Module Three Part Two: Monitor, Measure and Evaluate Strategies to Improve Health Equity
Who Are We?

Health Equity Project Leader
Access Alliance Multicultural Health and Community Services

Health Equity Project Capacity Building Partner
AOHC

Health Equity Project Champions
Chigamik, Planned Parenthood; North Lambton; Rideau; Somerset West; Témiskaming; and Women’s Health in Women’s Hands Community Health Centres

Health Equity Project Cross-Sector Partners
OCASI and Centre Francophone de Toronto
What We Are Doing Together

At the Champion level...

• Build organizational level knowledge, commitment and capacity to routinely use a health equity framework and evidence geared at overcoming systemic inequities in healthcare access, healthcare quality and health outcomes.

And beyond...

• Drive system-level leadership in equity focused planning and evaluation practices.
• Mobilize a community of practice within the CHC sector and across sectors (e.g. settlement) to inspire shared visions and actions for advancing health equity.
Health Equity Framework

Community
- Establish it as a strategic priority
- Cultivate partnerships & coalitions
- Decrease organizational discrimination/oppression
- Implement specific strategies on SDOH
- Develop structures & processes

Engagement
Module Three: Learning Objectives
Planning and Evaluating Health Equity Strategies

Planning to address inequities & prioritizing impactful feasible solutions
Design & implement strategies to advance health equity
Performance Management
Planning and Evaluation Cycle to Advance Health Equity

1. Strategic Priority for Health Equity
2. Equity-Focused Strategy Development
3. Implementation
4. Program Evaluation & Performance Measurement
5. Accountability

The cycle begins with Strategic Priority for Health Equity, followed by Equity-Focused Strategy Development, then Implementation, Program Evaluation & Performance Measurement, and finally Accountability, before returning to the beginning.
Health Equity Performance Management

Performance Measurement
• Data on program processes and outputs (e.g., attendance rates, demographic information, satisfaction)
• Used to determine whether a program or service is operating or performing efficiently
• Tied closely to accountability

Program Evaluation
• Data on program outcomes
• Used primarily to assess program effectiveness in terms of expected changes or outcomes
• Additional data collection
Performance Measurement vs. Program Evaluation

FIGURE 1
Performance Measurement-Evaluation Continuum

Performance measurement

Formative evaluation

Formative evaluation

Formative evaluation

Formative evaluation

Summative evaluation

Program timeline

Planning

Implementation
Case Story 1: South Riverdale CHC

Health Equity Issue: How *to use performance measurement* to identify health equity areas for improvement?

Steps:
1. Standardized client data collection
2. Analysis of health promotion data to identify access gaps
3. Targeted investments toward reducing access gaps
4. Continuous performance measurement to monitor progress
Step 1: Standardized Data Collection to Inform Strategy, Scope & Approach

FY 14-16

- **Sessions**: 1,221
  - Chronic Disease: 40 groups
  - Health & Wellness: 30 groups
  - Children & Families: 13 groups
  - Lived Experience: 495 sessions co-facilitated by volunteers/individuals with lived experience
  - Partnership: 240 sessions co-facilitated with community partners

- **Attendance**: 13,869

- **12%** Registered clients accessed at least one health promotion program in last two years
1,020

Individuals accessed health promotion programs at SRCHC FY14-15

Access

Client Profile: SRCHC Health Education Programs

77%

Clients accessing programming are living below the low income cut off.

7%

Client have household incomes above $35,000

Household Income

Education

15%

Have primary education or no formal education

37%

Have a post secondary education

Income Source

23% Canadian Pension & OAS

20% ODSP/Ontario works

17% employed (FT/PT)

Preferred language is Chinese

10%

Newcomers to Canada (less than 5 years)

7%

Homeless/ Couch surfing

Age

11%

under 19

24%

20-44

33%

45-65

32%

65 +
Step 2 – Analysis of health promotion data to identify access gaps

Issues Addressed In Groups

- 14% exercise
- 11% reducing social isolation
- 10% health education
- 5% chronic disease mgt.
- 5% community resources

Integration with Health Services

- 47% of clients who access group program access health services
- An average of 24 encounters per client over two years
- 30% of encounters address determinants of health (housing, legal etc.)

Complexity

- 22% of most complex clients are accessing health promotion programs
- 60% of individuals referred attend 3 or more group based programs
Step 3 - Targeted investments toward reducing access gaps

Transportation
- 28,390 trips on TTC
- 21% increase from previous year

Child Care
- Over 1,300 hours of childcare supports
- 42% increase from previous year

Language Services
- 44% increase from previous year

Food Access
- $5 average for each client who attends group session

Equity = Fairness
Equity is about making sure people get access to the same opportunities
Step 4 - Continuous performance measurement to monitor progress

Almost doubled the number of issues addressed in group programming compared to previous 3 month period (261 to 495)

Better reflection of health promotion work being done, especially re: food insecurity and access issues - transportation
Program Evaluation Planning Steps

1. Establish your evaluation team
2. Determine users and use of evaluation findings
3. Develop a logic model
4. Develop an evaluation plan
5. Identify and review evaluation findings
6. Use findings for accountability, learning, strategic planning
Evaluation 101

Evaluation Phases

• Formative
• Summative
Process vs. Outcome

Types of Evaluation

Focus of Evaluation

[.................Formative.................]  [..................Summative..........]
## Developing a Logic Model

<table>
<thead>
<tr>
<th>Main Goal/Sub-goals</th>
<th>To reduce health inequities in ...</th>
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<tbody>
<tr>
<td>Target Population</td>
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<tr>
<td>Inputs/Resources</td>
<td></td>
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<tr>
<td>Implementation/Process Objectives</td>
<td></td>
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<td>Outputs/Activities (Process Indicators)</td>
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<td>Short-Term Objectives/Outcomes</td>
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<td>Short-Term Indicators</td>
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<td>Med-Term Objectives/Outcomes</td>
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<td>Med-Term Indicators</td>
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### Process Evaluation

### Outcome Evaluation
Case Story #2: Rideau CHS
Equity Focused Program Evaluation

Health Equity Issue: How to implement an equity informed evaluation process for all of its programs, starting with Footcare Program.

Why Footcare?
• Valuable, affordable and a high demand program;
• Limited capacity and resources to meet demand;
• Rideau CHS resources are not being applied to those who need the service most/do not have access to other options.
Rideau Footcare Program
Evaluation Planning

1. Identification of baseline of data from situational analysis
   
   Target population:
   
   • People living with incomes of $29,000 or less;
   • People without access to health insurance coverage;
   • People who have diabetes and are in an education program

2. Development of a logic model, clearly defining Year One and Year Three equity targets and objectives

3. Use of performance measurement data to monitor progress against the equity plan

4. Use of evaluation data to measure long-term outcomes (Year 3)
# Draft Logic Model – Rideau Footcare Program

| Main Goal/Sub-goal | · To reduce health inequities in footcare  
|                   | · To reduce ulcerations and amputations |
| Target Population | · People living with incomes of $29,000 or less;  
|                   | · People without access to health insurance coverage;  
|                   | · People who have diabetes and are in an education program (tbd) |
| Implementation Objectives (by end of year 1) | · To increase #/% of high risk people who have access to footcare services and groups by end of year 1 |
| Outputs (Process Indicators) | · % of clients meet eligibility criteria (currently 52% of clients who report income are under LICO that is 165/316) (Target = 80%)  
|                   | · Reduce wait list among low income/at risk people for access to footcare (3rd next available)  
|                   | · Wait list other populations |
| Short to Medium-Term Objectives (end of year 3) | · To reduce the incidence of ulcerations among rostered clients  
|                   | · To decrease smoking rates (long term)  
|                   | · Improved care pathways within Rideau CHC for people who are at high risk |
| Short to Medium-Term Indicators | · # of escalations to chiropody or acute care  
|                   | · # of referrals to STOP Program  
|                   | · # of referrals to food security programs or other programs to help reduce risk or offset poverty  
|                   | · % of clients seen according to their care plan (Target = 80%) |
Program Evaluation to Improve Health Equity
Case Story 3: Chigamik CHC/CSC
Performance Measurement & Evaluation

**Health Equity Issue:** How to implement an equity informed *evaluation* process for all of its programs (rostered and un-rostered).

**Background:**
- Data collection on primary care clients was already in place;
- The collection of equity data on clients participating in non-rostered programs was identified as a priority for program improvement and evaluation.
Performance Measurement & Evaluation Planning Steps

1. **Establishment of a team** consisting of clinic manager, community program manager and data manager

2. **Review of current data** collected from un-rostered clients

3. **Data collection tool development** considerations e.g. Vital 8 indicators, OHIP#, socio-demographic & SDOH (e.g. sexual orientation, loneliness)

4. **Staff training** on tool

5. **Feedback** from program coordinators

6. **Data collection** (beginning Jan 2018)

7. **Equity-focused monitoring** and the creation of short and long-term **equity indicators**
Chigamik Evaluation Tool

Program Information

At CSC CHIGAMIK CHC we would like to collect additional information about our clients so we can help serve them better. Although you do not need to complete these questions, your participation will help us in program planning and funding applications. This information is entirely confidential, and will not be shared with any external parties including the Ministry of Health, other health care agencies, or any other agency without your consent.

1. How would you rate your **physical** health and well-being **today**? Choose one.
   - [ ] Poor
   - [ ] Fair
   - [ ] Good
   - [ ] Very Good

2. How would you rate your **mental** health and well-being **today**? Choose one.
   - [ ] Poor
   - [ ] Fair
   - [ ] Good
   - [ ] Very Good

3. Your community plays a role in your physical and mental health. How would you rate your sense of belonging in your community **today**? Choose one.
   - This means having a group you connect with who respects you, shared activities and experiences, emotional bonds with others, having people to care about and who care about you.
   - [ ] Poor
   - [ ] Fair
   - [ ] Good
   - [ ] Very Good

4. Do you have any of the following disabilities?
   - [ ] Chronic Illness
   - [ ] Developmental
   - [ ] Learning
   - [ ] Physical
   - [ ] Sensory
   - [ ] Other:

5. What is the highest level of education completed?
   - [ ] Grade 1-8
   - [ ] Grade 9-12
   - [ ] Post-secondary
   - [ ] Too young
   - [ ] No formal
   - [ ] Other:

6. What is your combined household income?
   - [ ] Less than $14,000 (Less than $1,249/month)
   - [ ] $15,000-19,000 ($1,250-1,667/month)
   - [ ] $20,000-24,999 ($1,668-2,083/month)
   - [ ] $25,000-29,999 ($2,084-2,500/month)
   - [ ] Do not know
   - [ ] $30,000-34,999 ($2,501-2,916/month)
   - [ ] $35,000-39,999 ($2,917-3,333/month)
   - [ ] $40,000-59,999 ($3,334-4,999/month)
   - [ ] More than $60,000 ($5,000/month)
   - [ ] Prefer not to answer
7. What is your housing status:
   □ Not homeless   □ Homeless, no address   □ Shelter   □ Staying with friends/family   □ Other:

8. Do you have mental health challenges or concerns: □ Yes   □ No   □ Prefer not to answer

9. Do you have addictions or substance misuse challenges: □ Yes   □ No   □ Prefer not to answer

10. How often do you feel you lack companionship? □ Hardly ever   □ Some of the time   □ Often

11. How often do you feel left out? □ Hardly ever   □ Some of the time   □ Often

12. How often do you feel isolated from others? □ Hardly ever   □ Some of the time   □ Often

13. What is your sexual orientation?
   □ Heterosexual   □ Homosexual   □ Bisexual   □ Do not know   □ Prefer not to answer

Chart #: ______________________

Name: ___________________________________________ Phone: ______________________

Address: _________________________________________ Postal Code: ________________

Email: ___________________________________________ Gender: □ Male □ Female □ Other: ______________________

Date of Birth (D/M/Y): ___________________________ OHIP #: ______________________

Emergency Contact: _____________________________ Phone: ______________________

Do you self-identify? □ First Nation □ Métis □ Inuit □ Francophone
Planning and Evaluation Cycle to Advance Health Equity

- **Strategic Priority for Health Equity**
- **Equity-Focused Strategy Development**
- **Program Evaluation & Performance Measurement**
- **Implementation**
- **Accountability**
Planning and Evaluation Cycle: Accountability

Health & Wellbeing
- Grounded in a Community Development Approach
- Based on the Determinants of Health
- Anti-Oppression and Culturally Safe
- Accessible
- Community Governed
- Interprofessional Integrated and Coordinated
- Population Needs-Based
- Accountable and Efficient

Health Equity and Social Justice
- Community Vitality and Belonging

Highest Quality, People and Community Centred
Vital Eight Core Indicators

1. % of organizations that offer programs/initiatives to reduce: tobacco use; unhealthy eating/food insecurity; problematic substance use; obesity/healthy weight management; physical inactivity; and social isolation

1. % of clients reporting involvement in care decisions

1. % reporting self-rated physical health as excellent or very good

1. % reporting self-rated mental health as excellent or very good

5. % of eligible clients who received/offered colorectal/cervical cancer screening stratified by income

5. % of clients who always feel comfortable and welcome at [your CHC]

5. % of ongoing primary care clients receiving inter-professional care

5. % clients reporting very strong or somewhat strong sense of community belonging
Tools and Resources

Establish Planning Team
- Research to Practice (R2P) Protocol

Stakeholder Analysis & Engagement
- Stakeholder Analysis Tool
- Stakeholder Engagement Plan Template

Reviewing Evidence to Generate Solutions
- Research to Practice (R2P) Protocol
- R2P Mapping Tool

Prioritizing Solutions
- Risk Assessment Framework

Planning Intervention
- Equity-Informed Project Charter
- Sample Project Charter
- Logic Model Template
- Equity-Informed Program Plan
- HEIA online course (English) – open using Internet Explorer
- HEIA online course (French) – open using Internet Explorer
- HEIA workbooks and templates

Change Management
- NCCSDO Organizational Change A review for health care managers, professionals and researchers

Performance Measurement
- CIHI Performance Measurement Framework

Developing Logic Model, Evaluation Plan
- Logic Model Template
- Equity-Informed Evaluation Plan Guide
- Evaluation Framework Template
- Good Evaluation Questions Checklist (CDC)

Accountability
- Vital 8 Webinar
- MHWB Evaluation Framework
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