

CENTRAL LOCAL HEALTH INTEGRATION NETWORK FRAMEWORK AND TEMPLATE FOR HOSPITAL HEALTH EQUITY PLANS

This document has three sections and an appendix:

- 1. The reason why Central LHIN is asking hospitals to develop health equity plans**

- 2. The framework for hospital health equity plans**
 - 2.1 Health equity as a shared responsibility
 - 2.2 A description of a cyclical approach to achieve health equity
 - 2.3 A statement of the foundation and pillars for hospital health equity plans
 - 2.4 A statement of how Central LHIN will use these health equity plans

- 3. The template for hospital health equity plan environmental scans**
 - 3.1 Guidelines for completing the template
 - 3.2 Central LHIN contact for more information on the framework and template
 - 3.3 The template

Appendix A. Definitions of Terms used in the Framework and Template for Hospital Health Equity Plans (Environmental Scan)

1. Why is Central LHIN asking hospitals to develop health equity plans?

Central LHIN is one of 14 local health integration networks established by the Government of Ontario to plan, co-ordinate, integrate and fund health care services to meet local health needs. Among the 14 LHINs, Central LHIN has the largest and fastest growing population. With growing socio-economic disparities and the largest number of recent immigrant, non-English speaking and racialized group populations, Central LHIN has enormous responsibilities and opportunities for creating an equitable local health system that contributes to reducing health disparities.

Central LHIN is responsible for allocating a 1.5 billion dollar budget in efficient, effective and equitable ways to health service providers within its mandate in order to improve health outcomes for all and to reduce health inequalities among regions and population groups in North York, York Region and South Simcoe. Health service providers within the LHIN mandate include a community care access centre, community health centres, community support services, hospitals, long-term care homes and mental health and addiction services

Significant avoidable illness, injury, deaths and related health care costs threaten system sustainability and indicate opportunities for improvements in access to services, service quality, performance and fairness in the distribution of health care resources. Health equity is about reducing the disparities (differences) in health status among our population groups as much as possible. Health equity creates equal opportunities for health and gives attention to people with the greatest health needs and least resources. Health equity strategies reduce differences in health status among population groups by: creating equal opportunities for health; giving attention to people with the greatest health needs and least resources; and, by creating a fairer health system. A fairer health system provides equitable access to services based on need, equitable utilization based on need, equitable distribution of resources and equally good quality of care for all.

Central LHIN expects the providers it funds to be accountable for ensuring that:

- Barriers to access to care are identified and removed
- Equally good quality services are provided to all
- Equity is integrated across the continuum of care and support.

Development and implementation of strategies such as these will result in improved services for marginalized populations and others facing barriers to access to services and contribute to reducing health disparities.

2. The Framework for Hospital Health Equity Plans

This framework has four components:

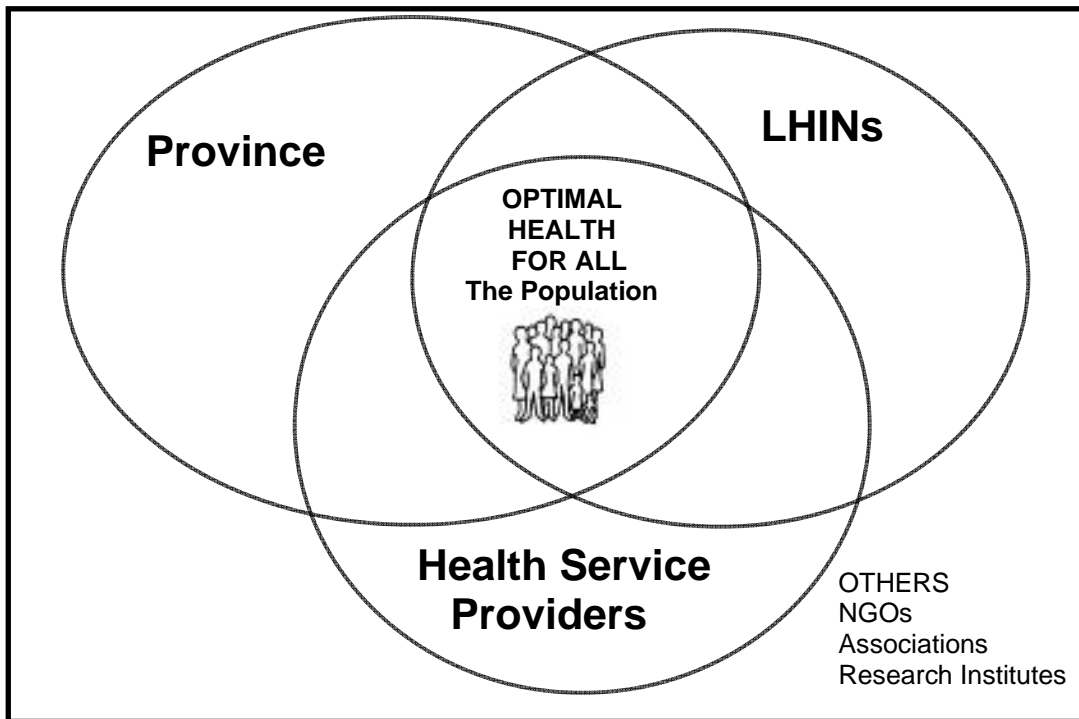
1. A statement of health equity as a shared responsibility
2. A description of a cyclical approach to achieve health equity
3. A statement of the foundation and pillars for hospital health equity plans
4. A statement of how Central LHIN will use hospital health equity plan environmental scans (current phase of the health equity cycle).

Each component is described below.

2.1 Health Equity as a Shared Responsibility

Central LHIN is developing a health equity framework as a foundation for its planning, decision making and funding responsibilities. The framework recognizes that social, economic and health care policies and practices influence health disparities and that **accountability for achieving health equity is a shared responsibility involving health service providers, the LHIN, the Province of Ontario, the population and others.** Examples of roles and responsibilities are provided in the table below.

Figure 1: Accountability for Health Equity is a Shared Responsibility



Health Equity is a Shared Responsibility				
Government of Ontario	Local Health Integration Networks (LHINs)	Health Service Providers	The Population	Others
Stewardship: Strategic leadership Legislation/ regulations/ policy Funding Provincial priorities Provincial health assessment Knowledge transfer	Health system manager: Community engagement Planning (local priorities and health assessment) Service integration Funding Performance management Knowledge transfer	Community Engagement Identify and reduce barriers to access Deliver equitable, culturally appropriate, equally good quality of care to all Accountability and performance management Knowledge transfer	Maintain health as best able Seek health information Use health services appropriately Shape health services by giving input, participating in care, etc.	Roles of NGOs, associations, research institutes, other stakeholders that contribute to health equity

2.2 A Cyclical Approach to Achieving Health Equity

Achieving health equity can be seen as a continuous planning, action and monitoring cycle that expands in scope, participation and in the outcomes achieved over time. The hospital health equity plan environmental scan is one of the early steps in this health equity cycle. All public hospitals are required to complete the hospital health equity environmental scan in accordance with Schedule B of the 2008/2010 Hospital Service Accountability Agreements. Other health service providers will be required to do so in future cycles.

As a result of the cyclical approach, equity will become increasingly embedded in leadership, governance, community engagement, operations, policies, programs and services, and performance monitoring and reporting.

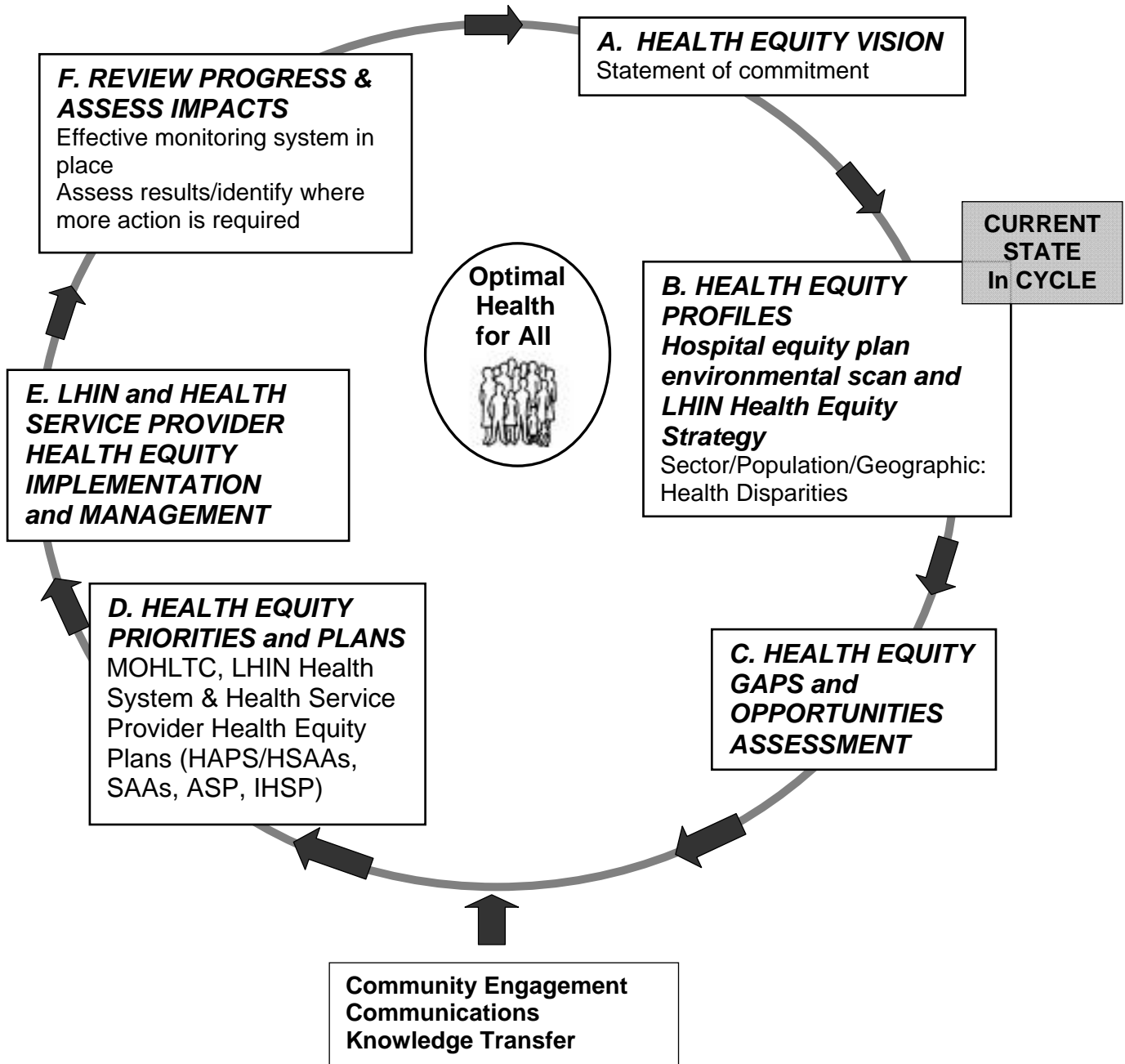
As per Figure 2, Central LHIN is in Phase B in the Health Equity process. The development of hospital health equity environmental scans submitted by March 31, 2009 will be aggregated by the LHIN to create a baseline of hospital readiness and status related to:

1. Integrating equity into hospital planning
2. Identifying priority populations or equity service areas
3. Developing and implementing health equity strategies
4. Establishing policies, procedures and standards to support health equity.

This information will assist in the assessment of health equity gaps and opportunities (Phase C).

The LHIN is currently developing additional health equity tools and guidelines and an inventory of promising practices. These resources along with ongoing collaboration on health equity (through the LHIN and through direct inter-hospital collaboration for instance) will assist in developing a coordinated approach to detailed health equity plans in the months ahead (Phase D).

Figure 2: Continuous Cycle/Process for Achieving Health Equity

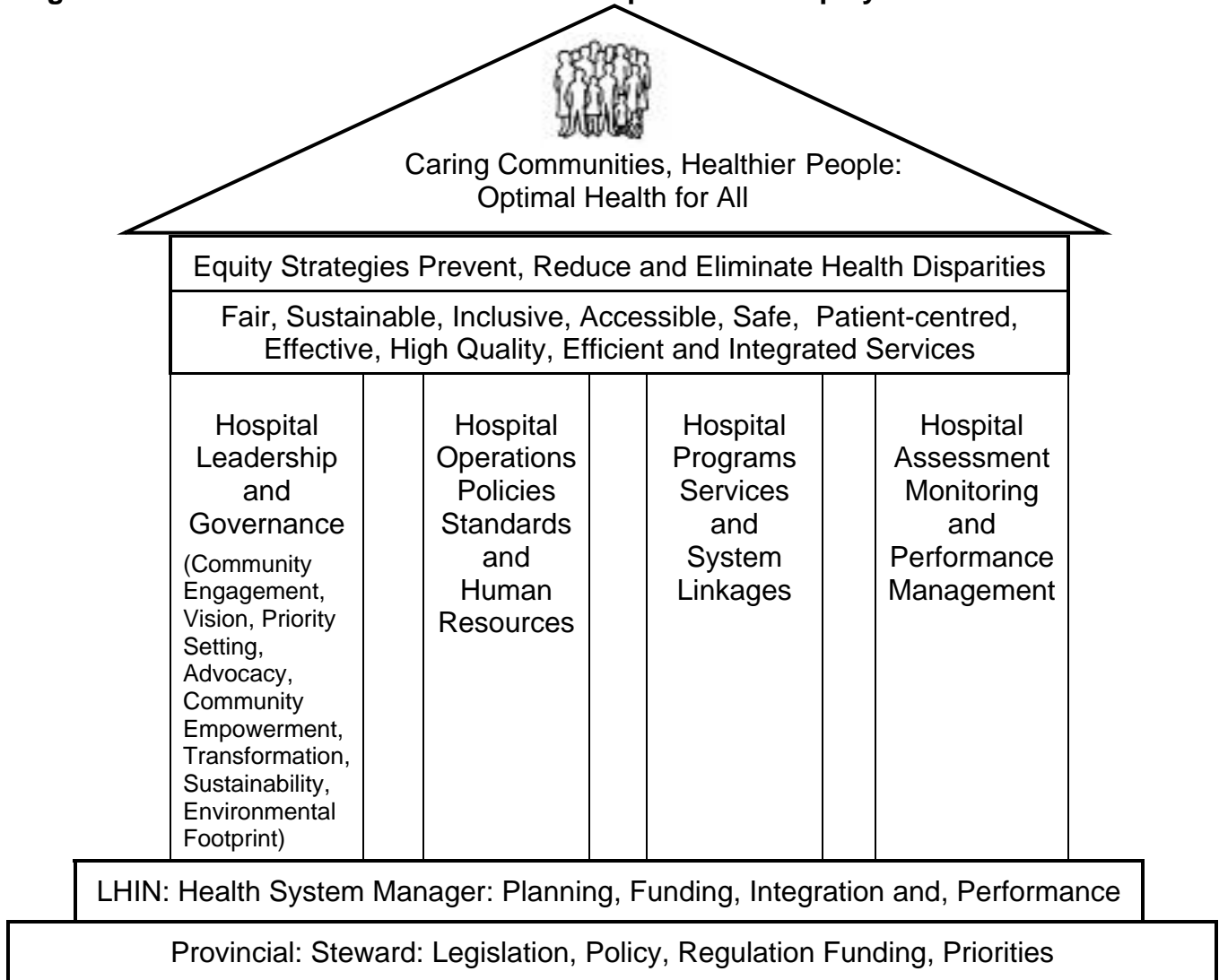


2.3 The Foundation and Pillars for Hospital Health Equity Plans

As Figure 3 shows, hospital health equity activities (clustered into four “pillars” in Figure 3) build on the foundations of provincial and LHIN health equity activities. These four hospital activity pillars in turn produce and support health equity improvements that contribute to optimal health outcomes for all.

- Hospital health equity planning should focus on strengthening these four pillars.
- This year’s health equity planning process should focus on providing the information needed to strengthen the pillars in subsequent planning cycles.

Figure 3: The Foundation and Pillars for Hospital Health Equity Plans



The pillars for effective health equity strategies have been identified from promising practices and experience world-wide, and from local advice, guidance and expertise.

This attached template for the hospital health equity plan environmental scan collects baseline information within these pillars. The template is adapted from a tool being used in Toronto Central LHIN which was developed by the Hospitals Collaborative on Marginalized Populations to create hospital health equity plans.

In accordance with the 2008-10 HSA, hospitals in Central LHIN are being asked to submit their completed hospital health equity plan environmental scans to Central LHIN by March 31, 2009, based on this template. Central LHIN will also be requesting health equity plans from community sector providers in the future.

2.4 How will Central LHIN use these health equity plan environmental scans?

Health equity planning will occur in a series of cycles. The first cycle of hospital plans will be an environmental scan that provides an understanding of current priorities at individual hospitals and uncover themes and common activities across the hospital sector. The scans will provide important data to aid the LHIN in its role as health system manager and to help hospitals as they work with each other, with community service providers and with other service sectors to improve health equity. For example, the plans will provide a basis for:

- Identifying health equity priorities, promising practices and potential areas for collaboration that could be promoted across the LHIN and among LHINs; particularly GTA partners with whom the LHIN shares boundaries and patients/clients
- Developing equity indicators and actions that can be included in Health Service Accountability Agreements
- Informing community health service providers' health equity plans
- Identifying LHIN-wide data support and analysis needs and opportunities and influence the development of province-wide data collection, analysis and dissemination tools
- Providing input into the refresh of the LHIN's new Integrated Health Service Plan (IHSP 2010-12)
- Influencing and informing provincial strategies such as funding models (e.g. Health Population Based Allocation Model), research funding, e-Health Ontario initiatives, decision-making tools and strategic priorities, to ensure that these support health equity objectives.

The information from the templates will be aggregated and used to prepare a summary of results that will form part of a current state "Health Equity Profile" that will be publicly available in the interests of openness and transparency to the community.

3. Hospital Health Equity Plan Environmental Scan Template

3.1 Guidelines for Completing the Environmental Scan

- The deadline for submitting the completed template to the LHIN is Tuesday March 31, 2009
- Please submit a hard copy with signatures to the LHIN to the attention of: Kim Baker
- An electronic version of the template can be completed on-line (will be available in March)
- The recommended length of the completed template should not exceed 20 pages (excluding any attached relevant examples)
- The data collected by the scan will be aggregated and the answers provided by individual hospitals will not be identified in any reports made publicly available.

3.2 Central LHIN Contact for More Information on the Framework and Template

If you have any questions about this process that your Health Equity Collaborative Task Group member is not able to address, please contact: Sandi Pelly sandi.pelly@lhins.on.ca or (905) 948-1872 ext 212

3.3. The Template for the Hospital Health Equity Plans (Environmental Scans) follows.

CENTRAL LOCAL HEALTH INTEGRATION NETWORK TEMPLATE FOR HOSPITAL HEALTH EQUITY PLANS (Environmental Scan)

Each of the questions in the template is categorized according to the component in the **Foundation and Pillars for Hospital Health Equity Plans** (Figure 3) to which it belongs: i.e., Leadership and Governance; Operations; Programs and Services; and, Monitoring and Performance Management. Options and examples are provided. If you provide attachments, please note the attachment number in the response box.

Section 1. Leadership and Governance

1a) Vision and Commitment to Health Equity: Please check any of the following that your hospital has produced. If you do not have any of the following, please detail any plans to develop them.

- Health equity vision
- Explicit reference to health equity in your hospital's corporate vision
- Most recent strategic plan addresses issues of health equity, diversity and inclusion
- Related policies (e.g., policies related to anti-oppression, anti-harassment, anti-racism, human rights, accommodation, accessibility). (Please list those available)
- Code of conduct: staff, physicians, patients, visitors/family, volunteers, contractors
- Code of Ethics
- Patient Charter, Bill of Rights
- Other (Please describe)

Please attach a copy of each of the items (or relevant section) checked above.

1b) Communications: Please briefly outline how the hospital shares each of the above (e.g., through orientation, in-service, performance reviews, performance contracts, posting in public view), and how you measure the effectiveness of this communication with the following:

Staff: _____

Physicians/physician leadership tables: _____

Board of Directors: _____

Other health and social service partners: _____

Leadership/management tables: _____

Patients, family, visitors, volunteers, students and community: _____

Other: _____

1c) Priority Populations: What, if any, specific population groups has your hospital identified as priorities for programs and services?

- Seniors
- New immigrants (please list the countries or regions of origin)
- Specific ethno-cultural groups (please list)
- People who are homeless
- People with mental illness
- People who are lesbian/bisexual/gay/queer/transgendered
- People with a disability (please list specific disabilities)
- Rural population
- Youth
- Others (Please list)

If yes, how were these identified? e.g., census, utilization analysis, patient surveys, focus groups, needs assessment, hospital program data, Central LHIN Service Needs Analysis and Gap Assessment, York Region or Toronto neighbourhood profiles.

1d) Social conditions (social determinants of health): What social conditions that influence health and barriers to access to care have you identified as priorities to be addressed through programs and services?

- Poverty and income barriers
- Transportation barriers
- Discrimination/racism
- Low education/low literacy
- Social isolation/lack of social support
- Others (Please list)

If yes, how did you identify these? (e.g., Canada Census analysis, community needs assessment, Central LHIN Service Needs Analysis and Gap Assessment, York Region planning data, other)

1e) Health Equity Priorities: Please outline your hospital's health equity priority areas. Please outline and explain:

- 1) The community engagement process your hospital used and who was engaged*
- 2) Those involved, including champions and leaders
- 3) Reasons for selecting these priority areas: e.g., research and analysis, legislated requirements (e.g., French Language Services Act, Ontarians with Disabilities Act), Accreditation Canada requirements, MOHLTC priorities (e.g., wait times), Central LHIN local priorities.

Examples of health equity priorities could include:

- Reducing barriers to access due to language
- Reducing barriers to access to and literacy
- Consistent response to serving people without OHIP
- Understanding and accommodating patient faith, cultural needs
- Reducing differential treatment (different quality of care) received by low income, homeless or racialized groups
- Geographic barriers to serving and engaging communities
- Providing ethno-racially appropriate services for diabetes care management
- Others (Please describe)

*** Please connect with your hospital's representative on the Central LHIN Community Engagement Collaborative Task Group in order to complete this question.**

1f) Unmet need/Underserved Population: Has your hospital engaged in a review of your hospital in-patient and out-patient populations and compared them to the profile of the people who live in your catchment area?

- Yes (Please describe. Was it for all clients, by age groups or for specific program users?)
- No

b) If not, are you planning to do a review?

c) If yes, how do you, or will you, use the data in your future planning? (i.e., to identify underserved communities and inequitable utilization of services in relation to need)

1g) Do you collect information to evaluate how well your employees, physicians, volunteers, and Board of Directors reflect the communities you serve? If yes, please describe how well your employees and Board reflect your communities and indicate your data sources. If not, please explain why.

- Yes – employee survey (results)
- Yes – Board of Director survey (results)

- No, but Board of Director members have identified responsibility to bring knowledge and experience of specific communities to the decision making (Please describe results)
- Neither (Please indicate reasons)

Section 2: Programs and Services: Promising Practices

2a) Please briefly describe a maximum of five current hospital initiatives that help to improve access to health services by underserved or underrepresented populations (populations identified in 1c), social conditions that create barriers to access in 1d) and/or equity priorities identified in 1e).

Which population(s) do they target and/or which access barrier(s) do they seek to remove?

In what ways is success being measured and what outcomes yielded as a result? Please provide samples of related documents if any.

2b) Describe specific partnerships, projects or activities that your hospital has undertaken with other organizations to address health equity, including those addressing the broader social conditions (e.g., social determinants of health such as income, housing, food, transportation, environment). Please include the names of those organizations and the anticipated and actual outcomes of the projects.

2c) Identify any care maps/clinical pathways that include the family/caregiver/substitute decision-maker in the decision-making process (collaborative patient-centred care). Please provide ones that show the most promise for addressing health disparities.

2d) Addressing communication barriers: what services for people with limited fluency in English are provided corporately? How are these services provided?

- List of physicians, staff and volunteers who speak languages other than English. Please identify how this information is kept up to date and disseminated.
- Strategies to address literacy barriers (e.g., symbols, pictographic resources for information, forms, consents) including training for front-line staff in how to use these resources
- AT&T language line with staff guidelines and training
- Key documents translated into languages relevant to patient population
- Instruction for non-English speaking patients to provide their own translator (e.g., family member or settlement worker, care provider)
- Making patients and potential patients aware of the right to a medical interpreter if needed and of the process for making arrangements
- Contractual agreements for interpreter services
- Staff positions with interpretation within job description
- Other methods (Please describe)

Please name or attach the list of languages available and the number of requests you receive for each language over the most recent 12 month period, if this is recorded. Please identify the language requests you were not able to meet, if this is recorded.

2e) Which, if any, of your hospital programs/departments (e.g., emergency departments, surgical programs, mental health programs) use certified medical interpreters? For these programs/departments, is the certified medical interpreter:

- In the program/department full-time?

- In the program/department part-time?
- On call?

2f) Do your hospital's programs/departments use information collected from patient registration in planning and delivering care (e.g., see item 4b)? If so, which information, and in which programs/departments is this information routinely used?

- Language for receiving and consenting to treatment
- Literacy
- Communication disabilities (e.g., hearing impairment, visual impairment, aphasia)
- Cultural restrictions (e.g., physician of same gender) (Please list)
- Alternative medicines used
- Others relevant to health equity (e.g., housing situation, income).

2g) Do you have any special programs and policies that address the needs of Aboriginal and Francophone populations?

- Aboriginal populations (Please describe the programs or policies)
- Francophone populations (Please describe the programs or policies)
- Other populations (Please identify the populations and describe the programs/policies)

Section 3: Operation: Policies, Procedures and Standards

3a) What specific policies, procedures and/or standards does your hospital have, to ensure equitable access and equally good quality of care for all patients?

- Patient charter or patient bill of rights communicated to patients, staff, volunteers and community
- Diversity/cultural competence and human rights training for all staff
- Diversity/cultural competency self-assessment or assessment tool
- Patient complaints invited/patient satisfaction requested
- Other (please describe)

How do you ensure that these policies are followed? (e.g., follow-up on complaints)

Please provide these documents as attachments.

3b) Describe ways that your hospital has tried to create an inclusive environment in which diverse patients feel comfortable and able to access services.

- Signage: e.g., words/pictures/Braille, sensitivity to people who cannot read (Please describe)
- Food services available based on faith/cultural requirements
 - kosher halal other (Please describe)
- Non-denominational prayer area
- Chaplaincy services (Please list faiths covered and availability to patients and their families)
- General hospital information
- Others (Please describe)

3c) Does your hospital have dedicated full time staff or other positions that promote, lead or address your health equity objectives? Please check all that apply.

- Coordinator/Manager/Director of Corporate Diversity (please specify title)
- Human Rights Officer
- Mentorship Coordinator
- Equity Trainer
- Other (Please list)

If yes, please list main role components of each position and whether they are full or part-time

3d) What committees does your hospital have to promote, lead or address your health equity objectives? What are their advisory or decision-making roles, and how this is advice or decision making implemented?

- Governance/Board (Please list)
- Accessibility
- Corporate equity diversity, inclusion
- Staff diversity/human rights
- Patient complaints
- Community/patient advisory
- Others (Please list)

Please attach relevant sections of the terms of reference that relate to health equity.

3e) Identify any initiatives your hospital uses to mentor, recruit and retain staff from diverse communities (e.g., where jobs are posted, internationally educated professionals projects, staff education). Please Indicate all that apply.

- Job openings advertised at sites that reach diverse communities (Please list the sites)
- Internationally educated professionals projects
- Mentoring projects (externally or internally coordinated)
- Anti-discrimination workplace harassment policies in place and implemented
- Younger and older generations
- Others (Please list)

Section 4: Monitoring and Performance Management

4a) What indicators and tools are used to monitor progress in achieving access and equity objectives?

- Interpreter requests (data collected and response reviewed)
- Monitoring and review of implementation of accessibility plan (Ontarians with Disabilities Act)
- Monitoring and review of health equity objectives in strategic plan
- Balanced scorecard
- Patients complaints and compliments/patient advocates reports/patient satisfaction surveys
- Evaluation (stakeholder)
- Staff performance monitoring
- Board quality assurance reporting

4b) Please identify and provide any intake/registration or program screening tools that collect information that can be used to plan and evaluate service equity: e.g., questions on:

- Language for receiving and consenting to treatment
- Food requirements based on culture or faith

- Transportation needs
- Communication ability (e.g., hearing impairment, visual impairment, aphasia)
- Cognitive ability (e.g., intellectual disability or impairment)
- Physical mobility
- Mental health or addictions issues
- Alternative medicines
- Cultural restrictions (e.g., staff of same gender or faith)
- Income
- Housing
- Education, literacy level
- Ethno-cultural/ethno-racial group

4c) Does your hospital conduct any research on health status and outcomes for marginalized populations? If yes, please provide very brief abstracts of research underway and research completed in the last five years. Please identify how you are using completed research (i.e., knowledge transfer processes).

4d) What other information and data would help to better identify and monitor health inequities?

Section 5: Potential Roles for the Central LHIN

5. Does your hospital have specific requests, actions or comments that the LHIN should consider to ensure a system-wide approach to improving health equity?

Section 6: Attachments

6. Please list all attachments to this report here.

Section 7: Contact and Authorization

Name:
Title: President and Chief Executive Officer
Hospital:
Address:
Phone:
E-mail:
Administrative Assistant:
Phone:
E-mail:
Signature: _____ **Date:** _____

Name:
Title: Chair, Board of Directors
Phone:
E-mail:
Signature: _____ **Date:** _____

Appendix A

Definitions of Terms used in the Framework and Template for Hospital Health Equity Plans (Environmental Scan)

Accessibility: Accessibility can be defined as a group's potential and realized access to the health care system. Four main components of accessibility are: financial, psychosocial (appropriate to one's faith, culture, language, understanding, literacy, etc.) geographic and timeliness. The development of "accessibility plans" is a requirement of the Ontarians with Disabilities Act, so the term accessibility sometimes is used to refer specifically to strategies that reduce barriers to access for people with disabilities.

Anti-oppression: Anti-oppressive practice is concerned with eradicating social injustice, such as injustice based on racial group, gender, sexual orientation and identity, age, class, ability and religion. Many forms of injustice and oppression are interconnected. Oppressions are often invisibly embedded in the dominant culture and social institutions. They affect the perception, attitudes and stereotypes that result in prejudging of individuals and situations and behaviours which can reduce access and limit participation.

Anti-racism: Anti-racism is the practice of identifying, challenging, preventing, eliminating, and changing the values, structures, policies, programs, practices, and behaviours that perpetuate racism. It is a way of thinking and acting against racism and white privilege.

Barriers to Access to Health Care: A "barrier" is anything that prevents a person from fully being able to obtain needed health care or to participate in all aspects of one's own health care including architectural, physical, informational, communications, attitudinal barrier, technological barriers or a policy or practice. Architectural refers to building design, size of doors, shape of rooms; physical refers to doors, windows, elevators, furniture, bathrooms, hardware; attitudinal refers to the values (acceptance, respect or discrimination, judgment, etc.) portrayed in communication and behaviours; technology refers to computers, telephones, assistive technologies; and, policy and practices refers to rules, regulations and protocols that may restrict access.

Care Maps/Clinical Pathway: Care maps and clinical pathways are tools for the mutual decision making (patients and providers teams) and organization of care for patients that enhance the quality of care by improving patient outcomes, promoting patient safety, increasing patient satisfaction, and optimizing the use of resources. Clinical Pathways is the term sometimes used to note the use of clinical practice guidelines and systematic, continuing audit into clinical practice for the continuity and co-ordination of care across different disciplines and sectors.

Cultural Competent/Diversity Competent Care and Organizations:

Cultural Competency is providing meaningful, respectful client-centered care, tailored to client social, cultural and linguistic needs and basing professional practice upon critical reflection, accountability, power-sharing, collaboration with marginalized groups, and valuing, legitimating and integrating the knowledge and experience of diverse cultural groups within the services and interventions provided. It also includes adopting the principles of anti-oppression and being aware of the power and hierarchy particularly between clients from marginalized groups and health care organizations.

Diversity competence refers not only to an organization's capacity to serve diverse groups in socially and culturally appropriate ways, but also to the organization's capacity to manage and support diversity within itself (policies and procedures supportive of diversity, diverse staff and volunteers, physical features that are supportive and reflective of diversity in the community, etc.) to produce and preserve diversity and to make organizations themselves diverse in terms of who they are (workforce), what they do (services) and whom they serve (clients).

Disparities in Health/Health Disparities: differences in health and health care experienced by different population groups defined according to characteristics such as income or education level, ethnicity/race or language, aboriginal status, ability/disability, sexual orientation, immigrant status, area of residence, housing situation or homelessness, etc. The term "health disparities" is currently used most commonly in North America while the term "health inequities" is used in Europe, UK and other countries to indicate that these differences or inequalities in health between socially defined population groups can be considered unfair or unjust and potentially avoidable because they are related to social economic and health care policies and practices which can be changed.

Ethno-cultural/Ethno-racial: Ethnocultural or ethnicity refers to group identity based on culture, religion, traditions, and customs (ideas, beliefs, values, behaviour) that are transmitted from one generation to the next. Sometimes the term "ethnocultural" includes groups that identify as "ethnoracial" or "racialized." But some use the latter terms instead of ethnocultural, to make it clear that groups distinguishable by a visible characteristic (such as skin colour) more often experience discrimination and disadvantage, and may not identify with "culture" as a shared identity. What emerges from research about data collection is the importance of self-identification – asking questions in a way that enables a person to use or choose a word to describe how they see themselves and their ancestry whether it is primarily ethnic or racial. In some cases language or religion may be the characteristic that affects how one is seen, treated or what affects how one is served or the barriers that one may face.

Equitable Access: Central LHIN's Diversity and Inclusion Advisory Group defined equitable access as: all individuals have similar capacity (with assistance when needed) and similar opportunity (with assistance when needed) to make use of necessary health services of similar quality, regardless of any barriers posed by social, geographical, ethnocultural/ linguistic, gender or socioeconomic factors, or physical, intellectual, cognitive, emotional or other challenges.

Equity in Health Care: creating opportunities for health and reducing health disparities by enabling equitable access to care, equitable utilization (use) of care, a fair distribution of health care resources and equally good quality of care for all. The term "equitable" rather than "equal" is used to note that access and use of care should be based on need, not on privilege or ability to pay and that different levels of need require different levels of service in order to be equitable. This includes equal use for equal need, and greater use for greater need.

Equity Lens: always considering if there are differential access, differential opportunity, differential benefit and taking steps to ensure that fairness according to "need" drives

decision making and that steps are taken to ensure decisions reduce rather than widen existing health inequities.

Health Equity: reducing differences in health and health status among population groups as much as possible. Health equity creates equal opportunities for health and gives attention to the people with the greatest need and least resources.

Marginalization/Marginalized groups: To “marginalize” a group of people is to make them feel isolated, or outside or on the edge “margins” of mainstream society, or not belonging or to deny them access to power and services. Groups in our society who are 'marginalized' in the sense of having less immediate access to services that are appropriate for their circumstances, include people with certain mental health problems or addictions, people with physical disabilities, Aboriginal peoples, injection drug users, some ethnic and ethno-racial groups, the homeless, those with particular sexual orientations, and people experiencing poverty. Members of marginalized groups may either have limited access to appropriate health services or feel constrained in accessing services even if they are available.

Racialized Groups: The Ontario Human Rights Commission 'Policy and Guidelines on Racism and Discrimination' states, "When it is necessary to describe people collectively, the term racialized person or racialized group is preferred over racial minority, visible minority, person of colour or non-White as it expresses race as a social construct rather than perceived biological traits."

Patient-Centered Care/Collaborative Patient-Centered Care: Patient-centered care is about respecting the patient's perspective on what matters most and then tailoring the care provided. Patient-centered care is quality healthcare achieved through a partnership between informed and respected patients and their families, and a coordinated healthcare team. The term “collaborative patient-centered practice” and “inter-professional collaborative patient centered practice” emphasize the active participation of several health care disciplines and professions while enhancing patient-, family-, and community-centered goals and values.

Social Determinants of Health: These are the economic, social and physical environmental conditions under which people live such as income, housing, working conditions, social relations (freedom from discrimination and abuse), social support; and the social policies and practices which create these conditions. These social conditions are the major contributors to health disparities among population groups and they have a greater impact on the health and well-being of the population than health behaviours or the health care system.