH STATUS	South East	Toronto Central LHIN
Chronic Disease (Age 20+)	Rate/100	
Diabetes Mellitus (DM)	10.3	8.9
Osteoarthritis	8.1	8.9
Ischemic Heart Disease	5.0	5.8
Cerebrovascular Disease	1.7	1.8
Chronic Obstructive Pulmonary Disease (COPD) (35+)	4.4	3.3

HEALTH SERVICE USE	South East	Toronto Central LHIN
Emergency Department Visits	Rate/100	
Total population	35	29
Children (<15)	31	28
Youth & Adults (15-64)	33	26
Seniors (65+)	51	48
ED Visits that could be managed elsewhere	Rate/1,000	
Total Population	9.9	8.4
Health Procedures (Age 20+)	Rate/100,000	
Cataract Surgery	915	1,191

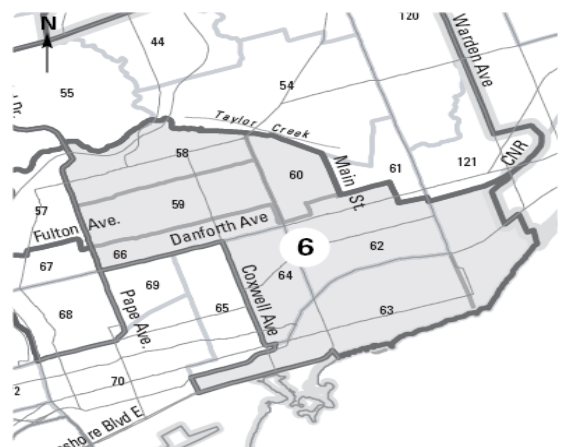
POPULATION CHARACTERISTICS	South East	Toronto Central LHIN
Total Immigrants	42%	41%
Recent Immigrants (2001 - 2006)	10%	8%
Francophone Population	3%	2%
No Knowledge of English or French	6%	5%
Aboriginal Population	1%	1%

SOCIOECONOMIC STATUS	South East	Toronto Central LHIN
Low Income	37%	24%
Lone-parent families	23%	19%
Age 25+ with No Certificate, Diploma or Degree	17%	16%
Age 25+ with High School Completion	20%	19%
Age 25+ with University Degree	37%	40%

ETHNOCULTURAL COMPOSITION	
Top 5 Communities of Colour	Top 5 Home Languages
Chinese (16%)	English (70%)
South Asian (9%)	Chinese (10%)
Black (9%)	Tagalog (2%)
Filipino (5%)	Tamil (1%)
Southeast Asia (2%)	Vietnamese (1%)
Top 5 Areas of Birth for Recent Immigrants (2001-2006)	
Eastern Asia (32%)	
Southern Asia (21%)	
Southeast Asia (12%)	
Africa (7%)	
Eastern Europe (7%)	

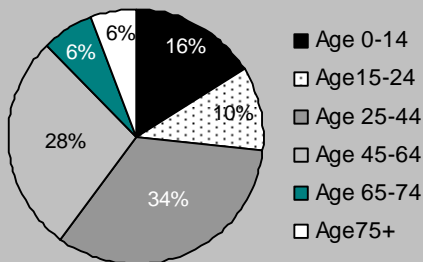
Diversity at a Glance

Neighbourhood Area 6 East: Old East York/East End/The Beach



AGE GROUPS

Total Population
 Males: 48,705
 Females: 52,985
Total: 101,690



9% of Toronto Central LHIN population

Source: 2006 Census, not adjusted for census undercount

SENIORS IN THE COMMUNITY	East	Toronto Central LHIN
Age 65+ Living Alone	34%	34%
Age 65+ with Low Income	24%	24%
Age 65+ with No Knowledge of English or French	13%	15%
Age 75+ Living in Institutions*	4%	15%
Age 75+ with Activity Limitation*	68%	66%

HEALTH STATUS	East	Toronto Central LHIN
Chronic Disease (Age 20+)	Rate/100	
Diabetes Mellitus (DM)	8.3	8.9
Osteoarthritis	9.4	8.9
Ischemic Heart Disease	6.4	5.8
Cerebrovascular Disease	1.7	1.8
Chronic Obstructive Pulmonary Disease (COPD) (35+)	4.1	3.3

HEALTH SERVICE USE	East	Toronto Central LHIN
Emergency Department Visits	Rate/100	
Total population	28	29
Children (<15)	28	28
Youth & Adults (15-64)	26	26
Seniors (65+)	46	48
ED Visits that could be managed elsewhere	Rate/1,000	
Total Population	5.9	8.4
Health Procedures (Age 20+)	Rate/100,000	
Cataract Surgery	1,245	1,191

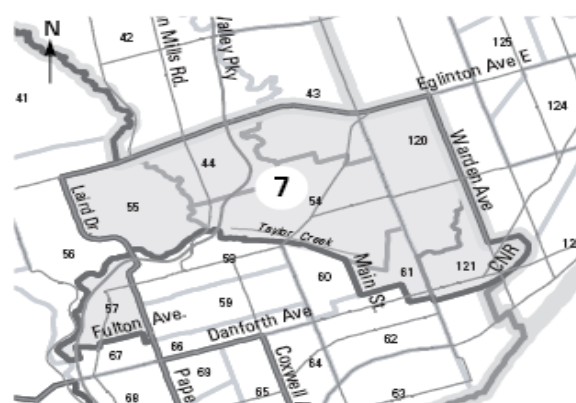
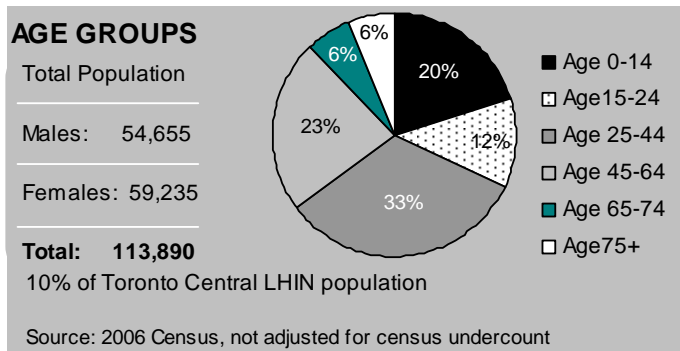
POPULATION CHARACTERISTICS	East	Toronto Central LHIN
Total Immigrants	30%	41%
Recent Immigrants (2001 - 2006)	4%	8%
Francophone Population	2%	2%
No Knowledge of English or French	3%	5%
Aboriginal Population	1%	1%

SOCIOECONOMIC STATUS	East	Toronto Central LHIN
Low Income	17%	24%
Lone-parent families	20%	19%
Age 25+ with No Certificate, Diploma or Degree	17%	16%
Age 25+ with High School Completion	21%	19%
Age 25+ with University Degree	35%	40%

ETHNOCULTURAL COMPOSITION	
Top 5 Communities of Colour	Top 5 Home Languages
Chinese (7%)	English (84%)
South Asian (5%)	Chinese (4%)
Black (4%)	Greek (2%)
Filipino (2%)	Italian (1%)
Latin American (1%)	Urdu (1%)
Top 5 Areas of Birth for Recent Immigrants (2001-2006)	
Southern Asia (23%)	
Eastern Asia (14%)	
West & Central Asia and the Middle East (9%)	
Southeast Asia (8%)	
United States (7%)	

Diversity at a Glance

Neighbourhood Area 7 North East: Flemingdon/ Thorncliffe/Crescent Town/Oakridge



SENIORS IN THE COMMUNITY	North East	Toronto Central LHIN
Age 65+ Living Alone	32%	34%
Age 65+ with Low Income	28%	24%
Age 65+ with No Knowledge of English or French	12%	15%
Age 75+ Living in Institutions*	14%	15%
Age 75+ with Activity Limitation*	65%	66%

POPULATION CHARACTERISTICS	North East	Toronto Central LHIN
Total Immigrants	58%	41%
Recent Immigrants (2001 - 2006)	20%	8%
Francophone Population	1%	2%
No Knowledge of English or French	5%	5%
Aboriginal Population	1%	1%

HEALTH STATUS	North East	Toronto Central LHIN
Chronic Disease (Age 20+)	Rate/100	
Diabetes Mellitus (DM)	11.7	8.9
Osteoarthritis	10.2	8.9
Ischemic Heart Disease	6.7	5.8
Cerebrovascular Disease	1.9	1.8
Chronic Obstructive Pulmonary Disease (COPD) (35+)	3.7	3.3

SOCIOECONOMIC STATUS	North East	Toronto Central LHIN
Low Income	37%	24%
Lone-parent families	22%	19%
Age 25+ with No Certificate, Diploma or Degree	18%	16%
Age 25+ with High School Completion	23%	19%
Age 25+ with University Degree	30%	40%

HEALTH SERVICE USE	North East	Toronto Central LHIN
Emergency Department Visits	Rate/100	
Total population	26	29
Children (<15)	25	28
Youth & Adults (15-64)	23	26
Seniors (65+)	46	48
ED Visits that could be managed elsewhere	Rate/1,000	
Total Population	5.7	8.4
Health Procedures (Age 20+)	Rate/100,000	
Cataract Surgery	1,321	1,191

ETHNOCULTURAL COMPOSITION	
Top 5 Communities of Colour	Top 5 Home Languages
Black (8%)	English (55%)
Chinese (7%)	Urdu (7%)
Filipino (6%)	Chinese (4%)
West Asia (4%)	Bengali (4%)
South Asian (3%)	Tamil (3%)
Top 5 Areas of Birth for Recent Immigrants (2001-2006)	
Southern Asia (52%)	
West & Central Asia and the Middle East (13%)	
Eastern Asia (8%)	
Eastern Europe (8%)	
Southeast Asia (8%)	

Healthy Connections 2008
Healthy Equity: From Challenges to Solutions

Solution Sheets – Access to Primary Care

1. Which barrier to equity or opportunity to reduce inequity does this solution address?
a. Lack of access to primary care b. Access to affordable housing/ appropriate supports availability c. Social isolation/ lack of social supports
2. Describe one change or strategy that could be implemented at the individual, organizational or community-level to address the barrier/opportunity noted above:
a. Lack of access to care: <ul style="list-style-type: none">• House calls team (multidisciplinary team)• Use of nurse practitioners (as part of the team instead of the general practitioners)• Mandate for general practitioner's to spend one day of week to see clients at home• More community health centres
3. Who are the key stakeholders that need to be involved in implementing this solution?
Ministry of Health LHIN OMA ONA Specific community advocates of the area (e.g. Advocacy centre for the elderly) College of Physicians and Surgeons
4. What resources, if any, are needed for this solution to be implemented successfully?
<ul style="list-style-type: none">• Resolution to integrated care• Resource: is the mediator to relinquish power and integrate the care (e.g. doctors vs. nurse practitioners)• College of Physicians and Surgeons: revisit standards/ competency requirements, improve the process• Incentive(s) for general practitioners doing house calls – similar to AFP (alternate funding plan)

1. Which barrier to equity or opportunity to reduce inequity does this solution address?

Lack of access to primary care!

2. Describe one change or strategy that could be implemented at the individual, organizational or community-level to address the barrier/opportunity noted above:

- Encouragement of medical students to enter or pursue family medicine
- Change the way clinics/ family practices meet the needs of patients - become “open/ advanced access”
- Widen/ extend hours of operation
- Utilization of nurse practitioners and increase scope of practice
- Increased education – self management of illness/ disease
- Use of Telehealth to needs triage needs
- Encourage practice to Federation of Holistic Therapists and Community Health Centres

3. Who are the key stakeholders that need to be involved in implementing this solution?

CMA
CNO
OMA
RNAO
Ministry of Health

4. What resources, if any, are needed for this solution to be implemented successfully?

Time and funding

1. Which barrier to equity or opportunity to reduce inequity does this solution address?

Resources to:

- People with addictions
- People with mental health problems } concurrent disorders
- Homeless population & under housed
- Seniors
- Uninsured (undocumented and documented)
- People experiencing poverty
- People not able to find general practitioner
- Pregnant women / speciality populations

<ul style="list-style-type: none"> • Immigrants • Looking for more holistic approach
2. Describe one change or strategy that could be implemented at the individual, organizational or community-level to address the barrier/opportunity noted above:
<ul style="list-style-type: none"> • Locating (granted) in new Community Health Centres / Aging at Home and emergency funding • Funding redirection from hospitals into community 5% • Increase partnership between Community Health Centres and hospitals - need dictated by grassroots • Nurse practitioners • Promotion of Community Health Centres services • Grassroots development of services that are culturally appropriate (shift in mainstream or specific cultural services – E.g. Anishnabe and access alliance) • Community-based mental health & addiction services (not hospital)
3. Who are the key stakeholders that need to be involved in implementing this solution?
<p>LHIN Communities (service users, providers, community at large) Hospitals Policy makers Community board structures need to be in place and have all voices Universities/ colleges for research</p>
4. What resources, if any, are needed for this solution to be implemented successfully?
<p>Funding 5%</p>

1. Which barrier to equity or opportunity to reduce inequity does this solution address?
<p>Access to primary Care</p>
2. Describe one change or strategy that could be implemented at the individual, organizational or community-level to address the barrier/opportunity noted above:
<ol style="list-style-type: none"> a. Encourage doctors to form “doctor collectives” with a different compensation model b. Incentives, either monetary or other, for new medical graduates, to become family doctors c. Increase the number of seats available for internationally trained medical graduates to write certification exams and places to intern

- d. Increase scope of practice of allied health professionals
- e. Financial support for nurses wishing to become nurse practitioners
- f. Make family doctors available in non-traditional settings

3. Who are the key stakeholders that need to be involved in implementing this solution?

OMA
 Professionals
 Community Health Centres
 Medical schools
 MOHLTC
 LHINs
 CCACs
 Hospital/ Federation of Holistic Therapists
 Family practitioners

4. What resources, if any, are needed for this solution to be implemented successfully?

- a. More seats for writing exams
- b. More resources for nurses to become nurse practitioners
- c. Financial incentives for family doctors

**Healthy Connections 2008
 Healthy Equity: From Challenges to Solutions**

Solution Sheets - Navigation

1. Which barrier to equity or opportunity to reduce inequity does this solution address?

Standardized appropriately disaggregated data sets/ templates/ collection that captures historically excluded/ marginalized/ disadvantages/ vulnerable populations or groups – racialized, disability, aboriginal, SES in particular.

2. Describe one change or strategy that could be implemented at the individual, organizational or community-level to address the barrier/opportunity noted above:

Implement a LHIN-wide (hopefully a proto-type for broader ownership – at the ministry and within other LHINS!) standardized data gathering/ capture framework or template – that allows for the client profile development that includes such dimensions as ethno-racial or cultural background, first or other language skills, faith identity, persons with disabilities, national background, aboriginal status (which?), sexual orientation (which?), etc. All community health and social service providers-

institutional, community-based and others are required to adopt and use!

3. Who are the key stakeholders that need to be involved in implementing this solution?

Toronto Central LHIN leadership and administration
MOHLTC
Hospital Leadership and Senior Staff
CHC's and other community health and social service providers

4. What resources, if any, are needed for this solution to be implemented successfully?

- Political and administrative will!!
- Need to appropriately adapt

1. Which barrier to equity or opportunity to reduce inequity does this solution address?

Navigation

2. Describe one change or strategy that could be implemented at the individual, organizational or community-level to address the barrier/opportunity noted above:

Integrated health and community info resources and common database through one stop access (e.g. all), not all separate i.e. CCAC, 1211, nutrition, telehealth, and multi language access with live people.

Fund Canadian health network model again!!

3. Who are the key stakeholders that need to be involved in implementing this solution?

LHINS
All partners with health

4. What resources, if any, are needed for this solution to be implemented successfully?

Funding, IT system

1. Which barrier to equity or opportunity to reduce inequity does this solution address?

(barrier) → Hospital/ Services separated from Community Services
(opportunity) → Hospital as natural resource platform

2. Describe one change or strategy that could be implemented at the individual, organizational or community-level to address the barrier/opportunity noted above:

- Hospital as resource Hub
- Hospital as a resource to all agencies
 - a. For information/ research compilation
 - b. For payroll management
 - c. For it support
 - d. Fundraising supports through hospital foundation
 - e. Meals on wheels
 - f. Research evaluation
 - g. Training: culturalization; capacity building
 - h. Standardized forms
 - i. Shared care agreements
 - j. Crisis shared models to reduce emergency beds with community crisis workers
 - k. Nurse practitioners from hospital into supportive housing
 - l. Agreements with LHIN - need this in them as goals
 - m. Building community capacity

3. Who are the key stakeholders that need to be involved in implementing this solution?

TC LHIN

4. What resources, if any, are needed for this solution to be implemented successfully?

- Big categories
- Infrastructure
- Knowledge
- Capital equipment/ space

1. Which barrier to equity or opportunity to reduce inequity does this solution address?

Health care services

2. Describe one change or strategy that could be implemented at the individual, organizational or community-level to address the barrier/opportunity noted above:

Organization

- Increase the number of family health teams
- Promote healthy living (exercises, good eating habit)
- Networking to improve access to family health care services
- Promote active offer of health services in the communities
- Provide health services at a reasonable distance from the community

Individual

- Interact with local community, be engaged with the local communities

Community

- Community agencies to inform/ guide their members in terms of health (new immigrant) promotion and places to get health services. Help new immigrants navigate in the system.

3. Who are the key stakeholders that need to be involved in implementing this solution?

LHIN

Local community organizations

Local communities

Health service providers

Health professionals

4. What resources, if any, are needed for this solution to be implemented successfully?

- Trained health professionals
- Health service providers at reasonable distance
- Available resources links to the needs of the population

1. Which barrier to equity or opportunity to reduce inequity does this solution address?

Navigation

2. Describe one change or strategy that could be implemented at the individual, organizational or community-level to address the barrier/opportunity noted above:

- a. Using the early or new immigrants to help, mentor, orient new immigrants to the Canadian

<p>health care, social service and settlement system</p> <p>b. Include credentials and accreditation</p> <p>c. Fund and train professional interpreters from new immigrant populations</p> <p>d. Sharing across different services of those populations e.g. housing settlement, health advice</p>
<p>3. Who are the key stakeholders that need to be involved in implementing this solution?</p> <p>Community agencies</p> <p>Housing providers and networks</p> <p>CHCs</p> <p>Hospitals</p> <p>CCACs</p>
<p>4. What resources, if any, are needed for this solution to be implemented successfully?</p> <p>Funding sustained (not as a pilot)</p>

<p>1. Which barrier to equity or opportunity to reduce inequity does this solution address?</p> <p>Large scale/ macro system integration</p> <ul style="list-style-type: none"> • COMSOC • LHIN's • HEALTH • Courts/ justice • Education • Poverty • Housing
<p>2. Describe one change or strategy that could be implemented at the individual, organizational or community-level to address the barrier/opportunity noted above:</p> <ul style="list-style-type: none"> a. Effective, all-inclusive needs based planned partnerships between hospitals CSS's, community groups, outreach and all key stakeholders, as necessary b. Balance power differential between organizations c. Redistribute the economic resources to be effective d. User friendly/ accessible resources – every door is the right door e. Specialized resources, as needed f. Reduce/ eliminate red tape

3. Who are the key stakeholders that need to be involved in implementing this solution?

The community-service users
Non-profits
Government
Community groups
LHIN's

4. What resources, if any, are needed for this solution to be implemented successfully?

Research barriers to equity

1. Which barrier to equity or opportunity to reduce inequity does this solution address?

Large scale/ macro system integration

- How can systems complement each other?
 - a. Income
 - b. Health (mental health, developmental issues, substance use)
 - c. Housing

2. Describe one change or strategy that could be implemented at the individual, organizational or community-level to address the barrier/opportunity noted above:

- Advocacy and coalition work
- Lobbying at network level - E.g. West End Urban Health Alliance, SETO, Solutions

Diversion of people who are charged with drug use and possession:

- Treatment: funded by corrections is cheaper
- Similar to mental health (stop the criminalization of the poor)

Elimination of safe street act:

- Education/ training
- Employment
- Re-integration of clients into the community

3. Who are the key stakeholders that need to be involved in implementing this solution?

Service Users
People who have been through corrections system

Funders
Service providers

4. What resources, if any, are needed for this solution to be implemented successfully?

From various sources (help integrate services – holistic integrated approach to services):

- Federal
- Provincial
- Municipal

1. Which barrier to equity or opportunity to reduce inequity does this solution address?

Large scale // macro system integration

2. Describe one change or strategy that could be implemented at the individual, organizational or community-level to address the barrier/opportunity noted above:

- a. Start with early effective intervention: Deconstructing case studies to determine the root causes and address root causes for future people
- b. Partnerships with power sharing (between hospitals, community, etc.)
- c. Reduce red-tape: Eliminate red-tape especially on government level (e.g. Immigration wait times, etc.)
- d. Balance between one-stop shopping and specific services (as needed): Culturally specific
- e. Adjust mainstream and have specific services specialized. Take a “system navigation” position. We all have a moral responsibility to service client.
- f. Address certain service gaps: mental health especially dual diagnosis, concurrent diagnosis, addictions

Prevention focus for future:

- e.g. “when the person first got into trouble”
- e.g. Is the root challenge immigration
- e.g. Do not criminalize youth behaviour

3. Who are the key stakeholders that need to be involved in implementing this solution?

The community “the service user”
Government ministries: open to change and suggestions
Non-profit
Policy makers

4. What resources, if any, are needed for this solution to be implemented successfully?

At community level:

- Qualitative research; research barriers and how they interact to equity
- Don't get stuck in research move to action
- Time and willingness to change

* Massive concentration of resources. At earliest possible juncture.*

1. Which barrier to equity or opportunity to reduce inequity does this solution address?

Fragmented service systems – all services that address determinants of health are disconnected from one another.

2. Describe one change or strategy that could be implemented at the individual, organizational or community-level to address the barrier/opportunity noted above:

- a. Family physician not connected, not accessible: change in system so that physicians are not responsible for gate keeping all information
- b. Access to more community services or psychiatrist not contingent on physician
- c. Integrating all government services
- d. Central intake – mental health – community services
- e. Privacy and confidentiality
- f. Partnership – collaboration
- g. Project funding vs. core funding is competition
- h. Research? Evidence?: measure

Possible models:

- Doctor: family health team
- Nurse practitioners
- Community: CHC model
- Walk-in clinics – multiservices
- Integration – e-health, telehealth, database required

3. Who are the key stakeholders that need to be involved in implementing this solution?

Service recipient – everyone

Ministry of health
 Social services
 Police
 Immigration
 Pharmacy
 Ethicists
 Privacy commissioner
 Teachers

4. What resources, if any, are needed for this solution to be implemented successfully?

Privacy commissioner
 Integrated database: IT
 Funding
 Research
 Buy in
 Coordination – pilot project
 CASI – service system Seaton House for homeless people

1. Which barrier to equity or opportunity to reduce inequity does this solution address?

Policy on collecting data & stats that indicate where the strongest need is

2. Describe one change or strategy that could be implemented at the individual, organizational or community-level to address the barrier/opportunity noted above:

LHINS sponsored forum or could be included in MIS/CDS data collection

3. Who are the key stakeholders that need to be involved in implementing this solution?

Service Users
 Care Givers
 Health Professionals

4. What resources, if any, are needed for this solution to be implemented successfully?

- Forum
- E Health Education
- Expertise on Data Collection

1. Which barrier to equity or opportunity to reduce inequity does this solution address?

(opportunity)

Organization Structures:

- Grassroots
- Decentralized
- Recovery oriented

2. Describe one change or strategy that could be implemented at the individual, organizational or community-level to address the barrier/opportunity noted above:

Motto: Respect, Compassion, Competence

- We know who the clients are and where they are concentrated
- Create clinics where they live
- Bring together the services they need: traditional & non-traditional care providers: TCM, naturopaths, dieticians, dentists, physicians, nurse practitioners, labs, x-ray, specialists etc. All together – make clinic barrier free. Allow referrals and good information for clients. It should be a centre of excellence with best practices.
- They would be teaching facilities for physicians, nurses, nurse practitioners and all allied health professionals
- Extended hours
- Include data collection and research as integral

Model:

- Albany Clinic on Danforth
- Ann Johnson Health Station

3. Who are the key stakeholders that need to be involved in implementing this solution?

Partnerships with community services and hospitals

Politicians & MOHLTC support

Surrounding community support at beginning and ongoing

Ongoing clients & family participation – i.e. Boards advisory committees

4. What resources, if any, are needed for this solution to be implemented successfully?

- Not an expensive model compared to hospitals
- Leverage research partnerships with universities for example
- Implement attracting provider compensation package that allows for choice

- Dental care will cost!

1. Which barrier to equity or opportunity to reduce inequity does this solution address?

Integrated macro system

2. Describe one change or strategy that could be implemented at the individual, organizational or community-level to address the barrier/opportunity noted above:

- Policy review between community and hospital
- Consumer involvement – client focused, centered
- Modifying system to meet clients need
- Cross-ministry linkage e.g. transportation, housing, ODSP, welfare, corrections
- Seamless integration between services
- Make bureaucratic rotate jobs – for 2 years
- Senior staff serving on front line for 2 months
- Senior staff / senior ministry/ senior field staff
- Accountability & transparency
- Conflict resolution & mediation

3. Who are the key stakeholders that need to be involved in implementing this solution?

Senior staff
 Senior ministry staff
 Senior field staff

4. What resources, if any, are needed for this solution to be implemented successfully?

Goodwill and commitment

1. Which barrier to equity or opportunity to reduce inequity does this solution address?

Opportunity: Organization structures

2. Describe one change or strategy that could be implemented at the individual, organizational or community-level to address the barrier/opportunity noted above:

Motto: Respect, Compassion, Competence

- Know who clients are & where they are & take service to them. We know where concentrations of clients come from because we keep stats. Accessibility and addressing inequities. Accessibility and addressing inequalities.
- Bring all together non-traditional specialists: TCM, naturopaths, and traditional providers (primary care) labs/ X-ray, chiropractors/ specialists – make barrier-free accessible with personal support people on site – referrals, public education.
- Information for patients. Centre of excellence / best practices available.

Model: Albany Clinic

- Data collection and research funded and embedded
- Make them teaching facilities for residents and allied health practitioners - make nurse practitioners partner for them to get training slots.

3. Who are the key stakeholders that need to be involved in implementing this solution?

Partnerships with community and hospitals

Politicians MOHLTC – Minister support

Community support and consideration – to ensure ownership include clients and families

Ongoing clients / family involvement: i.e. Board and advisory committees make them feel comfortable REAL Participation

4. What resources, if any, are needed for this solution to be implemented successfully?

- Not an expensive model compared to hospitals – known models available use them!
- Research partnerships
- Supportive policies and break down supportive policy barriers
- Do It Well Do It Right!
- Attractive package of provider compensation that allows for choice
- Dental care will cost

Healthy Connections 2008
Healthy Equity: From Challenges to Solutions

Solution Sheets – Integration of Marginalized Communities

1. Which barrier to equity or opportunity to reduce inequity does this solution address?
Percent can't get care (barrier) Accessibility and acceptability of services (issue) and availability
2. Describe one change or strategy that could be implemented at the individual, organizational or community-level to address the barrier/opportunity noted above:
<p>a. Use of technology – language lines, videoconferencing, etc. BUT – language only one piece – cultural issues etc very broad</p> <p>b. Cultural specificity differences - Patterns of learning, knowledge, cultural competence, etc.</p> <p>c. Change in the ethics of practice –and accountabilities to be more diverse</p> <p>d. Prevention education</p> <p>Need to have both community/ cultural specific care but at minimum need to have competent care (cultural youth/generational, health issue, etc.):</p> <ul style="list-style-type: none"> • Need to ask clients what makes comfortable (e.g. everything from accommodation to clothing)/ use CBR • Access to info of what's available: Outreach • Mode of providing services and info dissemination: E.g. where services/ outreach being provided • Intersectoral work and peer support • Inter-sectoral dissemination and collaboration
3. Who are the key stakeholders that need to be involved in implementing this solution?
Faculties and training institutions
4. What resources, if any, are needed for this solution to be implemented successfully?
<ul style="list-style-type: none"> • Training • Build on rich networks- fund them

1. Which barrier to equity or opportunity to reduce inequity does this solution address?
Social isolation / Limited social supports
2. Describe one change or strategy that could be implemented at the individual, organizational or community-level to address the barrier/opportunity noted above:
<p>Individual: n/a</p> <p>Organization(s):</p> <ul style="list-style-type: none"> • Educate “front-line” staff & those who interact directly with clients on the community services available • Share information (where possible) on potential high-risk individuals <p>Community:</p> <ul style="list-style-type: none"> • Make more (accessible) spaces available for groups to meet • Coordinate activities & profile of ‘basket of services’ that are available
3. Who are the key stakeholders that need to be involved in implementing this solution?
N/A
4. What resources, if any, are needed for this solution to be implemented successfully?
N/A

1. Which barrier to equity or opportunity to reduce inequity does this solution address?
Lack of integrated mental health (and addictions) services
2. Describe one change or strategy that could be implemented at the individual, organizational or community-level to address the barrier/opportunity noted above:
<p>a. Cross-training ongoing between multiple sectors</p> <p>b. Change to fee-for-service structure so services are available by salaries professionals</p>
3. Who are the key stakeholders that need to be involved in implementing this solution?
N/A

4. What resources, if any, are needed for this solution to be implemented successfully?
N/A

1. Which barrier to equity or opportunity to reduce inequity does this solution address?
Health care providers attitudes towards mental health & addictions
2. Describe one change or strategy that could be implemented at the individual, organizational or community-level to address the barrier/opportunity noted above:
Emergency room provider attitudes require a shift: this takes years of undergraduate medical school & nursing training. We used to help identify patients with addictions & mental health issues without judgement. In doing so we changed the supports in place for these patients once identifies to help reduce emergency visits rather than stabilizing them and sending them back to the street/shelter.
3. Who are the key stakeholders that need to be involved in implementing this solution?
Medical school deans and curricular coordinators Post-graduate program Departmental directors
4. What resources, if any, are needed for this solution to be implemented successfully?
<ul style="list-style-type: none"> • Will and motivation • Time • Funding

1. Which barrier to equity or opportunity to reduce inequity does this solution address?
Attitude and stigma
2. Describe one change or strategy that could be implemented at the individual, organizational or community-level to address the barrier/opportunity noted above:
a. Need to be held account to care

- b. For some providers attitude: costs as a barrier
- c. Cultural competency courses
- d. Teach as part of curriculum – cultural sensitivity
- e. CME credits for attitude/ stigma
- f. Do providers recognize this as a problem
- g. Pervasive in society – need to get us/ providers to acknowledge
- h. Health bias is pervasive – need to recognize problem
- i. Need to set targets for improvement/ change
- j. Need to empower people

3. Who are the key stakeholders that need to be involved in implementing this solution?

N/A

4. What resources, if any, are needed for this solution to be implemented successfully?

N/A

1. Which barrier to equity or opportunity to reduce inequity does this solution address?

Lack Of Integrated Mental Health Services

How to integrate mental health service providers with other health care providers when mental health issues?

2. Describe one change or strategy that could be implemented at the individual, organizational or community-level to address the barrier/opportunity noted above:

- a. Provide cross sectoral training to mental health professionals so they can work with professionals in other health areas e.g. children’s services, palliative care. Develop pilot projects.
- b. Share staff – borrow expertise across agencies to provide mental health services

3. Who are the key stakeholders that need to be involved in implementing this solution?

LHIN

Family doctors who make referrals

Community services e.g. shelters, drop-ins, schools, LTC

Family Health Teams

4. What resources, if any, are needed for this solution to be implemented successfully?

- a. Money for training, pilot projects

- b. Family health teams – more trained doctors, nurses social workers (allied health)
- c. Infrastructure for peer support

1. Which barrier to equity or opportunity to reduce inequity does this solution address?

Immigrants getting acknowledgement/ credentials in Canada for training/ degrees received in other countries

2. Describe one change or strategy that could be implemented at the individual, organizational or community-level to address the barrier/opportunity noted above:

- Change health care structures so doors open for immigrants to gain credentials for health care system
- Partnership between hospitals and community to train immigrants on health promotion
- Consolidated/ guided process for new Canadians to get credential: need advocacy/ voice
- Encourage all health service providers to providing shadowing opportunities and hiring new Canadians

3. Who are the key stakeholders that need to be involved in implementing this solution?

OMA
 CPSO
 Hospitals
 CHCs
 ONA
 Universities

4. What resources, if any, are needed for this solution to be implemented successfully?

- Legislated changes encouraging foreign-trained hires
- “Benchmarks of how healthcare settings are doing [with] progress in this area
- Increased training spots for foreign-trained professionals

1. Which barrier to equity or opportunity to reduce inequity does this solution address?
Education
2. Describe one change or strategy that could be implemented at the individual, organizational or community-level to address the barrier/opportunity noted above:
<ul style="list-style-type: none"> • Changing healthcare structure so doors open for immigrants to gain credentials for healthcare system • Partnership between hospitals and community to train immigrants in health promotion • Consolidated/ guided process for new Canadians to get credentials: need advocacy voice • Quality front-line education re: mental health care • Lens structured/ informal meetings between disciplines • Be part of school / university training • Incentives for people to work in the community
3. Who are the key stakeholders that need to be involved in implementing this solution?
N/A
4. What resources, if any, are needed for this solution to be implemented successfully?
N/A

**Healthy Connections 2008
Healthy Equity: From Challenges to Solutions**

Solution Sheets - Housing

1. Which barrier to equity or opportunity to reduce inequity does this solution address?
Poverty
2. Describe one change or strategy that could be implemented at the individual, organizational or community-level to address the barrier/opportunity noted above:
<ol style="list-style-type: none"> a. Redirect funding to community based services and PHC b. LHIN wide standardized data gathering framework or template c. LHIN put links to poverty groups for easy access

3. Who are the key stakeholders that need to be involved in implementing this solution?
LHIN
4. What resources, if any, are needed for this solution to be implemented successfully?
Cooperation from silos: <ul style="list-style-type: none"> • Hospitals • Community based organizations • Lobby groups

1. Which barrier to equity or opportunity to reduce inequity does this solution address?
Lack of affordable & appropriate housing
2. Describe one change or strategy that could be implemented at the individual, organizational or community-level to address the barrier/opportunity noted above:
<p>a. As an organization (Family Health Team), fundraise, collect donations (money, food, and clothing) or use some current funding as a “comfort food”. Use these resources for our clients in financial need.</p> <p>b. Educating patients/ clients of our practice about the issues of poverty, homelessness, low income & housing on health. Empower and encourage those who can assist or participate in community actions/ services (non profit).</p> <p>c. Ensuring patients are aware of services to assist them i.e. – low cost birth control, food banks, employment services</p>
3. Who are the key stakeholders that need to be involved in implementing this solution?
Community leaders Ministry of housing Public health FHT's CHC's
4. What resources, if any, are needed for this solution to be implemented successfully?
<ul style="list-style-type: none"> • Community support • Funding • Good communication, rapport between service provider – health provider organizations

1. Which barrier to equity or opportunity to reduce inequity does this solution address?
Housing, affordable, with cultural and linguistic considerations
2. Describe one change or strategy that could be implemented at the individual, organizational or community-level to address the barrier/opportunity noted above:
<ul style="list-style-type: none">• Condo or co-op on town homes, something not too small or large, where residents have equity. Size of units available to be variable.• Residents/ owners to be grouped by cultural and/or linguistic commonalities, perhaps even age• Mixed use buildings to be able to create business/ revenue streams. For example, main floors housing retail outlets (groceries/ pharmacy), public library, internet café, banquet hall(s), day/ childcare centre, chapel (multi-denominational) for visiting clergy.• Building/ complex served by a professional with corporate/ community resources, to offer or be available with information, linkages to resident-owners, e.g. with a customer Relationship Management model. The cost for this could be a small part of the housing cost/fee.
3. Who are the key stakeholders that need to be involved in implementing this solution?
LHIN Builders and developers Cultural/ Ethnic Associations Religious institutions/ clergy Schools to communicate through children/ students
4. What resources, if any, are needed for this solution to be implemented successfully?
N/A

1. Which barrier to equity or opportunity to reduce inequity does this solution address?
Housing: lack of subsidized & supportive
2. Describe one change or strategy that could be implemented at the individual, organizational or community-level to address the barrier/opportunity noted above:
Funds for needs already identified in street health report - evidence of successful outcomes for

people who are housed - present to politicians who allocate funding who can provide the necessary funds! We need people to advocate and we need people with a strong voice.

3. Who are the key stakeholders that need to be involved in implementing this solution?

Perhaps physicians who have a respected voice in the community can research and present data to municipal/ provincial decision-makers.

4. What resources, if any, are needed for this solution to be implemented successfully?

- Will
- Time
- Money

1. Which barrier to equity or opportunity to reduce inequity does this solution address?

Housing: funding for municipal, provincial and federal government: must be sustainable & accessible

2. Describe one change or strategy that could be implemented at the individual, organizational or community-level to address the barrier/opportunity noted above:

Community focus groups or forums? Take down stigma & barriers:

- Doctors, health care providers, support workers coming together and directly lobbying councillors/ MPs about the inequity within the relevance of lack of adequate housing & health
- Poverty: have low income, working poor and homeless people meet with housed people within their communities to voice common issues, value and needs and take the identified strategies to councillors, MP's etc.

3. Who are the key stakeholders that need to be involved in implementing this solution?

Community members
Doctors
HC providers
SW
Addiction workers: councillors
MPs

4. What resources, if any, are needed for this solution to be implemented successfully?

- Facilitate community level focus groups/ forums

- Commitment
- Funding
- Support resources

**Healthy Connections 2008
Healthy Equity: From Challenges to Solutions**

Solution Sheets with Multiple Barriers

1. Which barrier to equity or opportunity to reduce inequity does this solution address?

- a. Lack of access to primary care
- b. Social support & Isolation
- c. Affordable housing with appropriate supports

2. Describe one change or strategy that could be implemented at the individual, organizational or community-level to address the barrier/opportunity noted above:

Model of integrated service delivery (mostly in place already):

- Client : hospital
- Rehab, CCAC, PT, OT, RN, pharmacy, dietician, and CHC community health centre
- Emergency, and/or community support agency, supportive housing cluster care/ homemaking
- Wellness programs: social, recreational, and health promotion
- Transportation
- Social work/ care management
- Friendly visiting
- Every senior and/or mental health specific
- Subsidized buildings

Supportive housing on site:

Houses with seniors (localized areas) have a cluster care supportive housing model. This is provided by existing community agencies – already occurring.

These existing community agencies will have set boundaries and provide all of the same services. (Now there is a bit of variety in the services provided and lately it is becoming a free for all. Service providers no longer know where to refer for clients as it is no longer clearly defined.). Each community agency is connected with a community health service. Thus no gaps in service!

The LHIN and MDH determine with the hospitals, community agencies in the area, CNNV CCAC in

which area are more physicians needed, professionals speaking this or that language.
 The skeleton of this system is currently in place – strengthen and define it – very cost effective!

3. Who are the key stakeholders that need to be involved in implementing this solution?

MOHLTC / LHIN – definition of boundaries/ services
 Community agencies – e.g. CCEX, Sprint, SSS, Neighbourhood Link
 CCAC
 CHC (community health centres) and family physicians

4. What resources, if any, are needed for this solution to be implemented successfully?

- Co-ordination and definition of existing services
- Funding of supportive housing model and cluster care (nurse practitioner, PSW & RN); the reduced hospital visits will provide the dollars for the supportive housing costs

1. Which barrier to equity or opportunity to reduce inequity does this solution address?

- a. Adequate housing – affordable housing
- b. Lack of access to primary care
- c. Social isolation

2. Describe one change or strategy that could be implemented at the individual, organizational or community-level to address the barrier/opportunity noted above:

- c. Social isolation:
 - Organized } – emotional and cognitive/ physical assessment
 - Organizational: discharge planning – explore actual/ potential gaps
 - Organizational: establish connections with community services
- b. Lack of access to primary care:
 - More healthcare professionals accessible without first accessing a family physician
 - Provide services to individuals and schools, community centres

3. Who are the key stakeholders that need to be involved in implementing this solution?

N/A

4. What resources, if any, are needed for this solution to be implemented successfully?

N/A

1. Which barrier to equity or opportunity to reduce inequity does this solution address?

- a. Adequate and appropriate housing
- b. Social Isolation/ Limited social supports
- c. Lack of access to primary care

2. Describe one change or strategy that could be implemented at the individual, organizational or community-level to address the barrier/opportunity noted above:

- a. Rent controls:
 - Increase number in apartment buildings on ODSP
 - Increase co-ops
- b. Recreational therapy – (individualized):
 - Supportive housing –workers
 - Communication between services
- c. Health Ombudsman:
 - Get rid of soliciting
 - House doctors – (making house calls)

3. Who are the key stakeholders that need to be involved in implementing this solution?

N/A

4. What resources, if any, are needed for this solution to be implemented successfully?

N/A

1. Which barrier to equity or opportunity to reduce inequity does this solution address?

- a. Navigation
- b. Foreign trained physicians

c. Language barriers

2. Describe one change or strategy that could be implemented at the individual, organizational or community-level to address the barrier/opportunity noted above:

- a. Cultural health care providers to be used in innovative projects to improve outcomes via mechanisms that suit that neighbourhood or cultural community
 - Avoidance of emergency admission: is largely an issue of lack of family doctor
- b. Family health teams are good not having much impact
- c. Not having to renew referrals to specialist if 1 year has lapsed
- d. Do family doctors need to do referrals to specialists? To free up capacity evaluate whether some patients are being seen by specialists on an annual basis just to “maintain being a patient”.
- e. What about helping people to get to the system
- f. Help them to navigate to the resources health care service / resource brokers
- g. Why? (recent immigrants who have decrease in health) stress, lack of finances, lack of knowledge of resources
- h. Need to free up capacity to be able to increase access to those trying to get access
- i. Cultural settlement centres, neighbourhood community centres are visible evidence of health communities reaching out to these groups
- j. LIPs: local immigration partnerships
- k. CHC – fostered salaried doctors is a good model
 - l. They look at big picture. Who is not being treated?
- m. Citizenship committee
- n. South East Asian – Alzheimer chapters trying to expand these

3. Who are the key stakeholders that need to be involved in implementing this solution?

Community agencies
People living in the community
Business
Religious leaders
Cultural community

4. What resources, if any, are needed for this solution to be implemented successfully?

N/A

1. Which barrier to equity or opportunity to reduce inequity does this solution address?

Barriers: centralized, not holistic/ focused on medical model, not community based, not harm reduction, not recovery, not health promotion focused, not preventative-curative focused, structure of organizations.

Opportunity – opposite of above

- Client centred/ client feedback

2. Describe one change or strategy that could be implemented at the individual, organizational or community-level to address the barrier/opportunity noted above:

Create/ Development of policies:

- Client focused; social determinants of health
- Anti-oppression (client service and hiring) approach
- Cultural competence; harm reduction
- Accountability mechanisms; service deliveries
- Quality assurance
- Finding structures; accreditation process tied to outcomes (define outcomes)
- Adequate pay scales in small/ grassroots organizations
- “Qualified” people to run organizations
- Shift in accountability, coming away from only service units: look at quality and not just quantity

3. Who are the key stakeholders that need to be involved in implementing this solution?

Communities and boards of organizations

Hospitals

Service users

Funders

4. What resources, if any, are needed for this solution to be implemented successfully?

a. Funding for consultants/ staff training – ongoing:

- Organizational development

b. Increase and improve services

Results of Healthy Connection 2008 Conference Online Evaluations

Healthy Connections 2008 – Health Equity: From Challenges to Solutions

June 5, 2008

Ryerson University, Toronto, Ontario

Number of participants: 350 (morning session) and 200 (afternoon session)

Number of online evaluations received: 51 in total, 43 responses from the afternoon session

Question #1: What was the most valuable aspect of the Healthy Connections conference?

Most Common Answers:

- Keynote speaker and panel presentations
- Networking
- The morning session

All comments received (verbatim):

- Keynote, Panel presentations, small group discussions in the afternoon; green approach.
- Moving from a global to a very local and focused perspective with many opportunities to forge relationships and possible partnerships.
- The panel speakers.
- Diversity of the context in which health equity was discussed for a one-day program. And that no unnecessary papers were shared. Green Conference!
- Linking across sectors - hospital, LHIN and CSS in both my community and within the LHIN.
- The morning speakers were informative with diverse and different issues raised.
- Networking.
- Dr. James Orbinski was the highlight, as he spoke in effectively practical and yet inspirational ways to better practice health care.
- Keynote and last two speakers were fantastic.
- The international connections with James Orbinski and Anthony Culyer, both providing a context for the local/regional issues.
- Being able to hear all the excellent speakers discuss issues related to health inequity from different perspectives, but somehow touching on the same themes.
- Information regarding inequity that still exists.
- Networking and the first 2 speakers - very informative.
- Learning about key health equity issues in a variety of different sectors.
- The most valuable would be the afternoon break up sessions where everyone was involved in the finding resolutions. Dr. Orbinski's speech was extremely empowering, it reflected leadership in terms of making a difference in the world on different levels.
- Dr. James Orbinski was a wonderful speaker. It was amazing to hear his wisdom.
- Address Equity from top (conceptual framework) to field application.
- Meeting with service providers in my area and being able to compare challenges and how we could work to address them. Dialogue. Very practical, relevant. Having people from the LHIN's as participant, indicating what they need was good.
- Working with diverse group of stakeholders on solutions.
- Sharing of ideas, Ideas - philosophical ideas from the presenters.
- Listening to the speakers in the morning, very interesting and thought provoking.
- Participation.
- Strategies and barriers session.
- Morning session was extremely informative and diverse; liked the fact that speakers addressed issues from global to local.

- The morning session was outstanding and inspiring. Promoting advocacy, dialogue and grounding "healthy connections" in the socio-political realities.
- James Orbinski's speech. It was wonderful. His story was motivational and very pertinent.
- Hearing to what all the speakers had to say.
- The panel discussion because it expanded equity to refer to both equity in care as well as equity across providers. It would have been beneficial for there to have been more time for discussion.
- The guest speakers with their international experience.
- Speakers - all excellent, relevant.
- The hypothesis made by each presenter.
- Different perspectives presented from different aspects within the system.

Question #2: What was least valuable?

Most Common Answer:

- Little time for panel discussion
- Hard to find parking
- Not enough time in general to devote to such a broad issue

All comments received (verbatim):

- Slideshow was not readily accessible, I never saw it.
- The 2nd speaker was hard to follow. Time was a little constrained too with all the panel speakers.
- Won't say least valuable, but not as effective as it could have been--the afternoon session, needed to be prepared with more thought provoking questions to consider before hand. Unless the objective of the exercise was to brainstorm.
- Nothing particularly concerning.
- The summary wrap-up at the end of the day was far too long, unnecessarily reiterated too much of the day's proceedings, and went overtime. It appeared that the speaker was more interested in making his own comments than in pulling the day's work into a summary and providing a context for any follow-up.
- Nothing I can think of.
- We should have two days 1 day for speeches other day for responses.
- The small groups were very unproductive. There was not enough structure to focus the questions/answers being sought. Also, some of the persons there did not appear to have a lot of group work experience.
- All good.
- It was all very good, just in different ways.
- Everything was valuable.
- All was valuable, although Anthony Culyer was a little difficult to follow.
- The small work groups and the last morning presenter (entertaining but....).
- Each of the presenters were good - it was a well-rounded panel.
- Panel discussion - there was not enough time for questions to be asked and appropriately answered. Perhaps leaving some more time and/or having some questions prepared ahead of time would help facilitate this format of discussion.
- The scope was very general. As a Masters Student in the field, I believe it would have been beneficial to hear more specific stories (possibly at an additional conference).
- It was all well done!
- Afternoon sessions I found a bit simplistic. What good is talking about homelessness when other key players are not even present e.g. Ministry of Housing etc.
- PM session - insufficient time to discuss but reminded over and over again to work out a plan/strategy.
- The TC LHIN 7 neighbourhood detail was not specific enough to support the discussion.
- The panel was good, but it did not feel as if they presentations fit in with next steps.
- I didn't find the afternoon too useful but I was happy to give it a try.

- The wrap up at the end. Would have been more useful if it were sent to us afterwards. Made for too long an afternoon.
- We really didn't get a definition of equity, so people went away with the notion of equity that they came with.
- The final wrap up was too long and went overtime. I found it way too difficult to find the correct room for the lunch.
- No vehicle to act on our ideas.
- No handouts of any presentation were available.
- The afternoon session - networked with (wonderful) professionals but not the community within which I work. Would have liked to dialogue more and learn about how

- and with whom to connect for the purposes of advocacy, research etc.
- Round table discussions. I have heard the same good points for over 20 years. We are preaching to the converted. People the have the power to implement change need to be at the table.
- I enjoyed all of it.
- Afternoon exercise. It was too broad, too vague, and felt like "here we go again, let's talk about the situation again" but without ever defining a common language around equity. Or, to group people based first on barriers rather than neighbourhood so people from across the GTA could meet to discuss strategies around a topic of interest.

Question #3: How can we improve?

Most Common Answer:

- Keep on doing what you are doing
- More detailed information
- More time

All comments received (verbatim):

- Because of the separate buildings and rooms, there were fewer opportunities for networking.
- Less panel speakers.
- Have a list of critical questions to think about before the workshop. Would guide the audience in the direction of topic discussion.
- Do this annually.
- One important issue is that of access. Although every effort was made to accommodate my own hearing problem, if there is an interest in ensuring a broad cross-section of involvement and therefore a more comprehensive picture of the reality of the community and a fuller involvement of the community in any follow-up, there needs to be a more systematic consideration of, and the institution of strategies to overcome, the barriers for those with access concerns.
- Nothing I can think of.
- Sharing the schedule and subject of the presentations before the conference.
- To schedule two days for next time.
- More structured small-facilitated groups - perhaps group the knowledge skills for the

- small groups -Be clearer about the outcomes/answers that you are seeking.
- Nametags should include organization and role if at all possible. It was hard to know who was who.
- 1/2 day only.
- Have a clearer agenda of topics and events listed.
- Better directions, including to parking lots.
- If the morning presenters could have used their depth of experience to give advice to the LHIN rather than simply discussing the issues. This expert advice would have helped more precisely focus the workshop sessions in the afternoon.
- Have these Conferences on a regular basis.
- Providing a venue that allows the conference to remain in one facility. Although it was nice to walk outside a bit, it would have been less so if the weather had been inclement. Also less confusing.
- Great job!
- More similar conferences.
- More of the morning...

- Make the afternoon classes available to all who have registered for the morning classes.
- I was concerned that with so many attendees, there would be difficulty in maintaining the schedule - this wasn't the case.
- I think speakers should focus more on potential solutions. Although it is important to raise awareness of the issues, there should be more discussion on some potential solutions and how people can work together across different sectors (rather than just "blaming the system").
- Skip the break-out sessions.
- By mixing up people in the afternoon sessions.
- No comments.
- Cast a wider net, get more awareness out there, and involve other members of the community to get their ideas - e.g. activists from groups experiencing inequities.
- It was great. Try to get more senior decision makers at the breakout session in the afternoon.
- Keep the schedule.
- Allocate more time for each speaker as well as more time for questions.
- More detailed information about initiatives in the works now, the challenges they face and steps to address these. Again, making problems solvable.
- More pro-active facilitation. Our group voted not to have a facilitator and I think it led us to be a bit directionless.
- More time working on solutions less time identifying the problems.
- Time for break out groups should be shorter --1 1/2 is probably good enough.
- I think that it was excellent. Perhaps only a half-day followed by lunch would have sufficed.
- Make the afternoon discussions shorter, provide clear direction regarding the use of feedback generated in the small groups, have a reference person available to the group to give them background about the issues so the sessions do not end up being "just brainstorming". Lastly, I would have liked to know how the feedback will be used and to which extent so it does not feel like another "venting" session.
- Take the action step.
- Bring more decision makers to the table to exchange views.
- Liked very much the keynote speaker start and slowly through morning moving from global to local... great idea! Would suggest that some of the key ideas were mapped out and specific plans were detailed in collaboration to make them happen.
- With such good speakers, increase the time allocated for panel discussion and asking questions.
- It was great. Well done!
- Provide handouts of every presentation to audience to avoid 'head down writing' phenomena.
- Recommend organizations, councils, committees to join.
- More speakers who are actually making changes. It gives hope.
- I wonder if it would be helpful to be more specific about what the LHIN/system could do/would support before facilitating a broad discussion re: collaborative initiatives. Also, organizing discussion groups by neighbourhood/geography doesn't work for those that have a target population served both provincially and across the LHIN - maybe this could also be considered in future.
- Afternoon session was a little long. It's hard to put a lot of energy into partnership without knowing about follow up plans.
- The snacks were not healthy. Less sugar more nutrition.
- Offer range of workshops to select from in the afternoon that provide practical skills training - e.g., how to use neighbourhood data to build a case/program.
- 1. Other use of the afternoon sessions 2. Figure out how agencies can give meaningful input to LHINs.

Question #4: Rate your satisfaction with the conference:

Excellent – 38%

Very Good – 38%

Good – 18%

Fair – 6%

Poor – 0%

Question #5: What other topics or areas of interest would you like to see as the focus for future events?

Topics recommended:

- Aboriginal engagement.
- This was my first conference. Horizontal and Vertical Interventional strategies to integrate acute care hospital delivery with community care.
- Politics of Health, a provincial or federal issue. Business (free market) and Health and Medicine in our Universities.
- Focus on available resource that we have and funding.
- More on health equity; Think tank/brainstorm about specific community health challenges; planning opportunities for community approaches to specific issues.
- Additional sponsored sessions to assist partnership development, sharing of resources, leveraging of resources and ideas.
- Homelessness Addictions.
- Global health issue and its impact on local health issues.
- How to bridge the gap of poverty and health.
- Community Agencies Cutting Hospital Costs (and vice versa): The Theory and Practice of the economics of Integration. Training the impoverished and challenged to manage their own health care. (Reducing interaction with professionals, increasing interaction with health coaches within the context of peers, personal support staff and mutual help communities. Can we change supportive housing into mutually supportive communities?
- More discussions on Racism from a Black Woman's Perspective.
- Updates on LHIN priorities, projects, activities.
- Determinants of health care for non-insured.
- Encountering: Recognizing the differences in client needs.
- Taking "next steps" with speakers such as Dr.Orbinski and Anthony Culyer and Dr.Hwang.
- Equity across LHINs. Access to CT and MRI, etc.
- Eliminating the stigma attached to community healthcare.
- Health and poverty. Stress and .mental health in the workplace
- How to educate and over come racial profiling.
- Info on what other countries are doing. There is research going on in? Oregon vis a vis the homeless, could we get speakers or ideas from what is happening there?
- Integration: challenges and success.
- Primarily care showcase of positive progress.
- More active solutions and learning.
- Canadian healthcare and the visible minority woman.
- HOW to move to caring for chronic issues instead of acute. How to bridge the cultural bridge between hospital and community.
- Same program specific to seniors.

- Are there measures of equity?
- 1. Patient Empowerment/ Empowering People - how to really change our provider-centered health care system - 2. Revolutionizing our Patient Education systems and approaches to care to be person centered - What does this mean? What does it look like? 3. Inclusion and Belonging.
- Newcomer's health.
- Concrete ideas on how to work together and move ideas forward.
- Common threads in service delivery and future directions for decision makers.
- Connections of equity and gender.
- Access to health care. Wait times.
- How we can foster dialogue with other clinics and health centres in the developing world.
- Presenters who could give operational examples of how to address 'equity' in the real world of service delivery.
- Follow up a year later to see what has been implemented.
- How to improve hospital based in/out patient. Mental Health care even with the reality of fiscal restraints.
- Other aspects of equity & community health - how to serve/partner with specific communities: women, seniors, lgbt, disabilities, etc. The role of advocacy for health agencies around oral health, SRS, psychology, etc.
- Housing.
- Discrimination in health care practice - health inequities across disease classifications (e.g., lack of focus on mental illness or addictions vs. chronic disease).
- Substance use and mental health.

Question #6: Please rate the following regarding the afternoon working session:

General Format

Excellent - 18.6%
 Very Good – 27.9%
Good – 32.6%
 Fair – 14%
 Poor – 7%

Facilitator

Excellent – 18.6%
Very Good – 34.9%
 Good – 32.6%
 Fair 11.6%
 Poor 2.3%

Quality of Information

Excellent – 20.9%
 Very Good – 23.3%
Good – 30.2%
 Fair – 23.3%
 Poor – 2.3%

Venue

Excellent – 16.3%
Very Good – 37.2%
 Good – 32.6%
 Fair – 11.6 %
 Poor – 2.3%

Question #7: Do you feel that the afternoon workshop objective was met (i.e. to name and create concrete solutions for the health inequity challenges that resonate most for your community)?

Yes – 51.2%
 No – 48.8%

Question #7a: If not, why?

Additional comments received (verbatim):

- In the fact that it was a conscious raising brain storming exercise. I won't say, they are definite solutions instead areas for further research.
- Lack of time, the immensity and complexity of the problems, and the dominance of the agency staff.
- I think the questions were not put correctly but the major problem was the approach inherent to the present system. LHINs should follow policies and general program directives already set at the higher levels of governance and then evaluated on their performance on translating these into local action plans adapted to their specific situation, strengths and weaknesses not trying to define what is health equity and how it can be measured and addressed.
- People were not listening to each other, but rather that they had a specific point of view from which they were functioning -The room itself was not conducive to several small group discussions going on at the same time (too small) The objective was not clearly articulated so how could the outcome be achieved? A better facilitator was needed.
- Solutions take time. We had many ideas.
- Overwhelming to create solutions - impossible task for one afternoon. Identifying challenges is easy but creating solutions is too broad a goal for 2 hours.
- It was more difficult than I expected to actually get concrete proposals. My group finally got one based on the Hospital being a logistical support hub (research, information packages, meeting space, admin consulting, etc) in order to free community agencies to focus on inequity and health navigational issues.
- There was too much of the same complaining/issues.
- Ridiculous. Too many people with their own agendas and no understanding of the process of change.
- Naming the issues wasn't the problem it was finding realistic solutions with key players at the table.
- Too pushy to create a plan/strategy.
- If information not specific enough need to be more specific than 7 TC LHIN neighbourhoods needed more decision makers at the table.
- I think the primary issues facing my community were voiced but we didn't do too well with solutions.
- I'm not sure we learned anything new.
- We named solutions very well and I liked the consensus/voting, discussion, etc. However, it was challenging to really get to a solution when we tried to get into more detailed solution development with knowledge/resources at hand.
- Because there was no transparency around the use of the generated information. Also, it was not clear how serious the input/ suggestions would be taken.
- Too many participants and ideas that felt at time unfocused, not sure @ feasibility of some of the ideas, would have liked for more concrete resolutions that we could all continue to move on forward.
- We discussed ideas (many of which were not new) but not sure whether they were going to be realized. I would like to realize actions, not only talk about them.
- The concrete solutions have been around for years. Nothing new was said. What we need is implementation!!!
- Not sure yet - I will wait to see summary report and actions falling out of that. I think the questions should have been for specific, hard to focus on something feasible, breaking groups out by neighbourhood didn't work for my agency and didn't seem consistent with how I have understood the LHIN objectives, i.e. broad integration vs. pockets of integration.
- You can't solve this in 2 hours. It also wasn't always the "right" people sitting around the table to effectively bring forward these solutions. E.g., primary care but had no CHC reps sitting around the table. Was interest-based discussion.
- Too little time, too little meaningful structure, difficult to arrive at group consensus in limited time, don't feel info will be useful to LHIN.