Learning Essentials for Advancing Health Equity
Module Two, Part One: *Using Data to Advance Health Equity*

BUILDING CAPACITY FOR EQUITY-INFORMED PLANNING AND EVALUATION

Health Equity Project Leader
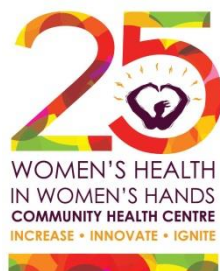*Access Alliance Multicultural Health and Community Services*

Health Equity Project Capacity Building Partner
Association of Ontario Health Centres

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

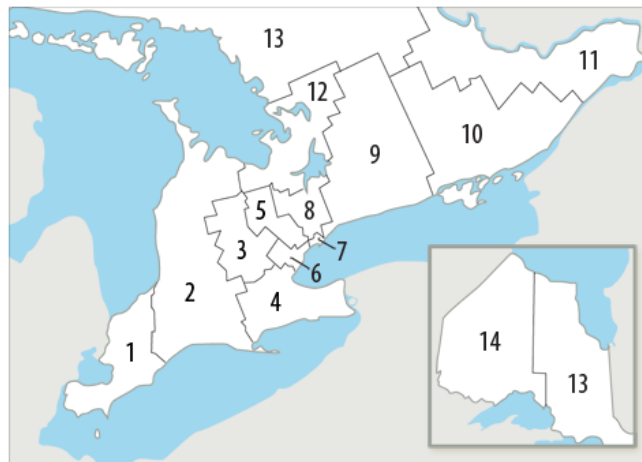***Funder: Ministry of Citizenship and Immigration***

Module Two, Part 1
Learning Objectives

➢Understand the key framework for doing equity analysis: the DIA (Disaggregated and Intersectional Analysis) framework

➢Understand the levels and types of data that are important to collect and analyze/utilize using the DIA framework to advance Health Equity
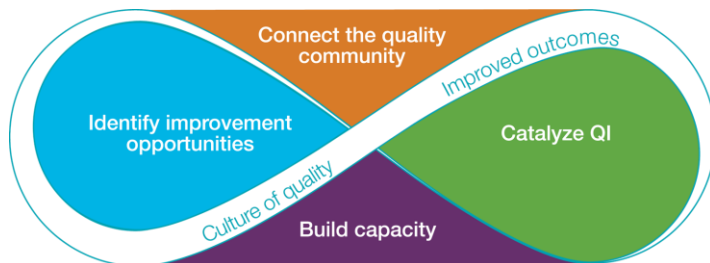
Already Collected by Everyone

Starting to Collect...

1. CHC-Specific Accountability Data

e.g. cancer screening rates, NP and GP retention rates, access to PC, etc.

"Vital 8" - CHC Equity Data

e.g. % clients screened by income, sense of belonging, self-rated health, etc.

2. QIP Primary Care Accountability Data

e.g. 7-day post hospital discharge, timely access, patient experience, etc.
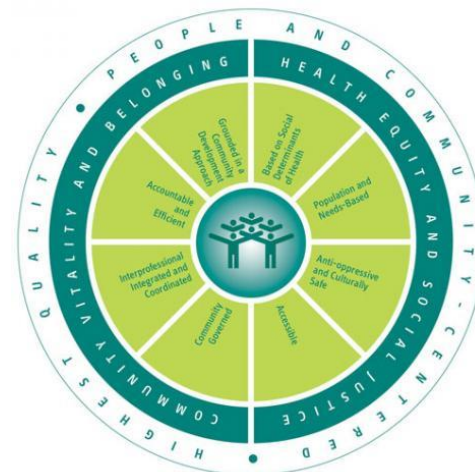
Key Considerations for Using Data to Advance Health Equity

- To advance health equity, we first need to understand health inequities - in all their complexities and variations.

- Specifically, we need to examine data on:
  - the nature, level, and types of health inequities (e.g is the inequity at the level of health access, quality, or outcome?)
  - the causes of these health inequities
  - how different groups are differentially and disproportionately impacted by these inequities

- This will help us decide what exact solutions are needed, at what level, and which groups to prioritize.

Key Considerations for Using Data to Advance Health Equity

- It is not necessary for everyone to have advanced analysis skills.

- More important is having the right organizational commitment, capacity and culture and the right "analytical framework" to produce, make sense of, and use data related to health equity/inequity.

- Internal colleagues with analysis skills (e.g DMC or RDSS) or external analysts can then support to conduct the analysis we need.

Key Considerations for Using Data to Advance Health Equity

Having the right analytical framework will ensure that:

- We are collecting or accessing the right type of data related to equity/inequity (ie. we have the right indicators)
- Data related to equity/inequity is high quality
- We appreciate and value this data
- We have the right language and tools to discuss, make sense of, and utilize this data
- We have the organizational commitment to mobilize actions/solutions to overcome these inequities

DIA - Disaggregated & Intersectional Analysis

To understand and overcome health inequities, we recommend the **Disaggregated and Intersectional Analysis (DIA) framework**, comprised of two interlinked steps:

1. Break down and pull apart "aggregate" (whole population level) data) into sub-populations or by different demographic indicators = **"disaggregated data"**

1. Explore how different indicators link and intersect to produce multiple or varied inequities = **"intersectional analysis"**
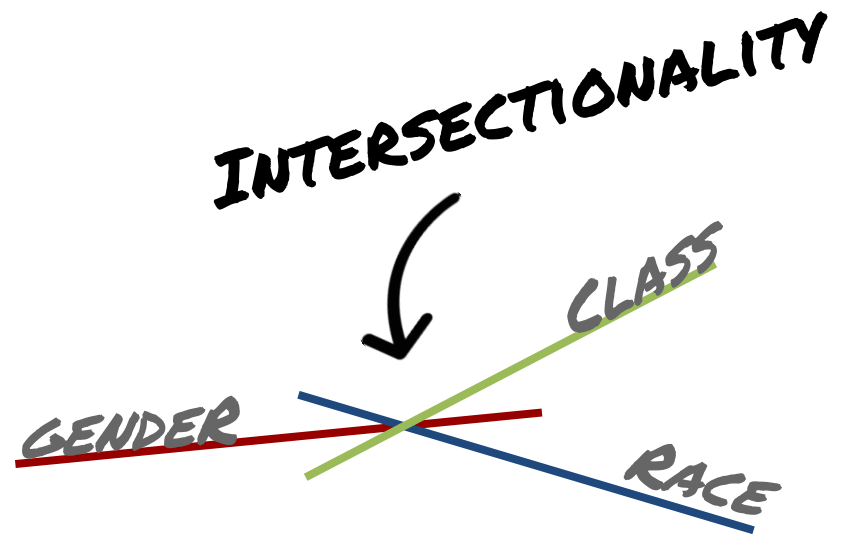
DIA - Disaggregated & Intersectional Analysis

Indicators for doing DIA can include:

1. Socio-cultural backgrounds (things that you cannot really change, e.g. gender, race/ethnicity, country of birth, sexual orientation, first/home language.

2. Structural/economic determinants (can be changed/improved), e.g. income/class, education level, employment status, official language fluency, and social isolation.

3. Organizational processes and practices within healthcare institutions, e.g. client eligibility criteria, hours of service, whether and what language interpretation services are offered, diversity of staff.

4. Health issues as determinants - having certain health issues (for eg. disability, mental health issue, or chronic health condition) may in turn be risk factor for other health issues or may be a barrier to healthcare access.

DIA - Disaggregated & Intersectional Analysis

Indicators of focus may vary by type of health inequity

For example, even in terms of healthcare access key determinants vary based on what kind of access we are talking about:

Key basis of inequity in OHIP coverage: precarious immigration status, being newly arrived (3 month wait OHIP), being homeless.

Key basis of inequity for healthcare not covered by OHIP (dental, vision, drug coverage): precarious employment with no extended health benefits, age (18-65), not eligible for social assistance, low income

Key basis of inequity in healthcare access among those who have OHIP: language barrier, race, income, sexual orientation, disability

The Three Interconnected Levels of Health Equity Data:

Macro

Meso

Micro
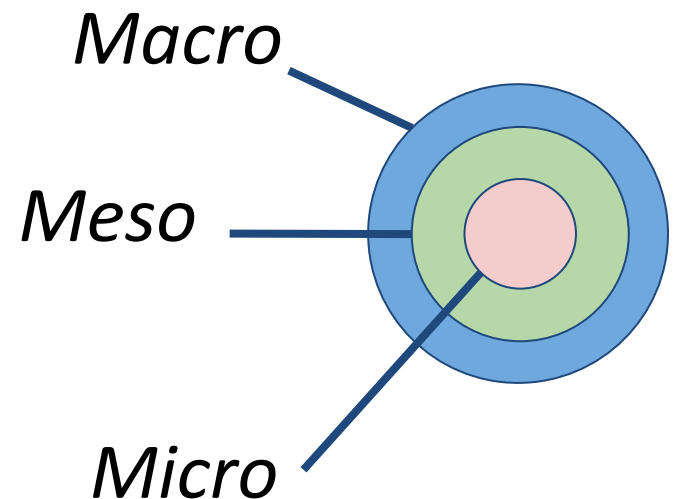
Health Equity Framework

Make health equity a strategic priority

Develop structures and processes to support health equity work

Specific strategies to address the multiple determinants of health on which organizations can have a direct impact
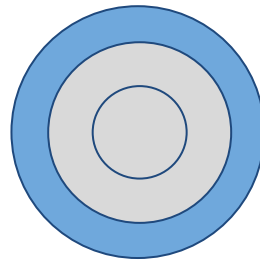
Decrease all forms of organizational discrimination & oppression

Develop partnerships with others to improve health and equity at societal/ population level

Macro Level Data

- Population-level data; big-dot indicators
- Can be used to identify which priority sub-groups to target;
- Can be used to understand types of inequities faced by your client community compared to average population; this can help you decide which programs/services to focus on
- Can be used to identify policy and advocacy, and building partnerships or coalitions for collective system level solutions

Examples:

- Food security
- Affordable housing
- Transportation

| Health equity as a strategic priority | Develop structures and processes | Specific strategies on multiple DOH | Decrease org. discrimin-ination/ oppress. | Develop partner-ships |

Using <u>Macro</u> Level Data to Advance Equity: Case Studies

Let's Talk Housing

Somerset West CHC - informed National Housing Strategy (health and housing in West-Central Ottawa)

CATIE

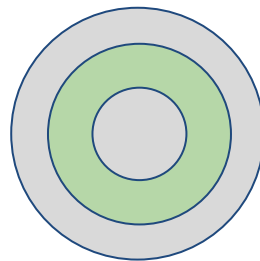**Ilene (HEq Coach)** - explored Hep C Screening & Treatment Needs in Recent Immigrants

My body is not something I should be taught to be ashamed of.

#supportsexed
join the conversation

planned parenthood toronto

Planned Parenthood Toronto - leader in #SupportSexEd campaign

Meso Level Data

- Organizational level data
- Used to align with Vision, Mission, Values and Strategic Priorities
- Meso level data is essential to shift the Organizational Culture

Examples:

- Employment equity survey
- Staff Inclusion and Diversity
- Training in Anti-oppression,
  Anti-racism,
  Cultural Humility/Safety
- Board Inclusion and Diversity

| Health equity as a strategic priority | Develop structures and processes | Specific strategies on multiple DOH | Decrease org. discrimin-ination/ oppress. | Develop partner-ships |

Using <u>Meso</u> Level Data to Advance Equity:
Champion Examples

Organizational Equity: 4/7 champions agreed current staff reflective of populations they serve
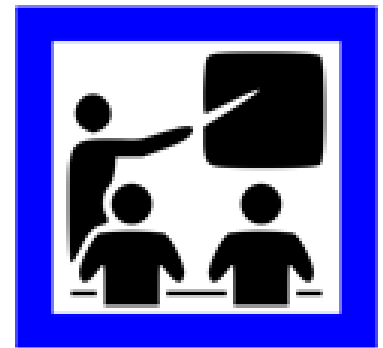
Organizational Structures: 3/7 champions have dedicated staff that promote, lead or address health equity objectives.
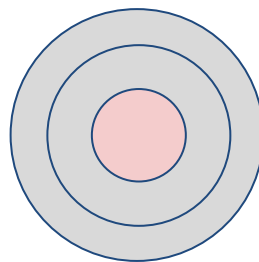
Organizational Culture: Most champions have given staff training on health equity in the past three years.

Micro Level Data

- Client/Service/Community Member Data; Health Outcomes
- Used to inform programming and service planning and delivery
- Essential for adopting a culture of quality in primary health care

Examples:
- (*Access*) Waiting days to see a clinical service provider.
- (*Quality*) Client feeling comfortable and welcome in the centre.
- (*Outcome*) Self-rated mental and physical health.

Health equity as a strategic priority

Develop structures and processes

Specific strategies on multiple DOH

Decrease org. discrimin-ination/ oppress.

Develop partner-ships
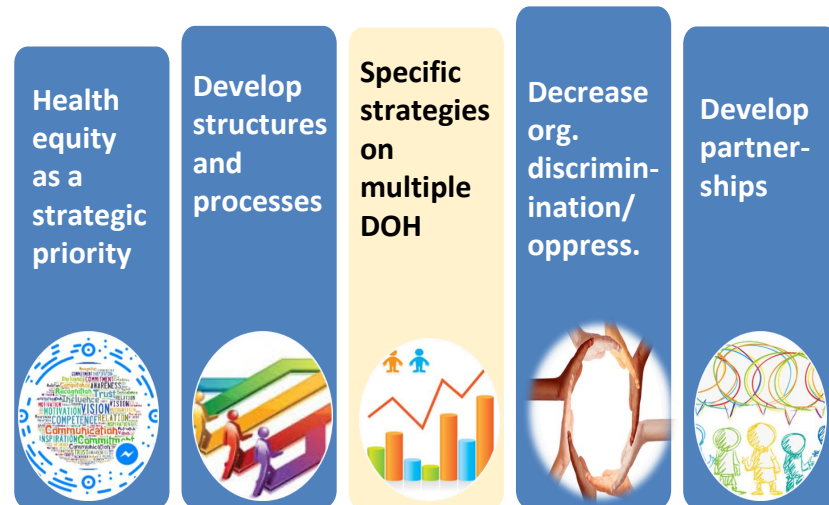
Which <u>Micro</u> Level Data are Champions Collecting?
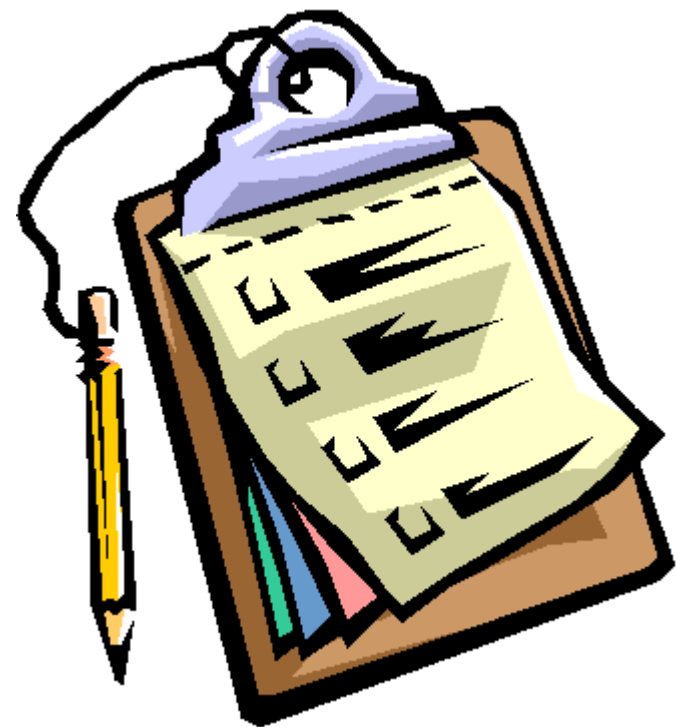
All champions collect demographic data on:

- preferred language
- country of origin
- education
- household composition
- household income
- number of people supported by the income

Six out of seven champions collect data on:

- sex
- gender
- sexual orientation
- insurance status
- date of arrival to Canada
- racial/ethnic group

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Reflection 1:

Think about the
data you collect and use to
advance Health Equity in your
organization.

1. *Are you aware of **which** levels of data you are collecting now?*
2. *Do you know **why** each are being collected?*
3. ***How** are you using these data currently OR planning to use them, at different levels?*

Macro

Meso

Micro
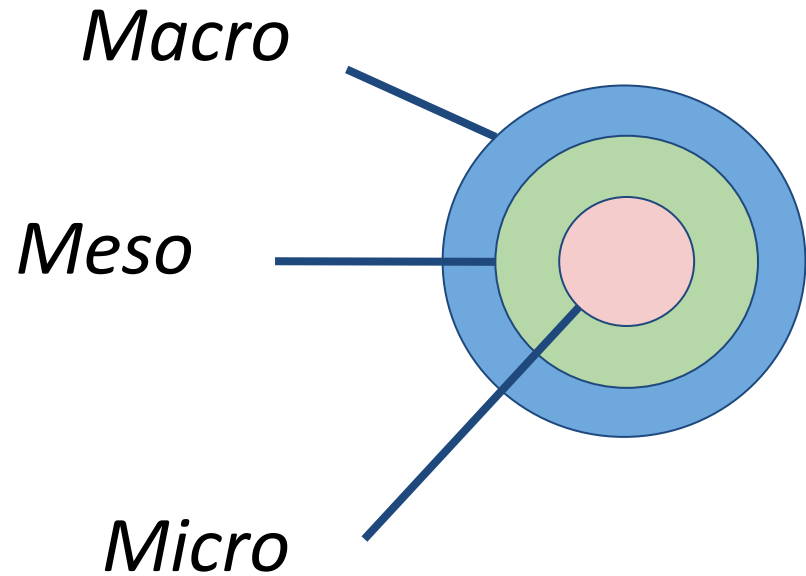
Basic Steps for Using the DIA Framework

First step: Disaggregate data by the specific demographic indicators/determinants (and/or groups or subgroups) that are of interest to your organization.

Second Step: Determine which intersections and links between demographic indicators/determinants are important to your organization, and then further disaggregate data based on these indicators or analyze to see how these indicators are linked

Using Disaggregated Data with an Intersectional Approach

Start

A — Collect quality data & define indicator of interest

B — Disaggregate demographic data

C — Stratify indicator of interest against demographic variables

D — Do intersectional analysis

E — Identify root causes of health inequities

F — Design, implement and evaluate strategies
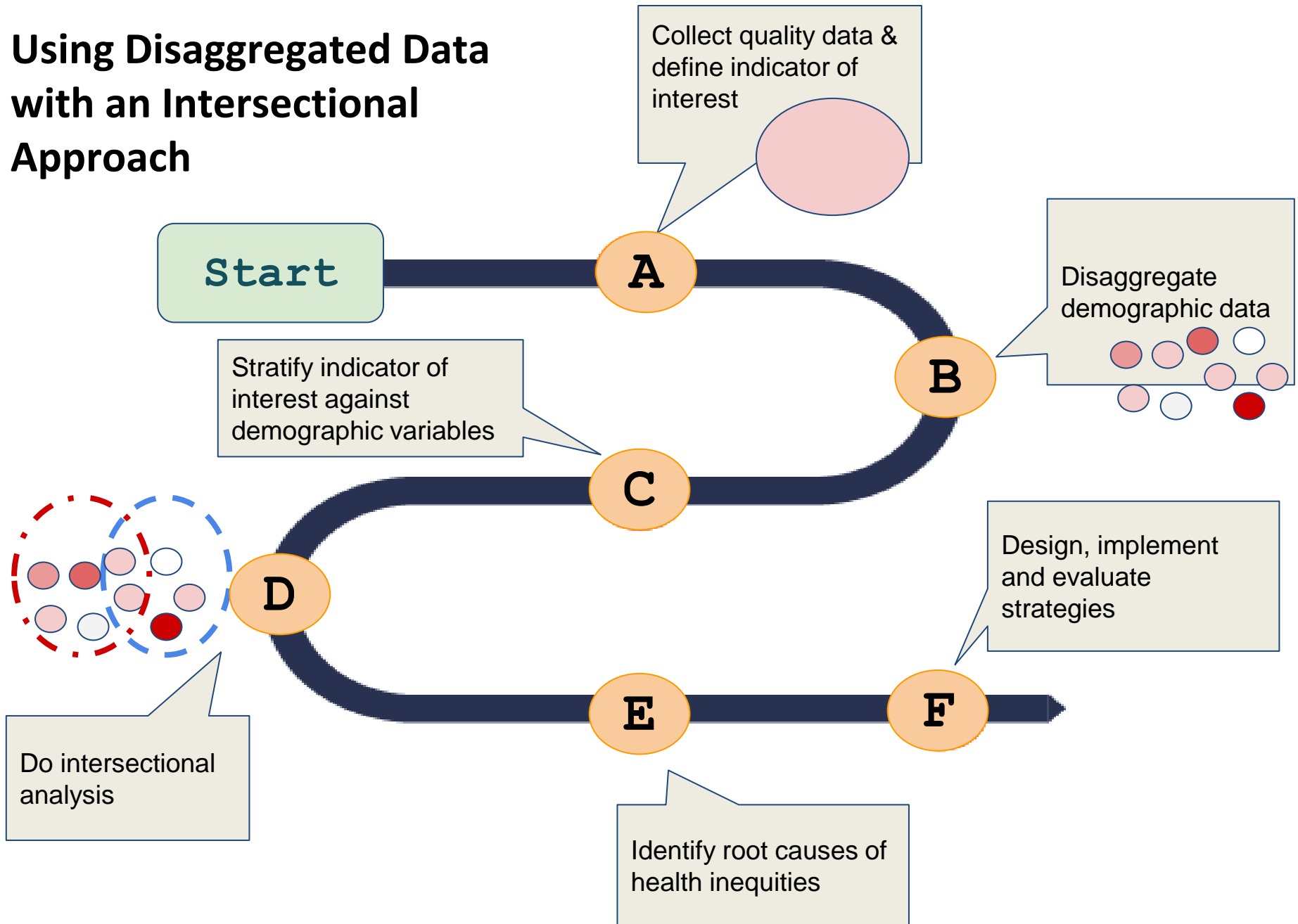
Connecting the Dots:
Coach Case Study

6 CHCs routinely collect cancer screening and demographic data

WEQIC forms, sets objectives

Disaggregated data pulled on variables of interest (income, place of birth, insurance status).

3 types of cancer screening data stratified against demographic variables

A

B

C

D

E

F

Tailored intervention created for each CHC based on unique needs

Intersectional analysis carried out across all 6 sets of data

Identification of root causes associated with low screening rates

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Connecting the Dots:
Champion Case Study

Objective of collecting this measure	Question What questions do you need to ask to determine that your objectives have been met?	Why	Dimension (s)	Information Required What information do you require to answer each of these questions?	What is the indicator/ measure?
To stratify existing socio-demographic data [age, income, education, Indigenous, non-Indigenous (North site only)] against cervical cancer screening data for all sites.	Are we screening these socio-demographics equitably?	Are there variations between CA screening completion and socio-demographics?	Reach, effectiveness, impact	Socio-demo data [age, income, education, Indigenous, non-Indigenous (North site only)] against cervical cancer screening data for all sites.	% of people screened for cervical CA for each socio-demographic (separately) by each site.

North Lambton CHC Measurement Plan Sample

Resources for DIA

[Pell Institute Toolkit](#)

Access Alliance practice documents (portal):
    a.   Draft Data Stratification Plan
    b.   AccessPoint on Danforth Health Needs Assessment Data Analysis Plan
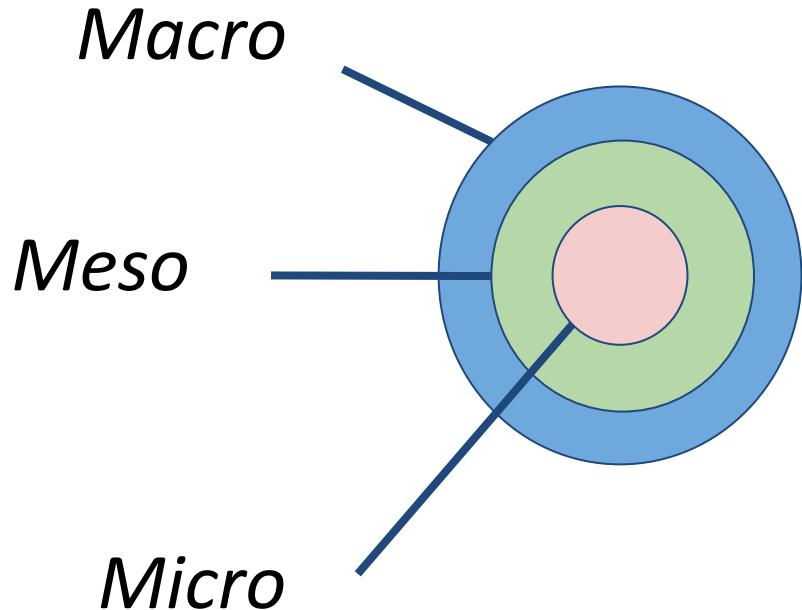
TC LHIN (portal):
    a.   Data Stratification Plan
    b.   2017 Report: Measuring Health Equity Demographic Data Collection and Use in Toronto Central LHIN Hospitals and Community Health Centres

[Data Analysis Using Excel](#)

Reflection 2:

Thinking about the primary client groups served by your organization, which are two or three indicators that would be most appropriate to consider using in a disaggregated intersectional analysis plan? I.e. that might best reveal inequities? E.g. income, racial/ethnic group, gender.

Macro

Meso

Micro

Tools for Using Data to Advance Health Equity

- [Pell Institute Toolkit](#)
- Access Alliance Draft Data Stratification Plan
- Access Alliance APOD Health Needs Assessment Data Analysis Plan *(available in French)*
- TC LHIN Data Stratification Plan
- TC LHIN 2017 Report: Measuring Health Equity Demographic Data Collection and Use in Toronto Central LHIN Hospitals and Community Health Centres
- [Data Analysis Using Excel](#)

THOSE NOT LINKED ARE AVAILABLE IN THE HEALTH EQUITY PROJECT TOOLKIT.

THANK YOU!

Please feel Free to share this Module!