

CASE 15

Going Beyond the Wheel Chair Ramp: Public Health Sudbury & Districts' Plan to Become Accessible to All

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Christina Peterson was sitting in her office on Wednesday, May 25th, 2014 getting her notebook ready for her monthly meeting with the Evidence-Informed Practice Working Group (EIPWG) at Public Health Sudbury & Districts (PHSD). As a Foundational Standards Specialist, Christina provides support and expertise to teams on evidence-informed decision-making, policy and practice in the areas of population health assessment, surveillance, education, research and knowledge exchange, core competency development, program evaluation, professional practice and development, and program planning. She was also the Co-Chair of the EIPWG and was the champion in advocating for various public health issues. EIPWG consisted of 15 to 20 staff members from various occupational backgrounds at PHSD, such as health promoters, foundational standards specialists, epidemiologists, managers, public health nurses, and others. EIPWG meets monthly to discuss new evidence regarding public health issues. The members assess the evidence and use it to inform practices within PHSD and make recommendations for any new programs or changes to existing programs. Generally, EIPWG works through two to three “practice-based questions” every year, which touch on a variety of topics. Examples include: “Does Lyme disease pose enough concern in our catchment area to merit enhanced Public Health intervention strategies?” and “What is the effectiveness of health promotion materials related to distracted driving?” The group then strikes sub-working groups who use various methods to answer the practice-based question and subsequently make recommendations for practice or policy.

Christina was very well-liked and respected within EIPWG and the organization; she brought a breadth of knowledge and experience to the table. She has been working at PHSD for a number of years carrying out research and supporting evidence-informed practice. She came into the public health sphere rather late, having prior experience as a nutritionist in the cardiac rehabilitation centre at Memorial Hospital in Sudbury. She worked specifically with the Diabetes Education team. Christina then moved on to the Manitoulin Health Centre in Little Current on Manitoulin Island—about an hour-and-a-half drive west from Sudbury. She got frustrated in the acute-care setting, because many of her patients in Little Current were unable to access

¹ The authors acknowledge this case note reflects the retrospective narrative of one main actor and does not present the multiple perspectives of other stakeholders at Public Health Sudbury & Districts nor does it accurately reflect the work to date in this portfolio. Of note: the organization described in this case note has recently changed its name from Sudbury & District Health Unit to Public Health Sudbury & Districts. Names of individuals described in this case note have been changed and are not the actual names of staff employed at the agency.

² Special thanks to Joanne Beyers for her assistance as well.

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adequate transportation to reach a grocery store with healthy food options, let alone purchase nutritious food. Much of her dietary knowledge was rendered useless, as the underlying social determinants of health, such as income and food security, were not being addressed. She questioned how useful she was in the clinical setting, and in 1990, she decided to make the switch into a role that would look at ways to address the social determinants of health for these populations, rather than strictly working with individual patients only.

The EIPWG members had tackled several practice-based questions related to priority populations since its inception. For instance, one of the questions that was being worked on was related to exploring housing inspections involving vulnerable populations. Specifically, they were assessing what was working and what was not working related to housing investigations involving marginalized populations, with an aim to propose solutions for improvement. However, there was one priority population that had yet to be focused on: individuals with a disability. Christina was a real advocate for people with disabilities. She had lived in the disability world for over 20 years, as her son James was born with autism. She had seen first-hand the challenges James faced at school with a curriculum designed for people without a disability. As James transitioned through the different stages of his life, from high school to post-secondary and to the workforce, she wondered whether these environments had the capacity to support his needs. She often worried whether professionals and supervisors were trained to work with individuals who have a disability. These fearful thoughts translated into her workplace environment: does PHSD have the capacity to provide services such as immunizations to individuals like James?

Another reason contributing to her motivation to improve PHSD's services to individuals with a disability was the current Accessibility for Ontarians with Disabilities (AODA) legislation. Established in 2005, it became the first of its kind in the world to provide mandatory accessibility standards for various types of organizations within Ontario. The five standards are: Accessible Customer Service, Accessible Information and Communication Standards, Employment Accessibility, Accessibility of Transportation, and the Design of Public Spaces Standard. The final goal is to have a fully accessible Ontario by 2025. The Government of Ontario and other designated public-sector organizations were required to comply with these standards by January 1st, 2010, and non-profit and private sector organizations with at least one employee had to comply by January 1st, 2012. The Employment Accessibility, Accessibility of Transportation, and the Design of Public Spaces Standards have not set compliance dates yet, but they will be made in the next few years. Finally, the Design of Public Spaces Standard had just been drafted, and has not been made law (People Access, 2011).

An AODA Task Group was set up at PHSD. It mainly comprised of individuals from the human resources team and others who were responsible for ensuring that the organization was meeting the legislative requirements. Christina knew that AODA had helped in fostering a more inclusive environment for individuals of all abilities. Although AODA had specifically pointed out that "unseen disabilities" are included in the definition of "disability", Christina thought that it did not provide enough guidelines to organizations looking to improve their services to individuals with unseen disabilities. There was a need to go "beyond the wheel chair ramp".

Christina had been Co-Chair of the EIPWG team for around six years alongside Valerie Stoville, a Manager in Knowledge and Strategic Services at PHSD. As Christina entered the meeting, she was greeted by typical smiles and laughter from the EIPWG team. After catching up, Christina and Valerie signalled the start of the meeting. Amy Lapierre and Megan Antonini, two health promoters working within the Health Promotion Division of PHSD, were first to present at the meeting, showing the final results from the previous practice-based question which

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assessed the best practices in reducing alcohol consumption amongst the post-secondary population. This was followed by John Leblanc, an epidemiologist who shared the availability of new population health data and discussing data gaps with the group. As the three-hour meeting reached its latter stages, Christina's mind had started to wander, going back to her thoughts surrounding the disability access issue. Once the meeting finished, and everybody began packing up, Christina suddenly stood up and exclaimed, "Guys, I really love the work we are doing with our practice-based questions, but I think we are missing a huge issue when it comes to providing the best possible health outcomes for our clients. It is regarding the accessibility of PHSD's services, programs, and infrastructure for both clients and employees."

There was a pause in the room. Everyone was a little startled by Christina's abrupt comment. People looked at one another wondering what to say. Realizing that someone needed to speak, Christina continued, "We have focused our efforts on many priority populations, people living in poverty, Indigenous populations and other vulnerable populations, which I am very proud of as it has brought so much success. However, we have not focussed much attention on people with disabilities. I know we already have a few practice-based questions lined up for the rest of the year, but it is time we should take a further look into this issue." Another pause followed. Christina brought forth a practice-based question to the EIPWG: "How does the PHSD operationally define "people with disabilities", particularly related to unseen or invisible disabilities?"

Rita Devlin, one of the other Foundational Standards Specialists, slowly stood up and said, "Christina, I agree with your comments, it is just that I don't know whether we have the time to pursue this issue right now, we have so much going on. Most of us are already working on other issues and are feeling rather stretched."

Christina responded by saying, "Listen, I know we are all very busy, but this is an important issue. I would like all of you to put yourselves in the shoes of an individual who has a disability and is applying for a job here, utilizing one of our services or accessing one of our sites. Let's give more thought to how our programs, services, infrastructure and policies meet the needs of people living with disabilities and let's bring this back to our next meeting. That is a good note for this meeting to end, right Valerie?" All agreed that further discussion was required.

Valerie agreed, and everyone began to file out of the room, leaving Valerie and Christina in the room. She then said, "Christina, your arguments were extremely valid. I can definitely relate to your plight. One of my son's friends is hard of hearing. I have seen how difficult it is sometimes for him to communicate with others and to hear important information. I will do my best to support you in championing this initiative. Let's connect with your director to see how this might fit in your workplan with support from a select few EIPWG members."

Christina replied, "Thank you for your continued support of my proposed initiatives."

In the following months, Christina gained support from her director to determine the scope of this practice-based question and gathered a small team of EIPWG members to work on the issue. Jim Greault, the Manager of Professional Practice and Development, was inspired by Christina's work and helped the issue to gain momentum. With support from her director, and further discussion and uptake at EIPWG, an EIPWG sub-group, known as the People with Disabilities Group (PWD) was established. With the help of Jim and other EIPWG members the scope of the question was refined: How does the agency operationally define "people with disabilities"? The question focused particularly on unseen/invisible disabilities.

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This PWD group consisted of Christina, Valerie, Rita, Amy, and Megan. Also joining the team was Chantal, another health promoter, and Jim. Within a few weeks of forming, a PWD logic model was established with the following objectives:

1. Programs and services at PHSD are fully accessible and inclusive particularly for people with disabilities, with an emphasis on unseen disabilities.
2. Staff at PHSD recognize, understand, and apply attitudes and practices that are sensitive to and appropriate for people with disabilities.
3. Staff have the knowledge, attitudes, and skills to ensure our programs and services are fully accessible and inclusive for people with disabilities.

Since PWD formed in early 2015, the group has made steady progress with its work. In 2016, a three-year work plan was established with further planned activities to increase PHSD's inclusivity. With the help of a Public Health and Preventative Medicine Resident from the Northern Ontario School of Medicine, a literature review was completed, which helped develop PHSD's definition of what a disability fully entails, and what the definition of an unseen disability is. Through an online survey, feedback collected from all PHSD staff was considered when developing a definition of disability and a definition of an unseen disability. A second literature review was done to compare the health outcomes of individuals who had a disability and individuals who did not. The research consistently demonstrated that individuals with a disability disproportionately suffered negative health outcomes in various facets.

One of the first steps to achieving Christina's long-term goals regarding PHSD's accessibility was to change the attitudes, beliefs, and knowledge of her fellow staff members. The results from this literature review helped inform the development of a primer for all staff. The primer would be used to educate staff on the various health disparities individuals with disabilities face, how to properly address them in person, and the approach that should be taken when interventions are planned.

From a policy standpoint, the PWD team had successfully managed to reach out to PHSD's Board of Health, who approved a motion for a person-centered language statement. This motion can serve as an avenue for change in how staff interact with a client or fellow employee at PHSD. The agency wanted its staff to use language that put the person before the disability, (i.e. 'people with disabilities' instead of 'disabled') (Public Health Sudbury & Districts, 2017a).

BACKGROUND

Originating in 1956, PHSD is one of the over 30 non-profit provincial public health agencies, evolving from a public health service operated by the City of Sudbury Health Department. Over the years, the agency has grown significantly and now employs over 250 staff who deliver provincially legislated public health programs and services. Its geographic area includes the municipalities of Sudbury, Chapleau, Sudbury East, Espanola, and the entirety of Manitoulin Island – the largest freshwater island in the world. There are three offices within Greater Sudbury and district offices in Chapleau, Espanola, Sudbury East, and Manitoulin Island. These offices serve a population of approximately 200,000 (Public Health Sudbury & Districts, 2016b). Exhibit 1 shows the full geographic area that PHSD serves and the locations of the district offices.

Since 2000, PHSD has been led by Dr. Irene Foster, the Medical Officer of Health and Chief Executive Officer, and more recently, Dr. Victoria Hinkel has joined the organization as an Associate Medical Officer of Health. There are five divisions within the organization: Health Promotion, Environmental Health, Clinical Services, Corporate Services, and Knowledge and

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Strategic Services. Each division is led by a director, who together with the Medical Officer of Health, Chief Executive Officer and Associate Medical Officer of Health, make up the Senior Management Executive Committee (EC).

INTRODUCTION TO DISABILITIES

According to the World Health Organization, the term “disability” has a wide-spanning definition and covers three main areas: impairments, activity limitations, and participation restrictions. ‘Impairments’ see the problem of disability from a biological and medical perspective, looking at disability as a problem in the body’s structure and function. ‘Activity limitations’ refer to a disability from a functional perspective, where individuals face difficulties in executing a task or action. The social model is emphasized within the facet of ‘participation restrictions’, where there are barriers faced by individuals in getting involved in everyday life situations (World Health Organization, n.d.). After looking at the results from the survey sent out to all PHSD staff exploring their perceptions of how a disability is defined, the team realized that most of the staff looked at a disability from the perspective of the medical model. This inferred that the staff looked at a disability from the individual-level only, rather than from a system-level perspective. These perceptions would almost always inhibit future action to foster a supportive environment to improve the health outcomes for individuals with disabilities, putting the onus only on the individual to adapt.

Christina wanted the staff and the rest of PHSD to think of disabilities from primarily the social model. She did not disregard the other two perspectives, but she felt that they could target the social model to help improve the outcomes for individuals with disabilities. Across Canada, approximately one in seven Canadians have some type of disability (Statistics Canada, 2013). Within the City of Greater Sudbury, excluding the other areas that PHSD serves, it is estimated that there are 24,000-26,000 citizens with a disability. Of this number, 11,000 are seniors over the age of 65. This is in stark contrast to citizens under the age of 15, where there are only about 1,000 individuals. Additionally, another 1,000 consist of teenagers and young adults (City of Greater Sudbury, n.d.a). Greater Sudbury’s population is approximately 164,500, but this population is rapidly aging (The Canadian Press, 2017; Sudbury Star Staff, 2017). There were around 13,000 people aged 75 years or older in Sudbury, and that number is projected to grow by approximately 38.1% by 2026 (Sudbury Star Staff, 2017). Due to the city’s large reliance on the mining sector, which comprises the bulk of its economy, there are often fluctuations in the job market. Often, young people migrate out of Sudbury in search of employment because of jobs having high turnover rates (MacDonald, 2013). This ageing population trend will likely continue into the future, necessitating PHSD to continue to focus on PWD’s as a priority population.

The health outcomes of people with disabilities is a pressing public health issue, as those with disabilities have poorer health outcomes than those without. This results in health inequities. Research from the United States has shown that people with disabilities suffer higher rates of chronic diseases such as diabetes, high blood pressure, arthritis, chronic pain, and heart disease (AUCD, 2016; CDC, 2013; CDC 2014; Havercamp & Scott, 2015). They also have higher rates of physical inactivity and have bodies that are classified as obese (CDC, 2014; Havercamp & Scott, 2015; NCBDDD, n.d; Ouellette-Kuntz, 2005; Rimmer & Wang, 2005;). Within Ontario, Lunsky, Klein-Geltink, and Yates (2013), showed similar results to the aforementioned studies and also reported that people with disabilities received a poorer quality of healthcare by practitioners at both the acute care and preventative care levels. They spent more time at emergency departments and had a higher probability of being hospitalized, especially for preventable ambulatory care sensitive conditions (ACS). They were also less likely to receive important healthcare screenings for breast, oral, and cervical cancers.

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An individual's disability can also interact with other determinants of health such as race and gender, resulting in intersectionality. This can affect the diagnosis, treatment, and management of disabilities. Disabilities are often diagnosed from a male perspective, which can lead to disabilities being overlooked in women (Banks & Kashcak, 2003). These overlooked conditions are viewed in a negative connotation, being seen instead as self-inflicted, trivialized, and hysterical (Banks & Kashcak, 2003). Intersectionality regarding disabilities can be seen at multiple levels. Shaw, Chan, & McMahon (2012) found that being older, female, a visible minority, and working in a smaller or larger company, in addition to having a disability, was associated with higher risks of disability harassment. Warner & Brown (2011) and Cramer & Plummer (2009) found similar results showing that multiple interactions can pose as barriers to accessing proper intervention services.

UNSEEN DISABILITIES

Arguably even more complex than visible disabilities, such as paralysis and Down syndrome, are unseen disabilities. Unseen disabilities capture a wide spectrum of conditions that are not immediately visible to another individual. They can include fibromyalgia (chronic musculoskeletal pain), chronic diseases such as diabetes and kidney conditions, mental health conditions such as schizophrenia and attention deficit and hyperactivity disorder, and auditory and visual impairments when hearing aids or corrective lenses are not used. Unseen disabilities can have varying degrees of severity and can be subjectively perceived in nature, as there is no standardized list (University of Massachusetts, 2015). Approximately 12% of all disabilities in Canada are considered to be unseen, but that number could be underestimated (Mullins & Preyde, 2013). Exhibit 3 shows a more detailed breakdown of disability types and prevalence within Ontario for individuals aged 15-64.

There is limited literature looking specifically at the health outcomes of individuals with unseen disabilities. From what was found, individuals with unseen disabilities face poorer social determinants of health compared to visible and other kinds of disabilities. For instance, 54% of Ontarians suffering from a mental health or addiction disability were not employed. In comparison, 42.9% of individuals with non-mental health or addiction disabilities and 21% of individuals without a disability were unemployed (Ontario Human Rights Commission, 2016). From an income standpoint, Ontarians with mental health and addiction disabilities had a median household income of only \$51,267. Again, in comparison, Ontarians with non-mental health or addiction disabilities made a median household income of \$59,474, and individuals without a disability made a median household income of \$82,631. Finally, Ontarians with mental health and addiction disabilities were also more likely to live alone, have inadequate housing, be divorced, and have lower levels of education than Ontarians with other kinds of disabilities, or Ontarians without a disability (Ontario Human Rights Commission, 2016). Similar results were seen for individuals with a developmental disability (Statistics Canada, 2015).

Individuals with both visible and unseen disabilities feel stigma and discrimination in multiple ways, hindering their social mobility, acceptance, and inclusion into modern society. Individuals with unseen disabilities face unique challenges. Their peers cannot see what they are going through on the surface. Unseen disabilities are often subject to skepticism, and some may think the individual is faking their disability for sympathy or attention. Individuals with unseen disabilities are left with a problematic situation. They can direct attention towards their disability to prove themselves, which could exacerbate and worsen their symptoms. Alternatively, they could act normal and lie about their disability without having to go through the trouble of explaining their disability to peers over and over. However, these feelings of deception can

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really take a physical and emotional toll on the individual. Many are left to internally struggle, whether they should reveal it or not and seek help (Shaw, 2012).

If this stigma and discrimination continues, people with disabilities will continue to face feelings of learned helplessness, and they will forever feel unwanted and useless to society. Russell, Turner, and Joiner (2009) found that individuals with a physical disability have more than twice the relative risk of suicidal ideation than individuals without a disability, and this was observed across all subgroups except older and married adults. This finding was echoed by Ludi and colleagues (2012), who found in their literature review that children with intellectual disabilities were at risk for suicide.

HEALTH EQUITY

Northern Ontario has unique challenges in regards to achieving optimal health compared to Southern Ontario and the rest of Canada. The influence of the social determinants of health include access to health services, an employment sector relying heavily on fluctuating resource markets, and a large Indigenous population (Health Quality Ontario, 2017). It illustrates the need for a health equity approach when PHSD develops public health programs, services, infrastructure, and policies for its clients.

Health equity implies that individuals can reach a maximum level of health, regardless of age, gender, ethnicity, race, religion, social class, socioeconomic status or any other socially determined circumstance, which should not pose a barrier (Public Health Sudbury & Districts, 2015). Inequities in health can result between different groups of individuals on a micro-level, such as attitudes, personal beliefs, and knowledge of people with disability. It can also occur on more meso- and macro-levels, which includes the natural and architectural environments, organizational and governmental policies, resource allotment, and much more. The onus to improve one's health should not only be placed on the individual with a disability but rather on fostering an inclusive environment around them. Oftentimes, people develop disabilities out of their control. It is the world's largest minority group, and one of the only ones in which any individual can become a part of at any time (Disabled World, 2017).

PHSD has a long history of working toward improving health equity and addressing social inequities in health. Since 2000, the organization has participated in raising awareness of social determinants of health amongst the staff and community and completing an intervention project outlining ten promising public health practices to reduce social inequities in health at the local level, with the potential to be scaled up to a larger contextual level (Public Health Sudbury & Districts, 2016a). Exhibit 3 displays the full framework of the ten promising public health practices to reduce social inequities in health.

The organization has also produced reports identifying health inequities in the community, supported local policy and strategies to reduce poverty and access to affordable food, and advocated and participated in provincial efforts to address health equity, including incorporating health equity as core work of public health. This dedication to health equity is easily seen in the organization's 2013-2017 strategic plan as it lists championing and leading equitable opportunities for health and supporting community actions that promote health equity as two main priorities (Public Health Sudbury & Districts, 2018).

People with disabilities generally do not benefit from health promotion screening and wellness programs. Healthcare professionals often focus on their disabilities rather than the needs of the whole person (U.S. Department of Health and Human Services, 2005). Public health programs, services, infrastructure, and policies are not designed with people with disabilities in mind

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(Welner & Temple, 2004). Continual efforts are needed using a health equity lens when PHSD looks to improve the health outcomes of people with disabilities.

To help achieve the previously mentioned objectives of the logic model made by the PWD team, one could try to apply some of the promising public health practices devised by PHSD to this file. The section below proposes three promising practices as a lens for which activities of the PWD team could be viewed.

PROMISING PUBLIC HEALTH PRACTICE #1: TO REDUCE SOCIAL INEQUITIES IN HEALTH: TARGETING WITHIN UNIVERSALISM

Targeting within universalism is the concept of using a universal approach but with slight adjustments to increase the accessibility for certain population groups that may not be routinely served compared to others. This will address inequalities in health outcomes and ensure that those population groups who are at greatest risk of poor health reap the most benefits of the work done by organizations. It is a positive step in achieving the ultimate goal of universal inclusive design. Inclusive design is the ideal goal for society, as no targeting of certain population groups is needed, as accessibility and inclusivity is a guarantee. For the long-term outcomes of the PWD working group's logic model to occur, the principles of inclusive design must be embedded in the organization's infrastructure, policies, customer service, technology, and other facets.

Inclusive design must be flexible, usable, and customizable and take into account one's ability, language, culture, gender, and age. It recognizes that individuals are different, and in daily life, people may perform tasks differently (OCAD University, n.d.). In the past, universal design benefitted higher privileged groups, such as those with the highest income, highest education levels, and the strongest social support networks more significantly. However, this is not the desired outcome. The desired outcome is that PWD and other priority populations receive the largest benefit, whilst improving the overall health of the entire population (Public Health Sudbury & Districts, 2015).

There are many misconceptions about achieving universal design in the built environment. In the workplace, there are often thoughts that accommodating people with disabilities is very expensive or that accommodation, if provided, is of little value. This is due to the common view that people with disabilities take more sick leave, need more supervision, and will perform the job less effectively than people without a disability. These thoughts are far from the truth, as most accommodations are of little to no cost. In fact, the average one-time accommodation is \$500 (Ability First, n.d.). Research shows that employers have consistently found that employees with disabilities rate average or above-average in attendance. Eight out of ten managers found people with disabilities needed no additional supervision when compared to abled people, and 90% of disabled employees performed their jobs as well or better than employees without a disability (Ability First, n.d.). Despite this evidence, 45% of prospective employees with a disability considered themselves to be disadvantaged in the employment process because of their condition. For those employees with a disability who were hired, 27% noted that their employers were not aware of their limitations (Arim, 2015). Due to the continual stigma, 67% of Canadian adults with disabilities lack the educational, workplace, and home supports needed for daily function (Council of Canadians with Disabilities, 2013).

The vision of the Customer Service Standard within AODA ensures that an organization's customer service actions are accessible for people with disabilities. The training manual provided by AODA provides some pointers for organizations to follow when interacting with customers with various disabilities, including invisible disabilities such as hearing loss, mental

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health, and intellectual disorders. There is also educational material regarding assistive devices used by some individuals with disabilities such as a teletypewriter (allows those who are deaf or hard of hearing to relay messages) and service animals (e.g., dogs who guide individuals who are blind). In its most recent accessibility plan, PHSD has stated its efforts to train relevant staff on these guidelines, allow the use of support persons and service animals within its buildings, and establish policies, practices, and procedures on providing goods and services to clients of various abilities (Public Health Sudbury & Districts, 2017b).

However, there is very little guidance for developing accessible buildings for organizations, in both exterior and interior design. Information and recommendations are not available for organizations on the design of accessible buildings within AODA's Design of Public Spaces Standard. The Design of Public Spaces Standard focuses on areas such as accessible parking and outdoor play spaces. Currently, the only legislative framework to follow in developing accessible buildings is through the Ontario Building Code. The most recent amendments of Ontario's Building Code in 2015 were geared towards accessibility, primarily focusing on visible disabilities. For instance, it provides recommendations on wider doorways, doors that require a lesser grip or twist to open, and availability of ramps in pool areas and spas. The only real amendment targeting unseen disabilities was mandating visual fire alarms, in addition to audible ones, in public buildings such as multi-unit residential dwellings, theatres, churches, and lecture halls. These requirements would only apply to newly constructed buildings, not existing buildings (Ministry of Municipal Affairs and Ministry of Housing, 2015).

Despite the promising amendments to accessibility under the Ontario Building Code, the PWD group knew there would be a gap in necessary accessibility requirements for people with unseen disabilities. For instance, individuals with autism may experience sensory overload from bright lights in a building, which could trigger a stressful episode (Irlen Institute, n.d.). Guidelines were needed for the building designers at PHSD so they could ensure an inclusive environment for people of all abilities within PHSD's infrastructure. These small changes would provide not only a benefit to individuals with disabilities but also to individuals without a disability.

What are some guidelines that could be developed to improve the accessibility of building design at PHSD for people with unseen disabilities such as autism?

PROMISING PUBLIC HEALTH PRACTICE #8: TO REDUCE SOCIAL INEQUITIES IN HEALTH: CONTRIBUTION TO THE EVIDENCE BASE

One of the challenges the PWD group anticipated, which could hinder PHSD in facilitating an inclusive design for individuals of all abilities, is a lack of a system in place to routinely collect information regarding any unseen disabilities clients may have. Individuals could be entering the agency at any point in time with an unseen disability and wanting to access services. Although an individual may not visibly show it, he or she may struggle when using a provided service that is not fully accessible.

People with disabilities may feel hesitant in revealing their disability to health services providers. There are a wide variety of reasons for this, such as feelings of unnecessary intrusion or perceptions that they would be treated differently because of their disabilities. Issues such as provider attitudes, communication, physical barriers, and transportation are consistent across the literature for people with disabilities in accessing healthcare and contributing to the aforementioned disparities in health (de Vries McClintock et al., 2016). Studies using focus groups and other qualitative methods have found that people with disabilities perceived marginalization, feelings of incompetency, and a poorer quality of care at both the individual and the systemic levels (de Vries McClintock et al., 2016; Mulumba et al., 2014). The PWD group

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realized that it would not be easy to collect this valuable information. They would have to organize information from all of PHSD's external visits and from clients visiting PHSD. She would have to somehow build trust with potential clients coming into the organization and let them know that it is a safe place to share this information. Staff would need to be directed to do this extra step of collecting information when working with new clients, adding to their rigorous list of duties.

In the long-term, the PWD group was proposing that there be a system in place where anyone using PHSD's services, either internally within the district offices or externally within the community, could feel comfortable in sharing information regarding a disability he or she may have. This would allow the PWD team and the rest of the PHSD staff to learn more about the various types of disabilities clients may experience. Over time, a database of local information can be built, which can be used to analyze the prevalence of disability types and to see if there are common themes within the PHSD area. The evidence base could help further inform program development and prioritization, adjustment of facilities, and inclusive policies.

What is the best way PHSD can set up an efficient surveillance system to capture relevant information about a client's possible visible or unseen disability? How can they convince hesitant clients to share this information?

PROMISING PUBLIC HEALTH PRACTICE #9: TO REDUCE SOCIAL INEQUITIES IN HEALTH: COMMUNITY ENGAGEMENT

To ensure PHSD develops programs, services, infrastructure, and policies that are accessible for people with various kinds of disabilities within its catchment area, community engagement must be undertaken to engage other disability-related organizations that could provide valuable input and expertise. Currently, PHSD has partnerships with some, but not all organizations that work with people with disabilities within their catchment area. Under the Ontario Public Health Standards of 2008, the importance of collaboration with relevant stakeholders such as the voluntary sector and non-governmental organizations in the community is emphasized within each standard. The development of these partnerships has the end goal of fostering a supportive environment, which will help inform the assessment, planning, delivery, service, management, and evaluation of programs and services (Ontario Ministry of Health and Long-Term Care, 2014).

If PHSD continues to build on its relationships with organizations such as the Canadian Hearing Society (CHS), Canadian National Institute for the Blind (CNIB), and reaches out to other local disability-related organizations, the benefits would be numerous. One such example of a local partnership is the Accessibility Advisory Panel. It consists of nine members, many of whom have a disability, and advises City of Greater Sudbury staff members on matters of improving the accessibility of municipal services, municipal programs, and municipal facilities as required by the Ontarians with Disabilities Act (2001) and the newer AODA legislation (2005) (City of Greater Sudbury, n.d.b). Such partnerships could help PHSD refer and direct clients who need information or other forms of assistance that is out of their capacity or scope. These partnerships could be used to better inform programs and services to become more accessible. Valuable education could be shared with PHSD staff and clients to help influence their knowledge, attitudes, and beliefs regarding visible and unseen disabilities.

Some clients may have disabilities and not use any of PHSD's services, but may use the services provided by other organizations. As previously indicated, there is a desire to increase surveillance with those who utilize services of PHSD. If these clients with disabilities are not using the organization's services, this create a gap in any surveillance method used by PHSD when collecting data about people with disabilities in PHSD's encatchment area. Partnerships

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with other organizations could enhance and make PHSD's information gathering system more comprehensive. From a qualitative standpoint, with the help of other organizations, PHSD could engage clients who use services from other organizations and use that feedback as part of their program planning process. Ongoing evaluation of the organization's programs, services, and infrastructure are essential to demonstrate that the desired impacts are being made with the proposed plans to make PHSD more accessible for all. CHS and CNIB could perform external audits of PHSD within their respective disciplines to mitigate any bias from any internal audits and to have an expert opinion from organizations mandated to improve the lives of people within the community.

However, there may be barriers for the organization in establishing these partnerships. What if the organizations are not interested in collaborating with PHSD? What if they prefer working alone? What if their staff do not have time to participate in meetings? PHSD had already established connections on a province-wide basis, being a part of the Ontario Public Health Association PWD Task Group, alongside Toronto, Lambton Public Health, Simcoe-Muskoka District Health Unit, Ryerson University, and York University, which was established in October of 2016. They were all eager to advance the progress of this issue, through sharing evidence-based practices, professional development, and influencing future policy development. However, Christina and the PWD group also needed to build upon partnerships at the local level.

How can PHSD engage other disability-related organizations to collaborate in their work? What are some ways that they can get together to share information in a cost and time effective manner?

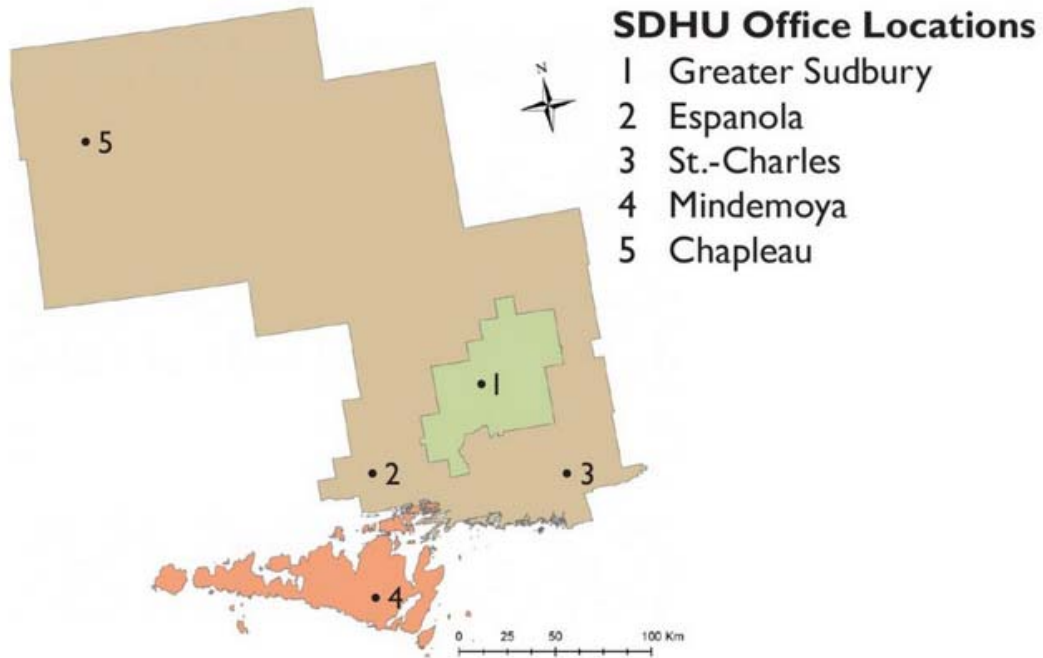
CONCLUSION

While some of the goals identified by the PWD Working Group have been achieved, there is always more work that can be done to achieve the longer-term goals. Three of the ten promising practices that PHSD has identified to reduce social inequities in health were presented: Targeting within universalism, contribution to the evidence base, and community engagement. With many activities outlined in their PWD plan, there are a lot of initiatives that could continue to be addressed and additional promising practices that could be used as a lens to inform their work. This is an important issue that should continue to be on the radar along with the various other priorities within the continually shifting public health landscape. Fortunately, there are several champions of this work within the organization who could continue to move it forward and integrate it into other initiatives including the health equity work and accessibility work.

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EXHIBIT 1

Geographical Representation Depicting the Area Public Health Sudbury & Districts Serves and Location of District Offices



Source: Public Health Sudbury & Districts, 2016b.

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EXHIBIT 2

Prevalence and Types of Disabilities Experienced by Individuals
Aged 15-64 Within Canada

Table 1

Prevalence of disability by type, Canada, 2012

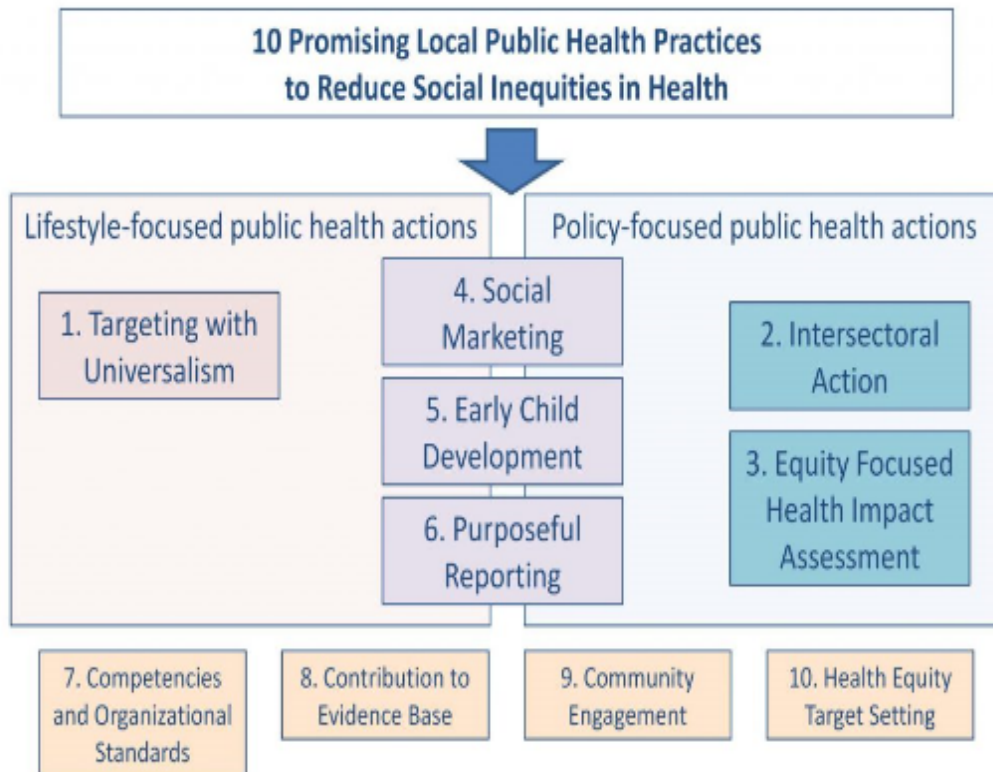
Disability type	%
Pain	9.7
Flexibility	7.6
Mobility	7.2
Mental/psychological	3.9
Dexterity	3.5
Hearing	3.2
Seeing	2.7
Memory	2.3
Learning	2.3
Developmental	0.6
Unknown	0.3

Source: Statistics Canada, 2017.

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EXHIBIT 3

Public Health Sudbury and District's Framework of 10 Promising Public Health Practices to Reduce Social Inequities in Health



Adapted from: Sudbury & District Health Unit. (2010, May). Implementing local public health practices to reduce social inequities in health. EXTRA [Executive Training for Research Application] Intervention Project: Final report.

Source: Public Health Sudbury & Districts, 2016a.

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INSTRUCTOR GUIDANCE

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BACKGROUND

Following years of advocacy work, Christina Peterson, foundational standards specialist at Public Health Sudbury & Districts (PHSD) and co-chair of the Evidence-Informed Practice Working Group (EIPWG), facilitated the formation of the People with Disabilities Working Group in early 2015. People with disabilities (PWD) faced significant health inequities compared to people without disabilities. The People with Disabilities Working Group had established three long-term outcomes from their logic model:

1. Programs and services at PHSD are fully accessible and inclusive, particularly for people with disabilities (especially for unseen disabilities).
2. Staff at PHSD have the ability to recognize, understand, and apply attitudes and practices that are sensitive to and appropriate for people with disabilities.
3. Staff have the knowledge, attitudes, and skills to ensure programs and services are fully accessible and inclusive for people with disabilities.

Oftentimes, public health programs, services, infrastructure, and policies are not designed with people with disabilities in mind. Healthcare professionals often focus on disabilities alone, rather than the needs of the whole person. PHSD recently developed ten promising local public health practices to reduce social inequities in a health framework. The PWD working group had made some progress towards their long-term goals, such as a board-approved motion for a person-centred language statement within PHSD. However, Christina knew that there was very little done that was based on the health equity framework they had established, especially for those with unseen disabilities. There was a need to go “beyond the wheel chair ramp”.

The goal of this case is for students to understand the definition of health equity and recognize its importance when planning, delivering, and evaluating public health programs, services, infrastructure, and policies within agencies. Based on a modern public health issue, students will have the opportunity to apply promising evidence-based public health practices to reduce social inequities in health and devise other programs when dealing with a marginalized population.

The backdrop of the case, which depicts Christina’s fight to create change within an organization, will highlight the social-ecological model of behaviour change typically applied in health promotion strategies.

¹ *Special thanks to Joanne Beyers for her assistance as well.*

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OBJECTIVES

1. Define health equity.
2. Describe the importance of using a health equity framework when planning, implementing, and evaluating programs, services, infrastructure, and policies within public health agencies.
3. Assess various complex, multi-faceted, and common issues in public health related to health equity and devise recommendations for improvement.
4. Define and apply the social-ecological model when advocating for change within an organization.

DISCUSSION QUESTIONS

1. What were some of the barriers Christina and the PWD team faced in advocating for the health outcomes for people with disabilities?
2. What are some other practices that PHSD can perform, which can reduce the social inequities for people with disabilities?
3. What are some of the benefits of using a health-equity framework when planning, delivering, and evaluating programs within PHSD?
4. Christina was an outstanding leader in this process. What are some of the qualities she possessed that helped create change?

KEYWORDS

Health equity; people with disabilities; unseen disabilities; universal design; surveillance; community engagement; social-ecological model of behaviour change.