March 31, 2004

EQUAL ACCESS PILOT PROJECT

Prepared by:
The Flett Consulting Group/
Social Data Research Ltd.
130 Slater Street, Suite 750
Ottawa, ON K1P 6E2

Prepared for:
People Services Department
Public Health and Community Servces Branch
495 Richmond Road
Ottawa, ON K2A 4A

FINAL REPORT

Table of Contents

Introduction **1**

Background 1

Objectives 3

Methodology **3**

Results **5**

Rating of the Data Collection Tool 5

Rating of the Data Collection Process 6

Statistical Analysis of the Indicators 7

Baseline Results of the Pilot Survey 7

Summary of Areas Where Programs are Doing Exceptionally Well 17

Summary of Potential Program Improvements for Increasing Access and Equality 18

Conclusions **20**

Appendix A: Template for Individual Program Reports

Equal Access Pilot Project
Final Report
March 31, 2004

Introduction

The Flett Consulting Group Inc. is pleased to present this report to the City of Ottawa Public Health and Community Services on the results of the *Equal Access Indicators Pilot Project.* The pilot project was initiated on September 4, 2003 and completed March 31, 2004. The main purpose of the pilot project was to develop and test a data collection process to gather information on the access indicators identified in the report entitled: ***Equal Access Indicators for Ontario's Mandatory Care Programming Requirements.***

This report provides some background about the project and the reason why it was conducted. It also describes the pilot project process and outcome. A workbook accompanies the final report. The workbook contains useful tools and resources developed as a result of the pilot project. These tools and resources can be made available to other health departments wishing to monitor equal access to programs and services.

Background
In 2001, the Ministry of Health developed a set of guidelines that all Health Departments in Ontario are required to implement, according to the Health Protection and Promotion Act. Equal access to all programs and services is fundamental to this Act. To assist in the implementation and monitoring of the general standards for Access and Equity across the province, the Ontario Public Health Association (OPHA)[1] identified success indicators and a process to measure performance in this area. The OPHA's Equity and Access Survey report entitled: *Environmental Scan Assessing the Activities engaged in by Health Units and Community Health Centres to Address Access and Equity in their Program Delivery and Services* provides the necessary background in terms of the types of indicators that should be measured.

There were three general indicator questions approved by the Ministry of Health and Long-Term Care:

1. Has the Board of Health developed and implemented policies and operational strategies that promote accessibility to all mandatory public health programs and services?
2. Has the Board of Health adjusted existing programs and/or developed special programs, including special educational materials, tailored service delivery and active outreach to increase accessibility to mandatory public health programs and services?

[1])The OPHA Access and Equity Standing Committee, co-chaired by Abebe Engdasaw, City of Ottawa Public Health and Community Services Branch, was the lead in this initiative.

3. Has the Board of Health developed an access monitoring system to identify and assess all mandatory public health programs and services in relation to accessibility for people in special groups for whom educational, social and environmental barriers exist?

The OPHA working group used the three questions as a framework to develop more specific access indicators for public health programs and services. The working group determined that the requirements for access for persons with physical disabilities were already well defined at the legislative level. Therefore, this project focused on socio/cultural issues.

For the purpose of this project access was defined as *"permission, liberty or ability to enter, approach, communicate with or pass to or from; freedom or ability to obtain or make use of; the action of going to or reaching; an increase by addition. There are two aspects to access: (a) client access – that is, the extent to which consumers are able to secure needed services; and (b) organizational access – the extent to which consumers are represented and/or participate in the planning, development, delivery and administration of those services."*

Persons with special needs refers to "*persons that may be denied access or have difficulty accessing services or resources (including print material) because of socio/cultural issues such as poverty, language, illiteracy, age, race, gender, or sexual orientation."*

The OPHA working Group used an iterative and consultative process to develop the more specific access indicators including:

- A review of key documents for multi-cultural access indicators
- A review of findings of recent public consultations with diverse "publics" to identify access barriers and enablers
- Identification and proposed useful indicators for each question
- Organization of two workshops (Ottawa and Toronto) where community members, academics and health units were invited for consultation
- A review of the proposed indicators

As a result of these activities, the OPHA working group produced a preliminary implementation tool that used a matrix format to further describe each of the three indicator questions in terms of:

1. Major components or areas to be measured for each question
2. The intended result for each of these components
3. Possible indicators of equal access
4. Possible methods that could be used to gather information related to the measurement of each component

The preliminary implementation tool was the starting point for the development of a data collection instrument for this project. The pilot project focused on the second of the three general indicator questions, that is, the adjustment of existing programs or development of special programs to increase accessibility to mandatory public health programs and services.

Objectives

The objectives of the pilot project were to:

1. Develop a data collection instrument to gather baseline and ongoing information on the indicators of equal access;
2. Develop a data collection process to gather baseline and ongoing information on the indicators of equal access;
3. Test the instrument and process by collecting baseline data on equal access from seven City of Ottawa public health programs (*Food Safety, Communicable Disease Control, Sexual Health Clinic, Francophone Program, Tobacco Program, Health Babies, Healthy Children and Early Years Program)*;
4. Prepare a report of the pilot project results to present to Public Health and Community Services Management Team; and
5. Develop a workbook for other public health departments that incorporates the lessons learned from the pilot project in Ottawa.

An advisory committee comprised of the Associate Medical Officer of Health, and program managers of departments included in the pilot oversaw the pilot and also participated actively in the process.

Methodology

The consulting team and the advisory committee used a *collaborative process* to conduct the pilot project. Prior to meeting with the advisory committee for the first time, the consulting team carefully reviewed the background report titled *Equal Access Indicators for Ontario's Mandatory Core Programming Requirements* as well as the provincial document titled *Mandatory Health Programs And Services Guidelines*.

The project began with an advisory committee meeting to finalize the parameters for the project. Following the start-up advisory committee meeting, individual meetings were held with each program area manager. The purpose of these meetings was to:

- Obtain the views of managers regarding the selected indicators of equal access. Were the indicators appropriate for their program? Were the indicators complete? If not, what were the gaps? These discussions served as further validity testing for the indicators developed by OPHA
- Discuss the protocol for data collection in each program area, identify challenges and brainstorm solutions
- Discuss progress for ensuring equal access to programs
- Identify gatekeepers of information in each program area

Based on the meetings with program managers it was decided that a self-administered survey delivered online would be the most efficient way to collect the information in the pilot. Managers were in general agreement that the proposed indicators of equal access were applicable to their programs. Some changes in wording to a few of the original indicators were suggested. Managers also requested that some space in the questionnaire be allotted for open-ended questions about "lessons learned" and "successes achieved" in relation to equal access.

The first step in the questionnaire development was to translate the indicators of equal access into a format appropriate for standard data collection. It was decided that a quantitative approach using "rating" questions was the most appropriate. The rating questions would allow respondents to indicate how well they thought their department was doing in each of the six areas covered by the questionnaire:

1. Data to Identify Barriers
2. Community and Stakeholder Participation
3. Program Development
4. Information Dissemination and Outreach
5. Reporting
6. Education and Training

A draft questionnaire was constructed. The indicators of equal access covered under each of the six areas were rated on a 5-point poor-to-excellent scale, where a score of 1 was the lowest score and a score of 5 was the highest. This standard approach to the data collection would assist departments in monitoring their progress on equal access to services over time by comparing scores from one time period to the next. The draft questionnaire also contained some open-ended questions where staff could list the "most successful initiatives" as well as "lessons learned".

A meeting was held with the advisory committee to finalize the questionnaire and accompanying instructions. The pilot questionnaire was programmed using

HTML and the URL was sent by email to the seven program managers who in turn forwarded it to the appropriate staff in their department. It was decided to allot two weeks for the completion of the questionnaire. A help line was established for staff to call if there were any problems in the field. The survey coordinator spoke with each program manager as well as staff completing the questionnaire during the field period to discuss their experience in completing the questionnaire online.

To view the piloted questionnaire please click: http://www.sdrsurvey.com/ottawa

One of the advantages of the online survey method is that survey responses are automatically entered into a database program – in this case SPSS (Statistical Package for the Social Sciences) for the purpose of analysis. This allowed the consultants to quickly produce a number of useful reports summarizing the survey responses in different ways. These reports were presented to program managers at a results workshop.

The results workshop provided program managers with an opportunity to discuss their experiences during the data collection phase, particularly in terms of what worked well and what needs to be improved for the future. This discussion provided valuable "lessons learned" which were incorporated in the workbook accompanying this report. Different ways that the results could be tabulated were also discussed at the workshop and incorporated into the workbook.

Results

This section presents the results of the pilot project from three perspectives. *First*, respondents were asked to rate the questionnaire itself in terms of its length, wording, completeness, and any gaps. *Second*, respondents were asked to comment on the survey process and provide suggestions on how to make the approach more user-friendly for respondents in the future. *Third*, the baseline results of the survey are presented for each of the six areas covered in the survey.

Response rate

All seven programs included in the pilot project responded to the survey.

Rating of the data collection tool

Respondents were asked to comment on a number of aspects related to the questionnaire including the length of time it took to complete, the clarity of the wording of questions, and the completeness of the content. All respondents (seven departments) indicated that the questionnaire was too long. In fact, on

average respondents reported that it took about one hour to complete the questionnaire. In one case it took two hours.

Respondents were split on the clarity of the questions with more than half indicating some questions were not clearly worded. Respondents were asked to list the questions and provide suggestions for rewording. These suggestions were incorporated in the revised questionnaire presented in the workbook.

Most respondents were of the opinion that questionnaire was complete in terms of overall content. Suggestions made about additional questions were discussed during the results workshop and considered in the revised questionnaire.

In some cases, respondents reported that questions were not meaningful and could be eliminated. In particular, it was suggested that questions around "lessons learned" and successful initiatives were repetitive. Once again, these suggestions were taken into account in the revised questionnaire.

Rating of the data collection process

The majority of respondents reported having difficulty completing the survey online. There were a number of reasons for this including:

- The length of the questionnaire – it was difficult to dedicate the time required to complete the questionnaire in one sitting (some respondents were frustrated with the fact that it was not possible to save the document midway and continue on a another day[2])
- It was difficult for more than one person to work on the survey at the same time
- Some respondents were not comfortable with the online technology
- The questionnaire was not translated into French.
- In two cases, respondents elected to print a hard copy of the questionnaire and complete the survey in the more traditional "pen and paper" manner (in these instances, the hard copies were entered into the database by the survey office – an additional step)

These issues were discussed at the results workshop and solutions were proposed for future surveys. To reduce the respondent burden and make it easier for several staff to work on the questionnaire at the same time, it was suggested that for future surveys the original questionnaire be broken down into six short modules – each of the different areas would essentially become a separate tool. As well, it was agreed that the survey should be designed in a way that would give departments the flexibility of administering the modules/questionnaires using either a traditional "mail-back" or "fax-back" survey

[2] In an online survey of this nature it is not possible to save the responses prior to their submission. The program did allow respondents to print the completed questionnaire prior to submission.

method or online method (or both). The workbook provides the revised data collection tools in a format that facilitates universal printing (PDF).[3]

Statistical analysis of the indicators

In response to the concern over the length of the questionnaire, correlation analysis was used to identify "a minimum set of indicators of equal access" for each of the six area covered in the survey: (number of individual items in each area given in brackets)

1. Data to Identify Barriers (Number of items=4)
2. Community and Stakeholder Participation (Number of items=4)
3. Program Development (Number of items=15)
4. Information Dissemination and Outreach (Number of items=6)
5. Reporting (Number of items=5)
6. Education and Training (Number of items=4)

The first step in this analysis was to create an index for each area by summing the rating scores on the individual items to form a composite score. The mean rating score for an item was assigned in those cases where a respondent did not rate a particular item. In the second step, each individual item in a particular area was correlated with the composite score for that component. Individual items were included in the "minimum set of indicators of equal access" if they correlated significantly with the composite score for that particular component.

To add content validity to this method, program managers and the City of Ottawa's Multicultural Team reviewed the minimum set of indicators of equal access to ensure their adequacy. Based on this review, a few indicators were added to the proposed minimum set. The accompanying workbook contains a short version questionnaire incorporating the recommended minimum set of indicators of equal access.

Baseline Results of the Pilot Survey

The results presented in this section are based on the responses given to each of the rating questions for the six areas covered by the survey. They provide a "global" picture across all seven departments on how staff rated their department in terms of equal access to services. An example of how the results can be presented for an individual program is attached in Appendix A.. Each of the seven programs involved in the pilot project received a report of the results for their own department (under separate cover).

[3] For more information or assistance with the administration of the survey tools, please contact Christine Davis, Social Data Research Ltd. Email: cdavis@sdrsurvey.com; Tel: 613-521-8052.

Target groups served by surveyed programs

In addition to the general population, programs surveyed target the following groups, organizations or special populations:

- Community groups/agencies/institutions
  Examples:
  Community Health Centres
  Ottawa Council on Smoking & Health
  Early Years Centres
  Community Resource Centres
  Food banks
  Hospitals
  Schools
  Senior Centres
  Long Term Care Facilities
  Ontario Restaurant Association
  Shelters
  Detention Centres

- Health care professionals
  Examples:
  Doctors
  Nurses
  Social Workers
  Pharmacists
  Dentists
  Nursing Home staff

- Specific target groups
  Examples:
  Food handlers
  Restaurant owners
  Immigrants/persons from multicultural groups
  Persons on low income
  Women
  Seniors
  Aboriginal persons
  Pregnant women
  Mothers with children up to 6 years old
  Tobacco retailers
  Youth
  Educators
  Parents

- Other groups
  Examples:
  Francophones
  Gay men

Main access barriers faced by clients

The following are examples of the types of access barriers faced by program clients:

- Lack of awareness about programs
- Social stigma attached to some programs
- Lack of finances
- Language
- Literacy level
- Cultural differences
- Lack of childcare
- Lack of transportation
- Social isolation
- Not enough staff

Reaching out to special populations

All programs reported reaching out to particular special populations.

Examples:
Training of food handlers with a Cantonese background
Multicultural low income young single parents
Promotion at Gay Pride Parade
Presentation at Sudanese community event
Sexually active youth
Street youth
People working in sex industry
People using substances
Parents with children in care facilities
Multicultural retailers

Ways that barriers were reduced
Providing information in different languages
Raising awareness
Providing a culturally adapted environment
Providing referrals to appropriate community agencies
Home visits to reduce isolation
Involving community leaders and raising profile of services

Overall Rating for Each Area

Exhibit 1 shows how each of the six areas ranked across the seven programs included in the pilot project based on the mean score of the composite rating for that area. A perfect score (highest) is 100. The Exhibit also shows the range in scores across the seven programs.

Exhibit 1 Overall Ratings for Each Component for all Programs

Component	Mean Score	Range
Access & Interpretation of Data	68.2	50-80
Education & Training	67.1	40-85
Community & Stakeholder Participation	67.1	55-85
Information Dissemination & Outreach	64.3	37-93
Program Development	63.2	45-65
Reporting	60.8	20-80

Exhibit 1 reveals two things. The first is that there is some room for improvement across the board. Total scores ranged from a high of 68.2 for "Access and Interpretation of Data" to a low of 60.8 for "Reporting". The second is that in all areas there was a wide range in the responses. This indicates that some programs feel they are doing better in the area of equal access than others.

Rating results within each component

Within each of the six areas, the seven programs revealed trends with respect to individual indicators of equal access that were rated higher or lower than average in each area. These results are presented below for each area as well as a list of the most common methods used by staff to ensure that information related to monitoring equal access is gathered and analyzed in each area on an ongoing basis.

Examining aspects that are lower or higher than average can help departments prioritize areas for action in the future.

1. DATA ACCESS AND INTERPRETATION

This area measures the extent to which program staff liaises on an ongoing basis with community, government and academic sources to find out about barriers at the local level and to use that data for program planning and evaluation. There were four indicators of equal access in this area. Those aspects rated above and below average are shown below.

Aspects rated higher than average (In order of highest rating)
Our staff has a good understanding of the demographics and characteristics of groups facing barriers in comparison to our general population.

Our program has facilitated the provision of data to community organizations.

Aspects rated lower than average (In order of lowest rating)
We regularly access community data relevant to identification of barriers at the local level.

We know that community data are accessed by the community groups we work with.

What's being done to monitor progress in the area of Access and Interpretation of Data:	Number of Programs
Program report documenting reviews of minutes and reports, committee meetings and surveys	**5**
Programs report reviewing and analyzing collected data and documents produced	**5**
Programs report reviewing tools and questionnaires used to collect data on general populations and on groups facing barriers especially for language and cultural validity	**5**
Programs report surveying staff who work with groups facing barriers	**4**
Programs report surveying community groups that represent populations facing barriers	**4**
Programs report keeping records of information requests from communities	**4**
Programs provided examples of other methods used to monitor progress	**4**

2. COMMUNITY AND STAKEHOLDER PARTICIPATION

This area measures the extent to which a program involves representatives of organizations representing or serving groups that face barriers in developing, planning and evaluating programs and services. There were four indicators of equal access in this area. Those aspects rated above and below average are shown below.

Aspects rated higher than average (In order of highest rating)
Our program has collected and used data appropriately on the population in general and on groups facing barriers.

Our program works with community groups to assess

local health/service needs.
Aspects rated lower than average (In order of lowest rating)
Our program keeps an updated list of organizations and groups represented or consulted in planning and evaluation of programs and services.

Our program works with community groups to identify areas where services do not meet local needs.

What's being done to monitor progress in the area of Community and Stakeholder Participation:	Number of Programs
Programs report periodically reviewing collected data and reports	**6**
Programs report reviewing minutes and reports of department meetings	**6**
Programs report periodically reviewing lists of community groups	**4**
Programs report surveying community groups	**3**
Programs provided examples of other methods used to monitor progress	**1**

3. PROGRAM DEVELOPMENT

This area measures the extent to which a program adjusts its services so that they are consistent with the principles of equal access for the changing needs and demographics of its client population. There were fifteen indicators of equal access in this area. Those aspects rated above and below average are shown below.

Aspects rated higher than average (In order of highest rating)
Our program is delivered in venues that are appropriate to the groups facing barriers (This could include community centers, schools, drop-in centers, shelters, multi-cultural centers, seniors centers etc.)

The programs targeting specific groups facing barriers are accessed based on the group's specific needs

Our program has identified systematic and non-systematic barriers to participation of groups in our mandatory public health program

When we plan new services we take into account the special needs of groups facing barriers

We review our program periodically for its ability to serve the needs of groups facing barriers

People with limited fluency in English or French are served by multilingual staff or through the purchase of professional interpretation services

Aspects rated lower than average (In order of lowest rating)
We have conducted a formal needs assessment with special group members to identify reasons for not accessing our mandatory core program

We provide supports (such as assistance with transportation, child care) to reduce or eliminate access barriers or facilitate access

We test our resources with specific client groups to ensure that they are accessible for groups facing barriers

We have found that groups facing barriers are accessing our mandatory public health program and services in greater numbers

The proportion of clients from “special needs” groups accessing our mandatory program and services is representative of the population in Ottawa with special needs (in terms of the number of clients and types of special needs)

Our programs are provided in languages other than English and French and reflect the linguistic composition of the area

Our program staff is from diverse backgrounds reflecting the composition of our region

We have developed and implemented special programs to facilitate access to our mandatory program

Our programs include content relevant to the needs and experiences of groups facing barriers

What's being done to monitor progress in the area of Program Development:	Number of Programs
Programs report collecting program participation figures on demographics comparable to Census data collection (mother tongue, home language, country of birth, gender, income and visible minority status)	**7**
Programs report periodically reviewing program content	**7**
Programs report consulting with experts	**6**
Programs report evaluating programs including client feedback	**6**
Programs report reviewing service plans	**5**
Programs report conducting needs assessment of special needs groups	**5**
Programs report reviewing process documents, which will lead to service plans	**3**
Programs report collecting staff data on demographics comparable to Census data collection categories and comparison with general population data	**1**
Programs report comparing mandatory care program participation figures with special group demographics in each community	**1**
Programs provided examples of other methods used to monitor progress	**2**

4. INFORMATION DISSEMINATION AND OUTREACH

This area measures the extent to which a program has developed effective dissemination and active outreach strategies to inform groups facing barriers about policies, programs and measures to improve access. There were six indicators of equal access in this area. Those aspects rated above and below average are shown below.

Aspects rated higher than average (In order of highest rating)
We review our educational and outreach materials periodically to ensure that groups facing access barriers are informed about available programs and services, and are receiving accurate health information in a linguistically and culturally appropriate way

We provide program information through a range of media, including community, multilingual, and ethno cultural media

We provide educational and program information through a range of venues, including locations and media accessible to groups facing barriers

Aspects rated lower than average (In order of lowest rating)
We produce educational and outreach materials in the most common languages other than English or French in our region (such as Chinese, Italian, Spanish, Arabic, Farsi, Somali)

We review our educational and outreach materials periodically for bias and stereotyping including images and language use

We produce audio, visual and print resources that are culturally and linguistically appropriate to the groups facing access barriers

What's being done to monitor progress in the area of Information Dissemination:	Number of Programs
Programs report reviewing social marketing, communication and outreach strategies	**5**
Programs report periodically reviewing language of educational material in comparison with demographic changes	**2**
Programs report conducting focus groups of members of groups facing barriers to review educational and program materials for accessibility, relevance and cultural appropriateness	**2**
Programs provided examples of other methods	**2**

5. REPORTING

This area measures the extent to which a program produces or contributes to the annual or biannual Ministry report that covers current key public health issues and includes issues that are of significance to groups facing barriers. There were four indicators of equal access in this area. Those aspects rated above and below average are shown below.[4]

Aspects rated higher than average (In order of highest rating)
As a result of our annual/biannual Ministry report, the public knows more about public health issues of significance to groups facing barriers

[4] It should be noted that there was a high degree of non-response in this area. A number of program were not actively involved in producing annual reports.

Our annual/biannual report to the Ministry represents these issues in a culturally sensitive manner that does not increase stereotyping or negative perceptions of these groups

Aspects rated lower than average (In order of lowest rating)
As a result of our annual/biannual Ministry report, our staff have knowledge about public health issues that are significant to groups facing barriers
We make summaries of our annual/biannual Ministry report available at a variety of local venues and through various media

Our report to the Ministry includes mention of public health issues of special significance to population groups facing barriers

What's being done to monitor progress in the area of Reporting:	Number of Programs
Programs report reviewing the content of annual/biannual Ministry report	**4**
Programs report reviewing recent literature, short consultations with community representatives and experts and or focus groups with community representatives and experts to validate issues of significance to groups facing barriers	**4**
Programs report reviewing dissemination strategies	**4**
Programs report surveying public health practitioners assessing knowledge of issues included in the Ministry report	**2**
Programs report surveying public assessing knowledge of issues included in the Ministry report	**2**
Programs provided examples of other methods used to monitor progress	**0**

6. EDUCATION AND TRAINING

This area measures the extent to which a program contributes to the development of competencies of public health staff to implement equal access standards through continuing education, ongoing training and incorporation into staff work plans. There were four indicators of equal access in this area. Those aspects rated above and below average are shown below.

Aspects rated higher than average (In order of highest rating)
Our program has determined the level of skills and knowledge required to provide services to groups facing barriers.

Our program staff is assessed to determine their skills and knowledge in providing programs and services to groups facing barriers.

Aspects rated lower than average (In order of lowest rating)
Our program staff is effectively trained in relation to specific diversity competencies and program content relevant to needs and experiences of groups facing barriers

Access and equity activities are included in staff work plans

What's being done to monitor progress in the area of Education and Training:	Number of Programs
Programs report reviewing literature, consultation with experts to determine key skills, knowledge and competencies	**5**
Programs report participation in cultural sensitivity workshops	**5**
Programs report reviewing staff work plans, activities activity databases etc.	**4**
Programs report reviewing training content	**3**
Programs report periodic staff surveys regarding competencies, knowledge, skills, learning needs	**3**
Programs report conducting client surveys regarding satisfaction with staff competencies in this regard	**3**
Programs report monitoring number of staff and other public health officials trained on how to work with population groups facing barriers	**2**
Programs provided examples of other methods used to monitor progress	**2**

Summary of Areas Where Programs are Doing Exceptionally Well

1. Staff has a good understanding of the demographics and characteristics of groups facing barriers in comparison to the general population.

2. Programs are good at facilitating the provision of data to community organizations.

3. Program are collecting and using data appropriately on the population in general and on groups facing barriers.

4. Programs are good at working with community groups to assess local health/service needs.

5. Programs are being delivered in venues that are appropriate to the groups facing barriers (This could include community centers, schools, drop-in centers, shelters, multi-cultural centers, seniors centers etc.)

6. Programs targeting specific groups facing barriers are accessed based on the group's specific needs.

7. Programs are good at identifying systematic and non-systematic barriers to participation of groups in the mandatory public health program.

8. Programs are good at reviewing their educational and outreach materials periodically to ensure that groups facing access barriers are informed about available programs and services, and are receiving accurate health information in a linguistically and culturally appropriate way.

9. Programs are providing program information through a range of media, including community, multilingual, and ethno cultural media.

10. Programs are good at determining the level of skills and knowledge required to provide services to groups facing barriers.

11. Programs are good at assessing their staff to determine their skills and knowledge in providing programs and services to groups facing barriers.

Summary of Potential Program Improvements for Increasing Access and Equality

Assuming that the areas that were rated lowest by program staff are areas where improvements could be made, the list of potential strategies would include the following:

1. Increase the search for and analysis of data about identification of barriers at the local level.

2. Share that information with community groups served by programs.

3. Keep updated lists of organizations and groups represented or consulted in planning and evaluation of programs and services.

4. Work with community groups to identify areas where services do not meet local needs.

5. Conduct formal needs assessments with special group members to identify reasons for not accessing the core program.

6. Provide supports (such as assistance with transportation, child care) to mitigate access barriers.

7. Test resources with specific client groups facing barriers to ensure they facilitate access.

8. Monitor and look for increases in the numbers of service users from groups facing access barriers to the mandatory public health program.

9. Set targets for the number of clients from special needs groups accessing the mandatory program that match the proportion of that population in Ottawa

10. Provide services in languages other than English and French that reflect the linguistic composition of the area.

11. Pursue diversity among program staff that reflects the composition of the region

12. Develop special strategies to facilitate access to the mandatory programs

13. Include program content relevant to the needs and experiences of groups facing barriers.

14. Produce educational and outreach materials in the most common languages other than English or French in our region (such as Chinese, Italian, Spanish, Arabic, Farsi, Somali).

15. Review educational and outreach materials periodically for bias and stereotyping in images and language use.

16. Produce audio, visual and print resources that are culturally and linguistically appropriate to the groups facing access barriers

17. Through the Ministry report, increase staff knowledge about public health issues that are significant to groups facing barriers.

18. Make summaries of our Ministry report available at a variety of local venues and through various media.

19. Include mention of public health issues of special significance to population groups facing barriers in the Ministry report.

20. Train staff on specific diversity competencies and program content relevant to needs and experiences of groups facing barriers.

21. Include access and equity activities in staff work plans.

Conclusions

The Equal Access pilot project provided an opportunity to develop a data gathering instrument and a data gathering process to monitor progress made towards the implementation of standards mandated by the Province. The pilot project also provided the opportunity to gain insights into how well the data collection instrument worked and how it could be improved. During its conduct, a number of observations were made. The following conclusions are based on these observations.

1. Indicators were developed by the Ontario Public Health Association, Access and Equity Committee, to measure performance towards addressing the second of the three broad indicator questions[5] approved by the Ministry of Health and Long –term Care. The indicators work well and, on the whole, made sense and were considered relevant by the seven program managers and their staff. Only minor modifications to a number of indicators were required to provide clarity.

2. Participation by program managers in the development and implementation of the pilot project raised their awareness of the standards and guidelines set forth by the Province. It increased their awareness of how well their respective programs were doing as well as the overall performance of the seven programs participating in the pilot project. Moreover, it helped the managers and their staff to identify where more work was required.

3. Notwithstanding the above, the data collection instrument was too long and the online data collection caused much frustration on the part of respondents. A shorter version of the questionnaire is required as well as a more flexible online process, which would enable survey respondents to complete sections rather than the whole questionnaire at one sitting. In addition, a hard copy version of the questionnaire would provide an option for those respondents who are less agile with the on-line process.

4. Program managers and staff are inundated with information requirements in an already demanding and stressful work environment. Additional

[5] Issue questions one and three were outside the scope of this pilot project.

requests for information and reporting increases the burden. For this new requirement not to be viewed as an imposition the information must be perceived as useful to the managers and staff; and, it should be integrated into existing reporting systems such as the Mandatory Activity Reporting System (MARS), as much as possible.

5. To be useful, the managers and staff will need to receive timely reports on their progress based on the information they provide by completing the reporting requirements on equity and access. Thus, analysis and dissemination of information provided by programs is required as part of the mandatory reporting system.

6. The Ministry of Health and Long-term Care approved three indicator questions and developed a set of guidelines that all Health Boards in Ontario are required to implement, according to the Health Protection and Promotion Act. This pilot project focused on the development of a monitoring system for the second indicator question, addressing progress made in the adaptation and development of new programs for improving accessibility. During the pilot project a number of questions arose regarding corporate responsibility and program responsibility. Were there some activities that are more efficiently and effectively conducted at the corporate level? The issue of the adequacy of resources associated with fulfillment of the standard also arose. A monitoring system to assess progress at the corporate level (Issue question one) is required to streamline the monitoring requirements and identify significant efficiencies.

ATTACHMENT A

TEMPLATE FOR INDIVIDUAL PROGRAM REPORTS

Appendix A
Equal Access Project Baseline Results
Generic Example - Program A
March 31, 2004

Results Of Program ID Questionnaire

Target groups program serves
Organizations (List types of organizations)
Health Care Professionals (List types of professionals)
Specific populations (List types of populations)

Main access barriers (Types of Examples)

- Lack of awareness
- Misperceptions about services
- Social stigma attached to services
- Financial issues
- Cultural/language barriers
- Literacy issues

Currently reaching out to: (Types of Examples)

- Visible & ethnic minorities
- Different language groups
- Gay men
- Sexually active youth
- Street involved youth
- Homeless
- People working in the sex industry
- People using substances
- School age children
- Children in care facilities

Barriers reduced/strategies (Types of Examples)
Access to services through outreach
Providing information to increase awareness of "risk" and about services available
Providing service in languages other than English & French
Involving religious leaders, translators

Results of Ratings For Each Module

Each statement was rated on a scale of 1 to 5, where 1=poor and 5=excellent.
Do not know = 6; and Not Applicable = 7 (6,7 was omitted from the total scoring)

Appendix A
Equal Access Project Baseline Results
Generic Example - Program A
March 31, 2004

MODULE ONE - DATA TO IDENTIFY BARRIERS

How successful program has been up to this point in the area of accessing data to identify and understand barriers

Statement	Median Program Score	Median Score for all Programs Surveyed
We regularly access community data relevant to Identification of barriers at the local level	2.5	3.0
Our program has facilitated the provision of data to community organizations	3.0	4.0
We know that community data are accessed by the community groups we work with	2.5	3.0
Our staff has a good understanding of the demographics and characteristics of groups facing barriers in comparison to our general population	4.0	4.0
Average for all items	**3.0**	**3.5**

Methods used to monitor progress

Document reviews of minutes and reports, committee meetings and surveys	Yes
Survey of staff who work with groups facing barriers	Yes
Survey of community groups that represent populations facing barriers	Yes
Records of information requests from communities	Yes
Review and analysis of collected data and documents produced	Yes
Review of tools and questionnaires used to collect data on general populations and on groups facing barriers especially for language and cultural validity	Yes
Other: List other	

MODULE TWO - COMMUNITY AND STAKEHOLDER PARTICIPATION

Statement	Median Program Score	Median Score for all Programs Surveyed
Our program keeps an updated list of organizations and groups represented/consulted in planning and evaluation of programs and services	3.5	3.0
Our program works with community groups to assess local health/service needs	3.0	3.0
Our program works with community groups to identify areas where services do not meet local needs	3.0	3.0
Our program has collected and used data appropriately on the population in general and on groups facing barriers	3.5	4.0
Average for all items	**3.25**	**3.25**

Appendix A
Equal Access Project Baseline Results
Generic Example - Program A
March 31, 2004

Methods used to monitor progress

Periodic review of collected data and reports	Yes
Periodic review of lists of community groups	Yes
Survey of community groups	Yes
Review of minutes and reports of department meetings	Yes
Other: List other	

MODULE THREE - PROGRAM DEVELOPMENT

Statement	Median Program Score	Median Score for all Programs Surveyed
Our program has identified systematic and non-systematic barriers to participation of groups facing barriers in our mandatory public health program	3.0	3.0
The proportion of clients from "special needs" groups accessing our mandatory program and services is representative of the population in Ottawa with special needs (in terms of the number of clients and types of special needs)	2.0	3.0
The programs targeting specific groups facing barriers are accessed based on the groups' specific needs	3.0	4.0
Our programs are provided in languages other than English and French and reflect the linguistic composition of the area	3.0	2.0
Our programs include content relevant to the needs and experiences of groups facing barriers	2.5	3.0
Our program staff is from diverse backgrounds reflecting the composition of our region	3.5	3.0
People with limited fluency in English or French are served by multilingual staff or through the purchase of professional interpretation services	3.0	3.5
Our program is delivered in venues that are appropriate to the groups facing barriers (This could include community centers, schools, drop-in centers, shelters, multi-cultural centers, seniors centers etc.)	4.0	5.0
We provide supports (such as assistance with transportation, child care) to reduce or eliminate access barriers or facilitate access	2.0	2.5
We have conducted a formal needs assessment with special group members to identify reasons for not accessing our mandatory core program	2.0	2.0
We have developed and implemented special programs to facilitate access to our mandatory program	3.5	3.0
We review our program periodically for its ability to serve the needs of groups facing barriers	3.0	4.0
We test our resources with specific client groups to ensure that they are accessible for groups facing barriers	2.0	2.0
We have found that groups facing barriers are accessing our mandatory public health program and services in greater numbers	3.5	3.0
When we plan new services we take into account the special needs of groups facing barriers	3.0	4.0
Average for all items	**2.9**	**3.1**

Appendix A
Equal Access Project Baseline Results
Generic Example - Program A
March 31, 2004

Methods used to monitor progress

Collection of program participation figures on demographics comparable to Census data collection (mother tongue, home language, country of birth, gender, income and visible minority status)	Yes
Periodic program content review	Yes
Consultation with experts	Yes
Review of service plans	Yes
Review of process documents, which will lead to service plans	Yes
Needs assessment of special needs groups	Yes
Evaluation of programs including client feedback	Yes
Collection of staff data on demographics comparable to Census data collection categories and comparison with general population data	Yes
Comparison of mandatory care program participation figures with special group demographics in each community	Yes
Other: List other	

MODULE FOUR - INFORMATION DISSEMINATION AND OUTREACH

Statement	Median Program Score	Median Score for all Programs Surveyed
We produce educational and outreach materials in the most common languages other than English or French in our region (such as Chinese, Italian, Spanish, Arabic, Farsi, Somali)	3.5	2.5
We review our educational and outreach materials periodically to ensure that groups facing access barriers are informed about available programs and services, and are receiving accurate health information in a linguistically and culturally appropriate way	4.5	4.0
We review our educational and outreach materials periodically for bias and stereotyping including images and language use	4.5	3.0
We provide program information through a range of media, including community, multilingual, and ethno cultural media	3.0	4.0
We produce audio, visual and print resources that are culturally and linguistically appropriate to the groups facing access barriers	3.0	3.0
We provide educational and program information through a range of venues, including locations and media accessible to groups facing barriers	3.0	3.0
Average for all items	**3.6**	**3.25**

Methods used to monitor progress

Periodic review of language of educational material in comparison with demographic changes	Yes
Focus groups of members of groups facing barriers to review educational and program materials for accessibility, relevance and cultural appropriateness	Yes
Review of social marketing, communication and outreach strategies	Yes
Other: List Other	

Appendix A
Equal Access Project Baseline Results
Generic Example - Program A
March 31, 2004

MODULE FIVE - REPORTING

Statement	Median Program Score	Median Score for all Programs Surveyed
Our report to the Ministry includes mention of public health issues of special significance to population groups facing barriers	2.0	2.0
Our annual/biannual report to the Ministry represents these issues in a culturally sensitive manner that does not increase stereotyping or negative perceptions of these groups	4.0	3.0
As a result of our annual/biannual Ministry report, our staff have knowledge about public health issues that are significant to groups facing barriers	1.5	1.5
As a result of our annual/biannual Ministry report, the public knows more about public health issues of significance to groups facing barriers	4.0	4.0
We make summaries of our annual/biannual Ministry report available at a variety of local venues and through various media	3.0	3.0
Average for all items	**2.9**	**2.7**

Methods used to monitor progress

Review of the content of your annual/biannual Ministry report	Yes
Review of recent literature, short consultations with community representatives and experts and or focus groups with community representatives and experts to validate issues of significance to groups facing barriers	Yes
Survey of public health practitioners assessing knowledge of issues included in the Ministry report	Yes
Survey of public assessing knowledge of issues included in the Ministry report	Yes
Review of dissemination strategies	Yes
Other: List Other	

MODULE SIX - EDUCATION AND TRAINING

Statement	Median Program Score	Median Score for all Programs Surveyed
Our program has determined the level of skills and knowledge required to provide services to groups facing barriers	3.5	4.0
Our program staff is assessed to determine their skills and knowledge in providing programs and services to groups facing barriers	3.5	4.0
Our program staff is effectively trained in relation to specific diversity competencies and program content relevant to needs and experiences of groups facing barriers	3.0	3.0
Access and equity activities are included in staff work plans	3.0	3.0
Average for all items	**3.25**	**3.5**

Appendix A
Equal Access Project Baseline Results
Generic Example - Program A
March 31, 2004

Methods used to monitor progress

Review of literature, consultation with experts to determine key skills, knowledge and competencies	Yes
Participation in cultural sensitivity workshops	Yes
Review of training content	Yes
Periodic staff surveys regarding competencies, knowledge, skills, learning needs	Yes
Client surveys regarding satisfaction with staff competencies in this regard	Yes
Review of staff work, plans, activities, activity databases etc.	Yes
Monitoring number of staff and other public health officials trained on how to work with population groups facing barriers	Yes
Other: List other	