Hamilton Family Health Team
Better care, together.

Community Nurse Networker Pilot

EXECUTIVE SUMMARY, August 2015

The current model of health care delivery is not sustainable for Canadians nor is it giving us our best health outcomes. Local hospitals, primary care, the City of Hamilton, community agencies and our communities are, therefore, currently generating a new vision of health care delivery in Hamilton which has a population health approach. It is clear that the shift to understanding the social determinants of health and the interplay between our physical and emotional health over time, from birth to end of life, means that we have to work together in our focus on health promotion and illness and injury prevention. Changes in our understanding and approach must be made and partnerships between these core agencies will be critical in actualizing more user friendly, integrated and effective health care.

The Community Nurse Networker (CNN) Pilot was one example of an innovative model of health care delivery that focused on promotion and prevention strategies and fostered partnerships between community and health care agencies. Specifically, the CNN pilot aimed to support people who, due to the impact of the Social Determinants of Health (SDOH), were unable to access available health programs and social services.

BACKGROUND

The Community Nurse Networker pilot project began in September 2013 and terminated in September 2015. The project was jointly funded by the Hamilton Family Health Team, the City of Hamilton Neighbourhood Action Strategy, and the Hamilton Community Foundation. The pilot received support from the McQuesten Neighbourhood Planning Team and the McMaster School of Nursing.

In order to facilitate and improve access to programs and services, the pilot developed the Community Nurse Networker (CNN) role. This role employed a highly skilled Public Health Nurse who had worked in the priority neighbourhood in which the pilot took place. The CNN had experience working in the mental health sector, had nursing experience across the age continuum, had excellent communication, problem-solving and conflict management skills and was knowledgeable regarding community resources and programs. The CNN used a motivational interviewing and brief solutions model in addition to her expertise in nursing assessment and intervention skills. The CNN worked

primarily out of two locations in the neighbourhood: the community center and a HFHT family practice. However, she also met with teaching staff and families at local schools and completed home visits when necessary. She worked with a variety of problems and helped people from early childhood years to the elderly.

COMMUNITY OUTCOMES

The McMaster School of Nursing completed a qualitative analysis of the experiences of community members with whom the CNN had worked. The evaluation demonstrated that the CNN created a welcoming and inclusive environment and built therapeutic relationships with residents, community leaders and service providers which developed a strong sense of trust. These relationships, combined with the CNN's nursing knowledge and skills, supported the CNN in performing holistic health and family assessments, providing education and support and in promoting and maintaining client and community health.

Throughout the pilot, the CNN had over 500 interactions with clients at the community center and connected approximately 80 individuals to family doctors. The CNN supported clients in breaking down barriers and addressing issues related to the following:

- health care
- mental health
- addictions
- recreation
- child care
- legal aid
- housing
- parenting
- finances
- employment
- education

The CNN's extensive knowledge of community resources and programs facilitated a rapid response in directly connecting residents to the appropriate services. In order to provide warm hand-offs to other service providers, the CNN created networks with over 200 service agencies and/or providers.

While the aim of the CNN was to assist people in navigating the health care system, the role did so by building capacity so that the individual would eventually be able to transfer skills to new situations without the aid of the CNN.

The CNN also worked collaboratively with the neighbourhood to identify gaps at the community level. The CNN then supported the community in building capacity and taking coordinated action to address the identified needs. The CNN pilot initiated or mobilized the following community initiatives that addressed gaps in service:

- Our Community Clothing Closet
- McQuesten Youth Opportunities Creators (MYOC)
- Jobs4Jobs (Youth Employment strategy)
- Ontario Works Community Placement at Hillcrest school
- Transportation to Rotary Summer Literacy Camp
- St. Charles ESL classes at the Community Center
- Community Calendars for Children and Youth Programs in McQuesten

PRIMARY CARE OUTCOMES

Throughout the course of the pilot project, the CNN worked with 150 patients and families from the Family Practice. The goal of the CNN at the family practice was to increase Hope and improve the Quality of Life for those struggling and those who were difficult to engage patients at the practice. Reasons for referral to the CNN included:

- Mental health issues
- Need for connection to community resources
- Social isolation
- Finances
- Relationships/abuse
- Addictions
- Housing
- Help completing forms
- Support with health issues
- Employment support

After meeting with the CNN, patients identified their needs and developed goals. The needs most frequently identified by referred patients included:

- Connections to community recreation and social programs
- Help with finances

- Health issue support
- Help with housing
- Mental health issue support

There was also a recognition of the needs, and integration of the response, at the school level. Often, schools reached out to the CNN for assistance in connecting families to a family doctor. Referrals to specialty mental health services for many school age children and young adults were facilitated as a result of the integration of the CNN neighbourhood approach, the family practice and the school. Both the needs of the patients and the integration of services between home, school and the family practice highlight the necessity for primary care to be connected to community agencies, programs and resources in order to provide comprehensive care.

A larger sample size of participants would be required in order to determine whether the CNN had an impact on patient QOL and Hope however, the data obtained during the pilot project demonstrated that the patients referred to the CNN had the lowest level of education, and reported the highest level of social isolation, poor mental health and high poverty levels. The pilot was therefore able to identify and engage some of those in the neighbourhood most in need.

LESSONS LEARNED

It is important to identify the lessons learned during this pilot project as they provide insight into successes and failures, and facilitate efficiency and better awareness of current and future community health initiatives. Below is a list of lessons learned from the CNN pilot project:

1. Time is required to build relationships and trust and to develop an in-depth understanding of the community context. It is therefore imperative that agencies integrate this lead-in time into community initiatives.
2. Care must be taken when developing community partnerships as trust, reputation and accountability can be negatively impacted when projects are initiated in communities and are then discontinued.
3. A population health approach is most effective when looking to understanding the impact of the social determinants of health and providing support in an integrated fashion in Hamilton neighbourhoods.
4. Primary care integration into the community must include schools in order to address early identification and intervention in children with behavioural problems

and mental health challenges**.** This is especially important as the Hamilton Wentworth School Board is beginning to implement its revised Mental Health Strategy, including a community-based and collaborative approach to supporting children's challenging behaviours.

5. There must be reciprocity among stakeholders with a shared framework for outcomes.
6. When looking to promote and improve generational changes in stability, health and opportunities, it is essential to build connections and provide supports that improve opportunities early in life. A framework, such as the CNN pilot, addresses challenges in connecting people across generations to existing resources and fosters a less expensive overall system and a healthier, more productive, society with a more balanced playing field.
7. Understand and acknowledge that there are many avenues or forums for citizens to be engaged and make change in a neighbourhood and each forum should be valued and supported.
8. There is a need for large scale funding to evaluate the impact and outcomes of community-based population health approaches to health care.
9. People require assistance navigating the health care and community services systems. In order for primary care and social services to refer patients to appropriate health and community services, there must be an avenue to share information. This enables effective program promotion, prevents service duplication and also highlights gaps. There is thus a need for a bridging role between individuals, community and health care systems such as that of the CNN.

RECOMMENDATIONS

The following are recommendations for each stakeholder based on the above lessons learned during the pilot project:

City Of Hamilton:

- Community:
    - The CNN met gaps and needs of a priority community. Both informal and formal evaluations indicated that both the community and service providers valued the CNN role and felt it was a unique strategy to address the various health needs of communities using a professional with a broad scope of practice. Since the CNN role bridged primary care, public health and community, a sustainable, shared funding model should be explored

which would allow for an expansion of the CNN position into other priority neighbourhoods across the city and enable it to develop its full potential.

- The Neighbourhood Action Strategy (NAS) could explore the following recommendations in order to provide enhanced support for the NAS initiative:
  - Develop a logic model for the Neighbourhood Action Plan that includes detailed actions, timelines and contributors for each Goal and Strategy in order to facilitate Goal completion. Review Action Plan on yearly basis to ensure forward movement and allow for revisions and additions.
  - Develop a Code of Conduct for Neighbourhood Planning Team members and volunteers which reflect the organizational values, communicates expectations and provides standards for our activities.
  - Create opportunities for employment by developing job skills training program with executive and coordinator positions.
  - Provide honorariums for Planning Team executive positions which act as training ground for employable skills development.
  - Create recruitment system from Neighbourhood Planning Teams so that these positions may lead to employment once tenure with Planning Team completed.

- Access:
  - Facilitate clients' access to health care by eliminating minimum number of monthly medical appointments necessary for OW and ODSP clients that enable them to qualify for transportation to medical appointments.
  - Facilitate clients' access to recreation programs by providing free bus tickets to children and youth registered for camp and other recreation and community programs.
  - Allow seniors to access Recreation Fee Assistance program in order to increase physical activity across the age spectrum.

HFHT:

- Partnerships:
  - In order to mitigate the impact of the SDOHs, partnerships with the community, including community centers, foodbanks, C&Y agencies, recreation centers and Neighbourhood Planning Teams should be created as these are useful resources for patients which address the SDOHs.

    - Patient care can be enhanced through regular communication with schools which will promote a comprehensive assessment of children and youth and provide valuable information regarding behaviour changes. The earlier these changes or problems with behaviour in children are recognized and interventions and support to children, parents and schools are provided, the better the opportunity to prevent long term problems with mental health complications which severely impact the long term picture for all of us. Partnerships with those who understand the problems children and families face and can provide the resources needed to identify and intervene early should be explored within the city and at other agency and governmental levels.
    - Existing and available programs such as Early Years and therapeutic day care could be better integrated and supported by family practices and schools by being more actively involved in encouraging enrollment.
    - A process that ensures families who are challenged by the SDOHs do not fall through the cracks should be developed to ensure that children and adults access both health and community services to which they have been suggested or referred.
- Communication:
    - Texting as a method of communication with patients is a quick and effective tool that is well-utilized by patients across the economic and age spectrums.
    - Reminder calls: These are effective when working with patients who have difficulty attending appointments.

McQuesten Neighbourhood Planning Team:

- Continue to explore opportunities for collaboration and reciprocal partnerships with agencies.
- Create opportunities for employment by developing job skills training program with executive and coordinator positions.
- Provide community access to Wi-Fi, telephone, fax, computers, printers and internet at Community Center.
- Continue with community program calendars for both children and youth which foster collaboration and communication between agencies and the community.

Addendum

Role and Accomplishments of the CNN in the Pilot Project

THEORETICAL FRAMEWORK

In the initial stages of the pilot the CNN and coordinator worked to develop a model of care specifically aimed at using a consistent theoretical framework to identify the people in the neighbourhood of all ages who may benefit from the help of the CNN. These people could be part of the Hamilton Family Health Team family practice, the school, both primary and secondary and the neighbourhood. This model was developed and used throughout the pilot by the CNN.

In using the model the CNN was able to employ a consistent approach of motivational interviewing and brief solutions strategies in speaking to people in order to help them develop their own plan and build their own capacity to learn about and navigate the social services, community and health care system. The CNN, according to accepted nursing standards of practice, documented each interaction and where possible outcomes of the interaction. The documentation provides evidence within the pilot that people involved were able to learn these skills and in many instances pass on the information to others in similar circumstances.

INSTRUMENTS - WHO QUAILITY OF LIFE AND HOPE SCALE

The instruments chosen as part of the information gathered and developed to confirm the health, social and economic profile of those referred or seeking services were the World Health Organization (WHO) Quality of Life and Hope scales. The consents were signed and these scales were completed by a number of people at the initial contact with the CNN and then again when she did follow up with them in the 3 and 6 months period afterward. We were able to do a random sample of patients coming in to the family doctor's office with the same scales as well, which outlined the differences in the two populations. Those referred to and seeing the CNN were much less well. They reported the lowest level of education, and the highest level of social isolation, poor mental health and highest poverty levels. There was a surprising match in the other demographics of the two groups. We did not have the resources within the pilot to continue with the screening and this would be an evaluation that would be beyond this

pilot work. The CNN and the pilot were able to identify and engage those most in need in the neighbourhood.

BRIGING THE SCHOOL- FAMILY PRACTICE and COMMUNITY

As planned the CNN worked as a bridge between the family practice and the schools in the area. Relationships were formed with the teachers and the community and this allowed the families and schools to ask for help with children and youth struggling with mental health issues. There were 12 referrals that were facilitated for psychiatric assessment in the age range from 5 years to 18 years and another six in the 19 to 25 year olds. The CNN helped the families by connecting the school concerns with the ability of the family doctor to request a psychiatric assessment and treatment.

Additional students were connected by the CNN with the Mohawk Outreach coordinator to explore finishing their education with support from the existing services.

Future work for the CNN should include the connecting and bridging of Early Years programs in the City of Hamilton with the family practices in the area. This would facilitate early identification and treatment of those children struggling and likely to struggle completing their education in the future. Family practices could help identify those children at risk for mental health issues and connect them with additional supports like the Early years centres and assessments with specialists where appropriate.

Community outcomes facilitated by the CNN are documented in detail in the body of the report.