



 Project for an Ontario Women's Health Evidence-Based Report

Using Performance Measurement and Reporting to Drive Equity in Health

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 For the POWER Study

ISQUA 2009 Annual Meeting
 Dublin, Ireland
 October 14th, 2009

A Tool for Monitoring and Improvement

- Performance measurement and reporting can be used to drive both health systems improvement and health equity.
- Quality improvement activities can narrow, maintain or widen inequities in health and health care.
- Overall performance improvement can mask inequities.
- The Project for an Ontario Women's Health Evidence-Based Report (**POWER**) is designed to serve as a tool to help policymakers and providers to improve the health of and reduce inequities among the women of Ontario.


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Ontario Women's Health Equity Report

Volume 1

- Burden of Illness
- Cancer
- Depression
- Cardiovascular disease
- Access to Health Care

Volume 2

- Diabetes
- HIV Infection
- Musculoskeletal Disorders (arthritis, osteoporosis)
- Reproductive and Gynecological Health
- Special Populations (low income, immigrant and older women)
- Social Determinants of Health


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Community-Engaged Research

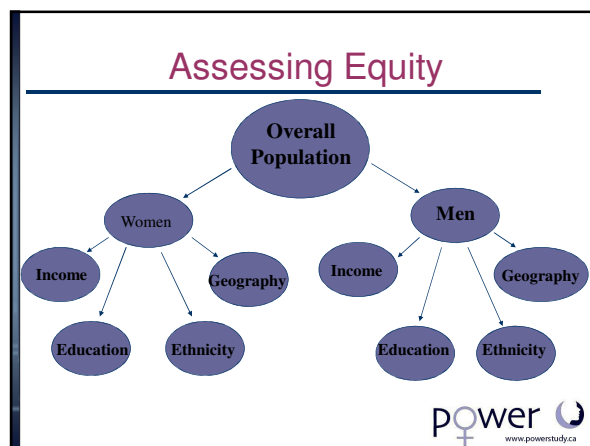
- POWER Study Roundtables
 - Inform indicator selection and Interpretation
 - Increase uptake of findings
- Consumers: representatives of community based organizations and associations
- Providers: Clinicians, Hospitals, Community Health Centres
- Policymakers: Government, Regional Health Authorities, Public Health, Health Data Agencies


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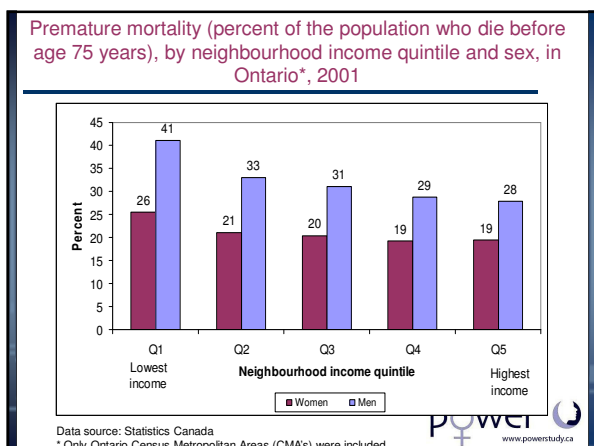
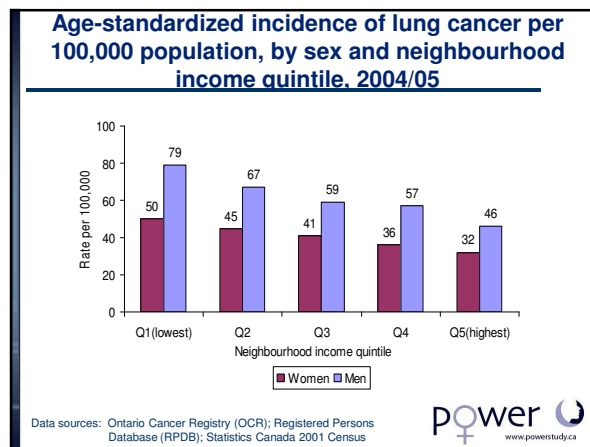
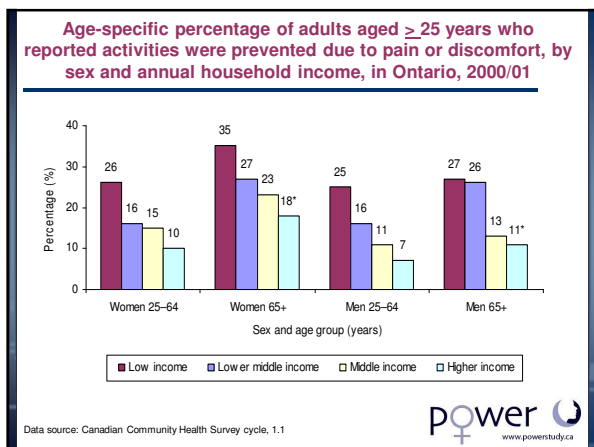
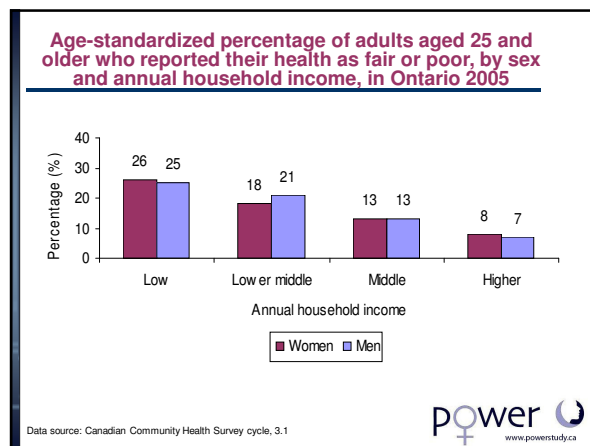
Methods

- Systematic review of peer-reviewed and grey literature to identify previously validated indicators across the continuum of care.
- A series eight of content specific technical expert panels used a modified Delphi process to select a comprehensive set of indicators for reporting.
- Indicators were measured using multiple secondary data sources including survey data, administrative data, disease registry data, and vital statistics data.
- Indicators were first stratified by sex and then by income, education, and ethnicity as data source allowed first at the provincial level and then at the level of Ontario's 14 Local Health Integration Networks.


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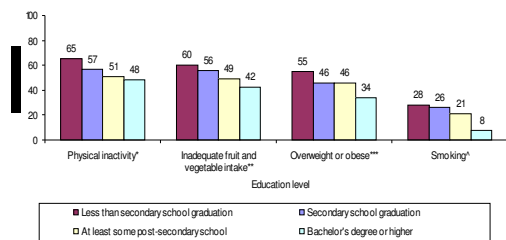
Health Status

- Risk Factors



Age-standardized percentage of women aged ≥ 25 who reported health behaviours that increase the risk of chronic diseases, by education level, in Ontario, 2005



Data source: Canadian Community Health Survey cycle, 3.1

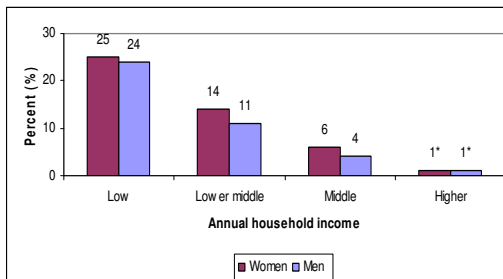
*Physical activity index was less than 1.5 kcal/kg/day

†Less than five servings per day

**Body Mass Index (BMI) >greater than or equal to 25 (calculated from self-reported height and weight)

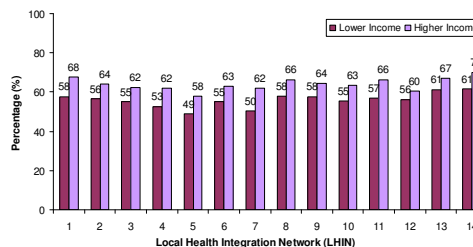


Age-standardized percentage of adults ≥ 25 years who reported food insecurity, by annual household income and sex, in Ontario, 2005



Screening

Screen-eligible women* who received a mammogram in the last 2 years, by neighbourhood income and LHIN, in Ontario 2005/06

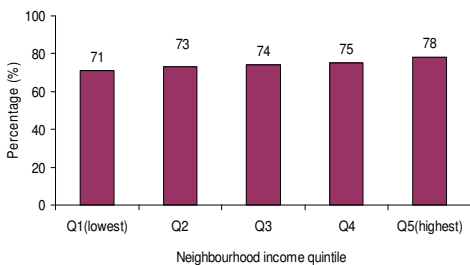


* Women aged 50 to 69 years with no history of breast cancer

Sources: Ontario Breast Screening Program (OBSP), Ontario Health Insurance Plan (OHIP), Ontario Cancer Registry (OCR), Registered Persons Database (RPDB), Statistics Canada 2001 Census



Age-standardized percentage of women who received radiation therapy after breast-conserving surgery, by neighbourhood income quintile, 2003/04 to 2004/05

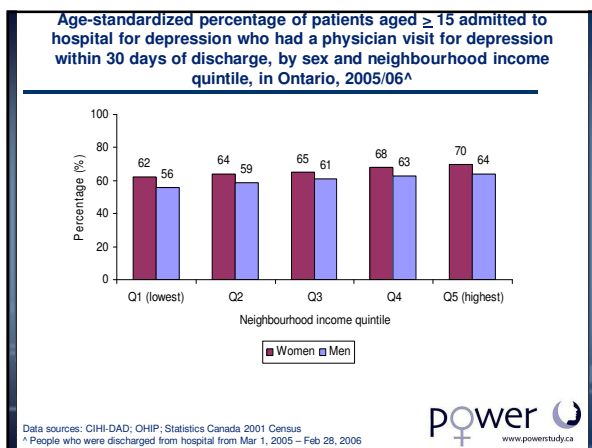
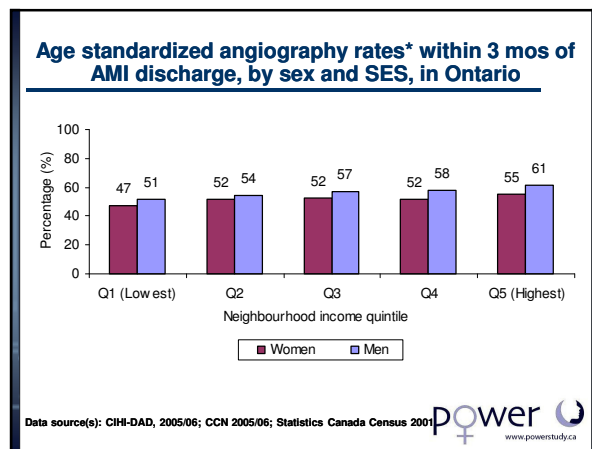
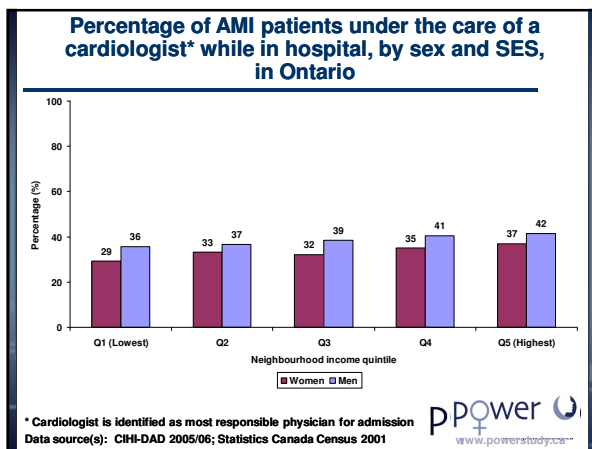
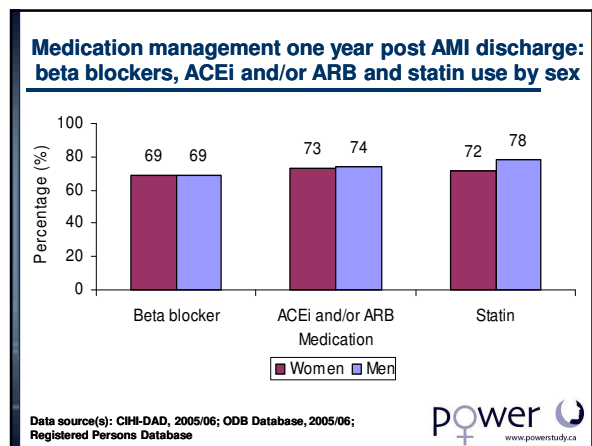
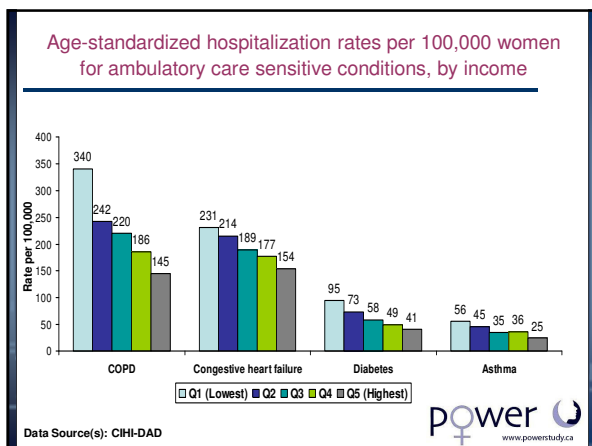


Data sources: OCR; CIHI-DAD; RPDB; OHIP; Statistics Canada 2001 Census



Hospital Care





Conclusions

- We found sizable and modifiable health inequities in Ontario associated with gender, income, education, ethnicity and geography. Many of these inequities result from chronic diseases and their risk factors.
- Inequities in health status were much greater than inequities in access to and quality of care.
- Inequities in screening and chronic disease management were greater than inequities in care of acute conditions.
- Our analyses identified many opportunities for intervention and improvement. We present objective evidence to inform priority setting, and provide a baseline from which to measure progress.

Impact of Inequities is Large

- If all Ontarians had the same health as Ontarians with higher incomes,
 - an estimated 318,000 fewer people (166,000 women and 152,000 men) would be in fair or poor health
 - an estimated 231,000 fewer people (110,000 women and 121,000 men) would be disabled;
 - There would be an estimated 3,373 fewer deaths each year (947 women and 2,426 men) among Ontarians living in metropolitan areas.



Limitations

- Limited to existing data.
- CCHS analyses used self-reported household income while analyses using administrative data used neighborhood income quintiles.
- No data on drug use among those under 65- may see larger SES inequities among those under 65 due to lack of access to perscription drugs
- Lack of data on access and quality of care in primary care and ambulatory care settings and it is possible that larger inequities are present at these sites.



Implications

- Our findings highlight the importance of routinely including gender and equity analysis in performance measurement.
- Need to incorporate a population health focus and address the social determinants of health.
- And health system redesign to improve chronic disease management specifically targeting those at greatest risk.
- Results are being used by the Ministry of Health and Long Term Care, Ministry of Health Promotion, the Local Health Integration Networks, and providers to inform priority settings and as a baseline from which to measure progress.



For more information, please contact us:

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The POWER Study is funded by Echo: Improving Women's Health in Ontario, an agency of the Ministry of Health and Long-Term Care. This presentation does not necessarily reflect the views of Echo or the Ministry.



Improving Women's
Health in Ontario
Pour l'amélioration de la
santé des femmes



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