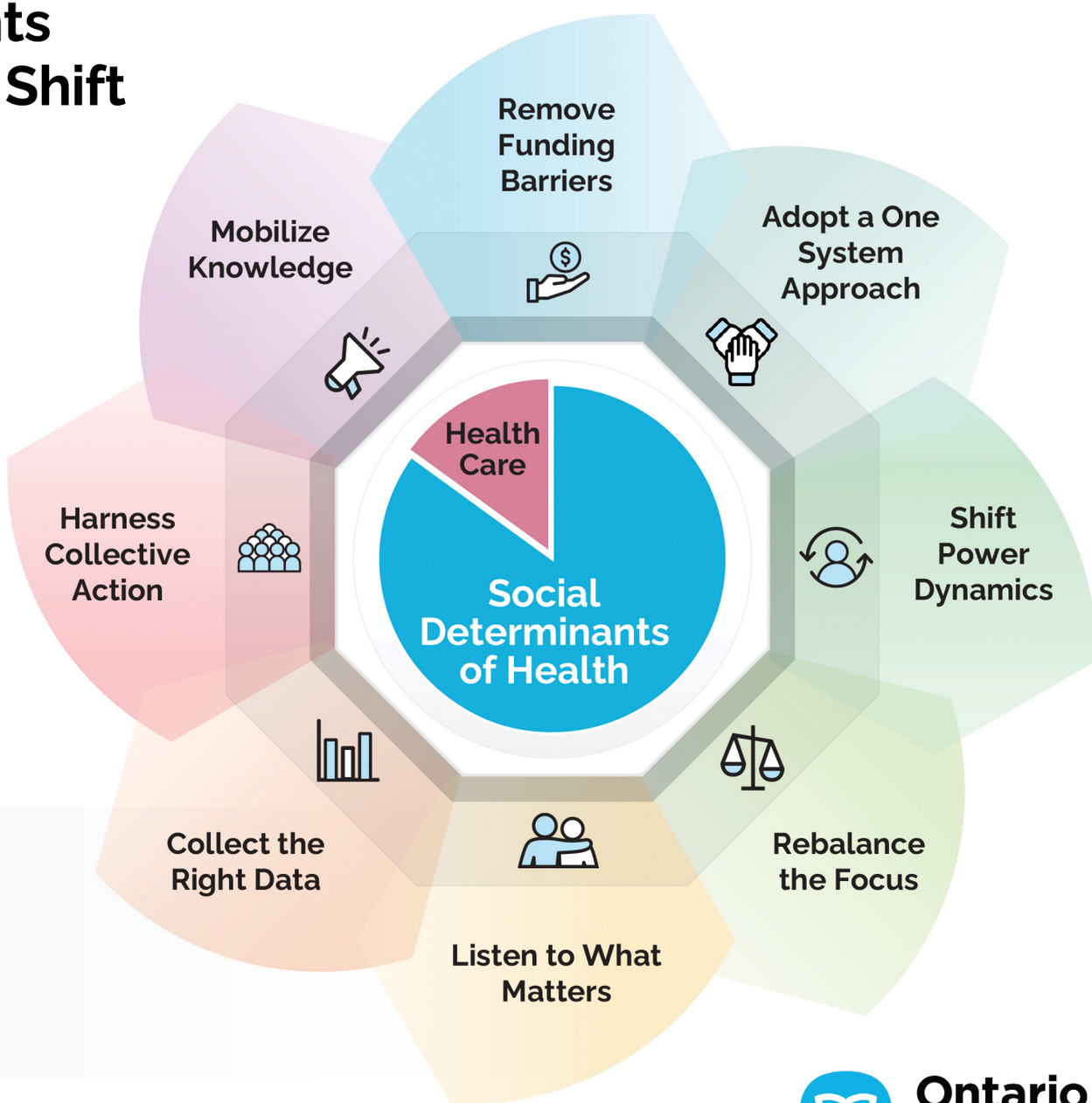
Ontario Health's Social Determinants of Health Framework... A Paradigm Shift

What Makes People Sick?

The World Health Organization states that "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."

Purpose of This Framework

We conducted in-depth research and consultations to understand the current state of SDoH work underway across the globe. This Framework brings together what we learned, outlining eight key principles and examples to address barriers while expanding adoption of a SDoH approach to transform care delivery and outcomes.



"Research shows that the social determinants can be **more important than health care or lifestyle choices** in influencing health."

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The Paradigm Shift

The Framework is intended to be a practical tool that can be used to guide our collective efforts to "shift the focus" to addressing underlying health inequities and root causes holding illness in place. Shifting from "*what's the matter with you?*" to "*what matters to you?*" and moving upstream to address population health needs. Below are the key evidence-based principles identified to drive action.

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.

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

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

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.

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

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

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

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.

Some Examples of Great Work Underway

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.

The **High Priority Communities Strategy** provides support for an **equity-based community-led approach**. The Strategy was originally launched to respond to COVID-19 and shone a light on the impact of social determinants and the important role trusted community providers play in improving health outcomes.

Southlake@home grew out of a need to **get at the root cause** of pressures that prevent effective ALC-to-home transfers. Recognizing that a common attribute was the presence of multiple conditions and non-health needs, this robust multi-sector collaboration first identifies then serves the population with comprehensive and appropriate solutions.

The **Alliance's Social Prescribing** uses a process of writing a prescription for internal and local social and community services that **support clients to improve their health** and wellbeing. It bridges the gap between clinical and social care by connecting clients to services that are chosen according to the client's interests, goals, and gifts.

Toronto area health care institutions have been collecting a standardized set of sociodemographic questions through the **Measuring Health Equity** project, developed through a **Tri-Hospital and Toronto Public Health research project**. This transformative effort represents an evidence-driven pathway to achieving equitable quality care.

The **Western Ottawa Community Resource Centre, one of 13 across the Ottawa** area, started as a grassroots community organization driven by people in neigbourhoods with a common vision. Together they drove change and built services that **bring care and community together.**

"Let's Start a Conversation About Health and Not Talk About Health Care at All", is a video developed by **Public Health Sudbury & Districts** that illustrates how public health organizations engage with community members, to understand local experiences of the social determinants of health, and identify innovative solutions together.

Let's Go Home (LEGHO) is an **innovative bundled care program** supporting ED diversion, admission avoidance and hospital discharge for seniors & adults with physical disabilities. An intensive 4-6 week program, it coordinates access and covers related patient-facing costs for meals, transportation, homemaking, caregiver supports and other community programs.

Improving Population Health Ensuring No One is Left Behind

"To **improve the health of the population**, we all need to work together. To achieve this end, we must have different strategies for how health and other social service leaders, providers, partners and impacted community members come together with a collective focus on the determinants of health."

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