Equity, Inclusion, Diversity, Anti-Racism

2024 - 2025 Highlights

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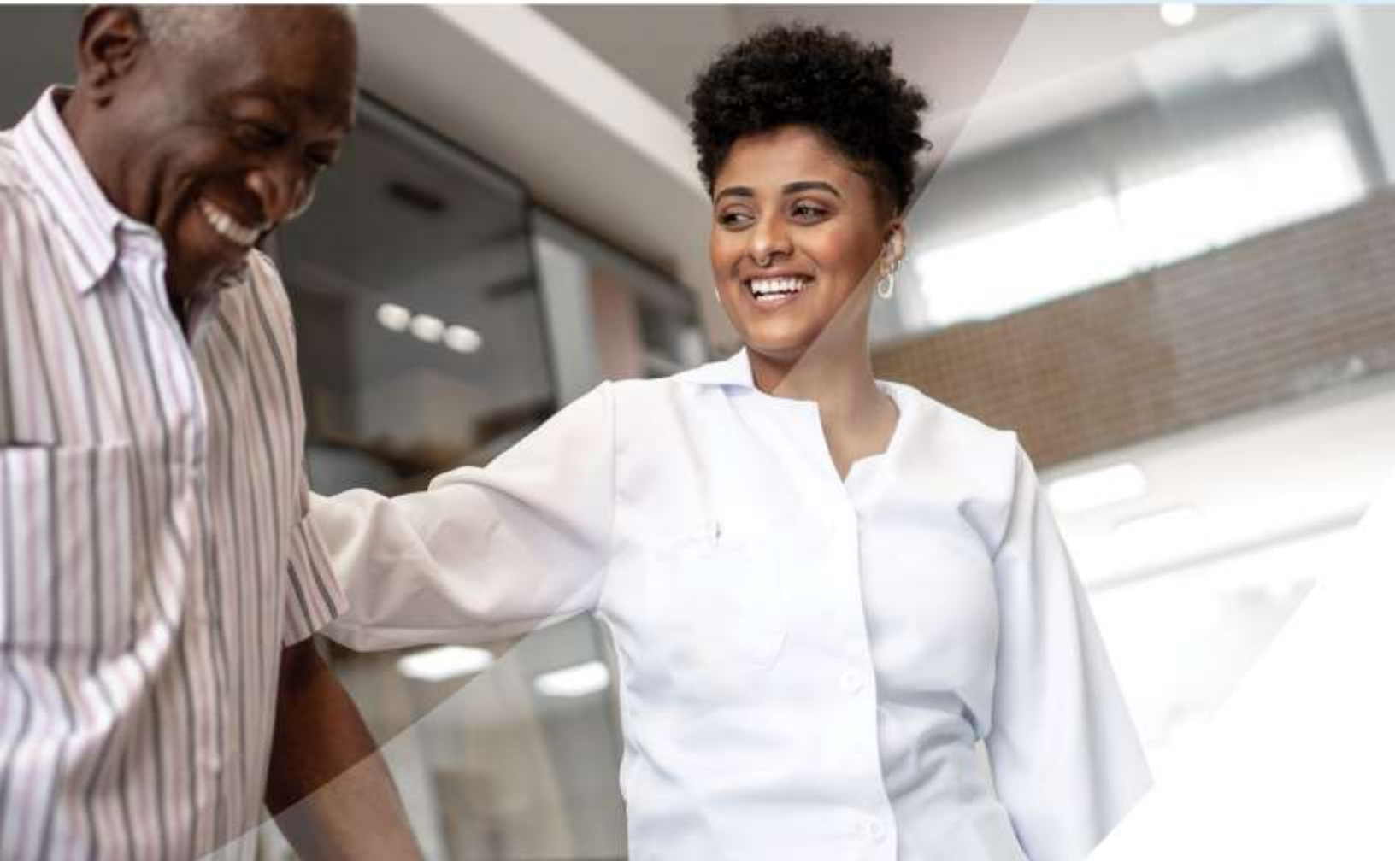

Ontario Health

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Equity, Inclusion, Diversity, and Anti-Racism 2024-2025: Progress Against Equity Plan Goals

Executive Summary

In 2020, Ontario Health introduced the Equity, Inclusion, Diversity and Anti-Racism (EIDAR) Framework to address persistent gaps in access, experience and outcomes across the province. Over the past year through coordinated work across population specific plans, community governed delivery models, a strengthened data infrastructure and a more inclusive workforce, the EIDA-R Framework was able to produce measurable progress toward a more equitable health system.

For example, Ontario's Black Health Plan enabled the delivery of culturally tailored primary and preventive care to more than 7,300 residents through Health Promotion Wellness Clinics. It also opened five additional sickle cell clinics, eliminated race-based adjustments in estimated glomerular filtration rate (eGFR) calculations and lowered breast cancer screening eligibility to age 40. In the Peel Region, partners secured a 16,200-square foot site for the Black Health and Social Services Hub to provide integrated primary care, mental health and social supports for Black Communities, and established a Community Advisory Council that ground service design in lived experience.

The 2SLGBTQIA+ Action Plan set a provincewide benchmark with Ontario's first Gender Affirming Care Quality Standard which set clear expectations for inclusive services. Self-directed courses, delivered by Rainbow Health Ontario, reached over 4,000 learners, approximately 2,900 learners went through instructor-led sessions, and more than 600 individuals received one-to-one consultations. Northern Ontario welcomed its first integrated Gender Diversity Clinic, which served 48 clients in its first eight months and extended virtual dialectical behaviour therapy across a vast geography.

Locally Driven Population Health Models dedicated 25 million dollars in base funding that empowered communities to identify local needs that were addressed. Expanding to every region, they connected more than a 250,000 people to prevention and navigation services and attached over 6,000 residents to primary care. The models of care build on priorities from the High Priorities Communities Strategy (HPCS) including, preventative care, mental health and substance use; population specific wellness models and addressing unmet primary health needs. Community Ambassadors effectively bridged social, cultural, and linguistic divides, engaged in health promotion and service navigation in a manner appropriate to their local community. Community Ambassadors recorded 1.5 million engagement contacts, guided over 31,800 individuals to health or social services, attached 6,200 residents to primary care, arranged more than 8,100 cancer screening appointments and facilitated mental health or addictions support for 10,800 people, with six Northern communities participating for the first time.

Partnerships with First Nations, Inuit, Métis and urban Indigenous organizations deepened through two formal relationship protocols, 12 Indigenous Liaison positions and the expansion of culturally safe cancer and renal initiatives. A total of 839 Ontario Health team members completed Indigenous Relationship and Cultural Awareness training, and refined data governance processes upheld Indigenous data sovereignty.

Five Central region providers advanced toward designation under the French Language Services Act, supported by bilingual signage, active offer protocols and staff training delivered in collaboration with Collège Boréal and Chigamik Community Health Centre. In the North, eight hospitals and community agencies submitted proposals to strengthen French language services.

A provincewide Core Sociodemographic Data Standard, an internal Sociodemographic Data Explorer and equity stratified performance scorecards improved equity-informed decisioning making and oversight. Three large hospitals began collecting person level sociodemographic data, and an 11-program Community of Practice resolved operational challenges related to data capture and consent.

Internal culture change continued through a 10-hour Advancing Health Equity workshop, with 322 registered with an 86 per cent completion rate. Eight Communities of Inclusion (COI) now engage with more than 750 Ontario Health team members. The COI mentorship program saw a 43% increase in mentor-mentee matches since Phase 1, with over 20 pairs and 95% reporting high satisfaction. An EIDA-R Strategic Advisor launched a comprehensive review of organizational respectful workplace and EIDA-R policies and programs.

Disease specific equity initiatives expanded access and improved quality. The Sickle Cell Disease Quality Standard is active in 14 adult and 10 paediatric sites, a provincewide registry is in development and a Community of Practice brings together 172 clinicians and community leaders. In kidney care, Ontario Health helped remove race modifiers from eGFR calculations, appointed a Provincial Medical Lead for Health Equity and issued travel grants for home dialysis training – addressing diagnostic bias and geographic barriers. Collectively, these measures helped to advance earlier detection, provide culturally responsive care and more consistent attachment to primary care providers. We also ensured that transparent dashboards and scorecards embedded equity metrics in decision making processes.

Upcoming priorities for 2025-2026 include extending the Gender Affirming Care Quality Standard to paediatric and long-term care settings, releasing the First Nations, Inuit, Métis and Urban Indigenous Health Plan, broadening person level sociodemographic data capture to six additional programs, aligning population health models with primary care expansion and opening Ontario's inaugural French Language Health Planning Centre scheduled for FY 2025-2026. These steps will build momentum and further translate commitment into equitable improvements for all Ontarians

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2024-2025 – By The Numbers

Black Health Plan

+7,300 people received culturally responsive primary and preventive care

2SLGBTQIA+ Action Plan

+4,000 health service providers completed 2SLGBTQIA+ affirming care education

Locally Driven Population Health Models

+250,000 people connected to prevention and navigation services

Equity Data and Analytics

13 OH programs participated in Sociodemographic Community of Practice

Partnerships with First Nations, Inuit, Métis and urban Indigenous organizations

180 Indigenous Tobacco Program workshops delivered in schools and health centres

French Language Health Services

+300 health service providers increased capacity in French language care

Internal EIDA-R

+750 OH staff engaged across 8 Communities of I nclusion (COIs)

Introduction

Ontario Health's 2024-2025 Annual Business Plan reinforces the measurable action under the Equity, Inclusion, Diversity and Anti-Racism (EIDAR) Framework. The data continues to highlight persistent and disproportionate health outcomes across the province. For example:

Premature mortality rates in Ontario's most marginalised neighbourhoods remain higher than in the least marginalised neighbourhood (Zygmunt et al., 2020).

Black women have up to an 80 per cent higher risk of death from stomach and uterine cancers and nearly 50 per cent higher mortality from diabetes and endocrine disorders (Statistics Canada, 2024).

Black men face a 33 per cent higher risk of prostate cancer death (Statistics Canada, 2024).

Emergency department visits for sickle cell disease acute pain episodes are concentrated among Black residents (Pendergrast et al., 2023).

Almost 40 per cent of transgender adults cannot find a trusted primary care provider (Kattari et al., 2021; Strauss et al., 2022); and

Recently incarcerated Black Ontarians are up to fifty times more likely to die of opioid overdose than their non-Black counterparts (Tjepkema et al., 2023).

Guided by these realities, Ontario Health translated the Framework into tangible impact.

The sections that follow describe initiatives that address these disparities and demonstrate how Ontario Health is closing the gap.

Advance the Black Health Plan to Expand Access to Culturally Responsive Care

Understanding the Gap

Black Ontarians experience higher rates of emergency visits for sickle cell disease acute pain episode, earlier onset of breast cancer, and disproportionate burdens of chronic kidney disease (Srikanthan, 2024). These persistent inequities informed the development of Ontario Health's Black Health Plan. The Black Health Plan is anchored by three outcome pillars – equitable primary and preventive care, culturally responsive chronic disease care, and accessible mental health and addictions services. The Black Health Plan is enabled by measurement, reporting and partnerships.

Key highlights of how we advance the Black Health Plan include:

- Culturally tailored Health Promotion Wellness Clinics operated in 13 communities and is serving more than 7,300 Black residents.
- Five new sickle cell clinics opened this year, improving timely access to evidence-based care and easing pressure on acute care services.
- New psychotherapy pathways and community-based supports were developed to address longstanding service gaps that have historically left many without appropriate care.
- Targeted investments enabled the creation of 70+ anti-racism tools and training sessions with 3300+ pediatric and family health providers trained.

Pillar 1 – Expanding Primary and Preventive Care

Culturally tailored Health Promotion Wellness Clinics operated in 13 communities and is serving more than 7,300 Black residents. Services included cancer screenings and support for navigating mental health resources. These efforts are reinforced by a suite of 70 anti-racism tools and 47 training sessions delivered to over 3,300 clinicians.

A province-wide toolkit and readiness assessment now support emerging Primary Care Networks, helping to embed anti-racist practices and community engagement as standard components of care – no longer being the exception.

By fiscal year 2025-26 this pillar will expand further, delivering integrated wraparound care to 1500+ clients at the Peel Hub and offering closer-to-home management for 700 children and adults across 12 hemoglobinopathy clinics.

Pillar 2 – Improving Chronic Disease Outcomes

Conditions causing the greatest avoidable harm received priority attention.

Sickle cell disease predominantly affects people of African descent. Black residents in Ontario visit emergency departments for sickle cell related pain crises at rates many times higher than the provincial average (Pendergrast et al., 2023; (Provincial Council for Maternal and Child Health & Ontario Ministry of Health and Long-Term Care, 2017). Addressing this disparity is integral to the Black Health Plan's goal of providing equitable chronic disease care.

Five new sickle cell clinics opened this year, improving timely access to evidence-based care and easing pressure on acute care services. Laboratories adopted a race neutral eGFR calculation, addressing longstanding bias in chronic kidney disease diagnosis.

Eligibility for the Ontario Breast Screening Program (OBSP) expanded to include individuals starting at the age of 40, reflecting data that Black women are more likely to develop breast cancer at a younger age.

Community partners continue to shape program design – informing improvements in diabetes care and contributing to Afrocentric educational materials for HPV and cervical cancer prevention and screening.

Pillar 3 – Strengthening Mental Health and Addictions Care

Cross organizational collaboration expanded culturally safe mental health and addictions services for Black children, youth and adults. New psychotherapy pathways and community-based supports were developed to address longstanding service gaps that have historically left many without appropriate care.

Enabler – Measurement, Reporting and Partnership

A Black Health Plan dashboard now tracks service reach, quality indicators and outcome trends – bringing new transparency to equity progress. The Black Health Plan Working Group continued to meet regularly to align community voices with provincial planning and ensure that lived experience guide every strategic decision.

Building System Capacity

Targeted investments enabled the creation of 70+ anti-racism tools and training sessions with 3300+ pediatric and family health providers trained. A new toolkit and readiness assessment now guide emerging primary care networks, embedding anti-racist, culturally responsive practices across the province.

Regional Highlights – Toronto and Central Regions: Embedding Equity Through Culturally Responsive Partnerships

- In Toronto Region, five health promotion and wellness clinics and six culturally responsive prevention models were implemented under the Black Health Action Plan, enabling providers to offer preventative primary care and wellness initiatives closer to home.
- In Central Region, pediatric recovery funds enabled the Newmarket African Caribbean Canadian Association to expand youth programs. LAMP Community Health Centre launched a specialized clinical team for newly arrived refugees, ensuring timely access to complex care support.

Black Health Plan in Action: Peel Black Health and Social Services Hub

The Integrated Care Launch

To support the first pillar of equitable primary and preventive care, the Peel Black Health and Social Services Hub (BHSSH) was designed to provide seamless and culturally responsive care and services to the local Black, African and Caribbean (BAC) communities in the Peel Region.

As in other parts of Ontario, BAC residents in the Peel Region face a higher likelihood of developing diabetes, hypertension and experiencing unplanned emergency department visits. Yet these same groups consistently report difficulty accessing culturally safe and coordinated services (Hassan, 2024; Dapaah et al., 2024).

Given that 20 per cent of Ontario's Black population live in the Peel Region (Caledon, Brampton, Mississauga), the Hub was created to close that gap by unifying medical, mental health and social supports under Black governance. It aims to demonstrate how the principles of the Black Health Plan can improve outcomes and relieve pressure on hospitals when applied at the community level.

Led jointly by Roots Community Services, the Canadian Mental Health Association Peel Dufferin and LAMP Community Health Centre, the Hub brings primary care, mental health supports and social service navigation together in one location, making culturally safe care available close to home.

The partnership secured a centrally located 16,200 sq. site in Brampton and invited community members to shape the design – making sure that the space reflected cultural identity and welcomed families. In September 2024, the Community Advisory Council developed the Hub's priorities, programming and evaluation framework, ensuring all decision made were grounded in lived experience.

Early outreach has been vigorous including a virtual town hall which drew more than 100 participants, a winter diabetes education event that reached 90 residents, and the symbolic wall breaking ceremony in March 2025 that marked the collective ownership of the renovation phase.

In December 2024, the BHSSH team hosted a winter holiday event that provided diabetes education to 90 community members. The event featured a culturally enriching reading session of the children's book, *I am Cherished*, led by author Onome Ako. Each child had the opportunity to meet the author and receive a signed copy of the book, affirming cultural pride among the attendees.

By integrating early intervention with social supports, the Hub demonstrated the Black Health Plan's principle that culturally rooted, community governed models can improve access, experience and outcomes for Black Ontarians – while reducing pressure on hospital services.

Black Health Plan Spotlight: Improving Care for People with Sickle Cell Disease

Sickle cell disease is one clinical focus of the Black Health Plan's chronic-disease pillar. About 3,500 people in Ontario and 6,500 people across Canada live with sickle cell disease. These numbers are expected to rise due to immigration from countries with high disease prevalence, new births in Canada to parents who carry the sickle cell disease trait, and improved care and treatment options that increase life expectancy (Health Quality Ontario, n.d.).

Yet, Black residents visit emergency departments for Sickle Cell Disease (SCD) acute pain episodes at rates several times higher than the provincial average (Pendergrast et al., 2023). The work described below shows how implementing the provincial quality standard is putting the Black Health Plan in action, closing access gaps and improving outcomes for Black communities across the province.

Implementing the quality standard at scale

Ontario Health directed almost $1.3 million in 2024-2025 to 14 adult care sites, including dedicated SCD centres, emergency departments, community clinics, and chronic pain services. 10 paediatric partners advanced parallel work so that children and youth transition smoothly into adult programs when ready.

Front-line teams completed antiracism, anti-oppression, and disease specific education. Five new dedicated SCD centres opened, and two existing ones were modernized to meet the quality standard requirements.

Regional Highlights – West and Northern Regions: Expanding Sickle Cell Disease Care Across Ontario

- In the West Region, Hamilton Health Sciences hosted a province-wide hemoglobinopathy symposium in April 2025, advancing evidence-informed care and fostering regional collaboration.
- In Northern Ontario, Health Sciences North in Sudbury opened the region's first hemoglobinopathy clinic to serve patients with sickle cell disease and thalassemia. Responding to shifting demographics and increased diversity in the north, the clinic provides care close to home, reducing the need for travel to Toronto for treatment.

Capacity building and real-time monitoring

A second edition of the Sickle Cell Disease Implementation Toolkit was completed during the 2024-2025 fiscal year and released in February 2025. It offers practical change ideas, tools, resources and measurement guidance.

An updated electronic SCD eReport now allows hospitals and regions track key indicators through the ONE ID portal. Managers receive immediate feedback on emergency department wait times and revisit rates, visit urgency, and volumes of emergency department visits and inpatient hospitalization for SCD. The eReport can be used by regions and hospital-level quality improvement initiatives.

Patient centred innovation

Patients now have access to culturally tailored education in multiple languages, virtual follow-up appointments, and an on demand information portal. Home infusion pumps are loaned to individuals requiring regular parenteral therapy, reducing travel burdens and hospital admissions.

A province-wide SCD registry is in development to support outcome tracking and research. The Hemoglobinopathy Symposium, held in spring 2025, strengthened knowledge exchange among clinicians, advocates and people with lived experience.

Figure 1. Dr. Jennifer Bryan, a clinical lead, presenting an overview on the development of provincial model for sickle cell disease

Coordinated leadership and learning network

Emergency physician Dr. Jennifer Bryan assumed the role of Provincial Clinical Lead in December 2024, aligning regional work with the organisation's equity priorities. A Community of Practice launched in May 2024 now connects 172 clinicians to educators and community advocates.

Digital decision-support tools developed through the Evidence2Practice program are integrated into acute care clinical processes. Education sessions held in Hamilton and Windsor have accelerated local adoption of best practices.

Toward an integrated provincial model of care

With adult initiatives completed at 14 sites and paediatric work under way at 10, the next phase will map clinical pathways, pair emerging clinics with mentors from established dedicated centres, and define roles across primary, community, acute, and specialty settings.

This framework will guide regional coordination and provincial oversight, ensuring that every person living with sickle cell disease receives timely, high quality, culturally safe care that directly addresses the inequities outlined in the Black Health Plan.

Advancing Health Equity for 2SLGBTQIA+ Communities

Key highlights of how we advance health equity for 2SLGBTQIA+ communities include:

- Over 7,500 learners engaged in gender-affirming care education, including 4,038 self-directed courses, 2,880 instructor-led sessions, and 626 clinical consultations.
- Ontario's first Gender-Affirming Care Quality Standard released, setting benchmarks for primary care, hospitals, and community programs.
- 23,000 legacy learners migrated to a new accessible learning platform, expanding reach and improving usability.
- The Gender Diversity Clinic in North Bay delivered interdisciplinary care to 48 patients in its first 8 months, including 12 children and youth.
- $2.5 million invested in youth-focused mental health and addictions initiatives, targeting rural and northern communities.
- Inclusive screening framework drafted to ensure trans and nonbinary patients receive appropriate breast and cervical cancer screening invitations.
- Ontario Health West convened a provincial steering committee and conducted the first French-language survey focused on Francophone 2SLGBTQIA+ individuals.
- Insights from 36 Francophone respondents informed a regional health forum report distributed to over 200 stakeholders.

Across Canada, 2SLGBTQIA+ (Two-Spirit, lesbian, gay, bisexual, transgender, queer or questioning, intersex, asexual, and other sexual orientations and gender identities) communities experience higher rates of cancer, chronic fatigue, heart disease, poor mental health, substance-use disorders and other chronic conditions (Canada 2022).

Multiple Ontario surveys show that past discrimination continues to deter transgender adults from seeking care (Scheim et al., 2021; MacKinnon et al., 2020; Tami et al., 2022). Trans PULSE Canada found in 2020 that 45 per cent of transgender and non-binary respondents had at least one unmet health care need, a figure mirrored by 44.4 per cent in a separate access study (Trans PULSE 2020). Longstanding discrimination and stigma have eroded trust in the health system and deepened these health inequities (Comeau et al., 2023; Hickey 2022).

These figures highlight gaps that align with Ontario Health's accountability commitments in its Annual Business Plan to improve equitable outcomes for 2SLGBTQIA+ communities. They help set the context for Ontario Health's 2024–2025 strategy to shift from awareness to measurable system change. This will be achieved through four streams: education, standards, service pathways, and policy. Through alignment across these streams, Ontario Health aims to embed culturally safe, affirming care across the province.

Building Capacity through Education and Standards

Ontario Health partnered with Rainbow Health Ontario to equip health care providers with queer-affirming practice skills to better engage with 2SLGBTQIA+ individuals. In the past fiscal year, 4,038 self-directed courses were completed, 2,880 individuals participated in instructor led sessions, and 626 received one-to-one clinical consultations.

In addition, 23,000 legacy learners migrated to a newly enhanced, accessible learning platform – expanding reach and improving usability. These training efforts coincided with the release of Ontario's first Gender-Affirming Care Quality Standard, which now serves as the benchmark for primary care teams, hospitals and community programs.

Patient-facing resources, such as *How to Prepare for Gender-Affirming Surgery*, were developed alongside the quality standard to ensure clinical guidance reflects lived experience and support informed, respectful care.

Expanding Access in Northern Ontario

Access to essential services remains most limited in the northern regions. The Gender Diversity Clinic at North Bay Regional Health Centre began closing that gap in August 2024. In its first eight months the interdisciplinary team delivered psychiatric consultation, psychotherapy, gender affirming primary care, social work and occupational therapy to 48 patients – 12 of whom were children or adolescents.

Figure 2. Artwork by an Indigenous artist from Ginoogaming First Nation was commissioned by the Gender Diversity Clinic to reflect inclusivity and community connection. It is part of ongoing renovations to create a more welcoming and culturally inclusive space.

Virtual and in person dialectical behaviour therapy groups extended reach across an area larger than many provinces. Renovations are underway to add technology enabled group rooms, dedicated assessment space and culturally inclusive design elements, including a commissioned Indigenous artwork that anchors the clinic in the local community.

Creating Inclusive Mental Health Pathways

Live-in treatment mental health settings often lack trans inclusive policies. The West Region's Trans Inclusive Live-in Treatment Table addresses this issue with practical tools for intake, room assignment and staff training.

A province-wide investment of $2.5 million in youth-focused mental health and addictions initiatives ensured that rural and northern communities received targeted funding where services were previously scarce.

Embedding Equity in Guidelines and Tools

Ontario Health drafted a breast and cervical screening framework that recognizes gender diversity in eligibility rules and data capture, ensuring that trans and non-binary patients receive appropriate invitations and follow up.

Inclusive language guidance and a community engagement toolkit were incorporated into regional planning cycles, making culturally safe practice a requirement rather than an option.

Regional Highlight – West Region: Amplifying Francophone 2SLGBTQIA+ Voices

- Francophone 2SLGBTQIA+ individuals often face a double barrier of language and stigma. Ontario Health West convened a provincial steering committee with seven partners and fielded the first French language survey focused on this population.
- 36 respondents provided detailed accounts of unmet needs. Their insights informed the 2024-2025 *Francophone 2SLGBTQIA+ Health Forum Report* and accompanying literature review, which were distributed to more than 200 stakeholders and now guide policy and program decisions.

Looking Ahead

Capacity built through education, the establishment of clear clinical benchmarks and the integration of equity into policy and data systems lay a foundation for sustained improvement.

In fiscal year 2025-2026 Ontario Health will expand the Gender Affirming Care Quality Standard into paediatric guidance, broaden long-term care training and launch a provincewide data initiative to capture gender identity uniformly – enabling more precise monitoring of access and outcomes for 2SLGBTQIA+ communities.

By the end of the 2025-26 fiscal year, Ontario Health will have trained over 4,000 learners in gender-affirming and 2SLGBTQIA+ inclusive care and will ground the provincial Action Plan in insights from three targeted community engagement sessions.

Expanding Locally Driven Population Health Models to Drive Equitable Access to Care

Figure 3. Carefirst's mobile health outreach combines onsite mobile screening and accessible health education tailored to diverse communities.

Key highlights of how the Locally Driven Population Health Models was expanded include:

- Over 3.7 million community engagement interactions and 2,350+ new partnerships formed across 10 sectors in the first year.
- 87,680+ individuals referred to services, with 54,240+ receiving direct wraparound supports.
- 28,300+ referrals made for cancer screening and 15,280+ individuals referred to primary care.
- 12,490+ individuals referred to mental health and addictions supports, with 14,730+ receiving direct services.
- 2,360+ Naloxone kits distributed to support harm reduction efforts.
- Carefirst Mobile Health Unit delivered tailored cervical cancer education and on-site pap smears for individuals with intellectual and developmental disabilities.
- Three pilot sites launched to test ambulatory systemic cancer treatment models focused on equity, supported by the Canadian Partnership Against Cancer.

Through targeted programming from 2020 to 2024, the High Priority Community Strategy addressed longstanding gaps in the health care system that were exposed during the COVID-19 pandemic. The successes and lessons learned from this initiative have since been embedded into broader system efforts – informing the work of Community Ambassadors and Ontario Health Teams through locally driven population health models.

The goal is to create a sustainable approach that reduces health inequities and improves population health by integrating insights from the High Priority Community Strategy into the wider health care system. This work supports equity-deserving groups and advances health system priorities across the province.

Achievements in 2024 – 2025

In 2024, $25 million in base funding was secured for locally driven population health models, enabling the expansion of the strategy to North East and North West regions – areas not historically included in the High Priority Community Strategy. This funding helped to bring more local solutions to rural and remote communities.

Lead agencies and community ambassadors continue to play a pivotal role in engaging local communities to identify opportunities to reduce disparities and improve access to primary care, mental health and addictions services, chronic care and social services – such as wraparound services – across the province.

Below is a summary of the impact locally driven population health models has made in its first year.

- 2,350+ new partnerships formed across 10 sectors
- 3,714,150+ community engagement interactions
- 87,680+ individuals were referred, while 54,240+ directly received wraparound supports
- 15,280+ individuals referred to primary care
- 28,300+ referrals for cancer screening
- 12,490+ individuals referred to mental health or addiction (MHA) supports, while 14,730+ individuals received MHA supports directly from Lead Agencies
- 2,360+ Naloxone kits distributed

Collaborations continued with strategic partners Health Commons Solutions Lab who supported the onboarding of six new communities from North East and North West regions, hosted ongoing bi-weekly open sessions for community ambassador education and training and enhanced preventative care by providing culturally responsive health care education resources.

Regional Highlights – Toronto and West Regions: Advancing Primary Care Access Through Community-Led Models

- In Toronto, West Toronto OHT opened iHelp Hubs inside Toronto Community Housing, connecting residents to nurse practitioner-led primary care and social supports. Midwest Toronto OHT's Open Door mobile unit provided attachment, chronic disease management and screening. North York Toronto Health Partners hosted community fairs that connected unattached residents to primary care and preventive services.
- In the West Region, Integrated Ambulatory Wellness teams reached over 7,000 residents, and 55 Community Health Ambassadors guided 1,210 individuals to primary care through local population health models. An equity scan across all OHTs informed new Communities of Practice and deliverables, strengthening regional coordination.

Looking Ahead: Fiscal Year 2025 – 2026

Ontario Health aims to embed the government's Primary Care Action Team mandate into its work supporting equity priorities related to primary care attachment and access.

Expanding preventive care services is essential to reduce reliance on the health care system. This requires a paradigm shift – one that focuses on maintaining health and well-being and promoting population health rather than responding to illness. To achieve this, Ontario Health will work with partners to identify individuals upstream, helping to prevent the need for downstream health care services.

Efforts will also focus on ensuring high-quality data is collected, analyzed and used to drive outcomes. This includes refining community selection methodologies and advancing work on sociodemographic data collection, use and governance.

Adapting preventive care for people living with intellectual and developmental disabilities in Central Region

In October 2023, Carefirst Seniors & Community Services Association collaborated with Reena and the Western York Region Ontario Health Team to deliver tailored cervical cancer education, preventative care conversations, and on-site pap smear clinic through the Carefirst Mobile Health Unit. This initiative specifically supported individuals living with intellectual and development disabilities, enabling access to preventive health services with fewer barriers and in a respectful manner.

Since 2023, Carefirst has continued to work with Reena and the Western York Region Ontario Health Team to co-design and co-implement accessible, equity-based cancer prevention initiatives as part of the Collaborative Quality Improvement Plan. On February 20, 2025, Carefirst hosted a virtual breast cancer awareness workshop for community members from diverse backgrounds. The planning team incorporated recommendations from patient and family advisors living with disabilities to ensure an accessible learning experience for all.

Additional preventative care and health promotions are planned for 2025-2026.

Carefirst offers a full range of comprehensive community support services to older adults. Reena provides support to individuals with developmental disabilities and their families.

Advancing health equity through ambulatory systemic treatment models of care

Ontario Health is leading a multi-year initiative to improve ambulatory systemic cancer treatment delivery, with a focus on advancing health equity. In response to increasing treatment volumes and complexity, recommendations were developed to optimize care models and improve quality, efficiency, and equity. These recommendations are outlined in the *Optimizing Ambulatory Systemic Treatment Models of Care* document.

With funding from the Canadian Partnership Against Cancer, Ontario Health started supporting three pilot sites — Scarborough Health Network, St. Michael's Hospital, and The Ottawa Hospital — implement and test models of care to enhance access, experience, and outcomes for equity-deserving populations. The initiative includes evaluation, sustainability planning, and sharing lessons to inform broader improvements and potential province-wide scaling. Implementation will continue in 2025-2026.

Advancing System Capacity to Improve Access to French Language Health Services

Francophones make up 4.6% of Ontario's population, yet patient experience surveys show they are twice as likely as anglophones to report language barriers during hospital visits (Murray, 2022; Timony, 2023). Closing that gap requires more providers to be formally designated under the French Language Services Act – a status that guarantees 20 criteria for active, culturally responsive care delivered in French and tailored to the needs of Francophone communities.

Key highlights of how we improve access to French Language Health Services:

- Five Central Region providers submitted formal proposals to advance towards meeting French Language Services Act designation criteria.
- Eight providers across North East and North West regions advanced designation efforts through detailed funding proposals.
- Ontario Health East co-designed a provincial model to improve remote care for Francophone patients in underserved communities.
- St. Joseph's Continuing Care Centre scaled its Remote Care Monitoring Program, enabling net new referrals across East Ontario.
- SHIP and CMHA Simcoe County launched structured capacity-building programs, including French-language proficiency and culturally competent care training.
- Waypoint Centre for Mental Health Care expanded French-language mental health services for youth.
- Extendicare Countryside newly identified for French Language Services in the North East region.
- Key milestones include meeting the Ministry's 90% HSP reporting target and preparing for the launch of Ontario's first French Language Health Planning Centre, which is scheduled for FY 2025–2026.

Progress Towards Designation in 2024-2025

Five Central Region providers – County of Simcoe, Canadian Mental Health Association (CMHA) – Simcoe County, Services and Housing in the Province (SHIP), Waypoint Centre for Mental Health Care, and William Osler Health System – filed detailed proposals addressing key designation criteria, embedding French-language care more deeply into regional infrastructure.

In Ontario Health's East region, two requests for designation were submitted and are currently under review by the Ministry of Health and the Ministry of Francophone Affairs.

Deepening Community Engagement and Strategic Alignment

All organizations worked closely with their respective French Language Health Planning Entities to pinpoint service gaps and co-create phased action plans, ensuring that designation efforts reflect local Francophone priorities.

Ensuring Equitable Access to French-Language Health Care

Health service providers (HSPs) submitted proposals that targeted critical elements of designation, including:

- Active offer of services in French, not just upon request.
- Improved bilingual signage support and navigation supports.
- Formal identification of bilingual staff.
- Expanded access to mental health services in French, with a focus on youth and adults.

Waypoint Centre for Mental Health Care incorporated strategies to address longstanding service gaps in mental health services for Francophone youth.

Capacity Building and Staff Training

Recognizing that sustained service excellence depends on a well-trained workforce, SHIP and CMHA Simcoe County launched structured capacity-building programs. These included culturally competent care training, specialized French-language proficiency programs and targeted professional development opportunities. By increasing workforce capacity, these providers are positioned to deliver reliable, patient-centred, care in French.

Measuring, Monitoring, and Accountability

To ensure long-term sustainability and accountability, several HSPs proposed tools to monitor their progress toward designation. These included self-evaluation frameworks, data collection strategies, and mechanisms for annual reporting.

Informing Provincial-Level Advancement

The collective efforts of these five Central Region providers reflect broader system-level objectives. Their innovative practices and rigorous planning offer valuable models that can be adopted, adapted, and scaled provincially.

As Ontario Health works toward increasing the number of fully designated French-language health service providers, these early successes serve as powerful exemplars for peer organizations across Ontario.

Looking Ahead: Achieving Full Designation and Lasting Impact

Persistent work on the 20 designation criteria positions these providers to attain full status – advancing Ontario Health's goal of equitable, culturally safe care for Francophone communities and strengthening health outcomes across the province.

Key milestones for 2025-2026 will include:

- Launching Ontario's inaugural French Language Health Planning Centre scheduled for FY 2025-2026
- Meeting the Ministry's 90 per cent HSP reporting target for French-language services
- Releasing a province-wide Ontario Health Guide to streamline designation and evaluation.

Regional Highlights – Central, East, Northern, and Toronto Regions - Expanding Access and Capacity in French Language Health Services

- Five providers in the Central region advanced toward French Language Services Act designation, while Collège Boréal and Chigamik Community Health Centre trained 58 professionals from more than 30 organizations in French language care. A waitlist of 70 signals strong demand for future cohorts.
- Ontario Health East is co-designing a provincial model to improve remote care for Francophone patients in underserved communities. St. Joseph's Continuing Care Centre is scaling its Remote Care Monitoring Program across Eastern Ontario, using virtual check-ins, health coaching, and monitoring kits to support patients post-discharge and reduce emergency visits. With Estrie Community Health Centre acting as a referral source through secure e-referrals, the program is accepting new referrals beyond its original catchment and sharing its proven model with other providers. Next steps include refining patient pathways, optimizing program duration, and expanding partnerships to broaden impact.
- Across the Northern Regions, two North West providers (Thunder Bay Regional Health Sciences Centre and Santé Manitouwadge Health) and six North East providers (St. Joseph's Villa, St. Joseph's Continuing Care Centre, Algoma Family Services, Blanche River Health, Temiskaming Hospital, and Meals on Wheels) submitted detailed proposals to advance French Language Services and meet designation criteria. Extendicare Countryside was newly identified for designation. Both the North West and North East Ontario Health Teams have also integrated strategies from the Réseau du mieux-être francophone du Nord de l'Ontario into their operational plans to strengthen French-language services.
- In Toronto Region, six Active Offer training sessions reached 170 participants from five Ontario Health Teams and 18 providers. Reporting compliance on French Language Health Services rose to 95 per cent. A Francophone engagement event at Women's College Hospital drew 70 participants, and an additional $3 million was allocated to Francophone initiatives through French Language Health Services and Black Health-related funding streams.

Advancing Indigenous Health

First Nations, Inuit, Métis and urban Indigenous (FNIMuI) peoples in Ontario continue to face life expectancy five to seven years shorter than the provincial average and disproportionately high rates of preventable hospitalization (Graham et al., 2023; Dion et al., 2024).

Ontario Health is committed to building strong relationships with FNIMuI leadership, organizations and communities, and ensuring that province's health care system reflects and responds to the needs of FNIMuI peoples – grounded in respect, partnerships and open communication.

Key highlights of how we advanced Indigenous health equity:

- Formal relationship protocols signed with the Ontario Native Women's Association and Anishinabek Nation, establishing shared priorities and accountability.
- Twelve Indigenous liaison roles funded to embed community leadership in Ontario Health initiatives.
- 839 staff completed Indigenous Relationship and Cultural Awareness training; 91 participated in OCAP® data sovereignty workshops.
- Cancer PROMs and PREMs translated into Oji-Cree and Inuktitut to reduce language barriers.
- Community Paramedicine program expanded to deliver urgent care in remote First Nations.
- 180 Indigenous Tobacco Program workshops delivered across schools and health centres.
- Nine Indigenous-led projects launched in the West Region, including the province's first Indigenous lower limb preservation pathway.
- All Regional Cancer Programs now have Indigenous navigators and project coordinators.
- Ten engagements and 26 discussions advanced the FNIMuI Health Plan, targeted for release in September 2026.

Building trust and accountability

Formal relationship protocols with the Ontario Native Women's Association and the Anishinabek Nation, signed in May 2024 and January 2025 respectively, set shared priorities and accountabilities.

Twelve new Indigenous liaison positions, funded within Indigenous led organizations, give communities direct capacity to shape Ontario Health initiatives. The joint Ontario Indigenous Health Committee meets regularly to align system action with community direction.

Expanding culturally safe services

Culturally safe practice are being embedded in provincial quality standards and draft expectations for an Indigenous pathway in the Ontario Structured Psychotherapy Program, designed to address depression and anxiety.

In the Central Region, a Community Paramedicine program was expanded to bring urgent care closer to a remote First Nation. Cancer Patient-Reported Outcome Measures (PROMs) and Patient-Reported Experience Measures (PREMs) will be available in multiple languages, including Oji-Cree and Inuktitut – reducing language barriers at diagnosis and during treatment.

Growing system capacity through education

A total of 839 Indigenous Relationship and Cultural Awareness courses were completed by Ontario Health team members. Events marking Indigenous days of significance were hosted internally to promote awareness.

A two-day forum brought together 60 Regional Cancer Program staff to share best practice, and a Navigator Community of Practice now connects 38 frontline navigators in the West Region.

Respecting data sovereignty

The Indigenous Data Governance Matters process, refined with Indigenous partners, ensures transparent and respectful use of Indigenous data.

A detailed Community Cancer Profile for the Sioux Lookout First Nations Health Authority (SLFNHA) provided data on cancer incidence, prevalence, mortality and five-year survival – broken down by age, sex, and cancer type – to support SLFNHA in setting local priorities.

To build internal understanding of Indigenous data sovereignty, 91 Ontario Health team members participated in the Fundamentals of OCAP® (Ownership, Control, Access, and Possession) workshop, facilitated by the First Nations Information Governance Council.

Aligning regional and provincial strategies

Ten engagements and 26 discussions advanced the provincewide FNIMuI Health Plan, targeted for release in September 2026.

All Regional Cancer Programs now have Indigenous navigators and project coordinators. The West Region published its first Indigenous Health Strategy after consulting 144 Indigenous leaders, establishing five priorities from relational care to Métis specific initiatives.

Innovating with community leadership

Community-designed solutions are driving measurable change, including:

- 180 Indigenous Tobacco Program workshops reached schools and health centres.
- HPV self collection began at two Indigenous sites.
- Nine Indigenous led projects in the West Region introduced the province's first Indigenous lower limb preservation pathway and expanded primary care access.

Regular Indigenous Hospital Leader and Inuit Service Provider tables were also hosted, and we continued work to expand the Screening Activity Reports to additional Indigenous communities.

Regional Highlights – Central and Northern Regions: Strengthening Indigenous Health Partnerships

- In Central Region, collaboration with the Indigenous Health Circle produced best practice guidance for culturally safe at-home services, now adopted by all Central AtHome providers. Four Indigenous health service providers also designed self-determined palliative care models, and the Community Paramedicine Program was extended to remote First Nations communities to improve access to urgent care.
- In the James Bay Region, culturally responsive wellness initiatives included a Men's Wellness Workshop in Moose Factory and Moosonee, rooted in Indigenous teachings such as the Seven Grandfather Teachings and Feather Teachings. During a local hockey tournament, the Indigenous Primary Care Team provided on-site screenings, identifying health issues and ensuring timely follow-up care.

Figure 4 and 5. Ontario Health formalized relationship protocols with the Ontario Native Women's Association (May 2024) and the Anishinabek Nation (January 2025). These agreements establish shared priorities and accountabilities, strengthening partnerships rooted in mutual respect and collaboration.

Advancing Equity-Driven Analytics to Improve Planning, Decision-Making, and Health Outcomes

Key highlights of how we strengthened equity-driven analytics to inform system planning and improve health outcomes include:

- Ontario Health launched the Sociodemographic Data Explorer and enhanced the Health Equity Analytics Toolkit with new variables and geographic detail.
- Core Sociodemographic Data Standard released and supported by a 13-program Community of Practice.
- Individual-level data collection expanded to three hospitals and across key programs including lung screening, renal reporting, preventive care, and PROMs/PREMs.
- Sociodemographic metrics integrated into Quality Improvement Plans and monitoring for sickle cell emergency visits and readmissions.
- Negotiations initiated to acquire data from Community Health Centres, immigration records, and mental health pilot sites.
- Ontario Marginalization Index used to guide gap assessments for Integrated Primary Care team rollouts.

Collecting reliable, person-level sociodemographic data is the engine that drives every equity intervention described in this report. Without knowing which populations are receiving fewer cancer screenings, waiting longer in emergency departments or experiencing higher readmission rates, Ontario Health cannot effectively deploy resources where they are most needed – or measure progress over time.

This year, Ontario Health focused on strengthening the entire lifecycle of sociodemographic data so that inequities can be detected and addressed with greater precision. Work advanced across four mutually reinforcing pillars: expanding analytic tools, broadening data collection, embedding ethical governance and tightening accountability for meaningful use.

Next year, the strategy will mature to measure sociodemographic data collection, analysis and use across six clinical programs, ensuring every planning decision is backed by equity insights.

Pillar 1: Expanding Analytical Tools and Methods

Equity stratifications were incorporated into a larger share of the Enterprise Scorecard, and the Health Equity Analytics Toolkit was enhanced with additional variables and smaller geographic areas.

To improve access to small-area sociodemographic and equity data across the organization, Ontario Health launched the Sociodemographic Data Explorer on Health System Reports (HSR) – its internal dashboard repository. This Explorer allows teams to inspect equity data directly.

Pillar 2: Enhancing Data Collection and Acquisition

The Core Sociodemographic Data Standard was released and reinforced through a 13-program Community of Practice, which continues to address practical questions around consent, operations, and data quality.

Individual-level data collection began at Humber River Hospital, North York General Hospital and Scarborough Health Network, as part of the expansion of the Measuring Health Equity Initiative. Significant progress have been made to advance data collection in participating programs, including:

- Ontario Lung Screening Program.
- Ontario Renal Reporting System.
- Preventive Care.
- Patient-Reported Outcome and Experience Measures program.

Negotiations also took place to secure datasets from Community Health Centre, permanent resident records from Immigration, Refugees and Citizenship Canada and pilot information from mental health and addictions sites.

Pillar 3: Strengthening Data Governance and Advisory Frameworks

Ontario Health's Data Governance Principles were shared with health service providers to align equity data initiatives with broader planning and information sharing protocols. These principles ensure that community data are treated with transparency and respect.

Pillar 4: Ensuring Meaningful Use, Action, and Accountability

Sociodemographic metrics are now integral to Quality Improvement Plans, emergency department and readmission monitoring for patients with sickle cell disease, and regional strategies that set explicit data collection targets.

Analyses using the Ontario Marginalization Index and forward sortation area profiling guided gap assessments for Integrated Primary Care team rollouts and other population health related initiatives.

Looking Forward

Unified data standards, richer analytic tools and stronger governance leave Ontario Health better positioned to identify inequities early and intervene effectively – reinforcing the organization's provincewide commitment to equitable health outcomes for all Ontarians.

Building a Safer, More Inclusive Workplace Through Internal EIDA-R Implementation

Key highlights of how we advanced internal equity, inclusion, diversity, and anti-racism (EIDA-R) priorities to strengthen workplace culture include:

- 322 team members registered for the 10-hour Advancing Health Equity in Ontario workshop, with an 86% completion rate and 95%+ satisfaction scores.
- Eight Communities of Inclusion (COIs) now engage nearly 800 staff, supported by a new reporting system and a 43% increase in mentorship matches.
- Ontario Health recruited a strategic advisor to review EIDA-R and Respectful Workplace policies, supporting inclusive recruitment and workplace practices.
- Cultural and commemorative events included Indigenous Days, Pride Month, Black History Month, Franco-Ontarian Day, and the first workplace accessibility forum.
- EIDA-R obligations will be embedded in Service Accountability Agreements for over 1,800 health service providers by 2025–2026.

This year, Ontario Health deepened its equity agenda through focused team member education – through a strengthened Communities of Inclusion (COI) and internal policy review.

Capacity Building and Team Member Education

Ontario Health's team member development focused on embedding equity into daily work. Training covered Francophone cultural linguistic care, Indigenous data governance, and updated gender-inclusive language standards.

Results from the March 2024 Employee Engagement Survey – which introduced diversity and experiential questions – were explored through leadership focus groups. These sessions generated recommendations for a multiyear cultural change action plan.

Strategic Review and Organizational Growth

Recognizing the importance of structural transformation, Ontario Health recruited a strategic advisor for Equity, Inclusion, Diversity and Anti-Racism (EIDA-R). This role focused on reviewing the Respectful Workplace policy, program and practices, and the EIDA-R policy in order to provide actionable recommendations to support inclusive practices, enhance diversity in recruitment processes and promote a greater implementation of the EIDA-R principles.

These steps reinforce Ontario Health's strategic objective to create a workforce reflective of Ontario's diverse populations.

Community-Led Learning and Engagement

Team member-driven learning remained active in 2024–25. The volunteer Health Equity and Population Health Community of Practice hosted five open-access sessions with strong attendance:

- Two webinars on food insecurity as a social determinant of health.
- A session on climate equity.
- An overview of the Health Equity Analysis Toolkit.
- A workshop on equity-driven population health planning with Health Commons Solution Lab.

Ontario Health also delivered 16 iterations of its 10-hour *Advancing Health Equity in Ontario* workshop. A total of 322 participants registered, with an 86 per cent completion rate in Q4. Post-session surveys consistently rated the program above 95 per cent on all standard adult education metrics.

Strengthening Communities of Inclusion

With executive sponsorship, dedicated funding, and release time, eight Communities of Inclusion now engage more than 750 team members. A newly formed Muslim COI expanded the network, and an enlarged mentorship program produced a 43 per cent rise in matches. The 24/25 evaluation of the COI Mentorship Program reported 72% network growth and cross-team visibility and 96% would recommend the program to a colleague. There continues to be a great demand in mentorship and interest in cultivating the next generation of diverse thought leaders.

A reporting system introduced by the COI Working Group now tracks membership, programming, and emerging needs across all equity-deserving groups.

Ontario Health will continue to dedicate paid community building time to nearly 800 team members across the eight COIs. By 2025-2026, Ontario Health will deliver recommendations that will strengthen the *Respectful Workplace Policy*, EIDA-R policies and Anti-Discrimination Plan, while embedding EIDA-R obligations in Service Accountability Agreements (SAA) for more than 1,800 health service providers (HSPs).

Communities of Inclusion (COIs)

Anti-Racism, Inclusion, Social Justice, Equity (ARISE) COI, East Asian COI, Jewish COI, Muslim COI, Nation to Nation, Pride in Health, South Asian Multicultural Alliance, and Women in Motion offered safe spaces, networking, and education.

Activities ranged from an open house that connected team members in person and online, to hosting speaker series featuring health system leaders and sessions on antisemitism that supported allyship and historical awareness.

Promoting a Culture of Inclusion

Ontario Health marked key cultural and commemorative dates through events that foster understanding and connection. Highlights included:

- Indigenous Days of Significance events.
- An Asian Heritage Month fireside chat.
- Pride Month dialogues on sovereignty and health equity.
- The organisation's first workplace accessibility forum.
- A Black History Month poetry and panel discussions
- An International Women's Day leadership panel.
- A Ramadan session hosted by the Muslim COI.

Book clubs such as *Black on the Page* and *BizhaanMamawiMaazinganan* sustained year-round learning.

Embedding Equity Requirements in Health Service Providers

Building upon previously embedded equity and Indigenous health equity obligations within SAAs, Ontario Health took strategic steps to further refine and strengthen these requirements.

In collaboration with regional partners, Ontario Health assessed and analyzed equity plans submitted by HSPs for 2023-2024. This comprehensive review informed a detailed provincewide summary report led to the development of a refined evaluation approach that effectively measures tangible equity outcomes across the health system.
As part of its preparation efforts for provincewide dissemination, Ontario Health held a webinar to communicate findings, facilitate dialogue, and guide subsequent planning cycles.

These continuous refinements aim to ensure HSP compliance, drive meaningful equity advancement, and systematically strengthen organizational accountability across Ontario's health care system.

By advancing robust internal equity practices, providing comprehensive educational support, and embedding meaningful accountability across organizational structures, Ontario Health continues to cultivate a workplace culture authentically reflective of the diverse communities it serves.

Cancer Continuum Equity Initiatives

Key highlights of how we advanced equity across the cancer continuum include:

- Ontario Breast Screening Program expanded eligibility to women aged 40–49; 4,238 culturally responsive screening conversations supported uptake.
- Preventive Care Program delivered in clinics and hubs, offering personalized plans and navigation support, with targeted outreach to Black, African, and Caribbean communities.
- Three Equity Engagement Tables co-designed culturally safe cancer diagnostic pathways for Black Ontarians, Francophones, and newcomers.
- Phases Two and Three launched to embed equity engagement into integrated diagnostic pathways and institutionalize community partnership.
- Equity engagement pilot conducted with the Institute for Better Health, aligned with Ontario Cancer Plan 6 to improve survival and trust.

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Equity in cancer care requires action along the continuum. Ontario Health begins with prevention and screening, then ensures that individuals who develop symptoms move through a diagnostic pathway that is timely, culturally safe and trusted.

Cancer Prevention and Screening

Preventive Care Program

Breast, cervical, and colorectal cancers together account for more than a quarter of all new cancer diagnoses in Ontario. However, screening participation remains lower among women under 50 due to several factors, including:

- Perceived low risk.
- Lack of awareness about screening recommendations.
- Socio-economic factors such as transportation difficulties for newcomers, and Black, African and Caribbean communities (Mathioudakis et al., 2019).

Historically, screening participation among women younger than 50 have been lower – reflecting the longstanding recommendation that average-risk breast and colorectal cancer screening begin at age 50.

Routine breast screening became available to women aged 40 to 49 with the October 2024 expansion of the Ontario Breast Screening Program (OBSP). Preliminary uptake data from the first three quarters of this expansion are now being analyzed.

Ontario Health's Preventive Care Program is a holistic initiative delivered through primary care and community-based settings. It aims to improve outcomes in underserved and equity-deserving communities, including Black populations, by addressing both the immediate health needs and broader factors that influence their long-term outcomes.

This is especially important for Black, African and Caribbean communities, which are disproportionately impacted by chronic diseases and other associated risk factors. Participants receive health education, chronic disease risk assessment and coaching from a trained prevention specialist and collaboratively develop a personalized preventive care plan.

Navigation support is also provided to connect participants with providers, programs and services that help them achieve their preventive health goals.

In 2024-2025, the program was delivered in clinics and community hubs across the province, including Roots Community Services in Peel – a community organization recognized for providing culturally relevant programs to inspire and empower Black, African and Caribbean communities to make positive changes towards health and well-being.

Regional Highlight – Northern Region: Successful Mammography Screening Campaign

- The Chronic Disease Prevention and Wellness team partnered with the Diagnostic Imaging team at Weeneebayko Area Health Authority to launch the Winter Mammography Blitz. Enhanced regional promotions helped exceed Ontario Breast Screening Program projections by 24 exams—achieving 66 mammograms during the campaign and a record 63.5 per cent attendance rate. The initiative highlighted the vital role of preventative care specialists and community ambassadors in driving participation.

Supporting Ontario Breast Screening Program 40 to 49 Expansion

Prevention specialists played a pivotal role in facilitating 4,238 culturally responsive breast screening conversations. They helped individuals understand their breast cancer risk using validated tools such as My CancerIQ and disseminated tailored resources to support informed decision-making. Specialists also provided direct system navigation and appointment-booking support, connecting eligible participants with OBSP sites for mammography. This comprehensive approach ensured that individuals newly eligible for breast cancer screening were fully informed, supported, and empowered to access preventive services aligned with their health needs and personal values.

Raising awareness of breast cancer risks and screening guidelines using tailored approaches for Black communities is an important step towards removing barriers to accessing routine screening.

Equitable Engagement in Cancer Diagnostics

Late-stage diagnosis remains more common among equity-deserving groups (Faugno et al., 2025; Garcia et al., 2014; Muray, 2022). This disparity is reflected in provincial cancer registry data and echoed in patient experience surveys, which cite language barriers, cultural disconnects and long waits for follow-up care as key factors.

In 2024-2025, Ontario Health set out to close this gap by redesigning how patients and families from underrepresented groups participate in shaping diagnostic services. The premise is simple – when those who carry the greatest burden of delay are embedded in decision-making, the pathways they help design become faster, safer and more culturally aligned, ultimately improving survival and trust.

Targeting communities most affected by delay

In partnership with the Institute for Better Health at Trillium Health Partners, the equity engagement pilot focused on three populations shown by evidence to face the greatest diagnostic barriers:

- Black Ontarians of African, Caribbean and other diasporic backgrounds.
- Francophones whose first language is French.
- Newcomers, including refugees, economic immigrants and temporary foreign workers.

Building representative engagement structures

Three dedicated Equity Engagement Tables – one for each priority community – were established and met regularly throughout 2024-2025. Their members co-designed a practical engagement model that outlines how to integrate cultural safety, language access and lived experience into every step of the diagnostic pathway.

Phase Two, launched in 2025, leveraged this model to support Ontario's integrated cancer diagnostic pathways.

Phase Three began late in the year and will continue through 2025, developing principles and recommendations to institutionalize these engagement structures within Ontario Health – ensuring accountability and sustained community partnership over time.

Anticipated impact

The work aligns directly with Ontario Cancer Plan 6, which calls for integrated, navigable and equitable diagnostic services. By institutionalizing equity-centred engagement, Ontario Health aims to shorten the time from first symptom to treatment, improve outcomes in populations with historically poorer survival and build durable trust with communities that have long felt excluded from cancer care planning.

Equitable Kidney Care: Ontario Renal Network

Key highlights of how we advanced equitable kidney care:

- Race-neutral eGFR equation adopted provincewide on April 1, 2024, eliminating race-based bias in kidney function diagnosis.
- Dr. Bourne Auguste appointed Provincial Medical Lead for Health Equity in kidney care, guiding strategy and systemic change.
- Community consultations and data analysis informed an evidence-based action plan to address kidney health inequities among Black Ontarians.
- Home Dialysis Training Remote Travel Grant reimbursed travel, meals, and accommodation for 85 patients learning home dialysis.
- New pilot program launched to cover transportation costs for patients traveling long distances for in-facility dialysis.

Chronic kidney disease is diagnosed later and progresses more quickly among many racialized, Black, and remote area populations in Ontario (Ferguson et al., 2024; Olaye, 2024; Domonkos et al., 2021). Ontario Health is focused on eliminating race based diagnostic bias, expanding culturally safe services, and reducing the travel and cost barriers that Black, other racialized and rural or remote patients face when accessing dialysis and specialist care.

Removing race bias from diagnosis

On April 1, 2024, every renal program, hospital and community laboratory adopted a race neutral estimated glomerular filtration rate (eGFR) equation. Eliminating the Black race modifier in kidney function calculation ends a practice that could delay referral and treatment for thousands of patients of African descent. This change sets a new clinical baseline for equitable kidney care across the province.

Embedding equity in system leadership

In December 2024, nephrologist Dr. Bourne Auguste became Provincial Medical Lead for Health Equity. His mandate is to guide strategy, identify systemic barriers, and embed equity imperatives across Ontario's kidney care system – underscoring Ontario Health, 's, intensified focus on fair access and outcomes.

Targeting gaps for Black communities

Throughout 2024-2025, Ontario Health collaborated closely with clinical experts, community organizations and the Black Health Plan Working Group to better understand the burden of chronic kidney disease. The work informed the development of an evidence-based action plan specifically addressing kidney health inequities among Black Ontarians.

Central to this work was the initiation of community consultations to engage individuals with lived experience. Chronic kidney disease surveillance data were systematically analyzed and stratified by racialized groupings to identify specific gaps, barriers, and disparities in care outcomes. This data-driven approach ensures targeted interventions are informed by both robust analytics and direct community input.

Reducing geographic and economic barriers

Distance and cost remain major obstacles for rural, remote and low-income patients. In 2024-2025 the Home Dialysis Training Remote Travel Grant reimbursed travel, meals and accommodation for 85 people learning to manage dialysis at home.

A new pilot program began covering transport expenses for patients who must travel long distances for in-facility dialysis, further levelling the playing field for those living at a distance from dialysis centres.

Through these combined actions, Ontario Health is translating policy into practice, making kidney care fairer for Black, rural and economically marginalized Ontarians.

Patient, Family & Caregiver Partnerships

Key highlights of how we strengthened patient, family, and caregiver partnerships:

- Health811 responded to over one million calls and online contacts, with equity-based improvements underway to better serve underserved populations.
- Partner Advisory Council refreshed to include members from 2SLGBTQIA+, Black, immigrant, newcomer, Francophone, and Indigenous communities.
- Symptom Assessment Tool refined to reflect an explicit equity lens based on lived experience input.
- Multi-year agreement launched with First Nations Digital Health Ontario to tailor Health811 for First Nations users and map culturally relevant service gaps.
- Planning initiated to make Health811 more affirming for gender diverse and trans users, with Rainbow Health Ontario validating language and communication protocols.

Equitable access to accurate, culturally safe health information is effective for lowering unnecessary emergency department visits and improving chronic disease self-management. Yet, survey data show that Indigenous callers, rural residents and gender-diverse people are still less likely to receive advice they trust (Tremblay et al., 2023).

Health811 – Equity-Centered Service

Health811 responds to more than one million calls and online contacts each year. While current data does not yet capture users' full sociodemographic profile, community engagement has highlighted opportunities to make the service more culturally safe and relevant for rural residents, Indigenous peoples and gender diverse individuals.

Recognizing that equitable access to trusted guidance can prevent emergency visits and support chronic disease management, Ontario Health has identified Health811 as a priority for ongoing equity-based quality improvements. The project team is working to reshape governance, expand content and remove barriers to better meet the needs of populations that have historically felt unseen within mainstream health services.

Strengthening Advisory Structures with Intersectional Representation

The Partner Advisory Council was refreshed to include members who self-identify as 2SLGBTQIA+, Black, immigrant or newcomer, Francophone, First Nations, Indigenous, Metis and urban Indigenous communities. Their lived experience has already shaped service upgrades. – for example, refinements to the Symptom Assessment Tool now reflect an explicit equity lens.

Deepening Indigenous Engagement through Partnerships

Year one of a multi-year agreement with First Nations Digital Health Ontario deepened collaboration aimed at building trust and tailoring Health811 for First Nations users. Joint work in 2025-2026 will map directory gaps so the platform more accurately lists culturally relevant services for First Nations Health teams and their communities.

Creating Inclusive Experiences for Gender Diverse and Trans Communities

Planning began to make Health811 more affirming for gender diverse and trans users. Language and communication protocols are being realigned with Ontario Health's guidelines, with Rainbow Health Ontario providing direct validation. These changes will help deliver a more respectful, inclusive experience for 2SLGBTQIA+ callers and online users.

Key Takeaways

In 2024-2025, Ontario Health advanced equity, inclusion, diversity, and anti-racism through community-led programming, stronger partnerships, enhanced data analytics and culturally responsive care. This work improved access and outcomes for equity-deserving populations while laying durable foundations for provincewide transformation.

To build on this progress, the following actions will guide next steps in 2025-2026:

- Embed equity metrics and reporting requirements into all funding agreements to drive accountability and transparency.
- Scale and sustain community-led models by securing long-term funding for population health teams and cultural tailored clinics.
- Expand core quality standards, such as Gender Affirming Care, Black Health equity, race-neutral protocols, across all regions and care settings.
- Broaden sociodemographic data capture and governance, leveraging real-time dashboards to support targeted interventions.
- Deepen formal partnerships with Indigenous and Francophone communities, including the launch of the French Language Health Planning Centre scheduled for FY 2025-2026.

Appendix

Acronyms

Acronym	Full Form	Example of Use in This Report
EIDA-R	Equity, Inclusion, Diversity, Anti-Racism	Equity, Inclusion, Diversity, Anti-Racism (EIDA-R) Framework
FLHS	French Language Health Services	French Language Health Services (FLHS)
2SLGBTQIA+	Two-Spirit, Lesbian, Gay, Bisexual, Trans, Queer, Intersex, Asexual, Plus	Enhancing access and quality of care for the 2SLGBTQIA+ community
eGFR	estimated Glomerular Filtration Rate	Implemented a new estimated Glomerular Filtration Rate (eGFR) equation
ON-Marg	Ontario Marginalization Index	The Health Equity Analytics Toolkit (HEAT) includes a set of tables with key sociodemographic data elements, primarily built from the Canadian Census and other analytics tools such as the Ontario Marginalization Index (ON-Marg)
FSA	Forward Sortation Area	The tables have over two dozen variables across the four axes of marginalization used to create the ON-Marg Index. These variables are available at the Forward Sortation Area (FSA) and the Dissemination Area (DA) level
IRCA	Indigenous Relationship and Cultural Awareness	Promoted Indigenous Relationship and Cultural Awareness (IRCA) courses among Ontario Health staff
COIs	Communities of Inclusion	Ontario Health upholds seven Communities of Inclusion (COIs) for equity deserving groups within the organization
JOIHC	Joint Ontario Indigenous Health Committee	The Joint Ontario Indigenous Cancer Committee approved an expansion of its mandate beyond cancer to include other Indigenous health priorities and is now the Joint Ontario Indigenous Health Committee (JOIHC)
FNIMUI	First Nations, Inuit, Métis and Urban Indigenous	The First Nations, Inuit, Métis and Urban Indigenous (FNIMUI) Health Framework was launched in January 2024
HEAT	Health Equity Analytics Toolkit	Launched the Health Equity Analytics Toolkit (HEAT)
IDGM	Indigenous Data Governance Matters	Working with First Nations, Inuit, Métis and urban Indigenous partners to develop and refine an internal Indigenous Data Governance Matters (IDGM) process

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