Resource Guide to Ontario Health's Social Determinants of Health Framework

A Paradigm Shift

OCTOBER 2024

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Glossary

Here are a few commonly used terms that appear in this Resource Guide:

For the purpose of this document:

Community partner – A community partner is an organization or group that collaborates, shares resources and expertise with another to achieve shared goals and address community needs. Depending on context, community partners could vary (e.g., they can include hospitals, long-term care homes and organizations that offer wraparound supports, (i.e. to assist with housing, transportation, food security, social services etc.)).

- Types of community partners include government agencies (municipal governments, public health units), non-profit organizations (associations, community-led groups, community support services, French language health planning entities), educational institutions (schools, colleges, universities), social service providers (settlement agencies that provide advice and supports to newcomers, organizations that provide emergency shelter and food services), Indigenous-led organizations, and organizations led by and for equity-deserving groups (offering culturally responsive services that specifically meet the needs of these underserved populations).

Patient/client – The term ‘patient’ is inclusive of those who identify as a client, citizen, resident, community member, those with lived/living experience, and any others who receive health and social care services. The terms “patient” and “client” are sometimes used interchangeably.

Ontario Health Team (OHT) – Ontario Health Teams (OHTs) are a new way of organizing and delivering care that is more connected to patients in their local communities. There are 58 OHTs across the province providing full provincial coverage and ensuring that every person in Ontario can have the support of an OHT. The goal is to ensure that everyone in Ontario can benefit from better coordinated, more integrated care. (https://www.ontario.ca/page/ontario-health-teams)

Social Determinants of Health (SDoH) – The social determinants of health (SDoH) are the non-medical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems. (World Health Organization)

The mention or listing of specific services in this Resource Guide is solely for educational purposes and does not imply endorsement by Ontario Health.

What is the Social Determinants of Health Resource Guide about?

Now, more than ever, health care and community leaders recognize we can't improve health and wellness if we don't address non-medical health-related social needs like nutritious food, quality housing and supportive social connections.

Through extensive research and consultations, Ontario Health has developed a Social Determinants of Health (SDoH) Framework that embodies eight key evidence-based principles. Anchored in a population health management approach, the goal of the SDoH Framework is to drive a paradigm shift, supporting Ontario Health Teams (OHTs) in their efforts to incorporate social needs into care planning at the individual and population level.

The SDoH Framework is intended to be a practical tool to guide efforts in shifting the population health curve, improving overall health by addressing underlying health inequities and root causes of illness. This requires OHTs to "shift the focus" from asking "*what's the matter with you*?" to "*what matters to you?*" and moving upstream to address the health and social needs of all people in their attributed populations that span across the socioeconomic spectrum.

The SDoH Framework is built upon Ontario Health's Equity Inclusion Diversity and Anti-Racism (EIDA-R) Framework's key principle, Contribute to Population Health, which states "*we must have different strategies for how health and other social services leaders, providers, partners and impacted community members come together with a collective focus on the determinants of health.*"

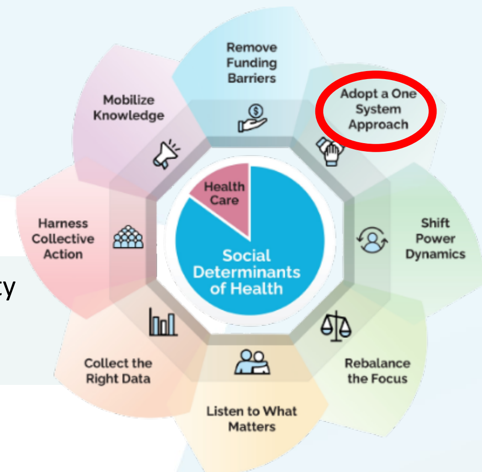
This accompanying Resource Guide dives deeper into each of the eight principles outlined in the SDoH Framework. This Guide is packed with actionable tools, resources, and real-world examples for OHTs to consider. As you navigate through this resource, remember to take your time. There's a wealth of information to process, and it's important to move at a pace that allows for full understanding and reflection.

We recognize this is complex work, however we will endeavour to take the advice from our subject matter experts who said, 'don't wait to get it perfect', 'don't try doing it alone', 'leverage the knowledge from early adopters' and let's journey down the path to learning together.

Together we can co-create healthier and more connected communities. We invite you to join us in driving this transformative change!

Do you have any examples of best practices in addressing SDoH? If so, we would like to hear from you. Please reach out to Elizabeth.Molinaro@ontariohealth.ca.

Adopt a one system approach



Adopt a one system approach by shifting from a siloed mentality that can cause unintended harms to integrating existing resources and expertise to collectively address needs.

This section is intended to provide clear actionable support for OHTs to *adopt a one system approach* by shifting from a siloed mentality to integrating existing resources and expertise to collectively address needs. To achieve meaningful and lasting improvements in individual and population health, efforts across diverse sectors including health care, public health, private sector, and social and human services must be aligned. The multiple causes of social problems, and the components of their solutions are interdependent and cannot be addressed by uncoordinated actions among isolated organizations.

When not aligned, siloed actions can cause unintended harms to people with complex social and health needs. For example, a parent may lose their housing subsidy if their child is placed in social care, as housing subsidies are sometimes reduced or terminated under such circumstances. This loss of housing stability can exacerbate existing chronic medical and mental health challenges for the parent, leading to increased burden on the health care system. Another example is the loss of mobility when a bus line discontinues service and transportation is required to access care.

Adopting a one system approach incorporates health considerations into decision making across sectors and policy areas. By challenging conventional thinking, we can advance bold ways of working with diverse partners to promote health, equity, and sustainability, and simultaneously advance other goals such as promoting job creation, transportation access and mobility, a strong agricultural system, and improved educational attainment.

What the research told us

The COVID-19 pandemic created an opportunity for more collaborative and integrated ways of working together, creating greater synergies and coordination across providers to *adopt a one system approach* to meet the needs of the population. The window has opened for sustainable change. To leverage this critical opportunity, we need to continue to move these relationships forward, expanding our efforts to maximize impact on the health of the public.

Here are recommendations from the research, some practical tips and examples to get started:

Shared Vision/Agenda

Collective impact is a network of community members, organizations, and institutions who advance equity by learning together, aligning, and integrating their actions to achieve population and systems level change. By building collective impact, we can bring people together in a structured way to achieve social change, starting with the creation of a shared vision/agenda for change, one that includes a

common understanding of the problem and a joint approach to solving it through agreed upon actions. Some practical tips to develop a shared vision/agenda are:

- Understand nuanced relationships between organizations, their incentives for collaboration, and any power imbalances that may apply.
- Consider including private sector, academic institutions of higher education, alliance, or coalition of organizations to play critical roles and/or lead key initiatives.
- Ensure work is a genuine shift from "downstream" problems to the "upstream" root causes.
- Allow time for partners to see that their own interests will be heard and ensure decisions are made based on objective evidence and that the best possible solution to the problem is used.

Example: Community Safety Well-being Toolkit was designed to assist municipalities, First Nations and their partners in developing, implementing, reviewing, evaluating and updating a local plan.

Mutually Reinforced Activities

The power of collective impact comes from the coordination of different skill sets, applied to individual activities that are aligned to a common agenda/vision. Invest time in understanding what others can bring to the table and identify population-level initiatives already in place that can be expanded upon. A practical tip to develop mutually reinforced activities is:

- Clearly communicate the common agenda/vision and allow each organization to be free to chart its own course aligned to it and have the team contribute to a shared measurement system to track impact and results.

Example: Situation Tables create a way of using systems and resources already in place in different, unified, and dynamic ways to address issues that require an integrated approach.

Shared Measurement Systems

Measuring a short list of indicators consistently across partners ensures efforts are aligned to the common vision and enables accountability and learning.

Ontario Health is implementing a standardized OHT performance framework to assist Ontario Health and OHTs to assess progress and identify improvement opportunities. The framework will be implemented in phases beginning with the initial 12 OHTs. OHTs are encouraged to select additional indicators and to build their capacities to measure and monitor their performance aligned to the OHT performance framework.

Practical tips include:

- **Create a common vocabulary** to ensure a shared understanding of terms and concepts.
- **Analyze results across multiple organizations** to learn from others, spot patterns, reveal inequities, and find solutions.
- **Use data to highlight interconnected problems** and common ground between sectors.

- **Apply shared measurement systems flexibly** to serve different needs.
- **Measure progress using standardized performance measures.**
- **Select additional local performance and process measures** that reflect OHT priorities and activities.
- **Leverage standardized patient and provider experience surveys** to understand outcomes and experiences and identify opportunities for improvement.
- **Develop a balanced scorecard aligned to the Quintuple Aim** that OHT Leadership Councils and management teams can use to monitor progress.

Example: Consider partnering with an information referral partner as you develop your shared measurement systems where you can find comprehensive, standardized resource data and visualized contact data for government and community partners.

Summary - Overall Questions to think about to *adopt a one system approach*:

1. Is the agenda grounded in shared objectives and are you leveraging comparative advantages of each partner?
2. Have you considered existing population-level initiatives focused on broader social determinants?
3. Have shared indicators been developed collaboratively to assess interaction between health and social services to guide integration?

How it works in real life

Community Wellness Hub - "One team, One vision, One plan"

The Community Wellness Hub, a partnership between the Halton Community Housing Corporation, the Burlington OHT and the Connected Care Halton OHT, exemplifies *a one system approach*, with their shared vision/agenda for change, and mutually reinforced activities.

This integrated model focuses on reducing hospital visits and allowing people to enjoy living independently in their home for as long as possible. It is based on a similar model from the United States, Program of All-Inclusive Care for the Elderly (PACE). The Community Wellness Hub is a free program for older adults living in affordable seniors housing that provides residents with health and social care provided by an integrated care team. The program's mission is to offer care and support through trusting relationships and an integrated approach that proactively identifies and responds to physical, mental, and social needs before individuals get into crisis and require acute care resources.

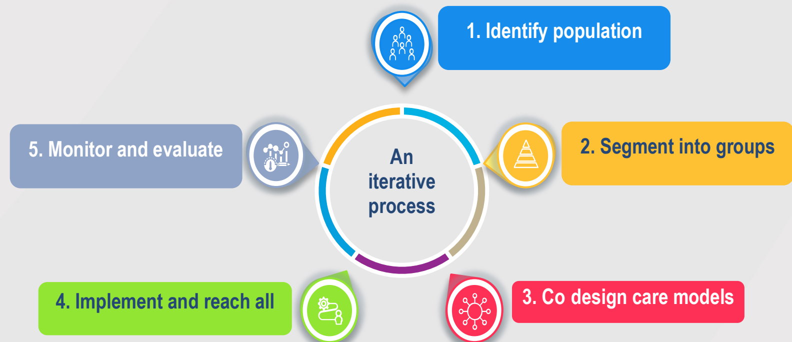
Services include:

- One-to-one support to connect to local health and wellness services.
- A community connector who helps coordinate care.
- Social events, exercise classes, and recreational activities to stay active and make new friends.
- Workshops about healthy living, mental health, managing medications and others.
- Tablet device loans and access to internet so people can stay connected with friends and loved ones.

Evaluation Results

Based on local measurement efforts, the Community Wellness Hub program has demonstrated the effectiveness of *a one system approach* by significantly reducing less urgent Emergency Department visits among its members by 14 per cent compared to a similar population segment in Ontario. When compared to their counterparts in Ontario with similar health complexities, Community Wellness Hub members exhibited lower hospitalization rates for Ambulatory Care Sensitive Conditions (ACSCs) such as asthma, diabetes, chronic obstructive pulmonary disease, heart failure, hypertension, angina, and epilepsy, in addition to experiencing shorter lengths of stay when hospitalized. This showcases the success of integrated care in addressing health needs proactively.

How does this align to OHT Population Health Management (PHM)?



OHTs are uniquely positioned to support population health through understanding their defined and priority populations' health and social needs and co-designing care models to best support those needs. To do this, OHTs are encouraged to use the five-component model for PHM in their work. *Adopting a one system approach* is critical for components applied across the five steps of the PHM model: it is essential to identify the priority population being targeted and gather segmentation data to uncover particular gaps in care and social needs. Co-designing and testing care models that address social determinants prepares OHTs to implement across all care delivery sites and once successful will require ongoing monitoring and evaluation as social determinants and evidence-based care changes over time.

Image and OHT Population Health Management content courtesy of Rapid-Improvement Support and Exchange (RISE), McMaster Health Forum

Where to learn more

UHN and the Gattuso Centre for Social Medicine, in partnership with the Government of Canada, the Province of Ontario, City of Toronto, United Way Greater Toronto and community organizations, are creating what is believed to be the first-of-its-kind-in Canada Social Medicine Supportive Housing site in Parkdale, Toronto.

Thorncliffe Park Community Hub, a member of the East Toronto Health Partners, breaks down silos and *adopts a one system approach*. Multiple collaborators bring together support services in one place under one roof to create a truly inclusive community space. From newcomer supports, language training and employment services to primary care and specialist services, seniors' programs, child and youth programs, and legal support and education, the Thorncliffe Park Community Hub offers comprehensive services tailored to diverse community needs.

Accountable Health Communities Model addresses health-related social needs through enhanced clinical-community collaboration. This model highlights *adopting a one system approach*, where clinical and community partners ensure services are responsive to population needs, improve health outcomes, and reduce health care costs. This model provides OHTs with a practical example of how social needs screening, referral, and community navigation services can improve integrated care.

Centre for Health Care Strategies spotlights health care organizations testing new ways to support individuals with complex health and social needs. OHTs can explore the numerous patient success stories and project case studies that exemplify *a one system approach* in action. OHTs can learn about innovative strategies and interventions that have been successful elsewhere, which can be adapted to their local contexts. These real-world examples can inspire and guide OHTs in creating more cohesive and integrated care systems.

Intersectoral action on the social determinants of health and health equity in Canada: December 2019 federal government mandate letter review identifies key commitments outside of the health sector that address the SDoH. Examples include areas where *a one system approach* can be strengthened (e.g., which ministers should work together, on which issues and to what end). OHTs can use this review to understand broad range of areas where federal departments will be taking action toward the common goals of social, health and economic well-being in ways that address SDoH. By leveraging this review, OHTs can strategize on fostering collaborations across sectors to address SDoH more effectively and promote health equity.

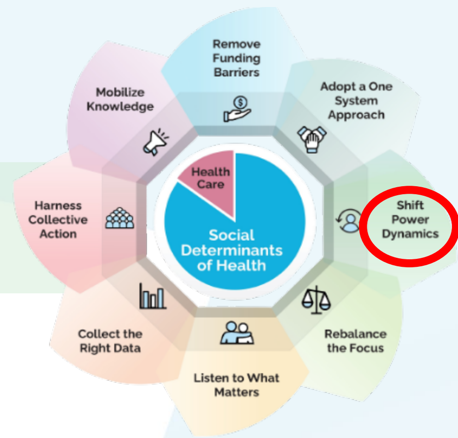
Lessons from COVID-19: Leveraging Integrated Care During Ontario's COVID-19 Response is a Rapid-Improvement Support and Exchange (RISE) rapid synthesis of both global and local research evidence related to integration efforts and lessons learned during the COVID-19 pandemic. OHT building blocks and strategies demonstrate how *a one system approach* is critical to integrated care. These lessons can help OHTs build more resilient and integrated teams.

Tools which may support implementation

Rural Health Information Hub links to numerous resources and tools to support organizations implementing programs to address SDoH in rural communities across the United States. This tool emphasizes the importance of *adopting a one system approach* to improve community buy-in, have the capacity to address SDoH, and make the most of limited resources in rural areas. OHTs serving rural communities can find strategies to improve community engagement and collaboration, ensuring *a one system approach* that maximizes available resources and effectively addresses SDoH.

Public Health and Quality Improvement Toolbox from the United States provides 40+ quality improvement tools, which give step-by-step instructions to assess a situation, make decisions, and plan a project collaboratively. These tools can help OHTs identify resources to best meet community needs and provide a structured method for continuous improvement and effective collaboration among diverse partners.

Shift power dynamics



Shift power dynamics to elevate the role of community partners who are well-positioned to lead based on their knowledge and trusted relationships.

This section is intended to provide clear actionable support for OHTs to *shift power dynamics* by elevating the role of community partners, including those who work outside the traditional health sector to lead based on their knowledge and trusted relationships. By recognizing opportunities to let others with this expertise lead, OHTs can accelerate progress by leveraging new resources and exploring new ways to deliver care that incorporate social needs.

The importance of *shifting power dynamics* was highlighted in the High Priority Community Strategy (now referred to as Locally Driven Population Health models [LDPHM]) originally launched to respond to the COVID-19 pandemic. It shone a bright light on the impact of the SDoH and the important role trusted community leaders play in helping individuals remove social barriers to improve health outcomes.

What the research told us

Research shows that SDoH can be more important than health care or lifestyle choices in influencing health. Moreover, sectors outside of health care, including education, municipalities, and social services, play pivotal roles in shaping population health outcomes. By fostering collaboration with these sectors, *shifting power dynamics,* and elevating the role of community partners, OHTs can work towards building diversified governance and leadership structures. This approach not only expands knowledge and skills, and enriches expertise, but also ensures a holistic focus on health and well-being for all, irrespective of people's interactions with traditional health care services.

Here are recommendations from the research, some practical tips and examples to get started:

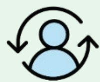
Shift leadership, roles, and responsibilities

- Ensure governance addresses social determinants by involving transparent and inclusive decision-making processes that give voice to all groups and sectors involved. This requires the development and implementation of transparent and inclusive practices that prioritize input from all diverse membership.
- Understand and acknowledge the nuanced relationships between organizations, their incentives for collaboration, and any power imbalances that apply, or competition for funding that may exist.

Example: Execute agreements and formally document mutual obligations and responsibilities, for example by using a Memorandum of Understanding. This process helps clarify roles and *shift power dynamics* by fostering collaborative decision-making among partners.

Establish shared goals, values, vision of care, and common understanding

- Clarify definitions and create a common language to enable a clear understanding of goals across providers.
- Understand the strengths and expertise available across partners and how each will contribute.
- Involve those with lived experiences and use their knowledge to understand inequities.
- Develop goals with equitable decision-making processes and shared leadership with interprofessional teams.



Example: Promote information sharing among all partners to increase understanding of the influence of SDoH and their root causes on health outcomes. Utilize frameworks like the Community Safety and Well-Being Planning Framework that highlights collaboration, information sharing and performance measurement in making communities safer and healthier. Developing strategies that are preventative as opposed to reactive will ensure efficiency, effectiveness, and sustainability.

Partner across organizations with previous experience working together

- Recognize where partnerships and collaborations already exist and continue to build on them to deepen trust and understanding of each other's goals and challenges.
- Define individual and collective roles within these partnerships to enhance health outcomes and reduce health inequities. This involves clarifying responsibilities and leveraging each organization's strengths to maximize impact.
- Learn the best methods for engagement in different contexts, supporting multiple approaches proposed by representatives from different sectors.
- Expand the definition of "care team" to include community-based organizations and local service providers fostering two-way information sharing and robust referral relationships. These relationships are essential in addressing SDoH, as community-based organizations have deep-rooted connections and expertise in addressing social and environmental factors that influence health outcomes.

Example: Community Paramedicine Programs, known for their ability to deliver sustainable and high-quality care in community settings, should be recognized as integral members of the expanded care team as they play a crucial role in bridging the gap between clinical and community-based services. By including them in the integrated care team, OHTs can leverage not only their unique perspectives and resources but also promote collaboration and *shift power dynamics* among diverse partners.

Support broader human services in addressing SDoH

- Support all sectors in the development of tools and capacity to address SDoH, recognizing integrating care requires a robust social service sector with inter-organizational infrastructure.

- Involve community partners in funding initiatives on equal footing such as digital and virtual care work.

Example: The South Georgian Bay OHT launched an electronic referral process to 211 for those facing SDoH-related challenges. This approach extends engagement with human services beyond traditional health care partners so patients can be connected to vital social and community resources via electronic referrals from primary care or the community. An outcome report is sent back to the primary care provider with the patient's consent, updating the patient's medical chart automatically.

Summary – Overall Questions to think about to *Shift Power Dynamics*:

1. Has leadership been established based on skill sets and ability to complement each other's contributions?
2. Are partnerships grounded in shared objectives and recognize the unique strengths and capabilities of each partner?
3. Have OHT resources, strengths, and capacities been documented? Has there been an asset mapping exercise focusing on broader social determinants?
4. Are social service referrals being tracked and evaluated to inform capacity development and resource allocation?

How it works in real life

Situation Tables

What is a Situation Table?

A Situation Table is a group of health and social service providers joining forces to deliver care, guided by common principles and processes to serve individuals or families in situations of acutely elevated risk, needing either secondary or tertiary prevention efforts which cannot be addressed by a single provider alone.

Situation Tables exemplify *shifting power dynamics* because they include and value the opinion of

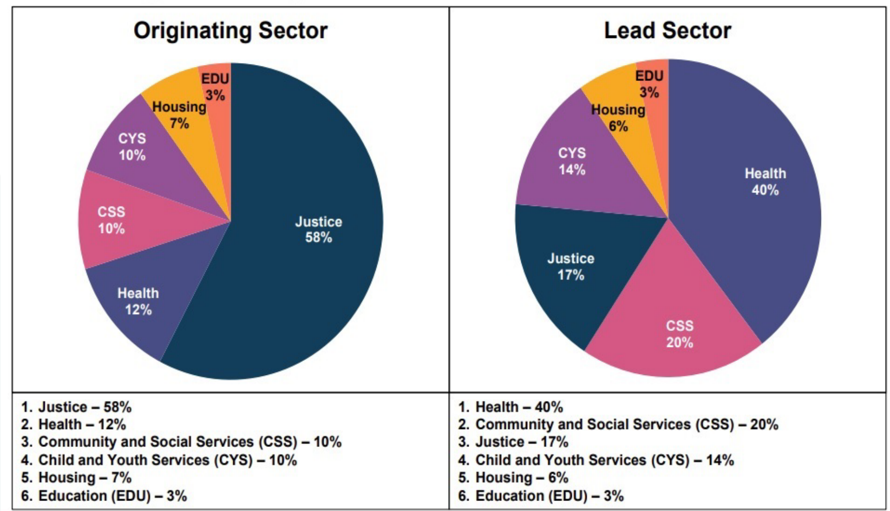


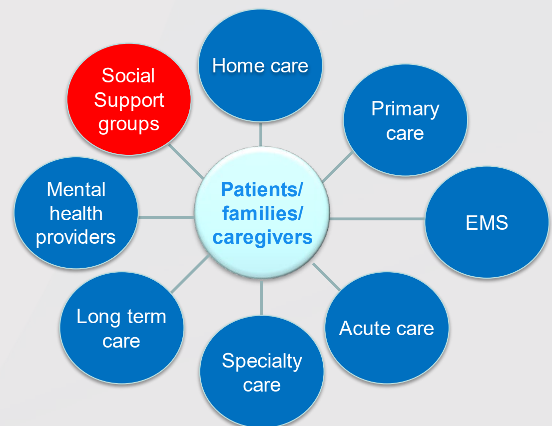
Fig 1: Risk-driven Tracking Database (RTD) for Situation Tables

professionals from a variety of human service backgrounds, including police officers, teachers, social workers, and youth workers. There are roughly 70 Situation Tables or variations of the model in Ontario.

What do these tables do?

Individuals, agencies, or organizations, work together to resolve situations of elevated risk for individuals in complex situations, acknowledging shared responsibility for reaching consensus in the interest of mutual outcomes. Everyone at the table contributes complementary capabilities; are willing to learn from each other; and benefit from diverse perspectives, methods, and approaches to common problems. Any partner can refer a client to the table, the client's situation is discussed, and the most appropriate service provider is identified to take the lead and interventions are planned from there. To learn more, Wilfrid Laurier University offers a free course called "Situation Table Training."

How does this align to OHT Population Health Management (PHM)?



Community partners that address SDoH bring important perspectives to population identification and segmentation. In some segments the role of SDoH may be the dominant factor when designing models of care. By ensuring we are building care models in full partnership with those who support members of our community on the ground, we are better equipped to design the models that truly meet the needs of those we intend to help.

Image and OHT Population Health Management content courtesy of Rapid-Improvement Support and Exchange (RISE), McMaster Health Forum

Where to learn more

TheDaCare: Leveraging Community Paramedics to Bridge Persistent Gaps in Care is participating in a Transforming Complex Care initiative supporting medically and socially complex people. By *shifting power dynamics to elevate the role of community partners,* community paramedics help close gaps in care for some of the highest-risk complex care patients who due to significant social and emotional issues, are not only experiencing serious challenges managing their health, but are also difficult to reach. OHTs can learn from this model as they work to engage community partners, thereby enhancing their capacity to reach and support complex care patients more effectively.

The Peel Black Health and Social Services Hub, expected to open in 2024, will provide integrated social services, mental health and primary care to holistically meet the needs of the Black African Caribbean community in Peel region. This unique hub *shifts power dynamics* by tapping into local expertise to leverage their knowledge and trusted relationships to inform the development of culturally safe and affirming services that improve health outcomes.

Rapid Synthesis: Examining the Intersections between Ontario Health Teams and Broader Human Services looks at evidence on integration of health and social services to support population health management. By *shifting power dynamics*, OHTs can leverage broader human services to improve the economic and social well-being of the population. These services could be related to childcare, children's and early-years services, disability services, employment and income supports, housing services, homelessness services and other community programs. OHTs can use this resource to develop strategies that incorporate diverse human resources, improving overall economic and social wellbeing for the populations they serve.

Tools which may support implementation

The King's Fund Communities and Health provides examples to build on community strengths to improve health outcomes that matter most to people and improve the factors that affect their health. By *shifting power dynamics,* integrated care systems value the role community partners play in improving and sustaining good health, working at the place and neighbourhood level where the link to communities is strongest. By using this resource, OHTs can learn how to integrate community partners into their teams, ensuring that interventions are relevant and effective at the local level.

Public Health England A Guide to Community-Centred Approaches for Health and Wellbeing outlines evidence-based community-centred approaches to health and well-being where community partners are empowered to contribute to improving health outcomes by developing local solutions that draw on community assets and resources. By using this resource, OHTs can learn about community-centred strategies to enhance engagement, build trust, and improve health outcomes through localized solutions.

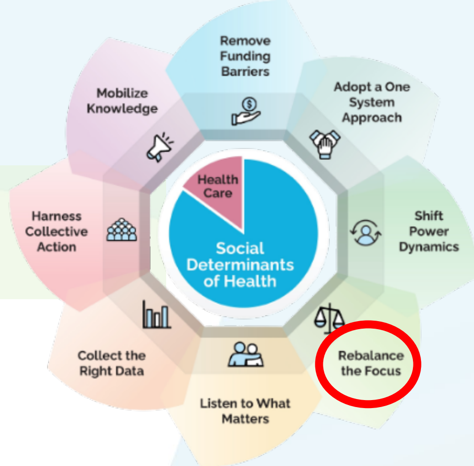
Partnership Assessment Tool for Health (PATH) is for community-based organizations providing human services and health care organizations working together to maximize the impact of partnership. By *shifting power dynamics*, PATH facilitates more effective collaboration and maximizes the expertise of community-based organizations serving low-income and socially marginalized people, including housing organizations, workforce development agencies, food banks and early childhood education providers. OHTs can use this tool to strengthen partnerships and ensure that interventions are comprehensive and inclusive, particularly for equity-deserving populations.

ReThink Health Conditions for a Healthy System of Health assessment tool captures 11 key conditions that together build momentum toward a transformed regional system of health. By *shifting power dynamics*, well-positioned community leaders can build on community strengths to improve health outcomes and focus on factors that matter most to people. This tool can support OHTs to foster community-led initiatives, ensuring that health improvements are sustainable and aligned with local needs and priorities.

Health Commons Solutions Lab's Locally Driven, Community-Led Toolkit provides ideas, tools and resources for any OHT in the process of designing integrated care through population health management and equity approaches. For those individuals adversely affected by the SDoH, achieving better health requires a team composed of more than health care professionals alone.

Health Commons Solutions Lab's Designing Community-Based Chronic Disease Prevention and Outreach Programs is a toolkit that describes the work of community providers to co-design integrated prevention and outreach programs. It serves as an illustration of the path OHTs can take to embrace equity-based population health approaches. Participants are supported through community health ambassadors.

Rebalance the focus



Rebalance the focus from a dominant biomedical model of managing illness to creating wellness, addressing the root causes holding illness in place.

This section is intended to provide clear actionable support for OHTs to *rebalance the focus* from a dominant biomedical model of managing illness to creating wellness, addressing the root causes holding illness in place. The field of medicine continues to operate under a “risk factor” paradigm focused on behavioural modification for high-risk groups as the main strategy for preventing disease (for example, smoking cessation, decreasing salt and fat intake and reducing sedentary lifestyle). Medical care is estimated to account for roughly 20 percent of the modifiable contributors to healthy outcomes for a population; the other ~80 percent are broadly called the SDoH: health-related behaviours, socioeconomic factors and environmental factors. There has been increasing evidence from around the world that improvements in the SDoH are crucial for a healthy population and we must look beyond the traditional health care system to improve population health.

What the research told us

All people struggle with social challenges at some point and require support in various areas at different stages of their lives. Challenges such as discrimination, social isolation or exposure to violence can occur regardless of socioeconomic status. We cannot effectively address the medical needs of individuals when their most basic social and economic needs are not being met. The COVID-19 pandemic provided an example of the impact of *rebalancing the focus* to underlying non-medical needs that resulted in holistic health care delivery with providers working in new ways with new partners, and we need to carry this momentum forward.

Here are recommendations from the research, some practical tips and examples to get started:

Review data, design interventions, and determine how success will be measured

- Understand the essential needs of your defined population.
- Involve community partners from the beginning, leveraging their expertise to understand the current resource landscape, gaps, and challenges.
- Integrate SDoH into existing workflows and share information across the expanded social care team.
- Develop shared goal(s) and performance metrics across partners that focus on wellness.

Example: The Toronto Population Health Status Indicators Dashboard provides an overview of health and well-being over time and across populations.

Implement interventions, both at the individual and community levels

- Ensure leadership buy-in to prioritize elevating the role of community partners.
- Develop a shared understanding and acceptance of the role of OHTs in addressing social needs.
- Establish a referral pathway that uses existing community providers who are best suited to directly work with clients to coordinate services.

Example: CP@clinic is an innovative, evidence-based chronic disease prevention, management, and health promotion program that shifts focus upstream and proactively builds interventions at the community level.

Evaluate results

- Build awareness of SDoH by routinely reporting on key essential needs and developed metrics to evaluate effectiveness.
- Use quality improvement methodologies to assess and enhance the impact of SDoH initiatives, informing their expansion and optimization.
- Evaluate and disseminate learnings across partners to improve service quality and access, ensuring continuous improvement and collective success.

Example: Unison Health & Community Services analyzes and uses data to inform the design of health/mental health promotion programs, including the Diabetes Education Program, Supported Independent Living, and Seniors Online Client-Centred Care.

Reflect on learnings with community partners and take next steps

- Compare information on needs from a variety of sources and mechanisms to deepen understanding.
- Continue expanding the care team to include broader community support service providers to advance integrated health and social care across the full care continuum.
- Continue expanding two-way information sharing and referral relationships.

Example: Inner City Family Health Team is committed to the health, happiness and full participation of homeless and previously homeless individuals in Toronto, and offers a holistic approach to care by distributing food, clothing, toiletries and transportation support, addressing not only medical needs but also SDoH.

Summary – Overall Questions to think about to *Rebalance the focus:*

1. Have OHT partnerships been broadened outside the health sector to understand population needs?
2. How can social service referrals be integrated into existing digital initiatives? How can this be built into OHT navigation services?
3. Is there a Community of Practice available to share knowledge and learning?
4. How can upstream and outreach approaches be used to improve population health management?

How it works in real life

I had diagnosed "abdominal pain" when the real problem was hunger; I confused social issues with medical problems in other patients, too. I mislabeled the hopelessness of long-term unemployment as depression and the poverty that causes patients to miss pills or appointments as noncompliance. In one older patient, I mistook the inability to read for dementia. My medical training had not prepared me for this ambush of social circumstance.

Laura Gottlieb, MD

San Francisco Chronicle 8/23/10

The St. Michael's Hospital Academic Family Health Team (FHT), Unity Health Toronto, a member of the Downtown East Toronto OHT, has become a leader in developing and implementing primary care-based programs to address SDoH and health inequities. Over the years, the multidisciplinary team continues to *rebalance the focus* by prioritizing the social risks to health within its programs.

Whether you work in an academic centre or small practice, there are steps that can be taken to address social needs that range from building programs in house to partnering with external community experts. Here are a few examples:

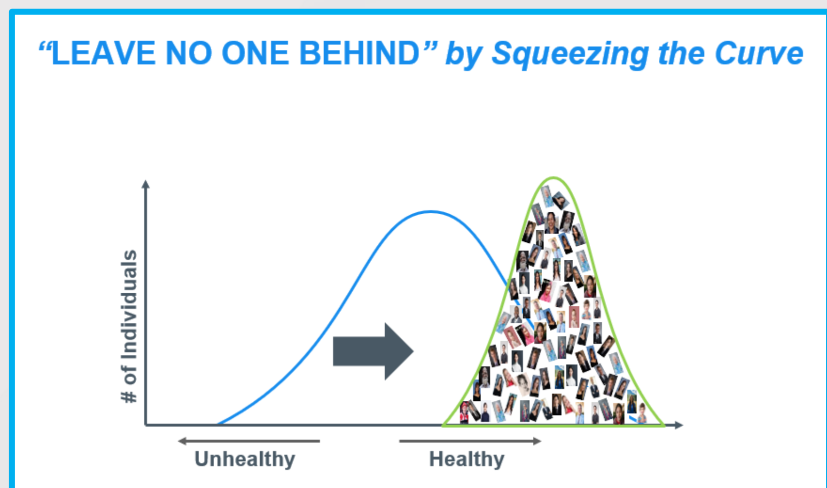
Income Support

- The Income Security Health Promotion Program at St. Michael's Hospital Academic Family Health Team, part of Unity Health Toronto and a member of the Downtown East Toronto OHT, has internal staff dedicated to supporting low-income clients. These efforts focus on interventions to enhance income security and financial literacy, activities may include helping clients file tax returns, and access eligible benefits.
- LAMP Community Health Centre's (CHC's) Income Tax Clinic leverages internal volunteers to assistance individuals who are unable to complete their own tax returns.
- Government of Canada offers a Free Tax Clinic program supported by volunteers and includes grants for hosting the clinics. In 2022 there were 1180 community organizations in Ontario, such as Somerset CHC, supported by 5300 volunteers helping 186,450 individuals that resulted in $629,402,000 refund, credit and benefits entitlements.

Literacy Support

- St. Michael's Hospital Academic FHT, Unity Health Toronto, a member of the Downtown East Toronto OHT, delivers a Reach Out and Read Literacy Program to children aged 5 and younger at their well-child visits which includes literacy-rich waiting rooms; counselling families regarding reading in the infant, toddler and preschool years and providing free age-appropriate, culturally diverse books.
- Milton Public Library introduced Baby Bee's First Reads Program in collaboration with Halton Healthcare and Milton Community Resource Centre which sends babies home from hospital with a literacy basket of goodies.
- Canadian Children's Literacy Foundation Early Words/Premiers mots program works with health care providers such as the Athens Family Health Team (FHT), a key partner in the Lanark, Leeds Grenville OHT, to help build strong baby brains and lay a foundation for literacy. The program provides high-quality culturally and age-appropriate books; evidence-based training for clinicians on how to talk to families about literacy development and practical resources to keep the conversation going at home for families. Its simplicity allows for easy implementation in primary care and community-based settings, ensuring widespread accessibility and impact. Parents and children appreciate the program as it fosters positive associations and interactions around reading, learning, and engagement with health care providers. In 2023 there were 34,000 books distributed and 25,000 children reached.

How does this align to OHT Population Health Management (PHM)?



When community partners with insights about SDoH are involved in co-designing person-centred care models and service mix, there is a natural shift to *rebalance the focus.* Co-design will incorporate the gaps uncovered during the segmentation of patient SDoH needs, risks and barriers, resulting in the "squeezing of the population curve" toward more people in the OHT's attributed population having access to medical care and social supports.

Image and OHT Population Health Management content courtesy of Rapid-Improvement Support and Exchange (RISE), McMaster Health Forum

Where to learn more

In early 2019, Southlake Regional Health Centre, as a member of the Northern York South Simcoe Ontario Health Team (OHT), introduced a groundbreaking integrated home and community care model known as Southlake@home—Ontario's first of its kind. Unlike traditional hospital-to-home bundled models, Southlake@home adopts a population-based approach, specifically targeting complex populations at the highest risk of becoming Alternate Level of Care (ALC). This innovative program redefines the integration of homecare services by incorporating social, community supports, and primary care mechanisms. This resource can support OHTs considering similar population-based integrated models of care.

Ontario Hospital Association Population Health Series highlights that SDoH are the non-medical factors that influence health outcomes and that SDoH affect everyone, underscoring the need to *rebalance the focus* away from just health care. This resource emphasizes that the better the conditions in which we are born, grow, work, live and age are, the more likely we are to experience better health and a longer life. OHTs can use this information to learn more about SDoH, thereby *rebalancing the focus* towards creating wellness and preventing illness.

Social Determinants of Health: The Canadian Facts 2nd Edition helps shift our thinking about what contributes to health and health inequities and what we can do about it. This go-to guide to address SDoH in Canada reminds us that what we really need to focus on is how to keep people healthy in the first place, *rebalancing the focus* away from medical interventions alone. This resource can support OHTs to shift their focus towards maintaining and promoting health by addressing the root causes of illness, moving beyond traditional medical interventions.

Tools which may support implementation

The College of Family Physicians of Canada - Social Accountability Working Group Resources take a SDoH approach to care delivery, aligning with the integrated, patient-centred focus of OHTs. Social accountability extends beyond direct patient interactions to encompass broader systemic responsibilities. This includes collaborating with policymakers, academic institutions, and community organizations to translate a vision of a socially accountable health care system into evidence-based, high-quality care. OHTs can leverage these tools to collaborate with various partners and work towards a socially accountable health system.

Canadian Housing First Toolkit provides useful “how to” information that can help community groups and individuals develop and implement Housing First programs. The toolkit was developed to assist other Canadian communities that are interested in adopting the Housing First approach. OHTs can leverage this resource to develop and implement Housing First programs and address housing instability, a critical SDoH.

Social Determinants of Health: Overcoming the Greatest Barriers to Patient Care -- Health Leads, a collective of public health, health care and community organizing professionals, advocates and change-makers, is working with United Way and 211 to share social needs challenges, barriers, and keys to success. These tools and programs help connect people with the essential community resources they need to be healthy and provide OHTs with strategies to connect patients with essential community resources and develop effective interventions to address SDoH, thereby improving patient outcomes and enhancing overall community well-being.

Social Determinants of Health Information Exchange Toolkit can support communities working toward achieving health equity through SDoH information exchange and the use of interoperable, standardized data. This toolkit offers strategies to collect, share and use SDoH data which can include both community- and individual-level data on access to food, housing, education, transportation, and other factors associated with health. This resource can support OHTs to effectively use SDoH data to ensure a holistic approach to care.

Health Commons Solutions Lab's Mobile Health Services Toolkit provides a curated set of resources to help organizations thinking about launching mobile services to provide access close to home for individuals who may have transportation or mobility issues. OHTs can explore how mobile health services can address the SDoH by improving access to care, reducing health disparities and promoting overall wellness.

Listen to what matters

Listen to what matters to people, using a strengths-based approach to better understand what works for individuals and how to address barriers that impact their health outcomes.

This section is intended to provide clear actionable support for OHTs on ways to *listen to what matters* to people, using a strengths-based approach to better understand what works for individuals and how to address barriers impacting their health outcomes. A 'strengths-based' approach to care involves understanding an individual's problems within the context of their unique strengths, identifying what they are good at, what they like to do as person, in addition to their medical issues. Identifying the resources someone has within themselves along with whom and what support they have around them are key elements to a holistic, person-centred, outcomes-focused, strengths-based approach.

For example, Myriam is a 67-year-old woman who speaks two languages, has a wide knowledge of international affairs, and environmental concerns. She is reliable, witty and loves interacting with people, learning, and teaching. She is also an elderly lonely person with mobility issues and sight loss who is finding it difficult to manage around the house and unable to go out on her own. Through a strengths-based approach to care, Myriam was supported to contact a nearby university where there are many international students needing help with their English conversation skills. Myriam now meets students twice a week and really enjoys the company and teaching which has addressed her feelings of isolation and loneliness.

By *listening to what matters* and using a strengths-based approach, Myriam's sense of purpose, skills and interests can be better understood and applied to enhance her self-worth while empowering her to improve her health and well-being.

What the research told us

Although clinicians recognize that social determinants influence health outcomes, many are unsure how they can intervene, often feeling helpless and frustrated when faced with the complex and intertwined health and social challenges of their patients. These issues are being felt worldwide, and organizations are coming together to tackle them, creating new ways of delivering good health and well-being.

Here are recommendations from the research, some practical tips and examples to get started:

What can be done at the patient level?

- Recognize that all patients, regardless of socioeconomic status, may face social challenges requiring support in various ways. These challenges can include discrimination, social isolation, or exposure to violence.
- Integrate social history questions into the patient encounter in a seamless way and document in the medical record ensuring the entire care team can take these considerations into account during care planning.

- Implement chart reminders and recall systems to flag patients, facilitating a shift towards more upstream practices.
- Ask about social issues in a safe space to make patients feel more comfortable talking about their concerns.
- Make referrals to social services and advocate for individual patients, for example writing letters on the patient's behalf to housing agencies, educational institutions, or the courts.

Example: Upstream Lab is a non-profit research lab based in Toronto dedicated to improving health and well-being of the population through addressing issues related to SDoH. Click here to learn more about an easy-to-complete tool for screening patients' social needs.

What can be done at the organizational level?

- Establish a social services referral pathway for the organization such as using existing staff to make connections leveraging OHT navigation work and maintained directories; train existing volunteers and add them to the team to connect with community programs; or develop a partnership(s) to hand referrals off to community experts.
- Provide resources, training, and ongoing support to ensure clinicians feel comfortable discussing social needs, creating a widespread culture change in the way everyone practices.
- Changes at the organizational level and senior management can help OHT partners create a more inclusive, supportive environment that addresses broader SDoH impacting health. Examples include facilitating easier access to appointments by covering transportation costs, ensuring effective communication for non-English speaking patients by offering interpreter services, and establishing referral targets by setting team goals to focus on addressing social needs, integrating SDoH into patient care.
- Use social determinants data to develop practice programs/policies to better intervene in your own context.
- Create patient experience surveys or set up a patient council to provide useful input toward redesigning clinical practices to be more accessible and responsive to patient social needs.

Example: Loving Spoonful, an innovative non-profit organization, co-located with the Kingston Community Health Centres, a member of the Frontenac Lennox and Addington OHT, ensures dignified access to local food. By *listening to what matters*, the initiative ensures that Local Food Stands are stocked with local produce at no cost, and Community Harvest Markets offer dignified access to food through a pay what you can model. This strengths-based approach leverages the assets of local farmers and volunteers, fostering a sustainable food system by actively involving community members in decision-making. Their Community Kitchens program offers cooking skills and provides a supportive environment, reducing social isolation. Loving Spoonful addresses health barriers, reduces food insecurity and enhances nutrition, working with various agencies to create a comprehensive support network.

What can be done at the community level?

- Partner with local organizations, private sector and public health to help identify local solutions that will have wide-ranging health effects on communities. For example, the Vanier Social Pediatric Hub has diverse partners that work effectively together to integrate a comprehensive and holistic approach to improve the health and wellbeing of children and families.
- Get involved in a community needs assessment by sharing knowledge on health impacts of social challenges and encourage broader policy responses to address them. For example Healthy Barrie is a partnership consisting of representatives from the City of Barrie, Simcoe Muskoka District Health Unit, Barrie Community Family Health Team and the University of Toronto's Dalla Lana School of Public Health.

Example: Establish partnerships with community groups, and social service leaders to provide individual services such as the seniors' Links2Wellbeing.

Summary – Overall Questions to think about to *listen to what matters:*

1. Are you using a strength-based approach? For example, asking, 'What does a good day look like to you?' How can this approach be integrated into patient interactions to foster a more holistic understanding of their needs?
2. Has a safe space been created to make patients feel comfortable sharing concerns openly? What steps can be taken to ensure confidentiality and trust in patient-provider interactions?
3. How can social history questions be seamlessly integrated into the patient encounter to capture relevant information for care planning? What strategies can be employed to ensure documentation of SDoH in medical records for comprehensive care coordination?
4. What resources, training, and ongoing support are needed to empower clinicians in discussing social needs with patients effectively? How can organizational leaders foster a culture change to prioritize SDoH considerations in clinical practice?
5. How can organizations leverage existing staff, volunteers, and community partnerships to establish robust social services referral pathways? What strategies can be implemented to ensure timely and appropriate referrals for patients in need?
6. How can patient experience surveys or patient councils be utilized to gather meaningful input for redesigning clinical practices to be more responsive to patient social needs? What steps can be taken to ensure diverse patient voices are heard and valued in the process?

How it works in real life

Social prescribing is a process that integrates social supports with medical care. By *listening to what matters*, health care providers can offer a way to refer patients to a range of non-clinical services in the community to address underlying causes of health issues through a 'social prescription'. Social prescribing is expanding globally in various forms and can be adapted to different communities and care

settings. Programs are currently running in OHTs at Community Health Centres (CHCs), Family Health Teams (FHTs), municipalities, pediatrics centres and acute care.

Pediatrics Models

What is social prescribing?

The Vanier Social Pediatric Hub asked children and youth what would make them feel happy and the answer was soccer, swimming, dance, basketball and more. The Hub's social and medical teams built a bank of activities and resources working with local businesses and organizations to help fund it. Families can self-refer, or a referral can be made by a health care provider or school. This gives children and youth a voice in their own care and draws on their strengths as well as those of their family and community to improve health and well-being.

Primary Care Models

Alliance for Healthier Communities launched a successful pilot in 2018 with eleven CHCs across the province working with mentors from the United Kingdom. They have been growing social prescribing ever since, becoming a leader in establishing it across Ontario and globally. They have several models in operation including a Social Prescribing for Better Mental Health and a Black-focused Social Prescribing Project. Their wealth of information is captured in this guidebook and they have established two Communities of Practice for ongoing learning.

Harrow Health Centre FHT , a member of the Windsor Essex OHT, has partnered with several organizations to connect individuals to a range of local, non-clinical services. Primary care providers forward a social prescription referral to an inhouse 'link worker' who then connects the individual with appropriate services based on specific needs. Patients can also self-refer to the program by accessing their website or calling the clinic and setting up an appointment with the 'link worker'.

Health Connectors in the Frontenac Lennox and Addington OHT use motivational interviewing strategies to understand what matters to patients and identify individual social needs. Through social prescribing, they provide guidance, help, and information about community resources. This approach empowers patients, giving them a greater sense of control over their lives, enabling them to address their SDoH and improve their quality of life.

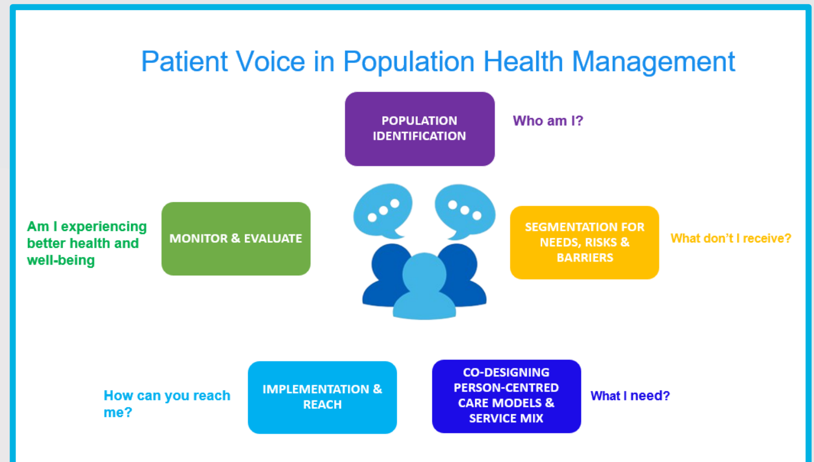
Seniors Models

Links2Wellbeing recognizes isolation and loneliness significantly impact the health and well-being of older adults and are working with Alliance for Healthier Communities, the Older Adults Centres' Association of Ontario and local city Seniors Active Living Centres (SALC). Providers send a referral to the local SALC who then connects the client with a volunteer 'link ambassador' who works with the individual to connect them with programs of interest.

Acute Care Models

A partnership between CBI Health, Southlake@home and Community & Home Assistance to Seniors (CHATS) developed a social prescribing pathway that supports transitions from hospital to home. It is accessible through multiple referral sources including self-referral, homecare, hospital, health care providers and self-referral. Individuals are screened by a CHATS 'link worker' and a shared care plan is developed based on a comprehensive, team-based process.

How does this align to OHT Population Health Management (PHM)?



Listening to what matters ensures the patient's, family's, caregiver's voices are incorporated at each step of PHM. Lived experience can fine tune population identification by highlighting marginalization that is not measured; it uncovers gaps, barriers, and risks during segmentation; and critically it ensures that care models address more than medical care improvements by uncovering the social support gaps that prevent patients from participating effectively in their care. Ongoing input from those with lived experience ensures that monitoring of the implemented care model remains aligned with the fundamental principles of addressing SDoH.

Image and OHT Population Health Management content courtesy of Rapid-Improvement Support and Exchange (RISE), McMaster Health Forum

Where to learn more

Lessons from the Wigan Deal shares highlights from a project implemented by The King's Fund in the UK, emphasizing the importance of adopting 'strength-based' or 'asset-based' approaches. These approaches focus on nurturing the strengths of individuals and communities to build independence and improve health. By leveraging this resource, OHTs can enhance their strategies and services to better align with the strengths and needs of their communities, *listening to what matters* and ensuring that care is both responsive and empowering.

National Academy for Social Prescribing in the UK has developed 13 publications to date which suggest that social prescribing can reduce costs and pressure in the health care system. Through this resource, OHTs can gain insights into integrating social prescribing into their services, which helps tailor care to what truly matters to individuals, promoting a more holistic approach to health and well-being. By leveraging these insights and *listening to what matters*, OHTs can implement social prescribing practices that address the broader SDoH, leading to improved patient satisfaction and outcomes.

Feed the Birds is a volunteer befriending initiative in the UK that illustrates the concept of *'listening to what matters'* to individuals. This initiative is dedicated to reaching those experiencing loneliness and social isolation, recognizing the profound impact of social determinants on health outcomes. Exploring initiatives like Feed the Birds, OHTs can be inspired to adopt similar community-driven strategies that foster meaningful connections and support networks, enhancing overall community health and resilience. Implementing such strategies can help OHTs address social isolation, a key determinant of health, thereby improving mental and physical well-being in their communities.

Tools which may support implementation

Current State of Social Prescribing in Canada is a 2022 summary report outlining pathways, implementation processes and examples. OHTs can leverage this resource to learn about the many programs, services and initiatives that are focused on connecting individuals to non-clinical supports that provide a person-centred approach to improving health and well-being.

WHO (World Health Organization) Toolkit on How to Implement Social Prescribing outlines the steps required to introduce social prescribing initiatives and includes sample materials which can be adapted to the local context. OHTs can use this toolkit to implement community interventions that are tailored to local needs, enhancing the effectiveness of social prescribing efforts.

Centre for Effective Practice Social Prescribing provides an evidence-based resource designed to support health professionals working in primary care to implement social prescribing in their practice. Health professionals in OHTs can learn practical ways to address SDoH by connecting people with a range of resources that support their holistic health and wellbeing.

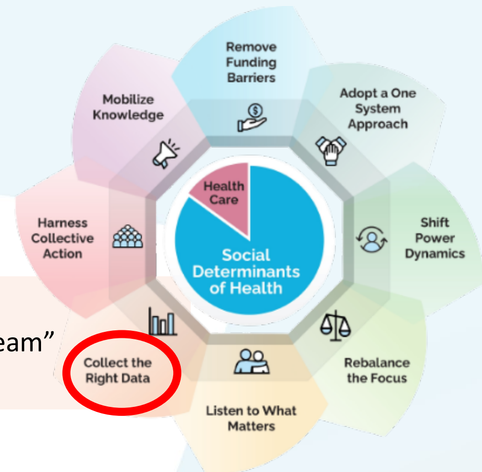
Bridges Out of Poverty provides tools to implementing a strength-based approach to working with people living in poverty, either generational or situational. This resource can support OHTs to gain insights on how to *listen to what matters*, to avoid the “fix-it” approach and focus on the building of resources at individual, organizational and community levels.

Canadian Institute for Social Prescribing (CISP) is a new national hub to link people and share practices that connect people to community-based supports and services that can help improve their health and wellbeing. CISP is committed to building and celebrating social prescribing that prioritizes health equity, community leadership and collaboration. It is part of a global movement of people bringing community capacity and health care services closer together by directly addressing the SDoH, from loneliness and social isolation to racism and ageism to income and housing and much more. OHTs can review CISP’s list of resources to learn more about the numerous tools available to support a person-centred approach that fosters holistic wellbeing and community belonging.

Health Commons Solutions Lab’s Culturally Informed Outreach Planning Tool – This toolkit shares a customizable process to co-design culturally sensitive outreach strategies. By *listening to what matters*, this comprehensive resource helps navigate the intricacies of preventative disease screening outreach, which vary across unique geographies, cultures and groups. It addresses how peer workers can tailor their outreach appropriately.

How to use social prescribing to support Population Health Management: A guide for Primary Care Networks offers social prescribing case studies, tips, questions to consider, resources and more. OHTs can use this resource to learn more about understanding population’s circumstances and needs, connecting together different aspects of care, and moving toward proactive, personalized and preventative interventions.

Collect and link the right data



Collect and link the right data on people's needs to enable a wellness approach to identify "upstream" causes of "downstream" problems.

Collecting and linking the right data is crucial for addressing SDoH and promoting health equity. This section is intended to provide clear actionable support for OHTs to *collect and link the right data* on people's needs, enabling the identification of "upstream" causes of "downstream" problems. The focus is transitioning from primarily relying on hospital data to a more inclusive approach that encompasses data for a variety of sources, including from community-based organizations, primary care practices, and housing and social service providers.

We can start by reviewing the health, sociodemographic, individual and community social needs data we have now. Next, we can integrate social services data by asking community support service partners to share their key data sources to understand the impact of SDoH (e.g., how many individuals need rides annually, how many meals are being provided to whom - for example, adults, seniors?). Then we can fill in the gaps by reaching out to non-traditional partners outside the health care sector such as municipalities that have additional community level data. Finally, we can work closely with those with lived experience and providers to fully understand and appreciate the story behind the data.

Integrate Social Needs Screening into Patient Consultations

To effectively address SDoH and promote health equity, it is essential to integrate comprehensive social needs screening into patient consultations. This involves gathering individual data—specific information about a person's unique social circumstances, such as their living conditions, access to food, education, employment, and social support networks. Unlike traditional medical inquiries that primarily focus on disease states and symptoms, social needs screening encompasses questions that identify barriers to health and well-being. For example, clinicians might ask about a patient's housing stability, financial constraints, transportation access, or experiences of discrimination.

Avoid assumptions that can lead to misdiagnosis, for example assuming someone who has post-secondary education would not be using a food bank, thereby missing the root cause of abdominal pain being hunger. By understanding these broader social factors, healthcare providers can tailor interventions more precisely to improve overall health outcomes and address inequities in healthcare access and quality. The data gathered from these screenings will inform the co-design of upstream, proactive, integrated, person-centred, and equitable solutions to improve population health. The data will inform the co-design of upstream proactive, integrated, person-centred and equitable solutions to improve population health.

What the research told us

Imagine if providers had meaningful information on "wellness/community vital signs" at the point of care to inform panel management efforts. All providers could see a client knowing not just their blood pressure, pulse, respiratory rate, and temperature, but also whether they live in the presence of poverty, healthy food and water sources, walkable streets and parks, what social capital they have and how these add up to predict increased risk of morbidity, early mortality, or other adverse health outcomes.

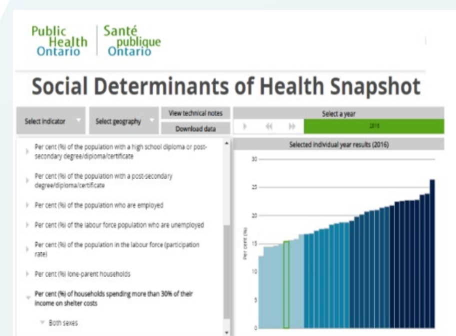
Start by thinking about what you want to learn about your community. What questions do you want the data to answer, for example 'What social needs are impacting the health of people in your community? What is the community saying they need to address these issues? Who currently provides services to meet these needs? What does demand look like and is it being fully met?' This will help narrow down what data is needed and determine how you will use it.

Here are recommendations from the research, some practical tips and examples to get started:

Use what you already have

- Work with community support service providers who have data and expertise on social services and the qualitative story on experience accessing services.
- Municipalities, District Social Service Administration Boards and Public Health engage and collect data from their communities and have existing tools to use.
- Along with the OHT Data Dashboard, Ontario Health is building a Provincial Health Services Directory working with 211, Healthline, Connex and others that will provide an up-to-date resource.

Fig 2. Public Health Ontario Data & Analysis



Example: Public Health Ontario's Social Determinants of Health Snapshot is a collection of interactive map-based dashboards showing both geographic and temporal trends for key public health indicators.

Understand what data is missing

- Build social services into planned asset mapping to identify new data opportunities and gaps.
- Select an existing data collection tool or revise or build a new one that meets all OHT partner needs.
- Reflect on multiple issues for social risk factors and focus on strengths vs. problem lists.
- Understand the perspectives of people in the community and community support service organizations who work closely with individuals with lived experience and can provide insight on trends and connections between issues. Involve them from the beginning in decision-making on what data is collected and how.
- Have a plan for the data and what it will reveal; consider how this information will inform clinical practice and connections to meet social needs.

Example: Health Commons Solutions Lab's [Mapping Neighbourhoods – A Field Guide for Creating Tools to Analyze Neighbourhood-level Data] provides practical advice on how OHT partners can join their data to give a comprehensive picture of health in their community.

Develop new metrics

- Develop new metrics that tell the full patient story and shift focus from measuring illness to wellness. For example, decreased number of visits to primary care or increases in social activities and services.
- Ensure metrics capture data for people using and not using health services, working with partners outside the health care sector to:
    1) Define SDoH domains of interest.
    2) Develop guiding principles for measuring and reporting patient-level SDoH across the OHT.
    3) Identify how SDoH data will be used for activities like care coordination and referrals, population health management and program evaluation.
- Start with process measurements such as the number of people screened, or the number of people connected to a social service agency as a standardized metric across OHT partners to understand social service demand. It might take more time to see outcomes, but having connected process measures will make sure things are moving in the right direction for the best results.

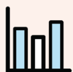
Example: In Appendix B of the Social Prescribing in Ontario Final Report March 2020, OHTs can access new metrics focusing on loneliness, social support, and self-reported wellbeing indicators. These metrics reflect a commitment to understanding individuals' holistic needs beyond clinical care.

The importance of who collects data and how they do it

- **Purpose and Training:** Ensure people collecting data understand why they are doing it, and what will be done with the information. Providers should be comfortable asking questions in a way that makes patients/clients comfortable and have received dedicated training for this purpose.
- **Involvement of Community Members:** Patients/clients and community members should be involved in the design of the data collection process. They can help create a comprehensive screening protocol – whether it involves specific tools or broader data collection methods - and follow-up plan that pays attention to community cultures and equity.
- **Respect for Autonomy:** Recognize not everyone will want assistance with their social needs. It is crucial to ask for permission before collecting this type of information. This means explaining the purpose of the questions and ensuring the participation is voluntary, thereby respecting the individual's autonomy and preferences.

- **Avoiding Stigma**: When collecting community health data, avoid words like “help”, “need”, to prevent feelings of stigma. Use neutral language that respects the dignity of individuals being surveyed.
- **Holistic Data Utilization**: Data may be used not just for immediate interventions but also to gain a holistic view of the defined population. This broader perspective can inform long-term planning and resource allocation to address SDoH.
- **Developing Workflows:** When developing workflows for data collection and utilization, consider the following:
    - **Indigenous Data Sovereignty:** Have Indigenous data sovereignty principles been considered? This involves recognizing and respecting the rights of Indigenous pepoles to control data about their communities.
    - **Privacy Considerations:** Have you consulted with your Privacy team on collection, use or disclosure of data? Ensuring compliance with privacy regulations and ethical standards is crucial.
    - **Screening Logistics:** Determine who conduct the social needs screening, when and how often it will be done. Decide whether the screening will be conducted using an Electronic Medical Record (EMR) , electronic tablet or paper and where this data will be securely stored. These decisions impact the efficiency and effectiveness of data collection.

By addressing these considersations, OHTs can ensure that the data collection process is respectful, efficient, and tailored to meet the needs of the communities while safeguarding privacy and promoting equity.



Example: Harrow Health Centre provides comprehensive resources and materials in collecting client demographic data.

How it works in real life

211 is a helpline that connects people to social services, programs, and community supports. When individuals contact 211, anonymized data is collected about their location, needs, service availability, gaps, and barriers. This data includes needs related to food security, housing, income support, family services, and employment, and is publicly available through their Business Intelligence (BI) Dashboard.

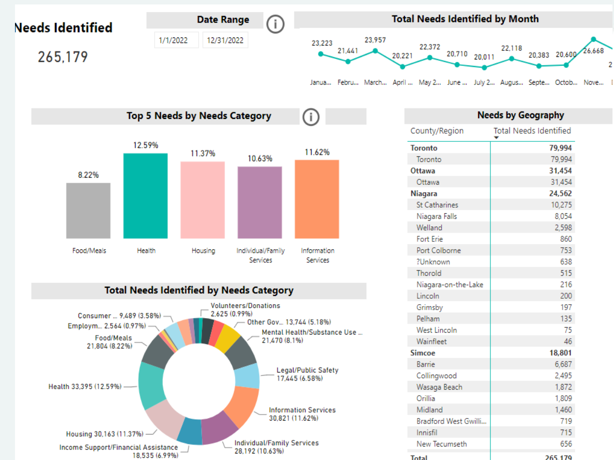


Fig 1. 211 Business Intelligence Dashboard

211 collaborates with the South Georgian Bay Ontario Health Team (SGB OHT) to build an electronic referral process connected to a Community Information Exchange (CIE), an online platform that enables access to coordination and system navigation services. As a result, referrals to 211 can be made by primary care

providers or through a web-based form. Outcome reports are sent back to the patient's primary care provider, and unattached patients are connected with SGB OHT Navigation for primary care support.

With patient consent, the CIE is populated with information from the initial 211 referral and subsequent interactions. This creates a longitudinal record accessible to all providers involved in a patient's care, including community-based organizations. This system reduces the need for patients to repeat their stories and ensures seamless transitions between services.

The CIE allows providers to combine health and social information to address root causes of illness and prevent further health issues. For example, a patient with uncontrolled diabetes due to lifestyle changes after a spouse's death can be connected to Meals on Wheels through 211. The data also helps identify service gaps, which can be addressed collectively by the OHT.

Benefits of the CIE

- **Individual Level**: Provides a universal, person-centered record enabling tailored services.
- **Agency Level**: Empowers partners to collaborate efficiently across sectors.
- **Community Level**: Offers insights into broader trends, addressing unmet needs and disparities, and informs local planning and policy advocacy.

How does this align to OHT Population Health Management (PHM)?

Upstream and Downstream Impacts of SDoH data

Collecting and linking the right data on SDoH is critical to determining where the identified population needs care model interventions. Segmenting based solely on medical outcomes data tells part of the picture. Including SDoH data can delineate where care model interventions are best targeted: upstream to prevent problems or downstream to reduce the impact of condition burdens.

Image and OHT Population Health Management content courtesy of Rapid-Improvement Support and Exchange (RISE), McMaster Health Forum

Where to learn more

211 and the Social Determinants of Health provides simple, concrete actions to standardize and integrate SDoH into work. By using this resource, OHTs can gain an understanding of the mission-centric value of SDoH integration, foster partnerships, and community impact. Referring people to social services through 211 can help them effectively manage health conditions and improve health outcomes.

Socio-demographic data and equity in health services in Ontario builds a strong foundation which reflects on the value of socio-demographic data in the context of health services in Ontario. This resource can support OHTs inform program interventions with robust data, enhancing the equity and effectiveness of health services.

Ontario Health Data Council Report: A Vision for Ontario's Health Data Ecosystem provides OHTs with advice on enhancing the management and use of health data to benefit the people of Ontario. By leveraging this report, OHTs can drive better and more equitable health outcomes, leading to healthier populations in Ontario.

Tools which may support implementation

Centre for Effective Practice Social Prescribing resource includes five social needs screening tools: IF-IT-HELPS; SPARKS tool; Your Current Life Situation (YCLS) tool; AAFP Social Needs Screening tool; Wheel of Life. OHTs can use these social needs screening tools to help individuals and communities feel supported. By utilizing these tools, OHTs can connect patients with resources that best meet their needs, improving overall health outcomes.

Ontario Community Health Profiles Partnership is an open-access, freely accessible website, providing free data and maps for everyone to use, download and share. They provide health and health-related indicators in three basic forms: data tables, bar charts and health data maps. This open-access website allows OHTs to address health equity concerns. By using these data resources, OHTs can identify and address gaps in access to care.

Measuring Health Equity provides practical advice, tools, and resources on how to plan, implement and use patient and client demographic data in health care settings. OHTs can use this tool to understand the importance of *collecting and linking the right data* to improve health equity.

Social Interventions Research & Evaluation Network compiles the content of several of the most widely used social health screening tools to facilitate comparisons (direct table link). OHTs can use these tools to determine the best methods for collecting and linking *the right* data on their population's needs.

The CLEAR toolkit helps health care workers address the social causes of poor health and act on social determinants in clinical practice. This clinical decision aid helps healthcare workers address the social causes of poor health. OHTs can use this toolkit to assess patient vulnerability contextually and identify key referral resources, improving patient care and outcomes.

Community Information Exchange Toolkit is designed to assist communities interested in learning how to harness the value of cross-sector collaboration and data sharing. OHTs can use this resource to gain a local understanding of community challenges and determine the best ways to support population needs.

Building a Foundation to Reduce Health Inequities: Routine Collection of Sociodemographic Data in Primary Care reports on data collection used in a family medicine clinic including the survey used. This report validates the feasibility and acceptability of collecting socio-demographic data. OHTs can use this research to inspire and implement new programs aimed at reducing health inequities.

Harness collective action

Harness collective action to drive change, shifting the focus from patient to communities to embed population health in all government activities and policy levers.

This section is intended to provide clear actionable support for OHTs to *harness collective action* to drive change, facilitating community interventions to influence government policy. Community engagement and facilitating social mobilization is crucial for taking action to address the SDoH. Social mobilization is a process that raises awareness and motivates people to demand change, for example, increasing minimum wage. It is a process where community members come together to take collective action and generate solutions to problems. Community interventions that involve peers, community members, or educators tend to be more effective than those involving health professionals alone. It leads to improvements in programs and services that better meet the needs of the community, increases levels of trust, and generates longer-term sustainable results.

The shift from working with patients and caregivers to whole communities is already underway. For example, Ontario Community Health Centres are community-governed organizations that have existed for over 40 years and explicitly seek to improve democratic engagement as a key determinant of individual, family and population health.

In Ottawa, there are 13 Community Health and Resource Centres that rose up from church basements and neighbourhood groups, mobilizing resources that make a difference in the well-being of their communities. Community members play an essential role in planning, development, and evaluation of services through local community governance, and strong community engagement mechanisms.

Moreover, The College of Family Physicians of Canada calls on physicians to be health advocates, responding to the needs of their communities as active partners for system-level change to address determinants of health.

What could interventions look like on a local level?

Communities can shape determinants of health through facilitating democratic engagement such as voting, ensuring voices of community members are heard and can be reflected in policies. Examples include offering “voter pop-ups” that help demystify the voting process through simulation and explanation, or hosting non-partisan town hall meetings for candidates to share their positions on health care and the SDoH.

What the research told us

Engagement and empowerment of the local community is needed to tackle deeply rooted challenges that have become engrained in the social norm. There is solid evidence that community engagement interventions have a positive impact on a range of health and psycho-social outcomes across various conditions. *Harnessing collective action* through meaningful involvement of the public to address SDoH

promotes empowerment, capacity building and skill development. Real change needs everyone's help. The power of *harnessing collective action* and aligned initiatives can have amazing results.

Here are recommendations from the research, some practical tips and examples to get started:

Ensure community engagement is an ongoing process

- **Make it easy for people to become involved in social mobilization**, especially those experiencing health inequities. Identify barriers to involvement and provide necessary supports such as offering daycare services during engagements or providing bus tickets to help people participate in person. Community-engaged strategies are promising for improving population health and well-being. Community members want to have a say in decisions that impact them directly, and research shows that effective social mobilization can make communities happier with services and provide useful information to tailor efforts to community- specific needs.
- **Expand patient and caregiver involvement** to include citizens or community members such as volunteers, parents, and teachers to understand community context and the role environment plays on the health of communities. Participation can include focus groups, needs assessments, program planning or board governance.

Example: Health Access St. James Town hosts an annual spring gathering where issues, concerns and community assets are discussed through facilitated table discussions. Residents, service providers and other partners use the input gathered to develop plans of action using their collective assets.

Leverage community strengths

- **Engage with local agencies, municipal partners, coalitions, and public health units** to address critical issues such as food security, poverty, housing, transportation, and early child development. During the COVID-19 pandemic, tens of thousands of emails and letters were written to provincial members of parliament to change the classification of community gardens from 'recreational amenities' to 'essential sources of fresh food'. This ensured the critical food supply remained open for those who needed it.
- **Partner with local public health units** and deliver population health messages such as public service announcements on local TV and radio stations to reach a broad audience. Build awareness among partners on the impact of income, food security, housing, and social connections on health to mobilize the public to engage in policy advocacy.

Example: Healthy Barrie, a community-based partnership, used SDoH data to inform strategies such as public health campaigns, city planning and health and wellness interventions.

Establish community advisory councils

- **Form diverse and representative community advisory councils** to ensure that a wide range of voices and perspectives are included in decision-making processes. These councils should include representatives from various community groups, especially those experiencing health inequities. These councils should be structured to ensure broad and meaningful participation, reflecting the diversity of the population. Build trust and make connections with local communities.
- **Establish community advisory councils** to provide guidance and ensure that more voices are heard at the leadership level. Community-wide collaborative initiatives can have far-reaching effects and really impact positive change.
- **Leverage the insights and guidance of community advisory councils** to inform and shape health-related programs and policies. These councils act as a bridge between the community and health organizations, ensuring that the services provided are tailored to the community's specific needs.

Example: The East Toronto Health Partners' (ETHP) Community Advisory Council is a diverse group of patients, caregivers and community members engaged in the co-design of various ETHP programs and services. Their experience, input and insight inform ETHP's strategic direction and help improve care for people in East Toronto.

How it works in real life

The Pathways to Education Program™ - A Community Coming Together

Regent Park Community Health Centre (RPCHC) began to see a rapid deterioration of the Regent Park community. Parents feared for their children's safety, and for their futures. The high school dropout rate was 56 percent, twice the average for the City of Toronto. And for the children of single parents and immigrants, it increased to more than 70 percent. Obstacles identified were lack of social, academic, and financial supports. By *harnessing collective action*, RPCHC alongside a passionate group of community advocates rallied together to break this cycle, and the Pathways to Education Program was born to shift the future for young people in Regent Park.

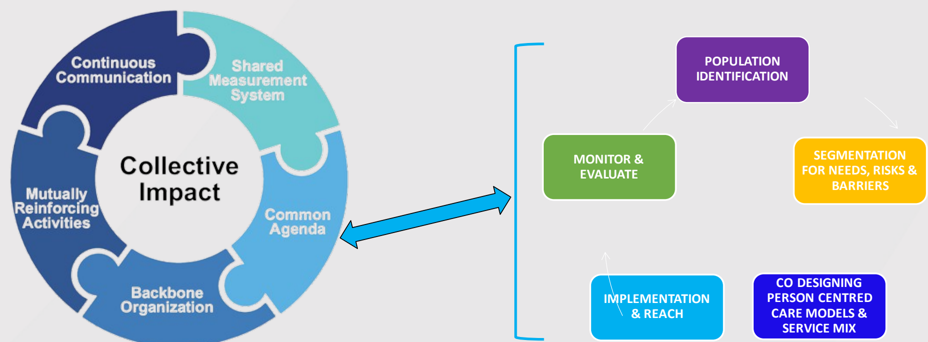
They developed tutoring opportunities for academic support, mentoring for social support, providing bus tickets to attend school and bursaries for completing high school. The program takes an all-inclusive approach, offering access to every Grade 8 student. Parents, schools, and community volunteers came together to get it done. Five years after the first group of students started the program in grade nine, high school dropout rates decreased by more than 70 percent and post-secondary attendance increased by more than 300 percent. In addition, the crime rate was impacted.

Research conducted on the program has driven policy changes to enable provision of additional supports. These include the Ministry of Education becoming a partner through a grant for the program and changes in the school board homework policy. By *harnessing collective action*, this award-winning program highlights how community-based approaches can address critical SDoH such as education and income.

The program has expanded nationally with 31 locations including 9 in Ontario that work with health care partners:

- Compass Community Health (Hamilton)
- Kingston Community Health Centres (Kingston)
- Camino Wellbeing & Mental Health (Kitchener)
- Pinecrest-Queensway Community Health Centre (Ottawa)
- Shkoday, Igniting the Spirit Within (Thunder Bay)
- Unison Health & Community Services (Lawrence Heights)
- Regent Care Community Health Centre (Regent Park)
- Rexdale Community Health Centre (Rexdale)
- YouthLink (Scarborough Village)

How does this align to OHT Population Health Management (PHM)?



Harness collective action begins with population identification and resonates throughout the five steps of PHM. OHTs are designed to include all community partners (medical and social support). Inclusion and collective action accelerate the PHM process to better outcomes as described in the Quintuple Aim. Collective action must also address inequities that SDoH highlight.

Image and OHT Population Health Management content courtesy of Rapid-Improvement Support and Exchange (RISE), McMaster Health Forum

Where to learn more

New Brunswick's Wellness Strategy 2014-2021 supports action on all dimensions of wellness and on determinants of health. It is based on best practices, experiences and evidence from wellness partners and current research. This strategy highlights best practices and evidence-based approaches from various sectors, helping OHTs to design and implement effective, community-focused wellness initiatives.

Alberta's Strategic Approach to Wellness acknowledges the vital role that communities, professional and community organizations, industry and all levels of government have in acting on health and wellness. This resource can support OHTs to shift the focus from health care delivery to holistic health and wellness. It underscores the importance of community and multi-sectoral involvement, providing a strategic framework for integrating wellness into daily life and policymaking.

Build Back Fairer in Greater Manchester: Health Equity and Dignified Lives includes bold and ambitious recommendations on how to reduce health inequities and build back fairer from the COVID-19 pandemic for future generations. This report from the UK focuses on those factors outside health care that affect health. By using this resource, OHTs can access bold recommendations for reducing health inequities post-COVID-19. It emphasizes the importance of placing health equity at the heart of governance and policy, providing a roadmap for regional collaboration and equitable resource allocation.

The Wellbeing Budget is a groundbreaking approach to government policy-making in New Zealand that puts people front and centre and offers a comprehensive framework focusing on mental health, child wellbeing, and socio-economic aspirations, serving as a model for transforming health and economic policies to prioritize population well-being. This resource can support OHTs to implement a people-centered approach.

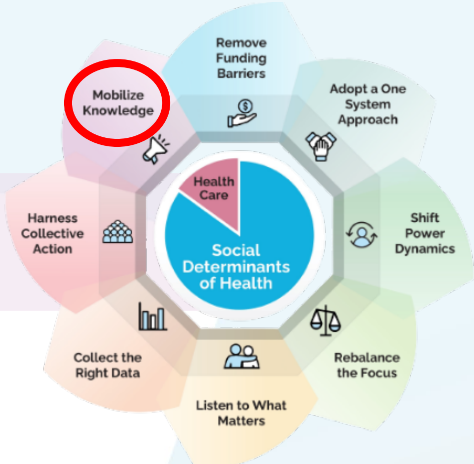
Tools which may support implementation

Social Accountability as the Framework for Engagement (SAFE) for Health Institutions provides a toolkit which empowers health organizations to create structures to support social accountability strategies focus on local population needs. SAFE provides practical guidance that OHTs can use for engaging communities, co-designing services, and prioritizing equity, which can help close health equity gaps and better meet local population needs.

Health Providers Against Poverty (HPAP) offers tools and practical examples, such as connecting vulnerable individuals with essential services which can help OHTs harness collective action strategies to enhance access to health and community supports for marginalized populations.

Designing Community-Based Chronic Disease Prevention and Outreach Programs is a toolkit that equips users with the knowledge, skills and resources necessary to design, implement and sustain effective prevention programs tailored to their community's unique needs. This comprehensive resource is designed to support individuals, lead agencies and organizations to *harness collective action* to promote community-led prevention programs.

Mobilize knowledge



Mobilize knowledge to action for clinicians, communities, and the public, building acceptance that health care alone is insufficient in ensuring better health outcomes.

This section is intended to provide clear actionable support for OHTs to *mobilize knowledge* to action for clinicians, communities, and the public, building acceptance that health care alone is insufficient in ensuring better health outcomes. *Mobilizing knowledge* means ensuring all relevant stakeholders understand why it is important for us to understand and act on social factors that influence our health.

SDoH has become a buzz word that means different things to different people, and we need to create a common understanding that can be collectively acted on when delivering care. When someone is asked what matters in their life and the lives of their family, their response is often related to happiness, having a home, a good job, family and friends, and being independent. What matters to individuals and their families is linked to the SDoH -- those essential elements a person has or does not have, that are both complex and interconnected and can greatly affect their health.

The Robert Wood Johnson Foundation conducted research to identify a new way to talk about the SDoH and concluded there is no silver bullet, no single word or fact that will suddenly transform how people think about health holistically. This research is crucial for mobilizing knowledge because it provides a foundation for crafting messages that resonate with diverse audiences, thereby fostering a common understanding and acceptance of the importance of SDoH. Each of us has a set of beliefs and values and as we listen to new concepts, we try to fit what we hear into them. The Robert Wood Johnson Foundation tested different phrases and selected this simple core message, "Health starts where we live, learn, work and play."

How the message is delivered is equally important to ensure it is acted on. Communicating the SDoH Guidelines for Common Messaging is a research-based document that looks at factors that influence audiences' receptivity to SDoH messages, such as preparing them to receive the message with facts or images they already believe or support, using conversational tone and customizing messages to specific audiences that address any myths or common misconceptions. For example, "When we think about health, it's easy to assume that it just means eating the right food and being active. Health is a lot more than that. Did you know that your education, job, relationships, and where you live account for up to 60% of what impacts your total health?"

People need to know why something is important to act on it. Increasing awareness and understanding of SDoH and their impact on health will lay the foundation to drive action that will address social needs and health inequalities.

What the research told us

Trying to say something simply can be a complicated process. Commonly held cultural beliefs influence how health information messages are received. The COVID-19 pandemic has offered a window of

opportunity by building people's understanding of SDoH and how they can impact health with real life stories shared through mass media. By *mobilizing knowledge*, we can set communications in motion to increase acceptance that health care alone is insufficient in ensuring better health outcomes.

Here are recommendations from the research, some practical tips and examples to get started:

Creating the Message

- The Robert Wood Johnson Foundation encourages us to prepare audiences to receive messages by making a connection between what they already believe, for example, patient care is critical to a healthy population, but it is not enough. We also need to address the root causes of illness such as loneliness and food insecurity.
- Use one strong compelling fact, a surprising point that arouses interest, attention, and emotion, for example, "…stop thinking of health as something we get at the doctor's office but instead as something that starts in our families, in our schools and workplaces, in our playgrounds and parks, and in the air we breathe and the water we drink."
- Use familiar, emotionally compelling plain language and present messages in a way that is consistent with audience values. Find ways to include people with lived experience, as they can provide valuable insight on what language will be effective.
- Where possible, avoid academic language, including terms like "social determinants," which do not resonate with audiences the way plain language does.
- Use stories the audience understands and can remember easily. If they can relate to a character or a set of circumstances, they are more likely to change their view about an issue. A good story can inspire audiences and convince them that action is both important and possible.

Example: Use concrete examples to bring information to life. An abstract concept such as 'food insecurity' can be explained by using examples that illustrate the implications: "approximately 1 in 6 Canadian children live in households experiencing poverty", which means that when students come to school hungry, they do not have a fair chance to learn.

Communicating the Message

- It is important that the communicator appears open and eager and that they use a familiar and conversational tone.
- Select the right tool. An example would be 10–20 second short statements or tag lines (sound bites). They can be used on their own or to introduce longer stories. Sound bites should convey one key idea in a clear and inspiring manner. They should be easy for the audience to remember and repeat.
- Images such as pictures, diagrams, maps, posters, or other visual aids that illustrate or reinforce the SDoH message can help make important points easier to remember.
- Evaluate the level of your audience's understanding before delivering your SDoH message. Do they believe in myths or common misconceptions? A well-informed audience may be better able to engage with a complex SDoH message. Audiences with little knowledge of SDoH will require more compelling and repetitive messaging that challenges their misconceptions.

- Public service announcements (local radio and television) can be used to raise public awareness of the importance of SDoH.
- Use modern communication methods to help spread the message. The faculty at the Department of Family and Community Medicine at the University of Toronto have used TED Talks as a springboard for teaching the important concepts of the SDoH to family medicine residents.

Example: "Stand Up for Health" is an immersive simulation that to helps participants better understand the SDoH through experiential learning. This innovative approach builds awareness and empathy among clinicians, community members, and the public about the challenges individuals face due to SDoH.

Putting the Message into Action

- Work within teams to create checklists to use to assess and address the SDoH in their interactions with patients. These checklists can include questions and prompts to help staff understand how factors like housing, employment, education, and social connections impact health, thereby promoting health equity.
- Mobilize citizens by raising awareness and promoting advocacy activities among community leaders and the public on the link between public policy and the SDoH. This can involve organizing workshops, town hall meetings, and informational campaigns that highlight how policies on housing, transportation, and education affect health outcomes.
- Partner with public health units to develop community-based interventions that tackle broader social issues impacting health, such as poverty, education, and social isolation.
- Engage municipal leaders to drive local action to address social needs, such as affordable housing and food security.
- Create or leverage an existing Community of Practice to share knowledge, skills, and leading practices across partners. This network can provide a platform for regular meetings, webinars and collaborative projects that focus on SDoH and health equity.

Example: Taking action on the SDoH in clinical practice offers practical recommendations on what can be done at the patient level, practice level and the community level to better understand and address the underlying causes of poor health. By using social needs screening tools, integrating SDoH considerations into protocols, and partnering with community organizations, providers can ensure that knowledge about SDoH is not only disseminated, but also actively applied to improve health outcomes. Each level of action demonstrates a commitment to understanding and addressing the root causes of poor health.

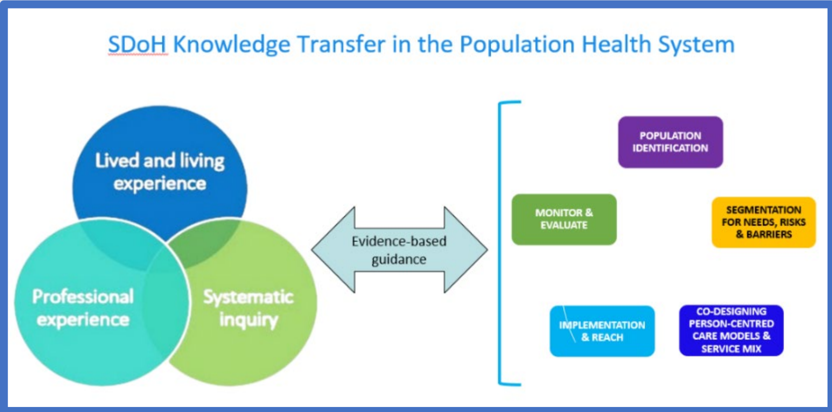
How it works in real life

The Sudbury and District Health Unit produced a short video called Let's Start a Conversation About Health… and Not Talk About Health Care at All , that *mobilizes knowledge* to tells a story explaining SDoH and how they create health issues. It draws on local data and context and shows what can be done to address SDoH in practical ways. A User Guide with tips and resources was developed to mobilize action among sectors and encourage the public to engage in a conversation on SDoH. The video has since been adapted by provincial and local public health authorities across Canada, and in communities in the United States and Australia, and it was profiled in the Rio Political Declaration on SDoH: A Snapshot of Canadian Actions 2015.

Public Health Agency of Canada also created an educational video that *mobilizes knowledge* on the SDoH. Although Canada is a healthy nation, this video calls out that not everyone enjoys all the benefits of good health due to the conditions in which we are born, live, play and work such as income, housing, education or job opportunities. Discrimination can make being healthy even more challenging. Canadian children living in communities with lower levels of education, employment and income have lower chances of reaching their full developmental potential.

Similarly, the Montréal Public Health YouTube video *mobilizes knowledge* by illustrating the effects of social inequalities in health in the city of Montréal. Using theoretical statistics which compare the impact of social inequalities on health between underprivileged and affluent population groups, it shows an individual's potential life trajectory depending on the population group the individual belongs to. It can be used to educate and engage various health and non-health sectors and the public on the impact of social and economic factors on health and well-being.

How does this align to OHT Population Health Management (PHM)?



Mobilizing knowledge to action should be a critical consideration in all components of PHM; collecting data on social factors understanding the population and stratifying the population by needs, designing care models that address social barriers to health and wellbeing, implementing changes to ensure they benefit all people and evaluating impact on SDoH in measurement strategies. Opportunities for education and knowledge transfer at each step of PHM ensures that SDoH cannot be overlooked and engages all community partners to consider their impact on health and well-being.

Image and OHT Population Health Management content courtesy of Rapid-Improvement Support and Exchange (RISE), McMaster Health Forum

Where to learn more

[Using TED Talks to Teach Social Determinants of Health] is a series of workshops on the SDoH that have been developed specifically for primary care; each workshop presentation centers around a TED Talk as a discussion point. There is increasing evidence of the importance of addressing these root causes to improve the health of our communities and platforms like TED can help disseminate that evidence. By leveraging this content, OHTs can mobilize knowledge to foster a deeper understanding of SDoH among clinicians and community members, ultimately leading to better health outcomes.

Public Health Agency of Canada's website on social determinants of health and health inequalities emphasizes that where we are born, grow, live, work and age have a significant influence on our health. By *mobilizing knowledge,* we can expand our understanding that although Canada is one of the healthiest countries in the world, some Canadians are healthier and have more opportunities to lead a healthy life. For example, Canadians with higher incomes are often healthier than those with lower incomes. This resource can support OHTs by providing comprehensive information and statistics that highlight the disparities in health outcomes among different population groups, helping to inform targeted interventions to reduce health inequalities.

Tools which may support implementation

The Health Foundation's How to talk about the building blocks of health is a communications toolkit that sets out how we frame communications to tell a more powerful story with recommendations to increase understanding of the role of determinants of health and support to action them. People tend to think of health as highly individualistic, for example, it is the food we eat and how much we exercise. However, by *mobilizing knowledge,* we can see how jobs, homes, hardship, and discrimination link to health. This resource can support OHTs by offering practical strategies to effectively communicate the impact of SDoH to the public and policymakers, thereby garnering support for necessary policies and actions to address these issues.

Reframing the conversation on the SDoH explains how to develop a deeper appreciation of the ways in which people understand and think about health to develop more effective approaches to communicating evidence. By *mobilizing knowledge*, we can broaden what is understood by the term 'health', increase understanding of the role of SDoH, and highlight how social and economic inequalities drive health inequalities. This resource can support OHTs by providing insights into effective messaging techniques that can shift public perception and generate support for policy actions needed to keep people healthy. OHTs can enhance their strategies for educating and engaging partners on the importance of SDoH, leading to more informed and equitable health interventions.

Remove funding barriers

Remove funding barriers by shifting away from fee-for-service and one-time funding to longer term, value-based models that invest in, and enable providers with the time and supports to focus on individual needs.

Considerations for policy makers

Evidence indicates that a key enabler to health system transformation is appropriate financial incentives. To drive meaningful change, it is essential to shift from fee-for-service and one-time funding models to longer-term, value-based models which prioritize patient outcomes over volumes and address individual and community health needs.

Value-based models provide an opportunity to address social conditions that are the underlying causes driving high system use and related costs. For example, the story of Million Dollar Murray, a person experiencing homelessness who over the course of 10 years consumed $1M in services, highlights the need for an investment in SDoH that shape health such as housing, income and social supports. This could save vast amounts of 'downstream' spending. People who experience homelessness in Ontario are 8 times more likely to visit emergency rooms, 4 times more likely to be admitted to hospital for medical or surgical reasons, and 9 times more likely to be admitted for psychiatric reasons.

Over the past several years, policy initiatives have been developed around the world to implement new funding structures. For example, in the United States there is a movement away from fee-for-service reimbursement to a value-based model where payment is based on quality measures and health outcomes. It has been designed to address Medicaid's delivery system problems such as fragmentation, high (re)admission rates, poor primary care infrastructure, lack of behavioral and physical health integration, all of which are rooted in how providers are reimbursed. In 2015, the Centers for Medicare and Medicaid Services approved the implementation of the Delivery System Reform Incentive Payment (DSRIP) program in New York State. It continues to align its efforts with the goal to move at least 80% of all Medicaid managed care payments, which were traditionally reimbursed through fee-for-service, into value-based payment arrangements.

A core mechanism in this model is the financial incentive that providers will have to keep the populations they serve as healthy as possible, to prevent at-risk populations from becoming chronically ill, and to prevent further morbidity and avoidable complications in members with chronic conditions. For example, providing supportive housing with air conditioning for people with asthma during summer months.

Considerations for OHTs

We recognize that OHTs do not have the power to remove policy or legislative barriers directly. OHTs can work with health service provider organizations within the OHT to make decisions that improve service delivery.

What the research told us

Focusing on social needs opens the door for organizations to look at funding more broadly. For example, working with anchor organizations such as large employers who derive value from a healthy community. These robust partners have the readiness, capacity, and willingness to commit years of time needed to make change happen. For example, the Vanier Social Pediatric Hub, a program offered by the Vanier Community Services Centre, has a 'Big Help = Big Steps' tiered donation model that has attracted funding from the National Arts Centre, Carleton University and Walmart to name a few.

Here are recommendations from the research, some practical tips and examples to get started:

- Work with broader government agencies including municipal, provincial, and federal, to identify strategies to align funding programs. For example, Alliance for Healthier Communities' Social Prescribing for Mental Health received funding from the Public Health Agency of Canada that had an aligned mental health focus. This funding was distributed across 28 Ontario-based Community Health Centres, Nurse Practitioner-Led Clinics, Indigenous Primary Health Care Organizations and Family Health Teams.
- Look for opportunities to reinvest cost savings from value-based models into social service capacity to ensure equitable access for individuals and families with unmet social needs.
- Use evaluations to measure the return on investment for multisector SDoH care models, ideally looking at the potential for long-term total savings. For example, The Commonwealth Fund ROI Calculator for Partnerships to Address SDoH evidence guide summarizes evidence available on the costs of health-related social need interventions and/or their impact on health care utilization and the cost of care for adults with complex health and social needs.
- Financially reward, rather than penalize, providers and programs that deliver high-value care that address underlying social needs, for example shifting payment to outcomes while protecting base funding.

Example: More than one in four families visiting McMaster Children's Hospital's emergency department reported challenges accessing enough food, so they started a food pantry pilot. It is being supported with funding from the Hamilton Health Sciences Foundation and a partnership with Fortinos, a local grocery store that provides fresh products grown or made in Ontario. The food pantry is available 24/7 and helps pediatric patients recover at home. It allows providers the opportunity to support patients and their families in the short term as partners in helping their children get better.

How it works in real life

Let’s Go Home (LEGHO) Program – Easing Hospital-to-Home Transition

LEGHO is a successful intervention allowing hospital and community partners to collaboratively support hospital discharge or diversion for senior and adults with physical disabilities needing supports related to the SDoH. LEGHO programs provide bundled access to meals, transportation, homemaking, wellness checks, and navigation/ connection to other community supports. These services are individually available through Community Support Services (CSS) agencies, but the LEGHO program provides bundling, coordination, and covers client-facing costs for a 4-to-6-week period. After this point, clients may continue with these services but will need to pay the client-facing fees for any services, as is customary with meals, transportation, and homemaking programs.

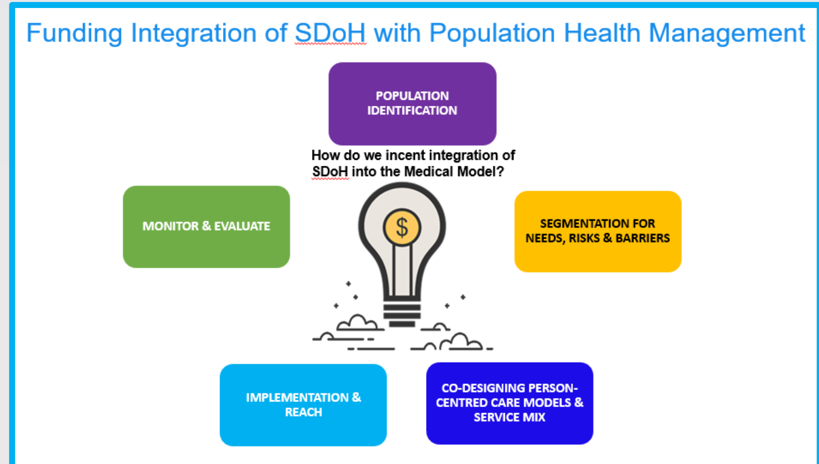
From late 2022 to March 31, 2024, the LEGHO program has provided services to approximately 6,588 people including more than 13,500 hours of homemaking and other home help, almost 66,000 meals, 1,200 rides home from the hospital, 4,600 rides to follow-up appointments and 17,000 home visits/wellness checks.

Here are some highlights:

- All 15 OHTs in the West Region are running this program using base funding.
- A LEGHO Lead CSS agency manages the LEGHO program within each OHT, works with local hospitals and coordinates LEGHO services with multiple CSS partners.
- It removes legislated co-payment that would require clients to pay a portion of the costs when they are unable to.
- It is providing a key investment in community capacity building.
- Data is being collected to evaluate the program.

OHT	LEGHO Lead CSS
Windsor Essex	Assisted Living Southwestern Ontario (Program is called WEGHO)
Chatham Kent and Sarnia Lambton	Red Cross Chatham Kent & Sarnia Lambton
Elgin	VON Middlesex Elgin
Oxford and Area	VON Oxford
Middlesex London	Cheshire London
Huron Perth and Area	ONE CARE Home & Community Support Services
Grey Bruce	Home & Community Support Services Grey Bruce
Kitchener, Waterloo, Wilmot, Woolwich, & Wellesley (KW4) and Cambridge North Dumfries (CND)	Community Care Concepts
Guelph Wellington	VON Waterloo Wellington Dufferin
Brantford Brant Norfolk	Participation Support Services
Burlington	Capability Support Services
Greater Hamilton Health Network	AbleLiving Services
Niagara	Community Support Services of Niagara

How does this align to OHT Population Health Management (PHM)?



Removing funding barriers is critical for a high functioning population health care system. While OHTs may not be able to remove policy or legislative barriers (this is the work of Ontario Health and the Ministry of Health), they can explore the reallocation of funds (where possible).

Ontario Health Teams: The Path Forward outlines future state integrated accountability and funding structures for an OHT's attributed populations. Early work to implement the direction set out in this document, which is ultimately supporting movement towards integrated funding envelopes for OHTs, will also allow greater consideration of social need investments.

Image and OHT Population Health Management content courtesy of Rapid-Improvement Support and Exchange (RISE), McMaster Health Forum

Where to learn more

Small Intervention, Big Impact: Health Care Cost Reductions Related to Medically Tailored Nutrition provides insights into how home-delivered, medically tailored meals can significantly reduce health care costs for people living with chronic illnesses like congestive heart failure, chronic obstructive pulmonary disease, and diabetes. By using this resource, OHTs can understand the impact of addressing food security as a critical aspect of health care, thereby improving patient outcomes, and reducing overall health care expenditures.

Investing in Social Services as a Core Strategy for Healthcare Organizations: Developing the Business Case is a practical guide to support provider investments in social services. Despite evidence of the importance of addressing SDoH to improve outcomes and lower medical costs, investments tend to be modest in scale and temporary, often provided through one-time funding or launched as pilots without a long-term strategy. By using this resource, OHTs can develop long-term strategies for incorporating social services into their teams. This can lead to sustained improvements in health outcomes and reductions in medical costs.

Tools which may support implementation

The One-Stop Shop for Healthcare & Community Partnerships This site offers tools to help healthcare organizations and social services demonstrate financial and social returns from their partnerships. By using this resource, OHTs can address the financial, operational, and technical aspects of forming and sustaining bilateral partnerships and multi-sector coalitions. This resource supports OHTs in overcoming funding barriers, facilitating more effective and sustainable collaborations.

Canada's 2030 Sustainable Development Goals Funding Program is a call to action to create and foster an enabling environment for whole-of-society collaboration to advance the 2030 Agenda and its 17 Sustainable Development Goals both domestically and abroad. By using this resource, OHTs can explore additional funding opportunities for new partnerships aimed at achieving sustainable development goals. This resource provides examples of past funded projects, highlighting how innovative collaborations can enhance health and social outcomes.

Social Determinants of Health - First Nations, Inuit, Métis and Urban Indigenous

This section highlights the unique expertise of First Nations, Inuit, Métis, and urban Indigenous communities in applying a SDoH approach to care delivery. In this Guide, we have included Indigenous driven frameworks and models which illustrate Indigenous health and wellness from a physical, emotional, mental, and spiritual worldview.

This section was developed by Ontario Health and collected from known institutions and sources. First Nations, Inuit, Métis, and urban Indigenous partners were not engaged in this process. Ontario Health recognizes the distinct approaches to SDoH that First Nations, Inuit, Métis, and urban Indigenous communities, organizations and nations may have.

Background

First Nations, Inuit, and Métis peoples are constitutionally recognized nations with Aboriginal, Treaty and inherent rights and land claim agreements. The Indigenous population consists of status and non-status First Nations people who may live on- and off-reserve, Inuit, and Métis in urban, rural, and remote areas in Ontario. Ontario is home to the largest Indigenous population in Canada, with an estimated population of 251,030 First Nations, 134,615 Métis, 4,310 Inuit and 9,515 Indigenous-identifying people. Importantly, the true number of Indigenous people in Ontario is likely to be much higher, as the Census of Population has been proven to significantly undercount First Nations, Inuit, and Métis peoples. It has been demonstrated that the size of the Indigenous population in Toronto was underestimated by a factor of 2:4 in the Census.

There are more than 40 Treaties and other land agreements covering Ontario, setting out the rights and responsibilities of First Nations and the provincial and federal governments. Each community and nation are unique, with their own histories, languages, cultures, beliefs, and practices as well as perspectives, protocols, infrastructure, accountabilities, jurisdictions and governance. Their health systems exist distinctly from the Ontario health care system.

“In the ‘Western’ world, using a social determinants lens is considered a relatively new approach to health and wellbeing. However, [for] Indigenous peoples throughout the world health [has long been] a holistic concept that extends beyond individual behaviours and genetics.” Despite this, many experience health disparities and inequities that are rooted in racism, marginalization, dislocation and social exclusion.

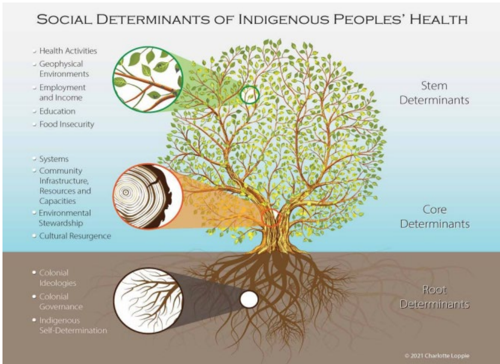
Learning from First Nations, Inuit, Métis, and Urban Indigenous expertise

The following resources detail how Indigenous ways of knowing and being can shape the social determinants of First Nations, Inuit, Métis, and urban Indigenous health:

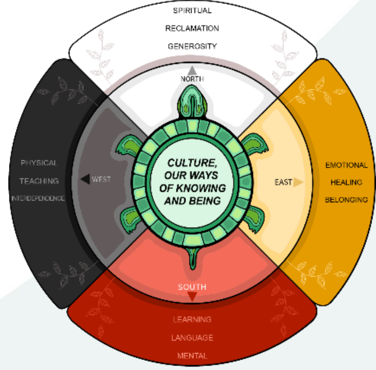
- Options for a First Nations 7 Generations Continuum of Care calls for a wholistic approach to develop a continuum of health and health-related supports for First Nations across the country.
- Social Determinants of Inuit Health in Canada discusses the social determinants of Inuit Health and is a reference for organizations working within the Canadian health and social services sector.
- Social Determinants of Métis Health focuses on the Métis holistic view of health and the impact of the ‘causes of causes’.
- The AHAC Model of Wholistic Health and Wellbeing emphasizes that cultural teachings and traditional practices vary between nations and regions, but all are recognized and respected.

Wholistic Wellness Approaches in Action

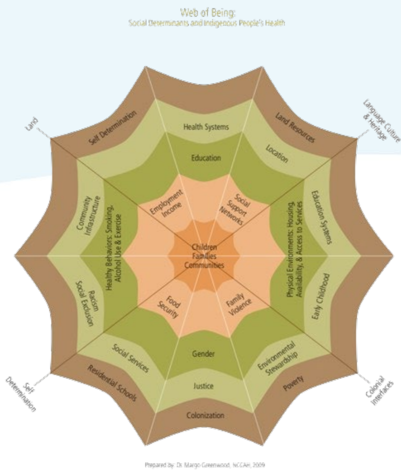
Included below are Indigenous frameworks and models that have been developed to further broaden an understanding of First Nations, Inuit, Métis, and urban Indigenous perspectives of wholistic health and wellness which address social determinants of health:



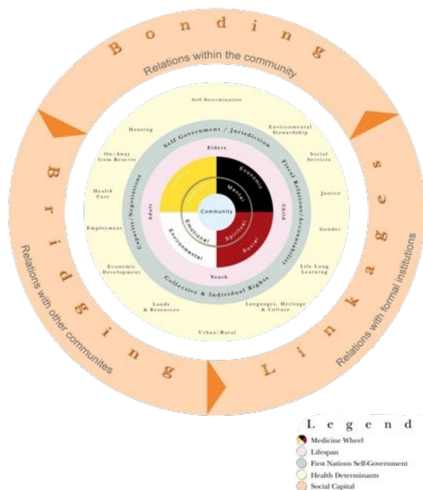
Understanding Indigenous Health Inequalities through a Social Determinants of Health Model introduces a tree metaphor for understanding the relationship between social determinants and various dimensions of Indigenous health.



The Indigenous Primary Health Care Council (IPHCC) promotes high quality care provision through the Model of Wholistic Health and Wellbeing. The model is rooted in a population needs based approach to health care planning and incorporates physical, mental, emotional, and spiritual elements of wellbeing and it is the belief that all elements must operate in harmony.



The [Web of Being](#) developed by the National Collaborating Centre on Indigenous Health, illustrates the many social determinants of health for Indigenous peoples and shows how these factors are interconnected to form a strong web that affects health and well-being.



The [First Nations Wholistic Policy & Planning Model](#) has a wholistic focus on determinants of well-being with community at its core, governance as its underpinning, inclusive of the four cycles of the lifespan (child, youth, adult, elder) and focuses on the three components of social capital (bonding, bridging, linkage).

Sharing Examples from Ontario

Here are examples of how culturally informed perspectives and recommendations can be implemented at the health systems level to address SDoH and influence health outcomes for First Nations, Inuit, Métis and urban Indigenous nations, communities, and organizations:

- Ontario Health First Nations, Inuit, Métis, and Urban Indigenous Health Framework. This Framework outlines the commitment Ontario Health is making to First Nations, Inuit, Métis, and urban Indigenous partners to initiate the development of a First Nations, Inuit, Métis, and urban Indigenous Health Plan. The Health Plan will provide focused areas of actions for Ontario Health, First Nations, Inuit, Métis, urban Indigenous partners, and health system partners to work together to improve Indigenous health and eliminate inequities, including racism.
- Path to Prevention – Recommendations for Reducing Chronic Disease in First Nations, Inuit, and Métis highlights 22 recommendations that include specific approaches to address the social determinants of Indigenous health. First Nations, Inuit, Métis, and Urban-Indigenous contributions guided the development of this report to inform provincial and federal governments on Indigenous health and wellness.

- Prevention System Quality Index 2023 Personal, familial and community resilience, restoring and promoting First Nations, Inuit, Métis and urban Indigenous identities, keeping cultures and languages alive and self-governance have all had positive impacts on overall health and wellness.

- Maamwesying OHT, serving Indigenous communities in Northeastern Ontario (seven First Nations communities along the Highway 17 corridor between Sudbury and Sault Ste Marie, four First Nations communities within Chapleau and Wawa, including the urban Indigenous population in Sault Ste. Marie), works to ensure that "Indigenous Health remains in Indigenous Hands." The mission of this fully Indigenous-led and Indigenous informed OHT is to work with community partners to provide accessible, quality, culturally safe and wholistic health care that supports and enhances the wellness of individuals, families and communities.
- Kiiwetinoong Healing Waters OHT, serving Dryden, Red Lake and Sioux Lookout, is currently comprised of 30+ Indigenous, municipal and health care members that represent health and social services across the North West region that work as one coordinated team. A diabetes management study was conducted to identify gaps and recommend future states of care for the OHT. Kiiwetinoong Healing Waters OHT members collaborate with patients, clients, family members, caregivers, individuals with lived and living experience and other citizens to co-design the best possible care for the region.
- The Noojmawing Sookatagaing (Healing Working Together) OHT amplifies the voice of Indigenous Peoples and brings health and social service providers together to network and collaborate to build trusting relationships and partnerships. The OHT's name highlights the emphasis on collaboration with communities and partner organizations to ensure the enhancement of health for all community members. The OHT's Collaboration Council establishes policies and protocols that reflect their principles and advances truth and reconciliation.

Learning More

The following courses and resources are available for further learning, understanding, and addressing determinants of health for First Nations, Inuit, Métis and urban Indigenous nations, communities, and organizations:

- Course (free): The First Nations, Inuit and Métis Culture, Colonization and the Determinants of Health course examines the impact social and economic measures have on First Nations, Inuit and Métis peoples. It explores the broader cultural determinants of health in an Indigenous context.
- Educational resource (free): Indigenous Healthcare Education and Practice: Applying Digital Teaching and Learning Resources to the TRC's Calls to Action. The aim of this project was to create an interactive digital collection that translates the TRC's Calls to Action into strategies that can be implemented in meaningful, accessible, practical, and culturally appropriate ways within health care education and practice.
- National Collaborating Centre for Indigenous Health highlights that Indigenous ways of knowing and being, including concepts of spirituality, connectedness and reciprocity to the land and all life, self-reliance, and self-determination advance health equality and outcomes.

- Cultural Education workshops are delivered to a variety of organizations. Some topics include Inuit history, country food, the Inuktitut language, Inuit lands and urban Inuit populations – Tungasuvvingat Inuit. Accessible and interactive learning opportunities and resources help increase awareness on Inuit health and wellness.
- The (Native Wellness Assessment) NWA™ tool provides culturally based interventions to guide treatment services from a whole person and strengths-based view. These can include: (1) Spending time on the land, (2) Learning from traditional teachers and healers, and (3) Joining in storytelling and dancing.
- Indigenous Health Systems Transformation: Foundations for IPHCC's OHT Provincial Framework highlights that "a population health approach uses evidence to identify Indigenous population issues, priorities and health inequities. Through co-design with Patient, Family, Caregiver and Community (PFFC), Indigenous providers develop interventions and measures to monitor health outcomes and progress on the Indigenous determinants of health."
- Interactive (free): A Primer on the Determinants of Indigenous Peoples' Health highlights that Indigenous peoples view health and wellness from a wholistic perspective and explores why Indigenous Health Perspectives are needed.
- Webinar (free): Indigenous Health Equity: Examining Racism as an Indigenous Social Determinant of Health is part of the Indigenous Cultural Safety Collaborative Learning Series. It is guided by an Advisory Circle of Indigenous and non-Indigenous leaders from across Canada.
- Truth and Reconciliation Commission of Canada: Calls to Action – The 94 Calls to Action are actionable policy recommendations meant to aid the healing process in two ways: acknowledging the full, horrifying history of the residential school system and creating systems to prevent these abuses from ever happening again in the future. Specific Health related Calls to Action are 18 – 24.
- United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) is a legal declaration on the rights of Indigenous peoples that received Royal Assent on June 21, 2021, in Canada. This Act establishes a framework for reconciliation, healing and peace, as well as harmonious and cooperative relations based on the principles of justice, democracy, respect for human rights, non-discrimination and good faith. Additionally, this Act establishes accountability and provides greater clarity regarding the collective responsibility of protecting and upholding the individual rights of Indigenous peoples and their ways of knowing and being.

General inquiries related to Indigenous Health Equity at Ontario Health can be sent to ihec@ontariohealth.ca.

Final Thoughts

This Resource Guide provides tangible examples and resources to Ontario Health's Social Determinants of Health Framework. Recognizing that each of the SDoH framework principles intersect with each other, just like the SDoH, you may have seen recurrent themes across the Guide which we hope illustrated how work done on one principle connects to and can support another.

This Resource Guide is a stepping stone down the path that will drive a paradigm shift in how we deliver care, and the acknowledgement that medical care alone isn't enough to ensure better health outcomes. We recognize this is complex work, however we will endeavour to take the advice from our subject matter experts who said, 'don't wait to get it perfect', 'don't try doing it alone', 'leverage the knowledge from early adopters' and let's journey down the path to learning together.

Do you have any examples of best practices in addressing SDoH? If so, we would like to hear from you. Please reach out to Elizabeth.Molinaro@ontariohealth.ca

Please note the resource lists and tools included in this resource guide are not exhaustive and not all resources were created by Ontario Health. We are not responsible for their content. This is for information sharing purposes only.

Need this information in an accessible format? 1-877-280-8538, TTY 1-800-855-0511, info@ontariohealth.ca

Document disponible en français en contactant info@ontariohealth.ca