MIDDLESEX-LONDON HEALTH UNIT

Status and Recommendations Regarding Health Equity Indicators

BRIEFING NOTE

Purpose

To provide an update on the status of the internal review of current compliance (as a baseline) with the "Health Equity Indicators for Ontario Local Public Health Agencies" prioritized for 2018, and recommended targets, benchmarks, and tracking processes for monitoring indicators in 2019 and beyond.

Recommendations (for more information, see Appendix A)

Role 1-1 Question: Does your public health agency conduct routine data analysis of health outcomes of public health importance stratified by demographic and/or socioeconomic variables?
Key Stakeholders Consulted: PHAST
Current State: Ad hoc data analysis of stratified health outcomes by demographic or SES variables is conducted. Some work to systematically analyze data has been developed (e.g. RRFSS data analysis process, CHSR 2018 update) but no routine process for population health assessment and surveillance exists.
Recommendations: Develop an effective monitoring system, which includes engagement with partners prior to measurement. Use a comprehensive list of outcomes and social stratifiers, focused on PHAC recommendations. Ensure the method used is applicable to the local context.
Process / Support: PHAST commits to prioritizing work so a plan for Health Equity Indicator development can be created in 2019. The team commits to implementing indicators in ongoing analysis of the Community Health Status Resource as the new HE measures are developed and data becomes available. An Epidemiologist will continue to have Health Equity as part of her portfolio.
Tracking: Data collected by PHAST through regular performance monitoring

Role 1-2 Question: Does your PH agency identify priority populations (as defined in the OPHS, 2018) in 100% of its programs using a standardized and explicit process and are programs adapted to meet the needs of PPs?
Key Stakeholders Consulted: PPE, Program Managers (through new Program Description Tool)
Current State: Currently 22% of MLHU programs report having identified at least one priority population (PP) (often confused with target populations) and 2% report the use of a standardized, explicit process to do this. 18% report having incorporated planning for identified PPs into programming. A further 13% report program adaptations but not who they support. Two major barriers to identifying PPs have been: confusion between the terms priority and target populations; lack of a standardized and explicit identification process (note: the Situational Assessment within the PEF now provides that process).
Recommendations: Establish an organizational requirement for all MLHU programs to become familiar with the PEF's Situational Assessment and begin using it to identify PPs by the end of 2019, and for all MLHU programs to identify PP's and plan for those PPs anytime teams engage in planning and evaluation processes. PPs will be reassessed when changes in programs are being considered and/or when new evidence supports the need to do so. This work will be prioritized over the next several years to ensure alignment with Ministry requirements outlined in the Annual Service Plan.
Process / Support: The PPE team and HECT will collaboratively provide staff capacity building in the use of the PEF. PPE team, HECT and PHAS team will provide data and/or consultation support to program staff during the identification of and planning for PP's. Program managers will identify team capacity for conducting Situational Assessments.
Tracking: Data collected through the PPE PEF tracking system – report on what % of our programs are doing this

Date: 2018 Dec 18

Role 4-1 Question: How many policy or position statements that reflect advocacy for priority populations experiencing (or at risk for experiencing) health inequities were submitted and approved by the BOH, in the past year?
Key Stakeholders Consulted: BOH reports (past year), HL leadership team
Current State: No MLHU-only position or policy statements have been approved by the BOH in the past year, however, a number of position or policy statements co-created by MLHU staff as part of coalitions with external partners have been endorsed by the BOH in the past year. Currently, the development of a BOH report does not include any requirements for program teams to consider including potential policy or position statements when making recommendations. (Note: in future, position and policy statements the board endorses, BOH-sponsored alPHa resolutions and consultation with program managers will be explicitly included in data collection).
Recommendations: Require all programs submitting BOH reports to assess the relevancy of advocacy for priority populations at risk for/experiencing health inequities, and if relevant, consider the benefits of including a recommendation for the BOH to approve related policy statements, primers or position statements. SLT members, the Policy Advisor, and the Communications manager will scan BOH reports prior to BOH meetings to consider feasible advocacy opportunities for MLHU [not just actions by the BOH) to make sure we take sufficient action to have desired impact].
Process / Support: Build/strengthen capacity to assess the relevance of advocacy to the subject of the BOH report (in consultation with the Policy Advisor and HECT). Add the step of considering inclusion of a policy or position paper with BOH reports to the PEF process. A repository will be created where all BOH endorsed position or policy statements will be captured, which will be used as a reference by staff when considering this step so duplication only occurs if planned.
Tracking: HECT staff will monitor and track public BOH reports, as well as BOH endorsements. The policy management software may be able to help track this.

Role 4-2 Question: In which SDOH area(s) have MLHU staff been engaged in cross-sectoral advocacy for policy development?
Key Stakeholders Consulted: HEAT-Advocacy Workgroup, Managers (through Advocacy Catalogue)
Current State: Approximately half of the advocacy activities staff were involved in over the past year were cause or systemic efforts that involved cross-sectoral advocacy for policy development. Each of these projects addressed the social determinants of health, and each of the SDOH areas were addressed.
Recommendations: All programs use the Situational Assessment in the PEF and the Advocacy: A Process Planning Guide to assess whether participating in cross-sectoral policy advocacy would be an effective strategy to use to achieve program goals, during program planning and review. Add/strengthen this assessment requirement in the PEF process. Ensure this information (including status, strategies used, 'lessons learned' and outcomes of advocacy efforts) is included in updates of the advocacy catalogue.
Process / Support: The PPE team and HECT will collaboratively provide staff capacity building in the use of the PEF and provide support in the form of consultation to program staff during this assessment process. Note: the newly-hired Policy Advisory will be consulted regarding involvement with this indicator.
Tracking: Managers will update the MLHU Advocacy Catalogue at least annually. Questions will be added to confirm whether cross-sectoral partners are/were involved or not, and what SDOH is being/was addressed.

Role 5-1 Question: Do the BOH Strategic plan and related divisional Balanced Score Cards include HE and PP considerations and related outcome targets?
Key Stakeholders Consulted: Manager, Strategic Projects and Manager, PPE Team
Current State: The MLHU Strategic Plan covers a five-year period and its Balanced Scorecard is reviewed annually. Although health equity is explicitly identified in the strategic plan (Program Excellence; Client & Community Confidence) and in each of the divisional Balanced Scorecards, no specific direction is provided

regarding consulting or addressing the needs of priority populations who experience health inequities. The Balanced Scorecards do not include health equity or priority populations outcome targets.
Recommendations: Strategic Plan and associated Balanced Scorecards will include clear and specific language relating to health equity and priority populations and outcome targets will be included, as identified through planning and evaluation.
Process / Support: All those responsible for the development of Balanced Scorecards will implement this recommendation where possible. HECT will provide consultative support, as needed.
Tracking: HECT staff will monitor BSC's and the agency Strategic Plans for inclusion of health equity, priority population considerations, and related outcome targets

Role 5-2 Question: Is there a human resource strategy in place to consider the workforce diversity (e.g. by age, gender, race/ethnicity, disability, Indigenous/Aboriginal identity) within the public health agency and if so, how does this distribution compare to the overall population diversity of your geographic catchment?
Key Stakeholders Consulted: HECT Health Promoter (Diversity and Inclusion initiative chair)
Current State: The Diversity and Inclusion Assessment strategic project has been delayed, with the RFP posted in early December. The internal Advisory Committee held its first meeting in November.
Recommendations: Recommendations will be received from the external consultant conducting the Diversity and Inclusion Assessment. The Advisory Committee will review the recommendations and consider implementation implications. SLT will provide approval and confirm implementation steps.
Process / Support: HECT and Human Resources are co-leading this project. Processes and supports cannot be determined until recommendations are received from the external consultant.
Tracking: Tracking processes will be identified once recommendations are reviewed and approved, and implementation steps are being considered. It is likely that Human Resources will track this indicator.

Role 5-3 Question: How does MLHU provide, track and evaluate the effectiveness of Health Equity staff capacity building?
Key Stakeholders Consulted: HE Staff Capacity-Building Workgroup, Program Managers, Corporate Trainer, Program Evaluator, other MLHU staff
Current State: MLHU has an approved Health Equity Staff Capacity Building plan which provides capacity-building opportunities related to the health equity core competencies of public health. Mandatory and optional opportunities were offered in three prioritized HE domains in 2018 (Indigenous Public Health Practice, Advocacy, Public Health Sciences). 100% of teams who prioritized the domains offered, had capacity for at least one member to attend. Feedback identified that capacity-building methods used were perceived as effective.
Recommendations: Continue to implement HE staff capacity-building opportunities. Offer all 9 HE domains by the end of 2020. Collect key feedback on capacity-building offerings (based on indicators developed in 2018 in consultation with the PPE team), and incorporate as able into future/ongoing planning. Support involvement of all teams who have prioritized each domain, with team attendance based on approval from manager.
Process / Support: HECT and HEAT will continue to implement health equity staff capacity-building plan. Program evaluator to continue to provide evaluation expertise as needed.
Tracking: Participation in HE capacity-building opportunities will be tracked by HECT staff and the Corporate Trainer/LMS. PPE measurement will help to determine whether staff are increasingly building HE into practice.

Key Considerations and Options (if applicable)

A draft Health Equity Indicator tracking tool (see Appendix C), created by an epidemiologist, captures the current state for 2018 prioritized indicators. This document such as this can be used to track current and future prioritized indicators, outline progress, identify areas for improvement, and support annual reports to SLT.

Conclusions and Next Steps

MLHU has various levels of compliance with its prioritized health equity indicators. Implementation of recommendations to meet indicator targets and benchmarks, monitor compliance with indicators, and perform an assessment of the remaining indicators will enhance accountability, identify areas for improvement, and highlight successes related to health equity. ***SLT approval regarding the above recommendations is required, as well as direction on next steps.*** HECT would be pleased to support ongoing work, as needed. Remaining HE indicators have been prioritized for 2019 and 2020 (see Appendix B) and ***require SLT approval to move forward*** using processes similar to those completed for the initially prioritized indicators. Need to have more discussion to ensure consistency in 'priority population' definition between MLHU and Ministry.

Background

- https://www.publichealthontario.ca/en/ServicesAndTools/Documents/LDCP/LDCP_user%20guide.pdf
- Received SLT and BOH approval on prioritized indicators, and plan to conduct assessment and identify recommendations for each indicator.
- Revised indicator questions so they would be SMART
- Looked for evidence (OPHS, MLHU strategic plan, and literature) to support setting targets/benchmarks
- Identified/consulted key stakeholders and used information to help identify current state, set realistic targets and benchmarks, and develop recommendations for future processes and supports.
- Prioritized HEIs for 2019 and 2020 using previously-developed criteria and information gained through assessment of initially prioritized HEIs.
- Draft plan shared with HL, HS and EHID leadership teams in Dec 2018 (going to HO in January 2019)

Appendices:

A - Further Assessment Details
B - Prioritized HEIs for Assessment in 2019 and 2020 and Prioritization Criteria
C – Draft HEI Tracking Template

Date: 2018 Dec 18