Evaluation of the Social Determinants of Health Nursing Initiative Among Health Units in Ontario

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Outline of Presentation

- Social Determinants of Health (SDOH) Nurses Initiative background;
- Ontario Public Health Standards Framework;
- Knowledge and skills of SDoH nurses;
- Identified priority populations;
- Tools/resources for situational assessments;
- Equitable access to services;
- Activities of SDoH nurses;
- Challenges identified by SDoH nurses; and
- Impacts of the initiative.

Background of the Initiative

- 9,000 Nurses Commitment – a workforce stabilization strategy that is the cornerstone of Ontario's Comprehensive Nursing Strategy.
- Government commitment on health human resources: HealthForceOntario – purpose to ensure Ontario has right number and mix of qualified health care professional in the system.
- Application for funding for 2 Social Determinants of Health (SDoH) nurses in each of Ontario's 36 Boards of Health.
- New positions to provide expertise on, and supports to:
  - Identified priority populations as per surveillance and assessment activities; and
  - Address program/service needs of specific populations impacted negatively by determinants of health.

Background of the Initiative continued...

- Expected outcomes of the initiative included:
  - To enhance public health nursing capacity in Ontario's 36 boards of health;
  - To enhance capacity in addressing the SDoH by recruiting PHNs with specific knowledge and expertise; and
  - To enhance supports to address the program and service needs of specific priority populations impacted most negatively by the determinants of health.
- The SDoH Nurses Initiative was rolled out in April 2011.
- To date, funding has been requested in 34 of 36 health units and 66 PHNs have been hired for the initiative.
- Evaluation of initiative implementation based on qualitative data received from health units on SDoH nurses activities in 2011.

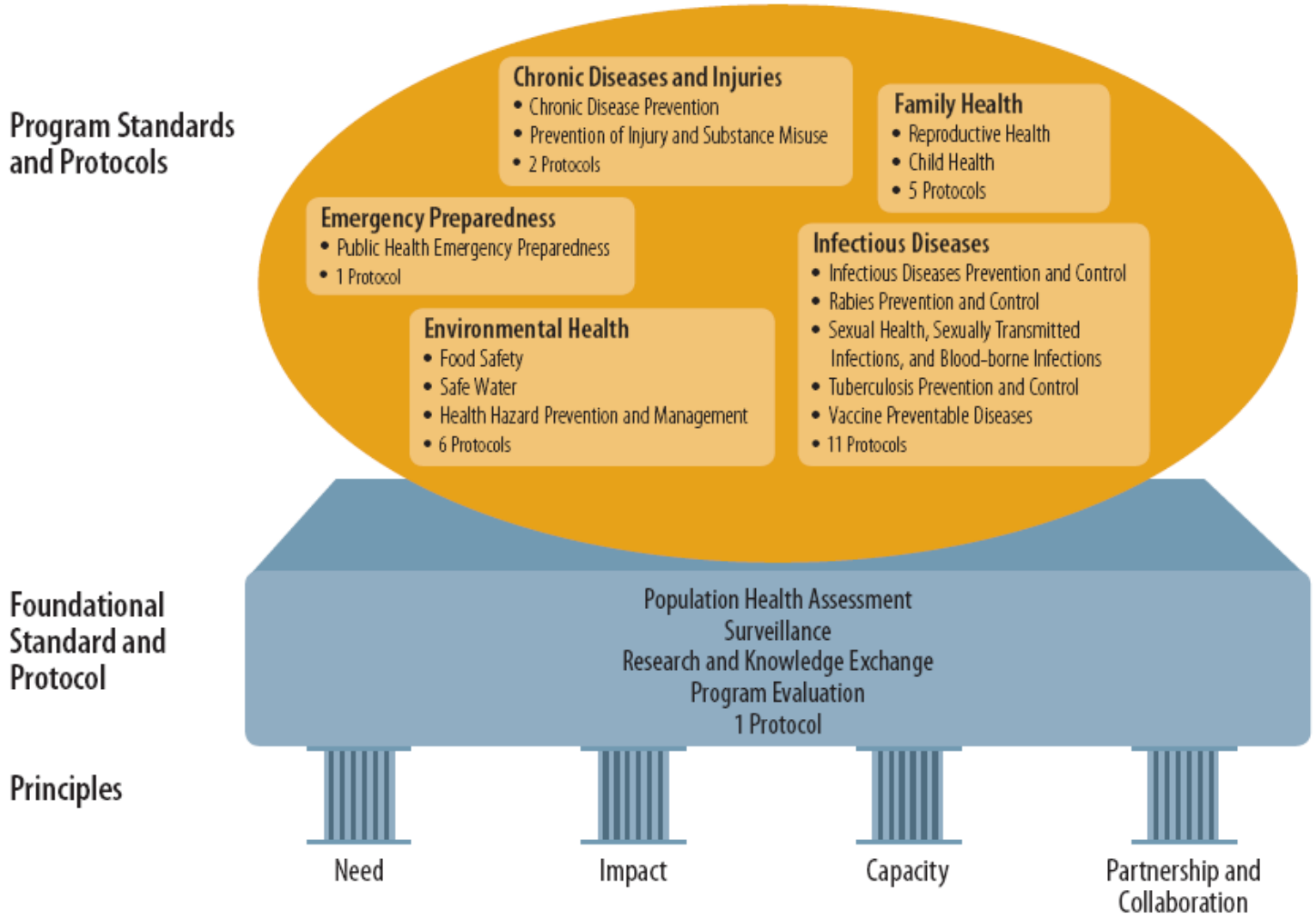
Framework for Public Health Services – The Ontario Public Health Standards

- The Ontario Public Health Standards (OPHS) establish Board of Health requirements for fundamental public health programs and services in Ontario.

- Boards of Health are required to consider the SDoH when identifying priority populations and their service/program needs.

- Boards of Health must:
  - Conduct surveillance to contribute to program planning and implementation;
  - Use population health, determinants of health and health inequities information to assess local population needs, including the identification of populations at risk; and
  - Determine groups that would most benefit from public health programs and services.

Ontario Public Health Standards - Atlas



Knowledge, Skills, Program Expertise of PHNs

- Years of experience in public health nursing:
  - Mostly cited from 10-19 years experience, followed by ≥ 20 years.
- Experience cited working with priority populations often identified within public health program streams.
- Under the OPHS Framework, programmatic expertise in:
  - **Family Health** -
    - *Child health*
    - *Reproductive health*
  - **Chronic Diseases and Injuries** -
    - *Prevention of injuries and substance misuse*; and
  - **Infectious Diseases** -
    - *Sexual health, STIs and BBIs* (e.g. harm reduction)
- **Mental health** (e.g. outreach work, marginalized groups, bed bugs) *

"Since early childhood development, as a key SDOH, is of particular relevance to the work in the Child Family Health Division, these priority populations … were determined to be the focus of the work for the PHN."

All quotes obtained from 2011 SDoH Nurses Initiative Activity Reports submitted by health units.

Knowledge, Skills, Program Expertise of PHNs

continued...

- Various public health core and public health nursing competencies brought to SDoH nurses role:
  - **Public health and nursing science** – theories, frameworks, health promotion, SDoH knowledge, health status of populations, illness and injury prevention;
  - **Assessment and analysis** – situational and community assessment, research skills, literature review skills, analysis of data and contextual factors;
  - **Policy and program planning, implementation and evaluation** – policy development within health units, reducing inequities to program and service delivery;
  - **Partnerships, collaboration and advocacy** – partnership development to share resources and access populations; community development initiatives; coalitions, advocacy for clients/communities, inter-sectoral engagement;

Knowledge, Skills, Program Expertise of PHNs

continued...

- **Diversity and inclusiveness** – priority populations with distinct histories/culture/contexts (e.g. First Nations, francophone, clandestine populations, etc.), cultural and diversity training, use of equity lens or frameworks;
- **Communication** – oral, written, inter-personal, presentation skills, social marketing skills, client interactions; and
- **Leadership** – networking, building capacity within the organization and with community partners on SDoH knowledge and learning, and self-directed/motivated.

"***PHN participates in surveillance activities and analysis and uses data to identify and address health issues within a population or community, and initiates strategies to improve health.***"

Priority Populations Identified

- Most common **priority populations** identified:
  - Children and youth,
  - Parents (single, teen, vulnerable),
  - Low income groups (e.g. families, individuals),
  - People experiencing mental health issues (child mental health, post-partum, suicide prevention),
  - Substance misuse/harm reduction clients,
  - Immigrant populations, newcomers, and displaced persons,
  - First Nations (urban, reserve, off-reserve), and
  - Homeless, under-housed, street involved.

- Much cross-over between priority populations and issues of SDoH (e.g. poverty, early childhood development, education, food security, etc.).

- Within some health units, SDoH nurses are focusing on **capacity building within the organization** and not a particular priority population.

Case Study: City of Hamilton Health Unit

- The Hamilton Health Unit utilized the SDoH nurses to build capacity within the organization across program streams by:
  - Engaging in activities to build awareness among staff and managers regarding the SDoH and of priority populations;
  - Working on a SDoH Committee to identify priority populations;
  - Adapting programs and services to better serve priority populations and reduce health inequities;
  - Supporting the development and utilization of practical tools to identify priority populations and address barriers; and
  - Developing SDoH communication plan and on-line resources.
- PHN #1 working to increase organization's capacity to identify vulnerable populations and address their needs systematically.
- PHN #2 focusing on neighbourhood development and will be working with external partners and organizations.

Conducting Situational Assessments

- The *Principles* and *Foundational Standard* of the OPHS call for situational assessments, use of data and evidence to inform program planning, implementation and evaluation, build partnership opportunities and capacity.

- SDoH nurses utilized tools and data sources to identify priority populations, community needs, and service and capacity gaps:
  - Agency data ;
  - Health reports;
  - Health surveys/studies;
  - Risk factors; and
  - Stakeholders.

"In 2009, --- Food Bank experienced a 30% increase in visits over 2008. Approximately 8% of --- households were considered food insecure in 2007/08."

Barriers Minimized and Facilitating Equitable Access

- SDoH nurses identified and made efforts to minimize barriers to programs and services. Themes reported included:
  - **Access to services** – referrals, hours of operation, translation, direct access for clients, tailored programs, etc.;
  - **Location** – mobile, remote regions, embedded in existing programs/sites, transportation fees;
  - **Client centered care** – working directly with vulnerable clients, building trust/rapport, therapeutic relationships, focus on education/skills building/self-efficacy programs;
  - **Low literacy** – appropriate materials/resources, face to face communications, minimal use of written materials;
  - **Cost** – no charge, minimal costs to clients, resource provision, cost-sharing with other agencies; and
  - **Food security** – food boxes/vouchers, meals, etc.

"***By bringing these services to their neighbourhood (in a unit of the complex), transportation was no longer a barrier.***"

Case Study: Thunder Bay District Health Unit

- Thunder Bay has developed activities to address the needs of priority populations and minimize barriers, jointly targeting several of the OPHS:
  - *Family Health Program Standards*
  - *Chronic Disease Prevention Standard*
  - *Food Safety Standard*

- Food skills and cooking programs for mothers and children conducted by health unit PHNs and dietician to address nutritional needs of mothers and children.
  - Emphasis is on food preparation skill development, low cost healthy eating and basic food safety skills.

- Tobacco cessation counselling and supports offered to mothers and their partners.

Reported Activities of the SDoH PHNs

Activities Internal to the Organization:

- **Situational assessments** – conducted to identify priority populations and high-need communities, identify gaps in service within health unit;
- **Literature review** – grey literature, evidence-based interventions for specific populations or geographical areas, review of data, etc.;
- **Program Planning, Implementation and Evaluation** – logic models, strategic planning, review of current health unit policies and procedures, best practice implementation, etc.
- **Building staff capacity** – e.g. training of all health unit staff, board of health members on SDoH, conducting situational assessment, etc.;
- **Use of equity lens** – tools, frameworks, integration into program planning and service delivery, organizational culture shift, etc.; and
- **Resource development** – SDoH library, modification/adoption of existing resources, priority populations assessment tools, etc.

" Three staff SDOH workshops were provided to approximately 90 ---- staff in November 2011 using a targeted approach."

Reported Activities of the SDoH PHNs continued...

Activities External to the Organization:

- **SDoH education** – presentations to agencies, partners, municipal government, etc., and actions to reduce barriers in accessing services;
- **SDoH committees** – PHN participation and engagement on committees and coalitions addressing SDoH, local inter-sectoral strategies, etc.;
- **SDoH PHN Network** – formation of an Ontario SDoH PHN community of practice to share resources, ideas, common interests in programs, etc.; and
- **Collaborative partnerships** – working in tandem with other organizations to engage and access priority populations and deliver services, etc.

"participating in interdisciplinary and inter-sectoral partnerships to enhance health of priority populations such as at the City planning tables to advocate for healthy public policy and resource allocation."

Case Study: Haldimand-Norfolk Health Unit

- People living in poverty and those with multiple barriers in receipt of Ontario Works (OW) were identified as priority populations.
- Due to time constraints, case managers at OW have been unable to offer some supports to their most vulnerable clients.
- Working in an integrated fashion with OW case managers, PHNs receive referrals and work on a one to one basis to provide supports to vulnerable OW clients.
- Utilizing the two PHNs for “grass roots” type of work to support vulnerable OW recipients by addressing barriers and facilitating seamless, integrated service to mutual clients.
- Examples of this work include obtaining identification; advocating for clients to stabilize their housing situations; and assisting clients to navigate complex community service system (including addictions and mental health supports).

Challenges Reported by Health Units

- **Complexity of clients, populations and SDoH issues** – stigmatization of populations, SDoH inter-connected, transient clients, issues beyond public health scope, culture shift;
- **Engaging priority populations** – hard to access, mistrust of government organizations, creative strategies required to maintain interest/build relationships, meet clients in community;
- **Transportation** – availability in rural areas, large geography, lack of public transportation, cost, community based locations;
- **Resources** – lack of time, limited staff, program and overhead costs, need for pooling resources or integrating services; and
- **Interventions** – finding evidence based strategies, minimal information on SDoH interventions, measurement indicators for evaluation, target and reach of programs.

"Clients have multiple issues – clients may present with one health issue but often have many other pertinent concerns that are not within the scope of public health."

Reported Impacts of the Initiative

- **Increased partnership opportunities** – development of new networks, resource sharing, collaborative approach to program design and implementation, targeted populations and geographical areas, and complementary work vs. duplication;
- **Clients** – greater access to vulnerable, hard-to-reach, isolated populations, increased referrals, delivery of multiple services;
- **Increased program uptake** – specific services, referrals received, telephone counselling, locations, and service hours;
- **SDoH awareness and equity lens** – educations sessions and organizational strategies increasing awareness of SDoH among health unit staff and external stakeholders, integration of equity lens in work conducted; and
- **Staff Capacity** – increased knowledge of staff on SDoH, greater focus on Foundational Standard, cultivating in-house experts on SDoH.

"This team has adopted a neighbourhood service delivery model that focuses on vulnerable populations in the 5th income quintile neighbourhoods and outlying areas. Programming is tailored to specific needs and supports the efforts of partners."

Questions?

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