THE MISSING LINK

The power of belonging

HealthLink
North Simcoe Community

Draft Report: October 2018
Ontario is improving care for seniors and others with complex conditions through Health Links. This innovative approach brings together health care providers in a community to better and more quickly coordinate care for high needs patients.

This is a new model of care, where all providers in a community, including family care providers, specialists, hospitals, long-term care, home care and other community supports, are charged with coordinating plans at the patient level. This will help improve patient transitions within the system and help ensure patients receive more responsive care that addresses their specific needs with the support of a tightly knit team of providers.

Patients with the greatest health care needs make up five percent of Ontario’s population but use services that account for approximately two-thirds of Ontario’s health care dollars. Better coordination of care for these patients will result in better care and significant health system savings that can be devoted to other patients, ultimately improving the sustainability of public health care.

Health Links supports the implementation of the NSM LHIN’s Care Connections - Partnering for Healthy Communities integrated health system plan and will work to achieve the North Simcoe Muskoka vision: Healthy People. Excellent Care. One System.
“There isn’t a lot of money to add to the system. We really need to use the money in the health care system better than we have been. We need to look beyond individual Ministry silos and consider if we spend in health care how we save down the line with other Ministries.”

(April 30, 2018)

Christine Elliot, Deputy Premier and Minister of Ministry of Health and Longer Term Care
One of the major findings that emerged out of our first report *Deepening Understanding Of the People We Serve Through the Lens of the Canadian Index of Wellbeing* was the high level of social isolation of Health Link patients. The outcomes that showed increased belonging stemming from concerted efforts were very encouraging.

In this report, *The Missing Link: The Power of Belonging*, we examine this work, and the necessary environment needed to perform such work, informed by the experiences of our patients.

In so doing, we are indebted to Dr. Elaine Weirsma and her team from the Department of Applied Health Science at Lakehead University. The insights generated from her study *Health Link: Experience of Health Care Users* proved to be indispensable. Likewise, we are grateful to to Tim Anfilogoff, Director of Community Resilience NHS Herts Valley CCG for their willingness to partner with us in bringing Social Prescribing to North America.

As was the case with our initial report, not enough can be said to thank the people that make up this Health Link for their amazing display of courage and emotional honesty. We can only hope that we do justice to the insights they have provided. Likewise, our staff and community advisory group have demonstrated a level of commitment and zeal that is contagious. We thank one and all!

Respectfully,

David Jeffery  
Co Chair

Andrew Shantz  
Co Chair
David Jeffery accepts Health Care Innovation Award at 2017 Transformative Change Ceremony
Over the course of the past several years, it has become increasingly clear that the initial premise on which Health Links were established doesn’t entirely hold water; namely, that improved health status and systems outcomes can be achieved by better linking medically complex patients with appropriate health care service providers in a timely manner.

This is not to suggest it is wrong, only that it is quite limited due in large part to the growing realization that the real issue is not so much the high level of medical complexity of Health Link patients, as it is the high level of social complexity which exacerbates the capacity to effectively treat the medical issues.

While much has been said about poverty, and with valid reasoning, there is one determinant of health which deserves far more attention than it has received to date. That is, belonging or what we refer to as the Missing Link, precisely because it has been so underrated, despite the growing body of evidence showing its influence on health status and its potential to deliver positive results.

Here we need look only as far as North Simcoe Community Health Link which continues to shine in terms of demonstrating major triple aim impacts (improving the individual experience of care, improving the health of populations and reducing the per capita costs of care):

- Greatly improved levels of social connection and wellbeing amongst its patients 75% and 72% respectively;
- Increased community capacity as evidenced by a volunteer community driving programs led by Community Reach TLC Program which reduced transportation costs by 98%;
- Lower hospital utilization rates in terms of Emergency room visit (40% lower) and hospital in-patient stays (36%)
- Reduced health care system costs which far exceed the operating costs which are minimal by comparison.

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EXECUTIVE SUMMARY

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Some level of caution is warranted before leaping to conclusions. In part because the process of helping Health Link patients become more socially connected contains many variables not the least of which is that staff are seen as an integral part of the social support system for Health Link patients.
Rarely is it as simple as referring someone to a community agency that provides opportunities for social connection, at least, in the initial stages of the care coordination process. Rather, helping Health Link patients become more socially connected might be better construed as a journey set against the backdrop of their own stories which often contain gut wrenching losses on multiple levels.

Early indications suggest that this work occurs best in smaller primary health care settings with an organizational culture that empowers staff to perform high quality care and an emphasis placed on best serving the needs of the patients. This is in contrast to an environment that focuses on a return on investment and increasing volume.

In closing, the fact that the NSM LHIN made a conscious choice not to be too prescriptive allowed for the bold innovation demonstrated by North Simcoe Community Health Link on matters pertaining to increased belonging. Already we can see the benefits of this choice creating a positive ripple effect well beyond its own region on to the international stage.

“The Health Links of Simcoe Muskoka have shown us that those who have the most complex health care needs very often are also those who are disadvantaged regarding the social determinants of health. The Health Links mitigate social isolation, disadvantage and health inequity by systematically connecting these people to the health and community services that they need to lead healthier lives. The findings of the Health Links also serve as an opportunity for us to enhance linkages to such services and resources more broadly for the many others in our communities who need them.”

Dr. Charles Gardner, Medical Officer of Health
Over the course of the past several years, there have been mounting concerns regarding the future of our health care system. And for good reason, health care spending consumes almost 44 cents of every dollar spent on provincial programs. Without a major change of course, health spending will increase to 70 percent of the provincial program spending within 12 years, thereby undermining our ability to pay for many other important priorities.

Such a course is neither sustainable, nor desirable. And yet, all is not doom and gloom. In fact, a strong case could be made that it is precisely conditions such as these that generate the impetus for change, such as we are witnessing via the establishment of the Local Health Integrated Networks and necessary legislative levers such as Patients First. Necessity is indeed proving to be the mother of invention.

Central to the paradigm shift that we see in its nascent form starting to take root is the growing realization that many of the solutions to what ail our health care system lie outside of a traditional medical treatment model. Bear in mind, of the 5 percent of people who currently use 2/3rds and the 10 percent who use 3/4ths of healthcare expenditures, the vast majority are poor, hungry and socially isolated.

“For a pedestrian hit by a minivan, there’s nowhere better than an emergency room. But these institutions are vastly inadequate for people with complex [social and medical] problems… It’s like arriving at a major construction project with nothing but a screwdriver and a crane.”

Atul Gawande, US surgeon, health systems researcher
It is in this boiling cauldron, we can trace the evolution of Health Links across the province. These entities are only too aware of the impact of the determinants of health on their patients. More importantly, several Health Links are responding in highly innovative ways to better meet the real needs of their clients by addressing both the high level of medical complexity and social complexity.

Such is clearly the case with North Simcoe Community Health Link which is essentially employing a hybrid Social Prescribing approach that encompasses a strong emphasis on community based leadership and care. Proving that in so doing, not only do its patients benefit in a significant way, so does the system in terms of reaping major reductions in hospital utilization rates and costs.

And yet, vitally important as the work of North Simcoe Health Link is in terms of showing there is another way to do care coordination within a radically transformed health care system. This in and of itself should not be regarded as a panacea. On the contrary, what it points to is the incredible toll that disconnection plays in our society as a whole.

Along these lines, our leaders would be well served to take seriously the warning Tommy Douglas issued several decades ago. He spoke about his concerns that the viability of our health care system would be at grave risk not because we did implement the vision, but rather because we conveniently pushed aside what he referred to as the 2nd Stage of Medicare.

“I am concerned about Medicare, as many people are, not with its fundamental principles, but with the problems we knew would arise. There were to be two phases of Medicare. The first was to remove financial barriers between those who provide health care services and those who receive the services. The second was to adapt our delivery of system so as to reduce costs through preventative medicine.”

-Tommy Douglas
In the first North Simcoe Community Health Link Report, the primary focus was to obtain a deeper understanding of who we were serving through the lens of the Canadian Index of Wellbeing. Through this investigation what became quite apparent is the high level of social complexity of Health Link patients as evidenced by extreme poverty, food insecurity and social isolation.

Of real significance, despite the high level of medical and social complexity, the North Simcoe Health Link was able to demonstrate significant impacts including major reductions in emergency room visits and number of admissions to hospital. So much so, the cost savings far exceed the operating costs.

All of this points to the question: WHY? In particular, what is it that is happening at ground zero? In the words of one Executive Director, “what is the ingredient in the secret sauce” that makes the North Simcoe Community Health Link such a high performer, in contrast to other Health Links, and able to achieve the impacts it does?

**What is the secret sauce?**

One way to respond to this question is through a process of elimination. For example, we know that most Health Links increase the number of referrals to other health care service providers, regardless if they are a top or low performer. Hence, it is highly unlikely that this is what contributes to major impacts.

Likewise, as was noted in the first report, the hard truth is that income levels, however inadequate to meet basic needs remained constant through the duration of the Health Link intervention. Hence, one cannot attribute the positive impacts to increased income levels and greater food security.

This, in turn, prompted researchers to closely examine belonging as a key factor contributing to the positive impacts and to really unpack it in a way that might lend itself to a more nuanced and better understanding. This is essential to obtain if the hope is to eventually develop best practices that might inform the future evolution of the Health Link.
Some of the key areas of focus for this particular study are as follows:

- What are staff are doing right to increase belonging, whether it be to combat social isolation or alienation from the health care system?
- What is it about their working environment that supports this work, be it the organizational culture, leadership, or case load size?
- And most importantly, what insights are provided by the patients about their journey through the health care system that detracted from or increased their sense of social connection?

In order to address these questions and deepen our understanding of what transpires between the time patients are first enrolled in the North Simcoe Community Health Link to the time that there are notable impacts, a blended qualitative and quantitative approach was employed.

The first phase involved a qualitative mapping exercise facilitated by Dr. Elaine Weirsma and her team from Lakehead University to document the experience of patients. This involved focus groups of North Simcoe Community Health Link patients and service providers. In so doing, a special focus was placed on social support.

In addition, there was a strong quantitative component consisting of relevant measures obtained from a modified Be Well survey (derived from the Canadian Index of Wellbeing), client experience measures that included social connection and wellbeing, and finally, hospitalization utilization rates and costs as was the case in the first report.
Most family doctors are quick to point out that the majority of life threatening illnesses they treat are entirely preventable. In fact, they advise their patients to quit smoking, exercise more, and lose weight. This is the undisputed gospel of disease prevention.

While there is no denying the health benefits that accrue from abiding by such advice, there is one notable omission. That is, having access to strong relationships and social supports, as well as having a valued social role, fosters a greater sense of social integration. Namely, the importance of belonging.

This is no minor omission for the simple reason that belonging far outranks all of the major lifestyle factors typically prescribed by medical practitioners. So much so that Susan Pinker, author of the Village Effect stated: “Access to social relationships and supports is more important than exercise, losing weight, and quitting smoking combined.”

What this in turn really underscores is the need to broaden our understanding of health as not just an individual outcome, but one that also takes into account the extent to which health is impacted in a very significant way by social cohesion, community ties and mutual support. The hard truth is loneliness kills!

Paradoxically, the way to achieve better individual health outcomes and to transform the health care system will happen only to the extent that those tasked with transforming the health care system acknowledge, conceive and implement interventions aimed at increasing belonging and social connection.

The good news is there are numerous comprehensive primary health care organizations performing this difficult but rewarding work across the province, including Health Links. Furthermore, there are promising new developments such as Social Prescribing emerging from other jurisdictions.
Given the significance of social connection as a key determinant of health, it is instructive to examine levels of belonging for Health Link patients prior to their involvement with North Simcoe Community Health Link. For the purposes of this research, this was gleaned from a number of questions ranging from their number of relatives and close friends to the extent to which they feel accepted and valued by the community.

I. Family & Friends
Starting with family and friends, what emerges is a rather stark picture of just how bereft many Health Link patients truly are with respect to having access to informal supports such as family and friends. As depicted below the majority of Health Link patients have very few, if any, family members or friends.

This stands in sharp contrast to Canadians as a whole that report having close ties with at least five or more family members. In fact, less than 4% of Canadians report having no relatives, in contrast to 25% of Health Link patients. Furthermore, while only 20% of Canadians have access to 3 or less family or friends which is at the low end of the spectrum, this is the reality for close to 50% of Health Link patients.

Not enough can be said about the incredible importance of family and friends both in terms of promoting higher levels of individual health and wellbeing, but also in bettering system outcomes. In a major analysis of overall health care system in Ontario, it was found that live in informal care providers “play an important role in maintaining clients in the community and are associated with lower total system costs than comparable clients.”

![Graph showing Friends and Family comparison](image)
Another question that was asked to Health Link patients was to describe their sense of belonging to their community; and in particular, the extent to which they feel connected to their community. Once again, standing in sharp contrast to most Canadians, most Health Link patients described their sense of belonging either as very or somewhat weak.

**Sense of Belonging to the Community of Health Link Patients**

Given the low levels of belonging, it should come as no surprise that the majority of Health Link patients’ participation levels in community events and activities was low. Most reported that they rarely attended any event or activities. None reported that they were active in their community.

No less disturbing is the fact the majority of North Simcoe Community Health Link patients do not feel accepted and valued in their community. Over seventy percent of Health Link patients reported that they rarely felt accepted or valued by their community in contrast to those who reported that they did.

In relation to 70% of other Canadians, only 46.75% of North Simcoe Community Health Link patients feel accepted.
“My day, every day – I get up in the morning. I test my blood sugar. I take my pills, have something to eat and test it at lunch time. Maybe I go out shopping, come back and test my blood before dinner. Then I sit down and watch tv, maybe read the paper. Take a pill before bedtime.

Everyday is the same for me.”
The high extent to which North Simcoe Community Health Link patients no longer feel accepted or valued speaks to the overall theme of loss. This is important to note since most Health Link patients reported that they had rather full lives prior to their health issues, after which there was what might best be described as cascade of loss.

Loss of Health
For most Health Link patients, the downward spiral they experienced began with the compounding effect of multiple chronic diseases. The vast majority of Health Link patients have a minimum of 4 or more chronic diseases, and many have upwards of seven or eight.

Chronic diseases

In order of their prevalence these include: mental health issues, pulmonary, diabetes and heart disease. germane to this report is the negative impact social isolation has on many of these diseases and in particular as it relates to mental health in which there is a strong body of research.
So too, there is research emerging that many medical conditions are proven to be adversely affected by loneliness including type 2 diabetes and heart disease.

**Most Prevalent Health Conditions**

Total 244 clients

- Diabetes (24.50%)
- COPD (21.89%)
- CHF (21.89%)
- Mental Health Condition (31.62%)
Of real significance is how the loss of health for many Health Link patients had a spillover effect into other areas of their lives. Several Health Link patients, for instance, lamented the loss of employment. This resulted in a major loss of income which only compounded their health issues due to their inability to afford adequate nutritious food and in some cases lose their homes.

“I always worked all my life to put money in my house. So was it worth it – all the blood and sweat for the house? It seemed a shame to me when I think back at how hard I worked only to end up losing it anyway. It’s hard to say goodbye to my house that I live in for twenty years, It was my home...”
LOSING IDENTITY AND SELF WORTH

Accompanying the loss of health and employment is, very often, an acutely felt loss of identity. “If I am not able to work and support myself such as I once was able to do, well then who am I?” One health link patient reflects,

“I used to think that life was about work. When I worked, my work helped me value myself and everything. I thought I had to be a hard worker. That was how I defined myself...”

Closely related is the lost sense of worth that arises from poor health. This is especially true in our culture that equates individual worth to income and progress to the Gross Domestic Product, never mind how the wealth is generated or what the consequences might be on others.

What the lost sense of worth also speaks to is the extent to which our society has yet to identify and honor the inherent gifts of all age groups, including seniors. Far from being seen as a source of wisdom and carriers of tradition, most seniors are seen as liabilities and forced to live in the margins of our communities.

“One of the real challenges that an aging society such as ours faces is the need to call to task our culture’s obsession with youth and its heavy ‘Forever Young’ bias. Indeed a strong case could be made that the health and wellbeing of our communities could be radically transformed if only we were to tap into the gifts of seniors.”
Finally, it is with no lack of irony that very often when people are in greatest need of social support, they are least likely to find it. Nowhere is this more true than in the case than with people whose health declines. Virtually all of the Health Link patients spoke to the loss of family and friends they experienced as a result of their health woes.

“After a while, all these people fall away. You end up just being like a little – well, sometimes I think of it as an island and those are the good days because then I’m not treading water in the middle if the ocean. So some days when I see people helping it’s a pond or if they’re not quite accessible it’s a lake. Or if I am completely ignored, it’s an ocean.”
Fortunately, for patients, staff and health administrators, there is some good news regarding social isolation. One such development rapidly emerging on the horizon is Social Prescribing. There is no denying the tremendous potential of this approach aimed at combatting social isolation that is acutely experienced by so many Health Link patients.

What is Social Prescribing? Simply stated, social prescribing occurs when referrals are made by primary health care staff on behalf of their patients to community and social supports. In the case of North Simcoe Community Health Link, there are several key components to Social Prescribing, including intake and assessment, counselling and goal setting, referrals and community capacity building.
a) Intake & Assessment

For North Simcoe Community Health Link patients, the social prescribing process begins during the initial intake during which questions are asked to ascertain the level of social connectedness of its clients. Some of the key questions that are asked to help glean this information are:

- How many family and friends do you have?
- Do you feel like you belong to the community?
- How active are you in the community?
- Do you feel accepted and valued?
- Are there any barriers that keep you from participating in group activities?

The importance of performing a comprehensive intake cannot be overemphasized in so far as if one does not start in a comprehensive way, one will never be able to optimize health and well-being. Far too often, intake assessments focus on physical and mental health status with little or no regard on social relationships, let alone community involvement.

And it is the failure to perform comprehensive assessments during intake that result more than anything in the inappropriate utilization of formal health care services. Why? Because if people are lonely, they will resort to whatever means necessary to fulfil their social needs, and frequent doctors’ offices and emergency rooms.

Such is the case with one elderly lady who was reported by CEO Bruce Lauckner as calling 911 over 100 times in one year. Each time an ambulance would arrive on the scene, very often with a fire truck and police cruiser only to find out she simply needed help getting food, or lifting a heavy object. Clearly this is not a wise use of health care dollars.
b) Goal Setting

Once the needs and capacities were identified specific to North Simcoe Community Health Link patients, a determination could be made as to whether they might benefit by having greater social supports. In this regard, there is often a seamless flow from questions asked during the intake to the basis for goals.

One matter which was strongly identified by North Simcoe Community Health Link patients as really critical is the extent to which the patients to feel listened to. As obvious as this might sound, one of patients major frustrations prior to their involvement with North Simcoe Community Health Link is the way they felt ignored.

Quite aside from the fact that active listening will result in a greater sense of ownership required to successfully meet the goals, it provides the staff with the necessary insight to establish goals that make sense given their patients unique situation and most especially when it comes to trying to increase social connection.

It makes little sense to make referrals to social and community supports, for example, if people lack the transportation to access these agencies. In fact, this was identified as a major barrier to belonging for North Simcoe Community Health Links in a previous report. Ditto for patients whose care givers are suffering from burn out.

“I don’t care if anybody can do something for me as long as they actually hear me – as long as I said something and they tried to listen.”
c) Referrals to Social and Community Agencies

Due to the fact that the North Simcoe Community Health Link employed a community development approach at its inception and continues to do so, it is blessed with a strong base of partnerships. While it includes the full gamut of health care service providers, its partnerships includes many community and social service partners.

Many of these organizations provide opportunities for greater social connection. These include, but are not restricted to such organizations as faith based organizations i.e. St. Pauls, recreational services i.e. YMCA and Waypoint Hero Recreational Services, community based programs i.e. Mindfulness Based Stress Reduction.

In keeping with earlier findings, the North Simcoe Health Link continues to perform excellent work by increasing the number of linkages for its patients. This is clearly demonstrated that the number of agencies linkages pre and post the patients’ involvement with Health Link increased by 60%.

What is significant for the purposes of this study is many of the new referrals are to non-medical organizations. In reviewing the data, it was found that over sixty percent of new referrals are to non-medical organizations; many of which offer a variety of social and community supports.
d) Community Capacity Building

While community development is not normally considered to be a part of Social Prescribing, the reality is its success is in many ways contingent on the level of capacity within the community to respond to the referrals. It makes little sense to refer people to agencies that have elongated waiting lists, since this will only engender frustration.

Here North Simcoe Community Health Link is to be commended for performing vitally important community development work geared to combating social isolation. Case in point is their success in increasing access to transportation which was identified in the previous report as a barrier to increased social interaction.

Another community development project undertaken by the North Simcoe Community Health Link was to respond to community needs articulated by leaders and residents of Christian Island to obtain necessary communications infrastructure. For, in its absence, its’ people were essentially cut off from the mainland. This is mentioned in large part because the potential of technology to combat social isolation for people has received thrift attention relative to other interventions. And yet, technology can be a lifeline between patients and their loved ones at a time when it is most needed.

“I’ve got a couple of good friends – with one friend, if I don’t go on facebook about every three days, if I don’t comment or put up a funny joke – they ask are you okay – are you sick? She phones me and asks are you okay?”
For the purposes of assessing the impact of the North Simcoe Community Health Link with a special focus on social connection, it was decided to use a triple aim impact approach. One that provides a robust picture that focuses on improved patient experience, reduced cost, and improved community health/capacity.

The reason for this, is one can obtain a rather skewed view by focusing on just one aspect in exclusion of the others. For example, the danger of looking at just reducing costs is it can easily detract from improved patient experience. Likewise, too often community development interventions are seen as an unnecessary cost without factoring its impact on improved patients experience resulting in reduced costs!

We have therefore elected to aim for a reasonably well balanced and nuanced view. It takes into account the inherent tension between seemingly conflicting goals at the same time as capitalizing on the synergistic properties of a triple aim approach, whereby the whole is greater than the sum of the parts.
a) Patient Experience

In keeping with the government’s commitment to improved patient experience, all Health Links are required to report on a variety of measures ranging from how meaningful is the extent to which the Health Link helped achieve client goals. This a welcome departure from simply viewing patients as passive consumers to keep satisfied.

Right across the board, the North Simcoe Community Health Link has achieved notable impacts in terms of improved client experience for its patients. For the purposes of this research, patients reported that the North Simcoe Health Link increased their social networks by 71.2%.

**How meaningful is the work of the Health Link?**

<table>
<thead>
<tr>
<th>Question</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Is being a patient of Health Link meaningful to you?</td>
<td>90.50%</td>
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<tr>
<td>Has your Health Link involvement increased your self-confidence?</td>
<td>69.7%</td>
</tr>
<tr>
<td>Has your Health Link involvement increased your social networks?</td>
<td>71.2%</td>
</tr>
<tr>
<td>Has your Health Link involvement increased your sense of wellbeing?</td>
<td>72.7%</td>
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<tr>
<td>Has your experience as a Health Link patient satisfied your goals?</td>
<td>58.67%</td>
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While it is not within the scope of this research to assess the interplay between the various measures, one need not go out on a limb to note the potential interconnections. It is highly likely that increased access to social networks would increase a patient’s sense of health and wellbeing.

This notwithstanding, one point that needs to be strongly emphasized is the fact that for the majority of patients, North Simcoe Community Health Link staff are regarded as part of their social network. Indeed, very often, staff serve as the only consistent and reliable person that the patients have known for quite some time and thereby serve as a lifeline.

“I’ve had such luck with Health Link. I don’t think I’d be alive without them, honestly.”
b) Community Health and Wellbeing

Due in large part to the prevailing value on individualism by our culture, short shrift is paid to attending to the health and wellbeing of our communities. So much so, it is as though many health administrators believe you can have healthy people in communities that are increasingly challenged by growing systemic health inequities.

And yet, as was clearly demonstrated in “Deepening Our Understanding of Those We Serve Through the Lens of the Canadian Index of Wellbeing” and again in this report, nothing could be further from the truth. For what is the white elephant in the room of most LHIN boards if not the majority of high cost users are poor, hungry and extremely socially isolated?

To the credit of the government, efforts have been made to integrate public health into the health care system given its mandate to promote population health. However, even here, one needs to be careful because in the absence of an adequate investment in health promotion and community development funds there will be little public health can do that will result in meaningful change. Simply writing reports is not the answer.

Despite the lack of investment by the LHIN in any community development staff, the North Simcoe Community Health Link has engaged in some significant community capacity building work. Moreover, what it clearly demonstrates is the magic that can happen when everyone who works in the health care system adopts a health promotion lens such as is the culture fostered by Chigamik CHC.

Case in point is the excellent community capacity building work aimed to combat social isolation. This starting with community nurses and social workers who rather than simply asking their patients how isolated they were, asked the far more important question WHY? In so doing, what they came to see was a pattern, namely, one of the major reasons their patients were so isolated is not that they didn’t have friends, but couldn’t afford to get out of their home.

In response, while the executive leadership could have complained about not having enough money to purchase taxi services for their patients, rather than look to the LHIN to finance ever increasing transportation costs, they chose to take a different approach; namely to help build the capacity of community partners with a mandate to assist people with transportation.
Arising from a request from Community Reach a community fundraising campaign was organized to purchase a vehicle and offset operating costs. Not only did this address the transportation needs of the patients, but it helped many other citizens living in Midland who are also house bound. As indicated below, due to the willingness of the leadership of the North Simcoe Community Health Link to invest in an existing community service, they have the capacity to provide an additional 225 rides per month to Health Link patients. This includes medical needs, social needs and activities of daily living (ie. Banking, grocery shopping ect.)

This, in turn, resulted in far lower operating costs for the Health Link. Prior to this community development work, the North Simcoe Community Health Link spent approximately $90,000 on transportation costs during their first year of operation. This was reduced dramatically to less than $2,000! Such is the power of community development work responsive to patients.

Support for the capital campaign also came from: The Rotary Club of Midland, Elmvale Lions Club, Midland Lions Club, Penetanguishene Lions Club, Victoria Harbour Lions Club, Port McNicoll Lions Club, Victoria Harbour Legion, MDRT, Midland Civitan Club

“The work we did to support Community Reach really is a great illustration of how when communities pull together everyone wins. The agencies. The government. And most important of all the people we all serve, whether it is Health Link patients or people across the community.”
c) Health Care Utilization Rates and Costs

With respect to the third triple aim of reducing costs, North Simcoe Community Health Link continues to yield extremely positive results. As depicted in the figure below there has been a net reduction of 51.6% in emergency room visits and 69.2% for inpatient visits. This totals a net reduction of 55.3% as seen in the far right column.

“In all my years of public service, I have never seen anything remotely as cost effective as North Simcoe Health Link. The work they do is just amazing and deserves far more support and credit.”

Alain Mayer, Board Treasurer, CSC CHIGAMIK CHC
If there is one major deterrent to transformation on the part of the government, it is the tendency to engage in lazy bureaucratic thinking. A prime example of this is when some LHIN program managers report that all Health Links are the same. Something akin to saying all hockey teams are the same. Bottom line as is the case with all things in life, there are high performers and low performers.

This is not to suggest that the North Simcoe Community Health Link is the only high performing Health Link. Rather, the message that needs to be imparted is ultimately the key to success is to learn from high performers so that eventually there might be a sufficient foundation to develop best practices. This would inform the future evolution of Health Links, versus painting every model with the same brush or worse still run the risk of throwing out the baby with the bathwater.

In order for this to happen, there needs to be comparative research such as is starting to emerge. In a major study performed under the leadership of Walter Wodchis through the Institute of Clinical Evaluation Studies, it was found “the pattern of use did not decrease among the first enrollees to Health Links in Ontario’s Central LHIN.”

### Results from difference-in-differences analysis for selected indicators

<table>
<thead>
<tr>
<th>Measure; group</th>
<th>Rate or mean (95% CI)</th>
<th>Pre-post difference, IRR (95% CI)</th>
<th>Difference-in-differences (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Before index date*</td>
<td>After index date</td>
<td></td>
</tr>
<tr>
<td>Hospital admissions†</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Links enrollees</td>
<td>2.26 (2.06-2.49)</td>
<td>2.07 (1.81-2.36)</td>
<td>0.91 (0.79-1.05)</td>
</tr>
<tr>
<td>Comparator group</td>
<td>2.06 (1.89-2.26)</td>
<td>1.08 (0.91-1.29)</td>
<td>0.53 (0.44-0.63)</td>
</tr>
<tr>
<td>Emergency department visits†</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Links enrollees</td>
<td>3.02 (2.42-3.78)</td>
<td>3.10 (2.09-4.59)</td>
<td>1.02 (0.80-1.31)</td>
</tr>
<tr>
<td>Comparator group</td>
<td>3.52 (2.97-4.18)</td>
<td>2.24 (1.72-2.9)</td>
<td>0.64 (0.52-0.77)</td>
</tr>
<tr>
<td>Days in acute care†</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Links enrollees</td>
<td>18.4 (16.3-20.8)</td>
<td>24.9 (20.7-30.0)</td>
<td>1.35 (1.11-1.65)</td>
</tr>
<tr>
<td>Comparator group</td>
<td>19.9 (17.3-23.1)</td>
<td>17.9 (13.5-23.8)</td>
<td>0.90 (0.66-1.21)</td>
</tr>
</tbody>
</table>
All of which begs the question, what is it that distinguishes North Simcoe Community Health Link from the Central LHIN Health Links? Short answer: all of the LHINs evaluated by Walter Wodchis were managed by hospitals and Community Care Access Centers. In other words, they are part of much larger, bureaucratic entities that are clearly less responsive to patients needs than their smaller primary health care counterparts.

To further add credence to this line of thinking are the findings of another Health Link managed by the Gateway Community Health Centre. Not only do Gateway Health Link patients exhibit similar levels of social isolation as North Simcoe, but they yield equally impressive results in terms of generating hard impacts.

All of the aforementioned certainly supports the Ministry of Health’s vision to firmly embed patient care and coordination within primary health care organizations. However, even here one needs to be careful since there are some Family Health Teams that have yielded poor results, such as is the case with the Guelph Family Health Team.

Upon closer examination, what was noteworthy in the case of Guelph, is how the patients managed by the Guelph Community Health Centre yielded far superior results; albeit the sample size is far smaller. Even so, it does raise the question as to whether Community Health Centres might be ideally suited to manage Health Link due to their track record working with socially complex patients.
While the sample size of this study is admittedly too small by which to make any definitive statements, it does nevertheless lend credence to the notion that by better meeting patients’ needs for social connection, this will for many translate into a greater sense of wellbeing and lower health care utilization rates and costs.

In this section, we will attempt to glean some of the key learnings that might help inform future work in this field. Derived largely from focus groups with patients and staff alike, as well as learnings from other major jurisdictions, this will focus on three broad headings: Clinical, Community and Policy.

**Learning in three areas:**

a) **Clinical** – importance of intake, asking the questions, the personal touch i.e. personally connecting people,

b) **Community** – far more can be done to build community capacity i.e. mobilize volunteers, Health Champions,

c) **Policy** – what policies can the government bring into effect to help combat loneliness which is one of the greatest epidemics of our time.
a) Clinical

As was the case in *Deepening Understanding Of the People We Serve Through the Lens of the Canadian Index of Wellbeing*, what we are reminded of is just how pivotal the role of community nurses are on multiple fronts, but most especially when it comes to combating the social isolation of their patients.

It is the healthcare workers, such as nurses and social workers, who after all who perform the comprehensive intakes, make the appropriate referrals, and very often accompany their patients to community agencies as this can be intimidating for people who feel overwhelmed by the magnitude of trying to cope with their lives. It is the nurses and social workers who help coordinate transportation. In short, community nurses and social workers are the axle around which their patients revolve.

Certainly, what came through in conversations with Health Link patients was not just the high regard in which they held their assigned community nurses, but the sharp contrast between their experience of their community nurses and social workers versus that of other health professionals throughout the health care system which they regard as remote and unresponsive.

While there are several reasons why this is the case, one factor that does serve mention is the way in which the healthcare workers are trained. Unlike many other medical professionals, a very important part of the learning is the strong emphasis on social determinants of health and the requirement that nurses and social workers do one community placement.

Of real significance on matters pertaining to increasing social connection is the strong support from the North Simcoe Muskoka Local Health Integrated Network. For starters, it has not imposed unrealistic caseloads such as is the case in other jurisdictions. This is vitally important since what is required in order for this work to succeed is the staff to patient ratio needs to be manageable.

That is why it has listened to the leadership of the North Simcoe Community Health Link and the recommendation of the previous report by providing access for social work services. Not only does this alleviate the workload, but the interdisciplinary approach helps renew ties with family members and friends and thereby rebuild their informal social support network.

One final point worthy of mention has to do with place, and in particular as it relates to increasing social connection for the most medically and socially complex patients. Along these lines, it would appear that the Health Links which are either managed by Community Health Centres and/or where there is a strong Community Health Centre presence are yielding the strongest impacts.
This is not to suggest that Community Health Centres should be regarded as the best health care service delivery model for all populations, but rather there is something to be said for the fact it is the best model for the most medically and social complex which we know is most high cost users of the health care system.

“Registered nurses working as community nurses possess a wide breadth and depth of knowledge, and are instrumental to assessing, planning and implementing a comprehensive care plan for their patients who have unpredictable health outcomes. As RNs, we take a holistic approach to care, and understand how positive health outcomes also encompass our patients’ social determinants of health.”

Vicki Mckenna, Ontario Nurses Association President

Key Recommendations

1. Develop best practices for Health Link staff with a special emphasis on increasing belonging.

2. Support the expansion and adoption of Social Prescribing as a tool to increase social connection for socially complex patients.

3. Acknowledge the leadership of the NSCHL for their leadership in supporting innovation and research.
b) Community Rx

To better understand why it is that Community Health Centres have a better track record in serving the most socially complex patients, one need only look as far as their model of care. The factors that really distinguish Community Health Centres from other models are the same factors that increase social connection.

Key amongst these is the manner in which Community Health Centres employ a community development approach aimed at increasing community vitality and belonging. Why community vitality and belonging? Short answer: Community Health Centres have learned that the number one factor which impacts on their patient’s health and wellbeing is the extent to which they feel like they belong.

Whether by accident or design, or some combination therein, there is no denying that a big part of ethos of the North Simcoe Community Health Link is governed by the values and principles of the Chigamik Community Health Centre, not the least of which is its strong commitment to employing a community development approach in a way that everyone benefits: patients, partners, funders. Such has been its modus operandi.

And yet, even here we need to be careful since there is so much that has yet to be done in terms of building community capacity. Far from resting on their laurels, the lion’s share of the work remains to be done. As one staff members states following a training session offered by the Alliance of Healthier Communities featuring leaders from Great Britain on Social Prescribing,

“The reason social prescribing can be so life-changing is that it shows zero tolerance of traditional agency boundaries. The link worker listens to the person about what matters to them, about why the ‘traditional’ responses of the complex and dis-integrated system aren’t helping, and then takes the time to find solutions and support in the community that will work for them. It is the very opposite of one size fits all. It gives people back control.”

- Tim Anfilogoff, Director of Community Resilience NHS Herts Valley CCG
Here it is important to note that while Social Prescribing works well for the ‘worried well’, challenges can arise for the most socially complex and/or when the community has yet to be mobilized. Case in point, some staff reported that they had nowhere to refer some of their patients since there was a lack of capacity and hence what ensues is over-dependency on staff.

In this regard, it needs to be stated that community development does not take place by itself. It requires a commitment of resources and proper supervision. Furthermore, it tends to work best when overseen by a community governed board, since the overriding concern is to serve community as distinct from a business model.

The good news is community development, if properly done, will reap benefits that far surpass the investment in staff dollars such as has already been illustrated by the huge return on investment for work that was done to support the community transportation. Everyone benefits. Patients. Communities. Funders. Such is the beauty of community development.

Key Recommendations

1. Advocate for the allocation of a community development staff to augment the work of North Simcoe Community Health Link.

2. Spearhead a Community Health Champion Initiative similar to ones in existence in Great Britain.

c) Policy Work

Virtually unheard of this day in age, all three political parties were supportive, and are to be commended in the passing of Bill 41 under the umbrella of Patient First legislation. Pertinent to this study, contained in this legislation are two items that the Alliance for Healthier Communities successfully advocated for in partnership with the Ontario Public Health Association.

Health Equity
To promote health equity, including equitable health outcomes, to reduce or eliminate health disparities and inequities, to recognize the impact of social determinants of health, and to respect the diversity of communities and the requirements of the French Language Services Act in the planning, design, delivery and evaluation of services.

Health Promotion
To participate in the development and implementation of health promotion strategies in cooperation with primary health care services, public health services and community-based services to support population health improvement and outcomes. Bill 41, Legislative Assembly of Ontario, December 8, 2016, pg 2.

The significance of these two objects cannot be underemphasized, since prior to their enactment, the Local Health Integrated Network were essentially in the business of managing formal health care services, whereas they now have a mandate by which to address the factors that most impact the demand for services and thereby transform the health care system.

To the credit of the government, the Ministry of Health is allocating funds to such health promotion initiatives as a major Social Prescribing initiative through a Health and Wellbeing grant. Also, very encouraging is the recent announcement of community development dollars aimed at supporting Naturally Occurring Retirement Communities in which a principle component is fostering stronger social connections amongst seniors.

It should be noted that the government’s commitment to investing in work to combat social isolation extends beyond the Ministry of Health. Case in point is the expansion of senior activity centres through the Ministry of Senior Affairs. All of this by way of saying that there are senior leaders within the government ranks who understand the significance of social connection.

Closely related to the concept of Naturally Occurring Retirement Communities is what is commonly referred to in the literature as Third Places. These are spaces that are intentionally open to the public in which people can convene and socialize. Examples include parks, community gardens, walking paths, libraries, and cafes.
The value of Third Places that encourage people to get out and socialize cannot be discounted, especially since very often there is a synergistic element to these places in which people receive multiple health and wellbeing benefits including exercise, fresh air, learning and growth, civic pride and belonging.

Bottom line, the responsibility for conceiving and implementing programs and policies aimed at increasing social connection needs to encompass a broad spectrum of community partners in order to register an impact. In so doing, it will be really important for leaders to connect the dots between social connection, health status, and health care utilization rates and costs.

Key Recommendations

1. Local Health Integrated Networks integrate into the implementation of Health Equity and Health Promotion a goal specific to social connectedness.

2. Spearhead a knowledge mobilization campaign to key stakeholders regarding the significance of social connection and what can be done.

3. Expand Social Prescribing model to include multiple Ministries and the private sector.
ACKNOWLEDGEMENTS

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And most important of all a deep and heartfelt thanks to the people we serve for their courage and inspiration.
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Be Well Survey, derived from the Canadian Index of Wellbeing, uwaterloo.ca/canadian-index-wellbeing
ABOUT THE CIW

Like most countries, Canada lacks a single, national instrument for tracking and reporting on the overall wellbeing of individuals and societies. Gross Domestic Product (GDP) fails to capture quality of life in its full breadth of expression.

One alternative measure of societal progress that has been recently developed is the Canadian Index of Wellbeing (CIW); one of the most widely recognized and praised initiatives. The CIW began its development in 1999 with the support of the Atkinson Charitable Foundation. Under one umbrella, an independent, non-partisan network of national and international indicator experts joined forces with a wide range of leaders, organizations and grassroots Canadians.

The goal was to develop an instrument that measures Canada’s overall quality of life in a rigorous and comprehensive way. Equipped with data about the domains of life Canadians really care about, decision makers could “connect the dots” between social aspirations, public policy and hard evidence.

From the start, the initiative has been rooted in the Canadian experience. The index’s development involved extensive consultation with Canadians about the values they believe should guide this country: fairness, diversity, equity, inclusion, health, safety, economic security, democracy, and sustainability.

The team created what is now known as the CIW framework: 64 indicators grouped into eight “domains” or quality of life categories. Aside from its power as a measurement tool, perhaps, the greatest attribute of the CIW is its capacity to help us see the Big Picture. It also provides a broader lens to appreciate how everything is interconnected in ways we would otherwise never imagine. Seeing our communities differently is what will help us make wiser, more informed policy choices.

“If we want Canadians to be the healthiest people in the world, we have to connect all the dots that will take us there. To connect the dots, we have to know what they are.”

The Honourable Roy Romanow
THIS REPORT IS A RESULT OF THE PARTNERSHIP OF THE FOLLOWING ORGANIZATIONS