EQUIP Healthcare
Research to Equip Primary Healthcare for Equity

Update on Research Activities
May 2013

We are pleased to update you on the latest EQUIP activities. We have much to report! If you have any questions, please contact us. We also invite your input and feedback on all areas.

Research Team Members

As we get further into the work, our team of people working on EQUIP has expanded considerably. Here is an overview of the staff and trainees currently working on the project.

UBC

Rochelle Einboden, Research Assistant
Alycia Fridkin, PhD Trainee
Alison Gerlach, PhD Trainee
Phoebe Long, Research Manager
Joanne Parker, Research Manager*
Lena Rinquist McCoy, Research Assistant

Victoria, BC

Bruce Wallace, Research Associate
Marion Selfridge, Research Assistant

Western University

Katie Big Canoe, Research Assistant
Catherine Blake, Research Assistant
Mary Beth Davies, Research Assistant
Meghan Fluit, Research Assistant
Christine Garinger, Graduate Student Trainee
Joanne Hammerton, Research Manager
Aleccia Hofstetter, Research Assistant
Tara Mantler, PhD Trainee
Marg Pepper, Research Assistant

* Joanne (Jo) Parker is currently working with us part-time on the project. She will transition to full-time when she takes over for Phoebe, who will be on maternity leave starting in July.

Introducing our newest Co-Investigator based in Ontario: Julie George, PhD

We are delighted to announce that Julie George has agreed to be a Co-Investigator with EQUIP. Julie is an Ojibway mother of four from the Chippewas of Kettle & Stony Point First Nation. She recently completed her dissertation employing Indigenous methodologies. As part of her doctoral research on Intimate Partner Violence (IPV), she worked in partnership with her community to develop a violence prevention and intervention program that includes a sustainable healing and support program. Currently, as a postdoctoral fellow with the Centre for Addiction and Mental Health (CAMH), Julie is working with First Nations communities to adapt and implement the Researching Health in Ontario Communities (RHOC) project – a multidisciplinary research program that seeks to improve understanding, prevention and treatment of mental health, substance use and violence (MSV) problems in communities across Ontario. She also co-leads the CAMH Research Priority on prevention in First Nation communities and is working on a team project to modify the Mental Health First Aid Canada program for First Nations. Julie has comprehensive community-based experience in the area of co-occurring mental health, addiction and violence (MHAV) problems. She previously coordinated the National Aboriginal Youth Suicide Prevention Strategy (NAYSPS) in four of the South West Area Health Board (SWAHB) First Nations, and is currently working in partnership with several southwestern Ontario First Nations to improve integration of, and access to, MHAV services. Julie currently sits on the Mnaasged Child & Family Services Board of Directors. Overall, her work prioritizes culturally appropriate research methodologies, partnership in research, community capacity-building, knowledge translation and knowledge mobilization.

Our aim is to hire a part-time Research Assistant based in the region of each primary health care (PHC) site to: a) work with the Practice Consultant during Organizational Tailoring and Integration; and b) maintain contact with our patient cohort at each site. We are interviewing potential RA candidates in Prince George in mid-May.

Study A: Equity-Sensitive PHC Indicators

We have received excellent feedback on how to refine and streamline the new PHC Indicators through the staff Delphi survey process undertaken as part of the Urban Aboriginal Health Centres (UAHC) study[1]. We have hosted two events with patients in Prince George and Vancouver, where we received invaluable feedback that helped us to further refine and revise the Indicators. We have now pared down the Indicators to a set of 25, which are being reviewed in the second round of the Delphi survey process with staff at the two UAHC sites. **If you are interested in seeing the set of 25 Indicators, please contact Phoebe for an overview, at** phoebe.long@nursing.ubc.ca.

Study B: EQUIP Intervention

Study B is the EQUIP Intervention, including multiple methods of measuring outcomes and processes of care. It is the largest and most complex part of EQUIP, and has been a focus of the past six months, especially in terms of refining data collection instruments, procedures and protocols, and Components Two and Three of the Intervention (see inset). Significant effort has gone into modifying the Indigenous Cultural Competency Training for Ontario and developing trauma- and violence-informed care training materials.

The EQUIP Intervention: Complex Organizational Intervention Tailored to Local Context

Two Approaches and Three Inter-Related Components

- **Approach 1 (12 Months):** Staff Education re:
  - **Component 1:** Orientation to Key Dimensions and 10 Strategies of Equity-Oriented PHC
  - **Component 2:** Cultural Competence
  - **Component 3:** Trauma- and Violence-Informed Care
- **Approach 2 (6 months):** Organizational Integration and Tailoring to local context

Component One: Key Dimensions of Equity-Oriented Primary Health Care

The conceptual model guiding EQUIP was recently published in the *International Journal for Equity in Health* (see http://www.equityhealthj.com/content/11/1/59/abstract).

> Browne, A. J., Varcoe, C. M., Wong, S. T., Smye, V. L., Lavoie, J., Littlejohn, D., et al. (2012). Closing the health equity gap: Evidence-based strategies for primary health care organizations. *International Journal for Equity in Health, 11*(59). doi: 10.1186/1475-9276-11-59.

As we were completing baseline data collection from patients and staff (see section below on Outcome Measures), we provided a brief, two-hour training workshop at each PHC site to orient staff to Component One

[1] The UAHC study is conducted in partnership two long-standing Urban Aboriginal Health Centres in BC: the Central Interior Native Health Society (in Prince George) and the Vancouver Native Health Society.

of the Intervention: Key Dimensions of Equity-Oriented Primary Health Care. These training sessions have been very well received and are generating a lot of good dialogue within each PHC site.

Component Two: Indigenous Cultural Competency Training *Plus*

The second key component of the EQUIP intervention includes completion of the Indigenous Cultural Competency (ICC) Training from the BC Provincial Health Services Authority (PHSA). PHSA will be releasing a *new* module in late Spring – early Summer 2013 (tentatively titled "Anti-racism"), designed to (a) explore Canadian discourses on power, privilege and discrimination, and (b) address issues of racism and discrimination in the workplace.

Component Two of the EQUIP Intervention will involve **all staff members at all PHC sites completing both the Core Health program of the ICC and this new "Anti-racism" program.** The intended target audience for the Core Health program is non-Aboriginal service providers working with Indigenous people in the health field. PHSA has been developing a version of the program that is geared to people who are Aboriginal, and for whom the ICC could have particular significance given their lived experiences. Though we had hoped to offer EQUIP participants the option of taking this new version, we have learned from PHSA that release of that curriculum has been delayed while they deepen their consideration and vetting of the content.

ICC Modifications to Reflect Ontario-Specific Content

Edward Connors, PhD, C.Psych

Ed is a Psychologist registered in the Province of Ontario. He is of Mohawk ancestry from Kahnawake Mohawk Territory, and has worked with First Nations communities across Canada since 1982 in both urban and rural centres. His work over this time has included Clinical Director for an Infant Mental Health Centre in the city of Regina and Director for the Sacred Circle, a Suicide Prevention Program developed to serve First Nations communities in Northwestern Ontario. His practice incorporates traditional knowledge about healing while also employing his training as a psychologist. He manages a health planning firm that provides health consultation and psychological services to First Nations communities throughout the Georgian Bay Muskoka region. He also serves as an elder/advisor for Enaahtig Learning and Healing Lodge and the Native Mental Health Association of Canada.

Because the ICC curriculum was developed for use in British Columbia, it contains some content that is specific to that province. We therefore recognized a need to **modify the ICC Core Health program so that it would be appropriate for staff members at our PHC sites in Ontario,** and would include information about the history, geography, politics, and health issues specific to that province.

Since the fall, we have been working with Dr. Ed Connors (inset, left), to adapt the curriculum content. We are pleased to have done this work with the leadership and input of Cheryl Ward and her team at PHSA to ensure consistency with the existing Core Health curriculum.

Modifications to curriculum content have been made and uploaded to a new platform wireframe, thanks to the work of Cheryl and her team. Our next steps will be to conduct feedback sessions with elders and stakeholders in Ontario to assess the feasibility and appropriateness of this new content. **The modified ICC Core Health program should be available for EQUIP participants at the two sites in Ontario to begin enrolling this summer.**

Component Three: Trauma- and Violence-Informed Care Training

The Trauma- and Violence-Informed Care (TVIC) curriculum for Component Three is nearly complete. We will seek input on our current draft from a representative from each PHC site. The training will be adapted and delivered by Practice Consultant Vicki Smye (see below) along with Colleen Varcoe at the BC sites and Marilyn Ford-Gilboe at the Ontario sites. The training will entail a total of eight hours of in-person training, with an additional two to four hours of reading and self-directed exercises. Workshop dates are being determined with each PHC site. We are currently applying for accreditation to offer CME credits for this component.

Approach 2: Organizational Integration and Tailoring to Local Context

We are pleased to welcome Dr. Vicki Smye as the Practice Consultant on EQUIP Healthcare. Vicki is a long-time collaborator with Annette Browne, Colleen Varcoe, and Marilyn Ford-Gilboe on multiple programs of research. She is currently listed as a Co-Investigator on the project grant, but will be transitioning into the role of Practice Consultant at all four primary health care sites. She is Associate Professor and Associate Director of Undergraduate Studies at the University of British Columbia School of Nursing. Vicki brings a wealth of expertise in:

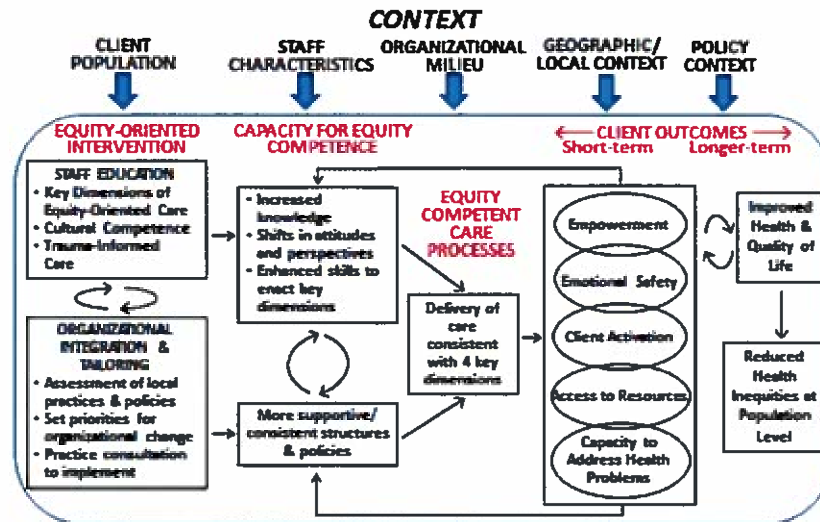
- Mental Health and Substance Use
- Aboriginal People's Health
- Health and Health Care Inequities
- Cultural Safety
- Violence Against Women
- Methadone Maintenance Treatment
- Organizational Change
- Health Care Administration

She has a long and successful history as a CIHR-funded researcher, and is currently leading a project titled *Aboriginal Men's Narratives: Reclaiming Our Lives*, examining appropriate, culturally safe health and social services and support for men whose lives have been influenced by multiple forms of trauma and violence and are shaped by substance use, poverty, chronic illness, etc. Vicki has years of experience as an administrative leader in a variety of community and acute health care settings, and has been involved in organizational change processes. She is a highly-skilled and sought-after group facilitator. She will be working closely with each PHC site as they implement the Organizational Integration and Tailoring portions of the EQUIP Intervention.

Outcome Measures to Study Effectiveness of the Intervention

Changes in selected constructs identified in our intervention theory will be examined using quantitative data collected from patients and staff. We expect that the most distal changes identified in the theory (i.e., shifts in patient health outcomes, quality of life and reduction in health inequities) may take considerable time to achieve, so we will focus primarily on more proximal outcomes in the model (i.e., changes in staff knowledge, organizational policies, processes of care and short-term impacts on patients). This is a first step in testing the intervention and the theory that informs it. The figure on the next page depicts these proximal and distal outcomes, and ways in which the intervention could ultimately lead to a reduction in health inequities at the population level.

Data collection instruments for use in patient interviews and staff surveys have been programmed into the computer-assisted data-entry (CADE) platform, Fluid Surveys. **If you are interested in seeing the patient or staff interview guides, please contact Phoebe at phoebe.long@nursing.ubc.ca.**



Patient Interviews

We will draw on client self-reports to measure changes in processes of care and client outcomes. Each type of indicator will be measured at 5 points in time: at baseline, and at subsequent intervals of 6 months, over a total of 2 years (at 6, 12, 18, and 24 months on the timeline). We expect that the impacts of this intervention will occur slowly, with minimal effects prior to organizational tailoring. However, in order to retain participants in our longitudinal cohort, we will need to have periodic, but regular, contact with individual patients at 3-month intervals in between the data collection points.

We are pleased to report that we **completed Wave 1 of patient interviews at our two sites in BC in February and March.** We were able to exceed our recruitment goals at each site, interviewing 154 patients at Cool Aid CHC in Victoria, and 156 patients at Central Interior Native Health Society in Prince George. **Interviews with patients at the two sites in Ontario are being conducted in April and May** – Health Zone Nurse Practitioner-Led Clinic in London, and North Lambton Community Health Centre in Forest and Kettle Point. So far recruitment and interviewing have been proceeding well, and we expect to meet our goals there as well. We would like to acknowledge all of the support and extra effort put forth by staff at each of our partnering sites, with a special nod to the reception/MOA staff. Their energy and commitment made our recruitment efforts successfully and smooth.

At baseline, our goal is to recruit a sample of 150 patients from each site. This sample will comprise a longitudinal cohort to be followed across time. A structured interview (approximately 45-60 minutes) has been conducted with patients who consented in a private room at the site. Patients are provided with an honorarium to acknowledge their time, and a detailed safety protocol – adapted from our previous studies – has been used to guide all interactions.

> ### *Pilot Testing of Patient Interviews*
> We pilot tested the patient interview with a small advisory committee of patients in Vancouver on February 5th. Some members of this advisory group have worked with our team in previous research projects. They provided invaluable and detailed input into the acceptability of the questions we are asking, and insights into the match between what we are intending to measure and what may be understood by a patient. Resulting refinements have been incorporated into our interview guide.

Staff Survey

All staff members at each partnering clinical site were invited to complete an online survey questionnaire, which includes three discrete sets of measures aligned with each of the three components of Staff Education (Equity, Cultural Competence, and Trauma- and Violence-Informed Care). The purpose of this survey is to assess knowledge, attitudes and practices related to the core concepts underlying the three components. Staff assessments will be conducted at three time points:

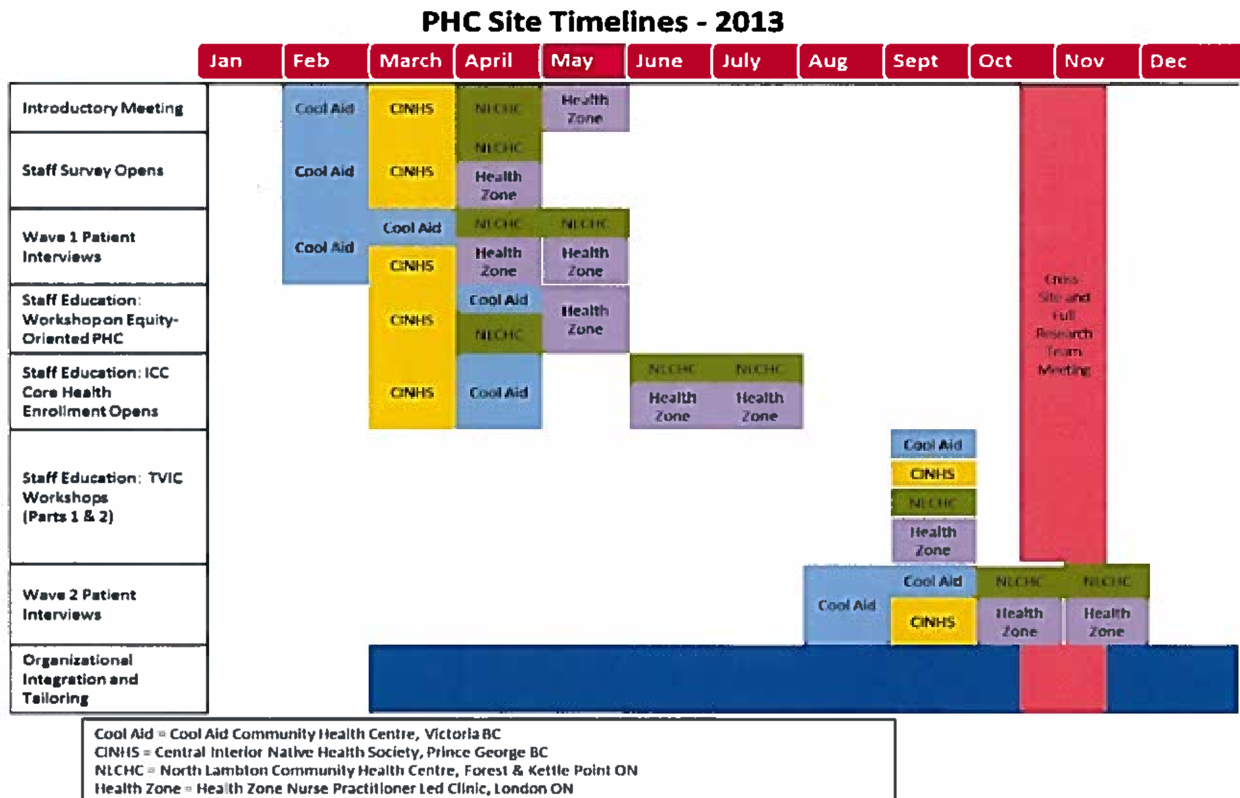
1. at baseline – before the intervention begins;
2. at 12 months – after educational components and organizational tailoring and integration have been completed; and
3. at 24 months – one year after intervention components have been implemented and integrated.

Staff at all of our partnering organizations have now completed the baseline assessment and, as noted above, have been participating in trainings related to Components One and Two of the intervention.

Use of Tablets and Data Collection Tool

Data in the patient interviews and the staff survey have been collected through the use of Fluid Surveys, a computer-assisted data platform. Patient interviews were conducted using a tablet interface, which allows the participant and interviewer to view questions and select responses together on the screen. Staff surveys were also administered through the Fluid Surveys platform, with each participant responding online.

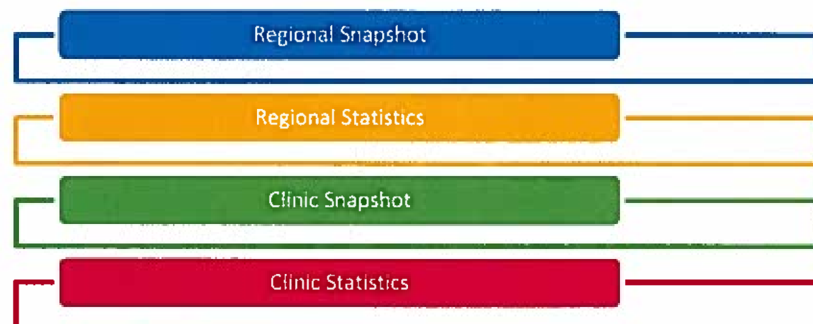
Timelines and Next Steps



We have established working timelines with each of the four PHC sites. We would like to bring everyone together in **October or November for a "Cross-Site and Full Research Team" meeting.** The goals will be: for representatives from each site to exchange ideas about their own processes of Organizational Tailoring and Integration; and for members of the full research team to come together. **More details will follow soon, with specific dates to hold open.**

Study C: Analysis of Policy and Funding Contexts

Study C analyzes policy and funding contexts for each PHC site with the goal of developing a context profile for each site to help describe their unique histories and populations and to examine similarities and differences across and between sites. To this end, we have created comprehensive statistical profiles of the communities of Prince George and Victoria, BC. We will create similar statistical profiles of Ontario's London and North Lambton regions, applying similar parameters and assumptions. In addition, we are drafting narrative 'snapshots' of the socio-political and historical contexts of each community. All of this data will be complemented by future primary data collection to include interviews with key stakeholders, and analysis of each organization's policy and funding documents.



New Clinical Sites – Updates and Opportunities

As you are aware, the four PHC clinics serving as case studies for implementation of the EQUIP intervention are somewhat "alternative" organizations when compared to usual models of PHC delivery in Canada, which generally function under a distinct set of structures, arrangements, and obligations in terms of funding, policy, and vision. We therefore feel the **need to position these more "alternative" organizations in comparison to more "typical" PHC clinics.** If the EQUIP intervention shows promise in changing important outcomes, it will be important to understand the factors, policies, and conditions needed for eventual scale-up to more "typical" sites. To do this, we propose **including data from two comparison ("typical") sites in BC and Ontario as part of Study C.** We have identified Blue Pine PHC Clinic in Prince George, and are working to identify an Ontario site.

We can maximize interpretation of EQUIP data by collecting from our comparison sites: (a) baseline data from site staff, and (b) contextual information compiled in Study C, as described above. These data will permit comparative analyses across all of the study sites to shed light on:

- how more "typical" sites organize their services to address the needs of marginalized patient-populations;
- similarities/differences between "typical" and "alternative" EQUIP PHC sites;

- the organizational conditions, policies and structures that need to be considered to scale up (as appropriate) implementation of the EQUIP intervention, and other equity-oriented interventions.

Current Sites for EQUIP Intervention

Ontario	British Columbia
Health Zone Nurse Practitioner Led Clinic, London	**Central Interior Native Health Society,** Prince George
➢ Merrymount Site	
➢ Southdale Site	
➢ Allen Rush Site	
North Lambton Community Health Centre	**Cool Aid Community Health Centre,** Victoria
➢ Forest Site	
➢ Kettle Point Site	

Comparison Sites

Ontario	British Columbia
TBD	**Blue Pine Primary Health Care Clinic,** Prince George

This analysis will allow us to consider how the PHC sector responds to changes, opportunities, policy windows, and public outcry in relation to equity issues, what the key challenges are, and how a more responsive system might be promoted. For example, we anticipate differences between needs as identified by providers and by clients, between priorities as identified by organizations and priorities as evident in funding pathways.

Knowledge Translation & Exchange (KTE) Activities

The KTE team would like to thank members for participating in the online survey to assess initial KTE strategies and audiences. Data from the survey will be very useful as we plan ongoing knowledge sharing activities.

Next Full Team Meeting

We would like to hold a **teleconference with the full research team in the next couple of months.** Please watch for messages from us asking for your availability in the coming weeks. Please also watch for a message confirming dates for a **Cross-Site and Full Research Team Meeting in the fall.**

We continue to evaluate options for a file-sharing platform, and a full project website. Stay tuned!

As always, if you have any ideas, questions, or input, please contact Phoebe at phoebe.long@nursing.ubc.ca.