OPHA
Ontario Public Health Association
l'Association pour la santé publique de l'Ontario
Established/Établi 1949

EQUAL ACCESS INDICATORS FOR ONTARIO'S MANDATORY CORE PROGRAMMING REQUIREMENTS

1. Introduction

The Ministry of Health has developed a set of guidelines that all Health Boards in Ontario are required to implement, according to the Health Protection and Promotion Act. These standards are seen as minimum requirements for public health programs and to ensure the delivery of comprehensive public health promotion and protection programming and clinical services across Ontario.

OPHA has taken particular interest in the implementation and monitoring of the general standard for Access and Equity, and the Ministry of Health has accepted three Indicator Questions for Equal Access as proposed by OPHA. The OPHA Equity and Access Survey Report, 2001, entitled: an "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" is very informative and provides a useful resource for measurement tools study.

The next step required development of relevant program requirements for the Equal Access Standard, and standardized measurement and monitoring tools. In August 2001, the Ontario Ministry of Health awarded a grant ($7000), to the Ontario Public Health Association (OPHA) for developing indicators for equal access in the provision of public health services. These requirements and indicators are to be incorporated into the Mandatory Health Programs and Services Guidelines.

Abebe Engdasaw, as a Co-Chair of the OPHA Access and Equity standing committee, led the project. This was done in alliance with City of Ottawa's Public Health Unit (PHU) and the Community Health Research Unit (CHRU) from the University of Ottawa. Kamila Tomcik represented City of Ottawa's PHU, Lynne MacLean, Alma Estable and Mechthild Meyer represented CHRU. Dr. Meenakshi Gupta was appointed as the Project Coordinator.

Three indicator questions were approved by the Ministry of Health and Long-Term Care:

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

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 working group used the three questions as a framework to develop more specific access requirements for public health programs and services (*attached, Equal Access Indicators*). The working team determined that the requirements for access for persons with physical disabilities are already well specified at the legislative level, thus they focussed on socio/cultural access issues. As approved and accepted by OPHA, the term "access" is 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. Access incorporates two aspects: 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."*

2. Research Process

This section elaborates upon the process the team undertook for developing these indicators:

1. Reviewed key documents for multi-cultural access indicators.
2. Reviewed findings of recent public consultations with diverse "publics", to identify access barriers and enablers.
3. Identified and proposed useful indicators for each question.
4. Organized two workshops, one each in Ottawa and Toronto, where community members, academics and health units were invited for consultation.
5. Revised the proposed indicators as necessary.

Once the group was formed, they met and developed the criteria for developing the questions for the project. During the weekly meetings, the team developed and proposed additions to the structure for Equal Access Framework Evaluation. Besides the proposed requirements, the team developed and suggested tools for implementing these requirements (see *Appendix 1, Requirements and Measurement Table*).

To gather feedback on the proposed requirements and the Suggested Implementation Tools we held our first workshop meeting on February 13, 2002 in Ottawa. The objective of this workshop was to request input related to whether the indicators are measuring what they are supposed to in terms of constructs, redundancy, gaps, etc. Participants for this workshop were selected on the basis of their expertise in equal access issues. We contacted a number of people working in the field of multicultural health issues, and sent

out the requirements to a group of local experts in the field of academics, public health policy, community health units, planning and evaluation, community stakeholders (women's groups, literacy groups, multicultural organizations, settlement agencies, different sexual orientation, and the physically challenged).

Based on the input received from the first workshop, changes were made to the proposed requirements and suggested implementation tools. A second workshop was organized in Toronto on March 3, 2002 to study the feasibility of the indicators. The proposed additions to the General Standards for Equal Access, along with the Suggested Tools for Implementation were sent out to a group of program managers, planning and evaluation officers, epidemiologists and multicultural health workers from five Ontario Public Health Units. The participants shared their knowledge and expertise related to Equal Access and implementation of Mandatory Guidelines in terms of whether the indicators and collection methods outlined in the Suggested Implementation Tools were appropriate and feasible for the proposed requirements. The participants also raised some important issues with regards to implementation of these requirements and indicators which have been attached with this report. (see *Appendix 2, Issues Raised*).

The developed proposed requirements are intended to ensure that all Ontarians have equal access to public health programs.

Given that several of the Mandatory Programs are in the process of being revised, we would like to take this opportunity to recommend that these draft program requirements, standardized measurement and monitoring tools for Equal Access Standards be incorporated into the Mandatory Programs and Services Standards.

Abebe Engdasaw
Co-Chair, Access and Equity Committee and Chair of the Research Project

April 10, 2002

General Standard: Equal Access (Mandatory Health Programs and Services Guidelines – 1997)

Goal: To ensure that all Ontarians have access to public health programs.

Objective: To reduce educational, social and environmental barriers to accessing mandatory public health programs.

Proposed additions to the General Standards: Equal Access

INDICATOR QUESTION 1

Has the Board of Health developed and implemented policies and operational strategies which promote accessibility to all mandatory public health programs and services? *(Ministry approved Indicator Question)*

Proposed requirements:

1. The Board of Health shall develop an access and equity policy framework for policies and strategic plans to promote equal access to all mandatory public health programs and services by groups facing barriers, by, as a minimum,
   a) including the principle of equal access to services and programs for population groups for whom barriers exist, in mission, vision, and value statements;
   b) ensuring that equal access principles are reflected in all organizational policies, communication and marketing, planning and evaluation;
   c) developing human resources policies that lead to staffing which reflects the diversity of the community at all levels;
   d) ensuring that community stakeholders are represented on committees and other bodies that develop and review policy.

2. The Board of Health shall implement operational plans to achieve accessible and equitable mandatory public health programs and services. These shall include, but not necessarily be limited to:
   a) concrete and measurable objectives, reviewed on an annual basis, to increase access and equity in programs and services where barriers to access are identified;
   b) adequate resources for implementation;
   c) procedures for reviewing the impact on groups facing barriers, of all decisions to increase, decrease or reallocate resources.

INDICATOR QUESTION 2

Has the Board of Health <u>adjusted existing programs and or developed special programs</u>, including special educational materials, tailored service delivery and active outreach to increase accessibility to mandatory public health programs and services? *(Ministry approved Indicator Question)*

Proposed requirements:

1. The Board of Health shall liaise on an on-going basis with appropriate community, government and academic sources in order to access and interpret data relevant to identification of barriers at the local level for program planning and evaluation.

2. The Board of Health shall include representatives of diverse organisations representing or serving groups facing barriers in developing, planning and evaluating all programs and services.

3. The Board of Health shall, develop new programs and maintain and adjust existing programs and services that are consistent with the principles of equal access, by:
   a) adjusting programs and services in areas to meet the changing needs and demographics of its client population;

b) developing and testing all resources to ensure that they are appropriate for groups facing barriers;
c) delivering programs and services in venues appropriate to groups facing barriers (e.g. accessible by public transport; barrier free location; flexible hours of operation);
d) providing appropriate supports to ensure access (e.g. child care and interpretation).

4. The Board of Health shall develop effective dissemination and active outreach strategies to inform groups facing barriers about policies, programs and measures to improve access.

5. The Board of Health, as part of active outreach, shall ensure that its annual report covering current key public health issue(s):
   a) includes issues that are of significance to groups facing barriers in each community;
   b) provides summaries in a range of formats and styles produced in partnership with groups facing barriers, including, as a minimum:
      - in the major non-official languages of groups in each community;
      - in plain language, large print and Braille;
      - in audio and visual format.
   c) is disseminated in co-operation with a range of health, social service, municipal, and voluntary sector organizations and venues that serve groups facing barriers.

6. The Board of Health shall to develop competency of public health practice to implement equal access standards, through:
   a) continuing education for public health practitioners to develop and maintain the knowledge and skills required to provide programs and services to population groups for whom barriers exist;
   b) training Board of Health staff to develop and maintain the knowledge and skills required to provide program and services to groups facing barriers (e.g. cultural competencies);
   c) incorporating access and equity competencies into Board of Health staff work plans.

INDICATOR QUESTION 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? *(Ministry approved Indicator Question)*

Proposed requirements:

1. The Board of Health shall identify and standardize tools to monitor and evaluate access to public health programs and services.

2. The Board of Health shall ensure that its annual assessment of community health status incorporates reliable and valid data on groups facing barriers, including, as a minimum:
   a) demographic data such as gender, income, age , ability, religion, sexual orientation, mother tongue, home language, language knowledge, immigrant status, number of years in Canada, ethnic origin;
   b) risk factor prevalence, mortality and morbidity rates, dental health indices and other health conditions related to groups facing barriers;
   c) reproductive outcomes for groups facing barriers.

3. The Board of Health shall collect information on populations served by mandatory programs and services that permit comparison of access by population groups facing barriers. This information shall include, but not be limited to demographic data described in requirement 2a) above.

4. The Board of Health shall ensure that collection of information is designed to permit assessment and valid comparison of the needs of population groups facing barriers to the general population. Standards, for valid comparison, will be developed in consultation with researchers, practitioners, clients and community groups by:
   a) developing a set of valid questions to identify and describe the population groups which may experience barriers to access;
   b) using these questions consistently and incorporating them into ongoing monitoring and evaluation of client population.

5. The Board of Health shall monitor and evaluate programs and services that shall include collection of information from people in groups facing barriers, both at the individual and community level.

6. The Board of Health shall evaluate removal of access barriers in all mandatory programs and services through periodic assessment of change (e.g. emerging issues/new public health issues).

Appendix 1

General Standard: Equal Access (Mandatory Health Programs and Services Guidelines – 1997)

Goal: To ensure that all Ontarians have access to public health programs.

Objective: To reduce educational, social and environmental barriers to accessing mandatory public health programs.

Requirements and Standards:

1. **The Board of Health shall provide mandatory public health programs and services, whenever practical and appropriate, which are accessible to people in special groups for whom barriers* exist. Broadening access may require adjusting existing programs, promoting accessibility and developing special programs including special educational materials, tailored service delivery and active outreach.**
2. **When planning to use facilities and sites for mandatory public health programs, the Board of Health shall select those which are barrier-free and have suitable access for special groups.**
3. **The Board of Health shall establish ongoing community processes to identify needs, recommend approaches and monitor progress toward achieving access to the mandatory public health programs and services.**

***Barriers can include, but are not limited to: literacy level, language, culture, geography, social factors, education, economic circumstance, and mental and physical ability.**

Proposed additions to the General Standards: Equal Access

INDICATOR QUESTION 1

Has the Board of Health developed and implemented policies and operational strategies which promote accessibility to all mandatory public health programs and services? *(Ministry approved Indicator Question)*

Proposed requirements:

1. The Board of Health shall develop an access and equity policy framework for policies and strategic plans to promote equal access to all mandatory public health programs and services by groups facing barriers, by, as a minimum,
   a) including the principle of equal access to services and programs for population groups for whom barriers exist, in mission, vision, and value statements;
   b) ensuring that equal access principles are reflected in all organizational policies, communication and marketing, planning and evaluation;
   c) developing human resources policies that lead to staffing which reflects the diversity of the community at all levels;
   d) ensuring that community stakeholders are represented on committees and other bodies that develop and review policy.

2. The Board of Health shall implement operational plans to achieve accessible and equitable mandatory public health programs and services These shall include, but not necessarily be limited to:
   a) concrete and measurable objectives, reviewed on an annual basis, to increase access and equity in programs and services where barriers to access are identified;
   b) adequate resources for implementation;
   c) procedures for reviewing the impact on groups facing barriers, of all decisions to increase, decrease or reallocate resources.

Suggested Implementation Tool:

COMPONENT	INTENDED RESULT	INDICATOR	METHODS
1. a) Policies, mission, vision and value statements.	Policies are developed to ensure access and equity for groups for whom barriers exist to all mandatory public health programs and services.	• The policy framework includes a statement of access and equity in their mission, vision and/or value statement. • Policies which ensure accessibility to all mandatory public health programs and services exist. • Vision, mission and value statements are communicated and implemented.	Document review: • Policy documents • Annual reports.
1. b) Equal access principles	Equal access principles are integral part of all policy and operational documents.	• Equal access principles are embodied in all organizational policies and documents. • Communication and marketing action plans incorporate strategies to reach groups for whom barriers exist. • Equal access principles are integrated in all planning and evaluating documents.	Document review: • Marketing and communication. • Policy papers and other publications. • Planning and evaluation documents.
1. c) Human resources	Human resource practices have enhanced equitable representation of staff from groups facing barriers, to the extent feasible and appropriate.	• Human resource policies reflect the principles of equitable access. • Recruitment, hiring, retention and promotion policies exist to ensure diverse work force. • Staff has cultural competencies. • Recruitment strategies include a variety of media and venues to advertise staff openings. • Hiring process includes criteria for reviewing cultural competencies.	• Review of human resource policies and practices • Review of training plans • Survey of staff competencies • Review of recruitment strategies • Review of hiring process • Review of job applications • Review of staff demographics • Review of staff promotion and retention
1.d) Community representation	The membership of the Board of Health and other committees includes community stakeholders who represent groups facing barriers.	• The Board of Health, annually, identifies key community organizations which serve groups facing barriers. • The Board of Health has recruited community stakeholders from these key organizations. • Community stakeholders sit on the Board, committees and other bodies. • The Board of Health is familiar with organizations and community stakeholders which represent each of the groups facing barriers.	Document review: • Composition of the Board of Health, committees, and other bodies • Board recruitment strategies or appointment process. • Document review: listing of organizations, community stakeholders; survey of Board of Health re: knowledge of and contact with such organizations.

2. a) Concrete and measurable objectives	The objectives that are outlined in the strategic plan are met.	• Operational plans include specific targets to increase participation for groups facing barriers in mandatory public health programs and services. • Objectives and targets outlined in the operational plan are met.	• Review operational plans.
2. b) Adequate resources for implementation	Sufficient resources are allocated to implement the programs.	• Resources are adequate to implement and review access and equity components of the operational plans.	• Review resource allocations.
2.c) Resource allocation		• The Board of Health has developed a procedure for reviewing resource allocation. • A procedure for reviewing resource allocation exists and takes into account the needs of groups facing barriers.	• Review of resource allocation, process and amount. • Review of criteria used to allocate resource. • Annual budget review.

Proposed additions to the General Standards: Equal Access

INDICATOR QUESTION 2

Has the Board of Health <u>adjusted existing programs and or developed special programs</u>, including special educational materials, tailored service delivery and active outreach to increase accessibility to mandatory public health programs and services? *(Ministry approved Indicator Question)*

Proposed requirements:

1. The Board of Health shall liaise on an on-going basis with appropriate community, government and academic sources in order to access and interpret data relevant to identification of barriers at the local level for program planning and evaluation.

2. The Board of Health shall include representatives of diverse organisations representing or serving groups facing barriers in developing, planning and evaluating all programs and services.

3. The Board of Health shall, develop new programs and maintain and adjust existing programs and services that are consistent with the principles of equal access, by:
   a) adjusting programs and services in areas to meet the changing needs and demographics of its client population;
   b) developing and testing all resources to ensure that they are appropriate for groups facing barriers;
   c) delivering programs and services in venues appropriate to groups facing barriers (e.g. accessible by public transport; barrier free location; flexible hours of operation);
   d) providing appropriate supports to ensure access (e.g. child care and interpretation).

4. The Board of Health shall develop effective dissemination and active outreach strategies to inform groups facing barriers about policies, programs and measures to improve access.

5. The Board of Health, as part of active outreach, shall ensure that its annual report covering current key public health issue(s):
   a) includes issues that are of significance to groups facing barriers in each community;
   b) provides summaries in a range of formats and styles produced in partnership with groups facing barriers, including, as a minimum:
      - in the major non-official languages of groups in each community;
      - in plain language, large print and Braille;
      - in audio and visual format.
   c) is disseminated in co-operation with a range of health, social service, municipal, and voluntary sector organizations and venues that serve groups facing barriers.

6. The Board of Health shall to develop competency of public health practice to implement equal access standards, through:
   a) continuing education for public health practitioners to develop and maintain the knowledge and skills required to provide programs and services to population groups for whom barriers exist;
   b) training Board of Health staff to develop and maintain the knowledge and skills required to provide program and services to groups facing barriers (e.g. cultural competencies);
   c) incorporating access and equity competencies into Board of Health staff workplans.

Suggested Implementation Tool:

COMPONENT	INTENDED RESULT	INDICATOR	METHODS
1. Liaison with community to access and interpret data	• Data relevant to identification of barriers at the local level are accessed. • Barriers to access are identified by the local community organizations. • Demographic & community health characteristics of the groups facing barriers in each community are understood, and can be compared to those for whom barriers do not exist.	• Community data relevant to identification of barriers at the local level are accessed by the Health Unit (See also Indicator Q 3, Requirements 2 -5). • Board of health has facilitated provision of data to community organisations. • Community data are accessed by community groups. • Demographic and other characteristics of groups facing barriers are understood & can be compared to the general population.	• Document review: minutes and reports of Board of Health, committees; survey of Board of Health; survey of local organizations (See Indicator Q 1, Requirement 1). • Health Unit staff survey (working with groups facing barriers). • Survey community groups. • Records of info requests from communities. • Health information requests & transfers (frequencies-periodic survey over set time). • Identification (inventory) of all tools (intake, programming, and data collection) that are used with the general population. • Review of tools and questions used to collect data on general populations and on groups facing barriers, especially for language and cultural validity. • Standardise tools. • Review of collected data and documents (reports) produced.
2. Community and stakeholder participation in program planning and evaluation	Community organisations are involved in planning & evaluating programs and services.	• List of organisations and groups represented/consulted in planning, evaluation of programs & services are updated regularly. • Local health /service needs for each group facing barriers are assessed by both Board of Health and by community groups. • Areas where services do not meet needs are identified by both Board of Health and by community groups. • Comparable data on the population in general and on groups facing barriers have been collected and used "appropriately".	• Review of collected data and documents (reports) produced. • Review of lists of organizational groups. • Document review: minutes and reports of Board of Health, committees; survey of Board of Health (See Indicator Q 1, Requirement 1d). • Health Unit staff survey (working with groups facing barriers). • Survey community groups.
3.a) Program adjustment and tailoring	All programs and services are adjusted to facilitate access for groups facing barriers.	• Systemic and non-systemic barriers to participation of groups facing barriers in all mandatory public health programs and services are identified. • The proportion of clients from "special needs" groups accessing mandatory programs and services is representative of the needs of the specific population, and • Programs targeting specific groups facing barriers are accessed based on the groups' specific needs. • Programs are provided in languages other than English and French,	• Program participation figures are collected on demographics comparable to Census data collection categories (mother tongue, home language, country of birth, gender, income and visible minority status). • Needs assessment of groups facing barriers. • Program content review. • Standard program evaluation methods including client feedback (quantitative and qualitative).

COMPONENT	INTENDED RESULT	INDICATOR	METHODS
		reflecting the linguistic composition of the area. • Programs include content relevant to the needs and experiences of groups facing barriers. • Program staff is from diverse backgrounds reflecting the composition of each region. • Programs and services are delivered in venues that are appropriate to the groups facing barriers. • Supports are provided to reduce or eliminate access barriers/facilitate access.	• Program content review; consultation with experts. • Staff data collected on demographics comparable to Census data collection categories, comparison with general population data.
	Programs and services are developed and provided where gaps and barriers exist.	• Needs assessments are conducted with special group members to identify reasons for not accessing mandatory core programs. • Special programs to facilitate access to mandatory programs have been developed and implemented. • Programs are reviewed periodically for their ability to serve the needs of groups facing barriers. • Resources are tested to ensure that they are accessible for groups facing barriers.	• Standard program evaluation measures including client feedback (qualitative and quantitative) • Needs assessments with population groups for whom barriers exist. • Comparison of mandatory core program participation figures with special group demographics in each community.
	Programs and services are tailored to the needs of groups facing barriers.	• Clients from groups facing barriers are accessing mandatory public health programs and services in greater numbers. • People with limited fluency in English or French are served by multilingual staff or through purchase of professional interpretation services.	• Standard program evaluation methods including client feedback.
	Any new services take into account the needs of groups facing barriers and are sensitive to these needs.	• The Board of Health has identified specific needs of populations/groups with access barriers which need to be considered when planning new services. • The planning process for new services has taken into account special needs of groups facing barriers.	Document review : • Service plans • Process documents which lead to service plans • Needs assessments of special needs groups
3.b) development and testing of resources 3.c) accessible venues	Resources are appropriate for groups facing barriers Clients can physically access programs and services Reduction or elimination of	• Programs are provided in languages other than English and French, reflecting the linguistic composition of the area. • Programs include content relevant to the needs and experiences of groups facing barriers. • Program staff is from diverse backgrounds reflecting the composition of each region. • Programs and services are delivered in venues that are appropriate to the	• Standard program evaluation methods including client feedback (quantitative and qualitative) • Program content review; consultation with experts. • Staff data collected on demographics comparable to Census data collection categories, comparison with general population data.

COMPONENT	INTENDED RESULT	INDICATOR	METHODS
3.d) Supports to enhance access	barriers such as transportation costs, child care	groups facing barriers. • Supports are provided to reduce or eliminate access barriers/facilitate access.	
4. Effective information dissemination and outreach	Educational materials are accessible to groups facing barriers. Groups facing barriers have accurate and appropriate information about health programs and services, and about specific health issues. Active outreach strategies are appropriate for groups facing barriers.	• Educational and outreach materials are produced in the most common languages other than English or French in each region. • Educational and outreach materials are reviewed 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. • Educational and outreach materials are reviewed periodically for bias and stereotyping, including images and language use. • Program information is provided through a range of media, including community, multilingual, and ethno cultural media. • Audio visual and print resources are culturally and linguistically appropriate to the groups facing access barriers. • Educational and program information is provided through a range of venues, including locations and media accessible to groups facing barriers.	• Periodic review of language of educational material in comparison with demographic changes. • Review of content and language of resources. • Focus groups with members of groups facing barriers to review educational and program materials for accessibility, relevance and cultural appropriateness. • Knowledge surveys comparing special group knowledge level in subjects that have been the target of health education and health promotion campaigns, with that of the general population. • Review of social marketing, communication, and outreach strategies.
5. Annual report and summaries	Groups facing barriers have an increased understanding of public health issues of significance to them.	• Annual report includes mention of at least three public health issues of special significance to at least three population groups facing barriers. • Annual report presents these issues in a culturally sensitive manner that does not increase stereotyping or negative perceptions of these groups. • Public health practitioners have knowledge about public health issues that are of significance to groups facing barriers. • Public knows more about public health issues of significance to groups facing barriers. • Annual report summaries are made available at a variety of local venues and through various media.	• Review of content of annual report. • Review of recent literature on issues; short consultations with community representatives and experts; focus groups with community representatives and experts. • Survey of public health practitioners assessing knowledge of issues included in annual report, prior to and after publication of annual report. • Survey of public assessing knowledge of issues included in annual report, prior to and after publication of annual report. • Review of dissemination strategies.
6. Public health practitioner competency to implement equal access standards	Public health practitioners have competence to implement equal access health standards.	• Level of skills and knowledge required to provide services to groups facing barriers has been determined. • Program staffs are assessed to determine their skills and knowledge in providing programs and services to groups facing barriers.	• Review of literature, consultation with experts, to determine key skills, knowledge, and competencies. • Review of training content. • Staff surveys re: competencies, knowledge, skills, learning needs. • Client surveys re: level of satisfaction with staff competencies in this

COMPONENT	INTENDED RESULT	INDICATOR	METHODS
		• Staff and practitioners in the community are 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.	regard. • Number of staff and other public health professionals trained on how to work with population groups facing barriers. • Periodic surveys to assess retention of knowledge, skills, and competencies post-training. • Review of staff work plans, activities, activity databases, etc.

Proposed additions to the General Standards: Equal Access

INDICATOR QUESTION 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? ***(Ministry approved Indicator Question)***

Proposed requirements:

1. The Board of Health shall identify and standardize tools to monitor and evaluate access to public health programs and services.

2. The Board of Health shall ensure that its annual assessment of community health status incorporates reliable and valid data on groups facing barriers, including, as a minimum:
   a) demographic data such as gender, income, age , ability, religion, sexual orientation, mother tongue, home language, language knowledge, immigrant status, number of years in Canada, ethnic origin;
   b) risk factor prevalence, mortality and morbidity rates, dental health indices and other health conditions related to groups facing barriers;
   c) reproductive outcomes for groups facing barriers.

3. The Board of Health shall collect information on populations served by mandatory programs and services that permit comparison of access by population groups facing barriers. This information shall include, but not be limited to demographic data described in requirement 2a) above.

4. The Board of Health shall ensure that collection of information is designed to permit assessment and valid comparison of the needs of population groups facing barriers to the general population. Standards, for valid comparison, will be developed in consultation with researchers, practitioners, clients and community groups by:
   a) developing a set of valid questions to identify and describe the population groups which may experience barriers to access
   b) using these questions consistently and incorporating them into ongoing monitoring and evaluation of client population

5. The Board of Health shall monitor and evaluate programs and services that shall include collection of information from people in groups facing barriers, both at the individual and community level.

6. The Board of Health shall evaluate removal of access barriers in all mandatory programs and services through periodic assessment of change (e.g. emerging issues/new public health issues).

Suggested Implementation Tool:

COMPONENT	INTENDED RESULT	INDICATOR	METHODS
3-1. Tools	The process for data collection is developed based on identified access monitoring needs: • Data collection needs are identified. • Data collection and analysis methods are identified. • Reliable and valid data is collected using appropriate tools.	The Board of Health has a process to monitor access using reliable, valid, and standardized instruments.	• Review of tools used to collect data on general populations and on groups facing barriers for appropriateness, especially language and cultural validity. • Periodic review of process.
3-2, a) – c) Reliable and valid data	Annual assessment of community health status incorporates reliable and valid data for groups facing barriers.	In assessing community health status, the Board of Health includes the following data: • Gender, income, age, sexual orientation, mother tongue, home language, language knowledge, immigrant status, number of years in Canada, ethnic origin; • Risk factor prevalence, mortality, and morbidity rates, dental health indices related to groups facing barriers; • Reproductive outcomes for groups facing barriers; • Health conditions that are known or suspected to be associated with groups facing barriers.	• Document review: community health status reports; secondary sources (relevant Statistics Canada, Social Planning Council, and other demographic reports); special surveys. • Identify (inventory) and standardize all tools (intake, programming, and data collection) that are used with the general population. • Review of tools used to collect data on general populations and on groups facing barriers for appropriateness, especially language and diversity validity, and standardization of questions. • Assessment of the community using ethnographic data.
3-3. Survey information for comparisons	• Baseline data on the health status and needs of the groups facing barriers is available. • Health status and needs of groups facing barriers with general population is comparable. • Impact of interventions (programs and services) on health status of groups facing barriers is measurable (See Program Guidelines, Mandatory Health Guidelines).	• Data collection system is in place, to collect data for all groups facing barriers, including their needs. • Baseline data on the population in general and all groups facing barriers is available.	• Demographic and health status data.
3-4. Standards for comparison	• Standards and valid questions to identify and describe the groups which may experience barriers to access are developed	• Standards for questions are developed and used consistently. • All tools used for data collection with the general population are	• Comparison of surveys with the standards to be used for the development of all survey and data collection tools.

COMPONENT	INTENDED RESULT	INDICATOR	METHODS
	• Surveys and other data collection tools use categories and set of questions consistently according to the standards (see above). • Health outcomes (programs and services) are comparable with general population.	validated for use with groups facing barriers. • Information is collected from the viewpoint of groups facing barriers.	• Survey review and revision process. • Adopt existing validated tools. • Community survey and client satisfaction information. • Ethnographic methods. • Focus groups.
3-5. Client viewpoint	• Client views are used to inform program monitoring and evaluation results.	• Client views are collected from individuals and client groups	• Surveys of randomly selected community members. • Questionnaires for program clients. • Interviews with program clients. • Interviews with key community informants.
3-6. Periodic assessment	• Access needs, especially those from groups facing barriers, are identified on an ongoing basis. • Changing and ongoing needs are identified. • Knowledge exists how barriers have been reduced and how they can be further mitigated.	• Data collection system about access barriers is in place • Data collection occurs regularly	• Needs assessments. • Program and service delivery evaluations. • Interviews with key informants from groups facing barriers. • Surveys

Appendix 2

Advice from Health Units for Implementing Equal Access in Public Health

Access & Equity for Public Health:

- There is a need to find evidence-based best practices for access and equity in public health since this is often a criterion used by health units to accept a program or a model.
- In order to reduce disparity in health outcomes, one needs to define "Equal Access" by looking at disparity, not by numbers served.
- A framework and specific indicators would be very helpful in selling Access & Equity changes to public health.
- Restructuring after an amalgamation can result in big challenges to maintain Access & Equity in public health, as programs and functions shift, and management changes.

Access & Equity Staff

- The Health Unit should designate at least one person for Access & Equity and/or Multicultural Health issues. A committee is even better.
- Involvement of Access & Equity staff with other public health groups at provincial and/or federal level can be helpful in raising the profile of such work.
- Involvement of Access & Equity staff with health unit evaluation committees is highly useful.

Senior Management:

- Getting senior management buy-in is key. However, when senior management changes, you may have to go back to zero as new management may have new priorities.
- Senior staff involvement with the community is important; the more senior health department staff meets with the community, the better. In some places, the community is now joining Health Unit boards, so senior management is more connected.

Health Unit Staff in General:

- All staff need to be reminded that, while they have to be involved and participate in equal access, they are already involved in it more than they realize through their day to day involvement with the community. It should not be seen as something new that is now being imposed on them.
- To reduce staff defensiveness, avoid using 'us' and 'them' language, in relation to who is working on equal access issues.
- To further reduce potential defensiveness of staff, place Access & Equity work within, or as part of, a full spectrum of activities.
- For some units, the lowest level of staff defensiveness to Access & Equity activities was with community activities celebrating diversity, while the highest level of defensiveness was regarding a staff survey of needs.

The Community:

- Getting community buy-in with Access & Equity activities or changes can be a challenge. However, it is important to develop a sense of ownership within the community by having all people participate. Representation of local people around the table is extremely important.

Equal Access Activities:

- An Access and Equity Audit/Review can be seen as a starting point for assessment, learning and community process, especially if there is representation from senior management, and all levels of staff and community working on the planning and approval of the review.

- Peel has developed a useful tool for collection of baseline data suitable for Access and Equity Audits/Reviews. This tool has since been modified and used successfully by Waterloo.

The Need for Continual Advocacy:

- It is a challenge to implement and increase access as resources/budgets are reduced and programs are cut.
- Passion and determination are needed to keep meeting new challenges.
- Never take it for granted that Access & Equity issues are accepted and supported, even after some successes. There is a need for continual advocacy.