The Health Care Equity Audit Guide

Saskatoon Health Region, Public Health Observatory

June 2014, v1

INTRODUCTION

Health equity is the principle of and commitment to incorporating fairness into health by reducing health inequalities.[1] It implies that all people can reach their full health potential and should not be disadvantaged from attaining it because of their race, ethnicity, religion, gender, sexual orientation, age, disability, social class, where they live, socioeconomic status or other socially determined circumstances.[2] Health inequity occurs in the absence of health equity.

Although equity in health is influenced by factors that are much broader than the health-care system (i.e., the social determinants of health), the system does make a difference and does have a role in addressing inequities.

PURPOSE

The goal of an equitable health care system is to support improved health outcomes for all while decreasing gaps between different population groups. In Saskatchewan, health equity contributes to the "Better Health" strategic direction.

The Health Care Equity Audit Guide[3] ("the Guide") was developed as a tool to assist health care providers and decision makers in examining how fairly the health care system resources are distributed relative to the needs of different population groups. The Guide describes the 4 stages of the audit cycle and provides worksheets and templates that can inform evidence-based practice and actions.

Through using the Guide, end-users are able to systematically identify health inequalities in the health care system (stage 1), develop actions to address health inequities (stage 2), implement evidence-based interventions and/or strategies (stage 3) and evaluate the impact of actions on reducing inequities. Furthermore, broad policy and program recommendations for improving health equity are included for those not ready to begin an audit cycle but still interested in ways to consider health equity in their work (See Appendix A – What You Can Do as a Health Care Provider and Decision-Maker).

WHO SHOULD USE THE HEALTH CARE EQUITY AUDIT GUIDE?

The Guide is intended to be used by decision makers and health care providers alike. Health equity should be a priority for ***all*** areas of the healthcare system.

WHEN TO USE THE HEALTHCARE EQUITY AUDIT GUIDE

The Health Care Equity Audit Guide can be used at various stages of program and policy development and planning to:

- → guide the development of new programs or actions;
- → explore an equity issue that has been raised by clients, staff, or senior leadership;
- → review existing policies, programs, services or plans;
- → complement existing planning and quality improvement efforts;
- → identify gaps and barriers in services and care;
- → improve understanding of health care equity;

- → to identify potential concerns; and
- → measure the equity within an existing program or service.

Understanding Health Equity – A Primer

Health inequalities (i.e. "disparities") are differences in health status or in the distribution of health determinants between different population groups[4] [WHO, 2014]. When we attempt to measure health inequities, we are typically measuring health inequalities. Health inequities, however, require an additional judgement to be made as to whether or not the inequality is deemed to be unfair. Thus, **health inequities are defined as differences that are unnecessary and avoidable, and deemed to be unjust.**[5]

Therefore, health inequalities ***describe differences in health experiences and health outcomes*** between different populations, while health inequities describes ***differences in opportunity*** for different population groups which result in unfair and unequal life chances, access to services, etc.

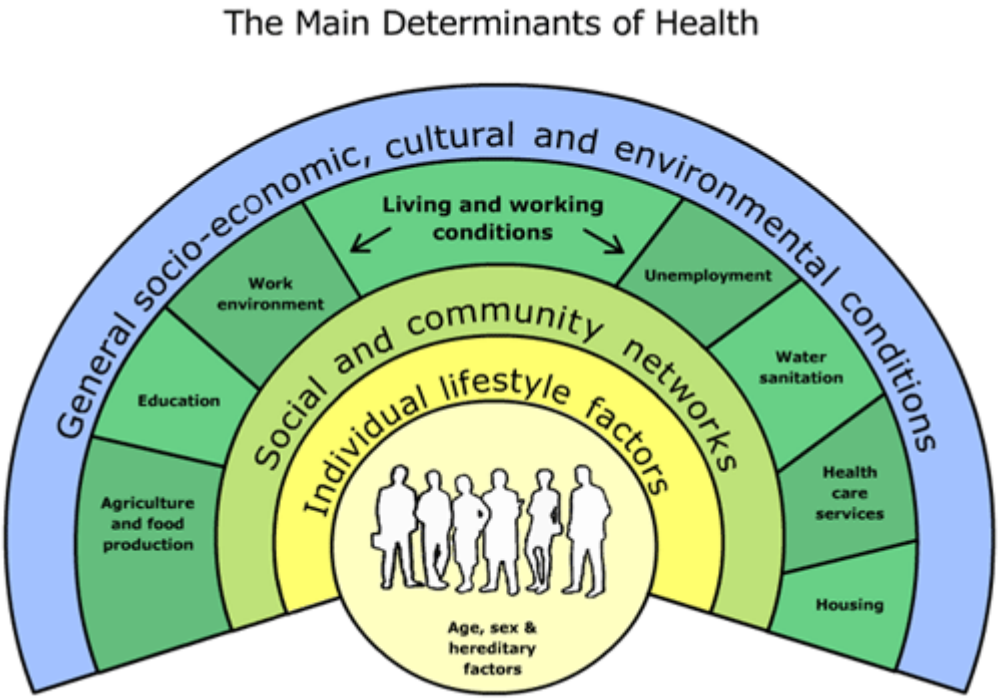
Differences in health between social groups and between different geographical areas are present in varying degrees across Canada. In Saskatoon, large differences in health have been found between males and females, urban and rural residents, and those living in the highest and lowest areas of deprivation in the city.[6]

Due to the additional judgement that is required to identify health inequities, there is an inherently moral and ethical dimension to the concept that is inclusive of the principles of social justice.[5]

> "**Social justice is about equality and fairness between human beings**. It works on the universal principles that guide people in knowing what is right and what is wrong. This is also about keeping a balance between groups of people in a society or a community.
>
> Social justice is an underlying principle for peaceful and prosperous coexistence within and among nations. We uphold the principles of social justice when we promote gender equality or the rights of indigenous peoples and migrants.
>
> **We advance social justice when we remove barriers that people face because of gender, age, race, ethnicity, religion, culture or disability**."
>
> Source: United Nations

Health inequalities, and consequently inequities, arise from the **social determinants of health**, which are defined as societal conditions in which people are born, grow, live, work and age, including the health-care system.[4] Figure 1 depicts a simple model of the main social determinants of health.

Figure 1. The Main Determinants of Health[7]

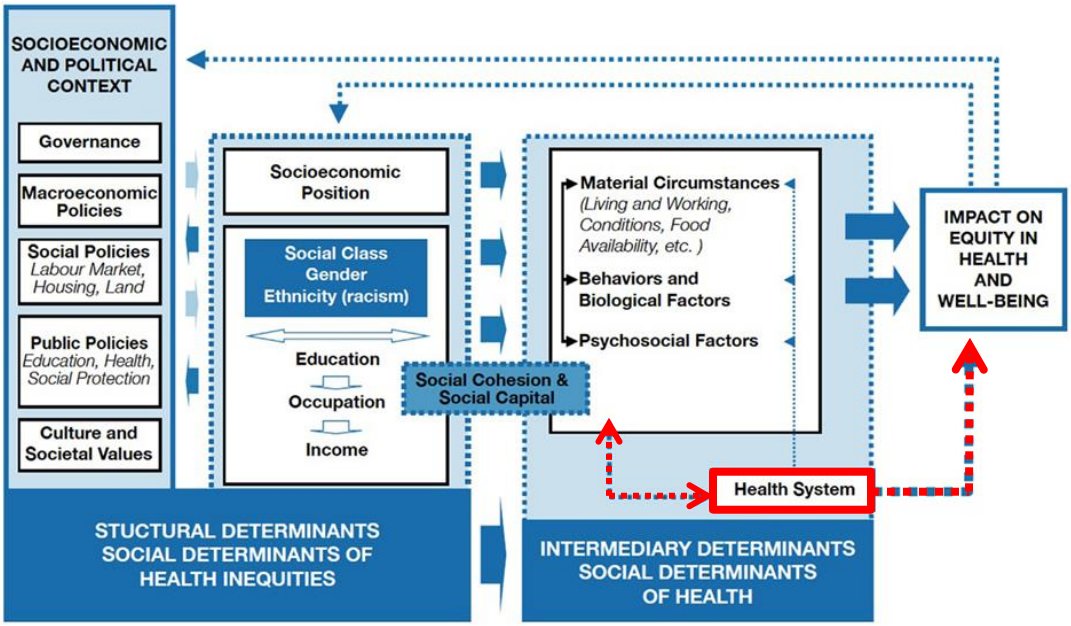


With consideration of the social determinants of health, health equity implies that all people can reach their full health potential and should not be disadvantaged from attaining it because of their race, ethnicity, religion, gender, age, social class, socioeconomic status or other socially determined circumstances.[2]

Achieving Equity in Health Care – A Role for the Health Sector

Although equity in health is influenced by factors that are much broader than the health-care system (i.e., the social determinants of health), the system does make a difference and does have a role in addressing inequities. Equity is an underlying principle of quality in a health care system.[8] It is important that health-care equity is considered in system planning (strategic and service/program) in order to provide and organize health services in ways that contribute to reducing overall health inequities. The health care system plays an integral part in the social determinants of health (figure 2).

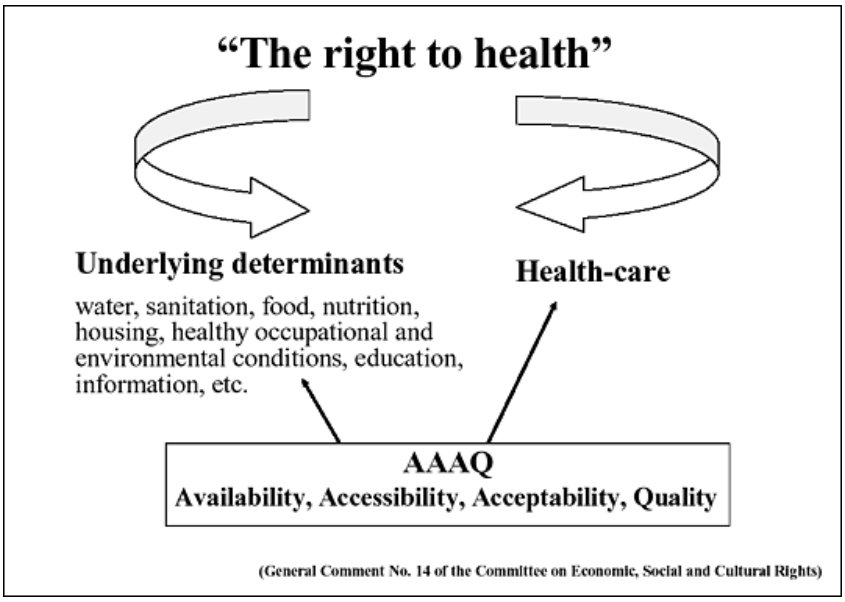
Figure 2: The Role of the Health System in the Social Determinants of Health[9]



There is a responsibility of the health care system to incorporate health equity as an underlying principle of care. As stated in the Canada Health Act (1984), "the primary objective of Canadian health care policy is to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers." At the core of this objective is the right to health.

Health care equity utilizes the same principles as the right to health which means that health care services should be available, accessible, and acceptable to everyone in the population, while also maintaining a high degree of quality [figure 3, figure 4].

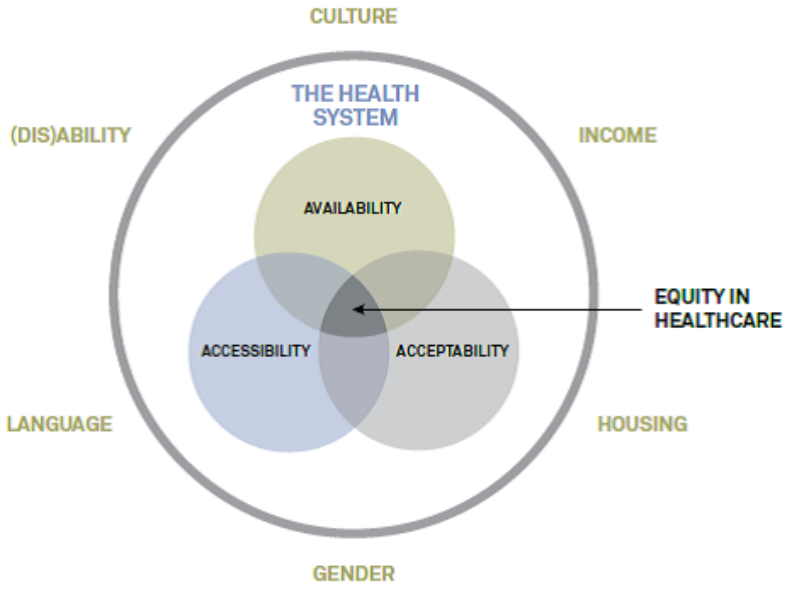
Figure 3. The Right to Health[10]



"The right to health can be understood as the right to an effective and integrated health system encompassing health care and the underlying determinants of health, which is responsive to national and local priorities, and accessible to all."

Source: "The Right to Health" Fact Sheet, WHO (2007)

Figure 4: A Framework for Conceptualizing Equity in Healthcare[11]



When health care decision-makers and providers are considering whether they are providing services in an equitable fashion, the following elements should be considered:

Accessibility of services refers to the extent to which health-care system is designed to meet the needs of the health system users. It means having health facilities, goods and services accessible to everyone in four overlapping dimensions – non-discrimination; physical accessibility; economical accessibility; and, information accessibility. The ultimate goal is not simply equitable access to health services, but equitable access to health.

Examples[11] of concerns and barriers of accessibility may include:

- literacy
- language
- gender, ethnicity, and socially determined circumstances
- affordability of services for non-insured health benefits
- mobility concerns linked to physical accessibility
- health literacy (language, use of jargon or advanced vocabulary, web-based rather than paper media, complexity of the health care system)

Availability of services, in simple terms, refers to whether services are provided within a community. It includes having sufficient and functioning public health and health care facilities, programs and services that address the entire disease course (primary, secondary and tertiary prevention and treatment), and life course (from prenatal to end of life care) such as timely diagnostic and treatment services, available primary care providers, and reasonable hours of operation to name a few.

Examples of concerns and barriers of availability may include:

- timely diagnostic and treatment services
- lack of access to primary care physicians or teams

- limited availability of specialty services, such as mental health and substance use programs, and obstetrics, maternity, and gynecological services
- within urban centres, services may be unavailable due to limited hours of operation, long waiting lists, or because they are not covered under Medicare.

Acceptability of services refers to whether services are provided in a way that meets the needs of distinct cultural, linguistic, ethnic, and social groups. The provision of culturally competent services and creation of culturally safe spaces are key components of the acceptability of services. All health facilities, goods and services must be respectful of medical ethics and culturally appropriate as well as sensitive to gender and life-cycle requirements.

Examples of concerns and barriers of acceptability may include:

- culturally competent services and safe spaces
- respectful and responsive to the diverse health beliefs, practices, and cultural and linguistic needs of patients

Quality and equity should be key dimensions of one another. Quality improvement initiatives that target the overall population and overlook the needs of specific population groups can result in health inequities (i.e. unequal quality).[12]

Quality care is defined as "doing the right thing for the right patient, at the right time, in the right way to achieve the best possible results".[13] Quality health care means providing services and programs that are safe, effective, timely, efficient, and patient/family-centered.

Equitable health care means providing services and programs that do not vary in quality because of race, ethnicity, religion, gender, sexual orientation, age, disability, social class, where they live, socioeconomic status or other socially determined circumstances.

The Health Care Equity Audit Cycle can and should be integrated within already existing processes. Ongoing quality improvement initiatives, such as LEAN management and strategic planning, provide opportune use of the HCEA Tool at both a regional and a department-specific level.

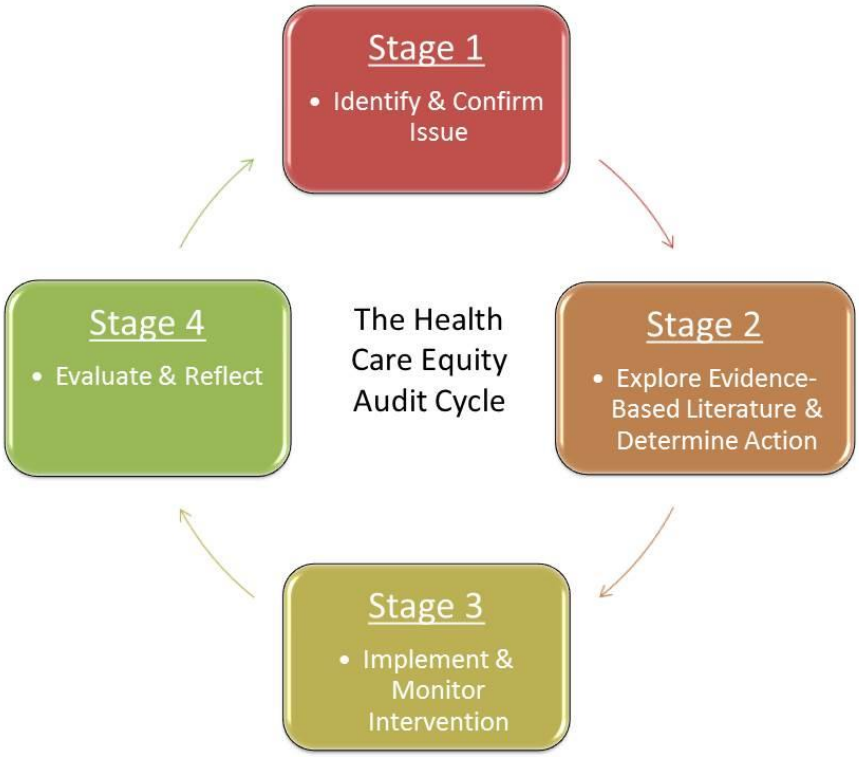
"**Equitable care does not mean treating every patient exactly the same**. Instead, equitable care ensures optimal outcomes for all patients regardless of their background or circumstances."

Source: The Roadmap to Reduce Disparities, Robert Wood Johnson Foundation (2014)

The Health Care Equity Audit Tool

The Health Care Equity Audit (HCEA) Tool is a cycle that can be used by decision makers and/or health care providers to systematically explore and identify potential health inequities that are producing unfair health differences in their community. Beyond identifying potential health inequities, evidence-based practices are implemented, evaluated and reflected on until gaps in health are addressed. Further action is often undertaken to address the inequities and incorporated into policy, plans and practice.[3]

Figure 5. The Health Care Equity Audit Cycle



Health care equity audits help decision makers focus on how fairly resources are distributed in relation to the health needs of different groups. Specifically, a HCEA measures accessibility, availability, acceptability, and quality within the health care system. Ultimately, the goal of the HCEA is to reduce inequities by matching services to the level of need. Equity is reached when the level of service is equal to the level of need for the service.

The Health Care Equity Audit Cycle, much like a Plan, Do, Study, Act cycle in quality improvement terms, will guide users through four stages to identify and work toward a solution for equity concerns (figure 5). The cycle is most valuable when completed in its entirety, however, once a complete cycle is finished, it may be appropriate to jump to a non-sequential stage to try a different solution to the problem. Each of the four stages is described in detail in the following sections.

Stage 1: Identify & Confirm Health Inequity

The Healthcare Equity Audit cycle is designed to provide an appropriate solution to a health inequity. The first step consists of **identifying the problem** (i.e. the perceived inequity and the associated factors) and **confirming the presence of a health inequity** (i.e. using identified data sources coupled with qualitative feedback).

Measuring health inequity is a difficult task. Though the language remains ambiguous at times, measuring health inequalities, can indicate that health inequity is present[1]. Health inequalities are differences in health outcomes between different groups in the same population. Health inequalities become health inequities when these differences are deemed unnecessary, avoidable, and unjust and unfair[5]. Thus, health inequalities are objective measures of difference, while health inequities have a moral and ethical dimension.

In the health sector, measuring health inequity can be achieved through examining the service to need ratio. Health care inequities can occur when population groups with equal need are not provided equal service.

Identifying a health inequity will commonly occur in one of the following ways:

- **Do we have a problem?**

  Service providers are not at all aware of any existing inequity, but they simply begin by **exploring** the issue.

- **We think we have a problem…?**

  Service providers suspect that there are health inequities in their services programs or department areas based on their own personal observations, but have not yet confirmed it using the appropriate data.

- **We know we have a problem!**

  Evidence is found or provided that clearly identifies the presence of health inequities.

Questions to Consider

- Are there any barriers to access or uptake of services and facilities amongst any particular population group or area that you frequently encounter?
- Is more targeted action with specific groups and areas required?
- Are the supports and resources available in the system to adequately address health inequities in your area? What other resources would be helpful?
- Are there any already existing priorities for action that contribute to improve health equity?
- What programmes, services, approaches/ practices already exist in your areas which might help in reducing gaps in inequity?
- What further action is required from existing services or structures to address gaps in equity?
- How can health equity principles be embedded into existing work?

Once a health inequity concern has been identified, available data should be explored to confirm that a health inequality is present. There are many different types of data and analysis techniques available to explore health inequalities. Table 1 illustrates various methods that can be used to explore and identify the presence of health inequalities. The information contained in each program area will vary. The table below shows examples of the types of stratification that is needed to conduct an equity audit. When necessary, additional data and/or analysis may be available through the Public Health Observatory or Strategic Health Information and Performance Support (SHIPS) in Saskatoon Health Region.

Table 1. Types of Data and Stratifiers for Identifying Health Inequalities

Program and (Data Source)	Types of Stratifiers
Mental Health (AMIS) Immunization (SIMS) Renal (MIQS)	Socio-economic status (Income, Employment, Education)* Ethnicity (Caucasian, Aboriginal, Other) Area of residence (Rural, Urban) Sex (Male, Female) Age (Child, Adult, Seniors)

*If individual level socio-economic information is not available, this can be achieved through converting where a patient lives to area of deprivation.

If the information available suggests that a health inequality is present (i.e. measurable differences in health status between social groups or between people living in different

geographical areas), a judgement needs to be made to determine if it is **unfair** and **unjust** (i.e. health inequity). There are many explanations for health inequalities among and between groups but those explanations can be categorized as health inequities if they are **systematic, socially produced, and unfair**.

Some health inequalities that are not health inequities can include those caused by natural, biological variation. For example, due to the natural aging process, 70 year old men are much more likely to have coronary heart disease than 20 year old men. Similarly, due to natural sex-specific traits, women are more likely than men to get osteoporosis. Health damaging behaviour, that is freely chosen, would also not be considered a health inequity. For example, some people choose to participate in certain sports or pastimes that are inherently dangerous and thus can create unequal health outcomes among populations.

Health inequalities that are also inequities include those health differences that are the result of a situation outside of the control of the person experiencing them. For example, health-damaging behaviour, where the degree of choice of lifestyles is severely restricted, would be a health inequity. This could include a poor diet because nutritious food is more expensive or less accessible to a person. Exposure to unhealthy, stressful living and working conditions creates health inequities. Inadequate availability, access, or acceptability to essential health and other public services also creates health inequities.

Once a suspected health equity issue has been identified and is ready to be further explored, users of the guide are ready to begin stage 2.

STAGE 2: EXPLORE EVIDENCE-BASED LITERATURE & DETERMINE ACTION

The second step consists of **identifying promising/best evidence-based interventions or actions**, based on priorities of the program/service area and the specific changes that are to be achieved. Once the evidence has been explored, it is necessary to **determine the best action** for the issue identified in stage 1.

Some common best and promising practices that have been found to be effective in the health-care system are provided in **Appendix A**. In addition to those general recommendations, it will be necessary to gather program or department specific interventions. The best way to explore possible interventions for the issue identified in stage 1 is through the use of a literature review to explore best and promising practices.

Literature reviews can be as comprehensive as you choose to make them. The purpose of a literature review is an account of what has been published on a topic by accredited scholars and academics, or other professionals in the field. The literature review may include academic articles, grey literature (i.e. evaluations, one pagers, etc.), and/or best and promising practices. The purpose of the literature review is to identify effective interventions that may be generalized to your area.

Useful Resource: The Health Equity Lib Guide [Saskatoon Health Region]

http://libguides.saskatoonhealthregion.ca/public-health

Found under the "Health Equity" tab of the Population and Public Health Lib Guide, this resource allows you to explore evidence-based literature on health equity and provides many useful journal articles, databases, tools and methods, and places where local data can be found. A short video on health equity is also available.

Once best and promising practices have been considered, along with general health equity considerations, an action plan can be generated and/or actions can be built into existing plans and strategies. The action plan should include the Program Assessment Template (completed in Stage 1) along with the evidence you have identified in this stage to implement the chosen evidence-based intervention to your program or service area. With an action plan in hand, it is time to move onto Stage 3 and implement and monitor the chosen intervention.

STAGE 3: IMPLEMENT & MONITOR INTERVENTION

The third stage includes **implementation and monitoring** of the intervention or action that was chosen in stage 2. Monitoring is crucial to determine effectiveness of the intervention and to allow for evaluation and reflection to occur in stage four.

Prior to implementing the intervention it is important to consider ***how*** the intervention will be evaluated or monitored. Consider the following evaluation questions:

Relevance

- Does the intervention meet the needs of the group that are experiencing the health inequity?
- To what extent is the intervention goal in line with the needs and priorities of the organization?

Efficiency

- Did the engagement method used in this intervention lead to similar numbers of participants from the target group as previous or other interventions at a comparable or lesser cost?

Effectiveness

- To what extent did the intervention lead to improved health outcomes among the specific target group? Among the overall population?
- To what extent did the engagement method encourage the target group to take part in the intervention?
- Did the intervention or action lead to efficiencies in other areas of the system (e.g. decrease in ED visits)?

Outcome

- To what extent has the intervention led to more sustainable behaviours in the target group?
- Were there any other unintended positive or negative outcomes from the intervention?

Sustainability

- To what extent can the intervention be replicated or sustained?

At this stage it is important to make sure monitoring activities align with evaluation questions to ensure the correct information is available to determine if the intervention has worked. Whenever possible, it is valuable to plan an evaluation before implementing the intervention.

One way to begin the process of identifying evaluation questions is through a logic model (see Appendix C for a template). A logic model is an illustration of how a program or intervention is intended to bring about change. In other words, how the intervention resources and activities will lead to outcomes in the participants or community.

The purpose of Stage 3 is not to answer these questions but to be able to collect the necessary information to answer them [i.e. Stage 4]. It is important to consider what information will be needed to allow for such a determination to take place (see Appendix D for Indicator Guide).

Once the big picture of the evaluation is painted, a more detailed plan can be made in the form of an evaluation framework (see Appendix E for a template). An evaluation framework or

plan should clearly set out the why, how, where, when, and with whom the evaluation will be conducted. The following is a list of considerations for the framework to ensure success:

- Brief background on program
- Purpose, audience and use of the evaluation
- Evaluation questions
- Existing monitoring sources
- Methods to answer the questions
- Evaluation team
- Work plan
- Reporting and dissemination
- Budget

There are many types and models of evaluation. One model that requires consideration when looking at health equity in any intervention is participatory evaluation. Participants can give a unique take on not only what they would like the intervention to accomplish, but how to best collect data. End users who are included in the evaluation process from the beginning will also more likely to pay attention to the results and include it in their decision making.

Now the intervention is ready to be implemented.

Useful Evaluation Guides

- WK Kellogg Foundation
  - http://www.wkkf.org/resource-directory#pp=10&p=1&q=evaluation
- Health Communication Unit website at the Centre for Health Promotion, Department of Public Health Sciences, University of Toronto
  - http://www.thcu.ca

STAGE 4: EVALUATE & REFLECT

The final step consists of **evaluating** and **reflecting** on the previous stages. The evaluation should assess the impact of the intervention as well as identify where more action is required and next steps. While it is ideal to create a systematic process of evaluation the intervention or action that has been put in place, it may not be plausible. Efforts should be made to, *at minimum*, reflect on the process and note any changes.

Through a process of critical reflection, and based on the evaluation results, a decision should be made to return to stage 2 and try a different intervention or to conclude that the implemented intervention was effective. If an intervention is effective, however, it is still vitally important to monitor the intervention and continue to investigate new ways of decreasing existing health inequities. It is unlikely that a health inequity will quickly be remedied, but through diligent and deliberate work, and with the help of the Healthcare Equity Audit Guide, one can hope to contribute to the reduction of health inequities in the healthcare system.

Here are some considerations in making this stage ideal as possible:

- Create a positive working relationship between program and evaluator/evaluation process
- Don't be afraid to ask for help this is a great opportunity for someone to help you build your knowledge base
- Evaluation should not be viewed as adversarial, but as part of the intervention
- All necessary data should be shared within ethical parameters
- Take into account if there are other attributes to the outcomes besides the program when reflecting on the program
- Share results with the evaluation partners
- Choose to share your results appropriately with your target audience

Once the evaluation findings are reflected upon it is time to put knowledge into action. Findings can be used to understand the intervention better, it can direct change to the intervention, it can help garner resources for the intervention (e.g., grant writing) and/or it can influence decision making and policy. Results can be shared in many different ways from presentations to your target audience to media coverage. Most importantly, results should directly influence the program/service by incorporating health equity findings into their everyday work and continuing to make improvements in achieving health equity in our Region.

REFERENCES

[1] Braveman, P. (2014). What are health disparities and health equity? We need to be clear, Public Health Reports, 129(Supplement 2), Available from: http://www.publichealthreports.org/issueopen.cfm?articleID=3074

[2] Whitehead M, Dahlgren G. Concepts and principles for tackling social inequities in health: Levelling up part 1. Geneva: World Health Organization; 2006 [cited 2012 Sept 21]. Available from: www.euro.who.int/__data/assets/pdf_file/0010/74737/E89383.pdf

[3] Department of Health (2004). Health Equity Audit: A Self-Assessment Tool. London, UK: Department of Health, National Health Service.

[4] World Health Organization (WHO). (2014). Health Impact Assessment, Glossary of terms used. Available from: http://www.who.int/hia/about/glos/en/index1.html

[5] Whitehead M (1990). The concepts and principles of equality and health. Copenhagen, WHO Regional Office for Europe (EUR/ICP/RPD 414; http://whqlibdoc.who.int/euro/-993/EUR_ICP_RPD_414.pdf).

[6] Lemstra, M., & Neudorf, C. (2008). *Health disparity in Saskatoon: analysis to intervention.* Retrieved from Saskatoon Health Region website: http://www.saskatoonhealthregion.ca/your_health/documents/PHO/HealthDisparityRept-complete.pdf

[7] Dahlgren, G. & Whitehead, M. (1992). Policies and strategies to promote social equity and health. Copenhagen: Wold Health Organization.

[8] The Organisation for Economic Co-operation and Development (OECD). (2012). Quality framework and guidelines for OECD statistical activities, version 2011/1. Available from: www.oecd.org/statistics/qualityframework

[9] World Health Organization (WHO). (2010). *A Conceptual Framework for Action on the Social Determinants of Health: Social Determinants of Health Discussion Paper 2 (Debates, Policy & Practice, Case Studies)*, eds O. Solar and A. Irwin (Geneva: WHO Press). Available at:http://www.who.int/sdhconference/resources/ConceptualframeworkforactiononSDH_eng.pdf

[10] The World Health Organization (2007). The Right to Health. Available at: http://www.who.int/mediacentre/factsheets/fs323_en.pdf

[11] Daghofer, D. (2013). Promoting Health Equity - Choosing Appropriate Indicators: Literature Scan, Provincial Health Services Authority, BC. Available from: http://www.phsa.ca/NR/rdonlyres/0F19BDB8-2153-49D1-A214-E7D0D0B9DA3B/66179/PHSALitScanEquityIndicatorsFINAL_2015.pdf

[12] The roadmap to reduce disparities. The Robert Wood Johnson Foundation (2014). Available from: http://www.solvingdisparities.org/tools/roadmap

[13] Agency for Healthcare Quality and Research. (2014). Available from: http://www.ahrq.gov/index.html

APPENDICES

APPENDIX A

What You Can Do as a Health Care Provider and Decision-Maker

Thirteen broad policy and program recommendations have been developed based on a literature search for leading best and promising practices across Canada. Consideration of the following key principles will aid in increasing equity within the health care system. These are also useful in considering Stages 1 and 2 of the Health Care Equity Audit cycle.

1. **The service/program area considers potential literacy and language diversity in the development of public messaging and materials.**

   A number of factors, such as language and education level can contribute to literacy and communication barriers. Addressing these barriers is important to ensure accessibility of service. Suggested approaches towards addressing these barriers include use of interpreters, use of native languages, and application of appropriate literacy level materials. Interactive and multimedia approaches may also be effective in overcoming communication barriers.

   Ideas to Consider:

   - Ensure clients are being served in the language of their choice whenever possible
   - Incorporate visuals into learning resources

2. **The service/program area integrates social supports.**

   Programs were found to be more effective when they included family-based interventions and mechanisms for social support. Health services and early childhood development interventions indicate the importance of an inclusive family approach. The inclusion of social supports within programming as well as peer support was also a consistent approach identified in the literature.

   Ideas to Consider:

   - Make sure that people have just-in-time assistance whenever they run into challenges trying out new actions
   - Ensure that people have others around them to call on whenever help or assistance is required
   - Identify the toughest obstacles to change and ensures that people have others around them to call on for help or assistance
   - Create safe ways for people to get help without feeling embarrassed or put on the spot

3. **The service/program area includes provider care systems to support equitable service provision.**

   Provider interventions such as the application of registries, flow sheets and reminder based systems allows for greater consistency of care. Standardization assists in ensuring that clinical practice guidelines are applied equitably regardless of client social demographics. The use of provider interventions also assists in the provision of equitable care.

Ideas to Consider:

- Use reminders, regular communications, flow sheets, and metrics to ensure that equitable care is 'top of mind' for **everyone**

4. **The service/program area orientates services to be provided within the home, school, workplace and/or community.**

   Communities, schools and workplaces were identified as effective settings for service provision for marginalized or hard to reach populations. Firstly, delivery of services within communities helps to reduce financial and logistic barriers to access. Thus, including community outreach and home visiting within services was identified as an effective approach towards addressing inequities. Secondly, schools have been identified as a setting which act as a service and programming hub in the community for the development of healthy environments, promotion of healthy behaviours and the creation of strong linkages to existing community resources. Lastly, work environments were identified as an important setting as both potential health promoting sites for hard to reach populations, and as environments that impact health outcomes and potential inequities.

Ideas to Consider:

- Provide services at times and in places that meet client needs
- Identify opportunities for service integration

5. **The service/program area delivers programs and/or services specifically for priority populations.**

Ideas to Consider:

- Provide programs or services to meet needs not addressed by other plans/strategies
- Provide programs or services tailored to needs of priority populations within scope of universal programming or services

6. **The service/program area ensures culturally-safe service provision.**

   Culture has been identified as a key social determinant of health. To respect cultural identities and to reduce existing equity gaps between cultures, a number of approaches were identified in the literature. Cultural tailoring, the use of native language, and the integration of community health workers and trained lay persons were consistently discussed as approaches towards creating health equity.

Ideas to Consider:

- Use translation services to overcome communication barriers
- Provide a workforce representative of the client population
- Develop knowledge or skills of workforce to provide culturally-safe services

7. **The service/program area develops innovative approaches for the inclusion of skill-building and interactive components for interventions.**

   The incorporation or development of skill building for clients /patients as a focus of behavioural interventions has been shown to be effective. Skill development is an important aspect of programming as it builds upon the capacity of the individual to support sustainable change.

Ideas to Consider:

- Assess people's readiness for change and tailor activities appropriately
- Provide guided and focused activities that address potential challenges with immediate feedback
- Help build skill so people can engage in the new action even in the toughest of circumstances

8. **The service/program area includes clients and/or families in health programming.**

Ideas to Consider:

- Engage clients and families in planning and decision-making at individual (client) level
- Engage clients and families in planning and decision-making at program level
- Ensure patient advisory committees are representative of the local population and geographies.

9. **The service/program area facilitates the formation of multidisciplinary teams, integrated services and case management for high risk and marginalized populations.**

   Case management is consistently recommended as an effective strategy towards creating health equity. The application of case management assists in addressing patient barriers to services. Similarly, integrated services allow for greater holistic client care, and assist in meeting fundamental client needs.

Ideas to Consider:

- Ensure that team members share any information necessary to support people making the needed changes
- Support advocacy for individual clients and families' needs

10. **The service/program area integrates community health and lay workers within health program delivery.**

    A multi-disciplinary approach to care may include the integration of trained community health workers or lay persons. The use of trained community health workers has been found to be effective in addressing cultural and communication barriers. Application of a community health worker model, or integration of trained lay persons, has the potential to increase the accessibility and acceptability of health services.

Ideas to Consider:

- Provide community members with innovative opportunities to learn new skills and play a role in the health care system (i.e. community program builders, Elders, etc.)

11. The service/program area works towards supporting long-term sustainable change.

The literature suggests that client interventions are more effective when they are intensive and of long duration. This approach acknowledges that behavioural changes require time and ongoing support. In order for programming to be effective, sustainability should be a key component of planning and ongoing implementation.

Ideas to Consider:

- Use a phased approach and/or break activities into mini goals that can be more easily addressed over time
- Identify a small number of actions that will lead to the greatest amount of positive change for all
- Build upon and/or scale up previously successful programming
- Include opinion leaders, people in positions of authority such as supervisors and managers, and create a specific strategy to get them involved to teach, model, praise and coach people toward the new action required
- Identify people who will be most resistant to change and make sure they are involved early

12. The service/program area identifies the role of sectors other than health (e.g. education, housing, social services etc.) as active partners in order to address the social determinants of health and increase equity.

Physical environments, such as housing or housing quality, are a key determinant of health. Interventions in the field of housing, including provision of housing to housing improvements, may positively support health equity. Supportive housing coupled with integrative services can be effective in addressing mental health and addictions issues within homeless populations.

Ideas to Consider:

- Engage in advocacy with or on behalf of disadvantaged communities or priority populations
- Collaborate with other sectors to address social determinants of health
- Educate and raise awareness of equity issues among other sectors
- Participate in community-oriented research partnerships
- Refer clients to a range of services to address root causes of ill health

13. The service/program area is regularly informed by evidence.

Ideas to Consider:

- Identify the exact result to be achieved and include how to know whether or not you are succeeding (target-setting)
- Search for credible sources who know about making changes and who have already succeeded under similar circumstances
- Conduct targeted literature reviews and/or present a plan for own data analysis to identify effective interventions
- Collect data to understand the client population and plan programming or services
- Participate in health care equity audits
- Undertake regular monitoring and evaluation activities
- Report regularly on progress

APPENDIX B

Program Assessment Template: Exploring Health Care Equity

What are the specific goals and expected outcomes of the program/service?
Are there any explicit goals relating to equity?
What, in your opinion are the key challenges to achieving better equity in this program/service?

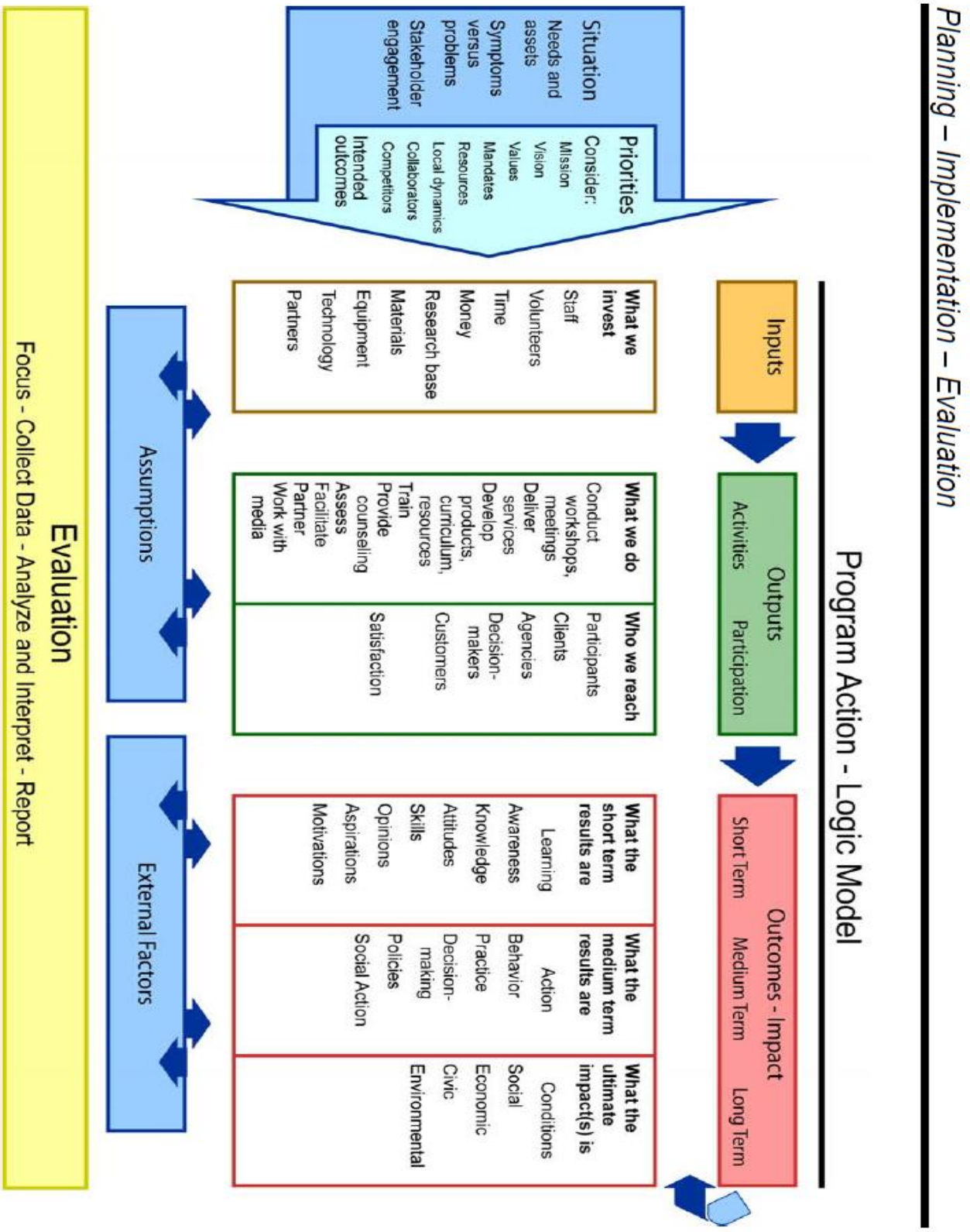
Are there any indicators that are currently being tracked?	List
Process Indicators i.e. wait times, length of stay, etc.	
Outcome Indicators i.e. hospitalizations, readmissions, prevalence/incidence rates, etc.	
Equity Indicators i.e. demographic variables, postal code, socioeconomic variables, etc.	
Other Indicators	

If known, describe the socio-demographic, geographic and economic characteristics of the target population.

Are there any particular population groups that the program/service has difficulty reaching?
Are there any particular population groups that participate in the program/service but do not have the health improvements that other groups have?

		Is care to the population…			
Identify the group(s) to be analyzed	Additional health care needs? Why?	Accessible?	Available?	Acceptable?	Other?
What type of information/data do you think might assist in understanding the above?					
Explain the main achievements/success stories within the program area (related to equity) so far.					

APPENDIX D


Planning – Implementation – Evaluation
Program Action - Logic Model
Priorities
Situation
Needs and assets
Symptoms versus problems
Stakeholder engagement
Consider:
Mission
Vision
Values
Mandates
Resources
Local dynamics
Collaborators
Competitors
Intended outcomes
Inputs
What we invest
Staff
Volunteers
Time
Money
Research base
Materials
Equipment
Technology
Partners
Outputs
Activities
Participation
What we do
Conduct workshops, meetings
Deliver services
Develop products, curriculum, resources
Train
Provide counseling
Assess
Facilitate
Partner
Work with media
Who we reach
Participants
Clients
Agencies
Decision-makers
Customers
Satisfaction
Outcomes - Impact
Short Term
Medium Term
Long Term
What the short term results are
Learning
Awareness
Knowledge
Attitudes
Skills
Opinions
Aspirations
Motivations
What the medium term results are
Action
Behavior
Practice
Decision-making
Policies
Social Action
What the ultimate impact(s) is
Conditions
Social
Economic
Civic
Environmental
Assumptions
External Factors
Evaluation
Focus - Collect Data - Analyze and Interpret - Report

APPENDIX C

Indicator Selection Guide[1]

Indicators are **succinct** measures that aim to **describe** as much about a system as possible in as few points as possible. They can be used in three ways:

1. For understanding (research)
2. For performance (monitoring)
3. For accountability

Indicators must be chosen and used in a way that relates very specifically to the objectives of the system in question.

Anatomy of an indicator
Indicator is known as the metadata – title, rationale, and information about how it is actually constructed. Will help you assess if the indicator is important, relevant, and can be populated with reliable data.

Ten key questions:

1. What is being measured?
2. Why is it being measured?
3. How is this indicator actually defined?
4. Who does it measure?
5. When does it measure it?
6. Will it measure absolute numbers or proportions?
7. Where do the data actually come from?
8. How accurate and complete will the data be?
9. Are there any caveats/warnings/problems?
10. Are particular tests needed such as standardization, significance tests, or statistical process control to test the meaning of the data and the variation they show?

Criteria

A. Does the indicator address an **important** issue?
   - Clarify on the most important aims of the system is essential to know if the indicator is important and relevant
   - Does the indicator focus on and measure a key part of the process or outcome?
   - Are you considering a set of indicators? If so, is the set balanced (all important areas covered without undue emphasis on any one area)?

B. Is the indicator scientifically **valid**?
   - Does the indicator measure really measure the issue?

Do not proceed until you have clarified A and B. Then ask:

C. Is it actually **possible** to populate the indicator with meaningful data?
   - Are sufficiently reliable data available at the right time with appropriate comparators?
   - If not, is the extra cost and effort justifiable?

D. What is the **meaning**? What is the indicator telling you and how much precision is there?
   - *Will the indicator be able to detect and display variation that is important enough to warrant further investigation (identify all the issues and only the issues that require further investigation)?*

[1] Adapted from NHS The Good Indicators Guide: Understanding how to use and choose indicators

- What does the indicator actually tell you and does it give enough accurate and precise information for you to be able to investigate further and take necessary action?
- Can the indicator be understood in order to understand the particular reasons for the results?
- Can the implications of the indicator results be communicated to, and believed/appreciated by the right audience?

E. What are the **implications**? What are you going to do about it?
- Is there sufficient understanding of the system so that issues identified can be investigated further and addressed effectively?
- Can the indicator monitor the issue regularly enough so that further investigation and action can be taken before the issue is revisited – system sufficiently responsive so problems are addressed early by not measured so often that the action has not had the chance to have had an effect.

APPENDIX E

Evaluation Framework Template

Outcomes Take directly from logic model	Evaluation Qs Specific Questions that relate to the outcomes	Methodology/Indicators A measure that is quantifiable to explore the evaluation questions	Data Source Where you will get the information for the indicator	Timeline
SHORT TERM OUTCOMES				
INTERMEDIATE OUTCOMES				
LONG TERM OUTCOMES				