RACE, ETHNICITY & INDIGENOUS IDENTITY DATA

EMERGENCY DEPARTMENT VISITS & CARE

PUBLIC REPORT - JUNE 2025

CancerCare Manitoba
ActionCancerManitoba

Interlake-Eastern
Regional Health Authority

NORTHERN
HEALTH REGION

PRAIRIE MOUNTAIN HEALTH
SANTÉ PRAIRIE MOUNTAIN

Shared health
Soins communs
Manitoba

Southern Health
Santé Sud

Winnipeg Regional
Health Authority

Office régional de la
santé de Winnipeg

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Acknowledgement

We gratefully acknowledge the many individuals, communities, and partners who contributed their time, insights, and lived experiences to this work. We extend particular thanks to the patients and families who have shared their identities and experiences, the front-line staff who have integrated this practice into their workflows, our Indigenous partners and community leaders who have guided this work with integrity, and the provincial and regional clinical and operational team members whose collaboration was essential. We also thank the public members of the REI Provincial Data Governance Steering Committee, whose oversight and stewardship of REI data ensure that its use remains grounded in transparency, accountability, and community priorities. Your dedication has been vital in shaping a more inclusive, responsive, and community-centred approach.

Introduction and Context

On May 11, 2023, hospitals in Manitoba started collecting racial, ethnic, and Indigenous identity data from people accessing care. The groundwork for this began around 2016, with the course needing adjustments as healthcare transformation and the COVID-19 pandemic unfolded. The purpose of collecting racial, ethnic, and Indigenous identity data (REI data) is to be able to measure the access to and quality of care that different communities in Manitoba receive so that identified gaps can be addressed. **The goal of this is to ensure that every person in Manitoba receives the highest quality of care that our system can provide.**

During the COVID-19 pandemic, REI identifiers were routinely collected during case investigation processes and on vaccine consent forms. The data was used effectively in COVID-19 response planning, including in vaccine prioritization and eligibility decisions.

As during the COVID-19 pandemic, there is an evolving governance structure that has been overseeing all aspects of this work. This gives members of diverse communities an opportunity to provide their expert input and work collaboratively to maximize the potential benefits of this type of data while minimizing potential risks. Bilateral processes between First Nations, Metis, and Inuit provincial representative organizations exist to govern all aspects of their Nation-specific data. For the non-Nation specific data, a provincial REI Data Governance Steering Committee oversees and provides direction to this work. Members of this committee were recruited through an open application process.

Collection Procedures

When patients access healthcare through a hospital in Manitoba, including if they only come for diagnostic imaging (like an MRI or CT scan), they visit patient registration to be registered for care. As part of this registration process, they are given the opportunity to self-identify. Registration staff are asked to follow a specific script when a person first presents for healthcare, and a confirmation script if the person has previously been asked to provide their REI identity.

There are regular audits done to check the completeness and accuracy of the REI identity data, and there is ongoing work to improve the quality of this data.

As the locations where this data is collected grow, such as potentially extending into publicly operated primary care settings, the processes for collection may change to adjust to different workflows and patient care experiences.

Key Terms to Know

Terms	Meaning
ED **Emergency Department**	Where people go for urgent medical help.
CTAS **Canadian Triage Acuity Scale**	Known as **Triage Score.** It helps hospitals decide how quickly a patient needs care. 1 = most serious, 5 = least serious.
WTBS Wait To Be Seen	Known as **WAIT TIMES**. The time from when a patient is assessed until they see a nurse or doctor.
LWBS Left Without Being Seen	After they are assessed, if a patient leaves the emergency department before they see a doctor or nurse, they **LEFT WITHOUT BEING SEEN**.
LAMA Left Against Medical Advice	When a patient chooses to leave the hospital, even though doctors advise them to stay.

Data Review and Contextual Analysis

Emergency Department Visits

For this initial analysis and release of the data we have focused on some elements of emergency department care. This was a high priority for all of the partners we talked to and it's also the site of care with the most data available right now. This is helpful because it strengthens our ability to disaggregate the data and report on it more accurately for different communities.

Figure 1 shows that from the time period of May 11, 2023 until September 30, 2024 there were over 618,000 emergency department visits where the person's REI identity is known. These are the visits that we have been able to look into further.

Figure 1: Total ED Visits May 2023 to Sept 2024

Race, Ethnicity and Indigenous Identities	Total ED Visits	% ED Visits
AFRICAN AND/OR BLACK	16,950	2.8%
EAST ASIAN AND/OR SOUTHEAST ASIAN	9,390	1.5%
FILIPINO	24,028	3.9%
LATIN AMERICAN	5,317	0.9%
MIDDLE EASTERN	5,147	0.8%
NORTH AMERICAN INDIGENOUS	226,547	36.9%
OTHER	4,144	0.7%
SOUTH ASIAN	15,918	2.6%
WHITE	311,362	50.7%
Total	**618,803**	**100%**

***Declined to Answer= 70,465, Unable to Interview = 83,544, Unknown = 90,529. This group combined represents 28.3% of visits.*

Visits where the response is recorded as "unknown" or "unable to answer" accounted for 174, 073 visits. We are working with the Health Information Management Teams to understand where these responses are not being used properly and support team members to use them more appropriately as part of our ongoing data quality work.

Only 8 per cent of people decline to answer when given the opportunity to self-identify. We need to continue to work on the processes and environment so that more people will feel safe providing this important information.

Figure 2: WRHA and Shared Health total ED visits by race, ethnicity and indigenous (REI) identity

Adults **Children's**

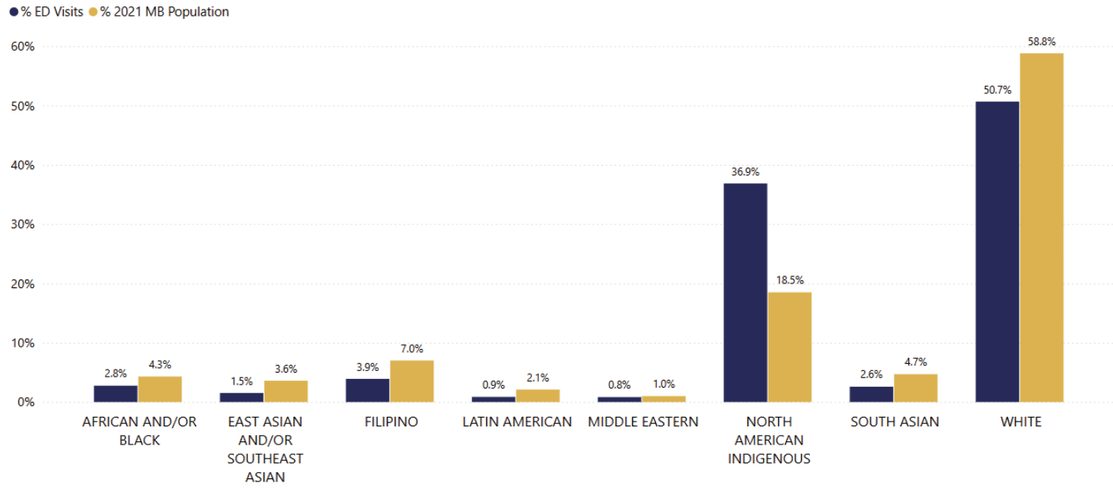
	Shared Health		Shared Health		WRHA	
Race, Ethnicity and Indigenous Identities	**Total ED Visits**	**% ED Visits**	**Total ED Visits**	**% ED Visits**	**Total ED Visits**	**% ED Visits**
AFRICAN AND/OR BLACK	2,658	4.5%	4,121	8.1%	7,673	4.4%
EAST ASIAN AND/OR SOUTHEAST ASIAN	863	1.5%	1,757	3.5%	5,061	2.9%
FILIPINO	3,170	5.3%	4,892	9.6%	10,795	6.1%
LATIN AMERICAN	388	0.7%	930	1.8%	2,343	1.3%
MIDDLE EASTERN	438	0.7%	1,082	2.1%	2,557	1.5%
NORTH AMERICAN INDIGENOUS	33,554	56.5%	18,537	36.4%	45,086	25.6%
SOUTH ASIAN	1,590	2.7%	3,643	7.2%	8,744	5.0%
WHITE	16,776	28.2%	15,922	31.3%	91,936	52.2%
Total	**59,437**	**100%**	**50,884**	**100%**	**175,976**	**100%**

As you can see in Figure 2, the vast majority of visits (almost 87 per cent) are by people who identify as White or as North American Indigenous. This number of visits allows us to provide more detailed information by other factors like health region and triage scores. For the population groups with smaller numbers, we cannot provide as detailed an analysis yet.

Throughout this report we will try to highlight patterns for the largest five population groups- White, North American Indigenous, Filipino, African and/ or Black, and South Asian. When the total number in any cell in a table is under 100 we will not show it.

As part of our plan, we will share additional information by SDO directly with the individual SDOs. However, because detailed data by triage score (for example) may result in small sample sizes for some population groups, this report will only include information for the province as a whole, as well as for Shared Health and WRHA.

Figure 3: Total emergency department visits and population representation



As has been mentioned previously, the vast majority of visits are by people who self-identify as White or North American Indigenous. In figure 3, we are comparing the proportion of ED visits by population group with their population representation according to the 2021 Census. It's important to note that even though there are more visits by North American Indigenous people compared to their population size in the province, this doesn't mean that ED use is inappropriate. This can reflect higher needs because of factors like underlying health gaps and lower access to other forms of care, (such as primary care,) that would help decrease the need for care in an ED.

One of the important ways that we can use race-based data is to challenge harmful narratives that can compromise the healthcare different populations receive. One of these harmful narratives is that Indigenous people over-use the ED and use it inappropriately. As we move through this data we will highlight where our data does not support that harmful narrative.

Figure 4: Emergency department visit rate per 10,000

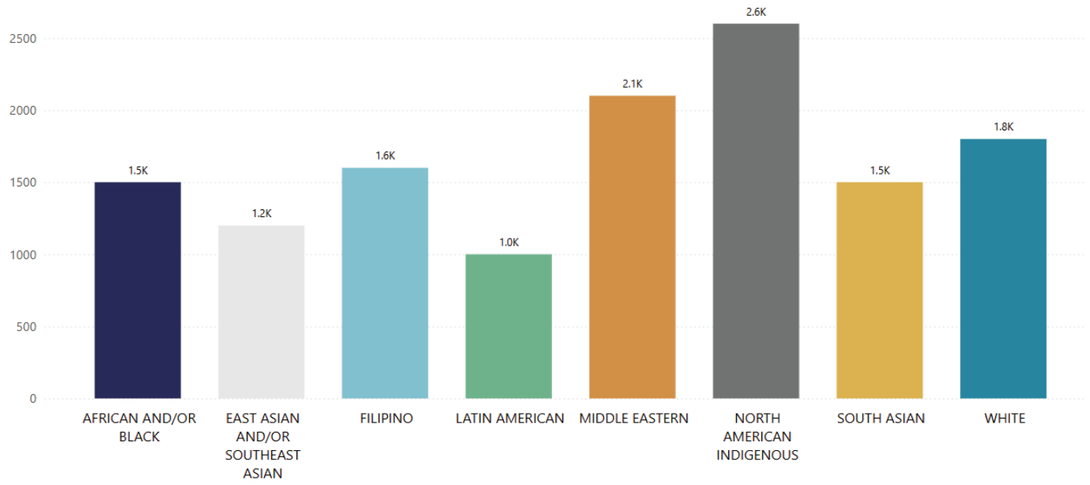


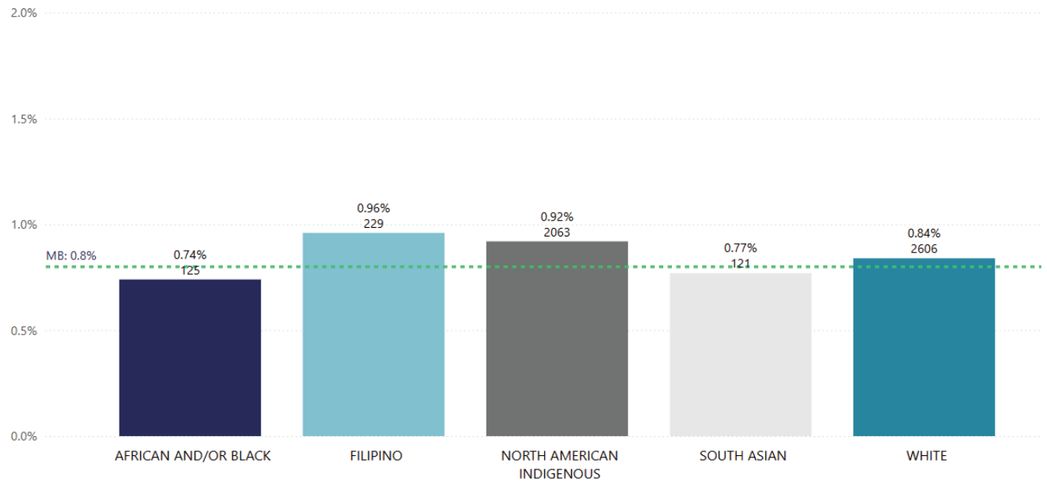
Figure 4 demonstrates a different way of looking at ED utilization by different population groups. In this figure, ED utilization is presented as the rate of ED visits per 10,000 people for each REI category. This is the rate over the period of time May 11, 2023 and September 30, 2024. These rates also show significant variation between groups, but without more information it is not possible to know why this is.

Emergency department Visits by Triage Score

The next series of information will show information about ED visits by triage scores and population group. The Canadian Triage and Acuity Scale (CTAS) provides guidance on how to categorize patients to ensure those who are the most ill get seen soonest. There are five different CTAS levels:

- CTAS 1: Resuscitation, for patients who are severely ill or have conditions that threaten life or limb
- CTAS 2: Emergent, for patients who have conditions that are a potential threat to life or limb function
- CTAS 3: Urgent, for patients who have conditions that could potentially progress to a serious problem
- CTAS 4: Less urgent
- CTAS 5: Non-urgent

Figure 5: % emergency department visits by canadian triage acuity scale (CTAS 1) and REI group



CTAS 1 accounts for the fewest number of ED visits. As a reminder, the CTAS 1 score is assigned to the most severely ill patients. Across different population groups, the proportion presenting to the ED with CTAS 1 are very similar, ranging from 0.7% to 1.0% of visits by that population group.

Figure 6: % emergency department visits by canadian triage acuity scale (CTAS 2) and REI Group

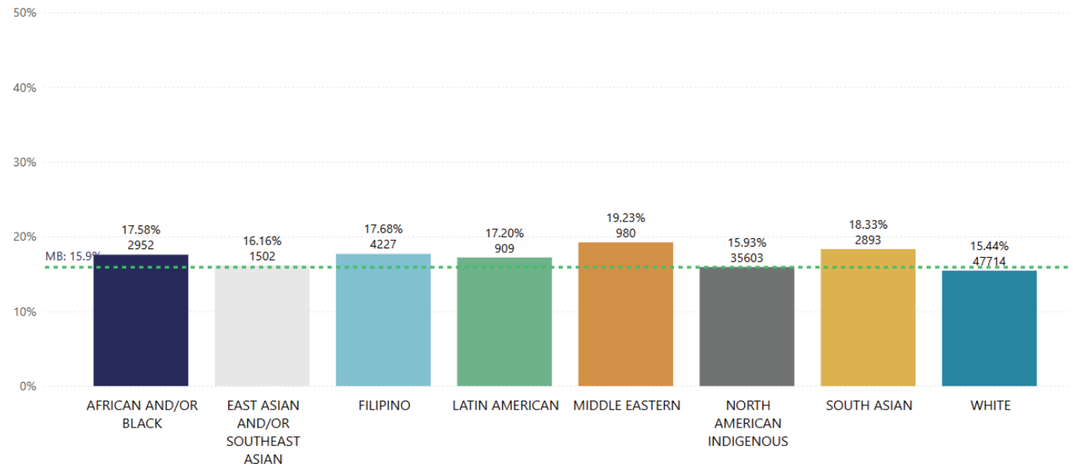


Figure 6 shows among people who receive a triage score of CTAS 2, we do see some variations with a smaller proportion of North American Indigenous patients (15.9%) and White patients (15.4%) compared to some other groups such as South Asian (18.3%) and Middle Eastern (19.2%).

Figure 7: % emergency department visits by canadian triage acuity scale (CTAS 3) and REI group

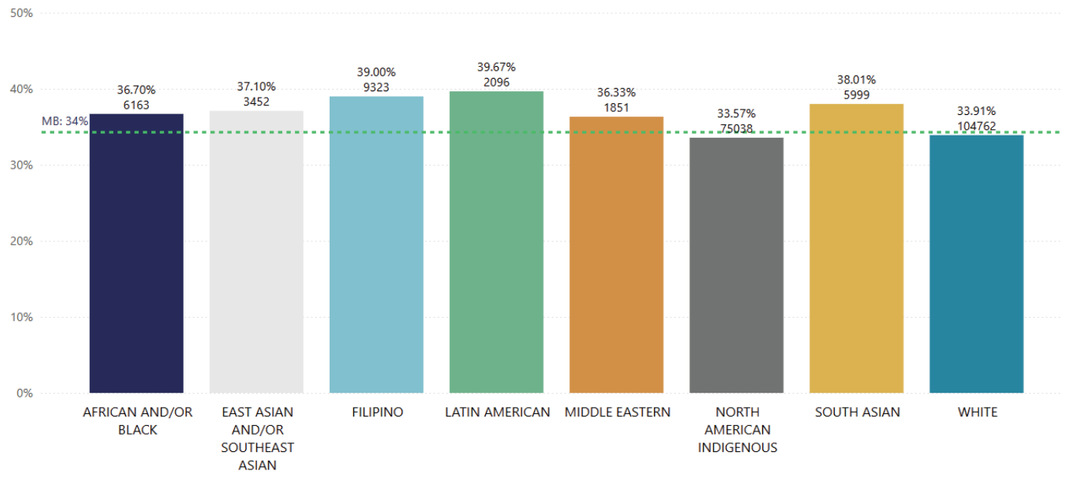
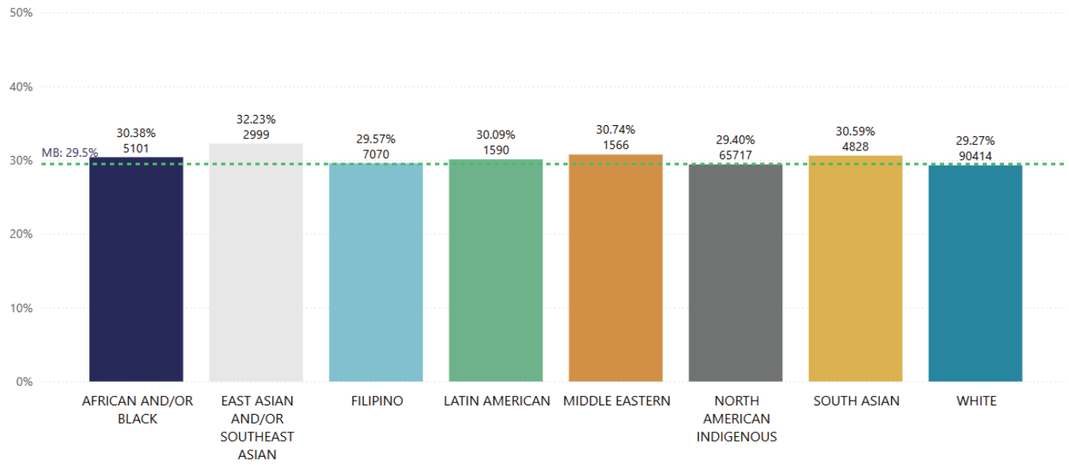


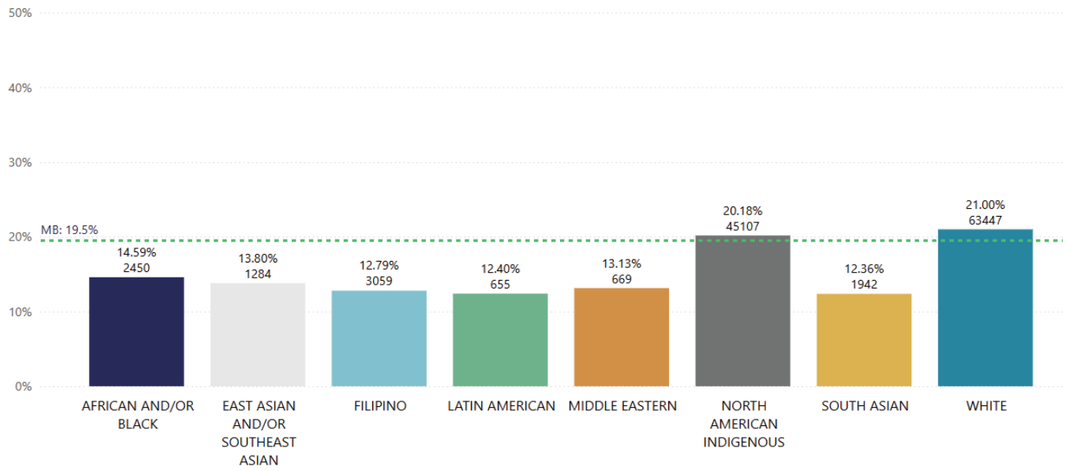
Figure 7 shows CTAS 3 is the most commonly assigned triage score. As with CTAS 2 we see that there are relatively fewer North American Indigenous patients (33.6%) and White patients (33.9%) presenting with CTAS 3 compared to other groups including Filipino patients (39.0%) and Latin American (39.7%).

Figure 8: % emergency department visits by canadian triage acuity scale (CTAS 4) and REI group



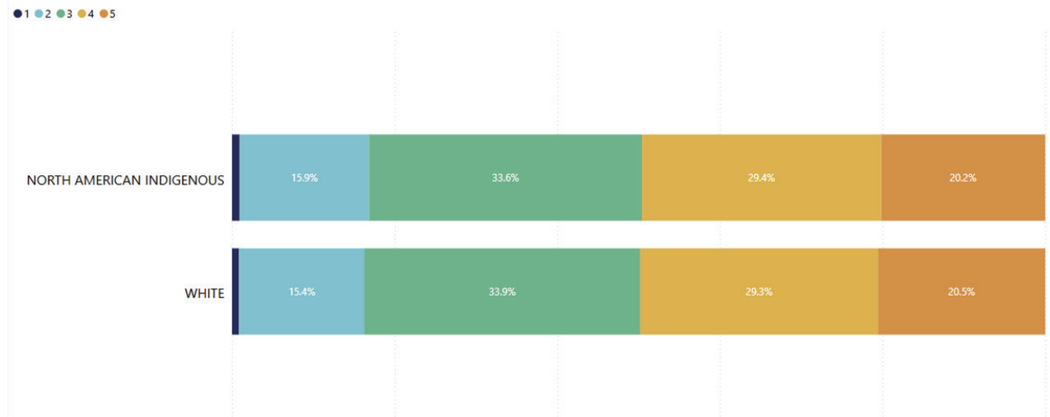
The proportion of patients within each population group who are assigned an initial score of CTAS 4 is overall very similar, around 29-30%.

Figure 9: % emergency department visits by canadian triage acuity scale (CTAS 5) and REI group



When we look at CTAS 5, it is notable that there are higher proportions of North American Indigenous and White patients assigned this lowest urgency triage score. People presenting to the ED who are assigned a CTAS 5 can often safely receive healthcare in a non-ED setting, if those services are accessible, high quality and safe.

Figure 10: % emergency department visits by canadian triage acuity scale (CTAS) and REI group

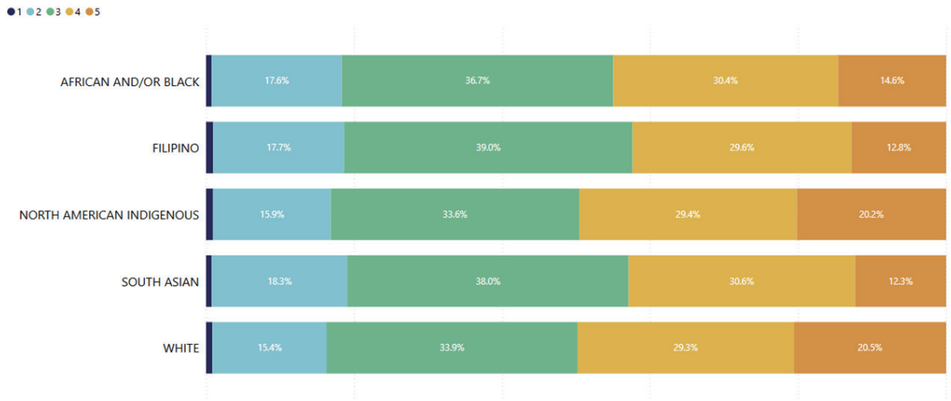


As mentioned earlier, one dominant narrative that can harm the healthcare that Indigenous Peoples receive is that they overuse the ED and use it inappropriately. As the In Plain Sight report documented, healthcare providers may hold many stereotypes about Indigenous Peoples, such as being “frequent flyers”, and that can interfere with quality of care. [1]

Figure 10 clearly shows that there are no real differences in the proportion of patients who are assigned each triage score between North American Indigenous and White patients. Although some might argue that folks who present and are assigned a score of CTAS 4 or 5 could be more appropriately seen elsewhere (like a minor injury clinic or after-hours primary care), Indigenous people are not more likely than White people to present with these lower acuity scores. This helps counter the narrative that Indigenous people use the ED more inappropriately than other people.

[1] In Plain Sight report: https://engage.gov.bc.ca/app/uploads/sites/613/2020/11/In-Plain-Sight-Summary-Report.pdf

Figure 11: % emergency department visits by canadian triage acuity scale (CTAS) and REI group



As we examine these differences in the proportion of patients assigned these different triage scores it's important to note that racism/ bias has been shown to affect the triage scores that Indigenous, Black and other racially marginalized people receive. [2]

For both more and less shows more urgent and less urgent complaints, White people are more likely to be assigned a more acute triage score (like CTAS 2 or 3). This has been shown to affect markers of access to and quality of care like the wait time to be seen, the wait time for diagnostic tests, and the total number of diagnostic tests. When we look at triage scores here, because of this pattern of evidence which has been seen in both Canada and the United States, it is possible that Indigenous and African and/or Black patients are systematically receiving lower triage scores than White people. Further work looking at where someone goes from the ED (for example if they are admitted to hospital) and the discharge diagnoses will help us to understand the potential impact of this in Manitoba Emergency Departments.

[2] Examples of studies:
https://www.cmaj.ca/content/194/2/e37
https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2796185

Another key finding to highlight on Figure 11 is that Filipino, African and/ or Black and South Asian people are less likely to present and be assigned a low acuity triage score of 5 and more likely to be assigned a higher acuity triage score of 2 or 3. This demonstrates a tendency towards more severity or acuity of illness when seeking emergency department care. As we move forward now to examine wait times, please notice and keep this finding in mind.

Wait to Be Seen

In the next section we will begin to explore the Wait to be Seen (WTBS) times for different population groups. Wait Times are the time from when a patient is assessed and triaged to when they are examined or treated by a doctor. Where we can, we will show variations between the province overall, Shared Health and WRHA. While there are some differences between the SDOs, we cannot share all the information for every SDO due to the lower number of visits and smaller population sizes in certain regions. The trends presented here are considered more reliable because they are based on a larger volume of data.

Figure 12: average wait to be seen (WTBS)

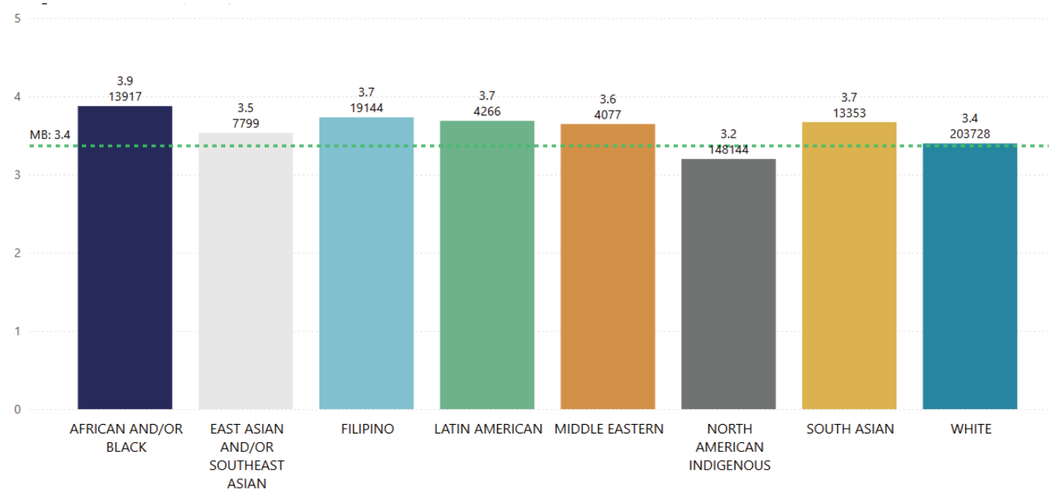
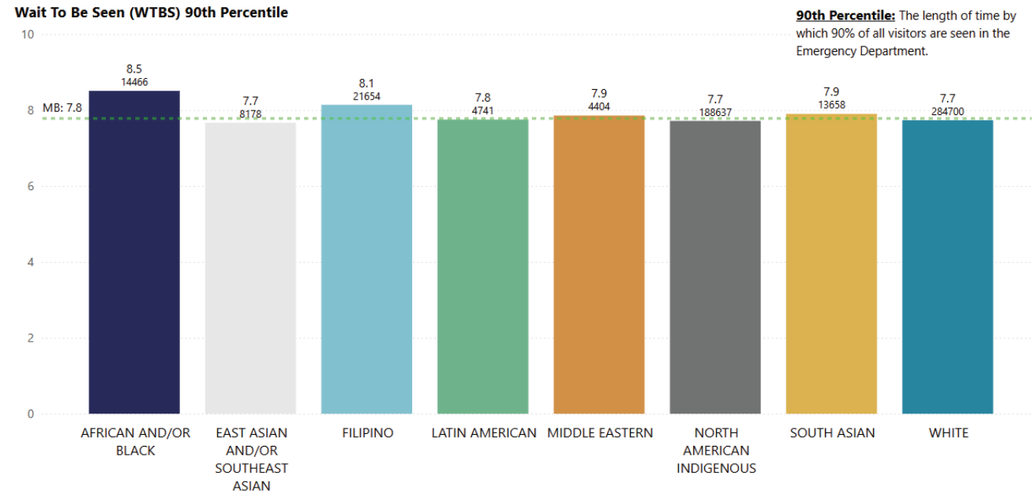


Figure 12 shows the average wait times for all patients across all SDOs and triage scores. It only includes sites that use a specific database called EDIS. It doesn't include people who ended up leaving without being seen (LWBS). The average wait time for all of Manitoba is 3.4 hours, with African and/or Black people waiting the longest at 3.9 hours.

Figure 13: average wait to be seen (WTBS) by SDO and REI group

When we look at average wait times in Shared Health and WRHA as shown in Figure 13, we can see very little difference among different population groups at HSC Children's. At HSC Adult and WRHA facilities we see more pronounced gradients with African and/ or Black and North American Indigenous Peoples waiting the longest.

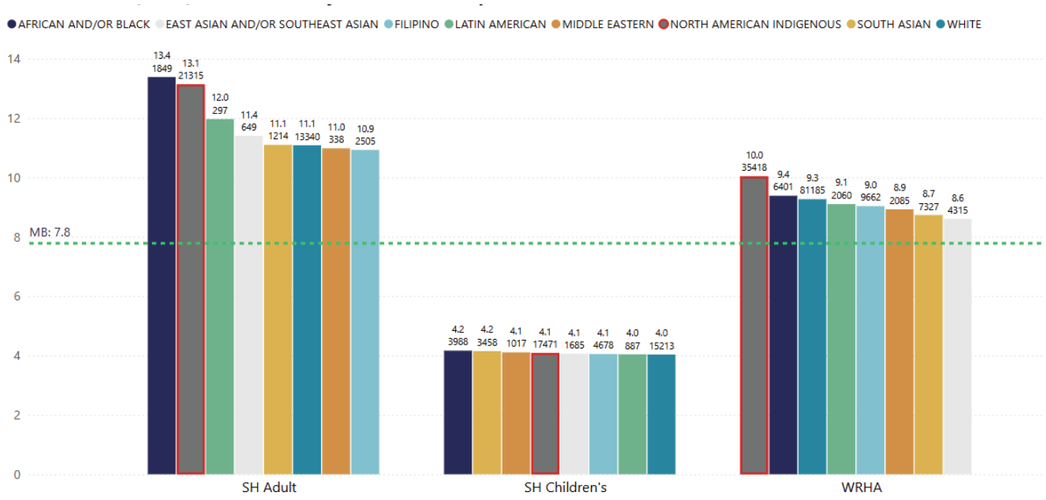
Figure 14: wait to be seen (WTBS) 90th percentile



The numbers in Figures 12 and 13 might seem lower than what you see when you check the wait times on SDO websites, or when you see stories in the news. This is because the times that are used can be different. Figure 14 shows the number of hours that it took for 90% of the patients in each group to be seen. This is called the WTBS 90th percentile. When we look at these numbers we still see that African and/ or Black patients wait the longest.

As shown in Figure 11, African and/ or Black patients were less likely to present and receive lower acuity triage scores. More work is needed to understand and intervene in this finding to close this gap in wait times for African and/ or Black people. Similarly Filipino and South Asian people wait longer than some other groups, even though they are also more likely to present and receive a higher acuity triage score.

Figure 15: wait to be seen (WTBS) 90th percentile by SDO and REI group



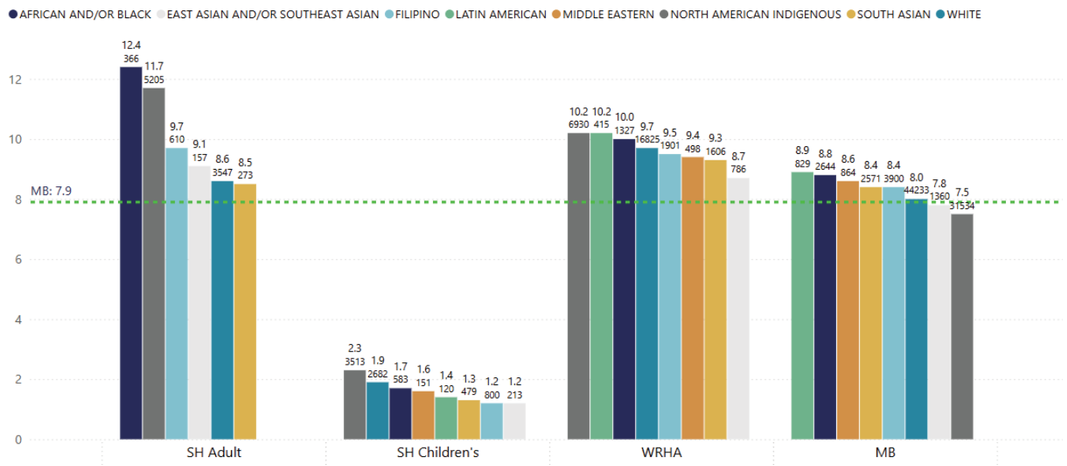
When we look at the WTBS 90th percentile for adults in Shared Health (HSC) and WRHA we see significant variation for different population groups with African and/ or Black and North American Indigenous people waiting the longest. This is consistent with the pattern that was seen when using the average wait times.

Wait To Be Seen By Triage Score

As mentioned above, the triage scoring process is meant to identify the patients with the most severe illness or injury who need to be seen first, and those who can wait longer to be seen. According to the CTAS Education Standards, each Triage Score has a goal time to assessment by a physician. [3] Within each triage score, the times to be seen (WTBS) are expected to be fairly common without wide variations.

[3] https://ctas-phctas.ca/wp-content/uploads/2018/05/ctased16_98.pdf

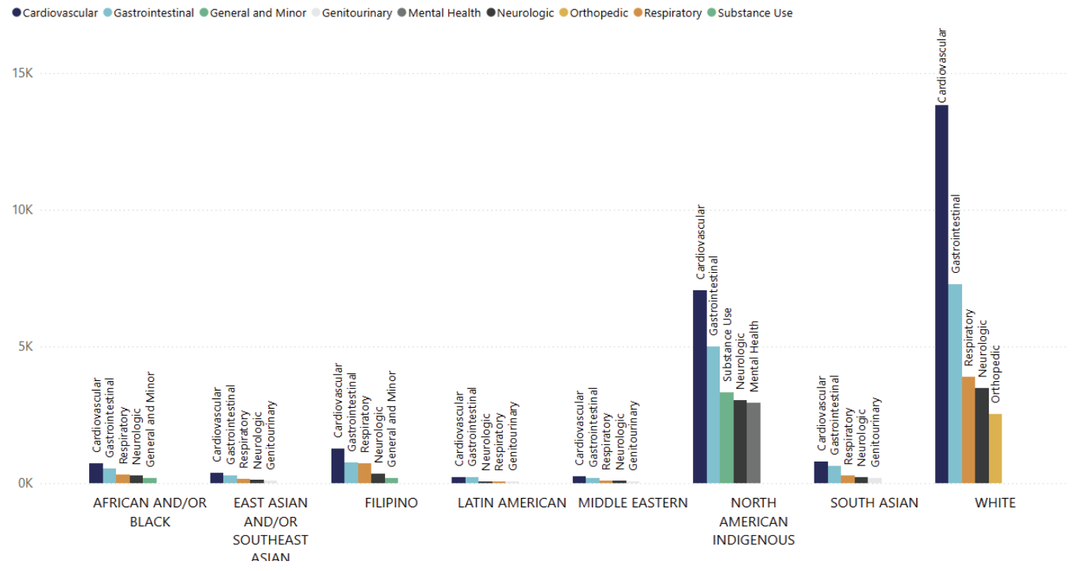
Figure 16: Canadian triage acuity scale (CTAS 2) wait to be seen (WTBS) 90th percentile



Since there are relatively few patients who require immediate care with a triage score of 1, there isn't enough data to examine for systematic differences.

Figure 16 is showing variations for people who were assigned CTAS 2 (emergent care needed) at Shared Health (HSC), Shared Health (Children's), WRHA and all Manitoba facilities combined. These differences are 1.5 hours in WRHA, and almost four hours at HSC. At HSC African and/or Black and North American Indigenous Peoples are waiting far longer, even for this second most acute triage score.

Figure 17: Canadian triage acuity scale (CTAS) 2 top 5 complaint category by REI group



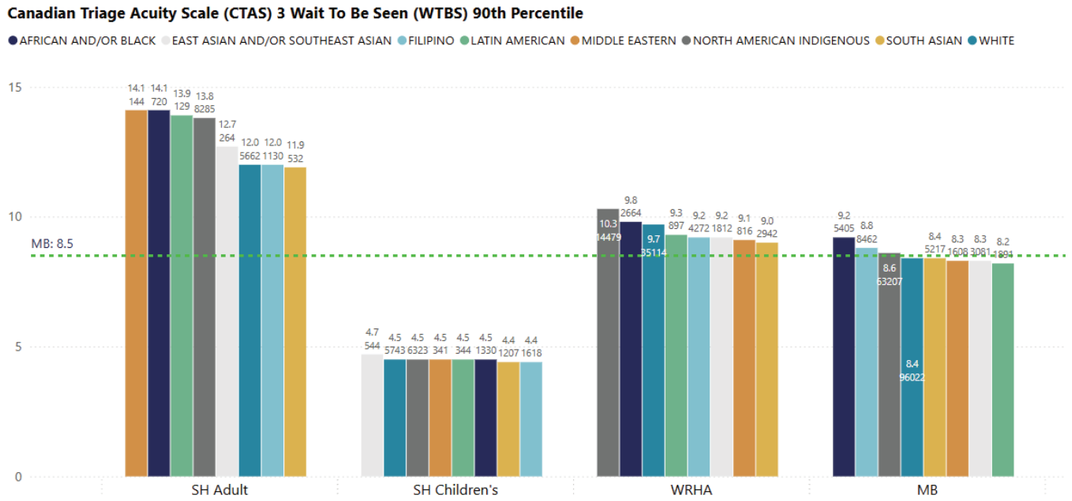
In Figure 17, the top two chief complaints for all people presenting with CTAS 2 are cardiovascular (for example, heart attacks) and gastrointestinal (for example, GI bleeding or severe abdominal pain). Looking at these top two complaints doesn't provide any further clarification of why the wait times would be so different for different population groups.

For North American Indigenous people, "substance misuse" and "mental health" are among the top five chief complaints, which is different from other population groups. However, the CTAS 2 score indicates that these were emergent presentations and, as such, required attention within the same time frame as others in the CTAS 2 category. In terms of understanding why this might not be happening, there was a study in Alberta where emergency department providers stated that if the perception is that if First Nations

patients are intoxicated they'll be parked in a waiting room chair for six to ten hours before seeing a doctor. They said that First Nations patients will usually disappear "so people just almost ignore them." Further examples of differential treatment of First Nations patients presumed to be intoxicated are shared in this paper by different emergency department providers. [4]

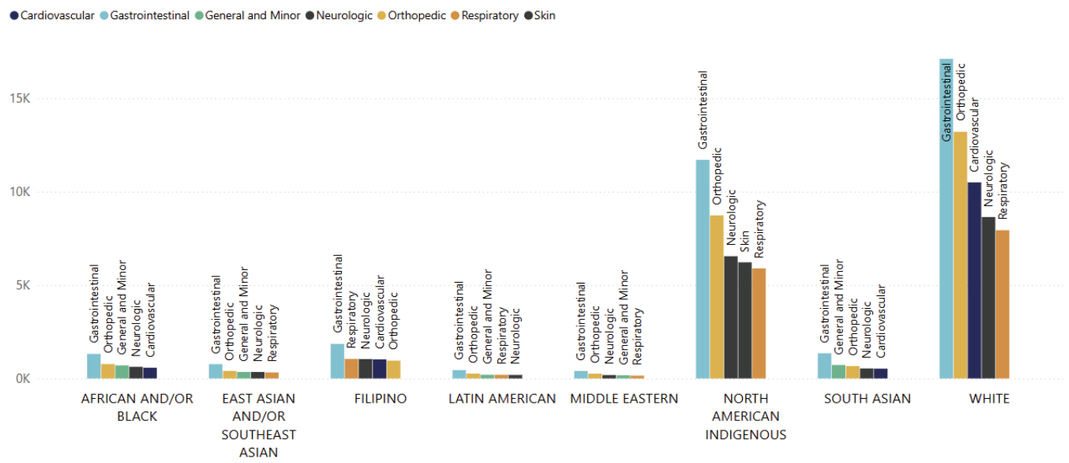
[4] McLane P, Mackey L et al. Impacts of racism on First Nations patients' emergency care: results of a thematic analysis of healthcare provider interview in Alberta, Canada. BMC Health Service Research. https://doi.org/10.1186/s12913-022-08129-5

Figure 18: Canadian triage acuity scale (CTAS) 3 wait to be seen (WTBS) 90th percentile



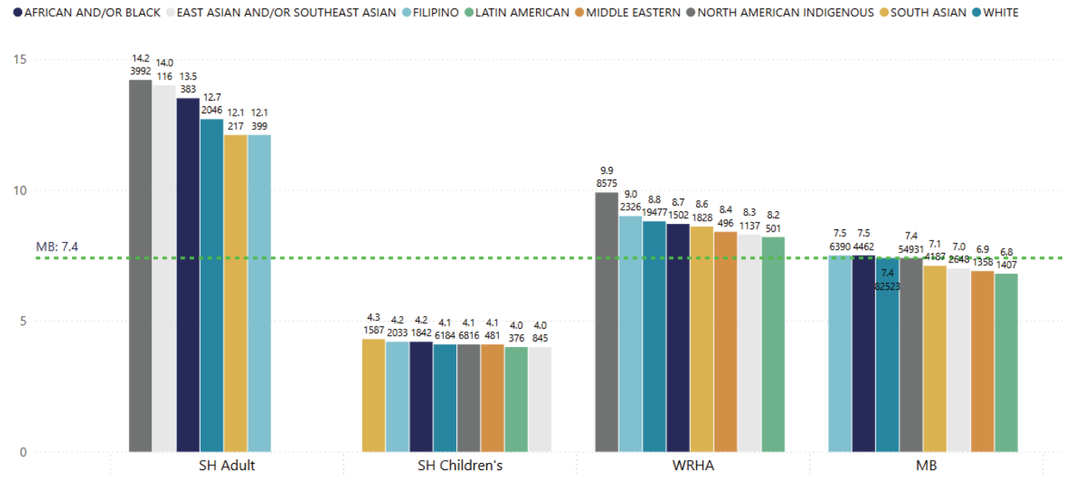
Patients receiving a CTAS 3 score make up the largest group of patients in the ED. Figure 18 shows differences within this triage score among different population groups at Shared Health HSC, Children's and in WRHA facilities. The differences are the smallest at HSC Children's.

Figure 19: Canadian triage acuity scale (CTAS) 3 top 5 complaint category by REI group



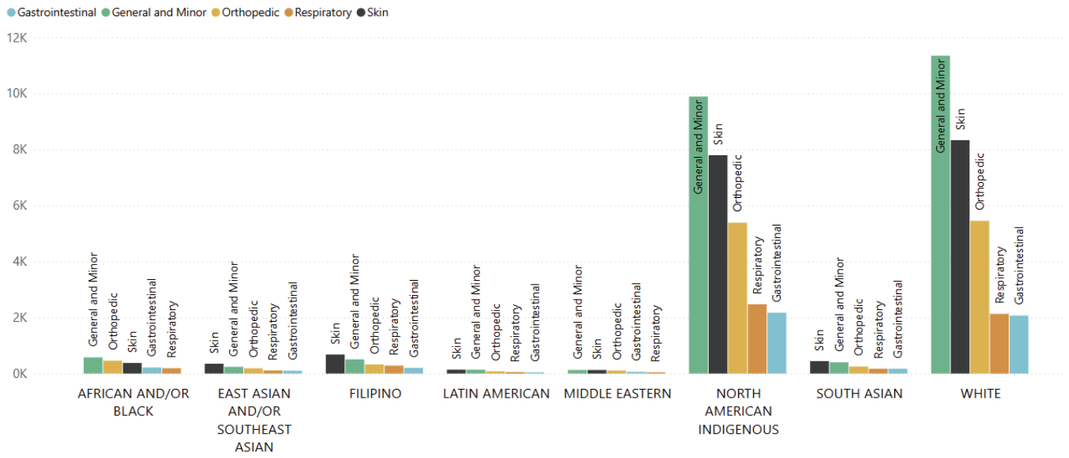
In Figure 19, the chief complaints for people assigned CTAS 3 are overall very similar. Some groups have “general and minor” listed which is a coding applied by a member of the healthcare team, not the complaint the person gave when they were being triaged. Gastrointestinal and orthopedic complaints were the top two complaints for almost all population groups.

Figure 20: Canadian triage acuity scale (CTAS) 4 wait to be seen (WTBS) 90th percentile



In Figure 20, the WTBS 90th percentiles for CTAS 4 also show gradients that are smaller at Children’s and largest at HSC. In this category, among adults North American Indigenous Peoples experience the longest wait times.

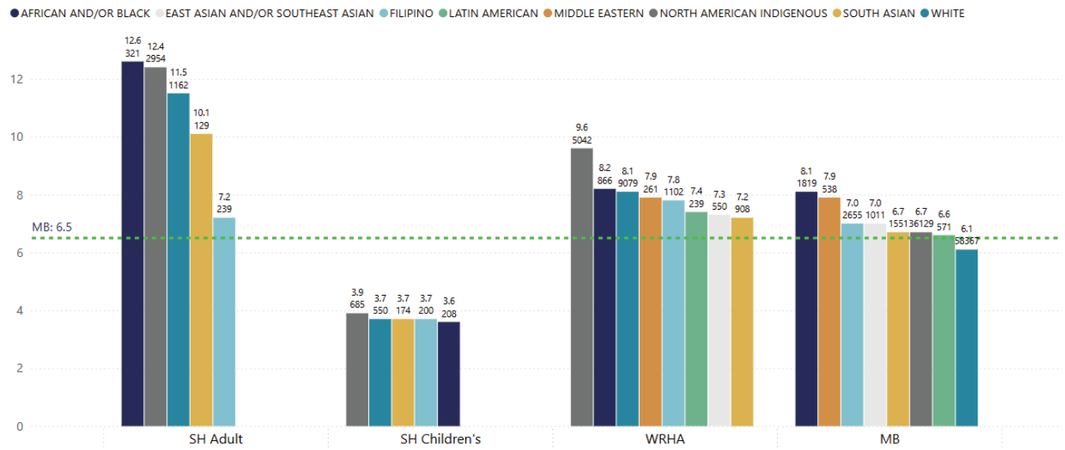
Figure 21: Canadian triage acuity scale (CTAS) 4 top 5 complaint category by REI group



In Figure 21, skin and orthopedic complaints are the most common two complaints across all population groups. “Substance misuse” only shows up in the top five for North American Indigenous Peoples. Given that the categorization we see here is applied by a member of the healthcare team (like the “General and Minor” category) it is important that we are aware of the very common stereotypes about Indigenous Peoples and substance use (see In Plain Sight report). It is important that we are aware of the medical mistakes that have happened with devastating consequences when healthcare providers have incorrectly assumed that an Indigenous person was intoxicated or only in the waiting room to “sleep it off.” Even when someone is intoxicated, they may be at the emergency department for care for another reason, and there are situations where those other important reasons are missed by members of the healthcare team.

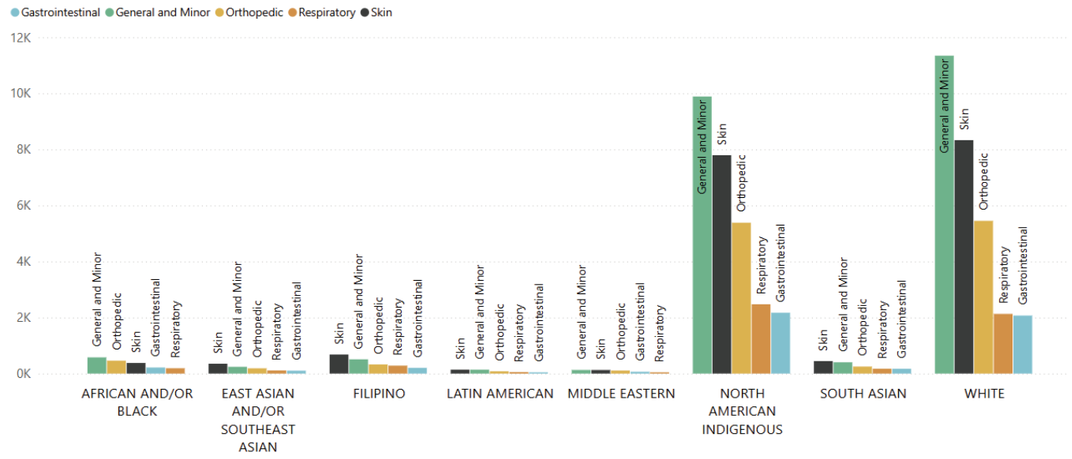
Any time we see a note about “substance misuse” and an Indigenous person it is imperative that we ask ourselves what the evidence for that is, if it is possible a stereotype has been incorrectly applied, and what else might be true or need further investigation and/or treatment.

Figure 22: Canadian triage Acuity Scale (CTAS) 5 Wait To Be Seen (WTBS) 90th Percentile



In CTAS 5 we see similar patterns of variations in wait times across population groups as we've seen in the other CTAS categories.

Figure 23: Canadian triage acuity scale (CTAS) 5 top 5 complaint category by REI group

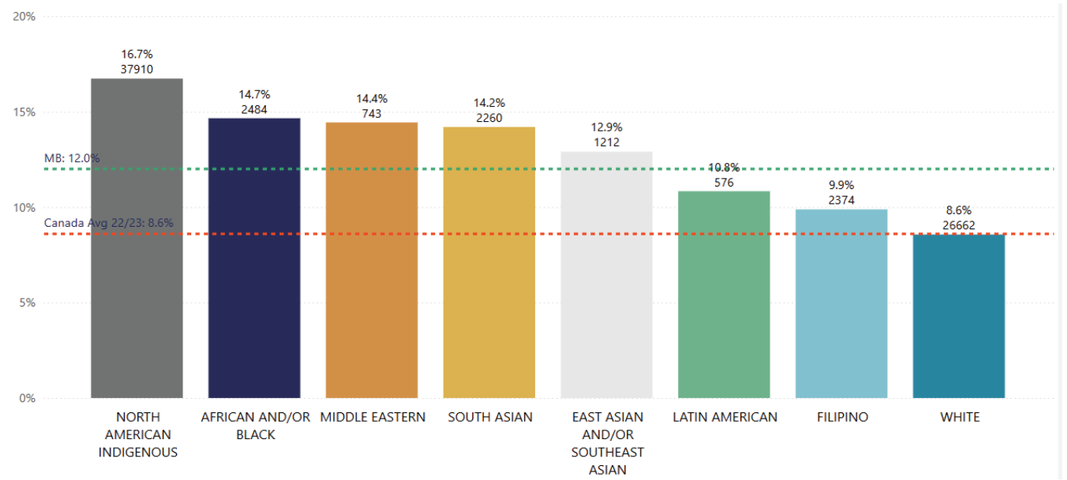


In Figure 23, there are no major differences in the Chief Complaints among population groups.

Left Without Being Seen

In this section data will be shared about people who ultimately leave the ED without being seen by a physician (LWBS).

Figure 24: % left without being seen (LWBS) by REI group



Across the different population groups, North American Indigenous and African and/ or Black people are the most likely to LWBS, and White patients are the least likely. When we consider only the patients who leave without being seen, more than half of them identify as North American Indigenous.

Wait times are known to be a key factor in whether someone decides to LWBS. The In Plain Sight report as well as other studies show that racism and discrimination are also reasons why Indigenous and African and/ or Black patients may leave. [5]

[5] Example stories:
https://www.cbc.ca/news/canada/edmonton/alberta-study-first-nations-patients-emergency-departments-1.7179342
https://ldi.upenn.edu/our-work/research-updates/black-patients-feel-dismissed-and-skeptical-after-their-experiences-in-the-ed/

Figure 25: % left without being seen (LWBS) by SDO and REI group

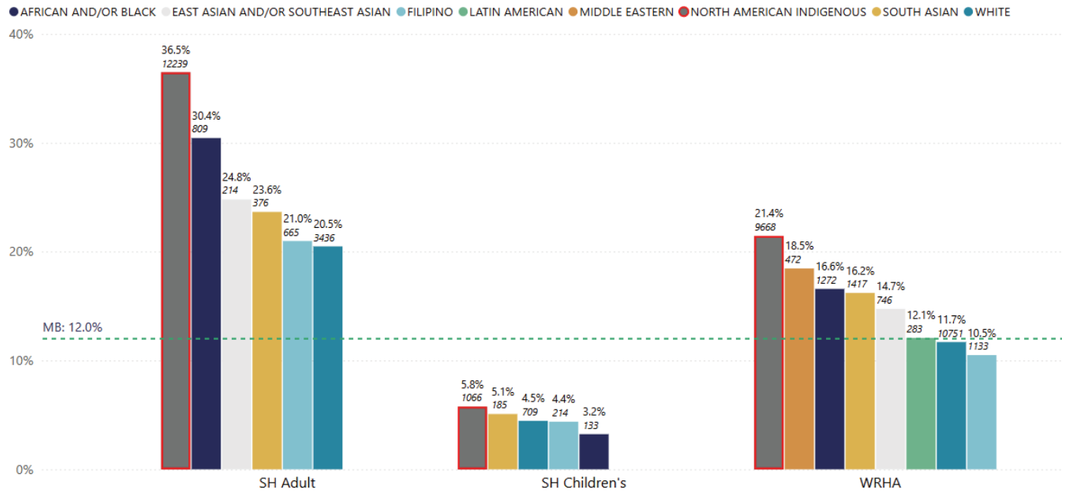


Figure 25 shows LWBS for Shared Health HSC, Children's and WRHA. Similar to the wait times, there is variation in the number and proportion of people who LWBS.

Figure 26: % left without being seen (LWBS) by Canadian triage acuity scale (CTAS) and REI group

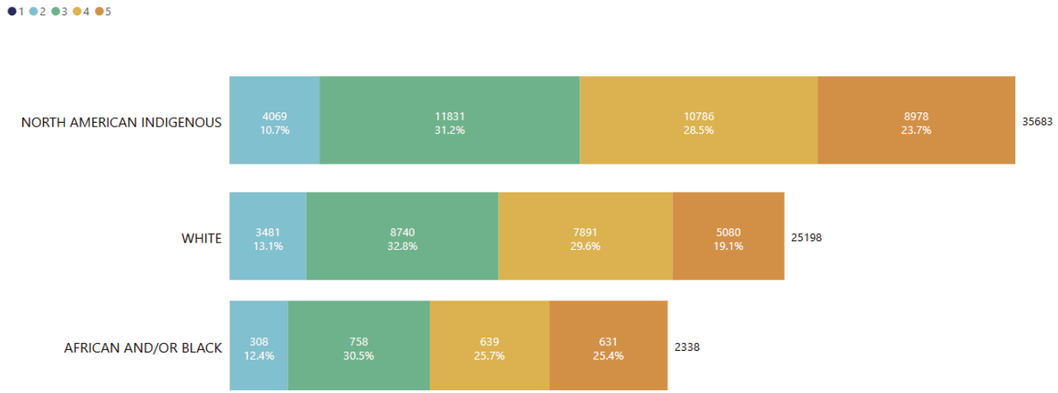


Figure 26 shows that people across CTAS scores, including those who need emergent care, LWBS and in surprisingly high numbers. It is reasonable to assume that especially for these more acute patients, that this likely presents a risk to their health and may result in worse outcomes.

Leaving Against Medical Advice

Once people have seen a physician and a diagnostic and/ or treatment plan has begun, sometimes people will choose to leave the healthcare facility and not participate in the ongoing care plan. This is categorized as Leaving Against Medical Advice (LAMA).

Figure 27: % left against medical advice (LAMA) by REI group

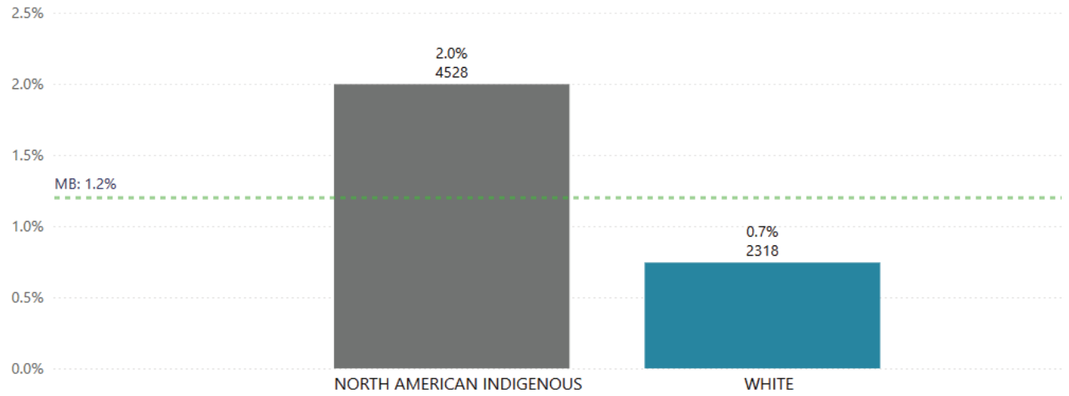


Figure 27 shows the vast majority of people who LAMA are North American Indigenous, accounting for 63.5% of all patients who LAMA.

Figure 28: % left against medical advice (LAMA) by Canadian triage acuity scale (CTAS) and REI group

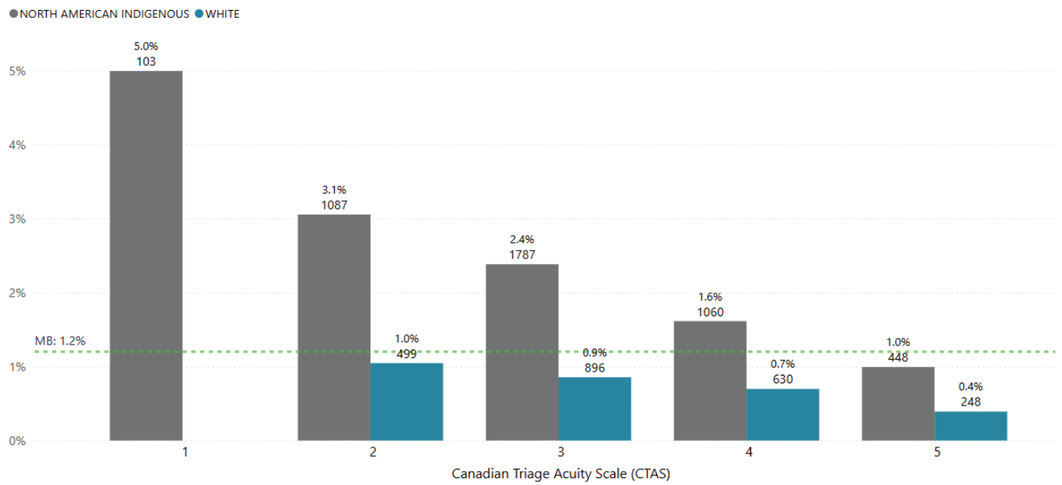


Figure 28 shows, similar to people who LWBS, people choose to LAMA across all severities of illness as represented by their CTAS scores.

According to the In Plain Sight Report, experiences of racism is a key driver of the higher rates of Indigenous Peoples leaving against medical advice. Since this is a finding that has also been reported for African and/or Black people, this will need to be monitored over time for other population groups as well. [6]

[6] https://www.medpagetoday.com/emergencymedicine/emergencymedicine/107566

Key Highlights

Our initial data analysis of access to healthcare in the emergency departments across Manitoba show similar findings to other published literature.

North American Indigenous patients present with remarkably similar triage scores to White patients, which counters against the common stereotype of Indigenous people using the emergency departments inappropriately.

African and/or Black patients wait the longest to be seen even though they are less likely to present in the lowest acuity triage scores.

The data presented here shows that in the WRHA and at HSC North American Indigenous and African and/ or Black patients wait the longest to be seen. When we look at data in the other health regions, there are differences in what population groups are waiting longer to be seen. Similar to the work done to prepare this report, this data will be shared with the regions and REI Data Governance Steering Committee for collaborative analysis and response planning.

Within each triage score category there are significant variations in wait times, which are larger than what would be expected for individuals who were assessed by the triage nurse as having the same priority for seeing a physician. This is not explained by systematic differences in chief complaints.

There is more work to be done. This is a large and complex data set, and we will continue to try to refine the data and understand it further. This will need to be paired with workflow/ patient journey assessments to understand where bias is creeping into the care pathways and can be addressed.

Since we began looking at this data we have been regularly meeting with the provincial emergency department clinical leadership. We share the health systems commitment to disrupting racism in all its forms, and specifically in acting on the gaps that our data is showing here today.

We want to note that as we continue to build the robustness of this data set we will look at other clinical areas where we are likely to see gaps in the care the African and/or Black, Indigenous, and other racially marginalized people receive. Systemic racism in healthcare is not isolated to emergency departments.

Emergency departments are very stressful environments to work in, and the health system is facing challenges in many areas. Unfortunately, in a system under stress it is often those who are the most marginalized and who have the fewest resources to draw on, facing the most severe impacts.

Chronic staffing shortages, and the experiences of racism and aggressive behaviour that emergency department team members face only add to and exacerbate these stressors. In a local study done, 86 per cent of Black, Indigenous and racially marginalized emergency department providers

experienced racism in the workplace and 63 per cent of White emergency department providers experienced discrimination. [7] And yet these team member show up day after day, trying their best to provide quality care within these system constraints. It's important that we all see this data as an opportunity to learn and grow together to improve the experience of patients and healthcare team members alike.

As an immediate step, we have recommended that all emergency department team members be prioritized for participation in the We Will Take Good Care of The People Indigenous Cultural Safety and Anti-Racism training. [8] This is one educational option that was developed by Ongomiizwin in partnership with Shared Health and the health regions. There are other options that can also be accessed initially or as part of the lifelong journey of antiracism education that is needed, including the First Nations Health and Social Secretariat Anti-Racism Training. [9]

[7] Cruz-Kan K, Dufault B, et al. Intersectional characterization of emergency department (ED) staff experiences of racism: a survey of ED healthcare workers for the Disrupting Racism in Emergency Medicine (DriEM) Investigators. Canadian Journal of Emergency Medicine. https://doi-org.uml.idm.oclc.org/10.1007/s43678-023-00533-y

[8] https://umanitoba.ca/ongomiizwin/education/we-will-take-good-care-of-the-people

[9] https://www.fnhssm.com/anti-indigenous-racism-project

The data also highlights the need to specifically understand and address anti-Black racism. We recommend that priority be given to participation in The Black Health Primer. The Black Health Primer is a series of online modules developed by the Black Health Education Collaborative to empower learners with tools and resources to address anti-Black racism in the Canadian healthcare system. More information on how to register as an individual or as a group is available on their website. [10]

The REI Data Project Team has been meeting with the emergency department program provincial clinical team (PCT) as well as the emergency department Lower Wait Time and System Improvement Team to collaboratively design next steps forward. This includes designing potential interventions and establishing timelines to review new data and monitor for improvements. Evidence-based interventions, as well as community wisdom around what will make emergency department waiting rooms and care environments safer and free from racism will be considered. There are champions in Manitoba's emergency departments who have shared recommendations that will be further considered, including:

- De-escalation and bystander intervention training;
- Posting regional anti-racism policies or commitments; and
- Reviewing and revising waiting room announcements to explicitly include messages of welcoming and belonging.

This collaborative approach to finding solutions will build on the strengths of all in responding to the needs of all.

It will take time to close the gaps in wait times that our data has demonstrated. However, we would like to thank every person who has given patients the opportunity to self-identify and every person who has shared their racial, ethnic or Indigenous identity with Manitoba's healthcare system. You have been a critical part of ensuring that we can make these gaps in healthcare visible which is our starting point for making a difference. Thank you for what you have done to improve the quality of care for every person in Manitoba that seeks it.

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[10] https://www.bhec.ca/bhp