Lambton Public Health

Building Organizational Capacity for Health Equity Action:

A Framework and Assessment Tool for Public Health

Summary Report

Lambton Public Health

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Finally, to the social determinants of health [SDOH] public health nurses in Ontario - this report has been a few years in the making, and we are hopeful that you, as health equity champions, can use this to continue the many capacity building efforts underway since the SDOH initiative began. Thank you for being a sounding board during the development of the framework, to ensure the elements of capacity for health equity was reflective of your experiences and practice.

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A complementary case study, entitled **"Returning to Our Roots: Building Capacity in Public Health for Action on the Social Determinants of Health" is also available on page 60 here:**
https://www.schulich.uwo.ca/publichealth/cases/Western%20MPH%20Casebook%202015%20e-version.pdf

Contents

Executive Summary

Public health experts in Ontario increasingly recognize that capacity building at the organizational level for health equity action must become a priority. Organizational capacity is a critical determinant of performance and is necessary for understanding systematic effectiveness[1]. A review of the literature revealed that while tools exist to measure performance of health equity initiatives within organizations, there is a great need to understand what conditions and capacities are required to strengthen and support health equity action in the first place.

Research was undertaken at Lambton Public Health [LPH] to develop a conceptual framework that outlines key elements needed to drive equity action at the local level. The framework attempts to capture the many dimensions of public health practice by specifically identifying two broad drivers of capacity for equity action: those internal to organizations, and those external to organizations.

The internal drivers capture the processes, knowledge and resources of an organization, and are categorized according to three levels of influence: individual, organizational and systems. The main internal drivers consist of seven elements:

- Leadership and Commitment
- Formal Systems
- Informal Systems
- Resources
- Accountability
- Governance and Decision-making
- Partnerships

The external drivers represent the contextual influences that promote or limit the uptake of health equity as a priority in the wider health, socio-economic and political systems. The elements that make up the external drivers have an indirect effect on organizational performance and capacity for equity action, and include:

- Current and historical macro-economic, social and public policies
- Perceived threats to health
- Epidemiological conditions
- Public support and trust
- Political will
- Best available evidence of the time

Overall, capacity for equity action is strengthened when the elements and their interactions, are increased.

A corresponding assessment tool was designed to enable LPH to assess our capacity against elements of the framework. The tool consists of 3 checklists that align with three levels of influence on health equity action: individual level, organizational level, and systems level. Information from the checklists was used to define issues, gaps and possible actions. Each team at LPH reviewed the issues identified and worked with the authors to develop action plans.

Overall, the tool provided LPH with a baseline assessment of our capacity for health equity action, which, coupled with action plans, will be monitored and evaluated over time.

LPH's experience demonstrates that public health is well positioned to mediate the relationship between systems that create health inequities, and the capacity required to act on them. The framework and assessment tool may serve to guide other public health organizations in applying a strategic approach to building organizational capacity for health equity.

The framework and assessment tool forces organizations to build up the infrastructure and set the context for change in promoting health equity action. Successfully implementing the framework will require incremental effort and adaptability. The importance of building motivation across the organization to champion the needed capacity building efforts cannot be overlooked. Efforts must focus on gaining buy-in from health equity champions, staff, and dedicated leaders internal and external to the organization to support and sustain an effective approach to capacity building for health equity.

Ultimately, if the assessment tool is implemented effectively and monitored over time, assessing and building capacity for health equity may gradually become a standard feature of public health practice.

Introduction

"Public health professionals practice at that intersection where societal attitudes, governmental policies, and people's lives meet. Such privilege creates a moral imperative to work to change social conditions contributing to poor health" – Adeline Falk Raphael

The growing field of health inequities research has demonstrated that Canadians are healthier than ever before, and live longer; but improvements in health outcomes are not distributed evenly between population groups.[2]

Inequalities in health - a term often used interchangeably with health disparities - refer to observable differences in the health status of individuals or population groups due to factors such as income, education, or race/ethnicity.[2] When the inequalities are unfair, avoidable and at times ethically unjust, they are often termed inequities.

Many recent contributions in the public health field have drawn attention to enhancing our understanding of the social determinants of health, and our role in reducing health inequities. Despite widespread agreement that health equity has received more attention in recent years, "the momentum has not yet resulted in significant, concrete actions to reduce health inequities".[3] While public health organizations in Canada devote considerable attention to identifying pathways that lead to unequal health outcomes, the challenge is no longer collecting evidence; but translating this evidence into concrete action. Without these actions, many health equity champions have voiced concern that public health interest in health equity may become a passing fad.

Literature Review

A review of the literature revealed that health equity action in Canadian public health has been limited for five main reasons,[2-10] which we refer to as the “5 c’s of inaction”:

1. **Clarity**

   This refers to a lack of clear direction on how to take action on health inequities at the organizational level. An overwhelming amount of literature alluded to the need for more clarity to guide public health units in Ontario to effectively reduce health inequities in practice. The Ontario Public Health Standards (2008) and Core Competencies for Public Health in Canada (2008) were examined, as they represent the structures in place, and set the context for public health equity action.

   The Ontario Public Health Standards [OPHS], 2008 (revised 2014):

The OPHS are a practical agenda for promoting health action across all programs and services in public health units. They state that, “action on health inequities are operationalized predominantly through the work on “priority populations”**.** In addition, the equity foundations in OPHS outline principles that public health practitioners are required to follow, and include:

- Need: Use epidemiology and other methods of gathering information to identify priority populations
- Impact: Examine accessibility of the existing programs and services to reduce barriers (physical, social, geographic, cultural or economic), AND plan, deliver, manage and evaluate the programs to reduce inequities in health, while maximizing health gain for the whole population
- Capacity: allocate resources to address health inequities
- Partnership and Collaboration: share knowledge and use partnerships and collaboration to engage the community

However, while the equity foundations in the OPHS outline principles that public health practitioner's must follow to reduce inequities in health, little guidance is given regarding interventions or pathways that are known to work. This leaves boards of health with *varying interpretations* of the types of actions required through the standards.

The Core Competencies for Public Health

The CC's explicitly state that, "Public Health is fundamentally concerned with action and advocacy to address the full range of potentially modifiable Determinants of Health.

The 36 core competencies are introduced by a section that identifies shared attitudes and values of public health practitioners that contain significant and explicit content about the determinants of health - they are clearly identified as being equally important as the knowledge and skills identified in the competency statements themselves. Examples include: “a commitment to equity, social justice and sustainable development

The challenge with this is that the action and advocacy required is vague and can lead to subjective interpretations. In addition, the set of attitudes and values is written as a preamble to the core competencies, not as specific competencies that are expected in practice. In fact, out of the seven broad categories of competencies, only five contain implicit information related to the determinants of health. Because of this, SDOH experts are calling for an additional review of existing public health competencies to ensure more explicit inclusion of health equity criteria.

The newly developed Pan-Canadian Health Promoter Competencies published in 2014 may provide an example of how more explicit language can support roles in health equity action.

2. Challenge

This refers to the challenges inherent in monitoring, evaluating and reporting the health impact of policies and interventions aiming to reduce health inequities between different socio-economic groups. This challenge has been noted due to:

- The complex, interconnected nature of the DOH, which makes it difficult to measure the health impacts of upstream interventions in the short term.
- The difficulty accessing local data to monitor reductions in health inequities. We need more community-level data that focuses on structures and conditions rather than individuals and their behaviours
- The difficulty evaluating health equity interventions by public health due to the inter-sectoral nature of our work
- The difficulty identifying best practices or evidence that allow us to make an impact. In fact, a lot of the knowledge we have in public health is produced by practitioners working in a service delivery context, in which publishing or report writing is not always a priority. Any evidence we do produce is usually small in scale and specific to a particular context and setting. Thus it might not be accepted in traditional academic outlets. While we do produce a lot of grey literature through reports and evaluations, they still don't represent the amount of knowledge that exists, and such literature is difficult to access.

3. Concepts

This refers to the continued need for clarity in health equity and social determinants of health concepts, and congruence of those concepts with individual, organizational and societal values. Within the literature, it seems that health concepts continued to be blurred despite increased comfort using health equity language. For example, health equity, health promotion and population health have all been used to describe efforts to reduce health inequities. In fact, many do not realise that the term SDOH can actually has two meanings **(WHO**):

- it refers to the *social conditions* that promote or undermine health of population groups (intermediate DOH)
- It refers to the social processes that shape how the conditions are distributed between population groups (structural DOH)

This distinction is important, as blurring of the language can lead to misguided policy choices and actions. Overall, clear language, and congruence of that language between personal and organizational values can advance health equity work by ensuring that all public health professionals share a similar understanding.

4. Complexity: The *Global Warming Problem*

The fourth issue is what we refer to as the "global warming problem", where equity action is perceived as too complex an issue, creating the tendency to ignore health equity in hopes it would be better addressed by other sectors and higher levels of government. The prevailing view is that complex problems require complex solutions that can only be generated through inter-sectoral action, which requires coordination, sharing, time, and a long-term

commitment to a common vision of reducing health inequities this type of action is difficult to achieve without strong leadership and a backbone institution. While public health is ideally positioned to take this on, we first need to reflect on what our vision for health equity is.

Our vision for health equity will inevitably have ethical, political, economic and social implications.

In terms of ***ethical*** implications, what philosophical principals are we choosing to follow? HE is often associated with social justice, as it highlights there is an unfair, unearned privilege given to some over others. But at what point do we decide an observed inequality becomes unjust or unfair to be called an inequity? This is subjective, and is heavily influenced by one's values and ideology (i.e. individual versus collective responsibility)

In terms of ***political*** implications, how do we secure political commitment for equity issues? This requires us to understand the policy process that thrives through a set of its own rules, values and norms where the ideal of health does not always predominate - we must understand the broader context of how decisions are influenced and made

In terms of ***economic*** implications, how do we demonstrate the return on investment when we promote the use of upstream interventions? Economic evidence in the study of population health is one way to continue making progress in public health during a climate of fiscal restraint – however, this is a recurring knowledge gap, where most public health professionals have not been provided with supports in this area

Finally in terms of ***social implications***, how engaged and aware are community members when it comes to health equity issues?

These implications issues must be carefully thought out in order for organizations to successfully differentiate between issues that must be addressed at the structural level (political realm) versus those that can be tackled at within their own organizations and between community partners. Knowing when a policy window has opened can enable us to take action at the systems level. When the policy window is closed, perhaps drawing more on what capacity we have at the intermediary level (within our organization) is the best use of our time and resources to best tackle health inequities. With a better understanding of which level of intervention is required, effective change can be achieved through health equity action.

5. Capacity

This final issue refers to the limited focus on measuring and defining organizational capacity for health equity action in public health. A defining characteristic of capacity building is the assumption that capacity is linked to performance. When performance in achieving goals is lacking, a need for capacity building is often identified in order to improve the processes that occur within:

- the health system as a whole and its ability to improve its function

- the organizations within the health system
- and the individual's ability to engage productively within the organization

The literature showed that while organizational capacity is recognized as a critical determinant of system performance in public health, capacity assessment is often neglected in favour of program development and performance, or evaluated within very narrow perspectives. But focusing on performance alone causes us to ignore other important elements of capacity that contribute to our ability to reduce inequities. Therefore, Meyer et al suggest that public health performance relative to the capacity of the organization is more useful – this enables us to ask how well we are doing given what we had to work with. Ultimately, in order to assess performance relative to the capacity of an organization to take action on health inequities, a great need exists to identify indicators at three levels of influence:

- *Individual-level indicators* - can help understand the gaps in the skills/competencies required to uncover and analyze inequities
- *Organizational-level indicators* - can help organizations capture progress toward health equity objectives
- *System-level indicators* - can help monitor community action on the broader conditions that impact health equity

While each of the 5 c's listed are major challenges, they point to the need for more direction, and to focus on capacity building as the foundation for action. Many complex health issues today will require a stronger focus on policy, systems and environmental improvement interventions. Such interventions have great potential to prevent and reduce health inequality and affect a large portion of a population, and can also be leveraged to address root causes, ensuring the greatest possible health impact is achieved over time.[4] When coupled with increased political will, long-term funding, and consideration of health determinants where people live, learn, work, and play, reduction of health inequalities may be achieved.

Public health organizations and the individuals within them are well positioned to address these issues. Their invaluable knowledge of the culture, needs and assets of their communities, when complemented by expertise in local health statistics, developing partnerships, and implementing and evaluating evidence-based interventions, have the potential to create effective and equitable health outcomes.[4] Ultimately, the literature continued to highlight that the challenge facing public health is no longer collecting evidence; it's translating this evidence into concrete action. The literature also revealed that while tools exist to measure performance on health equity initiatives within public health organizations, there is a great need to understand what conditions and capacities are needed to strengthen and support health equity action in the first place.[2-10] A greater understanding of the context, dynamics and capacities within which public health organizations work is required to drive action on reducing health inequities at the local level.[1]

Bringing Organizational Capacity for Equity Action at the Forefront of Public Health Practice in Ontario

Achieving a greater focus on equity action will require more than strengthening individual skills and abilities through knowledge transfer.[1] To date, many capacity building strategies in Ontario rely on changing awareness and attitudes towards health equity through training and workshops.[5] Although this approach can lead to some short-term outcomes such as addressing knowledge and skills gaps regarding health equity, a more sustainable and strategic approach is needed that considers the whole context, dynamics and capacities within which an organization works, and why; not just individual performance.[1,7]

According to **Nu'man et al (2007)**, "organizational capacity building is a strategic methodology or process that serves to enhance organizations and their staff members' ability to perform or carry out their duties better" (p. 32). A defining characteristic of capacity building is the assumption that capacity is linked to performance, such as achieving the goals and objectives related to improving health equity (Baille, Bjarnholt, Gruber and Hughes, 2008).

While public health experts in Ontario increasingly recognize that capacity building at the organizational level for health equity action must become a priority,[1] few public health organizations have identified a specific framework for organizational capacity to guide equity action in public health.

Relevant fields of study can be drawn upon to offer insight in how to assess organizational capacity. They include economics, public administration, manufacturing, non-profit/service, and operations research. In particular, service organizations may offer the greatest insight given the many similarities in structure and function compared to public health. Most of these fields use the term "organizational capacity" and emphasize the importance of quantifying capacity measures as the first step in systems research or evaluation for a desired change in practice.

Developing a framework more specific to organizational capacity for equity action can serve to identify what key elements are needed to successfully reduce health inequities in public health practice. Ultimately, understanding what this capacity entails will better enable public health organizations to develop, implement and sustain equity-focused and evidence-based decision-making processes, measures, methods and outcomes.

The need for a conceptual framework

Adopting a framework for building capacity for health equity action has the potential to impact every aspect of how an organization operates. Its application may affect how needs are assessed at the program level, thus influencing how programs are planned, implemented and evaluated. At the organizational level, such a framework can affect the priority setting process and how partnerships are developed. And at the systems level, a framework can influence how leadership is enacted.[6,7]

While many examples of capacity frameworks in public health exist (i.e. in health promotion, disease prevention and community capacity building) they tend to focus on one practice area. In order to capture the many dimensions of public health practice**, Meyer et al (2012)** maintain that the elements of organizational capacity must be broader to include:

- Both tangible and intangible assets and influences (i.e. mission, vision, legal authority, governance and decision-making structures, and information flows)
- An assessment of the different levels of the public health system (individual, organization, system)
- The ability to capture the processes, knowledge and resources of a public health system

Applied to health equity, a framework can enable an organization to look at the multiple levels of influence on their capacity, and clearly describe factors that impede or facilitate action. Overall, a framework offers a strategic, measurable and sustainable way to assess health equity action amongst public health organizations.[7]

Methods:

Research was undertaken at Lambton Public Health [LPH] to develop a conceptual framework that outlines key elements of capacity building needed to drive equity action at the local level.

This research was conducted in **4 main phases**:

1. The identification of current evidence supporting health equity action at individual, organizational and systems levels
2. The operationalization of the evidence through the development of a conceptual framework that will provide the foundation for building organizational capacity for equity action at LPH
3. The development of a corresponding assessment tool to enable LPH to assess our capacity against elements of the framework
4. The implementation of the assessment tool with all LPH teams to develop capacity building action plans for health equity, and work towards achieving Lambton Public Health's vision of equity in the 2014-2019 Strategic Plan **(LPH, 2014)**

A grounded theory approach, based heavily on the work of Brofenbrenner's ecological framework for human development and other socio-ecological models, was used to inform the various levels of influence on health equity action. This involved an extensive review of both grey and peer-reviewed published literature assisted by the observations and experiences of the author in practice.

Most of the literature reviewed was taken from the disciplines of public health, health promotion, public administration, and non-profit/service organizations. These disciplines, in particular, offered the greatest insight for quantifying organizational capacity measures for equity action given the many similarities in structure and function compared to public health.

The purpose of the literature review was two-fold:

- To identify the need, challenges and opportunities for developing a framework for organizational capacity for equity action
- To identify definitions of critical capacity building elements and strategies that have been successfully used in other research that can be adapted for facilitating health equity action

Keyword searches in electronic journal databases included Web of Science, PubMed, CINAHL, as well as the internet search engine Google to yield both peer-reviewed literature and grey literature specific to building organizational capacity for equity action within Canada, and within or related to the Public Health field. A custom search engine was used for both Canadian Public Health information and Ontario Public Health Unit Websites. International documents were also retrieved from credible and well known public health organizations, such as the World Health Organization, and Center for Disease Control.

The search strategy was conducted in three phases. The first phase involved searching for environmental scans or research highlighting the challenges and opportunities for health equity action in public health. This phase was guided by expert knowledge of existing scans from credible sources such as the National Collaborating Center for Determinants of Health, and the World Health Organization. The second phase involved using common capacity related search terms, such as 'capacity', capacity-building', 'organizational capacity', and 'capacity development', to identify relevant peer-reviewed literature. The third phase was informed by the literature found in the first two phases of searching, and included more specific capacity-related terms such as leadership, communication, workforce development, partnerships, governance, healthy public policy, health equity, and community development.

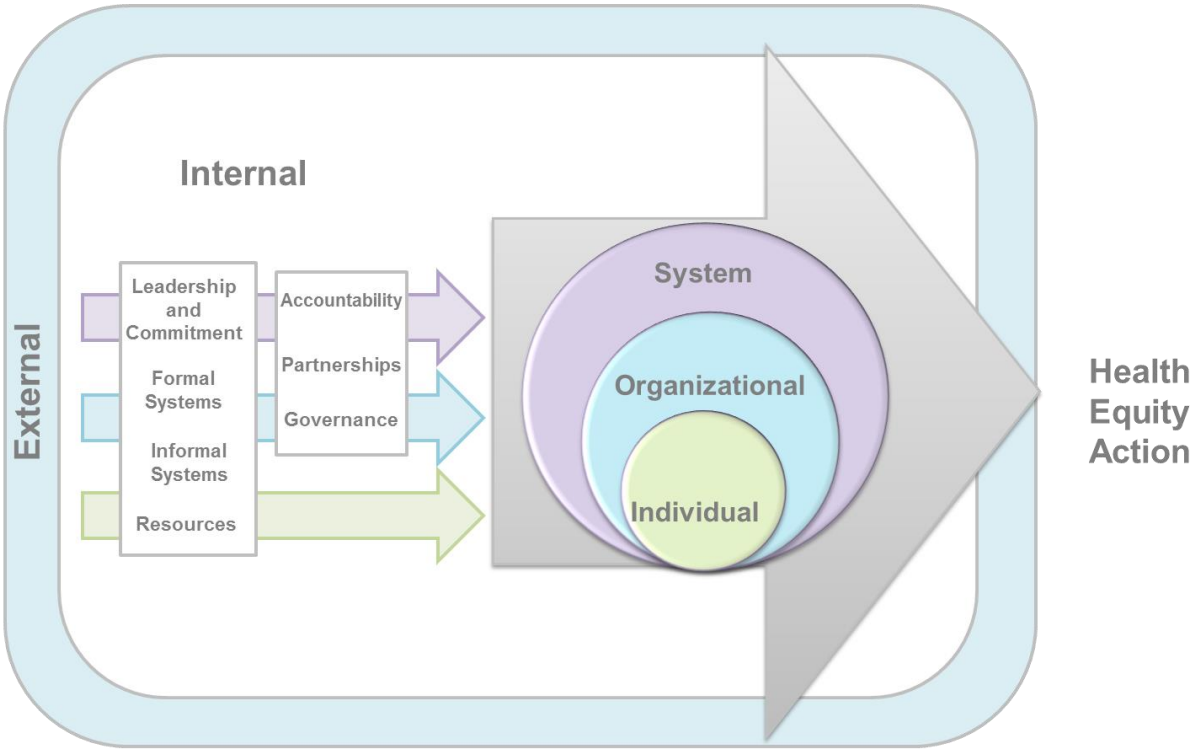
In addition to a non-exhaustive review of scholarship, key informant interviews with Senior Managers at LPH, as well as with public health nurses working in dedicated social determinant of health positions across South-western Ontario were consulted in order to validate the framework and inform needed changes. This step was helpful in both generating new insights and testing the proposed framework to identify any problems.

Results

Building on the work of Bronfenbrenner and other socio-ecological models, the framework illustrates the importance of considering individual capacity for health equity within a dynamic, embedded system characterized by the interrelatedness of multiple levels of influence.

The framework (figure one) attempts to capture the many dimensions of public health practice by specifically identifying two broad drivers of capacity for equity action: those internal to organizations, and those external to organizations.

Figure one: Organizational Capacity: A Conceptual Framework for Health Equity Action in Public Health



Both internal and external drivers are composed of unique **elements** that represent both tangible and intangible influences that can enhance or limit an organization's capacity for health equity action.

Internal Drivers:

The internal drivers capture the processes, knowledge and resources of an organization, and can be categorized according to three levels of influence:

- *Individual level* - refers to the characteristics of individuals within the organization that enable them to take action (i.e. congruence of personal values with that of social justice, professional background and expertise, professional goals, freedoms and constraints of their professional roles, skills and experience, access to resources, knowledge of community issues, and relations with other staff and management)
- *Organizational level* - refers to the processes and structures within an organization that serve to embed equity action into the mandate of the organization, and creates a culture that shapes the ability of individuals to identify health inequities and create opportunities to take effective action.
- *Structural level* - composed of the organizational policies, modes of governance, and decision making systems that affect the organization's (including individuals within the organization) capacity to take effective action.

The three levels are dynamic, and interact with each other and the broader macro-environment (external drivers).

Overall, the main internal drivers consist of seven elements. Four of these seven elements are common to all three levels of influence, including:

- Leadership and Commitment
- Formal Systems
- Informal Systems
- Resources

Potential sub-elements for measurement were also identified (see box 1.1)

Box 1.1: Elements and sub-elements common across individual, organizational, and systems level of influence.

Leadership and commitment	Formal Systems	Informal Systems	Resources
• Mission, vision, values • Dedicated health equity champions • Change management	• Organizational standards (policies, guidelines, accountability agreements) • Organizational structures (staff with sufficient time, funding and materials) • Workforce and human resources • Fiscal and economic resources	• Intra-organizational relations • Organizational culture and history • Perceptions of staff, leadership, senior-level decision makers re roles/responsibilities for health equity • Motivation for accountability and efficiency	• Knowledge and skill of staff and leaders • Knowledge management of health equity research, data, and tools •Support for innovation and core competency acquisition

The remaining three elements pertain only to the organizational and system levels:

- Accountability
- Governance and Decision-making
- Partnerships

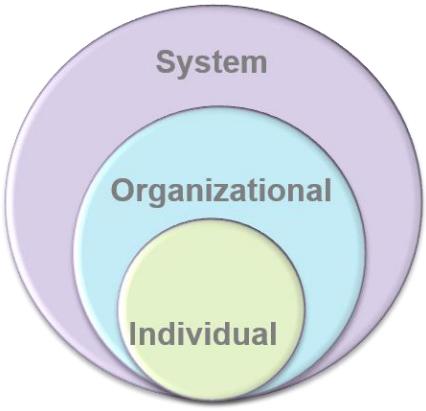
Potential sub-elements for measurement were also identified (see box 1.2)

Box 1.2: Elements and sub-elements common between organizational and systems level of influence

Accountability	Governance and Decision-making	Partnerships
• Quality improvement processes and performance measures • Capacity assessment indicators • Population health status reporting structures/processes	• Reporting relations with board of health • Changes in Leadership • Governance structure and decision-making • Advocacy tensions for PH based on governance structure • Geopolitical jurisdiction, boundaries and size	• Community partners and relations • Level of social participation, engagement and advocacy from community members • Inter-organizational and intersectoral partners and relations

As depicted in the framework, the system level encircles the organizational level, which then encircles the individual level (figure 2):

Figure 2: Levels of Influence for Health Equity Action



The three levels were depicted in this way to highlight two things:

- the inter-dependence of the elements within each level of influence;
- and the amount of influence each level has when considering the bigger picture of health equity work (individual is smaller, where system is larger)

For example, at the individual level, the skills and enthusiasm for health equity approaches are of limited use if the processes and infrastructure both within the organization and the system it must operate, are not in place. And while various champions can exist within the organization, their influence alone will not produce the same results as if leaders within the management of the organization and key decision makers within the system do not have 'buy-in', or do not devote resources. On the other hand, the system is unable to produce equitable health outcomes if the organizations and individuals operating within the system lack the necessary competencies and motivation to influence decisions made at the organizational and system level.

External Drivers:

The external drivers represent the contextual influences that promote or limit the uptake of health equity as a priority in the wider health, socio-economic and political systems. The elements that make up the external drivers have an indirect effect on organizational performance and capacity for equity action, and include:

- Current and historical macro-economic, social and public policies
- Perceived threats to health
- Epidemiological conditions
- Public support and trust
- Political will
- Best available evidence of the time

Overall, capacity for equity action is strengthened when these individual elements, sub-elements, and their interactions, are increased.

Elements and sub-elements within the Framework

As depicted in the framework, seven main elements exist that if present, act as internal drivers towards building organizational capacity for equity action.

Below is a summary of each element. For a more detailed description of each element, see **Appendix A.**

Element 1: Leadership and Commitment

Research has shown that leadership is the most critical organizational driver in enabling health equity action, and that such leadership support can be accomplished in three ways:

- Reflecting a commitment to health equity through the mission, vision and values of their organization
- Dedicating staff leaders (formal and informal) to become health equity champions
- Having leaders demonstrate support for health equity initiatives through effective change management processes

Element 2: Formal Systems

In addition to showing strong leadership, Canadian health sector organizations that have successfully implemented a health equity approach have established health equity as a priority through their formal systems, including:

- Organizational standards - institutional mandates such as the OPHS, strategic plans, guiding documents (e.g. core competencies for public health), and best or promising practices.
- Organizational structures - structures that enable equity considerations to be part of planning, evaluation, reporting and funding decisions; structures that enable collaboration (e.g. working groups), and structures that foster an understanding of learning needs

This element is strongly related to the leadership element, as leadership is essential to support the development and use of formal systems

Element 3: Informal Systems

Informal systems represent the informal structures and processes in place to support an organizational culture committed to health equity. Major informal systems consist of intra-organizational relations and the perceptions of staff, leadership and senior-level decision makers regarding their role in health equity.

They also refer to how the organizational culture and history have shaped action on health equity issues, including motivation for accountability and efficiency to reduce health inequities across the population.

Element 4: Resources

Organizational capacity for health equity action can be strengthened through structures that dedicate staff resources to health equity.
This includes providing public health professionals with opportunities to:

- Build on their health equity knowledge and skills through training that is tailored to their own individual needs (e.g. training, conferences, continuing education, etc.)
- Support equity-informed practice through using tools that increase access to research, and the sharing of information across the organization (e.g. file sharing, the hub, the virtual library)
- Drive innovation and core competency acquisition relating to health equity (e.g. developing projects that allow them to develop their competencies in creative ways)

Element 5: Accountability

Public health and its focus on population health and health equity make it a unique part of the health care system. Its focus on disease prevention, health hazards, health protection and health promotion are becoming more widely known.

However, its focus on health equity and SDOH is still minimal and not widely understood to the public. In order to increase visibility of the work we do in health equity, accountability must be enhanced at the organizational and systems level, including all levels of government, different sectors, and community members at large.

In order to do so, organizations and the systems that govern them must identify how equity is reflected through the following accountability measures: quality improvement processes and ways of measuring performance across the organization; capacity assessment indicators, and how we communicate to the community and stakeholders through population health status reporting.

Element 6: Governance and Decision-Making

Government structure heavily influences how much traction public health organizations can gain in equity action. All levels of government are broken down into departments, which manage different aspects of our lives. These departments are presided over by ministers or councilors, who are elected on a limited-term basis to represent our interests. These structures make the enormous task of governing a population possible. However, is makes focusing on upstream, long-term solutions much more difficult.

This means that problems like the 'social determinants of health' that are diffuse, complex and cross over many – if not all – departments of government, are unlikely to gain traction. Instead, they are dismissed as too difficult and risky for governments to tackle. Therefore, governance mechanisms with which public health organizations are part of must foster leadership for health equity through collaborative relations with decision-makers from all sectors, and recommending feasible solutions that are within the decision-makers' capacity to act.

Element 7: Partnerships

In order to guide effective, coordinated action on health equity, an understanding of community partners is essential. This includes familiarizing yourself with the goals of community organizations and coalitions from various sectors and aligning your goals to better influence health equity action.

This also involves understanding the predominant societal values, opinions and norms, whether they align with the values of your organization, and using this knowledge to garner community support for health equity intiatives.

As noted in the framework, each of these elements have sub-elements that can be used as indicators to assess capacity at various levels of influence: individual, organizational, and systems.

In order to assess Lambton Public Health's capacity against the elements of the framework, an assessment tool was developed.

Operationalizing the Conceptual Framework: The Assessment Tool

Goal

Embedding health equity into LPH as more than a value, and rather an actionable objective, has been a significant challenge. While LPH had some tools that measured how health equity is being addressed in our programs and services (e.g. program review - health equity assessment tool, program planning), we needed to understand what conditions and capacities were required to strengthen and support equity action in the first place.

Therefore, once the conceptual framework was complete, LPH developed a practical tool to assess our current level of organizational capacity according to the seven elements of the framework, including the sub-elements. A clear distinction between assessing capacity, not performance, was made during the design of the tool.

The main goal of designing the tool was to provide LPH with a set of criteria to assess:

- Our current capacity to embed health equity into organizational processes and structures
- Areas that need strengthening or further development

The main deliverable would be for each team at LPH to develop capacity building action plans based on priority areas that needed strengthening.

Overall, the assessment tool enabled LPH to assess how we are meeting the health equity requirements under the Ontario Public Health Foundational Standard, and Public Health Core Competencies. It also allowed LPH to begin to operationalize "equity" as one of our 2014-2019 Strategic Plan values.

Using the Tool

This tool was designed to foster organizational learning, sharing and reflection on what capacity is needed for equity action.

The tool consists of 3 checklists that align with three levels of influence on health equity action: individual level, organizational level, and systems level. Each checklist assesses health equity capacity according to some or all of the 7 elements and sub-elements of the Organizational Capacity for Health Equity Action framework. These elements and sub-elements represent the structures and processes that best support public health practice.

Health equity elements:

1. Leadership and Commitment
2. Formal systems
3. Informal systems

4. Resources
5. Accountability
6. Partnerships
7. Governance

Ideally, capacity is strengthened when these elements, or their interactions, are increased. Therefore, it is recommended that the tool be used as an interactive process involving front line practitioner's and management.

At LPH, we used Fluid Survey to enable teams consisting of front-line staff to complete the individual checklist, supervisors to complete the organizational checklist, and managers to complete the systems checklist. Once checklists were completed by each individual, results were examined by the authors according to each team or management group.

Using the Checklists

Within each of the three checklists are the following sections:

- A description of the capacity element being assessed
- An example or definition of the capacity element to provide a reference point and stimulate thinking
- A rating scale with 5 response options from 'strongly agree' to 'strongly disagree', and 'neither agree nor disagree'
- An evidence and comments section that can be used for future review and comparison

See appendix B, C and D for the full version of each checklist, as presented on fluid survey.

The Individual Capacity Checklist:

This checklist is designed to assess individual capacity for health equity action which refers to the characteristics of individuals within the organization that enable them to take action on equity issues. Characteristics include one's values, professional background, skills, experience, access to resources, and knowledge of community issues and whether they align with the goals of health equity work.

The checklist can be used to determine how to strengthen the everyday activities of public health professionals. It is primarily intended to act as an anonymous self-assessment and reflection tool that, once summarized, can be shared with each team during a facilitated priority setting meeting.

The checklist assesses capacity according to the first four elements of the framework (leadership and commitment, formal systems, informal systems and resources), including their sub-elements (30 total).

At LPH, a total of seven teams filled out the individual checklist:

- Child health

- Environmental health
- Dental health
- Reproductive health
- Chronic disease and injury prevention
- Infectious diseases prevention and control
- Central resources

*See **appendix B** for full version of the individual capacity checklist, including examples and definitions of each question.*

Element 1: Leadership and commitment

Sub-element: Mission, vision, values:

- I integrate the LPH value of equity into my public health practice
- I reduce barriers that prevent priority populations from accessing our programs and services

Sub-element: dedicated health equity champions

- I have advocated for greater health equity in my community
- I have identified and worked with local priority populations
- I am aware of how to access the SDOH nurses for support

Sub-element: change management

- I have advocated for needed changes to programs, policies and/or services to improve the health of priority populations
- I prioritize program activities according to the changing health needs of priority populations
- I have handled situations where public health interventions aimed at improving health outcomes for priority populations did not fit with societal norms and/or created controversy.

Element 2: Formal Systems

Sub-element: organizational standards

- I have a clear understanding of what the Ontario Public Health Standards say about health equity in order to guide my practice
- I plan and set priorities within my area of practice according to the equity foundations in the OPHS

Sub-element: organizational structures

- I have opportunities to collaborate with other program areas internally to develop shared health equity goals and objectives
- I have developed and practiced skills related to planning that is focused on health equity
- I have developed and practiced skills related to evaluation that is focused on health equity

- I have developed and practiced skills related to reporting that is focused on health equity

Sub-element: workforce development and human resources

- I have assessed my learning needs regarding health equity practice with my supervisor

Sub-element: fiscal and economic resources

- I have expressed the need for re-orientation of funding in programs and services to better meet the need of priority populations

<u>Element 3</u>: Informal Systems

Sub-element: intraorganizational relations

- I have informal conversations with colleagues to brainstorm ideas for interventions that may work with priority populations

Sub-element: organizational culture and history

- I believe health equity is a priority that is supported and encouraged by LPH staff
- I believe health equity is a priority that is supported and encouraged by LPH management

Sub-element: perceptions of staff regarding roles/responsibilities for health equity

- I have supportive colleagues who understand the value of health equity work
- I am encouraged to learn and be creative in my role to improve health outcomes for priority populations

Sub-element: Motivation for accountability, effectiveness, and efficiency

- I have taken initiative on leading projects focused on health equity

<u>Element 4</u>: Resources

Sub-element: knowledge and skill of staff

- I understand the concept of health equity
- I understand how the social determinants of health affect population health outcomes in my community
- I analyze public health issues across population groups, not just individuals, to inform program planning

Sub-element: knowledge mangaement of health equity research, data and tools

- I access and gather evidence relating to health equity and the social determinants of health to guide my practice
- I collect relevant data about the SDOH to inform my practice

Sub-element: support for innovation and core competency aqcuisition

- I have adequate time to engage in health equity promoting practice
- I have discussed health equity issues with my professional community of practice

- I have increased my knowledge about health equity and the social determinants of health through professional development opportunities

The Organizational Capacity Checklist:

This checklist was designed to assess organizational capacity for health equity, which refers to the processes and structures that serve to embed equity action into the mandate of the organization, thereby enabling individuals to identify health equity issues and take effective action.

The checklist can be used as a way to strengthen the processes and structures that shape how individuals within the organization practice. It was primarily intended to act as an anonymous self-assessment and reflection tool that the SDOH nurses can share with each team during a facilitated priority setting meeting.

The **organizational capacity checklist** assesses capacity according to all seven elements of the framework (leadership and commitment, formal systems, informal systems, resources, accountability, governance and decision-making and partnerships) including their sub-elements. The checklist has 54 questions total.

At LPH, six supervisors completed this checklist.

*See **appendix C** for fluid survey version of the organizational capacity checklist, including examples and definitions of each question.*

Element 1: Leadership and Commitment

Sub-element: mission, vision, values

- I integrate the LPH value of equity into my public health practice
- I understand the need to prioritize public health interventions that aim to reduce health inequities

Sub-element: dedicated health equity champions

- I have clearly stated my vision and commitment to health equity
- I have staff who advocate for greater health equity in our community

Sub-element: change management

- I have advocated for needed changes to programs, policies and services to improve the health of priority populations
- I have adapted my program delivery according to the changing health needs in the community
- I have handled situations where interventions aimed at improving health outcomes for priority populations did not fit with societal norms.
- I encourage staff to reflect upon how their own mental models about health equity and priority populations may enhance or limit action

Element 2: Formal Systems

Sub-element: organizational standards

- I have a clear understanding of what the Ontario Public Health Standards say about health equity in order to guide my program/service delivery decisions
- I plan and set priorities with staff according to the equity foundations in the OPHS *(need, impact, capacity, partnership and collaboration)*

Sub-element: organizational structures

- I have opportunities to collaborate with other program supervisors/managers internally to develop shared health equity goals and objectives
- I have developed and practiced skills related to equity-focused planning
- I have developed and practiced skills related to equity-focused evaluation
- I have developed and practiced skills related to equity-focused reporting

Sub-element: workforce and human resources

- I have given staff opportunities to assess their learning needs regarding health equity practice
- I have given staff opportunities to monitor their progress towards improvement in their health equity learning needs

Sub-element: fiscal and economic resources

- I have reoriented funding for programs within my team to better meet the needs of priority populations

Element 3: Informal Systems

Sub-element: intra-organizational relations

- I have informal conversations with colleagues about experiences working with priority populations
- I have informal conversations with colleagues to brainstorm ideas for interventions that may work with priority populations

Sub-element: organizational culture and history

- I believe health equity is a priority that is supported and encouraged by LPH staff
- I believe health equity is a priority that is supported and encouraged by LPH management

Sub-element: perceptions of leadership re roles/responsibilities for health equity

- I have supportive colleagues who value health equity work
- I generate and use evidence about priority population needs to inform program and service delivery

Sub-element: motivation for accountability, effectiveness and efficiency

- I have expressed my ideas to prioritize projects focused on health equity

- I have taken initiative on leading projects focused on health equity
- I encourage staff to use tools that support the routine consideration of health equity in the planning and evaluation of public health programs and services

Element 4: Resources

Sub-element: knowledge and skill of leaders

- I understand the concept of health equity
- I understand how the social determinants of health affect population health outcomes in my community
- I prioritize program and service delivery based on the needs of priority populations in my community
- I analyze public health issues across population groups, not just individuals, to inform program and service delivery

Sub-element: knowledge management of health equity research, data and tools

- I access relevant data about the impact of the SDOH on priority populations to inform program/service delivery decisions

Sub-element: support for innovation and core competency acquisition

- I have access to professional development opportunities to increase my knowledge about health equity and the SDOH
- I give staff adequate time to engage in health equity promoting practice
- I encourage staff to develop and improve upon core competencies specific to equity in their public health practice
- I have discussed health equity issues with my professional community of practice

Element 5: Accountability

Sub-element: quality improvement processes and performance measures

- I have access to quality improvement tools or supports that allow me to monitor outcomes related to equity action
- I monitor evidence of changed program implementation based on recommendations made from equity assessment tools

Sub-element: capacity assessment measures

- I have a mechanism to measure what staff in my program need to improve performance on health equity action

Sub-element: population health status reporting structures/processes

- I identify how my programs/services are meeting the requirements of the OPHS equity foundations when reporting to stakeholders
- I report on the health status of priority populations according to my program standards and protocols

Element 6: Governance and Decision-making

Sub-element: relations with the board of health

- I work in collaboration with the board of health to address the health needs of priority populations
- I understand what motivates members of the board of health, so that I am better able to frame health equity issues
- I am able to communicate health equity issues to the board of health in clear, concise manner

Sub-element: changes in leadership and decision-making structures

- I understand the decision-making structures that the board of health rely on and use them to advance equity action
- I encourage members of different government departments to collaborate on health equity issues and other public health priorities
- I work with public health colleagues to educate new members of government (at the municipal, provincial, or federal level) about long-term commitments to maintain momentum on health equity initiatives

Sub-element: geopolitical jurisdiction, boundaries and size

- I recommend feasible solutions for health equity issues that are within the government's capacity to act
- I recognize the importance of increasing public awareness of health equity issues in order to drive community demand for change in municipal public policy

Element 7: Partnerships

Sub-element: community partners and relations

- I collaborate with community stakeholders/coalitions to influence the social determinants of health, and advocate for healthy public policy
- I involve stakeholders in decision-making processes about future program or service delivery changes impacting priority populations

***Sub-element: l*evel of social participation, engagement and advocacy from community members**

- I am aware of community values, opinions, and norms
- I use community values, opinions and norms to point to initiatives most likely to garner support and engagement, and influence decision-maker priorities
- I engage priority populations in the planning and evaluation of programs, policies and services

Sub-element: inter-organizational and inter-sectoral partners and relations

- I collaborate with community organizations from all sectors to implement initiatives that advance action on health equity issues

The System's Capacity Checklist:

This checklist was designed to assess systems-level capacity for health equity, including organizational policies, modes of governance and decision-making systems that affect the organization's (and individuals within the organization) capacity to take effective equity action.

It was primarily intended to act as an anonymous self-assessment and reflection tool that can be shared with the management team during a facilitated priority setting meeting.

The checklist assesses capacity according to all seven elements of the framework (leadership and commitment, formal systems, informal systems, resources, accountability, governance and decision-making and partnerships) including their sub-elements. This checklist has 56 questions total.

At LPH, the checklist was completed by team members of the Office of the Medical Officer of Health [OMOH] team (four individuals) and two managers.

*See **Appendix D** for fluid survey version of the system's capacity checklist, including examples and definitions of each question.*

Element 1: Leadership and Commitment

Sub-element: mission, vision, values

- I integrate the LPH value of equity into my public health practice
- I understand the need to prioritize public health interventions that aim to reduce health inequities

Sub-element: dedicated health equity champions

- I have clearly stated my vision and commitment to health equity
- I have staff and/or supervisors who advocate for greater health equity in our community

Sub-element: change management

- I have advocated for needed changes to programs, policies and services to improve the health of priority populations
- I have adapted my program delivery according to changing health needs in the community
- I am prepared to handle situations where new evidence about health equity interventions challenges the status quo
- I encourage staff to reflect upon how their own mental models about health equity and priority populations may enhance or limit

Element 2: Formal Systems

Sub-element: organizational standards

- I have a clear understanding of what the Ontario Public Health Standards say about health equity in order to guide my program/service delivery decisions

- I plan and set priorities with staff according to the equity foundations in the OPHS *(need, impact, capacity, partnership and collaboration)*

Sub-element: organizational structures

- I have opportunities to collaborate with other program supervisors/managers internally to develop shared health equity goals and objectives
- I have developed and practiced skills related to equity-focused planning
- I have developed and practiced skills related to equity-focused evaluation
- I have developed and practiced skills related to equity-focused reporting
- I have restructured staff positions in my department to reflect the changing health needs of priority populations

Sub-element: workforce and human resources

- I have encouraged supervisors in my department to assess staff learning needs regarding health equity practice
- I have encouraged supervisors in my department to monitor their staff member's progress toward improvement in their health equity learning needs

Sub-element: fiscal and economic resources

- I have integrated health equity needs of priority populations into my departments annual budget
- I have reoriented funding for programs/services within my department to better meet the needs of priority populations

Element 3: Informal Systems

Sub-element: intra-organizational relations

- I have informal conversations with colleagues about decision-making processes related to the health needs of priority populations
- I have informal conversations with colleagues to brainstorm ideas for interventions that may work with priority populations

Sub-element: organizational culture and history

- I believe health equity is a priority that is supported and encouraged by LPH staff
- I believe health equity is a priority that is supported and encouraged by the board of health and other county decision-makers/stakeholders

Sub-element: perceptions of senior-level decision-makers, re roles/responsibilities for health equity

- I have supportive colleagues who value health equity work
- I generate and use evidence about priority population needs to inform program and service delivery

Sub-element: motivation for accountability, effectiveness and efficiency

- I have expressed my ideas to prioritize projects focused on health equity

- I have taken initiative on leading projects focused on health equity
- I encourage the board of health to consider health equity in decision-making processes that impact population health
- I encourage public health and community partners to consider health equity in decision-making processes that impact population health

Element 4: Resources

Sub-element: knowledge and skill of senior-level decision makers

- I understand the concept of health equity
- I understand how the social determinants of health affect population health outcomes in my community
- I prioritize program and service delivery based on the needs of priority populations in my community
- I influence decision-making processes by using the concept of health equity to explain population health outcomes

Sub-element: knowledge management of health equity research, data and tools

- I access relevant data about the impact of the SDOH on priority populations to inform funding/policy decisions

Sub-element: support for innovation and core competency acquisition

- I have increased my knowledge about health equity and the SDOH through professional development opportunities
- I encourage supervisors to develop and improve upon core competencies specific to equity in their own and their staff member's public health practice
- I have discussed health equity issues with my professional community of practice

Element 5: Accountability

Sub-element: quality improvement processes and performance measures

- I believe organizational standards and accountability agreements from public health governing authorities reflect equity-based public health practice
- I have access to quality improvement tools or supports that allow me to monitor outcomes in my department related to equity action
- I ensure commitments to improve health equity in my community are followed up on

Sub-element: capacity assessment measures

- I have a mechanism to measure what my program/department needs to improve performance on health equity action

Sub-element: population health status reporting structures/processes

- I report on the health status of priority populations according to my program standards and protocols
- I influence political will to act on equity issues by using reports to advocate for a health in all policies approach

Element 6: Governance and Decision-making

Sub-element: relations with the board of health

- I work in collaboration with the board of health to address the health needs of priority populations
- I understand what motivates members of the board of health, so that I am better able to frame health equity issues
- I am able to communicate health equity issues to the board of health in a clear, concise manner

Sub-element: changes in leadership and decision-making structures

- I understand the decision-making structures that the board of health rely on and use them to advance equity action
- I encourage members of different government departments to collaborate on health equity issues and other public health priorities
- I work with public health colleagues to educate new members of government (at the municipal, provincial, or federal level) about long-term commitments to maintain momentum on health equity initiatives

Sub-element: geopolitical jurisdiction, boundaries and size

- I recommend feasible solutions for health equity issues that are within the government's capacity to act
- I recognize the importance of increasing public awareness of health equity issues in order to drive community demand for change in municipal public policy

Element 7: Partnerships

Sub-element: community partners and relations

- I collaborate with community stakeholders/coalitions to influence the social determinants of health, and advocate for healthy public policy
- I involve stakeholders in decision-making processes about future program or service delivery changes impacting priority populations

Level of social participation, engagement and advocacy from community members

- I am aware of community values, opinions, and norms
- I use community values, opinions and norms to point to initiatives most likely to garner support and engagement, and influence decision-maker priorities
- I engage priority populations in the planning and evaluation of programs, policies and services

Inter-organizational and inter-sectoral partners and relations

- I collaborate with community organizations from all sectors to implement initiatives that advance action on health equity issues

Scoring the responses:

The raw data report from Fluid Survey provided us with team responses for each question of the corresponding checklist they were to fill out. We assigned a numerical value to each of the 5 response options for each question to represent either low or high capacity (1 being the lowest amount of capacity, and 5 being the highest amount of capacity):

- Strongly agree = 5
- Agree = 4
- Neither agree nor disagree = 3
- Disagree = 2
- Strongly disagree = 1

An average score for each question in the checklist was obtained. We then took the average score of each element, by summing the score for all questions within the element, and dividing by the number of questions for each element.

Each team ended up with four to seven scores, depending on the checklist they filled out. For example, the individual checklist only assessed the first four elements of capacity. Therefore staff on each team had four main scores. The organizational and systems checklists assessed all seven elements of capacity, and therefore the supervisor team and OMOH/manager team ended up with seven main scores.

The average scores for each element were then plotted onto the arms of a "spidergram" model (Prairie Region Health Promotion Research Center, 2011) that enabled us to visually assess each team's health equity capacity (see figure 3 and 4 for examples). The visual allows teams to discern both strengths and weaknesses easily, identify areas for improvement, and re-assess health equity capacity at a later date.

Figure 3: *Example of a Spidergram model from the individual checklist*

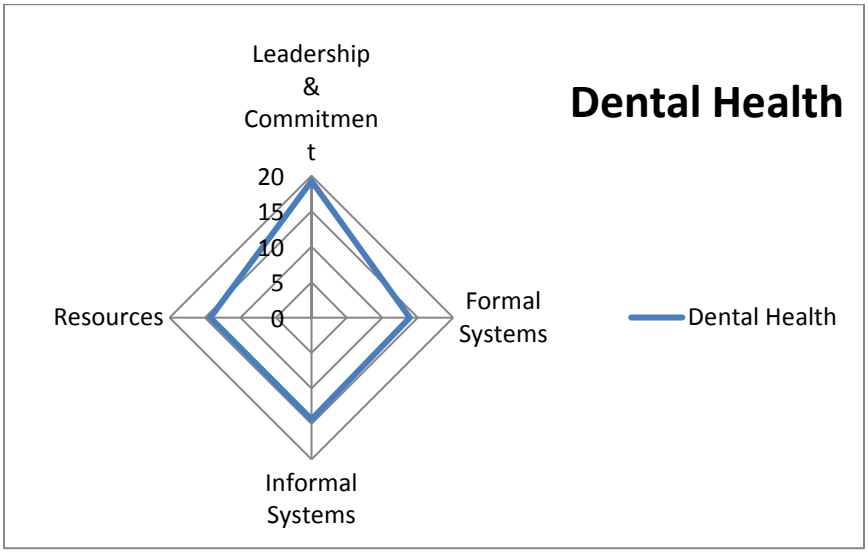


Figure 4: *Example of a Spidergram model from the organizational checklist*

Once the scores were calculated for each team, the authors met to review the scores against the raw data, which provided us with the valuable remarks from the comments/evidence section. When this section was filled out well, it provided us with the rationale for some of the responses. At times, it demonstrated that even though an individual answered “disagree” for a particular question, their responses may have demonstrated that they do in fact have capacity in that area and vice versa. Similarly, the evidence and comments section also allowed us to see where people may have responded high capacity, yet the responses contradicted the response option selected.

While a definite limitation, we welcomed this subjectivity into the analysis of the results, as we know that health equity language and concepts aren’t always fully understood, even though people action the work every day.

Meeting with Teams to review results and develop action plans

The authors reviewed scores for each team and identified their strongest elements of capacity, and elements that needed the most strengthening using a common evaluation template to guide the discussion (see **Appendix E**). Through this process, we brainstormed recommendations for each team which mainly focused on the areas of capacity that required strengthening.

Subsequent to these meetings, summary reports were written for each team using a strengths-based approach (see **Appendix F**). Within the report, a summary of their scores for each element was provided, including their spidergram. Below the scores, a definition for each element was provided, followed by a description of the questions they ranked highest in based on their scores and comments from the evidence/comments section of the assessment tool. The recommendations created were meant to be suggestions for how they could improve their

capacity. Once the reports were complete, we met first with the manager and supervisor of each team to present the summary report. The purpose of that meeting was to identify which recommendations are most feasible, and determine how they would like us to follow up with their staff.

Moving forward, the goal will be to share the results of the report, and recommendations with each team, walk them through a priority setting exercise, and empower them to select on recommendation they would like to implement, with an action plan detailing how they plan to achieve it.

Assessment tool: Implementation timeline at LPH

The following timeline was used to implement the assessemnt tool at LPH:

October-December 2015

- All three checklists were focus tested by selected staff and management. Edits and changes were made suggestions

January 2016:

- Presented the framework and tool to LPH management team and were given full support to proceed with developing an implementation plan
- Identified a team willing to pilot the tool
- Implementation schedule was developed based on program demands and each team's capacity to complete the checklists. For example, we needed to ensure the Environmental Health team could complete the tool before the end of April due to the demands of water, vector borne diseases, rabies and community events.

Feburary 2016:

- The framework and assessment tool were presented during an all staff public health rounds presentation. We provided an overview of how the tool was developed, how it will inform health equity action at LPH and proposed implementation plan.
- Meetings with teams during team meetings were subsequently held to provide more detail of how and when to compete the assessment tool

March 2016

- We took a pause to conduct a process evaluation after implementing the tool with a few teams. Some small modifications were made to the tool, such as eliminatin similar questions, or re-wording questions that may not have been clearly understood or defined

April – August 2016

- SDOH nurses launched the tool with the remaining teams and provided ongoing consultation support as needed

September – December 2016

- We completed tool summary reports for each team and held meetings with each team's supervisor and manager. During these meetings, we discussed recommendations and considered what was feasible/realistic. We also received a commitment to address some of the recommendations moving forward with the team

January 2017:

- Once all team summaries have been completed, our team will conduct an outcome evaluation the tool's effectiveness in assessing our organizational capacity for health equity action at LPH.

Applications and limitations of the tool:

While some definitions and clarifications for statements were provided, there was an assumed level of knowledge and familiarity with the basic health equity concepts. Therefore, somewhat experienced practitioners, managers and decision-makers benefitted most from using the tool. We decided not to ask administrative professional staff to fill out the individual checklist, with the goal of eventually creating a more appropriate assessment tool for their role within LPH. The following professionals did complete the assessment tool: public health nurses, public health inspectors, health promoters, dieticians, public health nutritionists, consultants, management, and our Medical Officer of Health.

Inter-rater reliability was an important issue to consider. In order to ensure the rater was being honest, responses remained anonymous, and the rater was encouraged to fill out the evidence/comments section to demonstrate how they've met or did not meet each question.

It is expected that information from the checklist be used to define issues, gaps and possible actions. It is recommended that each team reviews the issues and recommendations with the SDOH nurses, and build on the suggested actions through the development of an action plan to define feasibility, next steps, responsibilities, timeframes, and resource needs. This is important, as individual practitioners may find they do not know the complete organizational or systemic context. Similarly, managers and decision-makers may not understand the breadth and depth of responsibilities and activities the individual is engaged in.

Finally, the tool can be used as a baseline assessment, which, coupled with an action plan can be monitored and evaluated. Over time, the tool can be repeated such as through an annual review of practice (performance appraisal), review of organizational change, or an environmental scan of health equity capacity.

In the future, it is our hope that we can encourage our board of health to also complete the systems checklist to provide a fuller appreciation of LPH's capacity.

Discussion

Using the assessment tool has provided LPH with a snapshot of our current capacity, which can be monitored and evaluated over time.

The process of completing summary reports from the assessment tool, and meeting with each team has directly informed Lambton Public Health's SDOH nurse role for the next few years. The SDOH PHNs now have planned and meaningful connections with teams, in ways that were identified as needed and supported by management. In addition to identifying actionable recommendations for each team, we also noted consistent areas needing strengthening across teams, lending to the need to roll certain recommendations out across the whole organization.

Some important lessons were learned throughout the process that is noteworthy for any organization wanting to adapt the tool for their own use:

1. The examples used were helpful for most staff, however, some staff responses in the comments/evidence section responded to the example provided, providing us with a narrow lens of their capacity for that question.
2. The comments and evidence section, while at times tended to be based on the example provided, were invaluable in providing a rationale for some of the responses.
3. Through our pilot process, we learned that reviewing the results initially with teams, without reviewing feasibility of recommendations with supervisors and managers first, created some challenges gaining buy-in. We also changed the style of reporting the results to teams from discussing areas that needed strengthening only (which created defensiveness), to writing a strengths-based report which outlined both areas of highest capacity and recommendations for strengthening area of lower capacity
4. Staff perception and how much they valued health equity as core to their role influenced how they responded to the checklist greatly. It was clear that if people didn't perceive they had a role to play in health equity action, they likely didn't complete the tool in a meaningful way. Therefore, those individuals may have slightly skewed the results for that team.

Conclusion

Public Health is well positioned to mediate the relationship between systems that create health inequities and capacity required to act on them. The framework highlights the complexity and interdependence of the elements involved in building organizational capacity for equity action. The assessment tool may serve to guide other public health organizations in applying a strategic approach to health equity by identifying facilitators and barriers to organizational capacity that can be improved upon, monitored and evaluated over time. Both resources force

organizations to build up the infrastructure and set the context for change related to promoting health equity action.

If implemented effectively and monitored over time, capacity for health equity will gradually become a standard feature of public health practice.

Ultimately, the implementation of this framework and assessment tool in public health units must be complemented with the following overarching recommendations, if we are to truly move towards a public health system that effectively engages in health equity action:

Individual level:

- Identify and mobilize leaders within the organization to champion health equity action
- Motivate and hold staff accountable to acquiring the skills and competencies for health equity action
- Promote ongoing learning opportunities to increase clarity about the SDOH and health equity action
- Promote community leadership for equity action, especially among priority populations, through social marketing and public awareness campaigns

Organizational level:

- Create an organizational culture and mandate supportive of equity values and goals that is reflected in the processes and structures of the organization, and held accountable at the highest level of leadership
- Sustain and increase allocation of funding for equity-integrated initiatives
- Strengthen equity-oriented health information systems through improved collection, analysis, and reporting of socio-demographic and other health data from population subgroups.
    - i.e. Develop indicators to assess current capacity and monitor capacity over time within public health organizations (see *appendix B*)
    - i.e. Identify ways to collect better data on social conditions and institutional factors
- Enhance infrastructure for knowledge exchange related to health equity and the social determinants of health within public health and between public health partners
- Add explicit language about health equity into the public health core competencies for all public health practitioners in Canada
- Develop standards to guide the integration of equity into population health status reports for health units in Ontario

Systems level:

- Focus efforts on strengthening relationships with local decision-makers, politicians, boards of health, and other sectors in order to get health equity issues on their agendas

- Enable and empower "policy entrepreneurs" to communicate effectively on issues that improve equity
- Develop an advocacy framework for different public health governing structures to clarify professional boundaries, establish a role for health equity advocacy

In conclusion, successfully implementing the framework and assessment tool will require incremental effort, adaptability, on-going resource investments, and awareness of how the strategy is affecting stakeholder groups. The importance of building motivation across the organization and public health system to champion the needed capacity building efforts cannot be overlooked. Efforts must focus on gaining buy-in from health equity champions, staff, and dedicated leaders internal and external to the organization to support and sustain an effective approach to capacity building for health equity.

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Appendix A: Detailed Description of Each Element and Sub-element

ADD MORE HERE

1. Leadership and Commitment

Great variability in leadership support for equity action exists in Canada (NCCDH, 2010; NCCDH, 2014; PHAC, 2012, Senge et al. 2014). A common barrier cited that limited efforts for health equity action included a lack of political support (mostly provincial/territorial or federal) preventing public health leaders from focusing on more upstream interventions aiming to address the structural determinants of health inequities.

This holds true in Ontario, where the perceived lack of political support further impacts action to advance health equity by creating a disconnect between the apparent leadership commitment reflected in the Ontario Public Health Foundational Standard (2011) and tangible supports. However, having a backbone institution, such as PHU's, take the lead in coordinating health equity action was identified as very important in fostering support for health equity across sectors.

Public health Units who were considered early adopters in fostering strong leadership support for equity action accomplished this through three key sub-elements:

- Dedicating staff leaders (formal and informal) to become health equity champions
- Reflecting a commitment to health equity through the mission, vision and values of their organization; and
- Having leaders demonstrate support for health equity initiatives through effective change management processes

From this research, it became clear that leadership is the most critical internal driver in enabling action to reduce health inequities across individual, organizational, and systemic levels of influence.(NCCDH, 2010; Public Health Agency of Canada, 2008).

The following section outlines the three sub-elements for leadership according to all three levels of influence:

Individual level

Dedicated HE Champions:

Dedicated champions and informal staff leaders exist to support the development of champion behaviours among other staff and build organizational capacity to adopt new or complex interventions for health equity (REFERENCE 1). Health equity champions are vital in attaining "buy-in" from senior leaders to ensure they understand their role in reducing health inequities,

and enhance the leadership, commitment and support for health equity initiatives (Peirson, Ciliska, Dobbins, and Mowat (2012).

While health equity champions have always existed in public health, increasing the visibility and accessibility to such personnel is linked to improving an organization's capacity (NCCDH, 2014). For example, the SDOH nurse initiative in Ontario led to the establishment of organizational processes, structures, and communities of practice for health equity (NCCDH, 2014). Having this commitment so far has been attributed to increased capacity for public health action at the organizational and municipal level; however the level of commitment varies heavily between organizations due to variability in leadership support across each health unit. Therefore, a need exists to "level and scale up" existing actions taking place among organizations considered to be early adopters.

Mission, Vision, Values:

Addressing health equity is of central importance to the mission of public health, and is not meant to be a luxury on top of all the other work we do. Individuals within the organization must reflect a shared understanding of this mission, including the need to prioritize conditions and places, over individual risk factors and specific diseases.

Change Management:

Champion behaviours for health equity that individual leaders can foster include persistence in overcoming challenges with implementation, and the desire to spread enthusiasm for innovation throughout the organization. (REFERENCE 1)

It often takes time to build an organizational culture supportive of health equity. For example, many SDOH public health nurses have indicated that their influence has slowly started to encourage staff to think more deeply about how their programs are being delivered – this wisdom will only expand and grow over time, it is not expected to change overnight.

Organizational level

Dedicated HE Champions:

A strong, credible leader at the highest level of the organization must champion health equity initiatives by clearly stating their vision and commitment to health equity. They must also hold staff and senior leaders accountable to reducing health inequities.

Champions at this level are known to be adept at combining a foundation in science with "innovative social strategy, abundant political will, and supreme interpersonal skill" (PHAC, 2014)

Mission, Vision, Values:

When a leader includes equity in the organizations strategic mission, vision or values, greater outcomes in reducing health inequity can be achieved. It provides a focal point for collaboration,

and fosters a culture supportive of health equity action (PHAC, 2014). Momentum can then be leveraged when formal leaders establish mechanisms to pursue the objectives of health equity work that enable organizations to operationalize equity as part of the mission, vision or values. E.g. stable funding and allocation of staff resources.

In turn, those mechanisms can enable health equity leaders or champions to emerge and flourish. For example, SDHU's MOH and CEO conveyed an expectation for health equity to be built through investments in knowledge development, planning, tools, and staffing. Today, this health unit is recognized as an early adopter and leader in health equity. (PHAC 2014 REFERENCE)

Change Management:

Because taking on a health equity approach can be a strategic and complex task, strong champions and leaders within the organization must make long-term change processes explicit to staff at the individual level, and decision-makers and community members at the systems level. Such a process ensures a common agenda for health equity is shared and continuous communication is fostered.

For example, Alberta Health Services identified HE champions among its senior leadership, including MOH's. One result of their efforts so far was to designate MOH's as spokespeople to explain health inequities to staff and the public as health status reports are released. They also engage with leaders in other sectors to create a common understanding of the impact of social conditions on health, and on the sustainability of the health care sector (PHAC 2014 REFERENCE). As initiatives are implemented, change should be allowed to occur organically, and leaders must be adaptable and responsive to emerging and anticipated needs, challenges and opportunities.

Systems level

Dedicated HE Champions:

Senior leaders such as the board of health demonstrate commitment to health equity by extending their influence through new and existing partnerships with decision-makers, community members and other sectors.

Mission, Vision, Values:

Senior leaders who shape the systems within which PH organizations work have the potential to prioritize health equity as part of the mission of public health. In fact, senior leaders who perceive they do and can impact health inequities within their jurisdiction perform higher related to supporting health equity action within the organization (

In addition to showing strong leadership, Canadian health sector organizations that have successfully implemented a health equity approach have established a health equity priority through the institutional mandates, strategic plans, guidance documents and other means. Doing so signals its importance within the corporate culture by creating buy-in and

endorsement, and providing focused actions that contribute to strategic directions for health equity (PHAC, 2014)

Change Management:

This is demonstrated when senior leaders are able to adapt to the changing landscape of health equity evidence, especially when it challenges the values and opinions of the status quo. For example, Saskatoon's chief MOH fostered a strong evidence base regarding health disparities and used it to nurture community support – their health disparities report was widely disseminated. (PHAC 2014 REFERENCE). Senior leaders wanting to prioritize health equity action set performance expectations with governing authorities and decision-makers, like the board of health, including clear governing and policy roles related to health equity (e.g. HIA's for any new project that may impact community health) (PHAC, 2014)

Problems like poverty and health inequities require unprecedented collaboration among different organizations and sectors, and as a result, the need for systems leaders has never been more important. Senge et al (2014) explain that a systems leader is able to "catalyze and guide systemic change at a scale commensurate with the scale of problems we face (e.g. health inequity), and all of us see but dimly". System leaders hold **3 core capabilities** that allow them to build a shared understanding of complex problems and ultimately foster collective leadership.

1. The ability to see the larger system - this understanding enables collaborating organizations to jointly develop solutions not evident to any of them individually and to work together for the health of the whole system rather than just pursue symptomatic fixes to individual pieces

2. Fostering reflection and more generative conversations that result in truly innovative solutions - involves encouraging others to appreciate how their own mental models may limit action. Deep shared reflection enables groups of organizations and individuals to actually "hear" differing points of view and to appreciate emotionally and cognitively each other's reality. This is an essential doorway for building trust and collective creativity

3. The ability to shift the focus from reactive problem solving to co-creating the future - change often starts with conditions that are undesirable, but artful system leaders help people move beyond just reacting to those problems to building positive visions for the future (e.g. scenario planning). This shift involves not just building inspiring visions, but facing difficult truths about how to ease the tension between vision and reality to inspire truly new approaches (e.g. implementing a framework for assessing organizational capacity for health equity will allow us to get a baseline of what we want aka our vision, given what we have to work with aka our current reality/capacity. This process aims to inspire innovation in the way we address health equity at LPH.

Appendix B:
The assessment tool: individual checklist

Section one

Introduction

This checklist was created to provide Lambton Public Health with a way to assess our current capacity to embed health equity into the work we do.

Within the checklists are statements that you will examine one by one. Please answer whether you *strongly agree, agree, neither agree nor disagree, disagree, or strongly disagree*.

The goal of the checklist is to understand what your team's capacity needs for health equity are, and how they can be supported. It is not designed to judge your team's performance.

Therefore, please be as honest as you can. The "evidence" section is optional. However we encourage you to use it to explain your response or provide examples where relevant.

Additional notes:

- The checklist should take approximately 1 hour to complete.
- Responses are anonymous (they will be aggregated into a team result)
- You can save your responses and return to the survey at any time
- If you encounter any difficulty, or have questions, contact Karolyn LaCroix (ext. 3616), Victoria Morris (ext. 3642), or Giovanna Good (ext. 3618).

Thank you for your participation!

Section two

This checklist has 30 questions total that are designed to assess individual capacity for health equity.

Individual capacity for health equity refers to the characteristics of individuals within the organization that enable them to take action on equity issues. Characteristics include one’s values, professional background, skills, experience, access to resources, and knowledge of community issues, and whether they align with the goals of health equity work.

Section three

LEADERSHIP AND COMMITMENT

1. **I integrate the LPH value of equity into my public health practice.**
   - ☐ Strongly disagree
   - ☐ Disagree
   - ☐ Neither agree nor disagree
   - ☐ Agree
   - ☐ Strongly agree

Definition/example:
In our 2014-2019 strategic plan, we stated that in order to value equity, we must "aim to reduce barriers to that all people can achieve their full health potential"

In the Public Health Core Competencies (2008), equity was also described as "an important value in public health…rooted in an understanding of the broad determinants of health…"

Evidence/Comments:

2. **I reduce barriers that prevent priority populations from accessing our programs and services**
   - ☐ Strongly disagree
   - ☐ Disagree
   - ☐ Neither agree nor disagree
   - ☐ Agree
   - ☐ Strongly agree

Definition/example:
You identify that your client didn't have transportation to attend a follow-up rabies appointment at LPH. What would you do to overcome this barrier?

Evidence/Comments:

3. I have advocated for greater health equity in my community

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Neither agree nor disagree
- ☐ Agree
- ☐ Strongly agree

Definition/example:
Health equity means that all people can reach their full health potential and should not be disadvantaged from attaining it because of their race, ethnicity, religion, gender, age, social class, or other socially determined circumstance.
We can achieve health equity by ensuring the fair distribution of resources, fair access to opportunities that support health, and fairness in how we support people when ill.

While LPH strives to improve health outcomes for all population groups, the pursuit of health equity seeks to reduce the excess burden of ill health among populations who are most socially and economically disadvantaged (referred to as priority populations).

Evidence/Comments:

4. I have identified and worked with local priority populations

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Neither agree nor disagree
- ☐ Agree
- ☐ Strongly agree

Definition/example:
Being able to identify and work with local priority populations involves understanding that some population groups are less healthy than others not because of personal choice, but because of poorer social, economic and environmental circumstances that they experience over the course of their lives.

Understanding how to overcome those circumstances that are preventing them from reaching their full health potential is crucial to allowing priority populations to experience the same level of health as the general population.

Evidence/Comments:

5. **I am aware of when and how to access the social determinant of health nurses for support**
    - ☐ Strongly disagree
    - ☐ Disagree
    - ☐ Neither agree nor disagree
    - ☐ Agree
    - ☐ Strongly agree

Definition/example:
Research has demonstrated that champion behaviours among staff can be supported by informal staff leaders with experience in health equity advocacy.

Evidence/Comments:

6. **I have advocated for needed changes to programs, polices and services to improve the health of priority populations**
    - ☐ Strongly disagree
    - ☐ Disagree
    - ☐ Neither agree nor disagree
    - ☐ Agree
    - ☐ Strongly agree

Definition/example:
For example, during the program review process, you developed a recommendation to reorient the way services are currently delivered in order to better meet the needs of your identified priority population

Evidence/Comments:

7. **I prioritize program activities according to the changing health needs of priority populations**
    - ☐ Strongly disagree

☐ Disagree
☐ Neither agree nor disagree
☐ Agree
☐ Strongly agree

Definition/example:
You learn that transgendered men are at increased risk of domestic violence; however your program only screens women. Therefore, you look at best practices and work with your team to develop a new policy that screens for transgendered men.

Evidence/Comments:

8. I have handled situations where public health interventions aimed at improving health outcomes for priority populations did not fit with societal norms, and/or created controversy.

☐ Strongly disagree
☐ Disagree
☐ Neither agree nor disagree
☐ Agree
☐ Strongly agree

Definition/example:
A major challenge in applying public health interventions with priority populations is the negative moral evaluation, or stigma, attached to those who appear to lack control over their life situations.[7] This societal assessment is amplified when the behaviour is also illegal, such as in the case of drug use. This aspect introduces confusion over what equity promoting public health interventions aim to achieve, and controversy regarding their value to the rest of society. [7]

Harm reduction programs, such as needle exchange, are a perfect example of a controversial issue. Being able to explain their purpose (to reduce harm to vulnerable individuals where stopping drug use isn't possible, and prevent them from transmitting serious infections to the community at large) is an important skill.

Evidence/Comments:

FORMAL SYSTEMS

9. **I have a clear understanding of what the Ontario Public Health Standards say about health equity in order to guide my practice**
    - ☐ Strongly disagree
    - ☐ Disagree
    - ☐ Neither agree nor disagree
    - ☐ Agree
    - ☐ Strongly agree

Definition/example:
The standards indicate that "action on health inequities are operationalized predominantly through work on 'priority populations' defined as 'those populations that are at risk and for whom public health interventions may be reasonably considered to have substantial impact at the population level"

Evidence/Comments:

10. **I plan and set priorities within my area of practice according to the equity foundations in the Ontario Public Health Standards**
    - ☐ Strongly disagree
    - ☐ Disagree
    - ☐ Neither agree nor disagree
    - ☐ Agree
    - ☐ Strongly agree

Definition/example:
For example, you use epidemiology and other methods to gather information to identify priority populations. You examine the accessibility of your existing programs and services to reduce barriers. You plan, deliver, manage and evaluate programs to reduce health inequities. You share knowledge about the health issues faced by priority populations and collaborate with partners to reduce health inequities.

Evidence/Comments:

11. **I have opportunities to collaborate with other program areas internally to develop shared health equity goals and objectives**
    - ☐ Strongly disagree
    - ☐ Disagree
    - ☐ Neither agree nor disagree
    - ☐ Agree
    - ☐ Strongly agree

Definition/example:
Opportunities may exist through: public health rounds, webinars, training/education, joint planning processes with other teams, or sharing information at team meetings

Evidence/Comments:

12. **I have developed and practiced skills related to planning that is focused on health equity**
    - ☐ Strongly disagree
    - ☐ Disagree
    - ☐ Neither agree nor disagree
    - ☐ Agree
    - ☐ Strongly agree

Definition/example:
For example, you've participated in program planning, operational planning or strategic planning where health equity needs of priority populations were considered.

Evidence/Comments:

13. **I have developed and practiced skills related to evaluation that is focused on health equity**
    - ☐ Strongly disagree
    - ☐ Disagree
    - ☐ Neither agree nor disagree
    - ☐ Agree

☐ Strongly agree

Definition/example:
For example, you've completed the health equity assessment tool during program review, or used other tools to evaluate your program activities. You've ensured priority populations were considered in the development of your evaluation plan.

Evidence/Comments:

14. I have developed and practiced skills related to reporting that is focused on health equity

☐ Strongly disagree
☐ Disagree
☐ Neither agree nor disagree
☐ Agree
☐ Strongly agree

Definition/example:
For example, you've contributed evidence (e.g. statistics, literature, experiential/practical knowledge, etc.) related to the impact of your program/service on the health of priority populations when submitting reports to the board of health or to other important stakeholders

Evidence/Comments:

15. I have assessed my learning needs regarding health equity practice with my supervisor

☐ Strongly disagree
☐ Disagree
☐ Neither agree nor disagree
☐ Agree
☐ Strongly agree

Definition/example:
For example, during performance appraisals or as a result of completing program review

Evidence/Comments:

☐ Strongly disagree
☐ Disagree
☐ Neither agree nor disagree
☐ Agree
☐ Strongly agree

Definition/example:
For example, through discussions with your team and supervisor, through involvement in strategic planning, and/or through program review recommendations

Evidence/Comments:

INFORMAL SYSTEMS

17. I have informal conversations with colleagues to brainstorm ideas for interventions that may work with priority populations

☐ Strongly disagree
☐ Disagree
☐ Neither agree nor disagree
☐ Agree
☐ Strongly agree

Definition/example:
N/A

Evidence/Comments:

18. I believe health equity is a priority that is supported and encouraged by LPH staff

☐ Strongly disagree

☐ Disagree
☐ Neither agree nor disagree
☐ Agree
☐ Strongly agree

Definition/example:
N/A

Evidence/Comments:

19. I believe health equity is a priority that is supported and encouraged by LPH management

☐ Strongly disagree
☐ Disagree
☐ Neither agree nor disagree
☐ Agree
☐ Strongly agree

Definition/example:
N/A

Evidence/Comments:

20. I have supportive colleagues who understand the value of health equity work

☐ Strongly disagree
☐ Disagree
☐ Neither agree nor disagree
☐ Agree
☐ Strongly agree

Definition/example:
N/A

Evidence/Comments:

21. I am encouraged to learn and be creative in my role to improve health outcomes for priority populations

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Neither agree nor disagree
- ☐ Agree
- ☐ Strongly agree

Definition/example:
N/A

Evidence/Comments:

22. I have taken initiative on leading projects focused on health equity

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Neither agree nor disagree
- ☐ Agree
- ☐ Strongly agree

Definition/example:
N/A

Evidence/Comments:

RESOURCES

23. I understand the concept of health equity

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Neither agree nor disagree
- ☐ Agree
- ☐ Strongly agree

Definition/example:
N/A

Evidence/Comments:

24. I understand how the social determinants of health affect population health outcomes in my community

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Neither agree nor disagree
- ☐ Agree
- ☐ Strongly agree

Definition/example:
N/A

Evidence/Comments:

25. I analyze public health issues across population groups, not just individuals, to inform program planning

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Neither agree nor disagree
- ☐ Agree
- ☐ Strongly agree

Definition/example:
N/A

Evidence/Comments:

26. I access and gather evidence relating to health equity and the social determinants of health to guide my practice

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Neither agree nor disagree
- ☐ Agree
- ☐ Strongly agree

Definition/example:
N/A

Evidence/Comments:

27. I collect relevant data about the social determinants of health to inform my practice

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Neither agree nor disagree
- ☐ Agree
- ☐ Strongly agree

Definition/example:
N/A

Evidence/Comments:

28. I have adequate time to engage in health equity promoting practice

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Neither agree nor disagree
- ☐ Agree
- ☐ Strongly agree

Definition/example:
N/A

Evidence/Comments:

29. I have discussed health equity issues with my professional community of practice

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Neither agree nor disagree
- ☐ Agree
- ☐ Strongly agree

Definition/example:
Examples include your southwest public health unit network, or your professional advocacy body such as the RNAO (Registered Nurses association of Ontario)

Evidence/Comments:

30. I have increased my knowledge about health equity and the social determinants of health through professional development opportunities

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Neither agree nor disagree
- ☐ Agree
- ☐ Strongly agree

Definition/example:
Examples include attending Bridges out of Poverty, or other related workshops or conferences

Evidence/Comments:

Appendix C:
The assessment tool: organizational checklist

Section one

Introduction

This checklist was created to provide Lambton Public Health with a way to assess our current capacity to embed health equity into the work we do.

Within the checklists are statements that you will examine one by one. Please answer whether you *strongly agree, agree, neither agree nor disagree, disagree, or strongly disagree*.

The goal of the checklist is to understand what your team's capacity needs for health equity are, and how they can be supported. It is not designed to judge your team's performance.

Therefore, please be as honest as you can. The "evidence" section is optional. However we encourage you to use it to explain your response or provide examples where relevant.

Additional notes:

- The checklist should take 1-2 hours to complete.
- Responses are anonymous (they will be aggregated into a team result)
- You can save your responses and return to the survey at any time
- If you encounter any difficulty, or have questions, contact Karolyn LaCroix (ext. 3616), Victoria Morris (ext. 3642), or Giovanna Longo (ext. 3618).

Thank you for your participation!

Section two

This checklist has 54 indicators total that are designed to assess organizational capacity for health equity.

Organizational capacity for health equity refers to the processes and structures that embed equity action into the mandate of the organization, thereby enabling individuals to identify health equity issues and take effective action.

Section three

1. **I integrate the LPH value of equity into my public health practice.**
    - ☐ Strongly disagree
    - ☐ Disagree
    - ☐ Neither agree nor disagree
    - ☐ Agree

☐ Strongly agree

Definition/example:
In our 2014-2019 strategic plan, we stated that in order to value equity, we must "aim to reduce barriers to that all people can achieve their full health potential"

In the Public Health Core Competencies (2008), equity was also described as "an important value in public health…rooted in an understanding of the broad determinants of health…"

Evidence/Comments:

2. I understand the need to prioritize public health interventions that aim to reduce health inequities

☐ Strongly disagree
☐ Disagree
☐ Neither agree nor disagree
☐ Agree
☐ Strongly agree

Definition/example:
Health equity means that all people can reach their full health potential and should not be disadvantaged from attaining it because of their race, ethnicity, religion, gender, age, social class, or other socially determined circumstance.
We can achieve health equity by ensuring the fair distribution of resources, fair access to opportunities that support health, and fairness in how we support people when ill.

While LPH strives to improve health outcomes for all population groups, the pursuit of health equity seeks to reduce the excess burden of ill health among populations who are most socially and economically disadvantaged (referred to as priority populations).

Evidence/Comments:

3. I have clearly stated my vision and commitment to health equity

☐ Strongly disagree
☐ Disagree

☐ Neither agree nor disagree
☐ Agree
☐ Strongly agree

Definition/example:
For example, Alberta health services identified health equity champions among its management team, including the Medical Officer of Health. One result of their efforts was to designate one manager as a spokesperson to explain health inequities to staff and the public as health status reports are released. They also engage with leaders in other sectors to create a common understanding of the impact of social conditions on health, and on the sustainability of the health care sector.

Evidence/Comments:

4. I have staff who advocate for greater health equity in our community

☐ Strongly disagree
☐ Disagree
☐ Neither agree nor disagree
☐ Agree
☐ Strongly agree

Definition/example:
Research has demonstrated that champion behaviours among staff can be supported by formal and informal staff leaders with experience in health equity advocacy.

Evidence/Comments:

5. I have advocated for needed changes to programs, polices and services to improve the health of priority populations

☐ Strongly disagree
☐ Disagree
☐ Neither agree nor disagree
☐ Agree
☐ Strongly agree

Definition/example:
Being able to identify and work with local priority populations involves understanding that some population groups are less healthy than others not because of personal choice, but because of poorer social, economic and environmental circumstances that they experience over the course of their lives.

Understanding how to overcome those circumstances that are preventing them from reaching their full health potential is crucial to allowing priority populations to experience the same level of health as the general population.

Evidence/Comments:

6. **I have adapted my program delivery according to the changing health needs in the community**
   - ☐ Strongly disagree
   - ☐ Disagree
   - ☐ Neither agree nor disagree
   - ☐ Agree
   - ☐ Strongly agree

Definition/example:
For example, during the program review process, you developed a recommendation to reorient the way services are currently delivered in order to better meet the needs of your identified priority population

Evidence/Comments:

7. **I have handled situations where interventions aimed at improving health outcomes for priority populations did not fit with societal norms**
   - ☐ Strongly disagree
   - ☐ Disagree
   - ☐ Neither agree nor disagree
   - ☐ Agree
   - ☐ Strongly agree

Definition/example:
A major challenge in applying public health interventions with priority populations is the negative moral evaluation, or stigma, attached to those who appear to lack control over their life situations.[7] This societal assessment is amplified when the behaviour is also illegal, such as in the case of drug use. This aspect introduces confusion over what equity promoting public health interventions aim to achieve, and controversy regarding their value to the rest of society. [7]

Harm reduction programs, such as needle exchange, are a perfect example of a controversial issue. Being able to explain their purpose (to reduce harm to vulnerable individuals where stopping drug use isn't possible, and prevent them from transmitting serious infections to the community at large) is an important skill.

Evidence/Comments:

8. I encourage staff to reflect upon how their own mental models about health equity and priority populations may enhance or limit action

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Neither agree nor disagree
- ☐ Agree
- ☐ Strongly agree

Definition/example:
Take for example access to services for LGBTQ community members. While societal trends indicate we are more accepting of the LGBTQ community, personal values may sometimes conflict with organizational values of being a safe space for members of this community

Evidence/Comments:

9. I have a clear understanding of what the Ontario Public Health Standards say about health equity in order to guide my program and service delivery decisions

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Neither agree nor disagree
- ☐ Agree

☐ Strongly agree

Definition/example:
The standards indicate that "action on health inequities are operationalized predominantly through work on 'priority populations' defined as 'those populations that are at risk and for whom public health interventions may be reasonably considered to have substantial impact at the population level"

Evidence/Comments:

10. I plan and set priorities with staff according to the equity foundations in the Ontario Public Health Standards

☐ Strongly disagree
☐ Disagree
☐ Neither agree nor disagree
☐ Agree
☐ Strongly agree

Definition/example:
According to the 4 principles of need, impact, capacity, partnership and collaboration (respectively) you:

- *Use epidemiology and other methods to gather information to identify priority populations*
- *Examine the accessibility of your existing programs and services to reduce barriers*
- *Plan, deliver, manage and evaluate programs to reduce health inequities*
- *Share knowledge about the health issues faced by priority populations and collaborate with partners to reduce health inequities*

Evidence/Comments:

11. I have opportunities to collaborate with other program supervisors/managers internally to develop shared health equity goals and objectives

☐ Strongly disagree
☐ Disagree
☐ Neither agree nor disagree

☐ Agree
☐ Strongly agree

Definition/example:
Opportunities to collaborate on shared health equity goals and objectives could occur through organized events such as joint manager/supervisor meetings, public health rounds, webinars, training/education, or joint planning processes (e.g. hold meetings with other managers/ supervisors to identify shared goals)

Evidence/Comments:

12. I have developed and practiced skills related to equity-focused planning

☐ Strongly disagree
☐ Disagree
☐ Neither agree nor disagree
☐ Agree
☐ Strongly agree

Definition/example:
For example, you've participated in program planning, human resource planning, operational planning or strategic planning where health equity needs of priority populations were considered

Evidence/Comments:

13. I have developed and practiced skills related to equity-focused evaluation

☐ Strongly disagree
☐ Disagree
☐ Neither agree nor disagree
☐ Agree
☐ Strongly agree

Definition/example:
For example:

- *You've assisted your team in completing the health equity assessment tool during the program review process*
- *You've used other tools to evaluate programs or activities related to health equity, such as Health Impact Assessments or Health Equity Impact Assessments*
- *You've ensured priority populations were considered in the development of your evaluation plan*

Evidence/Comments:

14. I have developed and practiced skills related to equity-focused reporting

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Neither agree nor disagree
- ☐ Agree
- ☐ Strongly agree

Definition/example:
For example, you've included evidence relating to the impact of your program/service on the health of priority populations when submitting reports to the board of health or to other important stakeholders

Evidence/Comments:

15. I have given staff opportunities to assess their learning needs regarding health equity practice

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Neither agree nor disagree
- ☐ Agree
- ☐ Strongly agree

Definition/example:

For example, you integrate conversations about health equity practice into performance appraisals, and/or discuss at update meetings with staff.

Evidence/Comments:

16. I have given staff opportunities to monitor their progress towards improvement in their health equity learning needs

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Neither agree nor disagree
- ☐ Agree
- ☐ Strongly agree

Definition/example:
For example, you:

- *encourage staff to complete the core competencies self-assessment tool*
- *add equity learning needs into performance appraisal action plan*
- *encourage staff to outline equity learning needs in their discipline-specific Quality Assurance requirements*

Evidence/Comments:

17. I have reoriented funding for programs/services within my team to better meet the needs of priority populations

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Neither agree nor disagree
- ☐ Agree
- ☐ Strongly agree

Definition/example:
For example, the decision to reorient funding was made through discussions with staff and the management team, through involvement in strategic planning, and/or through program review recommendations

Evidence/Comments:

INFORMAL SYSTEMS:

18. I have informal conversations with colleagues about experiences working with priority populations

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Neither agree nor disagree
- ☐ Agree
- ☐ Strongly agree

Definition/example:
N/a

Evidence/Comments:

19. I have informal conversations with colleagues to brainstorm ideas for interventions that may work with priority populations

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Neither agree nor disagree
- ☐ Agree
- ☐ Strongly agree

Definition/example:
N/A

Evidence/Comments:

20. I believe health equity is a priority that is supported and encouraged by LPH staff

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Neither agree nor disagree
- ☐ Agree
- ☐ Strongly agree

Definition/example:
N/A

Evidence/Comments:

21. I believe health equity is a priority that is supported and encouraged by LPH management

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Neither agree nor disagree
- ☐ Agree
- ☐ Strongly agree

Definition/example:
N/A

Evidence/Comments:

22. I have supportive colleagues who value of health equity work

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Neither agree nor disagree
- ☐ Agree
- ☐ Strongly agree

Definition/example:
N/A

Evidence/Comments:

23. I generate and use evidence about priority population needs to inform program and service delivery

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Neither agree nor disagree
- ☐ Agree
- ☐ Strongly agree

Definition/example:
For example, searching the literature, conducting situational assessments and literature reviews

Evidence/Comments:

24. I have expressed my ideas to prioritize projects focused on health equity

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Neither agree nor disagree
- ☐ Agree
- ☐ Strongly agree

Definition/example:
N/A

Evidence/Comments:

25. I have taken initiative on leading projects focused on health equity

- ☐ Strongly disagree

☐ Disagree
☐ Neither agree nor disagree
☐ Agree
☐ Strongly agree

Definition/example:
N/A

Evidence/Comments:

26. I encourage staff to use tools that support the routine consideration of health equity in the planning/evaluation of public health programs and services

☐ Strongly disagree
☐ Disagree
☐ Neither agree nor disagree
☐ Agree
☐ Strongly agree

Definition/example:
For example: health equity impact assessments, LPH's program review health equity assessment, consultation with SDOH nurses during program planning, etc.

Evidence/Comments:

RESOURCES

27. I understand the concept of health equity

☐ Strongly disagree
☐ Disagree
☐ Neither agree nor disagree
☐ Agree
☐ Strongly agree

Definition/example:
N/A

Evidence/Comments:

28. I understand how the social determinants of health affect population health outcomes in my community

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Neither agree nor disagree
- ☐ Agree
- ☐ Strongly agree

Definition/example:
N/A

Evidence/Comments:

29. I prioritize program and service delivery based on the needs of priority populations in my community

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Neither agree nor disagree
- ☐ Agree
- ☐ Strongly agree

Definition/example:
N/A

Evidence/Comments:

30. I analyze public health issues across population groups, not just individuals, to inform program and service delivery

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Neither agree nor disagree
- ☐ Agree
- ☐ Strongly agree

Definition/example:
N/A

Evidence/Comments:

31. I access relevant data about the impact of the social determinants of health on priority populations to inform program and service delivery decisions

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Neither agree nor disagree
- ☐ Agree
- ☐ Strongly agree

Definition/example:
N/A

Evidence/Comments:

32. I have access to professional development opportunities to increase my knowledge about health equity and the social determinants of health

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Neither agree nor disagree
- ☐ Agree
- ☐ Strongly agree

Definition/example:
For example: conferences, webinars and training

Evidence/Comments:

33. I give staff adequate time to engage in health equity promoting practice

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Neither agree nor disagree
- ☐ Agree
- ☐ Strongly agree

Definition/example:
N/A

Evidence/Comments:

34. I encourage staff to develop and improve upon core competencies specific to equity in their public health practice

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Neither agree nor disagree
- ☐ Agree
- ☐ Strongly agree

Definition/example:
N/A

Evidence/Comments:

35. I have discussed health equity issues with my professional community of practice

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Neither agree nor disagree
- ☐ Agree
- ☐ Strongly agree

Definition/example:
Examples include your southwest public health managers group, or your professional advocacy body such as the Registered Nurses association of Ontario, HPO, OPHA, AIPHA, etc.

Evidence/Comments:

ACCOUNTABILITY:

36. I have access to quality improvement tools or supports that allow me to monitor outcomes related to equity action

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Neither agree nor disagree
- ☐ Agree
- ☐ Strongly agree

Definition/example:
N/A

Evidence/Comments:

37. I monitor evidence of changed program implementation based on recommendations made from equity assessment tools

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Neither agree nor disagree
- ☐ Agree

☐ Strongly agree

Definition/example:
For example:

- *follow up on program review equity recommendations with SDOH nurses and/or program review external committee*
- *follow up on findings from a completed health equity impact assessment*

Evidence/Comments:

38. I have a mechanism to measure what staff in my program need to improve performance on health equity action

☐ Strongly disagree
☐ Disagree
☐ Neither agree nor disagree
☐ Agree
☐ Strongly agree

Definition/example:
For example:

- *you follow up with staff who indicate they have learning needs relating to health equity practice during performance appraisals*
- *you conduct needs assessments with staff, etc.*

Evidence/Comments:

39. I identify how my programs/services are meeting the requirements of the OPHS equity foundations when reporting to stakeholders

☐ Strongly disagree
☐ Disagree
☐ Neither agree nor disagree
☐ Agree
☐ Strongly agree

Definition/example:
For example: through ministry reports, board of health committee reports, reports to stakeholders, etc.

Evidence/Comments:

40. I report on the health status of priority populations according to my program standards and protocols

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Neither agree nor disagree
- ☐ Agree
- ☐ Strongly agree

Definition/example:
For example through ministry reports, board of health committee reports or accountability agreements

Evidence/Comments:

GOVERNANCE AND DECISION-MAKING:

41. I work in collaboration with the board of health to address the health needs of priority populations

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Neither agree nor disagree
- ☐ Agree
- ☐ Strongly agree

Definition/example:
N/A

Evidence/Comments:

42. I understand what motivates members of the board of health, so that I am better able to frame health equity issues

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Neither agree nor disagree
- ☐ Agree
- ☐ Strongly agree

Definition/example:
N/A

Evidence/Comments:

43. I am able to communicate health equity issues to the board of health in a clear, concise manner

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Neither agree nor disagree
- ☐ Agree
- ☐ Strongly agree

Definition/example:
N/A

Evidence/Comments:

44. I understand the decision-making structures that the board of heath rely on, and use them to advance equity action

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Neither agree nor disagree
- ☐ Agree
- ☐ Strongly agree

Definition/example:
For example, the County of Lambton's strategic plan, sustainability plan, and budget submission process

Evidence/Comments:

45. I encourage members of different government departments to collaborate on health equity issues and other public health priorities

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Neither agree nor disagree
- ☐ Agree
- ☐ Strongly agree

Definition/example:
The governance mechanisms with which public health organizations are a part of must foster supportive leadership for health equity through organized groups of committees working within or across organizational structures.

For example, Alberta Health Services recently established a Population and Public Health Council, who is committed to promoting health equity. The council aims to facilitate necessary collaboration to address population and public health priorities, and enable realization of established goals and outcomes[9]

Evidence/Comments:

46. I work with public health colleagues to educate new members of government (at the municipal, provincial, or federal level) about long-term commitments to maintain momentum on health equity initiatives

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Neither agree nor disagree
- ☐ Agree
- ☐ Strongly agree

Definition/example:
Since government departments are presided over by ministers/ councilors who are elected on limited-term basis to represent our interests, focusing on long-term solutions is difficult. Therefore, having a way to educate new elected representatives is important.

For example, how is equity action reflected in the board of health orientation, or discussed during meetings with new ministers/councilors?

Evidence/Comments:

47. I recommend feasible solutions for health equity issues that are within the government's capability to act

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Neither agree nor disagree
- ☐ Agree
- ☐ Strongly agree

Definition/example:
The boundaries and size of your jurisdiction must be considered when bringing health equity issues forward, as the scale of the proposed solutions cannot greatly exceed the government's sense of capacity to act

Evidence/Comments:

48. I recognize the importance of increasing public health awareness of health equity issues in order to drive community demand for change in municipal policy

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Neither agree nor disagree
- ☐ Agree
- ☐ Strongly agree

Definition/example:
For example, municipal governments provide a favourable setting for the development of healthy public policy, as political commitment is often best gained through building community demand for change.

Offering stories of issues happening within their jurisdiction can sometimes be more powerful than evidence, resulting in greater citizen involvement.

Evidence/Comments:

PARTNERSHIPS:

49. I collaborate with community stakeholders/coalitions to influence the social determinants of health, and advocate for healthy public policy

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Neither agree nor disagree
- ☐ Agree
- ☐ Strongly agree

Definition/example:
For example, familiarity with community organizations already active in advancing health and social equity can also help to identify partners and opportunities for coordination and collaboration

Evidence/Comments:

50. I involve stakeholders in decision-making processes about future program or service delivery changes impacting priority populations

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Neither agree nor disagree
- ☐ Agree
- ☐ Strongly agree

Definition/example:
Involving stakeholders has been noted as an important aspect of community development strategies aimed at reducing health inequities.

Evidence/Comments:

51. I am aware of community values, opinions, and norms

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Neither agree nor disagree
- ☐ Agree
- ☐ Strongly agree

Definition/example:
Public health leaders need to understand their community values, opinions and norms to guide effective action on health equity

Evidence/Comments:

52. I use community values, opinions and norms to point to health equity initiatives most likely to garner support and engagement, and influence decision-makers priorities

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Neither agree nor disagree
- ☐ Agree
- ☐ Strongly agree

Definition/example:
For example, you learn that your local community values the importance of providing all children, especially those from food insecure families, with access to affordable, healthy food options in schools.

You therefore engage key influencers from the schools and parent teacher associations to join a committee that will advocate for policies relating to food security in schools, and advocate for support from your local municipality.

Evidence/Comments:

53. I engage priority populations in the planning and evaluation of programs, policies and services

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Neither agree nor disagree
- ☐ Agree
- ☐ Strongly agree

Definition/example:
For example:

- *Involving community members in focus groups, surveys, planning committees*
- *Identifying who the key influencers/ gatekeepers are amongst a particular priority population and interviewing them about the experiences of their community*

Evidence/Comments:

54. I collaborate with community organizations from all sectors to implement initiatives that advance action on health equity issues

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Neither agree nor disagree
- ☐ Agree
- ☐ Strongly agree

Definition/example:
Because the SDOH are so complex, they cut across the domain of many sectors. Therefore, working with leaders of those sectors within your community can greatly advance action on health equity through strengthening how priority populations have access to the determinants of health.

For example, in Saskatoon, public health leaders developed a report on the region's health inequities, and used that as a starting point to increase collaboration with other sectors on issues of shared responsibility and importance

Evidence/Comments:

Appendix D:
The assessment tool: systems checklist

Section One

Introduction

This checklist was created to provide Lambton Public Health with a way to assess our current capacity to embed health equity into the work we do.

Within the checklists are statements that you will examine one by one. Please answer whether you *strongly agree, agree, neither agree nor disagree, disagree, or strongly disagree*.

The goal of the checklist is to understand what the organizations capacity needs for health equity are, and how they can be supported. It is not designed to judge our organization's performance.

Therefore, please be as honest as you can. The "evidence" section is optional. However we encourage you to use it to explain your response or provide examples where relevant.

Additional notes:

- The checklist should take 1-3 hours to complete.
- Responses are anonymous (they will be aggregated into a team result)
- You can save your responses and return to the survey at any time
- If you encounter any difficulty, or have questions, contact Karolyn LaCroix (ext. 3616), Victoria Morris (ext. 3642), or Giovanna Longo (ext. 3618).

Thank you for your participation!

Section two:

This checklist has 56 indicators total that are designed to assess system-level capacity for health equity.

Systems capacity for health equity refers to the organizational policies, modes of governance and decision-making systems that affect the organization's (and individuals within the organization) capacity to take effective equity action.

Section three:

LEADERSHIP AND COMMITMENT

1. **I integrate the LPH value of equity into my public health practice.**
    - ☐ Strongly disagree
    - ☐ Disagree
    - ☐ Neither agree nor disagree
    - ☐ Agree
    - ☐ Strongly agree

Definition/example:
Canadian health sector organizations that have successfully implemented a health equity approach have established a health equity priority through the institutional mandates, strategic plans, guidance documents, and other means. Doing so signals its importance within the corporate culture by creating buy-in and endorsement, and providing focused actions that contribute to strategic directions for health equity[9]

In LPH's 2014-2019 strategic plan, we stated that in order to value equity, we must "aim to reduce barriers to that all people can achieve their full health potential

Evidence/Comments:

2. **I understand the need to prioritize public health interventions that aim to reduce health inequities**
    - ☐ Strongly disagree
    - ☐ Disagree
    - ☐ Neither agree nor disagree
    - ☐ Agree
    - ☐ Strongly agree

Definition/example:
Research has found that senior leaders who perceive they can and do impact health inequities within their program perform higher on health equity outcomes for their priority populations [10]

Definitions:
Health equity means that all people can reach their full health potential and should not be disadvantaged from attaining it because of their race, ethnicity, religion, gender, age, social class, or other socially determined circumstance.

We can achieve health equity by ensuring the fair distribution of resources, fair access to opportunities that support health, and fairness in how we support people when ill.

While LPH strives to improve health outcomes for all population groups, the pursuit of health equity seeks to reduce the excess burden of ill health among populations who are most socially and economically disadvantaged (referred to as priority populations).

Evidence/Comments:

3. I have clearly stated my vision and commitment to health equity

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Neither agree nor disagree
- ☐ Agree
- ☐ Strongly agree

Definition/example:
For example, Alberta health services identified health equity champions among its management team, including the Medical Officer of Health. One result of their efforts was to designate one manager as a spokesperson to explain health inequities to staff and the public as health status reports are released. They also engage with leaders in other sectors to create a common understanding of the impact of social conditions on health, and on the sustainability of the health care sector.

Evidence/Comments:

4. I have staff and/or supervisors who advocate for greater health equity in our community

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Neither agree nor disagree
- ☐ Agree
- ☐ Strongly agree

Definition/example:

Research has demonstrated that champion behaviours among staff can be supported by formal and informal staff leaders with experience in health equity advocacy.

Evidence/Comments:

5. **I have advocated for needed changes to programs, polices and services to improve the health of priority populations**
    - ☐ Strongly disagree
    - ☐ Disagree
    - ☐ Neither agree nor disagree
    - ☐ Agree
    - ☐ Strongly agree

Definition/example:
Being able to identify and work with local priority populations involves understanding that some population groups are less healthy than others not because of personal choice, but because of poorer social, economic and environmental circumstances that they experience over the course of their lives.

Understanding how to overcome those circumstances that are preventing them from reaching their full health potential is crucial to allowing priority populations to experience the same level of health as the general population.

Evidence/Comments:

6. **I have adapted my service area's program delivery according to the changing health needs in the community**
    - ☐ Strongly disagree
    - ☐ Disagree
    - ☐ Neither agree nor disagree
    - ☐ Agree
    - ☐ Strongly agree

Definition/example:

For example, during the program review process, you developed a recommendation to reorient the way services are currently delivered in order to better meet the needs of your identified priority population

Evidence/Comments:

7. **I have handled situations where public health interventions aimed at improving health outcomes for priority populations did not fit with societal norms and/or created controversy**
    - ☐ Strongly disagree
    - ☐ Disagree
    - ☐ Neither agree nor disagree
    - ☐ Agree
    - ☐ Strongly agree

Definition/example:
A major challenge in applying public health interventions with priority populations is the negative moral evaluation, or stigma, attached to those who appear to lack control over their life situations.[7] This societal assessment is amplified when the behaviour is also illegal, such as in the case of drug use. This aspect introduces confusion over what equity promoting public health interventions aim to achieve, and controversy regarding their value to the rest of society. [7]

Harm reduction programs, such as needle exchange, are a perfect example of a controversial issue. Being able to explain their purpose (to reduce harm to vulnerable individuals where stopping drug use isn't possible, and prevent them from transmitting serious infections to the community at large) is an important skill.

Evidence/Comments:

8. **I encourage staff to reflect upon how their own mental models about health equity and priority populations may enhance or limit action**
    - ☐ Strongly disagree
    - ☐ Disagree
    - ☐ Neither agree nor disagree
    - ☐ Agree

☐ Strongly agree

Definition/example:
Take for example access to services for LGBTQ community members. While societal trends indicate we are more accepting of the LGBTQ community, personal values may sometimes conflict with organizational values of being a safe space for members of this community

Evidence/Comments:

FORMAL SYSTEMS

9. I have a clear understanding of what the Ontario Public Health Standards say about health equity in order to guide my program and service delivery decisions

☐ Strongly disagree
☐ Disagree
☐ Neither agree nor disagree
☐ Agree
☐ Strongly agree

Definition/example:
The standards indicate that "action on health inequities are operationalized predominantly through work on 'priority populations' defined as 'those populations that are at risk and for whom public health interventions may be reasonably considered to have substantial impact at the population level"

Evidence/Comments:

10. I plan and set priorities with staff according to the equity foundations in the Ontario Public Health Standards

☐ Strongly disagree
☐ Disagree
☐ Neither agree nor disagree
☐ Agree
☐ Strongly agree

Definition/example:

According to the 4 principles of need, impact, capacity, partnership and collaboration (respectively) you:

- *Use epidemiology and other methods to gather information to identify priority populations*
- *Examine the accessibility of your existing programs and services to reduce barriers*
- *Plan, deliver, manage and evaluate programs to reduce health inequities*
- *Share knowledge about the health issues faced by priority populations and collaborate with partners to reduce health inequities*

Evidence/Comments:

11. I have opportunities to collaborate with other program supervisors/managers internally to develop shared health equity goals and objectives

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Neither agree nor disagree
- ☐ Agree
- ☐ Strongly agree

Definition/example:
Opportunities to collaborate on shared health equity goals and objectives could occur through organized events such as joint manager/supervisor meetings, public health rounds, webinars, training/education, or joint planning processes (e.g. hold meetings with other managers/ supervisors to identify shared goals)

Evidence/Comments:

12. I have developed and practiced skills related to equity-focused planning

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Neither agree nor disagree
- ☐ Agree
- ☐ Strongly agree

Definition/example:

For example, you've participated in program planning, human resource planning, operational planning or strategic planning where health equity needs of priority populations were considered

Evidence/Comments:

13. I have developed and practiced skills related to equity-focused evaluation

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Neither agree nor disagree
- ☐ Agree
- ☐ Strongly agree

Definition/example:
For example:

- *You've assisted your team in completing the health equity assessment tool during the program review process*
- *You've used other tools to evaluate programs or activities related to health equity, such as Health Impact Assessments or Health Equity Impact Assessments*
- *You've ensured priority populations were considered in the development of your evaluation plan*

Evidence/Comments:

14. I have developed and practiced skills related to equity-focused reporting

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Neither agree nor disagree
- ☐ Agree
- ☐ Strongly agree

Definition/example:

For example, you've included evidence relating to the impact of your program/service on the health of priority populations when submitting reports to the board of health or to other important stakeholders

Evidence/Comments:

15. I have encouraged supervisors in my service area to assess their learning needs regarding health equity practice

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Neither agree nor disagree
- ☐ Agree
- ☐ Strongly agree

Definition/example:
For example, you are aware that your supervisors integrate conversations about health equity practice into performance appraisals, and/or discuss learning needs at update meetings with staff.

Evidence/Comments:

16. I have encouraged supervisors in my service area to monitor their staff member's progress towards improvement in their health equity learning needs

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Neither agree nor disagree
- ☐ Agree
- ☐ Strongly agree

Definition/example:
For example, you are aware that your supervisors:

- *encourage staff to complete the core competencies self-assessment tool*
- *add equity learning needs into performance appraisal action plan*
- *encourage staff to outline equity learning needs in their discipline-specific Quality Assurance requirements*

Evidence/Comments:

17. I have integrated the health equity needs of priority populations into my service areas annual budget

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Neither agree nor disagree
- ☐ Agree
- ☐ Strongly agree

Definition/example:
For example, you have set aside funds for services that translate important documents into other languages or transportation vouchers to enable high risk clients to access our programs and services

Evidence/Comments:

18. I have reoriented funding for programs and services within my service area to better meet the needs of priority populations

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Neither agree nor disagree
- ☐ Agree
- ☐ Strongly agree

Definition/example:
For example, through discussions with staff and the management team, through involvement in strategic planning, and/or through program review recommendations

Evidence/Comments:

INFORMAL SYSTEMS:

19. I have informal conversations with colleagues about decision-making processes related to the health needs of priority populations

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Neither agree nor disagree
- ☐ Agree
- ☐ Strongly agree

Definition/example:
N/A

Evidence/Comments:

20. I have informal conversations with colleagues to brainstorm ideas for interventions that may work with priority populations

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Neither agree nor disagree
- ☐ Agree
- ☐ Strongly agree

Definition/example:
N/A

Evidence/Comments:

21. I believe health equity is a priority that is supported and encouraged by LPH staff and management team

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Neither agree nor disagree
- ☐ Agree

☐ Strongly agree

Definition/example:
N/A

Evidence/Comments:

22. I believe health equity is a priority that is supported and encouraged by the board of health and other county decision-makers and stakeholders

☐ Strongly disagree
☐ Disagree
☐ Neither agree nor disagree
☐ Agree
☐ Strongly agree

Definition/example:
N/A

Evidence/Comments:

23. I have supportive colleagues who value of health equity work

☐ Strongly disagree
☐ Disagree
☐ Neither agree nor disagree
☐ Agree
☐ Strongly agree

Definition/example:
N/A

Evidence/Comments:

24. I generate and use evidence about priority population needs to inform program and service delivery needs

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Neither agree nor disagree
- ☐ Agree
- ☐ Strongly agree

Definition/example:
For example, searching the literature, conducting situational assessments and literature reviews

Evidence/Comments:

25. I have expressed my ideas to prioritize projects focused on health equity

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Neither agree nor disagree
- ☐ Agree
- ☐ Strongly agree

Definition/example:
N/A

Evidence/Comments:

26. I have taken initiative on leading projects focused on health equity

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Neither agree nor disagree
- ☐ Agree
- ☐ Strongly agree

Definition/example:
N/A

Evidence/Comments:

27. I encourage the board of health to consider health equity in decision-making processes that impact population health

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Neither agree nor disagree
- ☐ Agree
- ☐ Strongly agree

Definition/example:
For example: health equity impact assessments, providing evidence about health outcomes of priority populations, or using LPH's program review health equity assessment results to communicate issues to the board of health

Evidence/Comments:

28. I encourage public health and community partners to consider health equity in decision-making processes that impact population health

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Neither agree nor disagree
- ☐ Agree
- ☐ Strongly agree

Definition/example:
For example: health equity impact assessments, providing evidence about health outcomes of priority populations, or using LPH's program review health equity assessment results to communicate issues to community partners

Evidence/Comments:

RESOURCES

29. I understand the concept of health equity

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Neither agree nor disagree
- ☐ Agree
- ☐ Strongly agree

Definition/example:
N/A

Evidence/Comments:

30. I understand how the social determinants of health affect population health outcomes in my community

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Neither agree nor disagree
- ☐ Agree
- ☐ Strongly agree

Definition/example:
N/A

Evidence/Comments:

31. I prioritize program and service delivery based on the needs of priority populations in my community

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Neither agree nor disagree
- ☐ Agree
- ☐ Strongly agree

Definition/example:
N/A

Evidence/Comments:

32. I influence decision-making processes by using the concept of health equity to explain population health outcomes

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Neither agree nor disagree
- ☐ Agree
- ☐ Strongly agree

Definition/example:
N/A

Evidence/Comments:

33. I access relevant data about the impact of the social determinants of health on priority populations to inform funding or policy-related decisions

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Neither agree nor disagree
- ☐ Agree
- ☐ Strongly agree

Definition/example:
N/A

Evidence/Comments:

34. I have increased my knowledge about health equity and the social determinants of health through professional development opportunities

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Neither agree nor disagree
- ☐ Agree
- ☐ Strongly agree

Definition/example:
For example: conferences, webinars and training

Evidence/Comments:

35. I encourage supervisors to develop and improve upon core competencies specific to equity in their own and the staff member's public health practice

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Neither agree nor disagree
- ☐ Agree
- ☐ Strongly agree

Definition/example:
N/A

Evidence/Comments:

36. I have discussed health equity issues with my professional community of practice

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Neither agree nor disagree
- ☐ Agree
- ☐ Strongly agree

Definition/example:
Examples include your southwest public health managers group, or your professional advocacy body such as the Registered Nurses association of Ontario, HPO, OPHA, AIPHA, etc.

Evidence/Comments:

ACCOUNTABILITY:

37. I believe organizational standards and accountability agreements from public health governing authorities reflect equity-based public health practice

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Neither agree nor disagree
- ☐ Agree
- ☐ Strongly agree

Definition/example:
N/A

Evidence/Comments:

38. I have access to quality improvement tools or supports that allow me to monitor outcomes in my service area related to equity action

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Neither agree nor disagree
- ☐ Agree

☐ Strongly agree

Definition/example:
N/A

Evidence/Comments:

39. I ensure commitments to improve health equity in my community are followed up on

☐ Strongly disagree
☐ Disagree
☐ Neither agree nor disagree
☐ Agree
☐ Strongly agree

Definition/example:
N/A

Evidence/Comments:

40. I have a mechanism to measure what my service area needs to improve performance regarding health equity action

☐ Strongly disagree
☐ Disagree
☐ Neither agree nor disagree
☐ Agree
☐ Strongly agree

Definition/example:
For example, discussions with supervisors about health equity from staff performance appraisals, understanding results of needs assessments conducted by your supervisor with staff, etc.

Evidence/Comments:

41. I report on the health status of priority populations according to my service areas standards and protocols

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Neither agree nor disagree
- ☐ Agree
- ☐ Strongly agree

Definition/example:
For example through ministry reports, board of health committee reports, accountability agreements or population health status reports.

Population health status reports, in particular, can be used to highlight differences in health outcomes that are due to inequity and inform decisions to reduce health disparities between population sub-groups.[11]

They can also outline implications of health inequities for programs and policies in order to improve programs, re- orient health systems, and generate recommendations for the whole community[11] *Thus, these reports can be used to demonstrate accountability of your organization.*

Evidence/Comments:

42. I influence political will to act on equity issues by using reports that advocate for a health in all policies approach

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Neither agree nor disagree
- ☐ Agree
- ☐ Strongly agree

Definition/example:
According to the World Health Organization (2011), "health in all policies…is one promising approach to enhance accountability in other sectors for health, as well as the promotion of health equity and more inclusive and productive societies".[12]

Evidence/Comments:

GOVERNANCE AND DECISION-MAKING:

43. I work in collaboration with the board of health to address the health needs of priority populations

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Neither agree nor disagree
- ☐ Agree
- ☐ Strongly agree

Definition/example:
N/A

Evidence/Comments:

44. I understand what motivates members of the board of health, so that I am better able to frame health equity issues

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Neither agree nor disagree
- ☐ Agree
- ☐ Strongly agree

Definition/example:
N/A

Evidence/Comments:

45. I am able to communicate health equity issues to the board of health in a clear, concise manner

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Neither agree nor disagree
- ☐ Agree

☐ Strongly agree

Definition/example:
N/A

Evidence/Comments:

46. I understand the decision-making structures that the board of heath rely on, and use them to advance equity action

☐ Strongly disagree
☐ Disagree
☐ Neither agree nor disagree
☐ Agree
☐ Strongly agree

Definition/example:
For example, the County of Lambton's strategic plan, sustainability plan, and budget submission process

Evidence/Comments:

47. I encourage members of different government departments to collaborate on health equity issues and other public health priorities

☐ Strongly disagree
☐ Disagree
☐ Neither agree nor disagree
☐ Agree
☐ Strongly agree

Definition/example:
The governance mechanisms with which public health organizations are a part of must foster supportive leadership for health equity through organized groups of committees working within or across organizational structures.

For example, Alberta Health Services recently established a Population and Public Health Council, who is committed to promoting health equity. The council aims to facilitate necessary collaboration to address population and public health priorities, and enable realization of established goals and outcomes[9]

Evidence/Comments:

48. I work with public health colleagues to educate new members of government (at the municipal, provincial, or federal level) about long-term commitments to maintain momentum on health equity initiatives

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Neither agree nor disagree
- ☐ Agree
- ☐ Strongly agree

Definition/example:
Since government departments are presided over by ministers/ councilors who are elected on limited-term basis to represent our interests, focusing on long-term solutions is difficult. Therefore, having a way to educate new elected representatives is important.

For example, how is equity action reflected in the board of health orientation, or discussed during meetings with new ministers/councilors?

Evidence/Comments:

49. I recommend feasible solutions for health equity issues that are within the government's capability to act

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Neither agree nor disagree
- ☐ Agree
- ☐ Strongly agree

Definition/example:

The boundaries and size of your jurisdiction must be considered when bringing health equity issues forward, as the scale of the proposed solutions cannot greatly exceed the government's sense of capacity to act

Evidence/Comments:

50. I recognize the importance of increasing public health awareness of health equity issues in order to drive community demand for change in municipal policy

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Neither agree nor disagree
- ☐ Agree
- ☐ Strongly agree

Definition/example:
For example, municipal governments provide a favourable setting for the development of healthy public policy, as political commitment is often best gained through building community demand for change.

Offering stories of issues happening within their jurisdiction can sometimes be more powerful than evidence, resulting in greater citizen involvement.

Evidence/Comments:

PARTNERSHIPS:

51. I collaborate with community stakeholders/coalitions to influence the social determinants of health, and advocate for healthy public policy

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Neither agree nor disagree
- ☐ Agree
- ☐ Strongly agree

Definition/example:

For example, familiarity with community organizations already active in advancing health and social equity can also help to identify partners and opportunities for coordination and collaboration

Evidence/Comments:

52. I involve stakeholders in decision-making processes about future program or service delivery changes impacting priority populations

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Neither agree nor disagree
- ☐ Agree
- ☐ Strongly agree

Definition/example:
Involving stakeholders has been noted as an important aspect of community development strategies aimed at reducing health inequities.

Evidence/Comments:

53. I am aware of community values, opinions, and norms

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Neither agree nor disagree
- ☐ Agree
- ☐ Strongly agree

Definition/example:
Public health leaders need to understand their community values, opinions and norms to guide effective action on health equity

Evidence/Comments:

54. I use community values, opinions and norms to point to health equity initiatives most likely to garner support and engagement, and influence decision-makers priorities

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Neither agree nor disagree
- ☐ Agree
- ☐ Strongly agree

Definition/example:
For example, you learn that your local community values the importance of providing all children, especially those from food insecure families, with access to affordable, healthy food options in schools.

You therefore engage key influencers from the schools and parent teacher associations to join a committee that will advocate for policies relating to food security in schools, and advocate for support from your local municipality.

Evidence/Comments:

55. I engage priority populations in the planning and evaluation of programs, policies and services

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Neither agree nor disagree
- ☐ Agree
- ☐ Strongly agree

Definition/example:
For example:

- *Involving community members in focus groups, surveys, planning committees*
- *Identifying who the key influencers/ gatekeepers are amongst a particular priority population and interviewing them about the experiences of their community*

Evidence/Comments:

56. I collaborate with community organizations from all sectors to implement initiatives that advance action on health equity issues

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Neither agree nor disagree
- ☐ Agree
- ☐ Strongly agree

Definition/example:
Because the SDOH are so complex, they cut across the domain of many sectors. Therefore, working with leaders of those sectors within your community can greatly advance action on health equity through strengthening how priority populations have access to the determinants of health.

For example, in Saskatoon, public health leaders developed a report on the region's health inequities, and used that as a starting point to increase collaboration with other sectors on issues of shared responsibility and importance

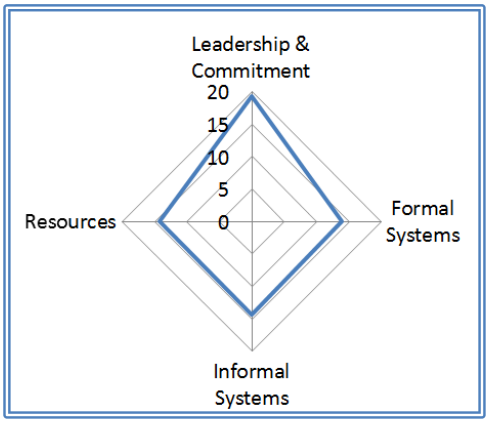
Evidence/Comments:

Appendix E:
Evaluating team scores template

Appendix F:
Example team summary report

Organizational Capacity for Health Equity Assessment Tool
Summary Report: Dental Health Team

Response Rate = 5/5 dental health staff = **100%**



Top 2 elements where organizational capacity exists:

- Leadership and commitment (average = 19.25)
- Informal systems (average = 14.36)

Elements that require building more organizational capacity:

- Formal systems (average = 14.25)
- Resources (average = 13.88)

Summary of results:

Indicator Score	Elements			
	Leadership and commitment	**Formal Systems**	**Informal Systems**	**Resources**
Highest scored questions	3	11, 14	17, 18, 19, 20	23, 30
Lowest scored questions	5, 7	13, 15	20, 22	28, 29

Leadership and commitment:

Research has shown that leadership is the most critical organizational driver in enabling health equity action, and that such leadership support can be accomplished in three ways:

- Reflecting a commitment to health equity through the mission, vision and values of their organization
- Dedicating staff leaders (formal and informal) to become health equity champions
- Having leaders demonstrate support for health equity initiatives through effective change management processes

Assessment of your team's results:

Your team is aware of the barriers that vulnerable populations experience when trying to access dental services. Your team takes initiative to reduce barriers where possible such as assisting

clients completing forms, and attending community programs and events (e.g. Mobile Market) to promote dental services to these hard-to-reach populations.

Advocacy can be challenging but it is important to your team. You have been leaders in various advocacy initiatives such as campaigns and petitions for adult dental programs and LGBTQ health. Your team feels constrained by the mandates pre-set by the government for the HSO program and this makes health equity and advocacy work even more challenging. Additionally, you find these pre-set guidelines problematic when trying to identify priority populations. However, you are aware of priority populations outside of the government-mandated groups as evidenced by your advocacy work. Connecting with the SDoH nurses can assist your team in determining local priority populations within the constraints of the mandated program.

Recommendations:

1. Build opportunities to connect with the SDoH nurses; the purpose of this would be to inform the SDoH nurses of the requirements/constraints of the dental program, which would then enable them to assist your team in identifying opportunities to make connections with priority populations in the community
2. Identify other program areas or networks to collaborate with to continue to accomplish advocacy work and to assist in implementing program activities

Formal Systems:

In addition to showing strong leadership, Canadian health sector organizations that have successfully implemented a health equity approach have established health equity as a priority through their formal systems, including:

- Organizational standards - institutional mandates such as the OPHS, strategic plans, guiding documents (e.g. core competencies for public health), and best or promising practices.
- Organizational structures - structures that enable equity considerations to be part of planning, evaluation, reporting and funding decisions; structures that enable collaboration (e.g. working groups), and structures that foster an understanding of learning needs

This element is strongly related to the leadership element, as leadership is essential to support the development and use of formal systems.

Assessment of your team's results:

Your strongest skill for this element is health equity reporting. Your team is very familiar with collecting information and reporting on it in a formal way, such as an annual health report to the board of health. You also go a step further and analyze the meaning of the information you're collecting which helps you to direct program activities. Other teams have found this skill to be challenging so your team should be identified as champions for the skill of reporting on health equity data.

Your team values collaboration with other program areas to develop and implement shared health equity goals and objectives. You understand that high needs populations experience many health issues and inequities and by partnering with other program areas more health needs can be addressed.

Your team identified evaluation as an area that you could be better supported in. Your clinical role and the pre-set mandates of the dental program make it challenging to focus on health equity evaluation. Fortunately, because your team is proficient at collecting and reporting on health information this will allow you to eventually complete evaluation that is meaningful for health equity objectives. In addition, your team actively seeks learning opportunities when possible, however it's not always possible to sit down and formally assess your learning needs with your supervisor.

Recommendations:

1. Identify ways that your team can be better supported to not only learn about evaluation but to create actionable goals so you can determine which program activities are currently effective and which ones may require changes (as allowable within your program's pre-set mandates)
2. Determine opportunities where your team can discuss/assess individual and team health equity learning needs during team meetings, performance appraisals, one-on-one with your supervisor, or even during informal discussions

Informal Systems:

Informal systems represent the informal structures and processes in place to support an organizational culture committed to health equity. Major informal systems consist of intra-organizational relations and the perceptions of staff, leadership and senior-level decision makers regarding their role in health equity.

They also refer to how the organizational culture and history have shaped action on health equity issues, including motivation for accountability and efficiency to reduce health inequities across the population.

Assessment of your team's results:

Your team showed many areas of strength in this element. You regularly have informal conversations with other colleagues about interventions to reduce barriers for priority populations. Research has shown that when staff members from different disciplines are given opportunities to collaborate, they will have a greater impact on promoting health equity for shared priority populations. Most of you believe that health equity is a value that is supported and understood by other staff and management. Furthermore, you also feel supported and encouraged to be creative in your role to improve outcomes for priority populations.

When it comes to taking initiative on leading health equity projects your team is split - some staff have lead projects and some have not. Identifying champions who have lead projects in the past can help your team build capacity to embed health equity work into everyday practice. Leveraging these health equity leadership skills will also ensure that all team members come to have a complete understanding of health equity work.

Recommendations:

1. Identify champions on your team that have initiated projects focused on health equity previously to support other staff and increase skill and knowledge capacity within your team

2. Build on your existing informal conversations by including more formal opportunities to discuss ideas for health equity projects during team meetings, or one-on-one with the supervisor

Resources:

Organizational capacity for health equity action can be strengthened through structures that dedicate staff resources to health equity.

This includes providing public health professionals with opportunities to:

- Build on their health equity knowledge and skills through training that is tailored to their own individual needs (e.g. training, conferences, continuing education, etc.)
- Support equity-informed practice through using tools that increase access to research, and the sharing of information across the organization (e.g. file sharing, the hub, the virtual library)
- Drive innovation and core competency acquisition relating to health equity (e.g. developing projects that allow them to develop their competencies in creative ways)

Assessment of your team's results:

Your team understands the concept of health equity and how the SDoH affect population outcomes. Even though there are pre-determined constraints for the dental program you understand that these restrictions at least mitigate the barriers faced for low income families with children who need dental care. The reason your team has an understanding of health equity is because all of you take opportunities to increase your knowledge about health equity and the SDoH when possible.

Your team identified that time to engage in health equity work is challenging due to mandated program guidelines and the clinical focus of your role. Even though you have regular informal conversations about health equity amongst yourselves, this is not a concept that is regularly discussed with your professional community of practice.

It should also be noted that your team is split with regards to accessing SDoH evidence and collecting SDoH data - some of you have done this and some have not. Leveraging the skills of champions on your team will build capacity in this area and enable you to shift more focus to health equity issues. This is important since most of you indicated that time constraints and lack of professional community support is a barrier to engage in health equity work.

Recommendations:

1. Work with the SDoH nurses so they can better understand the dental program and potentially help your team identify areas of the dental program where you can engage in advocacy and health equity work
2. Offer training to your team related to searching for evidence and collecting data that captures the impact of the SDoH

3. The SDoH nurses could help staff identify professional development opportunities related to health equity that could then enable you to discuss these issues with your community of practice

Next steps:

Choose one area for improvement/recommendation that you think the SDOH nurses can support you with over the next year.

What should be included in an action plan?

1. Recommendation identified that this team would like to act on
2. Goal(s) - must be SMART (Specific, measureable, actionable, realistic and timely)
3. Objectives
4. Overall strategy/strategies to overcome issue
5. Activities that compose the strategy
6. Indicators that tell you whether you are meeting your goals and objectives
7. Timeline for completion
8. Frequency of check-ins/consultations and follow up with SDOH nurses - this is to be negotiated
9. Will the goal fit into their everyday work, or will it add work?
10. How will the team work together to ensure they reach this goal?