



Niagara Region Public Health

Health Equity Strategic Plan: Background Report

2018

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Acronyms

AMOH	Associate Medical Officer of Health
CDIP	Chronic Disease and Injury Prevention
CSFs	Critical Success Factors
DMT	Departmental Management Team
e-MOT	electronic Menu of Tools
EMS	Emergency Medical Services
ER	Emergency Room
GP	General Practitioner
HBHC	Healthy Babies Healthy Children
HEAAP	Health Equity Assessment and Action Plan
HEIA	Health Equity Impact Assessment
HIV	Human Immunodeficiency Virus
IDUs	Injection Drug Users
IMT	Inter-municipal Transit
KT	Knowledge Translation
LGBTQ+	Lesbian, Gay, Bisexual, Transexual, Queer, and others
LHIN	Local Health Integrated Network
LMS	Learning Management System
MOHLTC	Ministry of Health and Long-Term Care
NCCDH	National Collaborating Centre for Determinants of Health
NRPH&ES	Niagara Region Public Health & Emergency Services
NST	Niagara Specialized Transit
ODSP	Ontario Disability Support Program
OHIP	Ontario Health Insurance Plan
OPHS	Ontario Public Health Standards
OW	Ontario Works
PHAC	Public Health Agency of Canada
PPE	Personal Protective Equipment
RNAO	Registered Nurses Association of Ontario
RRFSS	Rapid Risk Factor Surveillance System
SDOH	Social Determinants of Health
SMART	Specific, Measureable, Attainable, Relevant, and Time-Bound
SMT	Senior Management Team

Glossary of Terms

Health equity

All people have the opportunity to reach their full health potential and are free from social, economic, demographic, or geographic barriers to health.

Priority populations

The groups of people that would benefit most from public health programs. They include individuals or groups that are at higher risk of poor health outcomes due to the social determinants of health.

Social Determinants of Health

The social determinants of health (SDOH) are the interrelated social, political and economic factors that create the conditions in which people live, learn, work and play. The intersection of the social determinants of health causes these conditions to shift and change over time and across the life span, impacting the health of individuals, groups and communities in different ways (MOHLTC, 2018).

Executive Summary

Niagara Region Public Health and Emergency Services (NRPH&ES) has a long history of health equity work. In 2009, the NRPH&ES Senior Management Team (SMT) created a strategic goal aimed at addressing health equity and the social determinants of health, which led to establishing Social Determinants of Health (SDOH) Champions in 2010. Three phases of Champions worked on projects including selecting, developing, and providing training on SDOH tools, leading workshops, and developing an electronic menu of tools (e-MOT) to support program planning and evaluation.

More recently, three projects focused on the SDOH and health equity: one assessed the role and capacity of Public Health Nurses, one examined challenges and opportunities for staff in the Chronic Disease and Injury Prevention Division, and one piloted work through primary care physicians. These three projects presented their findings to the Senior Management Team (SMT) in May 2017. The findings aligned with the departmental strategic priority matrix that had health equity at the centre. SMT approved the recommendations to develop a departmental health equity strategy to support staff that would provide leadership and guidance, accountability, and staff learning and development. The Health Equity Strategy team began work in June 2017.

The Drivers Model (Wilkinson, 2011) was selected as the process to guide the development of the strategy. To inform the process, the team reviewed health equity strategies from other local public health agencies, surveyed internal health equity related documents, and scanned recent literature. Additionally 228 participants were involved in a survey, focus groups, or interviews including internal staff, community members, community organizations, and other Niagara Region departments.

Key Findings

A recent literature review on Organizational Capacity of Health Equity work in public health (Simms, 2017) identified five themes.

- 1) Strong and effective leadership,
- 2) Expand the evidence base and foster knowledge translation and exchange,
- 3) Collaborate and partner with intersectoral stakeholders and communities,
- 4) Demonstrate and increase competencies, and
- 5) Embed equity into the organizational mandate, policies, and procedures.

The Ontario Public Health Standards (2018) include a foundational standard on health equity with four requirements based on the four key roles for public health action as

outlined by the National Collaborating Centre on the Determinants of Health (NCCDH, 2013): 1) Assess and Report, 2) Modify and Orient, 3) Engage in multi-sectoral collaboration, and 4) Lead, support, and participate with other stakeholders in health equity analysis, policy development, and advancing health public policies.

The survey, focus groups, and interviews revealed four main barriers that Niagara residents face when accessing public health and health programs.

- 1) Transportation
- 2) Service accessibility
- 3) Limited income for healthy living
- 4) Discrimination

Additional organizational level barriers to fully integrating health equity into public health work include lack of consistent support for staff, limited resources, education, and data, lack of coordination of health equity work, and limited community engagement.

Participants discussed the success of NRPH&ES in their outreach, experienced and knowledgeable personnel, and thorough collaboration. Four themes came from the responses about the role of NRPH&ES that were used to develop the Health Equity Strategic Plan (2018-2024): data and program planning, skills and capacity, collaboration, and communication and awareness.

Health Equity Strategic Plan

The NRPH&ES Health Equity Strategic Plan has the vision for “a Niagara where everyone is empowered and has the opportunity to reach their full health potential”. The mission is “to maximize everyone’s opportunities for health and wellbeing through: mobilizing data, evidence, and knowledge; delivering service where people are; collaborating with and enabling partners and stakeholders; and advocating for equitable policies and programs.”

The Strategic Plan has three goals, seven guiding principles, nine objectives, and nineteen indicators. The plan is divided into four streams aligning with the themes from the background work done: data and program planning, skills and capacity building, collaboration, and communication and awareness. Each stream has strategies and associated activities.

Through implementing the Health Equity Strategic Plan, NRPH&ES aims to improve population health outcomes for the residents of Niagara. A team of staff will implement the strategic plan, monitor the indicators, and conduct regular evaluations to ensure the plan is successful.

1 Introduction

Niagara Region Public Health & Emergency Services (NRPH&ES) has a long history of health equity work. This background document provides an overview of the process and information used to create the NRPH&ES Health Equity Strategic Plan (2018-2024). This report begins with some key accomplishments that led to the creation of the strategic plan, a review of the methodology used, and a summary of the literature and primary data collected. The final section outlines the details of the strategic plan and the path forward.

1.1 Background

The first Ontario Public Health Standards to mandate the inclusion of the social determinants of health (SDOH) and reduction of health inequities into public health practice was in 2008 (MOHLTC, 2008). The Standards (MOHLTC, 2008:1) explain, “The health of individuals and communities is significantly influenced by complex interactions between social and economic factors, the physical environment, and individual behaviours and conditions. These factors are referred to as the determinants of health, and together they play a key role in determining the health status of the population as a whole.”

While divisions within NRPH&ES worked to address the SDOH prior to 2008, these standards led the Senior Management Team to create a strategic goal aimed at addressing the social determinants of health and improving health equity. The departmental strategic goal was created in 2009, and led to identifying Social Determinants of Health Champions, established in 2010. Three phases of champions were selected to work on specific projects (see Appendix A for full list of champions). During phase one, the Champions increased knowledge and awareness of the SDOH among staff through workshops and the use of a Health Equity Tool that could be used to support program planning by including the consideration of priority populations. In phase two, a menu of tools was developed and trainings were provided on the menu of printed tools. Phase three focused on making an electronic version of the Menu of Tools (e-MOT), conducting Health Equity Impact Assessments (HEIAs), and a roadshow to educate staff about the e-MOT. Evaluations were conducted with each phase, which helped to inform the subsequent phases.

In conjunction with the SDOH Champions, two Priority Population Networks began as communities of practice for those working in the SDOH, one in the Chronic Disease and Injury Prevention division, and the other in the Clinical Services division (which includes staff working on vaccination, infectious diseases including sexually transmitted infections, and outpatient mental health assessment and treatment). In 2012, the two networks combined and opened membership to the rest of the department. The Network was

created to provide a regular forum to communicate between public health programs and services that target priority populations, to share program directions, and to discuss common issues. The Network meets quarterly and has presentations from external organizations and internal programs, as well as sharing of program updates.

Phase three evaluations of the SDOH Champion work led to a research project focused specifically on the role and capacity of Public Health Nurses to use the e-MOT, conducted by Pam Lof and funded by Registered Nurses Association of Ontario (RNAO) and NRPH&ES. The results of this study, along with presentations from Carolyn Dyer about an income screening and response project with Primary Care Physicians¹, and from the Health Equity Assessment and Action Plan (HEAAP) team from the Chronic Disease and Injury Prevention (CDIP) division², were presented to the NRPH&ES Senior Management Team (SMT) in May of 2017. The three reports had overlapping conclusions and presented a recommendation to SMT for the development of a departmental health equity strategy to support staff that would provide leadership and guidance, accountability, and staff learning and development. SMT embraced this recommendation as it aligned with their recently developed strategic Priority Matrix, which had health equity at the centre (see Figure 1). A project team was formed to create the Health Equity Strategic Plan with Senior Management support including managers and frontline staff from a variety of professions and began work in June 2017.

¹ This income screening pilot engaged three Niagara Family Health Teams to screen their patients by asking 'Do you ever have difficulty making ends meet at the end of the month?' If the response was positive the doctors referred the patient to a local service directory, 211, who put the client in touch with needed services.

² This research was conducted with the purpose to assess the current state of health equity practice in CDIP using the 10 Promising Practices document, and to create a summary report of key findings.



Figure 1: Niagara Region Public Health & Emergency Services Priority Matrix

1.2 Purpose

The purpose of this document is to provide an overview of the background, methodology, and key findings that led to the creation of the NRPH&ES Health Equity Strategic Plan. This document provides a summary of the key components of the Health Equity Strategic Plan and can be used as a reference document for the implementation of the strategy.

1.3 Objectives

The objective of this document is to provide NRPH&ES staff members with detailed information to reference during the implementation of the strategic plan. Additionally, other local public health agencies can use this document to support the development of their own health equity related strategies.

2 Methods

This section reviews the process that directed the planning of the strategic plan, as well as the methods used for primary and secondary data collection and analysis, the sample, limitations, and the process of creating the strategic plan.

2.1 Strategic Planning Process

Selecting a strategic planning process to utilize was the first step for the project team. Four processes were considered that provided different approaches to planning a strategy. Each process was reviewed and analyzed by the project team.

The four processes that were analyzed were

- A Playbook for Strategy: The Five Essential Question at the Heart of Any Winning Strategy (Lafley et al, 2013).
- Developing a Local Health Department Strategic Plan: A How-To Guide (NACCHO, 2010).
- Taking Action to Reduce Health Inequities: A Strategic Plan for Cultural Competence, Diversity and Social Inclusion at Capital Health (Capital Health, 2011).
- The executive guide to facilitating strategy: featuring the Drivers Model. Leadership Strategies (Wilkinson, 2011).

The **Drivers Model** (Wilkinson, 2011) was selected by the project team as the best fit for the Niagara context. The team considered it to be a comprehensive model, it was supported by the National Collaborating Centre for Methods and Tools, and included the important aspects from the other processes. The Drivers Model is a five step process:

1. **Start with an accurate picture of today**
2. **Create a shared vision**
 - a. Vision – the preferred picture of the future
 - b. Mission – A statement of the overall purpose of an organization
 - c. Goals – Broad, long-term aims that define accomplishment of the mission
 - d. Objectives – Specific, quantifiable realistic targets that measure the accomplishment of a goal
3. **Understand your Critical Success Factors (CSFs) and Barriers**
 - a. CSFs – Key conditions that must be created to achieve one or more objectives
 - b. Barriers – Existing or potential challenges that hinder the achievement of objectives

4. Define your drivers

- a. Strategies – Broad activities required to achieve an objective, create a critical condition or overcome a barrier
- b. Actions – Specific steps to be taken, by whom and by when, to implement a strategy

5. Monitor

The details of how we conducted the research to satisfy these steps is included in the following design section.

2.2 Design

Data was collected to inform the research on the accurate picture of today and in order to understand the critical success factors (CSFs) and barriers to potential objectives, as well as gather ideas for strategies moving forward.

The process started with a review and analysis of secondary documents available internally at NRPH&ES, and an environmental scan was conducted of health equity strategies in Ontario. Internal documents analyzed included past reports, operational plans, and minutes from Priority Population Network meetings. See Appendix B for a list of the internal documents that were reviewed.

As background for the shared vision, mission, goals and objectives, a working group analyzed health equity strategies from other local public health agencies and similar organizations. Health equity strategies from 14 other local public health agencies across Ontario were analyzed, with themes distilled for comparison and contrast. Two health equity strategies from outside of Ontario were chosen to review due to the detail of their strategies and the progress of their agencies in terms of health equity work. These strategies were from the California Department of Public Health and the County of Riverside Department of Public Health. The health equity strategy from one non-local public health agency, Health Quality Ontario, was reviewed.

A full literature review was not conducted due to the recent publication of a thorough literature review conducted for Health Nexus (Simms, 2017). Some key documents included in the literature review were consulted, and included in the thematic analysis.

In order to include the perspectives of NRPH&ES staff, and voices from community partners and community members, the project team conducted qualitative research. This approach allowed for a wider reach of input for the strategy. A survey was sent to all employees of NRPH&ES that returned 97 responses. The survey was offered online as

well in person, with 39 respondents completing the questions online and 58 responding in person. Additionally, ten focus groups and twenty interviews were conducted, involving a total of 228 people. See details in the sample section below.

All interviews and focus groups were conducted by a facilitator and a transcriber. Interviews were conducted either in person or over the phone. Data was analyzed thematically using NVivo, a qualitative computer-aided analysis program. Three team members conducted independent coding, any disagreements were discussed and an agreement was reached on what should or should not be included in specific themes.

After the data was collected and analyzed thematically, the project team used one full day and four half days to create the Strategic Plan. See Table 1 for an outline of the brainstorming sessions. Two facilitators external to the project team utilized multiple brainstorming techniques to guide the process, including SWOT analysis, dot voting, and effort-impact matrix plotting.

Table 1: Health Equity Strategic Plan Brainstorming Sessions Overview

Date	Length of Time	Focus Areas
January 22, 2018	Full day	Vision, mission, goals, guiding principles
January 29, 2018	Half day	Discuss CSFs & barriers, objectives
February 12, 2018	Half day	Finalize mission, goals, objectives, begin discussion on strategies
February 27, 2018	Half day	Finalize timeline for objectives, develop strategies and activities
March 9, 2018	Half day	Finalize details, identify risks

Once the strategic plan was finalized, the project team presented the details to the Senior Management Team on March 15, 2018 and received approval in principle. The Draft Strategic Plan was then presented to all six management teams and community members at the seven locations of the original focus groups for feedback and validation of the research findings as they translated into the strategic plan.

The strategy was adjusted based on feedback from the management teams and community members and a final version was presented to and approved by Senior Management on June 26, 2018. See Figure 1 for a full timeline of the project activities.

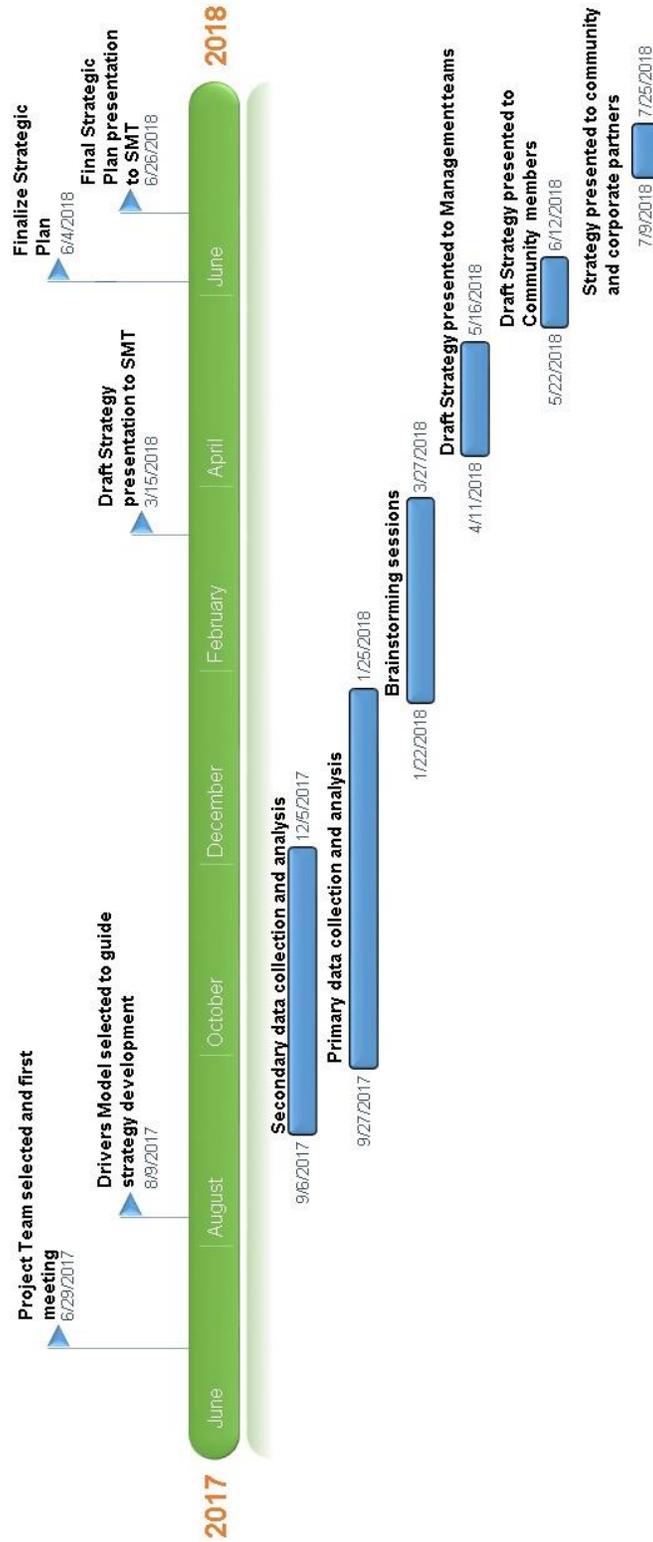


Figure 2: Health Equity Strategic Plan Development Timeline

2.3 Sample

A total of 228 individuals were involved in this research. See table 2 below for details of the sample.

Table 2: Research sample

Research Method	Group	# of Participants
Online Survey	NRPH&ES Staff	39
In person Survey	NRPH&ES Staff	58
	Sub-Total People	97
Focus Group - Internal	Senior Management Team	12
	Managers	9
	Priority Population Network	12
	Sub-Total People	33
Focus Group – Community	Low Income Women, St. Catharines	14
	Older Adults, Regional Housing, Niagara Falls	6
	Youth, Regional Housing, Niagara Falls	10
	Community Health Centre, Fort Erie	6
	New Immigrants, St. Catharines	15
	Indigenous People, Thorold	3
	Homeless Men, St. Catharines	21
	Sub-Total People	75
Interviews	Community Partners (organizations)	12
	(people)	15
	Other Niagara Region Departments/Divisions	8
	Sub-Total People	23
	Total People	228
	Total locations/organizations	28

2.4 Limitations

This data collection was conducted over a short period of time and began as side projects for the majority of team members, which led to a few limitations. There is a lack of published evidence and data relating to health equity and strategy planning in public

health, leading to the use of multiple grey literature sources. Difficulty contacting and securing organizations for focus groups meant there were some voices that were not heard or not as strong from different parts of the region. We were unable to visit all 12 municipalities, and there were some vulnerable populations that were not well represented, including the LGBTQ+ community and people who reside in institutions (correctional facilities, long-term care homes, etc.). Although we recognize that not everyone in the region was included, the aim was to include a diverse group of people and organizations to have a wide range of input, the project team felt the main themes reached saturation. Additionally, there is an understanding that programs will include more thorough data collection with the relevant groups for their program when conducting planning and evaluation through support provided by this strategic plan.

3 Findings

The findings from the qualitative research are summarized in the following four sections. First, the findings from the key literature are provided, followed by the three main categories that arose from the primary data collected: barriers, strengths, and role of NRPH&ES in relation to health equity.

3.1 Literature

Simms (2017) summarized the Health Nexus literature review on Organizational Capacity of Health Equity work into five themes.

- 1) **Strong and effective leadership.** Leadership should be philosophical and operational with concrete actions, associated with evaluation and reporting.
- 2) **Expand the evidence base and foster Knowledge Translation (KT) and Exchange.** Collect health equity data, use data to design and evaluate policies, programs, and services (Cohen et al., 2013). Use KT models and different modes to share experiences, knowledge, theoretical, and methodological innovations
- 3) **Collaborate and partner with intersectoral stakeholders and communities.** Begin with the community, use participatory methods, work across departments and sectors, and involve marginalized populations in decision-making.
- 4) **Demonstrate and increase competencies.** Including Public Health Agency of Canada (PHAC) Core Competencies (2008) and professional competencies for effective health equity action (Underwood, Harlos, & Viven-Book, 2013). Develop and expand leadership competencies, create learning paths, and create a supportive learning environment.
- 5) **Embed equity into the organizational mandate, policies, and procedures.** Have clear duties and expectations for staff to include equity in decision-making processes, use consistent language and a multidisciplinary approach.

Planning, evaluation, and reporting cut across all five themes and are important to increase accountability.

The Ministry of Health & Long Term Care released updated *Ontario Public Health Standards: Requirements for Programs, Services, and Accountability* in January 2018. This included a new foundational standard, Health Equity. This standard is based on the four key roles for public health action as outlined by the NCCDH (2013). The four requirements can be summarized as follows.

- 1) **Assess and report** on the health of local populations
- 2) **Modify and orient** public health interventions to decrease health inequalities

- 3) **Engage in multi-sectoral collaboration** with municipalities, LHINs, Indigenous communities and organizations, and other relevant stakeholders
- 4) **Lead, support, and participate** in health equity analysis, policy development, and advancing healthy public policies

3.2 Barriers

Through interviews with 75 community members, 15 community partners (from 12 organizations), 8 corporate partners, and 130 internal staff, a few key themes arose regarding the barriers people face when accessing services relating to health care in general, or public health specifically. The four main themes are barriers due to transportation, access to services, income, and discrimination. Additionally, internal staff and community partners identified organizational level barriers that included limited: consistent managerial support for staff, coordination of health equity related activities, resources, education, data, and community engagement.

Transportation

Community members consistently mentioned transportation as a primary barrier to accessing services in Niagara. One participant noted,

“Public transportation could be better; a lot of restricted areas you cannot get too; especially when it is cold and slippery, increases time to get there.”

Community partners frequently noted transportation being a barrier for clients accessing their services, as well as accessing health related services. One partner stated,

“Centralized services are a challenge. Populations are dispersed. No consistency in cities, rural settings. Access to services and clients regionally is a major issue. How do you connect these people? Transportation—how do you get those services to them?”

NRPH&ES staff also recognize transportation barriers for people to get to the programs offered. One staff commented,

“[The] main mental health office (3550 Schmon Parkway) is not fully accessible (e.g. automatic door openers, accessible bathrooms). This makes it difficult for some seniors and people with mobility issues to easily participate in groups that are only run from that location. Many clients do not have transportation for group programs and we are not always successful in advocating with Ontario Works (OW) and Ontario Disability Support Program (ODSP) for assistance. In additional wheelchair transit is limited and at times unreliable as a way to have a client attend weekly type programs.”

The transportation department at Niagara Region has been working to provide additional services and improve transportation options for people in Niagara, however even within those services there are barriers:

“Special needs, vision, mobility, different treatment income related. Inter-municipal transit (IMT) individuals, don’t have a car. Other disabilities, Niagara Specialized Transit (NST) dealing with disability in some regard, treatment or disability, criteria they need to meet.”

Providing services to residents who live in a wide variety of urban or rural settings across Niagara is a challenge. Even when public transit is available, there are additional barriers of individual mobility, cost, and limited times when the services are available.

Access to services

Community partners and internal staff commented that NRPH&ES provides many services in the community, where people are located, which helps to reduce the reliance on a limited, costly, or time-consuming public transit system. However, many people do not know about the services NRPH&ES offers, where to find them, or who to connect with to find more information. There are also challenges with literacy levels and language options with programs and services that are provided for new immigrants, temporary foreign workers, and Francophones. The third aspect of accessing services is the limited amount of mental health services available.

Most of the community members who participated in the focus groups did not know what programs and services were provided by NRPH&ES. One participant asked, “What does public health do for seniors now?” Another stated, “I do not know where to find public health, where are you located?”

Community partners agreed that there are many valuable programs, such as “tobacco programming, that a lot of people don’t know about”. Community partners also struggle with the “large bureaucracy, knowing who does what. Don’t know where people are coming from or their role”. One suggested “it would be helpful to have ‘a door’ so we know who to talk to at public health with questions.”

One community partner highlighted one of the challenges with increasing awareness in the public about the services available,

“One of the things with the services, people don’t want to hear about them until they need them, which isn’t the best point to be reaching out and making decisions. How to educate people on what’s available to them, so they can access services when they need them?”

Even if clients are able to find out about services, and get there, there is a challenge for some to understand how to apply for services, “Even if [the client] speak[s the] language, [they] don’t understand how to fill it out. Difficulty in understanding the application, language and process.” Another community partner stated, “process/steps to access services are complicated and hard to follow.”

Accessing mental health services was a challenge discussed by multiple participants. One community partner stated, “Programs are not easily accessible to clients, when referrals are being made by staff. For example, wait lists or clients do not qualify for programs.” Another community partner stated that there are no long term mental health treatments available in Niagara Region, intensive treatment is lacking, and transitions to post treatment is a challenge. “There is not enough housing, not enough treatment centres.” Two other community partners highlight the challenges clients face.

“Some of the programs, access can be an issue: mental health supports can be a real challenge. The intake process can be challenging, a lot of back and forth, a lot of communication; often times does not ‘pan out’.”

“Mental health long term treatment: want it and ready for it; waiting 6 months to get in; too much can happen in 6 months can change that and then have lost them; when people want treatment, can’t get it.”

A community health centre provided this example of the struggles of one individual.

“One participant was leaving the hospital (mental health services) and was connected to a public health nurse. [She] didn’t understand how she got connected to this service. This should have been better explained. [She] was referred to another service for more treatment but didn’t complete the program. [She] lost [her] phone and had communication barriers with the office.”

Some clients need more specialized services, such as new immigrants.

“Need mental health services—specific counsellor in terms of the language and understanding the background”

Access to mental health services in a timely manner is important, but strains on the current programs, long wait times, and confusing intake processes limit the proper access for clients in need.

Income/Cost of dental services

Many clients who access NRPH&ES services are impacted by the social determinants of health, of which a primary determinant is income. Clients have limited funds to spend on

healthy food, transportation, healthy living arrangements, and health care. One area in particular that was raised by many clients and community partners was access and cost of dental care for adults.

Here are a few comments from community members and partners.

“Part of being healthy is having good teeth. Dental cost is huge, for someone with limited income, and big family. Kids have free coverage. For two or three people in the house, \$300 just for scaling and cleaning.”

“Why is dental health not covered by OHIP? Teeth are part of the body. Seniors are lacking coverage in this area.”

“Adult dental care not being covered makes you not feel valued as an individual. Why are children covered by the government and not adults? Treatment of adults by dentists is not consistent either, not always high quality.”

As the participants noted, affordable dental care is important for overall health, however the cost is often a barrier for many people in need.

Discrimination

The final main barrier to services discussed in the focus groups and interviews was discrimination towards certain groups of people. Some of the examples included here are discrimination by the general public, others from health care workers, while some specify NRPH&ES in particular.

A number of different groups of people discussed experiencing discrimination, including older adults, young mothers, people who are homeless, intravenous drug users, transsexual, HIV-infected, or identify as Indigenous.

Older adults

“As you get older you feel less valued by society “

“Over 65 feel they are left behind”

Single

“Social isolation, when you are single you feel guilty asking others for help, so it’s just easier to stay inside and be alone, sometimes you wonder why you even have a phone at all, nobody calls.”

“Single people have other issues as well, it’s a difficult life to live, hard to get supports since most services are family oriented, it’s difficult to reach out to people because you don’t have the same networks.”

Homeless

“Experience of judgement: across the board. No particular setting they experience this the most; access to ER, their own Doctor. [They are] seen as non-compliant; not understanding their barriers or other factors in their life that may impact them missing medications or appointments and therefore they can be easily dismissed”

“Those that are chronically homeless—to listen to their barriers as they are often forgotten”

“While Public Health staff are well qualified, there have been times when Public Health staff have not related well to clients, had difficulty engaging with them. Clients have felt judged by Public Health staff in the past, this is hard when they already feel marginalized, trust is hard to build.”

Indigenous

“Lack of trust in the system. Residential schools, Indian hospitals, having to be dependent on a system that was detrimental to their people. Lack of education in the mainstream population about colonization and effect of colonization. Some people think ‘you need to get over it’ but don’t realize the problems were still ongoing very recently, not way back.”

“If someone comes from native community—don’t have birth certificates or identification or health cards or how to navigate the system. When you’re rooted in going from crisis to crisis, your hierarchy of needs is different. [You] don’t go to the dentist or get your feet checked.”

“Indigenous people have higher poverty rate, so should be accessing services at a higher rate, but because their families are rooted in historical traumas (residential schools, etc.), not everyone can overcome this. Their ability to enter the ‘system’, they cannot have a job, go to school, get kids to school, pay for things. Things others take for granted, this community doesn’t get access to. Many people are not registered because children have been taken, put in residential school, mistrust of the system, hesitation for men and women to go into the ‘system’ because of 60s scoop, western medicine has not been ‘good to our people’ so why would they try to enter the system.”

“Mainstream agencies don’t know how to approach or interact with indigenous agencies.”

Other

“Young moms get stigmatized. If coming from health, seen as authority, individuals get defensive and nervous, here not to help but pick apart. Parents know they want their children to eat well but don’t know how.”

“Intravenous Drug Users (IDUs)—over 900 clients, no GP, stigmatized, discrimination, talk to service providers, clients won’t go to hospital or access services because of the stigma”

“Feel judged and unwelcomed in other service models; i.e. book a mammogram, challenges of booking an appointment, confirming date, getting to the hospital; another example of being an Intravenous user being able to access the hospital, being a trans individual being called by the chosen name”

“HIV stigma is huge—people singled out because of their status, health care people don’t know current status of HIV treatment, and level of knowledge, some wear PPE unnecessarily”

Many groups of people face discrimination in Niagara as they access services to enhance their health. Discrimination, limited income, lack of access to services, and transportation challenges all contribute to poor health outcomes.

Organizational

In addition to the barriers identified for people to access services and reach their full health potential, NRPH&ES staff discussed internal or organizational barriers that restrict their ability to fully integrate health equity into their work. These barriers include the lack of consistent resources for staff, a lack of education and data, restricted or unclear managerial support, and poor coordination of health equity work across the organization and with community partners.

Many staff discussed the lack of resources, which included insufficient “financial resources for adequate staffing to meet client needs”, outreach staff in particular. One staff commented, “trust and relationships [are] important, sometimes our work doesn’t lend enough time to nurture these with clients or community partners.” Another staff described the barrier further, “short timelines for projects that do not always allow enough time to truly consult with the populations served.”

There is a general lack of education regarding equity, culture, and religious beliefs. For instance, one staff commented, there is a “lack of cultural training to meet culturally sensitive needs of various groups of people (trans people, people with substance abuse

disorder, Muslim).” Other areas that require education include the social determinants of health, and the “complex health needs of marginalized clients.”

Some staff felt restricted by current bureaucratic processes or current models of programming that they felt reduced their ability to make needed changes in their programs and in the community. Some staff expressed the barrier that they are “not supported to do outreach with and work with or in the community.” Other staff were unsure of the role and scope of public health, and felt there was a “lack of a clear health equity mandate”, or a “very limited scope of practice as determined by management.” Staff felt that the support to use social media was limited, as “social media and communication campaigns [are] often not approved – and are therefore not reaching target audiences.”

At least five staff commented that a lack of data or understanding of the health inequities in a certain population or location is a challenge. This includes time to conduct “deep dives” into the data, conduct more qualitative data collection and analysis, as well as a lack of data available at a local level. One staff asked, “What is the process we should be following to identify and meet the needs of specific priority populations?”

Staff commented that there is a “lack of knowledge about both internal and external agencies’ roles”. This lack of communication between programs and divisions leads to a lack of knowledge about cross divisional work and “siloed divisions”, which in turn leads to duplication of services instead of working better together for a “uniform approach”. Additionally, there is a lack of coordination at times with community groups or other government services, which requires time to build relationships and genuinely conduct community engagement.

Despite all of these barriers, there are ways that NRPH&ES are breaking down silos, utilizing current resources creatively, and collaborating with community partners. The following section highlights strengths identified in the current programs, services, and practices.

3.3 Strengths in current practices

Community members and partner organizations were asked what they thought NRPH&ES was doing well. There were three main themes that participants discussed; outreach, personnel, and collaboration and referrals. There were also a few positive comments about the Niagara Region website and the epidemiologists.

Outreach

Community members were familiar with the NRPH&ES Sexual Health Outreach Nurses, Scott dePass and Stacey Allegro (although they were not always associated with NRPH&ES). Other known programs or services were dental screening, CASTLE, Public Health Nurses in the schools, flu clinics, immunizations, and the water wagon. Community partners made the following comments:

“Great communication with outreach team”

“Meet people where they are at, approach to care, everyone knows who Scott and Stacey are”

Internal NRPH&ES staff expressed similar comments in the strengths of current programs and approaches. In delivering programs, it was recognized that it is important that NRPH&ES is client-focused; this is considered important to build trust, adapt programs to fit the needs of clients, and involve community members in decision-making processes. Programs that are provided are considered diverse, incorporating a variety of models for service, and offer different approaches to common issues. The locations where services are provided are in the locations where people are found, using remote offices to serve the mix of urban and rural communities in the region, as well as providing outreach and home visits in multiple programs.

Personnel

Other than a few examples of discrimination or lack of sensitivity to cultural practices, NRPH&ES staff were recognized as educated, experienced, and supportive. Here are a few quotes from community and corporate partners regarding NRPH&ES staff:

“They have the people that know what they talk about, i.e. schools, child care, know the topic [topic area specialists]”

“Ability of Public Health to handle a crisis in Niagara. Feel comfortable that we could handle a crisis based on the expertise in Public Health and EMS”

“Looking for training and learning opportunities for the staff. More education we have as a group, better for staff and for the community. ... the more beneficial for everyone and easier to reach out, eliminate barriers for the clients, when collaborate together.”

Internal NRPH&ES staff highlighted the strengths in some of our current staff, who have a diversity of skills, are knowledgeable and skilled in addressing the effects of the social determinants of health, are passionate and interested in health equity, and build trust with clients.

Collaboration and Referrals

Most of the comments about collaboration came from the community organizations and corporate partners, who worked with NRPH&ES on many different projects, including the sexual health clinics, various youth projects, mental health, and EMS. They commented that NRPH&ES is engaged in the community on a broad spectrum, is a strong presence in community health, provides cross-fertilization of ideas between programs, and sits on many regional networks and committees. There are connections between NRPH&ES and other departments within the Regional Municipality of Niagara, including providing facts and statistics about health risks, outbreaks, or other health related topics. In return for the collaborative relationships, community and corporate partners stated that they referred clients to some of our programs, notably sexual health, Health Babies Healthy Children (HBHC), EMS, and Community Paramedicine.

Internal staff agreed that we have a strong community connection through frontline staff, as well as collaborative, humble partnerships with a wide variety of community partners and cross-divisional collaborations. One staff described how their work contributes to equitable health, “building partnerships with outside organizations that serve priority populations.”

In addition to the themes that arose from the external sources, some internal NRPH&ES staff found the current approaches to planning and decision-making and the management support to be strengths, however as noted in the previous section, this was not consistent across the department and other staff expressed limitations in the current structure and managerial support. Management support, including having flexible managers who are willing to take risks and try new things, having SDOH tools to support work, and the priority matrix to guide decisions with health equity at the centre, were all highlighted as important to improve the daily health equity work throughout the department.

3.4 Role of NRPH&ES

Internal staff and external partners had a lot of ideas of what NRPH&ES should do in regards to health equity. Four key themes emerged from the research that aligned with the literature review and led to the development of four streams for the health equity strategic plan: data and program planning, skills and capacity building, collaboration, and communication and awareness.

Data and Program Planning

Accessing, analyzing, sharing, and using data to inform program planning was a common theme internally and externally regarding the role of NRPH&ES. Having quality local data helps to target populations in program planning, provides a comprehensive picture of the community, and helps identify common health issues. It also helps to evaluate and plan where to focus time and resources in the community using consistent, systematic, and data-based evidence. Some external partners made the following comments:

“Make stories from the data—not just sharing the numbers”

“Access to an epidemiologist and data comes in handy, expanding access to community”

“Data, helping to inform regional and LHIN policies, addressing the need across the system for good data, planning, information to inform service delivery”

NRPH&ES staff described the following roles regarding data and health equity, “have the data drive how we adapt,” and “collect socio-demographic data (across public health).” Participants suggested using data to re-orient services and programs through a flexible approach that is willing to take risks, be open to change, and uses patient-centered techniques that includes stories, qualitative research, and involving the community at all stages. This increases the accessibility of services, and provides relevant education in places where people are looking for services. Capturing different types of data, including qualitative stories can help measure the impact, not just the outcomes.

Skills and Capacity

Supporting staff through training, resources, education, and consistency across the organization will build trust, recognize staff strengths, and improve the services offered. Internal education should be mandatory and go beyond taking a course, as on staff stated, education needs to involve “paradigm shifts with personal experiences, being physically present rather than head knowledge. Experiential learning.” Internal knowledge translation, through committee members, managers, or health equity champions can improve the flow of data, increase awareness of programs offered in other areas of the department and increase cross-divisional collaborations. Having thorough and clear reporting, tracking, and sharing processes increases transparency and accountability, which in turn increases the trust and confidence of community partners and members towards the programs and services offered by NRPH&ES.

Supporting staff members through shared vision, clear job descriptions, consistent communication, embracing innovation, and working together to prioritize activities and programs will allow staff members to excel in their work and improve their ability to serve the needs of the community.

Collaboration

Community partners had the most comments about improving collaborative efforts between organizations. NRPH&ES was recognized as a resource for data sharing, capacity building, and sharing of best practices. NRPH&ES is comfortable participating in and chairing community networks, providing referrals, becoming embedded in the community, and liaising with other governmental departments.

Some organizations felt that NRPH&ES should take more leadership roles in planning, forming partnerships, and reaching out to priority populations.

“Public Health should be the key lead—form a strong partnership to get more funding for Niagara to face these challenges”

“Public Health, EMS, need to do the reaching out, the indigenous have reached out enough, need to own the mistakes of the past and make substantive changes.”

“Reaching out and engage with community groups”

Other organizations discussed working closer together with community groups, including improving communication, training, and partnerships. Training and knowledge translation is important as the foundation of skills and knowledge for staff and community partners to provide quality, relevant programs and services.

“Developing training modules, and consult, early stages to help Public Health to reach out to the entire population, include indigenous population”

“Bring communication to the table and see how we can work together”

“Partnership, communication, education, programs working on need to be broadcasted. Everyone has great input on how we can make it better.”

Internal staff agreed that NRPH&ES has a role to play in working with community partners, including supporting education and working in collaboration with other groups.

“Provide education for professionals and the community on health equity.”

“Work through coalitions, influence through other groups, use skills, but not necessarily be the in front leaders.”

Collaboration with communities to advance common goals is key to success in addressing the SDOH and working towards a Niagara where everyone has the opportunity to reach their full health potential.

Communication and Awareness

The final theme that arose was around improving communication with community members, raising awareness of available services, providing training to other organizations, and increasing advocacy and policies promoting health equity. External organizations had many ideas of how NRPH&ES could support communication and more clearly promote who is involved in which program.

“Understanding the different departments and who does what is critical. So many different things that are happening, if people knew about them or communicated corporately, conversations would be easier, know who to contact, senior retreats and departments. Come in with updates. Bring communication to table and see how can work together”

“Understanding what resources Public Health has and how these could intersect with our services”

External organizations felt NRPH&ES could be a positive advocate for broad and specific topics including the importance of non-traditional health services, and improving services for people in need, for the broader health community, and for increased funding for services. Policy improvements that could be led, or supported by NRPH&ES, include policies about basic income, recruiting more Indigenous people in the public health or health care workforce, and having mandatory cultural safety training for everyone.

“Be the voice for the residents of Niagara”

“Advocacy especially with opportunities to have evidence-based practice and working with community agencies and boards”

“Develop a strong anti-racism, anti-discriminatory policy that will be enforced”

“Looking for PH policies and mandates to be inclusive and how we can support one another to improve”

NRPH&ES Staff concurred, “we need to do more advocacy”. Another staff described how to reach more stakeholders,

“speak the language of stakeholders, with the economic numbers – use the statistics we have, frame the message around the audience, if that is what will impact change, then use those messages for the people who have the power to change decisions.”

Community members, partner organizations, and internal staff discussed many positive and potential roles for NRPH&ES. Working together with the community and advocating for inclusive, anti-discriminatory policies will contribute to advancing health equity for all Niagara residents.

4 Health Equity Strategic Plan 2018-2014

This section provides the details of the Health Equity Strategic Plan that was developed based on primary and secondary data collected and analyzed, as presented in the previous sections. The Drivers Model (Wilkinson, 2011) was used as the strategic planning process through five facilitated brainstorming sessions. See the methodology section (2.2) for further details. This section outlines the vision, mission, goals, guiding principles, objectives, indicators, strategies, and activities of the Health Equity Strategic Plan. See Appendix C for a map of how all the components of the strategic plan fit together and Appendix D for a timeline of the objectives.

4.1 Vision

A Niagara where everyone is empowered and has the opportunity to reach their full health potential

4.2 Mission

To maximize everyone's opportunities for health and wellbeing through

- Mobilizing data, evidence, and knowledge
- Delivering service where people are
- Collaborating with and enabling partners and stakeholders
- Advocating for equitable policies and programs

4.3 Goals

1. Re-orient government and community programs to better support priority populations
2. Partners and stakeholders will be more effective in advancing their health related goals
3. Increase awareness of and public support for health equity issues and priority populations

4.4 Guiding Principles

- Humility and self-reflection
- Meet people where they are
- Invest in impact
- Bold and innovative

- Listen to our communities
- Act upon the voice of priority populations
- Leaders in evidence

4.5 Objectives, Indicators, Strategies, and Activities

The objectives are the specific, quantifiable targets that measure the accomplishment of a goal, while the indicators are how we will measure the objectives. Objectives should be SMART, specific, measurable, attainable, relevant, and time-bound. There are nine objectives in four categories, with 19 associated indicators listed below each objective. This section outlines the four streams of strategies of how we plan to reach our objectives and associated activities listed below each of the strategies. The list of activities are not in chronological order.

Data and Program Planning

Collecting and using quality local demographic, health outcome, and risk factor data to design and evaluate policies and programs is an important foundation for health equity work (Cohen et al, 2013; Simms, 2017). This stream focuses on having analyzed data stratified by demographic and socioeconomic variables, available for internal and external use. This data can then be used in conjunction with consultation with priority populations and community organizations to effectively plan, evaluate, and re-orient NRPH&ES programs. This stream addresses the first two requirements of the OPHS Health Equity Foundational Standard (MOHLTC, 2018), assess and report on the health of local populations, and modify and orient public health interventions to decrease health inequalities.

Table 3: Data and Program Planning Objectives and Indicators

Objective or Indicator	Description
Objective 1	By July 2020, analyzed data relating to defined health outcomes and risk factors, stratified by available demographic and socioeconomic variables, will be available internally and externally
Indicator 1a	80% of data on defined health outcomes is stratified by identified demographic and socioeconomic variables by July 2019
Indicator 1b	All data relating to defined health outcomes will be available on our externally facing website in a user friendly manner by July 2020

Objective or Indicator	Description
Objective 2	By July 2023, data on defined health outcomes and risk factors, stratified by available demographic and socioeconomic variables, is used for program planning and evaluation in all NRPH&ES programs
Indicator 2a	By 2023 all divisions will have conducted an HEIA on all current programs (one program per division by 2020)
Indicator 2b	By 2023, all program and department planning documents include at least one health equity related outcome indicator
Objective 3	By July 2024, all NRPH&ES programs are assessed and re-oriented to reduce barriers to health and wellbeing of priority populations (one program per division by July 2021)
Indicator 3a	100% of NRPH&ES programs have engaged with priority populations to identify the program related barriers to health and wellbeing for priority populations
Indicator 3b	100% of NRPH&ES programs have been re-oriented to reduce the identified program related barriers to health and wellbeing for priority populations

Strategies and associated activities:

Improve access to data broken down by demographics and socio-economics in a consistent way

- Have defined set of health outcomes and risk factors
- Use consistent demographic and socioeconomic variables
- Collect consistent internal data
- Develop data visualization tools
- Make data accessible internally and externally

Provide programs and services to meet people where they are

- Use a standard method to identify priority populations
- Use data for program planning and evaluation

Skills and Capacity Building

In order to succeed in advancing health equity, public health organizations need to exhibit strong organizational capacity. Three themes from the Health Nexus literature review on Organizational Capacity of Health Equity work are encompassed within this stream of the strategic plan. First of all, there needs to be strong and effective leadership, associated with evaluation and reporting. The NRPH&ES Senior Management Team have selected

Health Equity as their primary focus and are accountable for the implementation of this Strategic Plan. Secondly, equity needs to be embedded into the organizational mandate, policies, and procedures. This stream outlines how health equity will be integrated into team culture and practices, through inclusion in performance objectives and work plans. Thirdly, there should be a demonstration and increase in core and professional competencies (PHAC, 2008; Underwood, Harlos, & Viven-Book, 2013). This is addressed through staff completing a basic health equity course, developing health equity related learning paths, and creating a supportive learning environment.

Table 4: Skills and Capacity Objectives and Indicators

Objective or Indicator	Description
Objective 4	By July 2020, all DMT members will integrate Health Equity into team culture and practices
Indicator 4a	100% of DMT have at least one performance objective related to health equity - July 2019
Indicator 4b	100% of staff completed a defined basic health equity online course – July 2020
Objective 5	By July 2023, all NRPH&ES staff have the skill and capacity to integrate health equity into their work
Indicator 5a	100% of staff have participated in division specific health equity related trainings
Indicator 5b	100% of program planning and evaluation processes use at least one health equity related tool
Indicator 5c	All employees have at least one health equity related performance objective or item on their work plan
Indicator 5d	All staff demonstrate competency in regards to their relevant health equity curriculum

Strategies and associated activities:

Health Equity skill and capacity building integrated into a broad performance management system

- Select/develop basic health equity training for all staff
- Develop learning paths and associated tools to support all divisions and roles
 - Data literacy
 - Program planning and evaluation (i.e. Health Equity Impact Assessments)
 - Core competency development
 - Community engagement/collective impact
 - Advocacy/policy analysis, development, advancement
- Update list of standardized tools and resources, including standardized priority population identification and program assessment

- Develop structure of ongoing support for trainings and tools (i.e. peer-to-peer learning)
- Track use of tools
- Align health equity outcome indicators with Annual Service Plan
- Accountability
 - Integrating performance objectives into work plans and development plans
 - Track completion of trainings with Niagara Region Learning Management System (LMS)
 - Health Equity Impact Assessments (HEIAs) recommended changes signed off by Director and Associate Medical Officer of Health (AMOH)
 - Change management approach

Collaboration

Advancing health equity requires collaboration and partnerships with multiple stakeholders and communities (Simms, 2017). This is the third requirement from the OPHS Health Equity Foundational Standard (MOHLTC, 2018), engage in multi-sectoral collaboration. This stream includes a focus on engaging with the local Indigenous communities to improve the health outcomes of the Indigenous population. Secondly, this stream aims to maximize collaborations with local organizations who support priority populations in order to advance health equity.

Table 5: Collaboration Objectives and Indicators

Objective or Indicator	Description
Objective 6	By July 2021, all NRPH&ES divisions will be engaging with Indigenous communities and organizations in order to improve health outcomes of the Indigenous population
Indicator 6a	100% of divisions are engaged with at least one Indigenous community or organization
Objective 7	By July 2023, all NRPH&ES divisions will maximize collaborations with local organizations who support priority populations
Indicator 7a	80% of NRPH&ES partnerships with local organizations are advancing health equity
Indicator 7b	80% of community organizations report having effective engagement with NRPH&ES based on the five guiding principles for community engagement

Strategies and associated activities:

Work together with partners in a coordinated way

- Support collective impact approach for advancing healthy public policy goals among partners
- Coordinate partnerships
- Share data with and train community partners to use data
- Incorporate health equity values and diversity into hiring practices (increase diversity of staff hired, include health equity in interview questions)
- Hire Indigenous Community Engagement Officer (or similar) from Indigenous population
- Engage partners and community members at all stages of program planning and evaluation
- Update list of community partners and track using Partnership Tracking Tool
- Use appropriate tools such as the community and stakeholder engagement toolkit

Communication and awareness

The final stream has a broader purpose to change the population level understanding of health equity and the social determinants of health with the aim to advance health equity focused public policy goals. The fourth requirement of the OPHS Health Equity Standard (MOHLTC, 2018) is for public health to lead, support, and participate in health equity analysis, policy development, and advancing health public policies. This strategic plan aims to achieve those aspirations through pursuing health equity goals with community partners using a collective impact approach, tracking the advancement of health equity focused public policy goals, and increasing the amount of media messages that explain the social determinants of health in relation to health issues in order to increase public awareness.

Table 6: Communication and Awareness Objectives and Indicators

Objective or Indicator	Description
Objective 8	By July 2022, NRPH&ES will be advancing health equity focused public policy goals using a collective impact approach
Indicator 8a	100% of identified health equity focused public policy goals are being pursued using a collective impact approach
Indicator 8b	60% of identified health equity focused public policy goals are advancing

Objective or Indicator	Description
Objective 9	By July 2024, there will be greater public awareness that social determinants of health impact individual health outcomes
Indicator 9a	Community members surveyed report an increased understanding of the impacts of the social determinants of health, based on RRFSS module scores (7% increase in income, education, and employment scores; 2% increase in housing, social support, health services, and coping skills)
Indicator 9b	40% increase in the number of media releases that explain the social determinants of health in relation to a health issue

Strategies and associated activities:

Coordinated communication plan

- Develop communication strategy
- Standard method for integrating social determinants of health into media messaging
- Promote and track public policy advancement
- Social media campaign
- Support centralized provincial campaign
- Incorporate messaging into community collaborations
- Communication plans developed for
 - Health Equity strategy
 - Data that is available
 - Results of internal evaluations or assessments
- Communication plans should include:
 - Internal staff
 - Niagara Region Departments
 - Community partners
 - LHIN
 - Other government partners

Staff members have been identified to lead the teams that will implement the strategic plan. The plan will be evaluated annually through the use of an indicator matrix to measure success, with a more comprehensive evaluation being conducted half way through the strategy in 2021.

5 Conclusion

The NRPH&ES Health Equity Strategy is the next step in a journey towards improving the health and wellbeing of all the residents of Niagara. The journey that began decades ago was focused through the creation of Social Determinants of Health (SDOH) Champions in 2010, and progressed through work in all the divisions of NRPH&ES. After receiving direction from the Senior Management Team as aligned with the strategic priority matrix, a team of ten staff members used the Drivers Model to collect and analyze primary and secondary qualitative data leading to the creation of a Health Equity Strategic Plan (2018-2024).

This strategy sets out an ambitious plan to improve health equity in Niagara based on four themes that brought together recent literature, the Ontario Public Health Standards, and the perspectives of internal public health staff, community and corporate partners, and community members. Having quality local data stratified by socioeconomic and demographic variables for use in standardized program planning and evaluation is the basis of being able to assess and report on the health of local populations and modify and orient public health interventions to decrease health inequities (NCCDH, 2013).

Putting health equity at the centre of the NRPH&ES strategic priority matrix, with Senior Management responsibility and leadership, guiding resource alignment, and providing quality resources in a supportive learning environment, demonstrates strong and effective leadership (Simms, 2017) and will build the skills and capacity of public health staff to integrate health equity into their work. Multi-sectoral collaboration is essential for addressing the roots of health inequities and the social determinants of health (Simms, 2017; NCCDH, 2013). Finally, in order to influence population level change, public health needs to lead, support, and participate in advancing healthy public policies (MOHLTC, 2018) through communicating about health equity and increasing public awareness of the social determinants of health.

Moving forward, staff members have been identified to lead future teams tasked with implementing the strategic plan. The plan will be evaluated annually through the use of an indicator matrix to measure success, with a more comprehensive evaluation being conducted half way through the strategy in 2021. To be successful it will require the collaboration of staff at all levels, community partners, and community members, as we work towards a Niagara where everyone is empowered and has the opportunity to reach their full health potential.

References

Capital Health. (2011). Taking Action to Reduce Health Inequities: A Strategic Plan for Cultural Competence, Diversity and Social Inclusion at Capital Health. Halifax, Nova Scotia.

Cohen, B.E., Schultz, A., McGibbon, E., VanderPlaat, M., Bassett, R., GermAnn, K., Beanlands, H., & Fuga, L.A. (2013) A Conceptual Framework of Organizational Capacity for Public Health Equity Action (OC-PHEA). *Canadian Journal of Public Health*, 104(3):e262-266.

Lafley, A.G., Martin, R., Riel, J. (2013). A Playbook for Strategy: The Five Essential Question at the Heart of Any Winning Strategy. Rotman Magazine. Winter.

National Association of County & City Health Officials (NACCHO). (2010). Developing a Local Health Department Strategic Plan: A How-To Guide. National Association of County & City Health Officials. Washington, DC.

National Collaborating Centre for Determinants of Health (NCCDH). (2013). Let's Talk: Public Health Roles for Improving Health Equity. Antigonish, NS: National Collaborating Centre for Determinants of Health, St. Francis Xavier University.
<http://nccdh.ca/resources/entry/lets-talk-public-health-roles>.

Ministry of Health and Long-Term Care (MOHLTC). (2008). Ontario Public Health Standards 2008. Ontario: Queen's Printer of Ontario.

Ministry of Health and Long-Term Care (MOHLTC). (2018). Health Equity Guideline, 2018. Ontario: Queen's Printer of Ontario.

Public Health Agency of Canada (PHAC). (2008). Core Competencies for Public Health in Canada, Release 1.0. Ottawa: Her Majesty the Queen in Right of Canada.

Simms, C. (2017). Increasing Organizational Capacity for Health Equity Work: A Literature Review for Health Nexus. Health Nexus.
<http://en.healthnexus.ca/news/increasing-organizational-capacity-health-equity-work-literature-review-health-nexus>

Underwood, J., Harlos, S., Vivian-Book, L. (2013). "What Does It Take to Be a Leader for Health Equity?" March 14, 2013. http://chnet-works.ca/index.php?option=com_rsevents&view=events&layout=show&cid=216%3Anccdh-what-does-it-take-to-be-a-leader-for-health-equity&Itemid=25&lang=en.

Wilkinson, M. (2011). The executive guide to facilitating strategy: featuring the Drivers Model. Leadership Strategies Publishing, Atlanta, Georgia.



Appendix A – SDOH Champions

List of Social Determinants of Health (SDOH) Champions

Name	Division	Phase(s)
Anne Biscaro	Family Health	1
Sandy Dupuis	Organizational and Foundational Standards	2
Jackie Gervais	Chronic Disease and Injury Prevention	2
Kristina Nickel	Chronic Disease and Injury Prevention	1 & 2
Kim Ouellette	Chronic Disease and Injury Prevention	1 & 2
Sandra Romagnoli	Clinical Services	1 & 2
Tina Welsh	Environmental Health	2
Marty Mako	Chronic Disease and Injury Prevention	1, 2 & 3
James Macintosh	Organizational and Foundational Standards	1, 2 & 3
Nicole Stefanovici	Organizational and Foundational Standards	1, 2 & 3
Pam Lof	Clinical Services	1 & 3
Zeau Ismail	Clinical Services	2
Gisele Richard	Family Health	1, 2 & 3
Andrea Selimi	Clinical Services	2 & 3
Gina Spratt	Family Health	2 & 3
Lindsay Beaugard	Family Health	3
Gillian Chappell	Chronic Disease and Injury Prevention	3
Eric Huffman	Emergency Medical Services	3
Teryl Larmand	Clinical Services	3
Lisa Traver	Family Health	3
Kelly Catherwood	Clinical Services	3
Nicole Niedra	Chronic Disease and Injury Prevention	3
Felicia Tisi	Family Health	3

Appendix B – Internal documents reviewed

List of internal documents reviewed

Dyer, C. (2017). Screening for Health Equity in Smithville Family Health Team. Niagara Region Public Health. Thorold, Ontario.

E-Menu of Tools for the Social Determinants of Health

Lof, P. (2017). Recommendations to address the barriers and challenges in utilization of health equity tools in Public Health Nursing practice. Niagara Region Public Health. Thorold, Ontario.

Niagara Region Public Health, Brock University, McMaster University. (2016). Screening for Health Equity: Review of Smithville Family Health Team Pilot.

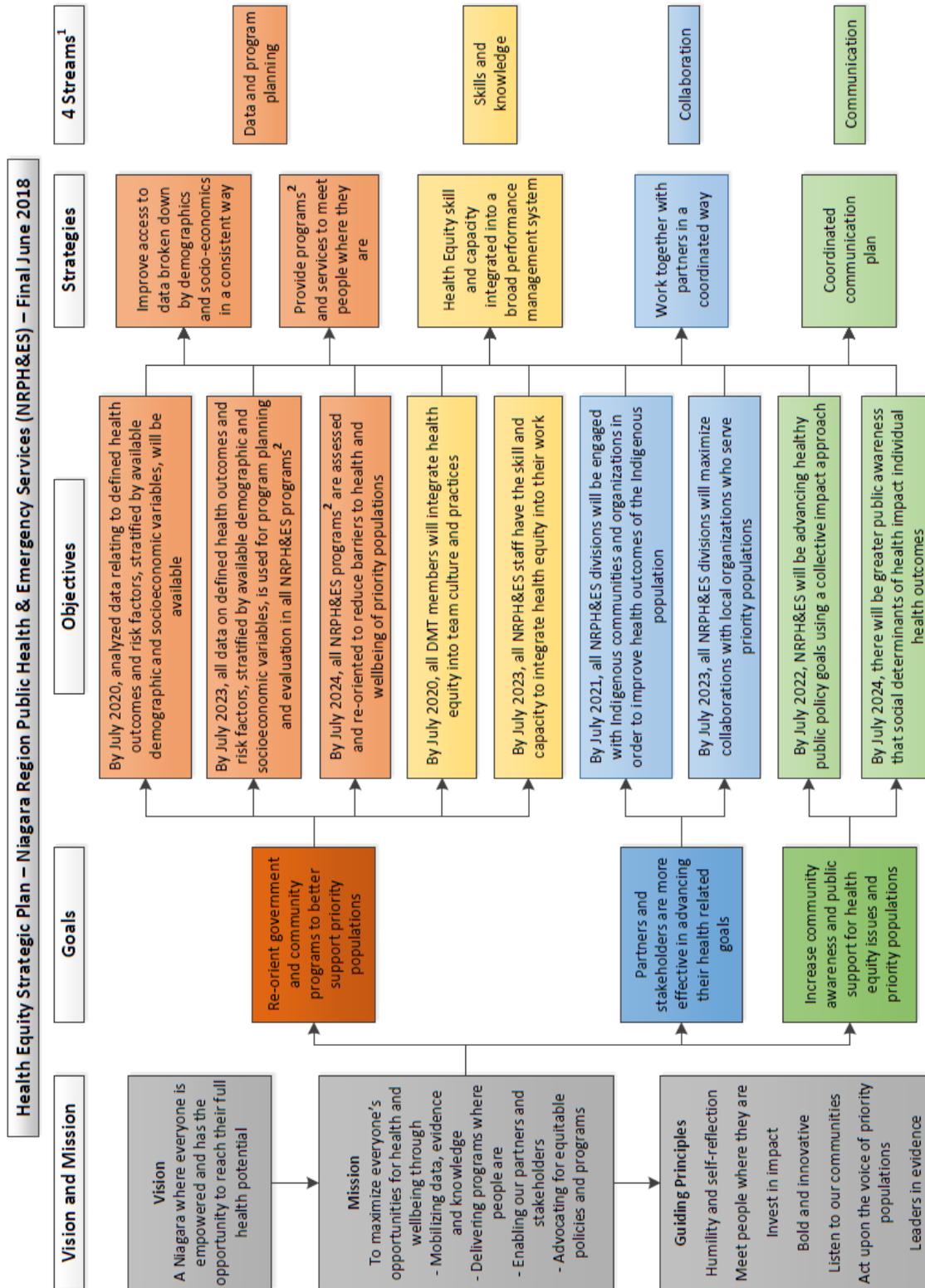
Niagara Region Public Health (2017). Chronic Disease and Injury Prevention: Health Equity Assessment. Thorold, Ontario. [Health Equity Assessment and Action Plan]

Priority Populations Network minutes from 2015-2017

Public Health Priority Matrix

Tenenbaum, M. (2016). Advancing Health Equity in Niagara Region: Evidence Brief to support a Deliberative Dialogue. Course material for MPH Epidemiology, University of Toronto. Toronto, Ontario.

Appendix C – Strategic Map



1. The four streams are interconnected and do not stand in isolation 2. Programs includes services

