Health for All: Looking Forward

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April 2018

1. Introduction

Since the release of the Health Equity Position Statement in 2012, employees at the Winnipeg Regional Health Authority have done significant work around health equity, sometimes under the banner of *Health for All*. 2017-2018 has brought changes in the structure and direction of Manitoba health care, with implications for health equity. Now is an opportune time to take stock of how far regional health equity efforts have come and where they should go next.

2. Methods

I completed this project during a Masters of Public Health practicum at the WRHA from January to April 2018. Based on the question, *Where is the WRHA's health equity work at and where should it go next?* I conducted interviews with five WRHA employees who have been closely involved in *Health for All* and four who have taken one or both of the Health Equity workshops developed for managers and directors. Of the nine interviewees, two were frontline staff, one was a manager and six were directors. Two interviewees worked at a community site, five at an acute care site and five worked for a regional program; some worked at more than one type of program/site. Interviewees were drawn from beyond Population and Public Health to allow for reflection on the region-wide future of *Health for All*.

Using the question, *What are the characteristics of successful health organizational change initiatives to promote health equity?* I also searched for literature published after 2007 on health system efforts to promote health equity in Canadian and similar health care systems. I also conducted targeted searches on issues emerging from the interviews.

The first part of this document describes what interviewees said about the state of health equity at the WRHA and their recommendations for the future. I then present the key themes that emerged from my analysis of the interviews and some considerations for moving forward. The document closes with a bibliography based on my literature scan to support future health equity work.

3. What's going on?

3.1. Actions to promote health equity at the WRHA

Interviewees told me about a number of actions that they, their colleagues, and the WRHA as a whole are doing to promote equity. They also noted what was not happening but ought to be and offered thoughts about ways forward.

Education and dialogue: Formal education about health equity happens through events, presentations, workshops and staff newsletter articles. Education also happens informally through conversation at meetings, employees educating each other in the course of patient care and during planning or policy change processes. Education and dialogue involves building buy-in, introducing people to concepts, supporting people to think through what they can do, and reinforcing principles of equity in everyday practice. A key challenge noted by interviewees is the danger of a little knowledge. On one hand, people may have enough knowledge to identify a situation as 'an equity issue' but not enough to feel they can take action. On the other hand, people with only a basic understanding of equity might inappropriately stamp everything that resembles the concept – for example, any issue involving Indigenous people – with an equity lens. Another challenge involves people feeling "attacked" by educational content on privilege and colonization and thus being less likely to act. One interviewee felt that emotional engagement with health equity should be a key part of educational offerings. Appendix B reports on what interviewees said about the two Health Equity workshops.

Interviewee quotes

On educational activities: "We held some workshops, we used the *Health for All* PowerPoint that's out there, so we talked about that. [We would] talk about our community profile and some of the relationships between health equity and our community profile. We were putting things in our [staff newsletter]… trying to send people to the health equity workshop. And then we hosted the poverty simulation through the United Way."

On the danger of a little knowledge about equity: "When the only tool you have is a hammer [the concept of equity], everything looks like a nail [an issue of equity]. … So I think there's potentially some harm that could be done there by not actually seeing what is actually happening."

Improving service provision: Interviewees and their colleagues promote equity by making care more person-centered, using team-based models, supporting patients to access the social determinants of health, and trying to equitably distribute resources among programs and/or clients. However, the health system is still provider-centred rather than person-centred and some providers continue to be paternalistic. When current ways of working do not serve equity, sometimes improving service provision involves "bending the rules".

Interviewee quotes

On measures: "Because [equity] is a philosophy, how do you measure that? … Does that mean we have fewer failed discharges? Or does that mean I've got happier folks, less complaints in the RL6 [incident reporting] system? … Because it's difficult to measure, it might actually be difficult to implement."

On targets: "If we had markers of success that included, 'we're gonna make this structural [i.e. WRHA-wide] at this level, and this level, in the next two years', we'd have a path, instead of what feels a bit meandery right now because no one's really sure where it's going."

On workplace behaviour policies: "It shouldn't be like, I need to negotiate with you what the consequences are if I say something inappropriate. If I hit you, in an employment, it'd be pretty clear, I would be disciplined, I would be sent home, so if I say something inappropriate does it need to be more heavy handed?"

Changing policies & procedures: However, some WRHA employees are going beyond improved service provision or "bending the rules" to changing policies and procedures. A number of interviewees talked about making changes to clinical practice guidelines using an equity lens and others talked about revising policies such as clinic intake procedures to better serve 'disadvantaged' clients.

Collaboration: Collaboration was seen as an essential part of equity work. Collaboration within the WRHA took the form of service coordination, lateral education between staff, and equity committees. Interviewees collaborated with other systems by helping clients navigate housing or Employment and Income Assistance (EIA) and by working with people in those systems to decrease barriers to access.

Using an equity lens: As a formal part of procedures or informally in conversation, this involves trying to think about clients, issues and solutions in a new way, asking reflective questions to oneself or to colleagues, and "raising the flag" to identify occurrences of inequity.

Messaging and framing: Interviewees spoke about the need to strategically frame health equity, both to the public and to WRHA leadership. One interviewee was adamant that the WRHA should not be afraid to openly communicate to the public when equity goals drive the redistribution of services and noted that "more often than not, actually, the public, it does resonate with them." Others discussed the need to frame the potential cost saving nature of equity work to bolster its value in the eyes of current provincial and WRHA leadership.

Data & measurement: Interviewees discussed three interrelated issues in data and measurement. First, the WRHA lacks information on inequities experienced by patients and populations due to the absence of sociodemographic indicators (e.g. Indigenous identity) in population data and patient records. Some interviewees were frustrated that after 10 years of discussion, the WRHA still does not have an Indigenous identifier. Others noted that the main barriers to organizational readiness are providers' comfort and a perceived risk of damaging patient-provider relationships. One interviewee suggested that the *Health for All* working groups should put energy towards supporting the creation of an Indigenous identifier. Second, it is difficult to measure the impact of health equity work because of the lack of equity-related measures. Third, targets have not been set for system or program performance on health equity, which makes the work harder to implement because there is no clear path forward. Interviewees recommended creating standardized program-specific or system-wide measures and targets for health equity.

Human resource-related equity issues: Some interviewees talked about the apparent lack of diversity beyond front-line staff (e.g., management/leadership). Others mentioned incidents of employees discriminating against clients or colleagues, which is exacerbated by the lack of clear policy and procedures to deal with such incidents.

3.2. The *Health for All* initiative

Interviewees who are closely involved with *Health for All* value the initiative and believe that staff who support the initiative are doing great work with the resources they have. The working groups are seen as a key element although some interviewees are unsure if the current working group structure is most appropriate or what they should do next. Some interviewees said that they do not attend working group meetings because of the lack of tangible benefits to their own work. A few interviewees noted that the Learning & Engagement and Economic Inclusion working groups have had the most tangible task-based outcomes, while others emphasized that the Partnership and Knowledge working groups have allowed for valuable relationship building and idea sharing that is foundational to health equity work in the region.

Interviewees believe that the role of *Health for All* is to convene people, flag issues of inequity, legitimize existing equity work, and offer up tools and resources, but not do all the work. To one interviewee, *Health for All* should aim to work itself out of existence as an initiative. Another noted that moving the initiative to Shared Health Services would ensure the regional (and provincial) spread and endorsement of equity work.

3.3. Barriers and facilitators of equity work

Interviewees described a number of factors, listed in Figure 1, that have helped and hindered the work they are doing to promote health equity.

Uncertainty about what equity looks like in practice: One of the most common concerns for interviewees and their colleagues was not knowing what to do. Even people who understand equity conceptually may struggle to translate concepts into practices, sometimes due to time constraints, sometimes due to a lack of knowledge. Although senior leaders and management had embraced equity and it is now in the WRHA strategic plan, the practice of equity has not yet "rolled down" to frontline staff or into operational plans. However, one interviewee felt strongly that some people in management also do not deeply understand equity or know how to implement it at the ground level.

Tools help, and they aren't enough: A few interviewees noted that staff are "hungry" for resources, tools and information to help them provide more equitable care. Although interviewees mentioned using the What Can I Do? diagram and the Get Your Benefits booklet, others wanted case studies, reflective questions, or measurement toolkits. Although tools provide a useful entry point into equity work, they often cannot provide the emotional and conceptual shifts required for deep equity-oriented changes in practice.

Time constraints: The urgent and time-stretched health care environment and the current emphasis on efficiency and patient flow were described as exacerbating not knowing what to do in two ways. First, it limits opportunities for learning about equity and figuring out how to translate it into practice, and second, it does not allow providers to step outside their daily tasks to test out new ways of working. Instead, employees "do what they can," for example, by quickly referring people to other services.

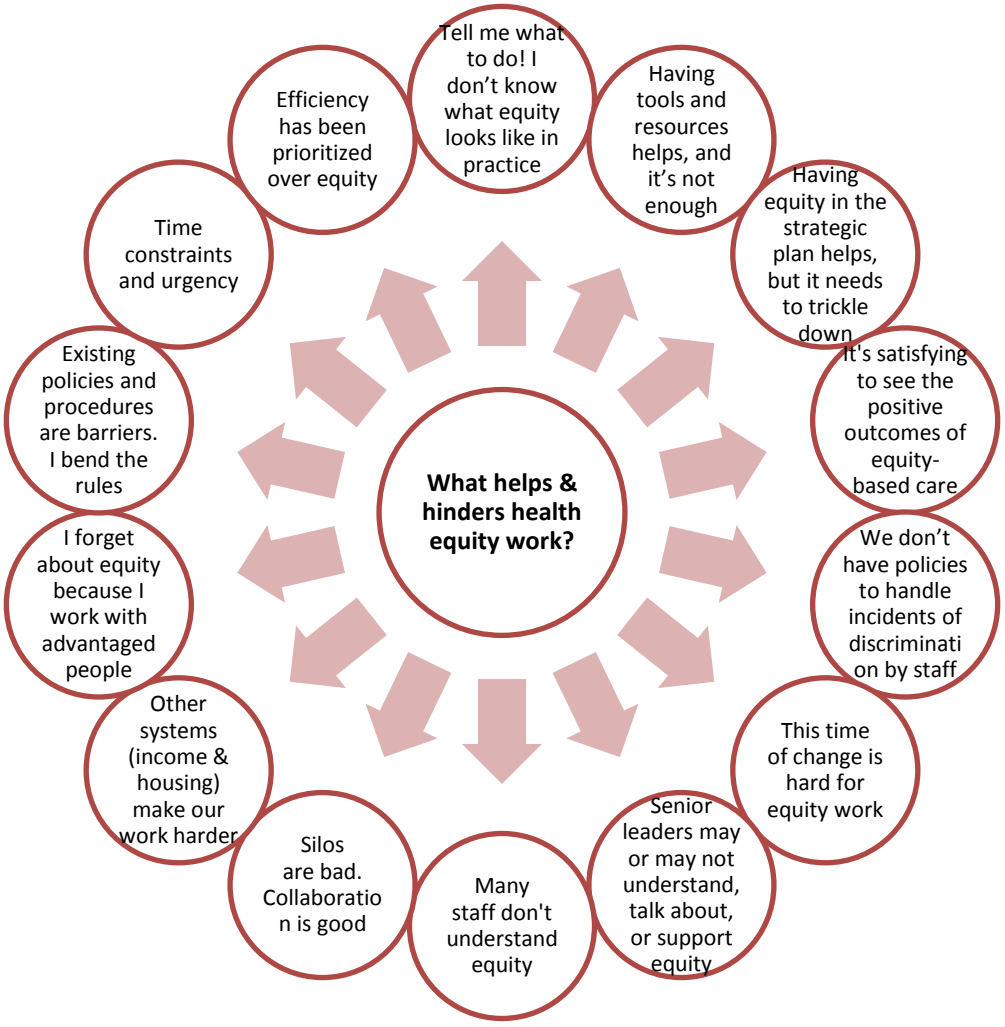

Figure 1: Barriers and facilitators of health equity work

Interviewee quotes

On time constraints: "As a health system we are so focused on patient flow that we're missing so many opportunities, because there's real wealth out there in terms of community services [to which we could refer patients] but we don't have time to leverage them."

On collaborative relationships: "It's not like [my working group] has a task-specific job to do, but … just bringing all of those players together, and we're all talking the same thing, and just trying to figure out ways to address those barriers. … So then hearing about [a new practice change] makes me think, well, how could we do that here? … But that would never have been an idea of mine, well, maybe it would, I don't know, but just by being at that table you hear about other ideas."

Seeing the positive impact of equity work: Taking a risk to work in a new way can catalyze a positive feedback loop of equity-related change. When providers try working in a way that promotes equity, for example, by redistributing resources or doing person-centered care, they feel the satisfaction of the positive impact of that change, which fortifies their buy-in for more equity-focused practice.

Who you work with allows you to see inequity: Interviewees who work in public health or community areas with a predominance of disadvantaged clients "live and work [equity] every day". However, people who work in other areas struggle to remember that inequity exists in the populations they serve.

Existing policies & procedures: A few interviewees talked about the health system being a barrier to equity as it is far from 'person-centered'. Specific policies that impede equity-informed care include providers not being permitted to work around open alcohol or to text or email clients, as well as various service eligibility criteria. To deal with these constraints, providers make exceptions to their standard practices or "bend the rules".

Collaborative relationships: Although relationships and partnerships are "foundational to the work of the health system in supporting marginalized populations," silos between WRHA programs and between systems hinder health equity by getting in the way of service coordination. Because it is difficult to measure relationship-building as an outcome of equity work, it is often not valued as essential in the process of equity-oriented change.

Housing & income: Challenges related to non-health systems, particularly housing and income, hinder WRHA employees' ability to promote health equity. The most frequently mentioned issues were a lack of housing at discharge and a lack of access to EIA and other benefits.

When senior leaders value equity: Senior leaders explicitly communicating that they see equity as a priority (e.g. via equity in the strategic plan, regular emails to employees or the creation of the Health Equity workshops) legitimizes equity. These endorsements in the initial years of *Health for All* created space for employees who had been 'doing equity' for many years to feel proud of their expertise and "gave us license to make it [equity work] more official."

'This time of change' is hard for equity: With system transformation, the emphasis on patient flow and a lack of senior-level direction on equity, some interviewees feel that equity work is 'on pause'. Employees are too busy with clinical consolidation to do the 'extra' work of considering equity or are afraid to take risks and try new things in the midst of job uncertainty and with no clear path forward. These factors have also resulted in a deeper divide between employees who do and do not value equity.

4. What does it mean? Insights from the interviews

This section outlines the key themes that emerged from my analysis of the current state of health equity work.

A valuable space: It is clear that *Health for All* has opened a valuable space at the WRHA to talk about and work towards health equity. Despite uncertainty about the direction of health equity work in the context of system transformation, there is considerable interest, commitment, and momentum across many programs and sites.

Varied understandings of health equity: As one interviewee remarked, "equity means something different to everyone." Figure 2 outlines the range of conceptual understandings of health equity action implied by interviewees' comments, along a continuum of individual/interpersonal to systemic. People who had attended the health equity workshops tended to occupy the left side of the continuum and people closely involved in *Health for All* working groups and committees the right side. Correspondingly, interviewees disagreed about whether equity work should prioritize "changing hearts and minds" (individual/interpersonal) or "construct[ing] a system that supports [equity]" through policy and procedure (systemic). Other differences in the way people understood health equity included: health for everyone vs. health for disadvantaged populations, and equity according to socioeconomic factors vs. equity according to socioeconomic plus other identity based factors (e.g. gender identity, race).

Three groups of employees: A rough typology of three kinds of WRHA employees emerged. 'The experienced' have been doing health equity work for years and are knowledgeable about the concepts and practice. 'The new & eager' have been newly introduced to health equity, see its potential to improve health and health care, and are hungry for education, information and tools. All of my interviewees fell into these first two groups. However, some struggled with engaging a third kind of employee, 'the unconverted', who don't see the value of promoting health equity. Some felt that 'the unconverted' could be engaged through first voice stories but others did not see 'converting the unconverted' as their responsibility.

Tensions about practical vs. conceptual vs. emotional education: A current key challenge is "rolling down" conceptual understandings of health equity into practice. Educational offerings that focus on the practical can support employees with frontline and operational responsibilities to think through the context-specific actions they can take. However, education must retain strong conceptual content so learners gain a depth of understanding and the ability to apply core concepts to a range of patient/client situations. However, emotional engagement with health equity is also valuable in order to shift the way people approach the issue and the action they take.

Equity as extra vs. woven in: Equity is far from "woven in" to frontline practice across the region, and many see it as an "extra" responsibility. The success of *Health for All* can be measured by the extent to which equity is 'business as usual', at which point there may no longer be a need for the initiative.

Two stories about 'this time of change': A difference emerged in the way interviewees with strategic vs. operational roles spoke about the impact of system transformation on equity work. All concerns about equity work being 'on pause' came from directors. For people doing frontline service, professional education, or operational planning the story of equity was not about pause, but about growing momentum, working to translate concepts into practice, and a hunger for more knowledge and resources. Although my sample of nine only reflects the kind of WRHA employee who is already interested in health equity, my findings demonstrate that there is a motivated pool of people who value and are deeply committed to promoting equity at the WRHA.

Interviewee quotes

On individual vs. systemic intervention: "Maybe it's more systems and process based than what we actually do at the frontline. Because maybe if the processes were designed to be more equitable we would just do them that way. … Like, changing a process vs. the behaviour. And that process can eventually inform the behaviour."

On reaching 'the unconverted': "If you're going to make a difference, you gotta welcome the people who don't agree with you, not just build your models with the people who do agree with you."

"If somebody wants to be [prejudiced], that's what they're gonna do. It's not my job to make somebody feel differently. My job is to give people whatever information they can to make the best decision at the time, and not act that way."

On weaving equity in: "The work that equity has done needs to show up in the work that everybody else is doing, and that's when it's a success, when those things are not only common language, and used correctly, but common thought and actually truly embedded in whatever planning people are doing."

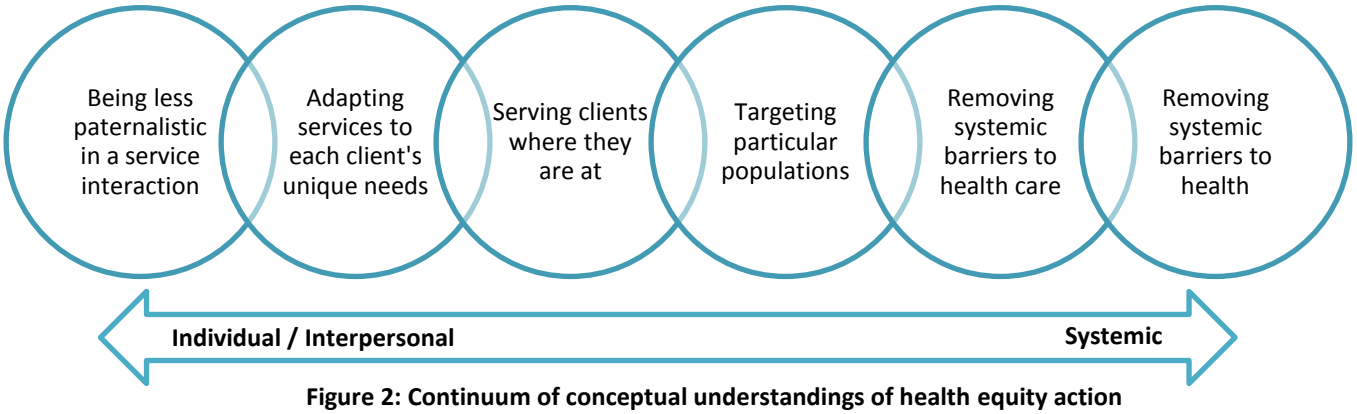

Figure 2: Continuum of conceptual understandings of health equity action

5. What's next? Considerations for moving forward

This section outlines considerations for discussion by the Health for All Coordinating Committee (HACC) and the working groups.

5.1. For HACC & all working groups

'This time of change': Imagine the bold steps needed in this moment to secure health equity principles as integral to the new systems and processes being developed. Imagine what *Health for All* can do to take these bold steps.

Involve senior leaders: The participation of leaders is essential for region-wide health equity work to flourish.

Stay upstream: Don't lose *Health for All*'s upstream emphasis on social determinants of health. Given the current focus on clinical care, *Health for All* can continue to be a dedicated home for upstream work at the WRHA.

Review & renew targets: Review progress on the outcomes in the 2015 *Health for All* Logic Model. This project confirms that these goals are still relevant. A review would give HACC and working group members a sense of the status of the initiative, provide options for future goal-setting, and allow for reporting to stakeholders.

Re-frame health equity: Building on past efforts to frame equity in the language of patient flow, think about the utility of framing health equity work in the language of 'value for money' or efficiency. Assess the risks of such framing.

Frame equity as quality improvement: Investigate how quality improvement can be a useful frame for advocating for the inclusion of health equity targets in strategic and operational planning processes. See Appendix A for resources containing examples of system-level performance indicators.

Commit to workforce equity: Use workforce equity as an alternate angle to approach 'building a culture of equity'. Appendix A contains resources for conceptually linking workforce equity to health equity and strategies for increasing it. Build on the learnings of Indigenous Health's Workforce Development Program.

Strengthen workplace conduct policies: Open conversations with Human Resources about policies and procedures for incidents of discrimination by employees. Discuss how to make processes clearer, better known and more effective.

Continue learning about organizational change: Devote one meeting of HACC and each working group to learning about organizational change. HACC and working group members can be powerful agents of change but not all see themselves as such. Supporting members to see their own role within a larger arc of organizational history may help to alleviate concern about the function of the committees. Invite someone from a health system further down a path of equity-oriented change to speak, or collectively read and discuss relevant literature (see Appendix A for resources).

5.2. Learning & Engagement working group

Peer to peer education: To address the need for practical education on health equity, create a peer to peer coaching or mentorship initiative that draws on the expertise of WRHA employees who have been doing equity-oriented work for years. This could be a formal program or could involve informally connecting learners and mentors. In keeping with the hub-and-spoke model of *Health for All*, this strategy would: a) expand the pool of 'equity experts', decreasing pressure on *Health for All* staff and reaching more learners; b) build a cadre of trainers with practical knowledge about what equity looks like in various system contexts; and c) cultivate equity champions across programs and sites.

Training plus organizational change support: To target *Health for All* resources where they will be most effective, combine training with facilitated organizational or practice change processes for programs/sites that are ready for it. Appendix A contains examples of change processes in health organizations that combine employee or senior leader training about health equity with facilitated planning processes and ongoing support from a change consultant. A custom *Health Equity: What Can I Do?* workshop could function as the backbone for such an initiative.

5.3. Knowledge working group

Sociodemographic indicators: Push forward conversations about the utility of and process for creating sociodemographic indicators for population data and patient records. Invite Indigenous Health to present about the challenges and benefits of an Indigenous identifier or learn about other regions' experiences with sociodemographic data (see Appendix A for resources). Discuss barriers to data collection for employees and clients and focus energy on building organizational readiness.

Appendix A: Resources for moving forward (literature scan results)

This annotated bibliography includes resources from my literature scan that may be useful as starting points for strategic or planning conversations. The headings reflect key areas for action that emerged from my findings.

Clipboard of frameworks for health equity organizational change

Kouri, D. (2013). *Learning from Others: Health Equity Strategies and Initiatives from Canadian Regional Health Authorities*. Toronto: Wellesley Institute. Based on a set of key informant interviews and website searches, this report summarizes strategic and operational activities being undertaken by regional health authorities in Canada. Although the specific activities are likely out of date, it provides a useful typology of strategies health authorities are using to promote equity.	Gardner, B. (2012). *Health equity road map: Overview*. Toronto: Wellesley Institute. This overview summarizes a seven-point roadmap for building equity into health care systems, some of which involve aligning health equity with system priorities and deliverables. Others focus on targeted services, thinking upstream and enabling innovation.
Chin, M. H., Clarke, A. R., Nocon, R. S., Casey, A. A., Goddu, A. P., Keesecker, N. M., & Cook, S. C. (2012). A Roadmap and Best Practices for Organizations to Reduce Racial and Ethnic Disparities in Health Care. *Journal of General Internal Medicine*, *27*(8), 992–1000. This paper synthesizes the findings of a series of systematic reviews on disparity reduction activities in the US. It provides a detailed framework that includes six steps for reducing disparities in care, an overview of common disparity reduction interventions and best practices for implementing those interventions.	Browne, A.J., Varcoe, C.M., Wong, S.T., Smye, V.L., Lavoie, J., Littlejohn, D., … Lennox, S. (2015). Closing the health equity gap: Evidence-based strategies for primary health care organizations. *Intl J Equity Health*, *12*, 152. Drawing from an ethnographic study of two Canadian primary health care clinics that serve marginalized populations, this paper outlines four key dimensions of equity-oriented primary health care and ten strategies for operationalizing equity-oriented services.

Health care services

Ouimet, M.-J., Pineault, R., Prud'homme, A., Provost, S., Fournier, M., & Levesque, J.-F. (2015). The impact of primary healthcare reform on equity of utilization of services in the province of Quebec: A 2003–2010 follow-up. *Intl J Equity Health*, *14*(1).

> Primary health care reform in Québec that involved the creation of multidisciplinary clinics with longer opening hours and better access to technical and specialist services has not necessarily improved health care utilization for people with very low socioeconomic status (SES). Instead, new care models have favoured people with high SES.

Blanchet Garneau, A., Browne, A.J., & Varcoe, C. (2016). *Dialectical relations between equity discourses and healthcare practices in primary health care*. Presented at the Centre for Culture, Ethnicity and Health, Melbourne.

> This paper discusses some key themes that emerged in my interviews, namely, equity being seen as 'extra' to usual practice and the challenges of creating new hybrid models of care. It also discusses contradictions in providers' internal responses to equity principles and strategies.

Quality improvement & performance measurement

Nakaima, A., Sridharan, S., & Gardner, B. (2013). Towards a performance measurement system for health equity in a local health integration network. *Evaluation and Program Planning*, *36*(1), 204–212.

> Describes the development of a health equity performance measurement plan in a Toronto health system. The system-wide plan was informed by existing hospital equity plans and feedback from hospitals. The article outlines a series of principles and considerations for creating measures, targets and infrastructure for health equity performance measurement.

Wong, S.T., Browne, A.J., Varcoe, C., et al. (2014). Development of Health Equity Indicators in Primary Health Care Organizations Using a Modified Delphi. *PLOS ONE*, *9*(12), e114563.

Based on an ethnographic study conducted in two Aboriginal health centers in Canada and consultation with patients and staff, this paper proposes a set of indicators for equity-oriented primary health care. Indicators reflect three areas: the clinic context (e.g. staff training), processes of care (e.g. trauma-informed care), and treatment outcomes (e.g. patient quality of life).

Health Quality Ontario. (2017). *Health equity in the 2016/17 Quality Improvement Plans*. Toronto: Queen's Printer.

A Canadian example of how health equity is being incorporated into quality improvement. Provides examples of custom health equity indicators contained in over 1000 quality improvement plans submitted by health care organizations and summarizes strategies being used by these organizations.

Increasing workforce & leadership diversity

Williams, S. D., Hansen, K., Smithey, M., Burnley, J., Koplitz, M., Koyama, K., … Bakos, A. (2014). Using Social Determinants of Health to Link Health Workforce Diversity, Care Quality and Access, and Health Disparities to Achieve Health Equity in Nursing. *Public Health Reports*, *129*(1_suppl2), 32–36.

A conceptual model that links nursing workforce diversity to health equity via the social determinants of health. This model is based on the assumption that health providers who are racialized or come from socioeconomically disadvantaged backgrounds provide better care to racialized and disadvantaged patients.

Health Research & Educational Trust. (2015a). *Equity of Care: A Toolkit for Eliminating Health Care Disparities*. Chicago: Health Research & Educational Trust.

Health Research & Educational Trust. (2015b). *Increasing Supplier Diversity in Health Care*. Chicago: Health Research & Educational Trust.

The US-based *Institute for Diversity and Health Equity* aims to support the advancement of racialized people into health care leadership positions. These two resources discuss strategies for increasing diversity in boards and management and increasing supplier diversity in health care.

Education & dialogue

Signal, L., Martin, J., Reid, P., Carroll, C., Howden-Chapman, P., Ormsby, V. K., … Wall, T. (2007). Tackling health inequalities: Moving theory to action. *Intl J Equity Health*, *6*(1).

Describes a workshop designed to raise awareness about health inequalities for senior health sector staff in New Zealand. The workshop used racism as a case study to explore how institutional practices contribute to inequalities. Participants practiced using a health equity assessment tool and created action plans for promoting equity through structural and institutional means.

Browne, A.J., Varcoe, C., Ford-Gilboe, M., & Wathen, C.N. (2015). EQUIP Healthcare: An overview of a multi-component intervention to enhance equity-oriented care in primary health care settings. *Intl J Equity Health*, *14*(1).

An overview of an organizational change intervention in four primary health care clinics in Canada that used standardized training modules (e.g. on cultural safety, trauma informed care) along with the support of a change consultant to help staff integrate their learnings into intervention design and practice.

Betancourt, J. R., Tan-McGrory, A., Kenst, K. S., Phan, T. H., & Lopez, L. (2017). Organizational change management for health equity: Perspectives from the Disparities Leadership Program. *Health Affairs*, *36*(6), 1095–1101.

The paper describes the educational components of a US-based program to build the capacity of health system leaders to address health disparities. It also reports on program participants' perceptions of the factors that are important for the success of organization-level disparity reduction efforts.

Blanchet Garneau, A., Pepin, J., & Gendron, S. (2017). Nurse-Environment Interactions in the Development of Cultural Competence. *Intl J Nursing Education Scholarship*, *14*(1).

Discusses the barriers faced by nurses in applying new learnings about cultural competence. The study found that nurses must often 'sidestep' institutional barriers, but that they deepen their understanding of cultural competence through their attempts to deal with and transform organizational constraints.

Sociodemographic indicators

Sinai Health System. (2017). *Measuring Health Equity: Demographic Data Collection and Use in Toronto Central LHIN Hospitals and Community Health Centres*. Toronto: Toronto Central LHIN.

This document describes Toronto's experience implementing mandatory sociodemographic data collection at hospitals and health centres. It reports on progress to date and outlines factors that helped and hindered implementation. The appendix contains the 8-item questionnaire currently in use.

Kirst, M., Shankardass, K., Bomze, S., et al. (2013). Sociodemographic data collection for health equity measurement: A mixed methods study examining public opinions. *Intl J Equity Health*, *12*(1), 75.

This Ontario study found mixed levels of support for sociodemographic data collection. Interviewees were most supportive of language questions and least comfortable disclosing income, sexual orientation and education, and preferred to have data collected face-to-face by a physician or clerk. Discrimination as a result of disclosure, data security, and misuse of information were key concerns.

Browne, A.J., Varcoe, C.M., Wong, S.T., et al. (2014). Can ethnicity data collected at an organizational level be useful in addressing health and healthcare inequities? *Ethnicity & Health*, *19*(2), 240–254.

Varcoe, C., Browne, A.J., Wong, S., & Smye, V.L. (2009). Harms and benefits: Collecting ethnicity data in a clinical context. *Social Science & Medicine*, *68*(9), 1659–1666.

These two Canadian papers discuss the challenges of collecting patient-level ethnicity data. The 2009 paper notes that although most people see the value of having ethnicity data, the process of data collection can be harmful, especially for racialized patients and communities. The 2014 paper calls for ethnicity data to be linked with measures of discrimination and other determinants of inequity and argues that more data is not necessary for meaningful action on inequities.

Callahan, E.J., Sitkin, N., Ton, H., et al. (2015). Introducing sexual orientation and gender identity into the electronic health record: One academic health center's experience. *Academic Medicine*, *90*(2), 154–160.

After 3½ years of preparation, the UC Davis Health System became the first in the US to collect sexual orientation and gender identity data on patients as a way to improve care. Building organizational readiness involved initial resistance from providers, conversation and education with staff, consideration of patient safety, multiple formats for data collection and improvements in the organizational climate for LGBT people.