

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



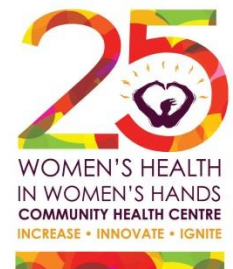
Health Equity Project Capacity Building Partner

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...

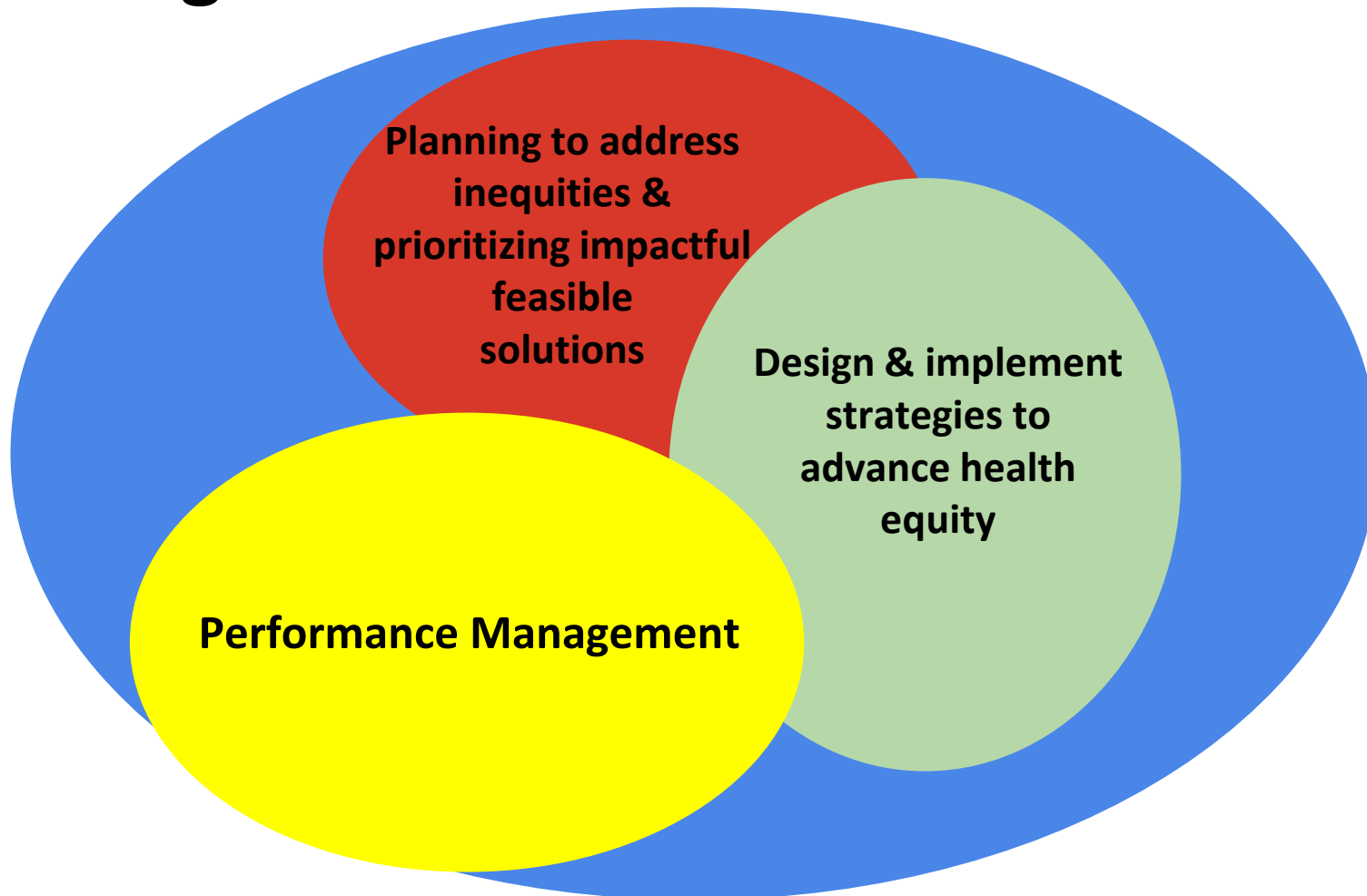
- Drive system-level leadership in equity focused planning and evaluation practices.
- Mobilize a community of practice within the CHC sector and across sectors (e.g. settlement) to inspire shared visions and actions for advancing health equity.

Health Equity Framework

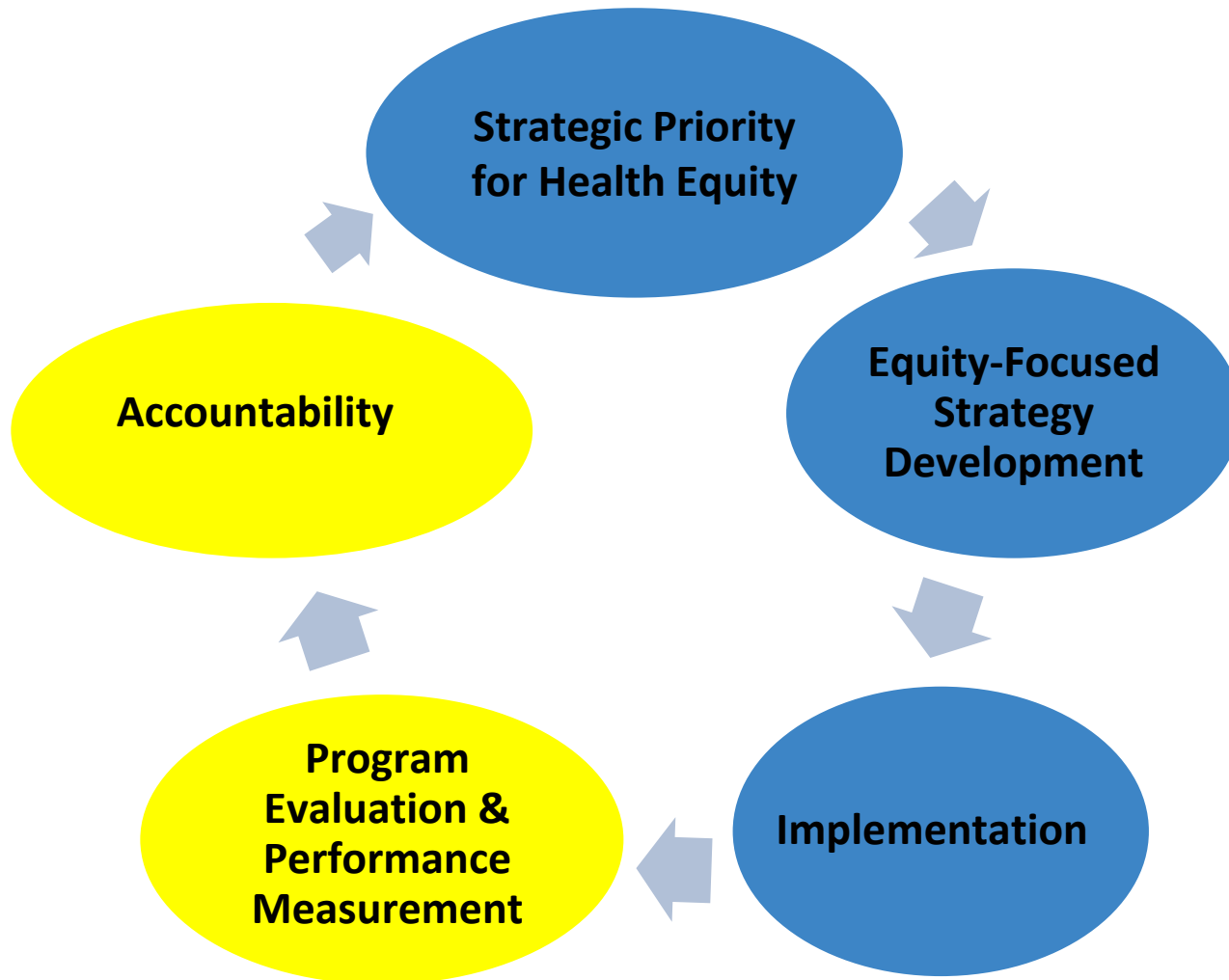


Module Three: Learning Objectives

Planning and Evaluating Health Equity Strategies



Planning and Evaluation Cycle to Advance Health Equity



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

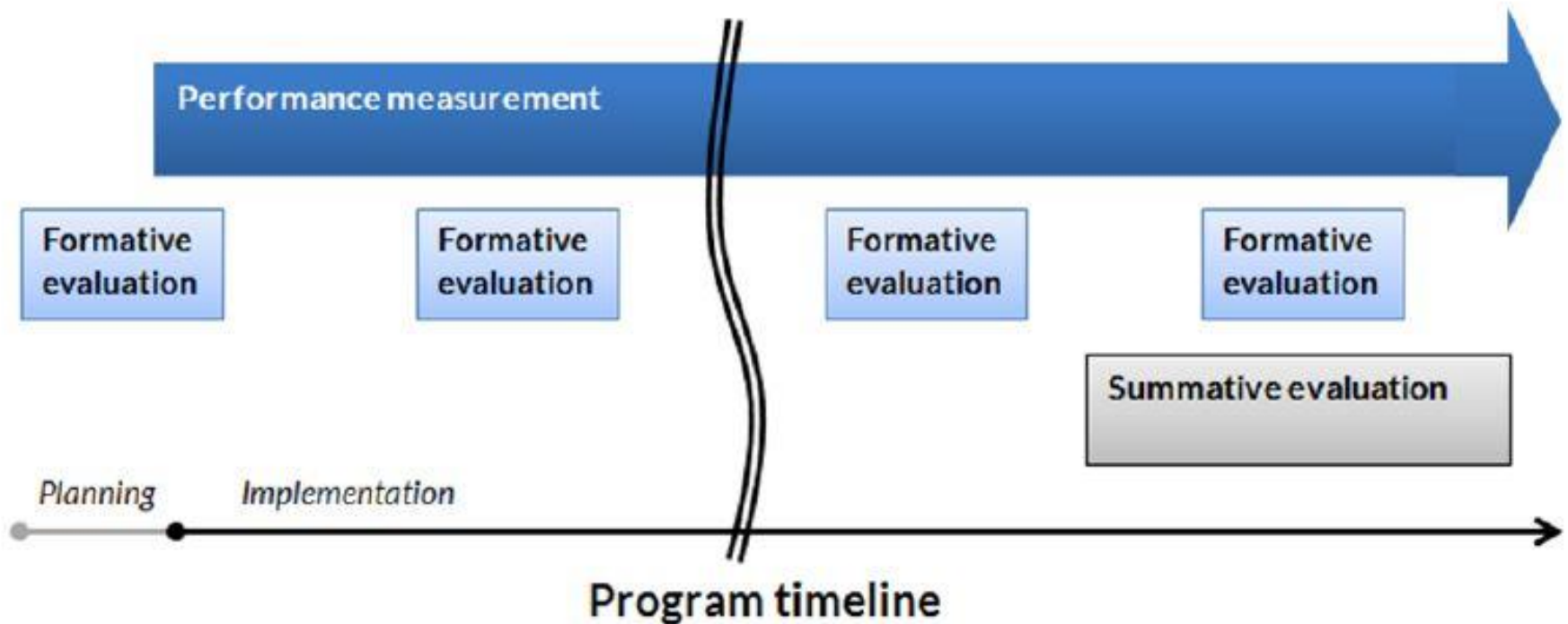
Program Evaluation

- 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



Case Story 1: South Riverdale CHC

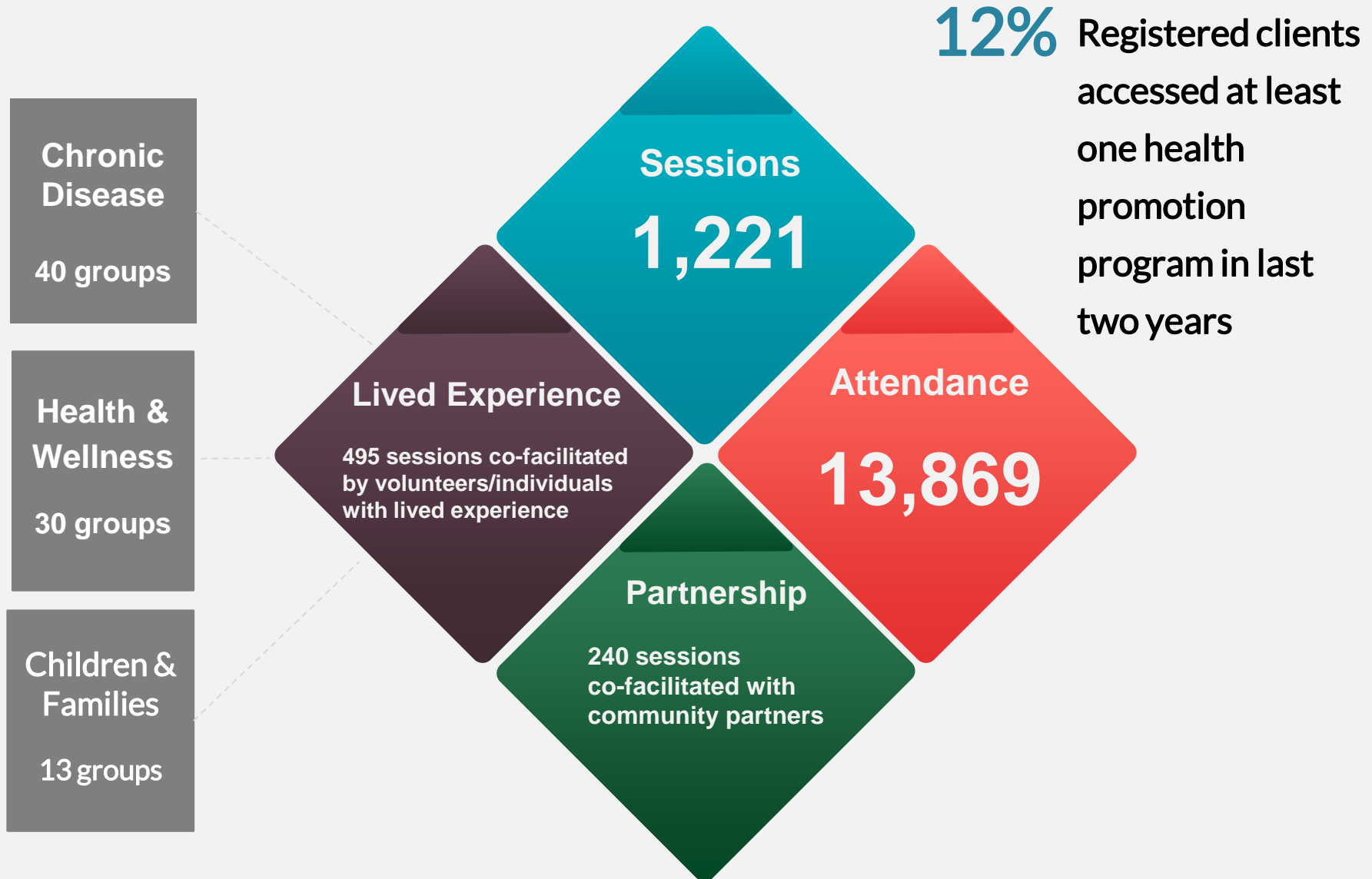
Health Equity Issue: How *to use performance measurement* to identify health equity areas for improvement?

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





1,020

Individuals accessed health promotion programs at SRCHC FY14-15

Access

Client Profile:
SRCHC Health
Education
Programs

Household Income

77%

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

7%

Client have household incomes above \$35,000

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)

40%

Preferred language is Chinese

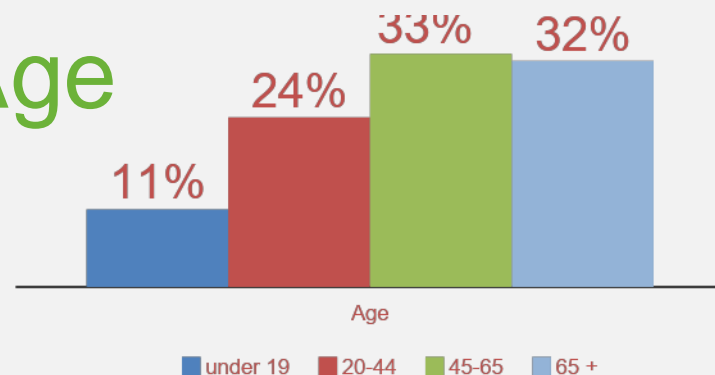
10%

Newcomers to Canada (less than 5 years)

7%

Homeless/
Couch surfing

Age



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



Equity = Fairness

Equity is about making sure people get access to the same opportunities

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



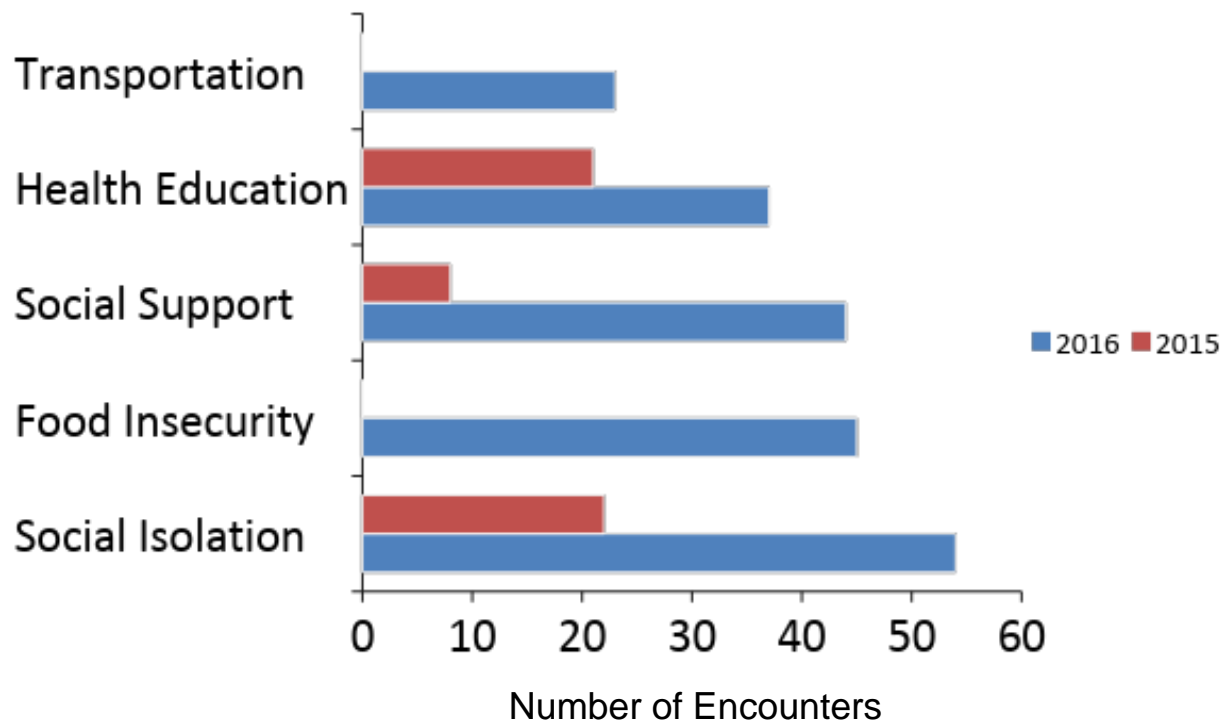
- 44% increase from previous year

Food Access



- \$5 average for each client who attends group session

Step 4 - Continuous performance measurement to monitor progress

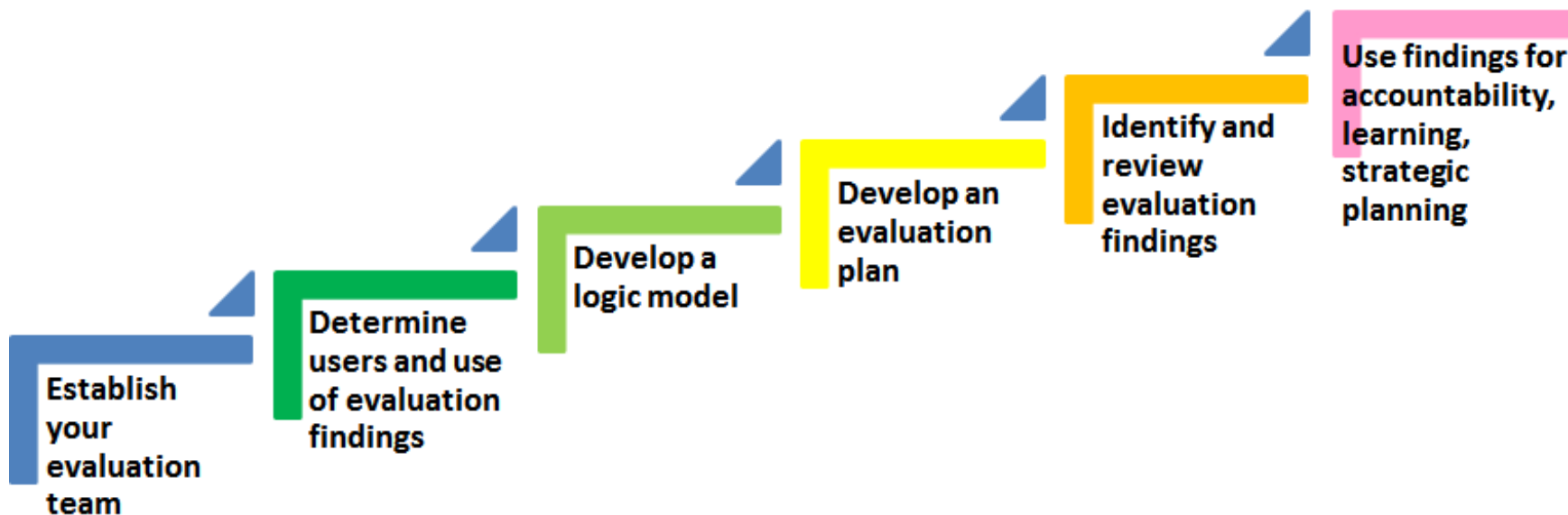


Almost doubled the number of issues addressed in group programming compared to previous 3 month period (261 to 495)

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



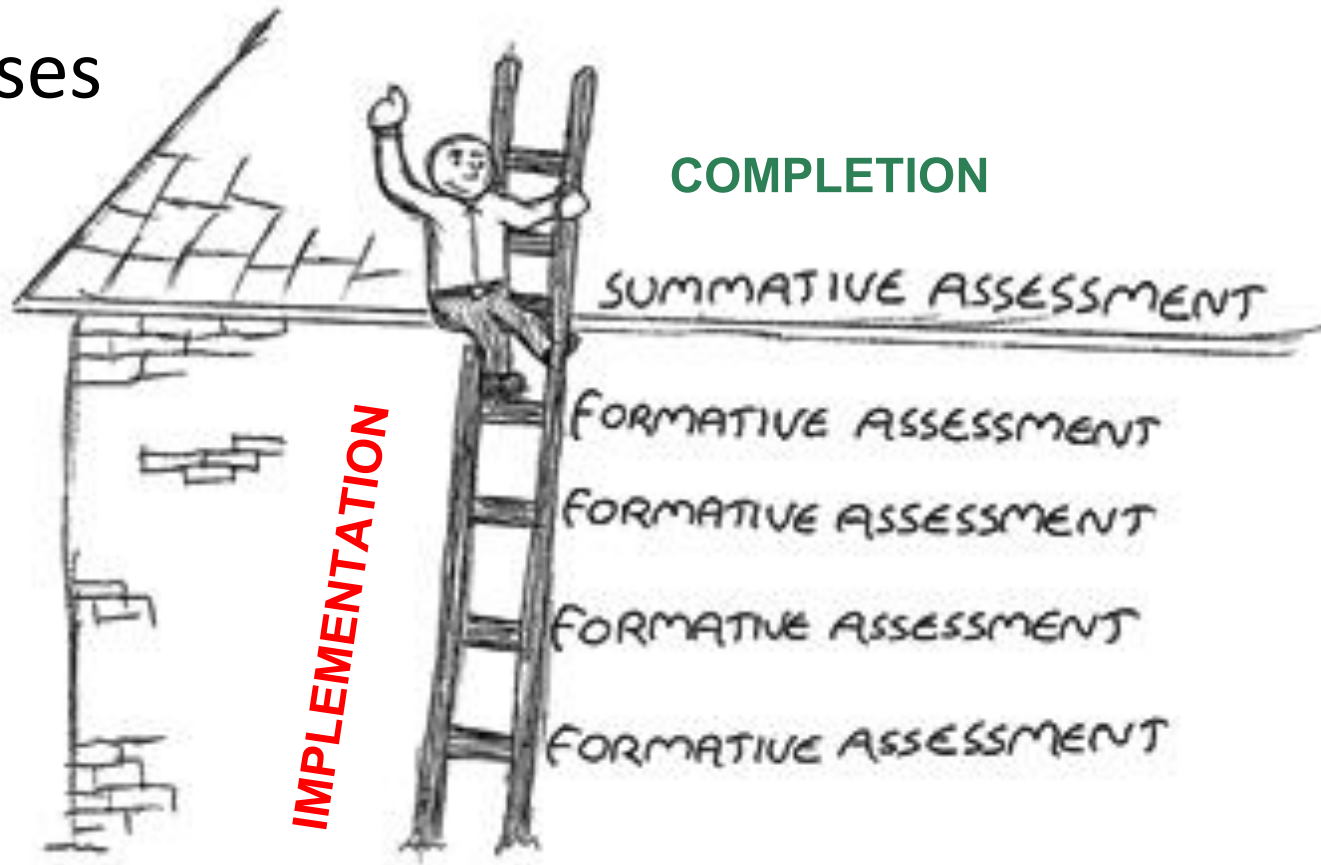
Program Evaluation Planning Steps



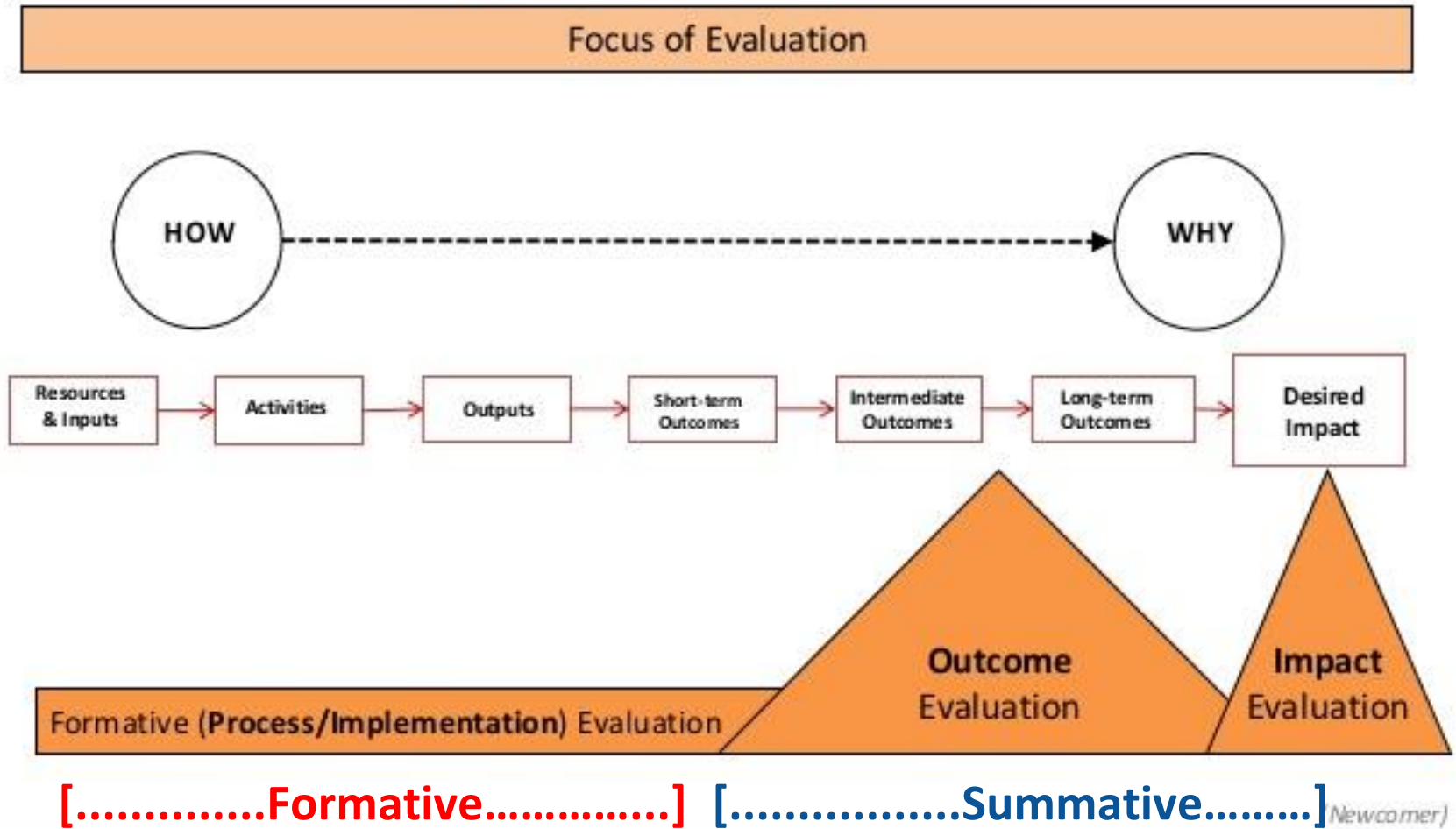
Evaluation 101

Evaluation Phases

- Formative
- Summative



Process vs. Outcome Types of Evaluation



Developing a Logic Model

Main Goal/Sub-goals	To reduce health inequities in ...		
Target Population			
Inputs/Resources			
Implementation/Process Objectives	}		
Outputs/Activities (Process Indicators)			
Short-Term Objectives/Outcomes	}		
Short-Term Indicators			
Med-Term Objectives/Outcomes)			
Med-Term Indicators			

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	<ul style="list-style-type: none"> · To reduce health inequities in footcare · To reduce ulcerations and amputations
Target Population	<ul style="list-style-type: none"> · 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)	<ul style="list-style-type: none"> · To increase #/% of high risk people who have access to footcare services and groups by end of year 1
Outputs (Process Indicators)	<ul style="list-style-type: none"> · % 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)	<ul style="list-style-type: none"> · 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	<ul style="list-style-type: none"> · # 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?

- | | |
|---|--|
| <input type="checkbox"/> Less than \$14,000 (Less than \$1,249/month) | <input type="checkbox"/> \$30,000-34,999 (\$2,501-2,916/month) |
| <input type="checkbox"/> \$15,000-19,000 (\$1,250-1,667/month) | <input type="checkbox"/> \$35,000-39,999 (\$2,917-3,333/month) |
| <input type="checkbox"/> \$20,000-24,999 (\$1,668-2,083/month) | <input type="checkbox"/> \$40,000-59,999 (\$3,334-4,999/month) |
| <input type="checkbox"/> \$25,000-29,999 (\$2,084-2,500/month) | <input type="checkbox"/> More than \$60,000 (\$5,000/month) |
| <input type="checkbox"/> Do not know | <input type="checkbox"/> 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



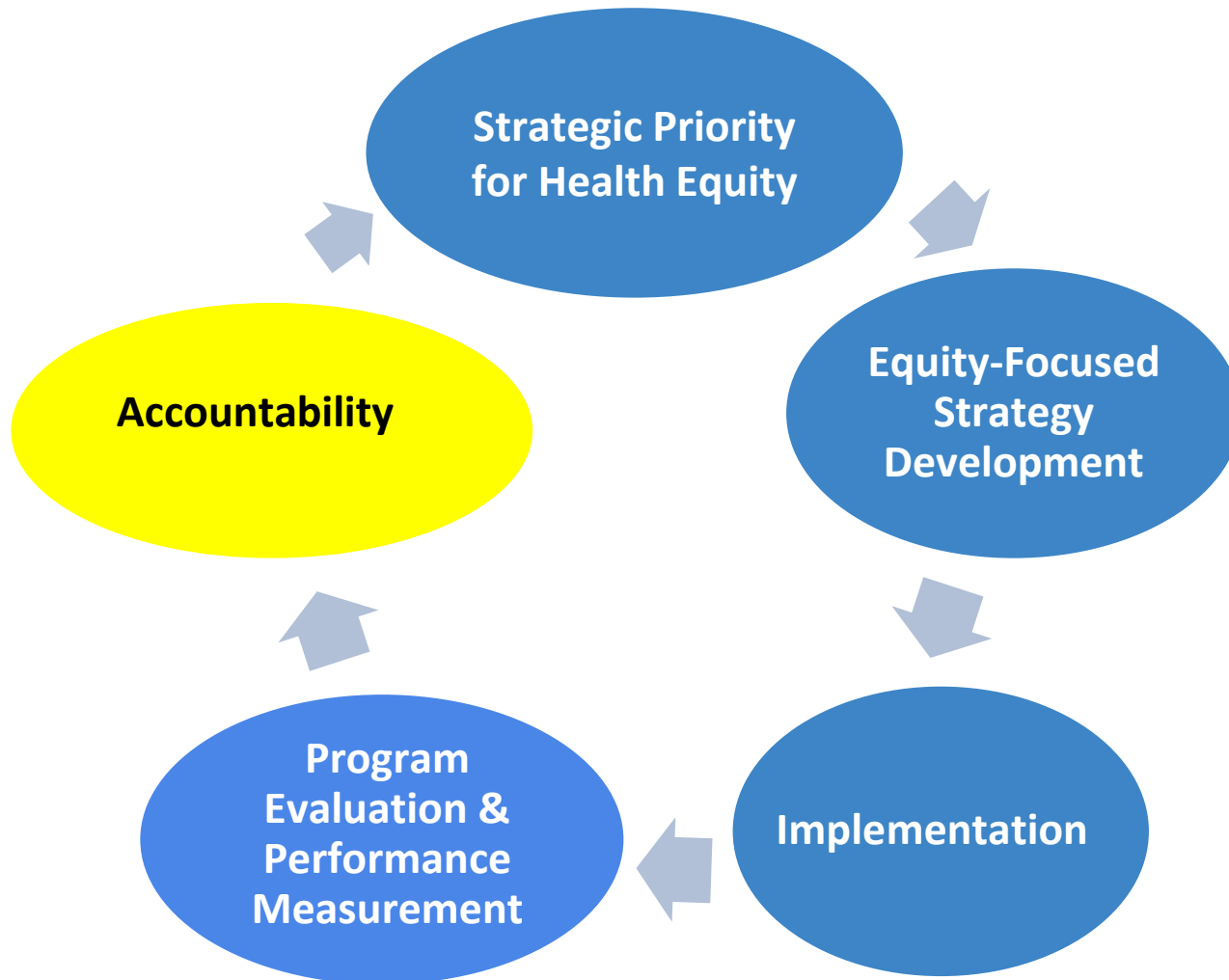
**Centre de santé communautaire
CHIGAMIK
Community Health Centre**
La place du peuple – The Peoples' Place

**Every One Matters.
Chaque personne compte.**

Chart # : _____

Name: _____	Phone: _____
Address: _____	Postal Code: _____
Email: _____	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other _____
Date of Birth (D/M/Y): _____	OHIP #: _____
Emergency Contact: _____	Phone: _____
Do you self-identify? <input type="checkbox"/> First Nation <input type="checkbox"/> Métis <input type="checkbox"/> Inuit <input type="checkbox"/> Francophone	

Planning and Evaluation Cycle to Advance Health Equity



Planning and Evaluation Cycle: Accountability



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

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 \(CDC\)](#)

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](#)

Accountability

- [Vital 8 Webinar](#)
- [MHWB Evaluation Framework](#)

Acknowledgements

Thank you to our Coaches:
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