City of Hamilton
PUBLIC HEALTH COMMITTEE
AGENDA

Meeting #:	23-007
Date:	June 12, 2023
Time:	9:30 a.m.
Location:	Council Chambers Hamilton City Hall 71 Main Street West

Matt Gauthier, Legislative Coordinator (905) 546-2424 ext. 6437

---

1. CEREMONIAL ACTIVITIES

1.1 Public Health Services 150th Anniversary

2. APPROVAL OF AGENDA

(Added Items, if applicable, will be noted with *)

3. DECLARATIONS OF INTEREST

4. APPROVAL OF MINUTES OF PREVIOUS MEETING

4.1 May 1, 2023

4.2 May 15, 2023 - Special

5. COMMUNICATIONS

5.1 Correspondence from Middlesex-London Health Unit, respecting Monitoring Food Affordability and Implications for Public Policy and Action

Recommendation: Be Received.

5.2 Correspondence from Huron Perth Public Health, respecting a Request for Immediate Funding for Student Nutrition Programs and to Increase Funding for Future School Years

Recommendation: Be Endorsed.

5.3 Correspondence from Huron Perth Public Health, respecting Federal School Food Policy

Recommendation: Be Endorsed.

5.4 Correspondence from Public Health Sudbury and Districts respecting Bill 93, Joshua's Law (Lifejackets for Life), 2023

Recommendation: Be Endorsed

5.5 Correspondence from Timiskaming Health Unit respecting Addressing Household Food Insecurity in Ontario

Recommendation: Be Endorsed.

5.6 Correspondence from Chatham-Kent Public Health respecting Universal, No-cost Coverage for all Prescription Contraceptive Options to all People Living in Ontario

Recommendation: Be Endorsed.

5.7 Correspondence from Peterborough Public Health respecting Public Health 2024 Budget

Recommendation: Be Received.

6. DELEGATION REQUESTS

7. DELEGATIONS

8. STAFF PRESENTATIONS

8.1 Collective Impact: Healthy and Safe Communities and the Greater Hamilton Health Network 2023 Update (BOH23020) (City Wide)

8.2 Hamilton Opioid Action Plan (BOH23021) (City Wide)

9. CONSENT ITEMS

10. DISCUSSION ITEMS

10.1 Cold Alert Threshold Review (BOH23005(a)) (City Wide)

Members of the public can contact the Clerk’s Office to acquire the documents considered at this meeting, in an alternate format.

11. MOTIONS

11.1 Air Pollution & Mental Health Impacts

12. NOTICES OF MOTION

13. GENERAL INFORMATION / OTHER BUSINESS

13.1 Amendments to the Outstanding Business List:

a. Items Considered Complete and Needing to be Removed:

a. Clean Air Hamilton Annual Progress Report 2021 (BOH230010)

OBL Item: 2023-D

Date Added: March 20, 2023 (BOH Report 23-003 - Item 1)

Date Completed: May 1, 2023 (PHC Report 23-005 - Item 1)

b. Modelling Morbidity and Mortality using the Hamilton Airshed Modelling System (BOH18016(a))

OBL Item: 2023-E

Date Added: March 20, 2023 (BOH Report 23-003 - Item 2)

Date Completed: May 1, 2023 (PHC Report 23-005 - Item 2)

b. Items Requiring a New Due Date:

a. Municipal Actions to Reduce Harms Associated with Alcohol Use (BOH19032)

OBL Item: 2019-V

Current Due Date: July 2023

Proposed Due Date: September 2023

b. Child & Adolescent Services 2021-2022 Budget and Base Funding Increase of Five Percent (BOH 21010) (City Wide)

OBL Item: 2021-G

Current Due Date: April 2023

Proposed Due Date: September 2023

Members of the public can contact the Clerk’s Office to acquire the documents considered at this meeting, in an alternate format.

c. Item to be Referred to the Public Works Committee

a. Correspondence from Dr. Penny Sutcliffe, Medical Officer of health and Chief Executive Officer, Public Health Sudbury & Districts, respecting Physical Literacy for Healthy Active Children (Daily School Route)

OBL Item: 2023-B

14. PRIVATE AND CONFIDENTIAL

15. ADJOURNMENT

Members of the public can contact the Clerk's Office to acquire the documents considered at this meeting, in an alternate format.

PUBLIC HEALTH COMMITTEE
(Formerly the Board of Health)
MINUTES 23-005

9:30 a.m.
Monday, May 1, 2023
Council Chambers, City Hall, 2nd Floor
71 Main Street West, Hamilton, Ontario

Present: Mayor A. Horwath (Chair)
Councillor M. Wilson (Vice-Chair)
Councillors C. Cassar, B. Clark, J.P. Danko, M. Francis, T. Hwang, T. Jackson, C. Kroetsch, T. McMeekin, N. Nann, E. Pauls, M. Spadafora, M. Tadeson, A. Wilson

Absent with Regrets: Councillor J. Beattie - Personal

THE FOLLOWING ITEMS WERE REFERRED TO THE BOARD OF HEALTH FOR CONSIDERATION:

1. Site Specific Air Standards for Air Quality in Hamilton (BOH23016) (City Wide) (Outstanding Business List) (Item 8.1)

(A. Wilson/Cassar)
That Report BOH23016, respecting Site Specific Air Standards for Air Quality in Hamilton, be received.

Result: Motion CARRIED by a vote of 14 to 0, as follows:

Yes	-	Mayor Andrea Horwath	
Absent	-	Ward 10	Councillor Jeff Beattie
Yes	-	Ward 12	Councillor Craig Cassar
Yes	-	Ward 9	Councillor Brad Clark
Yes	-	Ward 8	Councillor John-Paul Danko
Yes	-	Ward 5	Councillor Matt Francis
Yes	-	Ward 4	Councillor Tammy Hwang
Yes	-	Ward 6	Councillor Tom Jackson
Absent	-	Ward 2	Councillor Cameron Kroetsch
Yes	-	Ward 15	Councillor Ted McMeekin
Yes	-	Ward 3	Councillor Nrinder Nann
Yes	-	Ward 7	Councillor Esther Pauls

Yes	-	Ward 14	Councillor Mike Spadafora
Yes	-	Ward 11	Councillor Mark Tadeson
Yes	-	Ward 13	Councillor Alex Wilson
Yes	-	Ward 1	Councillor Maureen Wilson

2. Feasibility of Health Check Identifying the Impact of Air Pollution on Mental Health (BOH23018) (City Wide) (Outstanding Business List) (Item 9.2)

(Nann/Tadeson)
That Report BOH23018, respecting Feasibility of Health Check Identifying the Impact of Air Pollution on Mental Health, be received.

Result: Motion CARRIED by a vote of 14 to 0, as follows:

Yes	-	Mayor Andrea Horwath	
Absent	-	Ward 10	Councillor Jeff Beattie
Yes	-	Ward 12	Councillor Craig Cassar
Yes	-	Ward 9	Councillor Brad Clark
Yes	-	Ward 8	Councillor John-Paul Danko
Yes	-	Ward 5	Councillor Matt Francis
Yes	-	Ward 4	Councillor Tammy Hwang
Yes	-	Ward 6	Councillor Tom Jackson
Absent	-	Ward 2	Councillor Cameron Kroetsch
Yes	-	Ward 15	Councillor Ted McMeekin
Yes	-	Ward 3	Councillor Nrinder Nann
Yes	-	Ward 7	Councillor Esther Pauls
Yes	-	Ward 14	Councillor Mike Spadafora
Yes	-	Ward 11	Councillor Mark Tadeson
Yes	-	Ward 13	Councillor Alex Wilson
Yes	-	Ward 1	Councillor Maureen Wilson

3. Hamilton’s Waterpipe By-Law (BOH23017) (City Wide) (Item 9.3)

(Pauls/Tadeson)
That Report BOH23017, respecting Hamilton’s Waterpipe By-Law, be received.

Result: Motion CARRIED by a vote of 14 to 0, as follows:

Yes	-	Mayor Andrea Horwath	
Absent	-	Ward 10	Councillor Jeff Beattie
Yes	-	Ward 12	Councillor Craig Cassar
Yes	-	Ward 9	Councillor Brad Clark
Yes	-	Ward 8	Councillor John-Paul Danko
Yes	-	Ward 5	Councillor Matt Francis
Yes	-	Ward 4	Councillor Tammy Hwang

Yes	-	Ward 6	Councillor Tom Jackson
Absent	-	Ward 2	Councillor Cameron Kroetsch
Yes	-	Ward 15	Councillor Ted McMeekin
Yes	-	Ward 3	Councillor Nrinder Nann
Yes	-	Ward 7	Councillor Esther Pauls
Yes	-	Ward 14	Councillor Mike Spadafora
Yes	-	Ward 11	Councillor Mark Tadeson
Yes	-	Ward 13	Councillor Alex Wilson
Yes	-	Ward 1	Councillor Maureen Wilson

4. Prohibiting Smoking and Vaping within City Parks and Recreation Property (BOH07034(o)) (City Wide) (Item 10.1)

(Jackson/McMeekin)
That the Amending Bylaw to the City of Hamilton By-law No. 11-080, being a by-law to Prohibit Smoking within City Parks and Recreation Properties, attached as Appendix “A” to Report BOH07034(o), and which has been prepared in a form satisfactory to the City Solicitor, be approved.

Result: Motion CARRIED by a vote of 14 to 0, as follows:

Yes	-	Mayor Andrea Horwath	
Absent	-	Ward 10	Councillor Jeff Beattie
Yes	-	Ward 12	Councillor Craig Cassar
Yes	-	Ward 9	Councillor Brad Clark
Yes	-	Ward 8	Councillor John-Paul Danko
Yes	-	Ward 5	Councillor Matt Francis
Yes	-	Ward 4	Councillor Tammy Hwang
Yes	-	Ward 6	Councillor Tom Jackson
Absent	-	Ward 2	Councillor Cameron Kroetsch
Yes	-	Ward 15	Councillor Ted McMeekin
Yes	-	Ward 3	Councillor Nrinder Nann
Yes	-	Ward 7	Councillor Esther Pauls
Yes	-	Ward 14	Councillor Mike Spadafora
Yes	-	Ward 11	Councillor Mark Tadeson
Yes	-	Ward 13	Councillor Alex Wilson
Yes	-	Ward 1	Councillor Maureen Wilson

FOR INFORMATION:

(a) CHANGES TO THE AGENDA (Item 2)

The Committee Clerk advised the Committee of the following changes to the agenda:

CHANGE TO THE ORDER OF ITEMS:

Item 9.1 respecting Site Specific Air Standards for Air Quality in Hamilton was moved under Staff Presentations (Item 8) as Item 8.1, as a presentation has been added to the Item.

(Tadeson/Pauls)
That the agenda for the May 1, 2023 Public Health Committee be approved, as amended.

Result: Motion CARRIED by a vote of 13 to 0, as follows:

Yes	-	Mayor Andrea Horwath	
Absent	-	Ward 10	Councillor Jeff Beattie
Yes	-	Ward 12	Councillor Craig Cassar
Yes	-	Ward 9	Councillor Brad Clark
Yes	-	Ward 8	Councillor John-Paul Danko
Yes	-	Ward 5	Councillor Matt Francis
Yes	-	Ward 4	Councillor Tammy Hwang
Absent	-	Ward 6	Councillor Tom Jackson
Yes	-	Ward 2	Councillor Cameron Kroetsch
Yes	-	Ward 15	Councillor Ted McMeekin
Yes	-	Ward 3	Councillor Nrinder Nann
Yes	-	Ward 7	Councillor Esther Pauls
Absent	-	Ward 14	Councillor Mike Spadafora
Yes	-	Ward 11	Councillor Mark Tadeson
Yes	-	Ward 13	Councillor Alex Wilson
Yes	-	Ward 1	Councillor Maureen Wilson

(b) DECLARATIONS OF INTEREST (Item 3)

There were no declarations of interest.

(c) APPROVAL OF MINUTES OF PREVIOUS MEETING (Item 4)

(i) **April 3, 2023 (Item 4.1)**

(McMeekin/Kroetsch)
That the Minutes of the April 3, 2023 meeting of the Board of Health be approved, as presented.

Result: Motion CARRIED by a vote of 13 to 0, as follows:

Yes	-	Mayor Andrea Horwath	
Absent	-	Ward 10	Councillor Jeff Beattie
Yes	-	Ward 12	Councillor Craig Cassar
Yes	-	Ward 9	Councillor Brad Clark
Yes	-	Ward 8	Councillor John-Paul Danko
Yes	-	Ward 5	Councillor Matt Francis
Yes	-	Ward 4	Councillor Tammy Hwang
Absent	-	Ward 6	Councillor Tom Jackson
Yes	-	Ward 2	Councillor Cameron Kroetsch
Yes	-	Ward 15	Councillor Ted McMeekin
Yes	-	Ward 3	Councillor Nrinder Nann
Yes	-	Ward 7	Councillor Esther Pauls
Absent	-	Ward 14	Councillor Mike Spadafora
Yes	-	Ward 11	Councillor Mark Tadeson
Yes	-	Ward 13	Councillor Alex Wilson
Yes	-	Ward 1	Councillor Maureen Wilson

(d) COMMUNICATIONS (Item 5)

(i) **(Hwang/Tadeson)**
That the Communication items be approved, as ***amended***, as follows:

(a) Correspondence from Rene Lapierre, Chair, Board of Health, Public Health Sudbury & Districts, respecting Ontario Minimum Wage Increase (Item 5.1)

Recommendation: Be received.

(b) Correspondence from Zoe Kazakos, respecting Industrial Polluters (Item 5.2)

Recommendation: Be received ***and referred to the consideration of Item 8.1 – Site Specific Air Standards for Air Quality in Hamilton (BOH23016).***

(c) Correspondence from Loretta Ryan, Executive Director, Association of Local Public Health Agencies (alPHa), respecting the Chief Medical Officer of Health's Statement and Resources for National Immunization Awareness Week (Item 5.3)

Recommendation: Be received.

(d) Correspondence from Loretta Ryan, Executive Director, Association of Local Public Health Agencies (alPHa), respecting alPHa's Annual General Meeting and Conference Update (Item 5.4)

Recommendation: Be received.

(e) Correspondence from Association of Local Public Health Agencies (alPHa), respecting April 2023 InfoBreak (Item 5.5)

Recommendation: Be received.

Result: Motion on the Communication Items, as *amended*, CARRIED, by a vote of 14 to 0, as follows:

Yes	-	Mayor Andrea Horwath	
Absent	-	Ward 10	Councillor Jeff Beattie
Yes	-	Ward 12	Councillor Craig Cassar
Yes	-	Ward 9	Councillor Brad Clark
Yes	-	Ward 8	Councillor John-Paul Danko
Yes	-	Ward 5	Councillor Matt Francis
Yes	-	Ward 4	Councillor Tammy Hwang
Absent	-	Ward 6	Councillor Tom Jackson
Yes	-	Ward 2	Councillor Cameron Kroetsch
Yes	-	Ward 15	Councillor Ted McMeekin
Yes	-	Ward 3	Councillor Nrinder Nann
Yes	-	Ward 7	Councillor Esther Pauls
Yes	-	Ward 14	Councillor Mike Spadafora
Yes	-	Ward 11	Councillor Mark Tadeson
Yes	-	Ward 13	Councillor Alex Wilson
Yes	-	Ward 1	Councillor Maureen Wilson

(e) DELEGATION REQUESTS (Item 6)

(Pauls/Hwang)
That the following Delegation Request, be approved for today's meeting:

(i) Tim Sholhan, respecting National Organ and Tissue Donation Awareness Week (Item 6.1)

Result: Motion CARRIED by a vote of 14 to 0, as follows:

Yes	-	Mayor Andrea Horwath	
Absent	-	Ward 10	Councillor Jeff Beattie
Yes	-	Ward 12	Councillor Craig Cassar
Yes	-	Ward 9	Councillor Brad Clark
Yes	-	Ward 8	Councillor John-Paul Danko
Yes	-	Ward 5	Councillor Matt Francis
Yes	-	Ward 4	Councillor Tammy Hwang
Absent	-	Ward 6	Councillor Tom Jackson
Yes	-	Ward 2	Councillor Cameron Kroetsch
Yes	-	Ward 15	Councillor Ted McMeekin
Yes	-	Ward 3	Councillor Nrinder Nann
Yes	-	Ward 7	Councillor Esther Pauls
Yes	-	Ward 14	Councillor Mike Spadafora
Yes	-	Ward 11	Councillor Mark Tadeson
Yes	-	Ward 13	Councillor Alex Wilson
Yes	-	Ward 1	Councillor Maureen Wilson

(f) DELEGATIONS (Item 7)

(i) Tim Sholhan, respecting National Organ and Tissue Donation Awareness Week (for today's meeting) (Item 7.1)

Tim Sholhan addressed the Committee respecting National Organ and Tissue Donation Awareness Week.

(Hwang/Cassar)
That the Delegation from Tim Sholhan, respecting National Organ and Tissue Donation Awareness Week, be received.

Result: Motion CARRIED by a vote of 14 to 0, as follows:

Yes	-	Mayor Andrea Horwath	
Absent	-	Ward 10	Councillor Jeff Beattie
Yes	-	Ward 12	Councillor Craig Cassar
Yes	-	Ward 9	Councillor Brad Clark
Yes	-	Ward 8	Councillor John-Paul Danko
Yes	-	Ward 5	Councillor Matt Francis
Yes	-	Ward 4	Councillor Tammy Hwang
Absent	-	Ward 6	Councillor Tom Jackson
Yes	-	Ward 2	Councillor Cameron Kroetsch
Yes	-	Ward 15	Councillor Ted McMeekin
Yes	-	Ward 3	Councillor Nrinder Nann

Yes	-	Ward 7	Councillor Esther Pauls
Yes	-	Ward 14	Councillor Mike Spadafora
Yes	-	Ward 11	Councillor Mark Tadeson
Yes	-	Ward 13	Councillor Alex Wilson
Yes	-	Ward 1	Councillor Maureen Wilson

(g) STAFF PRESENTATIONS (Item 8)

(i) Site Specific Air Standards for Air Quality in Hamilton (BOH23016) (City Wide) (Outstanding Business List Item) (Item 8.1)

Kevin McDonald, Director, Healthy Environments, introduced Jeff Burdon, Rachel Melzer, and Stephen Burt from the Ontario Ministry of the Environment, Conservation and Parks, who addressed the Committee respecting Site Specific Air Standards for Air Quality in Hamilton, with the aide of a presentation.

(Hwang/Tadeson)
That the presentation respecting Report BOH23016, Site Specific Air Standards for Air Quality in Hamilton, be received.

Result: Motion CARRIED by a vote of 15 to 0, as follows:

Yes	-	Mayor Andrea Horwath	
Absent	-	Ward 10	Councillor Jeff Beattie
Yes	-	Ward 12	Councillor Craig Cassar
Yes	-	Ward 9	Councillor Brad Clark
Yes	-	Ward 8	Councillor John-Paul Danko
Yes	-	Ward 5	Councillor Matt Francis
Yes	-	Ward 4	Councillor Tammy Hwang
Yes	-	Ward 6	Councillor Tom Jackson
Yes	-	Ward 2	Councillor Cameron Kroetsch
Yes	-	Ward 15	Councillor Ted McMeekin
Yes	-	Ward 3	Councillor Nrinder Nann
Yes	-	Ward 7	Councillor Esther Pauls
Yes	-	Ward 14	Councillor Mike Spadafora
Yes	-	Ward 11	Councillor Mark Tadeson
Yes	-	Ward 13	Councillor Alex Wilson
Yes	-	Ward 1	Councillor Maureen Wilson

For disposition of this matter, please refer to Item 4.

(h) ADJOURNMENT (Item 15)

(Francis/Tadeson)
That, there being no further business, the Public Health Committee be adjourned at 12:12 p.m.

Result: Motion CARRIED by a vote of 14 to 0, as follows:

Yes	-	Mayor Andrea Horwath	
Absent	-	Ward 10	Councillor Jeff Beattie
Yes	-	Ward 12	Councillor Craig Cassar
Yes	-	Ward 9	Councillor Brad Clark
Yes	-	Ward 8	Councillor John-Paul Danko
Yes	-	Ward 5	Councillor Matt Francis
Yes	-	Ward 4	Councillor Tammy Hwang
Yes	-	Ward 6	Councillor Tom Jackson
Absent	-	Ward 2	Councillor Cameron Kroetsch
Yes	-	Ward 15	Councillor Ted McMeekin
Yes	-	Ward 3	Councillor Nrinder Nann
Yes	-	Ward 7	Councillor Esther Pauls
Yes	-	Ward 14	Councillor Mike Spadafora
Yes	-	Ward 11	Councillor Mark Tadeson
Yes	-	Ward 13	Councillor Alex Wilson
Yes	-	Ward 1	Councillor Maureen Wilson

Respectfully submitted,

Mayor Andrea Horwath
Chair, Public Health Committee

Matt Gauthier
Legislative Coordinator
Office of the City Clerk

SPECIAL PUBLIC HEALTH COMMITTEE
(Formerly the Board of Health)
MINUTES 23-006

9:30 a.m.
Monday, May 15, 2023
Council Chambers, City Hall, 2nd Floor
71 Main Street West, Hamilton, Ontario

Present:	Councillor M. Wilson (Vice-Chair) Councillors J. Beattie, C. Cassar, B. Clark, M. Francis, T. Hwang, T. Jackson, C. Kroetsch, N. Nann, E. Pauls, M. Tadeson, A. Wilson
Absent with Regrets:	Mayor A. Horwath (Chair) – City Business, Councillors J.P. Danko – Personal, T. McMeekin – Personal, M. Spadafora - Personal

THE FOLLOWING ITEMS WERE REFERRED TO THE BOARD OF HEALTH FOR CONSIDERATION:

1. 2023 Hamilton Community Heat Response Plan (BOH23019) (City Wide) (Item 6.1)

(a) (Kroetsch/Hwang)

WHEREAS the City has a Adequate Heat By-law in place to ensure that adequate heating is provided to all Hamiltonians during colder months;

WHEREAS the City recognized, in 2016, that it needed to modify the Adequate Heat By-law by shifting the start of the colder season from August 31 to September 15;

WHEREAS the City of Mississauga introduced an Adequate Temperature By-law on June 6, 2018 that defined “adequate and suitable cooling” to be a temperature in a “unit that does not exceed 26 degrees Celsius (26°C)”;

WHEREAS the City of Mississauga’s bylaw only applies to spaces where a landlord already provides air conditioning and does not address the gaps where a landlord does not;

WHEREAS in 2020 Montgomery County Council (Washington) voted unanimously to require that property owners “supply and maintain” air conditioning service at 80°F or less during the summer months following on similar measures taken in Dallas and Phoenix;

WHEREAS extreme heat continues to have increasingly harmful impacts on the physical and mental health of Hamiltonians;

WHEREAS residents in other municipalities, notably in Chicago (1995), Quebec (2018), British Columbia (2021), and Paris (2003, 2022), have died from the impacts of extreme heat indoors because they didn't have access to cooling;

WHEREAS many renters in parts of the City with the highest urban heat impacts do not have access to air conditioned spaces;

WHEREAS an Adequate Temperature By-law would be one of a number of significant new by-law initiatives designed to better protect tenants as well as respond to the Climate Emergency; and

WHEREAS Council wants to ensure that there are sufficient resources within the Licensing and By-law Services Division to develop, implement and enforce new and existing City by-laws in order to protect tenants and respond to the Climate Emergency.

THEREFORE, BE IT RESOLVED:

(a) That staff in the Licensing and By-law Services Division be directed to prepare an Information Report for Q4 2023 identifying the 2024 priorities and timelines for the development of new by-laws, including an Adequate Temperature By-law and report back to the Planning Committee;

(b) That the following staffing resources, and related costs, to expand the Licensing and By-law Services Division's capacity to develop, update and enforce City by-laws to protect tenants and respond to the Climate Emergency, including the development of a new Adequate Temperature By-law, be referred to the 2024 Tax Supported Operating Budget process:

    (i) One new Manager FTE and one new Senior Project Manager FTE within the Licensing and By-law Services Division;

    (ii) One new Municipal Law Enforcement Supervisor FTE and one new Municipal Law Enforcement Officer FTE within the Licensing and By-law Services Division;

    (iii) 0.5 FTE for Legal Services, to support the Licensing and By-law Services Division;

(c) That staff be directed to include in the 2024 Tax Supported Capital Budget a Municipal By-law Review and Development project, with a purpose to undertake research, community engagement and leverage external

expertise for the development of new City by-laws, with a budget of $100,000;

(d) That staff in Healthy and Safe Communities be directed to report back to the Emergency & Community Services Committee on the feasibility of the development of a municipal program to support low-income tenants with the cost to run an air conditioning unit and to support retrofits of private purpose-built rental housing in Q4 2023; and,

(e) That staff in Healthy and Safe Communities and Public Health be directed to report back to the Public Health Committee on the feasibility of tracking heat-related deaths and illnesses in Hamilton in Q4 2023.

Result: Motion CARRIED by a vote of 10 to 0, as follows:

Absent	-	Mayor Andrea Horwath	
Absent	-	Ward 10	Councillor Jeff Beattie
Yes	-	Ward 12	Councillor Craig Cassar
Yes	-	Ward 9	Councillor Brad Clark
Absent	-	Ward 8	Councillor John-Paul Danko
Yes	-	Ward 5	Councillor Matt Francis
Yes	-	Ward 4	Councillor Tammy Hwang
Absent	-	Ward 6	Councillor Tom Jackson
Yes	-	Ward 2	Councillor Cameron Kroetsch
Absent	-	Ward 15	Councillor Ted McMeekin
Yes	-	Ward 3	Councillor Nrinder Nann
Yes	-	Ward 7	Councillor Esther Pauls
Absent	-	Ward 14	Councillor Mike Spadafora
Yes	-	Ward 11	Councillor Mark Tadeson
Yes	-	Ward 13	Councillor Alex Wilson
Yes	-	Ward 1	Councillor Maureen Wilson

(b) (Clark/Kroetsch)
That Report BOH23019, respecting 2023 Hamilton Community Heat Response Plan, be received.

Result: Motion CARRIED by a vote of 9 to 0, as follows:

Absent	-	Mayor Andrea Horwath	
Yes	-	Ward 10	Councillor Jeff Beattie
Yes	-	Ward 12	Councillor Craig Cassar
Yes	-	Ward 9	Councillor Brad Clark
Absent	-	Ward 8	Councillor John-Paul Danko
Absent	-	Ward 5	Councillor Matt Francis
Yes	-	Ward 4	Councillor Tammy Hwang

Absent	-	Ward 6	Councillor Tom Jackson
Yes	-	Ward 2	Councillor Cameron Kroetsch
Absent	-	Ward 15	Councillor Ted McMeekin
Yes	-	Ward 3	Councillor Nrinder Nann
Yes	-	Ward 7	Councillor Esther Pauls
Absent	-	Ward 14	Councillor Mike Spadafora
Yes	-	Ward 11	Councillor Mark Tadeson
Absent	-	Ward 13	Councillor Alex Wilson
Yes	-	Ward 1	Councillor Maureen Wilson

FOR INFORMATION:

(a) CHANGES TO THE AGENDA (Item 1)

The Committee Clerk advised the Committee of the following changes to the agenda:

3. COMMUNICATIONS

3.1 Correspondence from Hamilton ACORN, respecting Full Temperature Control for Tenants - Protecting Tenants from Extreme Heat

Recommendation: Be received and referred to the consideration of Item 6.1.

3.2 Correspondence from ACORN Hamilton, Canadian Environmental Law Association and Hamilton Community Legal Clinic, respecting 2023 Hamilton Community Heat Response Plan (BOH23019) (City Wide)

Recommendation: Be received and referred to the consideration of Item 6.1.

4. DELEGATIONS REQUESTS

4.1 Delegation Requests, respecting 2023 Hamilton Community Heat Response Plan (BOH23019) (City Wide) (for today's meeting):

(c) James Kemp
(d) Zoe St Pierre, Canadian Environmental Law Association
(e) Jacqueline Wilson, Low Income Energy Network
(f) Christine Neale, ACORN
(g) Karl Andrus
(h) Tom Cooper, Hamilton Roundtable for Poverty Reduction
(i) Clare Freeman and Merima Menzildzic, Hamilton Community Legal Clinic
(j) Katie King, Hamilton Community Benefits Network
(k) Arnim Hughes, ACORN
(l) Adeola Egbeyemi, Environment Hamilton

(m) Marnie Schurter, ACORN
(n) Liz Scott, ACORN

(Pauls/Tadeson)
That the agenda for the May 15, 2023 Public Health Committee be approved, as amended.

Result: Motion CARRIED by a vote of 9 to 0, as follows:

Absent	-	Mayor Andrea Horwath	
Absent	-	Ward 10	Councillor Jeff Beattie
Yes	-	Ward 12	Councillor Craig Cassar
Yes	-	Ward 9	Councillor Brad Clark
Absent	-	Ward 8	Councillor John-Paul Danko
Yes	-	Ward 5	Councillor Matt Francis
Yes	-	Ward 4	Councillor Tammy Hwang
Absent	-	Ward 6	Councillor Tom Jackson
Yes	-	Ward 2	Councillor Cameron Kroetsch
Absent	-	Ward 15	Councillor Ted McMeekin
Absent	-	Ward 3	Councillor Nrinder Nann
Yes	-	Ward 7	Councillor Esther Pauls
Absent	-	Ward 14	Councillor Mike Spadafora
Yes	-	Ward 11	Councillor Mark Tadeson
Yes	-	Ward 13	Councillor Alex Wilson
Yes	-	Ward 1	Councillor Maureen Wilson

(b) DECLARATIONS OF INTEREST (Item 2)

There were no declarations of interest.

(c) COMMUNICATIONS (Item 3)

(i) **(Kroetsch/Hwang)**
That the following Communication items be approved, as presented:

(a) Correspondence from Hamilton ACORN, respecting Full Temperature Control for Tenants - Protecting Tenants from Extreme Heat (Added Item 3.1)

Recommendation: Be received and referred to the consideration of Item 6.1.

(b) Correspondence from ACORN Hamilton, Canadian Environmental Law Association and Hamilton Community Legal Clinic, respecting 2023 Hamilton Community Heat Response Plan (BOH23019) (City Wide) (Added Item 3.2)

Recommendation: Be received and referred to the consideration of Item 6.1.

Result: Motion CARRIED by a vote of 9 to 0, as follows:

Absent	-	Mayor Andrea Horwath	
Absent	-	Ward 10	Councillor Jeff Beattie
Yes	-	Ward 12	Councillor Craig Cassar
Yes	-	Ward 9	Councillor Brad Clark
Absent	-	Ward 8	Councillor John-Paul Danko
Yes	-	Ward 5	Councillor Matt Francis
Yes	-	Ward 4	Councillor Tammy Hwang
Absent	-	Ward 6	Councillor Tom Jackson
Yes	-	Ward 2	Councillor Cameron Kroetsch
Absent	-	Ward 15	Councillor Ted McMeekin
Absent	-	Ward 3	Councillor Nrinder Nann
Yes	-	Ward 7	Councillor Esther Pauls
Absent	-	Ward 14	Councillor Mike Spadafora
Yes	-	Ward 11	Councillor Mark Tadeson
Yes	-	Ward 13	Councillor Alex Wilson
Yes	-	Ward 1	Councillor Maureen Wilson

(d) DELEGATION REQUESTS (Item 4)

(Cassar/Clark)
That the following Delegation Requests, be approved for today's meeting:

(i) Delegation Requests, respecting 2023 Hamilton Community Heat Response Plan (BOH23019) (City Wide) (Item 4.1)

(a) Stewart Klazinga, ACORN Hamilton – East End Chapter (Item 4.1(a))

(b) Damien Ash, ACORN (Item 4.1(b))

(c) James Kemp (Added Item 4.1(c))

(d) Zoe St Pierre, Canadian Environmental Law Association (Added Item 4.1(d))

(e) Jacqueline Wilson, Low Income Energy Network (Added Item 4.1(e))

(f) Christine Neale, ACORN (Added Item 4.1(f))

(g) Karl Andrus (Added Item 4.1(g))

(h) Tom Cooper, Hamilton Roundtable for Poverty Reduction (Added Item 4.1(h))

(i) Clare Freeman and Merima Menzildzic, Hamilton Community Legal Clinic (Added Item 4.1(i))

(j) Katie King, Hamilton Community Benefits Network (Added Item 4.1(j))

(k) Arnim Hughes, ACORN (Added Item 4.1(k))

(l) Adeola Egbeyemi, Environment Hamilton (Added Item 4.1(l))

(m) Marnie Schurter, ACORN (Added Item 4.1(m))

(n) Liz Scott, ACORN (Added Item 4.1(n))

Result: Motion CARRIED by a vote of 9 to 0, as follows:

Absent	-	Mayor Andrea Horwath	
Absent	-	Ward 10	Councillor Jeff Beattie
Yes	-	Ward 12	Councillor Craig Cassar
Yes	-	Ward 9	Councillor Brad Clark
Absent	-	Ward 8	Councillor John-Paul Danko
Yes	-	Ward 5	Councillor Matt Francis
Yes	-	Ward 4	Councillor Tammy Hwang
Absent	-	Ward 6	Councillor Tom Jackson
Yes	-	Ward 2	Councillor Cameron Kroetsch
Absent	-	Ward 15	Councillor Ted McMeekin
Absent	-	Ward 3	Councillor Nrinder Nann
Yes	-	Ward 7	Councillor Esther Pauls
Absent	-	Ward 14	Councillor Mike Spadafora
Yes	-	Ward 11	Councillor Mark Tadeson
Yes	-	Ward 13	Councillor Alex Wilson
Yes	-	Ward 1	Councillor Maureen Wilson

(e) DELEGATIONS (Item 5)

(i) The following delegates addressed the Committee respecting the 2023 Hamilton Community Heat Response Plan (BOH23019) (City Wide) (Item 5.1):

(a) Stewart Klazinga, ACORN Hamilton – East End Chapter (Item 5.1(a))

(b) Damien Ash, ACORN (Item 5.1(b))

(c) James Kemp (Added Item 5.1(c))

(d) Zoe St Pierre, Canadian Environmental Law Association (Added Item 5.1(d))

(e) Jacqueline Wilson, Low Income Energy Network (Added Item 5.1(e))

(f) Christine Neale, ACORN (Added Item 5.1(f))

(g) Karl Andrus (Added Item 5.1(g))

(h) Tom Cooper, Hamilton Roundtable for Poverty Reduction (Added Item 5.1(h))

(i) Clare Freeman and Merima Menzildzic, Hamilton Community Legal Clinic (Added Item 5.1(i))

(j) Katie King, Hamilton Community Benefits Network (Added Item 5.1(j))

(k) Arnim Hughes, ACORN (Added Item 5.1(k))

(l) Marnie Schurter, ACORN (Added Item 5.1(m))

(m) Liz Scott, ACORN (Added Item 5.1(n))

(ii) The following delegate was not present when called upon:

(a) Adeola Egbeyemi, Environment Hamilton (Added Item 5.1(l))

(Nann/Beattie)
That the following Delegations, be received:

(a) Stewart Klazinga, ACORN Hamilton – East End Chapter (Item 5.1(a))

(b) Damien Ash, ACORN (Item 5.1(b))

(c) James Kemp (Added Item 5.1(c))

(d) Zoe St Pierre, Canadian Environmental Law Association (Added Item 5.1(d))

(e) Jacqueline Wilson, Low Income Energy Network (Added Item 5.1(e))

(f) Christine Neale, ACORN (Added Item 5.1(f))

(g) Karl Andrus (Added Item 5.1(g))

(h) Tom Cooper, Hamilton Roundtable for Poverty Reduction (Added Item 5.1(h))

(i) Clare Freeman and Merima Menzildzic, Hamilton Community Legal Clinic (Added Item 5.1(i))

(j) Katie King, Hamilton Community Benefits Network (Added Item 5.1(j))

(k) Arnim Hughes, ACORN (Added Item 5.1(k))

(l) Marnie Schurter, ACORN (Added Item 5.1(m))

(m) Liz Scott, ACORN (Added Item 5.1(n))

Result: Motion CARRIED by a vote of 12 to 0, as follows:

Absent	-	Mayor Andrea Horwath	
Yes	-	Ward 10	Councillor Jeff Beattie
Yes	-	Ward 12	Councillor Craig Cassar
Yes	-	Ward 9	Councillor Brad Clark
Absent	-	Ward 8	Councillor John-Paul Danko
Yes	-	Ward 5	Councillor Matt Francis
Yes	-	Ward 4	Councillor Tammy Hwang
Yes	-	Ward 6	Councillor Tom Jackson
Yes	-	Ward 2	Councillor Cameron Kroetsch
Absent	-	Ward 15	Councillor Ted McMeekin
Yes	-	Ward 3	Councillor Nrinder Nann
Yes	-	Ward 7	Councillor Esther Pauls
Absent	-	Ward 14	Councillor Mike Spadafora
Yes	-	Ward 11	Councillor Mark Tadeson
Yes	-	Ward 13	Councillor Alex Wilson
Yes	-	Ward 1	Councillor Maureen Wilson

For disposition of this matter, please refer to Item 1.

(f) ADJOURNMENT (Item 7)

(Cassar/Beattie)
That, there being no further business, the Public Health Committee be adjourned at 12:38 p.m.

Result: Motion CARRIED by a vote of 8 to 0, as follows:

Absent - Mayor Andrea Horwath

Yes	-	Ward 10	Councillor Jeff Beattie
Yes	-	Ward 12	Councillor Craig Cassar
Yes	-	Ward 9	Councillor Brad Clark
Absent	-	Ward 8	Councillor John-Paul Danko
Absent	-	Ward 5	Councillor Matt Francis
Yes	-	Ward 4	Councillor Tammy Hwang
Absent	-	Ward 6	Councillor Tom Jackson
Yes	-	Ward 2	Councillor Cameron Kroetsch
Absent	-	Ward 15	Councillor Ted McMeekin
Absent	-	Ward 3	Councillor Nrinder Nann
Yes	-	Ward 7	Councillor Esther Pauls
Absent	-	Ward 14	Councillor Mike Spadafora
Yes	-	Ward 11	Councillor Mark Tadeson
Absent	-	Ward 13	Councillor Alex Wilson
Yes	-	Ward 1	Councillor Maureen Wilson

Respectfully submitted,

Councillor Maureen Wilson
Chair, Public Health Committee

Matt Gauthier
Legislative Coordinator
Office of the City Clerk

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 25-23

TO: Chair and Members of the Board of Health

FROM: Dr. Alexander Summers, Medical Officer of Health
Emily Williams, Chief Executive Officer

DATE: 2023 April 20

MONITORING FOOD AFFORDABILITY AND IMPLICATIONS FOR PUBLIC POLICY AND ACTION

Recommendation

It is recommended that the Board of Health:

1) ***Receive Report No. 25-23, re: "Monitoring Food Affordability and Implications for Public Policy and Action" for information; and***
2) ***Forward Report No. 25-23 re: "Monitoring Food Affordability and Implications for Public Policy and Action" to Ontario boards of health, the City of London, Middlesex County, and appropriate community agencies***.

Key Points

- Local food affordability monitoring is a requirement of the Ontario Public Health Standards.
- The 2022 Nutritious Food Basket survey results demonstrate that incomes, particularly when dependent on social assistance, are not adequate for many Middlesex-London residents to afford basic needs.
- Food insecurity has a pervasive impact on health; and there is a need for income-based solutions.

Background and 2022 Nutritious Food Basket Survey Results

Food insecurity, defined as inadequate or insecure access to food due to financial constraints, is a key social determinant of health[1]. In 2020, approximately one in five households in Middlesex-London were food insecure[2]. Food insecurity is associated with an increased risk of a wide range of challenges to physical and mental health, including chronic conditions, non-communicable diseases, infections, depression, anxiety, and stress[3-10] (Appendix A).

Routine monitoring of food affordability helps generate evidence-based recommendations for collective public health action to address food insecurity and income inadequacy. The Ontario Public Health Standards require monitoring local food affordability as mandated in the Population Health Assessment and Surveillance Protocol, 2018. The Nutritious Food Basket (NFB) is a survey tool that measures the cost of eating as represented by current national nutrition recommendations and average food purchasing patterns.

Local food affordability monitoring was paused in 2020 and 2021 due to the COVID-19 pandemic. In 2022, MLHU staff participated in the provincial pilot testing of the Ontario Dietitians in Public Health's (ODPH) new costing tool using a hybrid model of in-store and online data collection.

In May 2022, using the ODPH tools, the estimated local monthly cost to feed a family of four was $1,084 (Appendix B). In Ontario, according to the Consumer Price Index, the price of food purchased from stores in January 2023 was 10.1% higher than in January 2022, rising at an annual rate not seen since the early 1980s[11].

Local monthly food and average rental costs are compared to a variety of household and income scenarios, including households receiving social assistance, minimum wage earners, and median incomes (see Appendix B). The scenarios include food and rent only and are not inclusive of other needs (i.e., utilities, Internet, phone, transportation, household operations and supplies, personal care items, clothing etc.). Households with low incomes spend up to 45% of their after-tax income on food, whereas, Middlesex-London residents who have adequate incomes (family of 4) need to spend approximately 12% of their after-tax income. The scenarios highlight that Middlesex-London residents with low incomes cannot afford to eat after meeting other essential needs for basic living. Unfortunately, this demonstrates that incomes and social assistances rates have not kept pace with the increased cost of living.

Opportunities

Upstream-level approaches that address the systems that create and maintain food insecurity, including income inadequacy and poverty, are the most effective in reducing food insecurity[1].

In October 2022, the ODPH urged the Ontario government to adopt income-based policy solutions that effectively reduce food insecurity. These solutions may include higher minimum wage rates, increasing social assistance rates, and reducing income tax rates for the lowest income households. Additionally, ODPH submitted a resolution to advocate for increased social assistance rates to address food insecurity for consideration at alPHa's Annual Conference in June 2023. MLHU registered dietitians continue to work locally, regionally and provincially with public health counterparts and community partners and will explore potential healthy public policy priorities in this area over the upcoming year.

Healthy Living Division staff will complete and submit the results of 2023 local food affordability monitoring to the Board of Health in Q4 2023.

This report was submitted by the Healthy Living Division.

Alexander Summers, MD, MPH, CCFP, FRCPC
Medical Officer of Health

Emily Williams, BScN, RN, MBA, CNE
Chief Executive Officer

Huron Perth Public Health

June 1, 2023

The Honourable Michael Parsa
Minister of Children, Community and Social Services

Email: michael.parsaco@pc.ola.org

Dear Honourable Minister Parsa:

Re: Request for Immediate Funding for Student Nutrition Programs and to Increase Funding for Future School Years

I'm writing to you on behalf of Huron Perth Public Health. HPPH has recently endorsed the Coalition for Healthy School Food (CHSF). The Ontario-chapter (ON-CHSF) members – many of whom deliver school breakfast, lunch, snack or other nutrition and food literacy programs – have identified the same concerns with their local *Student Nutrition Programs* (SNPs) as we are seeing locally.[1]

Currently across Ontario, many school programs are unable to meet current demands, shutting down before the end of the school year or having to limit the foods served in order to get through to the end of the year, due to insufficient funds. There has not been a substantial annual increase to core Ontario SNP funding since 2014. Many programs have felt the strain for years, but the rising food costs of the last two years[2] and increased demand have significantly out-paced current funding. Other schools who have not previously had a program are seeing a demand, but there are no funds for new programs.

There are urgent and immediate needs now. Children and youth need access to nourishing food to thrive and, without further investment, many schools will be unable to continue to provide adequate nourishing food through the remaining school year. ON-CHSF members report, projected budget shortfall for future years is substantial.

We are writing to you to highlight the immediate and longer-term funding needs of SNPs in Ontario. The current reliance on fundraising, volunteers, and donations is inconsistent, unsustainable, and disadvantages those schools who most need the support.

A growing body of research demonstrates that school food programs can benefit students' physical and mental health, improve food choices, and lead to student success (e.g. academic performance, student behaviour, and school attendance).[3] These programs help reduce the $5.6 billion/year in costs due to nutrition-related chronic disease injuries in Ontario. Well-designed and non-stigmatizing SNPs also have broad, positive impacts on families, communities, and the economy by reducing household food costs, creating jobs, and strengthening Ontario's agri-food sector.[4]

The Ontario government was among the first provincial governments to fund school food programs in Canada and now provides an annual $27.9M for SNPs in the province. Since Ontario's initial investment, all provincial and

---

1 The national Coalition for Healthy School Food consists of over 250 member and 125 endorser organizations from every province and territory, representing the largest school food network in Canada. Together, we are advocating for the creation of a universal cost-shared school food program that would see all K-12 students in Canada having daily access to healthy food at school.

2 Consumer Price Index, monthly, not seasonally adjusted. Statistics Canada. Sept 2021 to Sept 2022, food costs increased 11.5% (have rates this high since 1981).

3 The case for a Canadian national school food program. Hernandez et al., 2018; Nourishing Young Minds. Toronto Public Health, 2012; The impact of Canadian School Food Programs on Children's Nutrition and Health. Colley et al., 2018; Coalition for Healthy School Food

4 The Burden of Chronic Disease in Ontario. CCO & PHO 2019.

territorial governments have followed Ontario's lead. In response to recent urgent calls for additional funding because of greater participation and rising food costs, which are not unique to Ontario[5], many provincial and territorial governments have increased their investments in school food. The 2022-23 school food funding increases include: $500,000 in Newfoundland and Labrador; $2 million in New Brunswick; $2 million in emergency funding in Nova Scotia; $1.3 million in Manitoba; $16 million in Quebec; $214.5 million over three years in Budget 2023 in BC; and $500,000 in the Yukon. Many of these increases are to the programs' annual operating budgets. However, there has not been a substantial annual increase to core Ontario SNP funding since 2014.

We know Ontario's student nutrition programs have greatly appreciated the additional support that MCCSS provided to SNPs throughout the pandemic, and also your recent statement that no student will go hungry under your watch. We ask MCCSS to again recognize the urgent need at this time and to (1) allocate urgent funding to those programs who need it immediately, and (2) allocate more core funding to programs for the 2023/24 and future school years, when significant shortfalls are expected.

As the federal government prepares to release a National School Food Policy and invest in programs across the country, greater provincial investment in Ontario programs will be seen favourably. We believe that there is a great opportunity for Ontario to show further provincial leadership on student nutrition at this time and to ensure students are well-nourished during the school day.

Your attention to this urgent issue is needed.

Sincerely,

Bernie MacLellan, Board Chair
Huron Perth Public Health

cc. Hon. Stephen Lecce, Minister of Education (Stephen.Lecceco@pc.ola.org)
Hon. Sylvia Jones, Minister of Health (sylvia.jones@pc.ola.org)
John Nater, MP Perth-Wellington (john.nater@parl.gc.ca)
Ben Lobb, MP Huron-Bruce (ben.lobb@parl.gc.ca)
Matthew Rae MPP Perth-Wellington (matthew.rae@pc.ola.org)
Hon. Lisa Thompson MPP Huron-Bruce (lisa.thompsonco@pc.ola.org)
Ontario Boards of Health (allhealthunits@lists.alphaweb.org)

[5] For example, see recent media coverage from PEI and Newfoundland and Labrador.

June 1, 2023

Honourable Karina Gould
Ministry of Families, Children and Social Development
Email: karina.gould@parl.gc.ca

Honourable Marie-Claude Bibeau
Ministry of Agriculture and Agri-Food
Email: Marie-Claude.Bibeau@parl.gc.ca

Honourable Jean-Yves Duclos
Ministry of Health
Email: jean-yves.duclos@parl.gc.ca

Dear Federal Ministers Gould, Bibeau and Duclos:

Re: Federal School Food Policy

I write on behalf of the Huron Perth Public Health Board of Health. As the federal government prepares to release a National School Food Policy and invest in programs across the county, we wish to reiterate the call for the development of a universal, cost-shared school food program for Canada and share our concerns about the current state of student nutrition programs in Ontario and our region.

Currently across Ontario, many school programs are unable to meet current demands, shutting down before the end of the school year or having to limit the foods served in order to get through the to the end of the year due to insufficient funds. Many programs have felt the strain with limited increases to provincial funding since 2014, while the rising food costs of the last two years and increased demand have significantly out-paced current funding. Other schools who have not previously had a program are seeing a demand, but there are no funds for new programs. There are urgent and immediate needs now. Children and youth need access to nourishing food to thrive and, without further investment, many will not have access to nourishing food at school. The current state of school food programs across Canada is patch-work and resource-limited. While many schools in Ontario do have student nutrition programs partially funded by the Ministry of Children, Community and Social Services, a significant investment from the federal government would allow for expansion of services and to address existing gaps. The current reliance on fundraising, volunteers, and donations is inconsistent, unsustainable, and puts schools who most need the support at a significant disadvantage. School food programs offer many academic and nutritional benefits and should be implemented along with additional income supports to reduce health inequities and food insecurity for families across Canada. School food policy and programs alone cannot alleviate poverty and food insecurity.[1,2] School food programs can, however, play an important role in improving nutrition

[1] PROOF, Open Letter: Stop headlining the pan-Canadian school food policy as a way to reduce food insecurity among children. Dec 9, 2022. https://proof.utoronto.ca/resource/open-letter-on-school-food-policy-consultation/
[2] Ontario Dietitians on Public Health, Position Statement and Recommendations on Response to Food Insecurity. Dec 2020. https://www.odph.ca/odph-position-statement-on-responses-to-food-insecurity-1

intake, supporting healthy growth and development, supporting academic success, attendance and educational attainment, and improving mental health and well-being.[3]

Currently many elementary schools do not have adequate facilities to allow safe food handling and production of onsite food for meal/snack programs or for hands-on food literacy learning opportunities for students. Adequate funding for infrastructure improvements would benefit school food programs and academic learning across health and physical education, science and technology and other cross-curricular learning opportunities, which can build critical food skills for students when transitioning into adulthood.

School food programs should be designed to[4]:

- serve tasty, nourishing, culturally appropriate foods
- ensure that ALL students in a school can access the program in a non-stigmatizing manner
- be a cost-shared model, including federal support
- be flexible and locally adapted to the context of the school and region, including commitment to Indigenous control over programs for Indigenous students
- support Canadian farmers and local food producers
- promote food literacy

Huron Perth Public Health Board of Health stands alongside other Boards of Health, School Boards, Municipalities, and other government agencies and organizations in supporting the Coalition for Healthy School Food's vision that every school-aged child and youth has a nutritious meal or snack at school daily.

We urge the federal Ministries of Families, Children and Social Development and Agriculture and Agri-Food to continue your work towards a comprehensive, cost-shared, universally accessible National School Food Policy and national school nutritious meal program with provinces, territories, municipalities, Indigenous partners and stakeholders.[5] Every investment in children and youth counts.

Sincerely,

Bernie MacLellan, Board Chair
Huron Perth Public Health

BM/ikl

[3] Hernandez, Kimberley & Engler-Stringer, Rachel & Kirk, Sara & Wittman, Hannah & McNicholl, Sasha. (2018). The case for a Canadian national school food program. Canadian Food Studies / La Revue canadienne des études sur l'alimentation. 5. 208-229. 10.15353/cfs-rcea.v5i3.260. https://canadianfoodstudies.uwaterloo.ca/index.php/cfs/article/view/260

[4] Coalition for Healthy School Food. Guiding Principles. 2022. https://www.healthyschoolfood.ca/guiding-principles

[5] Prime Minister Mandate Letters. 2021. https://pm.gc.ca/en/mandate-letters/2021/12/16/minister-families-children-and-social-development-mandate-letter and https://pm.gc.ca/en/mandate-letters/2021/12/16/minister-agriculture-and-agri-food-mandate-letter

cc. Honourable Michael Parsa, Minister of Children Community and Social Services; michael.parsaco@pc.ola.org
Honourable Stephen Lecce, Minister of Education; minister.edu@ontario.ca
Honourable Sylvia Jones, Minister of Health; sylvia.jones@ontario.ca
John Nater, MP Perth-Wellington; john.nater@parl.gc.ca
Ben Lobb, MP Huron-Bruce; ben.lobb@parl.gc.ca
Matthew Rae, MPP Perth-Wellington; matthew.rae@pc.ola.org
Honourable Thompson, MPP Huron-Bruce; lisa.thompson@pc.ola.org
Ontario Boards of Health (allhealthunits@lists.alphaweb.org)
alPHa (info@alphaweb.org)

Public Health
Santé publique
SUDBURY & DISTRICTS

May 16, 2022

VIA ELECTRONIC MAIL

The Honourable Doug Ford
Premier of Ontario
Legislative Building, Queen's Park
Toronto ON M7A 1A1

Dear Premier Ford:

Re: Bill 93, Joshua's Law (Lifejackets for Life), 2023

On behalf of the Board of Health for Public Health Sudbury & Districts, I am writing to convey the Board's support for Bill 93 Joshua's Law (Lifejackets for Life), 2023 which recently passed second reading.

The matter of boating safety and drowning prevention is of great interest to the Board of Health for Public Health Sudbury & Districts. On September 22, 2022, we advised your office of the Board's resolution to request the Government of Ontario to enact legislation requiring all individuals in a pleasure boat to wear a lifejacket or PFD.

Over the 10-year period from 2012 to 2021, 2147 Ontarians (65 Sudbury and districts) had emergency department visits that resulted from a drowning or submersion injury related to watercraft and, over the last 10 years of available death data (2009-2018), 198 Ontarians (8 Sudbury and districts) died of a drowning or submersion injury related to watercraft. The Board of Health is aware that of the nationally reported boating deaths from 2013 to 2017 for which data were available, 79% were not wearing a lifejacket or personal floatation device (PFD). Not wearing a lifejacket is the most common behavioural risk factor associated with boating drownings across the lifespan. In Canadian drowning deaths from 2013 to 2017 for which PFD data were available, 87% of 15–34-year-olds, 75% of 35–64-year-olds, and 80% of 65+ year olds were not wearing lifejackets. Not wearing lifejackets continues to be identified as the most common risk factor in drowning deaths beyond childhood.

Sudbury
1300 rue Paris Street
Sudbury ON P3E 3A3
t: 705.522.9200
f: 705.522.5182

Elm Place
10 rue Elm Street
Unit / Unité 130
Sudbury ON P3C 5N3
t: 705.522.9200
f: 705.677.9611

Sudbury East / Sudbury-Est
1 rue King Street
Box / Boîte 58
St.-Charles ON P0M 2W0
t: 705.222.9201
f: 705.867.0474

Espanola
800 rue Centre Street
Unit / Unité 100 C
Espanola ON P5E 1J3
t: 705.222.9202
f: 705.869.5583

Île Manitoulin Island
6163 Highway / Route 542
Box / Boîte 87
Mindemoya ON P0P 1S0
t: 705.370.9200
f: 705.377.5580

Chapleau
34 rue Birch Street
Box / Boîte 485
Chapleau ON P0M 1K0
t: 705.860.9200
f: 705.864.0820

toll-free / sans frais
1.866.522.9200

phsd.ca

Bill 93 is an important first step to saving lives. Public Health will continue to strongly advocate for the Government of Ontario to enact legislation requiring all individuals to wear a personal flotation device (PFD) or lifejacket while on a pleasure boat that is underway, or while being towed behind a pleasure boat using recreational water equipment.

Thank you for your attention on this important issue.

Sincerely,

René Lapierre
Chair, Board of Health

cc: Honourable C. Mulroney, Minister of Transportation
Honourable S. Jones, Minister of Health
Jamie West, Member of Provincial Parliament, Sudbury
France Gélinas, Member of Provincial Parliament, Nickel Belt
Michael Mantha, Member of Provincial Parliament, Algoma-Manitoulin
Viviane Lapointe, Member of Parliament, Sudbury
Marc Serré, Member of Parliament, Nickel Belt
Carol Hugues, Member of Parliament, Algoma-Manitoulin-Kapuskasing
Association of Local Public Health Agencies
All Ontario Boards of Health

Services de santé du TIMISKAMING Health Unit
Enhancing your health in so many ways.

Head Office:
247 Whitewood Avenue, Unit 43
PO Box 1090
New Liskeard, ON P0J 1P0
Tel.: 705-647-4305 Fax: 705-647-5779

Branch Offices:
Englehart Tel.: 705-544-2221 Fax: 705-544-8698
Kirkland Lake Tel.: 705-567-9355 Fax: 705-567-5476

www.timiskaminghu.com

May 8, 2023

The Honourable Doug Ford
Premier of Ontario
Legislative Building, Rm 281
Queens Park
Toronto, ON M7A 1A1
Sent via email: doug.fordco@pc.ola.org

The Honourable Michael Parsa
Minister of Children, Community and Social Services
438 University Ave, 7th Floor.
Toronto, ON M5G 2K8
Sent via email: michael.parsaco@pc.ola.org

The Honourable Sylvia Jones
Minister of Health/Deputy Premier
777 Bay Street, College Park, 5th Floor.
Toronto, ON M7A 2J3
Sent via email: sylvia.jones@pc.ola.org

Dear Premier Ford, Deputy Premier and Minister Jones, and Minister Parsa

Re: Addressing Household Food Insecurity in Ontario

On April 05, 2023, at a regular meeting of the Board of Health (Board) for the Timiskaming Health Unit, the Board recognized Household Food Insecurity (HFI) as an income-driven problem that requires income-based solutions.

Household food insecurity is a significant issue affecting our region, with 1 in 5 households in Timiskaming experiencing some form of food insecurity.[2] This vulnerability is closely linked to household income, and families with lower incomes are more likely to struggle with affording food, rent and other basic needs.[1]

The 2022 Monitoring Food Affordability findings show that a family of four in Timiskaming spends $1,152 monthly on food.[2] This family would need to allocate a significant portion of their income towards rent and food, with 50% and 41%, respectively. Consequently, they would have a meagre average of $228 left to cover other basic necessities such as childcare, transportation, utilities, and medication.[2] To afford the actual cost of living in Timiskaming, individuals would need to earn a living wage of $19.70, highlighting a discrepancy between the current minimum wage and the living wage.[3]

Accordingly, the Board endorsed the enclosed correspondence from the Ontario Dietitians in Public Health (ODPH) urging the Ontario government to adopt income-based solutions that effectively reduce HFI; these include the reinstatement of the basic income guarantee project, closing the gap between

Services de santé du TIMISKAMING Health Unit
Enhancing your health in so many ways.

Head Office:
247 Whitewood Avenue, Unit 43
PO Box 1090
New Liskeard, ON P0J 1P0
Tel.: 705-647-4305 Fax: 705-647-5779

Branch Offices:
Englehart Tel.: 705-544-2221 Fax: 705-544-8698
Kirkland Lake Tel.: 705-567-9355 Fax: 705-567-5476

www.timiskaminghu.com

the minimum wage and living wage, increasing social assistance rates and indexing them to match the true cost of living, and reducing income tax rates for lowest-income households. These policies effectively reduce household food insecurity, improve health outcomes, and reduce long-term healthcare costs.[1]

Our Board recognizes that the province of Ontario has the power to reduce food insecurity and extreme poverty for households receiving social assistance. We kindly request that you take into consideration the motion passed by our Board regarding this pressing issue.

We appreciate your attention to this significant matter.

Sincerely,

Stacy Wight
Board of Health Chair

cc John Vanthof, MPP – Timiskaming-Cochrane
Anthony Rota, MP – Timiskaming-Nipissing
Charlie Angus, MP –Timmins-James Bay
Association of Local Public Health Agencies (alPHa)
Association of Municipalities of Ontario (AMO)
Federation of Canadian Municipalities (FCM)
Ontario Public Health Association (OPHA)
Ontario Dietitians in Public Health (ODPH)
Ontario Boards of Health
Health Unit Member Municipalities

References

1. Tarasuk V, Li T, Fafard St-Germain AA. (2022) Household food insecurity in Canada, 2021. Toronto: Research to identify policy options to reduce food insecurity (PROOF). Retrieved from https://proof.utoronto.ca/
2. Timiskaming Health Unit. (2023) The Cost of Eating Well in Timiskaming – Monitoring Food Affordability Report, 2022. Retrieved from https://bit.ly/3ZTGh7f
3. Coleman, A., Shaban, R. (2022). Calculating Ontario's Living Wages. Ontario Living Wage Network.

Services de santé du TIMISKAMING Health Unit
Enhancing your health in so many ways.

Head Office:
247 Whitewood Avenue, Unit 43
PO Box 1090
New Liskeard, ON P0J 1P0
Tel.: 705-647-4305 Fax: 705-647-5779

Branch Offices:
Englehart Tel.: 705-544-2221 Fax: 705-544-8698
Kirkland Lake Tel.: 705-567-9355 Fax: 705-567-5476

www.timiskaminghu.com

Board of Health MOTION #21R-2023 – April 05, 2023

Moved by: Curtis Arthur *Seconded by*: Mark Wilson

WHEREAS, *it is a requirement under the Ontario Public Health Standards for public health units to monitor food affordability, assess and report on the health of local populations, and describe the existence and impact of health disparities; AND*

WHEREAS, *food insecurity is widely known to have adverse effects on both physical and mental health; AND adequate income is a crucial social determinant of health that significantly affects food security; AND*

WHEREAS, *67% of households in Ontario with social assistance as their primary income source experience food insecurity; AND*

WHEREAS, *the 2022 Monitoring food affordability results demonstrate that households relying on social assistance do not have enough money to cover their living expenses, including food; AND*

FURTHERMORE, BE IT RESOLVED, *that the Board of Health for the Timiskaming Health Unit (Board) continues to increase awareness of, and work to reduce, health inequities, including those related to food insecurity; AND*

FURTHERMORE, BE IT RESOLVED, *that the Board endorses the Ontario Dietitians in Public Health (ODPH) call for the provincial government to take swift and immediate action in implementing income-based policy interventions for all in Ontario, aged 18–64 years as an effective and long-term response to household food insecurity; AND*

FURTHERMORE, BE IT RESOLVED, *that the Board calls on the Province of Ontario to increase social assistance rates to reflect the true costs of living, and to index Ontario Works rates to inflation moving forward; AND*

FURTHERMORE, BE IT RESOLVED, *that the Board urges the Province to resume exploring the feasibility of creating a guaranteed living wage (basic income) in the Province of Ontario; AND*

FURTHERMORE, BE IT RESOLVED, *That the Board of Health provide correspondence of these resolutions to John Vanthof, MPP (Timiskaming-Cochrane), Anthony Rota, MP (Timiskaming-Nipissing), Charlie Angus, MP (Timmins-James Bay), Association of Local Public Health Agencies (alPHa), Association of Municipalities of Ontario (AMO), Federation of Canadian Municipalities (FCM), Ontario Public Health Association (OPHA), Ontario Dietitians in Public Health (ODPH), Ontario Boards of Health , and Health Unit Member Municipalities.*

CARRIED

Municipality of Chatham-Kent
Public Health
PO Box 1136, 435 Grand Avenue West
Chatham, ON N7M 5L8
Tel: 519.352.7270 Fax: 519.352.2166

April 25, 2023

The Honourable Doug Ford
Premier of Ontario
Delivered via email: premier@ontario.ca

The Honourable Sylvia Jones
Deputy Premier
Minister of Health
Delivered via email: sylvia.jones@pc.ola.org

Dear Premier Ford and Deputy Premier and Minister Jones:

RE: Universal, No-cost Coverage for all Prescription Contraceptive Options to all People Living in Ontario

At its meeting held on March 15, 2023, the Chatham-Kent Board of Health passed the following motion:

> "That Administration prepare a letter of advocacy to the Provincial government encouraging them to cover the cost of birth control for all Ontario residents, and that this letter be copied to alPHa and any other appropriate partners."

It is estimated that 30-40% of all pregnancies in Canada are unintended with those of lower socioeconomic status being one of the leading vulnerable groups impacted[1]. Timely access to effective contraception directly influences the rate of unintended pregnancies. In Canada, cost is the leading barrier preventing individuals from gaining access to effective contraceptives[2/3]. Cost should not be a barrier Ontarians face to obtain consistent and timely access to effective contraceptives.

OHIP+ has begun to address this issue in Ontario by providing no cost coverage for anyone under the age of 25 who is not covered by a private plan. This coverage needs to be expanded to all Ontarians without the restrictions put on those with private plans or those over the age of 24. Ontarians should have universal, no-cost, confidential access to effective contraceptives.

At the beginning of April, British Columbia started the journey of providing prescription contraceptive access equality for their province and we are advocating for Ontario in this journey.

…/2

Thank you for your attention to this important issue. We stand firmly in support of protecting and advancing sexual and reproductive health rights.

Sincerely,

Original signed by

Brock McGregor
Chair, Chatham-Kent Board of Health

Copy to:
Hon. Monte McNaughton, MPP, Lambton-Kent-Middlesex, Minister of Labour, Training and Skills Development
Trevor Jones, MPP, Chatham-Kent-Leamington
Loretta Ryan, Executive Director, Association of Local Public Health Agencies (alPHa)
Ontario Public Health Units

1 Nethery E, Schummers L, Maginley S, Dunn S and Norman W. “Household income and contraceptive methods among female youth:a cross sectional study using the Canadian Community Health Survey (2009-2010 And 2013-2014)”. CMAJ Open, vol. 7, no. 4, 2019 Retrieved from www.cmajopen.ca/content/7/4/E646
2 Hulme Jennifer, et al. “Barriers and Facilitators to Family Planning Access in Canada.” Healthcare Policy, Politiques De Sante, vol 10, no.3, 2015, pp. 48-63., doi:10.12927/hcpol.2015.24169
3 Black, Amanda Y., et al. “The Cost of Unintended Pregnancies in Canada: Estimating Direct Cost, Role of Imperfect Adherence, and the Potential Impact of Increased Use of Long-Acting Reversible Contraceptives.” Journal of Obstetrics and Gynaecology Canada, vol. 37, no. 12, 2015.pp. pp. 1086-1097., doi:101016/s1701-2163(16)30074-3.

Peterborough Public Health

Jackson Square, **185 King Street**, Peterborough, ON K9J 2R8
P: **705-743-1000** or 1-877-743-0101
F: 705-743-2897
peterboroughpublichealth.ca

May 19, 2023

The Honourable Sylvia Jones
Deputy Premier of Ontario
Minister of Health
sylvia.jones@ontario.ca

Re: Peterborough Public Health 2024 Budget

Dear Minister Jones:

The PPH Board of Health (BOH) recently met with our Members of Provincial Parliament and representatives from the City of Peterborough, the County of Peterborough, Curve Lake First Nation, and Hiawatha First Nation to discuss our shared concerns surrounding the financial challenges facing public health.

We recognize that it is still early in the budget process, and that the 2023 provincial budget implementation is still progressing. However, because of the breadth of uncertainties and financial risks facing public health in our region, we wanted the opportunity to discuss our current and forthcoming challenges. We are grateful for the engagement of MPPs Piccini, Scott and Smith, and appreciate their thoughtful reflections and willingness to follow up on concerns from local funders.

The BOH is proud to work with provincial and local funding partners to deliver public health services to our region. The provincial role in public health funding has been essential throughout the COVID-19 pandemic, and we are appreciative of the support we have received from your Government through one-time extraordinary funding to ensure the most effective response possible.

From previous communication from PPH, and other local public health agencies, you will likely be aware that there are longstanding challenges with the sustainability of public health funding in Ontario. PPH has worked to maximize efficiencies in operations, and for years now has seen funding agreements fall short of inflationary increases. We have now reached a point where we cannot continue to deliver critical public health services with the funding we receive.

There are three significant financial concerns facing public health in 2024:

1. PPH, like other sectors, must account for cost increasing at an average rate of 2-3% per year just to maintain the same level of programming. In 2023, the approved PPH cost-shared budget increased by 1.94%, as we continue to be careful stewards of public funds, while maintaining needed services. Yet provincial funding increases have not kept pace. Will your government ensure adequate continued base funding increases to, at minimum, maintain existing service levels?

2. COVID-19 funding has been extended for 2023; however, we are uncertain whether this will continue beyond the current year. This uncertainty undermines our ability to retain the human health resources required to maintain a proportionate response to the ongoing threat of COVID-19. It also further erodes our ability to ensure readiness for future threats to population health, as has been prioritized

by Ontario's Chief Medical Officer of Health in his 2022 Annual Report. Will your government continue to ensure PPH is funded at a level to adequately maintain a proportionate COVID-19 contact tracing and vaccination response, and ensure readiness for future threats to population health?

3. The Province of Ontario moved from a 75/25 to a 70/30 funding split; however, mitigation funding has delayed this download to municipalities. Will your government reverse the decision to move to a 70/30 funding split and maintain that additional contribution to public health? If not, will you consider supporting phasing this in over multiple years to ensure that this download can be effectively managed by local funders?

We continue to value our partnership with the Province of Ontario on advancing public health issues in this community. The COVID-19 pandemic and the aforementioned Ontario CMOH 2022 Annual Report have highlighted the need to ensure the stability of public health funding for continued response to COVID-19 and future health threats, which may be just around the corner. The work of public health extends further to improving the health and prosperity of our community.

In the City, County, Curve Lake First Nation and Hiawatha First Nation, further loss of public health programs will mean that businesses cannot operate safely, people cannot access important public health services, and health and economic development throughout our region will suffer. Without addressing these acute funding issues our community may experience:

- Diminished capacity to respond to and manage disease outbreaks in Long-Term Care, risking the lives of elderly and medically fragile residents;
- Negative economic consequences for over 1,500 local businesses and significant risks to public safety as food premises and small drinking water systems are left uninspected or face delayed openings;
- Reduced ability to vaccinate school-aged children against infectious diseases and screen for urgent oral health issues, undermining lifelong health and opportunities for future employment.

The pandemic has taught us that healthy communities and economies cannot exist without healthy people. With all that we have learned over the past three years, we seek your support and investment to ensure a strengthened and resilient public health system without creating undue strain on local funders.

We look forward to hearing from you.

Miigwech,

Original signed by

Councillor Kathryn Wilson
Chair, Board of Health

/ag

cc: The Hon. Doug Ford, Premier of Ontario
Local Councils
Local MPPs
The Association of Local Public Health Agencies
Ontario Boards of Health

INFORMATION REPORT

TO:	Mayor and Members Public Health Committee
COMMITTEE DATE:	June 12, 2023
SUBJECT/REPORT NO:	Collective Impact: Healthy and Safe Communities and the Greater Hamilton Health Network 2023 Update (BOH23020) (City Wide)
WARD(S) AFFECTED:	City Wide
PREPARED BY:	Erin Walters (905) 546-2424 Ext. 6793
SUBMITTED BY: **SIGNATURE:**	Dr. Elizabeth Richardson, MD, MHSc, FRCPC Medical Officer of Health Public Health Services

COUNCIL DIRECTION

Not Applicable.

INFORMATION

In follow up to the August 19, 2019 Board of Health Report BOH19020(a), regarding the Ontario Health Team Update, the purpose of this Information Report and presentation is to provide an update on the collaborative work between the City, as the Healthy and Safe Communities Department (HSC), and the Greater Hamilton Health Network (GHHN). This update includes an overview of the development of the GHHN as Hamilton's Ontario Health Team (OHT), examples of early collective outcomes this partnership has achieved to-date, and highlights the importance of continued collaboration. This update will be provided to the Public Health Committee on an annual basis.

Development of Ontario Health Teams

In 2018, the Ontario government created a new vision for health care delivery in the province. The goal was to create a more integrated system that is centred around

patients, caregivers and providers.[1] On a local level, this meant developing teams of health care and social service providers known as OHTs. The idea is that local providers, irrespective of the care they provide or where they provide care, work as one coordinated health team and deliver a full continuum of care to the populations they serve.[1] The approach is designed to enhance partnerships between local health care providers to deliver high-quality, coordinated care for their patients, while also supporting providers to be more responsive to the diverse health needs of the communities that they serve.[1]

Development of the Greater Hamilton Health Network

In 2019, in response to Ontario Health's call to develop OHTs, a group of over 20 health care and social service providers from across Hamilton came together to complete the self-assessment and application process. A steering committee, which included representation from HSC and Corporate Services, co-designed a strategy and plan to implement the OHT model at the local level. This plan was approved by the Ministry of Health in late 2019, making the GHHN one of the first OHTs in Ontario (BOH19020(a)). Although the original application focused on service provision in Hamilton, in 2021 the Ministry of Health advised the Hamilton OHT to integrate with the Haldimand OHT. With this, the network rebranded from the Hamilton Health Team to the Greater Hamilton Health Network, to reflect their new geographic scope which includes Hamilton, Haldimand, and Niagara North West. The Ministry of Health has defined OHT expectations for each stage of growth related to issues addressing patient experience, patient partnership, community engagement, population health outcomes, performance measurement, governance, and fiscal responsibilities.[1]

The GHHN continues to evolve and expand to incorporate new members. Currently, member representation includes over 40 local health and social service organizations that span the continuum of care and are responsible for contributing their unique expertise to guide the overall direction of the GHHN. The GHHN governance structure, including a list of the GHHN's current partners, supporters, and collaborators, are included in Appendix "A" to Report BOH23020. Effective collaboration acknowledges that each member organization brings a different set of assets to the network and has a specific role in improving the health of the community.

Within the network, the GHHN plays a service system manager role. In this role, the goal is that the GHHN will lead the coordination of local planning and operation of health care services. At maturity, the GHHN will be accountable for achieving the outcomes

[1] Ministry of Health and Long-Term Care. (2019). Ontario health teams: Guidance for health care providers and organizations. https://health.gov.on.ca/en/pro/programs/connectedcare/oht/docs/guidance_doc_en.pdf

put forward by Ontario Health and will play a role in allocating funding based on local needs.

The HSC General Manager and the Medical Officer of Health are members of the GHHN's Board of Directors. As Board members, they have contributed their expertise by informing the overall direction of the network, including the development of a governance strategy that resulted in the GHHN becoming the first incorporated not-for-profit OHT in the province. In late 2022, the Ministry of Health announced this model as the gold standard model all OHTs should adopt.

Greater Hamilton Health Network's Strategic Priorities

The GHHN's collective vision for Hamilton, Haldimand, and Niagara North West is to work towards healthier communities and provide an equitable and seamless continuum of care that actively improves population health and meets the individual needs of our community.

The GHHN's Strategic Plan identifies five focus areas that are a blend of both local and provincial priorities; they include: integrated population health, governance, primary care leadership and engagement, COVID-19 response and recovery, and patient navigation/digital care. These focus areas are influenced by three overarching principles: equitable healthcare approaches, environmentally sustainable healthcare, and patient and community engagement. The GHHN delivers these focus areas through specialized working groups. Staff from across HSC divisions participate in these working groups. Representation is based on alignment with a division and/or program mandate, and where their expertise is most valued in supporting the GHHN's priorities. More information on HSC's involvement in various GHHN tables and working groups can be found in Appendix "B" to Report BOH23020.

The GHHN and HSC are committed to advancing health equity. Both partner organizations understand the importance of addressing the unique needs of vulnerable populations facing the highest barriers to health in order to improve the health of the entire community. As one of the GHHN's three overarching principles, the network has created a Health Equity Council. Through this Council, the GHHN's Health Equity Framework was developed to advance the equitable health agenda community-wide. This framework identifies 24 actions items that are based on anti-oppressive and anti-racist principles. GHHN's full Health Equity Framework is included in Appendix "C" to Report BOH23020.

Healthy and Safe Communities within the Greater Hamilton Health Network

Municipalities, often in partnership with community organizations, play a critical role in supporting health in communities by providing essential services such as social and community programming, supportive housing, community outreach and engagement,

and substance and addictions support services. As such, HSC staff and leaders have played an important role in supporting the GHHN in achieving their vision. Contributions range from informing GHHN's strategic direction, sharing population health data and intelligence, coordinating relevant City service partners and participating in collective impact activities to achieve shared goals. A key component of health system transformation is transitioning from individual level care to one that emphases a population health approach, impacting the entire community through population-based policies and interventions. This approach moves beyond individual factors that impact health to explore the social factors that have the greater potential to influence the health of the community, such as income, education and race. It also uses a more comprehensive understanding of health, incorporating physical, mental and social wellbeing as well as quality of life.[2] In order to achieve this, it requires integrating all aspects of the healthcare spectrum, from health promotion, prevention and protection to diagnosis and treatment, over the lifespan.[3]

Through population health assessment, PHS plays a key role in identifying and monitoring community health needs. Assessing population health produces important information about emerging health issues, health inequities and priority populations that informs planning and decision-making (Report BOH23002). In order to address the health issues and inequities identified, this information needs to be shared broadly with the community to influence and inform planning and delivery of local services.[2] Locally, PHS is responsible for sharing this information within internal and external stakeholders, including the GHHN and their members. This data will guide the network's strategic planning and support their collective action. This process ensures resources are spent in a way that will have a greatest return on investment and positive impact in our community.

Update for the Transfer of the Physician Recruitment and Retention Program to the GHHN

With the development of OHTs, there are responsibilities that once rested with HSC that now fall within the GHHN's new mandate. Given the GHHN's service system manager role, most health system-wide planning and coordination now sits under the GHHN's mandate. On August 12, 2022 Hamilton's City Council approved the transfer of the

---

[2] Ministry of Health (2021). Ontario Public Health Standards: Requirements for Programs, Services, and Accountability (Standards). https://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/docs/protocols_guidelines/Ontario_Public_Health_Standards_2021.pdf

[3] Ministry of Health and Long-Term Care. (2018). Population Health Assessment and Surveillance Protocol. https://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/docs/protocols_guidelines/Population_Health_Assessment_Surveillance_2018_en.pdf

Physician Recruitment and Retention program to the Greater Hamilton Health Network (GHHN) (Physician Recruitment and Retention Steering Committee Report 23-001). The move of the program to the GHHN is designed to address some of the challenges with the program structure by increasing clarity on accountability and operational oversight, reducing operational and reporting inefficiencies, and stabilizing funding agreements and staffing structure.

In the "Summary Report Regarding Proposal to Transfer Program into the Greater Hamilton Health Network" (attached as Appendix "D" to Report BOH23020) the Ad-Hoc Working Group reported on various components of the transfer and the following is an update regarding those components:

1. **Transfer of Funds Currently Held by the City of Hamilton to the GHHN:**
   The funds held by the City of Hamilton have not been transferred yet; however, the parties are very close to finalizing the Funding Agreement. In current state, the GHHN is working closely with St. Joseph's Healthcare Hamilton ("St. Joe's") who will be holding onto the funds on behalf of the GHHN. The funding agreement is being amended to take into consideration this model and to ensure proper insurance is in place. With regards to the annual funding contributions from other community partners, the program continues to work with partners on their yearly funding agreements.

2. **Transfer of Physician Retention and Recruitment Staff to GHHN:**
   St. Joe's has hired the Director for the Physician Recruitment and Retention and will be doing all the payroll administration and expense reimbursement until further notice. The base role of the Director of Physician Recruitment is with St. Joseph's Healthcare Hamilton. The Director is seconded to the GHHN and reports directly to the GHHN Executive Director. St. Joseph's Healthcare Hamilton provides back office support for human resources and finance.

3. **Co-Location Agreement with McMaster's Department of Family Medicine:**
   Staff currently have office space at the David Braley Health Sciences Centre, which is provided as an in-kind contribution from the McMaster University Department of Family Medicine, under a co-location agreement that extends to December 31, 2023. A new co-location agreement has been finalized between the GHHN and the McMaster University Department Family of Medicine effective March 1, 2023 to December 31, 2023.

4. **Transfer of Hamilton Physicians Property:**
   Property purchased by the Physician Recruitment and Retention Program, including office equipment, supplies, and furniture have been transferred to the

GHHN, effective March 1, 2023.

5. **Key Performance Indicators:**
   Key performance indicators will be reported to the Executive Council of the GHHN on an annual basis. In August 2022, Physician Recruitment and Retention Metrics for 2021-2022 were reported (Physician Recruitment and Retention Steering Committee Report 22-008). Moving forward the Physician Recruitment and Retention Program will report on key performance indicators annually through this report to the Public Health Committee.

Examples of Collective Impact

The GHHN is working to achieve outcomes that are aligned with the Quadruple Aim framework. In this framework, the GHHN has prioritized patient experience, provider experience, value and population health outcomes.[4] Key examples highlighting how the GHHN is beginning to achieve these outcomes are:

1. **Better Patient Experience**
   When it comes to improving the clinical experience for our local population, the GHHN's long term goal is to ensure that patients have easy access to the supports they need, when and where they need them.[3] This includes receiving wrap-around care where all members of the patient's care team are engaged, informed and working together to address the patient's concerns. A considerable amount of change is needed to achieve this goal for the entire local population, however the GHHN has had success with certain priority populations. For example, in 2021 the GHHN coordinated the Women's Health Drop-In Day clinics to better support women who are homeless. These clinics coordinate multiple local health care and social service partners to co-locate together and create a "one-stop shopping" experience for women seeking support, reducing access and navigation barriers in a more seamless way. HSC contributes to these clinics by offering a variety of supports to patients including COVID-19 and flu vaccinations, sexually transmitted infection (STI) testing and education, naloxone training and kits, housing supports, food, clothing, and social activities. To date, these clinics have been held once a quarter at different shelter locations and have served 480 homeless and precariously housed women across Hamilton. Notably, in 2022, this service delivery model was recognized for excellence and positive community impact by winning a top award at the International

[4] Premier's Council on Improving Healthcare and Ending Hallway Medicine. (June 2019). A healthy Ontario: Building a sustainable health care system. https://files.ontario.ca/moh-healthy-ontario-building-sustainable-health-care-en-2019-06-25.pdf

Conference of Integrated Care in Denmark.

2. **Better Provider Experience**
   When it comes to improving the experience for health care and social service providers, the GHHN is beginning to advance work that makes it easier for providers to support their clients.[3] For example, the GHHN's Digital Health Strategy creates patient-facing digital tools to enhance patient experience and reduce barriers to accessing care as well as offering tools to connect providers from different sectors. This includes initiatives to link hospital medical record systems and integrating an electronic referral platform. As this technology continues to expand, it will help providers make referrals to HSC programs and services more easily and allow HSC staff to be more active inpatient care teams. To date, the GHHN has supported 16 digital health initiatives spanning acute and community care, supported by an engaged and diverse Digital Health Working Group and a $2M digital funding grant received in 2022. As the Digital Health Strategy continues to be implemented, digital systems will continue to be more connected, resulting in efficiencies and system improvements for service providers.

3. **Better Value**
   When it comes to reducing healthcare spending, the GHHN contributes to reducing health care costs per capita, while maintaining the quality of care and patient experience.[3] To achieve this, the GHHN is working to provide more coordinated care to clients, especially those with complex health and social needs who require large care teams. When health care and social service providers work together in a more integrated way, it reduces redundancies in care and connects clients directly with the most appropriate service provider of the care team. For example, the GHHN has implemented a Let's Go Home Program (LEGHO) that connects priority populations to bundled community services to reduce hospital admissions. This program works with patients that frequently access hospital emergency departments and may benefit from ongoing, personalized, patient centred and community-based care. Patients are connected to community programs and services, including those offered through HSC, such as housing supports, income supports, recreation services and a variety of public health services.

4. **Population Health Outcomes**
   During the COVID-19 pandemic response, Public Health Services led collaborative planning efforts through the Hamilton COVID-19 Response Table (HCRT) and the Vaccine Readiness Network. GHHN leadership and membership was involved in these planning tables. The HCRT was established to plan and execute a collaborative, multi-sectoral response to COVID-19 including

monitoring and surveillance, assessment and testing, infection control practices, capacity planning, and vaccination. Meanwhile, the Vaccine Readiness Network was responsible for addressing equitable access to both vaccine information and appointments. Applying a population health approach, Public Health Services provided ongoing population health data and insights that informed the planning and decision-making of these two networks.[5] This information helped to identify priority populations who were disproportionately impacted by COVID-19 and the populations who were underrepresented during vaccine roll out. Additionally, this information was used by the GHHN, including primary care providers and long-term care homes, to develop focused strategies to best support priority populations and reduce barriers when accessing care for COVID-19.

Next Steps

This Information Report highlights several key examples of the collective impact between the GHHN and HSC. As the GHHN continues to evolve, strengthen and expand their partnerships and take on further responsibilities, this collective impact will continue to grow. The need for a collaborative and efficient health care system has never been greater as our region is facing immense pressure to address the growing health care shortages and waitlists; it is critical that cross sectoral approaches are applied to manage complex health and social issues within our community. Currently, complex local issues and demands are placing significant pressure on our health and social services system. This includes approximately 55,000 residents without a primary care provider, growing wait lists for mental health and substance use supports, and the need for integrated supportive housing environments. The GHHN and HSC will continue to prioritize as these demands increase while remaining nimble enough to respond to ongoing system and community pressures and work to improve the OHT model. Rather than function as individual organizations, it is important that the GHHN and HSC continue to work together to improve the health of the community by leading local health system transformation, resulting in a healthier community for everyone.

APPENDICES AND SCHEDULES ATTACHED

Appendix “A” to Report BOH23020	Greater Hamilton Health Network Governance Structure and Current Membership

[5] Covid-19 data. City of Hamilton. https://www.hamilton.ca/people-programs/public-health/diseases-conditions/coronavirus-covid/covid-19-data#social-determinants

Appendix “B” to Report BOH23020	Greater Hamilton Health Network Tables and Working Groups; HSC Participation by Division
Appendix “C” to Report BOH23020	Greater Hamilton Health Network Health Equity Report
Appendix “D” to Report BOH23020	Summary Report Regarding Proposal to Transfer Program into the Greater Hamilton Health Network

Appendix "A" to Report BOH23020 – Greater Hamilton Health Network Governance Structure and Current Membership

The Ministry of Health has directed Ontario Health Teams to determine the governance model that works best for them and the communities they serve, and that the structure must incorporate patients and their families/caregivers. The selected governance model must be capable of coordinating care delivery for patients, supporting the achievement of performance targets, and enabling the achievement of accountability objectives.

The Greater Hamilton Health Network (GHHN) governance structure is comprised of an 18-seat Board of Directors. Of these seats, 15 are nominated based on the sector they serve, or through their participation on a GHHN stakeholder council. The 3 remaining seats are filled by independent directors based on the required skills and competencies of the board. A comprehensive breakdown of the seat allocation can be found below.

Board Seats	Number of Seats
Primary Care Council *	2
Patient Family and Care Partner Leadership Council *	2
Health Equity Council *	1
Haldimand Council *	1
Home Care Sector	1
Hospital Sector	2
Community Organization (General)	1
Community Organization (Mental Health and Addictions)	1
Congregate Setting/ Long-Term Care Home	1
City of Hamilton – Municipality	1
Indigenous Sector	1
Francophone Sector	1
Independent Seats	3

* Nominated based on GHHN stakeholder council participation

For the City of Hamilton, Angela Burden, the General Manager of Healthy & Safe Communities, and Dr. Elizabeth Richardson, the Medical Officer of Health, both are directors on the GHHN's Board. Angela Burden holds the City of Hamilton – Municipality seat and Dr. Elizabeth Richardson holds one of the independent seats.

In addition to the board, the GHHN has incorporated an extensive list of partners that span the health and social service sector into their secretariats and working groups. These partners, along with patients and their families, collectively work to co-design a local health care system. The list of partners is always expanding and evolving. The current list of partners includes:

Alternatives for Youth	Hamilton Family Health Team
Alzheimer Society of Brant, Haldimand Norfolk, Hamilton Halton	Hamilton Health Sciences
Beamsville Family Health Team	Hamilton Trans Health Coalition
Birthmark	HamSmart
Bob Kemp Hospice	Indwell
Body Brave	Keeping Six
Canadian Mental Health Association – Hamilton	Lynwood Charlton Centre
Catholic Children's Aid Society	McMaster Family Health Team
Centre de Sante Communautaire	McMaster Research Shop
Children's Aid Society	McMaster University (School of Nursing)
City of Hamilton	Mission Services
Community Addiction and Mental Health Services – Haldimand	Refuge
Compass Community Health Centre	Shelter Health Network
De Dwa Da Dehs Nye>s Aboriginal Health Centre	Smithville Family Health Team
Department of Family Medicine, McMaster University	St. Elizabeth's Health Care
Edgewater Gardens	St. Joseph's Health Care Hamilton
Good Shepherd Centres	Thrive Group
Haldimand County	Urban Core Community Health Centre
Haldimand Family Health Team	Wayside House of Hamilton
Haldimand Norfolk Public Health	Wesley Urban Ministries
Haldimand War Memorial Hospital	West Haldimand Hospital
Hamilton Community Foundation	YWCA

Appendix "B" to Report BOH23020 – Greater Hamilton Health Network (GHHN) Working Groups and Healthy & Safe Communities (HSC): Participation by Division

	Priority	**GHHN Working Group** *(not a comprehensive list)*	**HSC Participation by Division**
Overarching Principles	Environmental Sustainability in Healthcare	Environmental Sustainability Advisory Committee	Not applicable
	Equitable Healthcare Approaches	Health Equity Council Equity Data Working Group Subcommittee for Health Equity Council Action Plan	Public Health Services
	Patient/Community Engagement	Engagement Community of Practice	Not applicable
Strategic Priorities	Integrated Population Health	Mental Health and Addictions Secretariat Safe Supply and Harm Reduction Working Group Women's Homelessness Working Group Women's Health Drop-in Days Planning Committee Hospital Shelter Working Group Long-Term Care Advisory Committee Residential Care Facility Steering Committee Residential Care Facility Pilot Homes Committee Medical Assistance in Dying Steering Committee	Public Health Services Paramedic Services Housing Services Lodges Division
	Digital Health	Digital Health Secretariat Primary Care Digital Caucus	Paramedic Services Corporate
	Primary Care	Primary Care Stakeholder Council	Public Health Services

	Governance	Board	General Manager's Office Public Health Services
	Haldimand	Haldimand Stakeholder Council	Not Applicable


GHHN
Health
Equity
REPORT
Greater Hamilton Health Network
Building community health together.
| WWW.GREATERHAMILTONHEALTHNETWORK.CA |

Greater Hamilton Health Network's Health Equity Framework:

An anti-oppression, anti-racism, sex/gender based, intersectional approach.

Final Report submitted to

GHHN Executive Council

June 24, 2021

Submitted by:
Adrianna Tetley
Special Advisor to the GHHN EDI ARAO Steering Committee
at@adriannatetley.ca

Land Acknowledgement

The work of the Greater Hamilton Health Network and its Partnership Council members takes place on traditional territories of the Erie, Neutral, Huron-Wendat, Haudenosaunee and Mississaugas. Indigenous people who have lived here since time immemorial and have deep connections to these lands.

This land is covered by the Dish With One Spoon Wampum Belt Covenant, which was an agreement between the Haudenosaunee and Anishinaabek to share and care for the resources around the Great Lakes. We further acknowledge that this land is covered by the Between the Lakes Purchase, 1792, between the Crown and the Mississauga of the Credit First Nation.

Hamilton continues to be home to vibrant, diverse Indigenous communities who have distinct and specific histories and needs, as well as a constitutionally protected treaty. Greater Hamilton Health Network is located next to Six Nations of the Grand River but most Indigenous peoples in the GHHN catchment area live in urban Hamilton. We honour this diversity and respect the knowledge, leadership and governance frameworks within Indigenous communities.

We are grateful for the opportunity to live, meet and work on this territory.

Table of Contents

Letter from the GHHN EDI ARAO Steering Committee to the GHHN Executive Council

Dear Executive Council members

Over the past five months, the GHHN EDI ARAO Steering Committee has taken its role and responsibilities seriously and know that much of what we have undertaken is just a small step in the journey towards transforming Ontario's health care services.

We understood our responsibility to ensure we engaged the communities who have experienced barriers to accessing health care services that are rooted in systemic and structural discrimination, racism, and oppression. The responsibility of righting the wrongs of current practices is not a one-report process but rather a sustained need to build a health equity approach that conveys collaboration and integrity to the communities we serve.

We are honoured that the communities who we engaged were open and provided valuable insight into ways they have experienced being excluded, harmed, or marginalized within the health care and broader community services. We made a commitment to ensure the integrity and value of their voices would be heard. We feel an accountability to the communities.

As a Steering Committee, we shared our knowledge, expertise, and evidence, informed by our community engagements. We had brave conversations and moved the imperative from equity, diversity and inclusion to anti-racism, anti-oppression, sex/gender discrimination and the need to address imbalances and systemic barriers.

We are firmly committed to the population health approach with a focus on populations that face the most significant barriers to health. We believe that this commitment is critical to achieving equitable health outcomes for all.

For the GHHN EDI ARAO Steering Committee and the voices of the communities we spoke with, racism, sex / gender-based discrimination, oppression and systemic discrimination does affect individual and population health outcomes. We heard, that to move forward, health care must understand its own historical and current practices that have harmed communities including Indigenous, Francophone, Black, Two Spirit and LGBTQIA+, people who use drugs, people living with disabilities, precariously housed, and so on. To address these inequities and harms, the work forward needs to be collaborative, sustained and co-designed by the communities most impacted.

For us, this report and the supplementary report have a heart – it beats – it is living, and it is real. It is our hopes and our aspirations. While the challenges are big, we are energized by the vision and its commitments.

While the report is not perfect, we believe it provides a vital "first draft" road map to ensure all people are provided the rights under the Canada Health Care Act and that discrimination based on the grounds within the Canadian and Ontario Human Rights are upheld. We believe that, when the recommendations are implemented that it will be significant first steps towards transformational change.

We wanted also to take this moment to acknowledge the new posting for Manager – Strategic Initiatives and Health Equity- as a significant demonstration of the GHHN's commitment to continue to do this important health equity work.

Never have the inequities in our society been more in the forefront as in the past few months – with the unmarked graves in Kamloops Residential School, the deliberate murders of a Muslim family, the opioid catastrophe facing us each day and the inequities experienced during COVID. While the challenges in our society are big, it our collective responsibility to do our part by taking action in addressing the inequities in our health care system.

We are committed to continuing to work with you to implement these recommendations and to champion this vision and commitment with the GHHN partners, members, and the communities we collectively serve.

Sincerely

GHHN EDI ARAO Steering Committee:

Clare Freeman - Dr. Bob Kemp Hospice
Comfort Afari - Hamilton Black Community Leaders Forum, Chair
Connie McKnight - De Dwa Da Dehs Nye>s
Haider Saeed (MD) - Hamilton Family Health Team, member of the HFHT EDI Work
Kyle Weitz - Compass CHC
Laura Cattari - Hamilton Roundtable for Poverty Reduction
Lisa Jeffs – Youth Wellness Centre, St. Joseph's Health Care
Medora Uppal – YWCA Hamilton
Nhlaloenhle (Nala) Ndwana - Hamilton Urban Core CHC
Nora Melara-Lopez - Compass CHC, Co-Chair, Racial Justice, Diversity and Inclusion Committee
Sunjay Sharma, MD – Hamilton Health Sciences, Co-Chair, President's Task Force on EDI
Tara Galitz – Centre de Santé Communautaire Hamilton Niagara
Tim McClemont - The AIDS Network, Executive Director

<u>Liaisons with GHHN Executive Council</u>
Bernice King, Patient Advisor
Melissa Farrell, St Joseph's Health Care

Executive Summary

In the fall of 2020, the Greater Hamilton Health Network started the important work of implementing their values of diversity and equity within its vision to provide an equitable and seamless continuum of care that actively improves population health while meeting the individual needs of the community.

As part of this work the GHHN recognized and identified that they needed to engage the voices of communities who face systemic discrimination or marginalization to understand how this impacts barriers to access to universal and accessible health care guaranteed to all people in Canada under Canada's Health Care Act. One of the first steps the Council took was to establish an Equity, Diversity, and Inclusion (EDI) advisory committee whose role was to review and provide insight into the following:

1. the governance and corporate culture of the Greater Hamilton Health Network;
2. delivering care to patients from a lens of health equity; and
3. the operations of the Greater Hamilton Health Network (staff level).

The 14-member EDI ARAO Steering Committee, like the GHHN itself, understands the privilege and responsibilities it has to the communities they serve and engaged. The process for selecting community members was done through an open call for interested community members and health system leaders to apply for a position. Members were selected based on a matrix of diverse identities and networks within communities who have experienced barriers as well as expertise in EDI governance or implementation of EDI. In addition, two members of the Executive Council and the GHHN staff were part of the work. This report is the culmination of five months of consultations, reviews of reports, population-specific focus groups including Indigenous, Francophone, racialized with a focus on the Black community, immigrants and refugees, Two Spirit and LGBTQIA+, cis gender female, people who use drugs, and rural communities. Discussions were also held with the Executive Council, and regular meetings with the GHHN EDI ARAO Steering Committee and GHHN staff.

The GHHN EDI ARAO Steering Committee established core values and approaches to engaging communities in this work. There is consensus amongst the members of the GHHN EDI ARAO Steering Committee and the communities they engaged in this project that a population health approach, a social determinant approach and an anti-racism and anti-oppression approach must be embedded in the principals of health equity work. The committee also recognized that peoples' lives intersect within many communities and the impacts of multiple marginalization must be considered in how this impacts barriers to health care. Finally, the Steering Committee recognized that the community engagement was limited and that this work must continue to engage and expand to communities that were not engaged for this project.

To support the recommendations found in this report, there is a separate *GHHN Health Equity Supplementary Report with a Focus on Population-specific Communities* that reflects the dialogues the GHHN EDI ARAO Steering Committee had with population-specific groups within the GHHN. The report consists of seven chapters, each chapter focused on a specific population. It will be important to read the supplementary report along with the main report as it captures the experiences and population-specific recommendations that informed the recommendations in the main report. Each chapter was co-authored with members of the GHHN EDI ARAO Steering Committee and other community partners

who facilitated the conversations. According to one member of the GHHN EDI ARAO Steering Committee, the reports did justice to our voices and showcased our experiences.

This supplementary report must be viewed within the context and limitation of the timelines and scope of the project. The Steering Committee does not view this report or its work as complete. The report provides valuable insight and direction to the GHHN on how to begin to deconstruct barriers, open opportunity for engagement; and move forward to address health inequities with the goal to build universal health care for all. This work will require collaboration with all partners and communities and involve deep listening, difficult conversations and sustained commitment.

Fundamental to the success of this work is for the GHHN to fully integrate the Health Equity Framework within the governance structure and within all work engaged under the GHHN. Once this approach is integrated within governance, this will inform the way that communities will be engaged, how priorities will be identified and how the membership of GHHN will operationalize this important work. To support this work, it is recommended that a refreshed GHHN Health Equity Committee be engaged to continue to work alongside the GHHN Executive Council and Partnership Council to further develop and integrate the recommendations found in the two reports.

The GHHN Executive Council mandated the GHHN EDI ARAO to develop a framework and to address three areas: governance, service delivery and operations. While it is within the mandate of the GHHN partnership to adopt the framework and to implement the recommendations in governance and operations, the GHHN EDI ARAO Steering Committee recognizes that the work to deliver care within the lens of health equity will require the collaboration of the leaders of health and community service delivery and the diverse communities they serve.

SUMMARY OF RECOMMENDATIONS:

I. Health Equity Framework:

The vision of the GHHN is “to provide an equitable and seamless continuum of care that actively improves population health while meeting the individual needs of the community”.

Recommendations:

To be resolute on the journey toward fulfilling the vision of the Greater Hamilton Health Network and achieving equitable health outcomes, it is recommended:

1. The GHHN acknowledges that oppression, including racism and hatred in all its forms, makes people sick. GHHN commits to addressing systemic racism and oppression, challenging the status quo, addressing systemic barriers, and changing practices.

2. The GHHN adopt a Health Equity Framework that is inclusive of anti-Indigenous and anti-Black racism and anti-oppression strategies, ensures provision of French Language Services, uses a sex/gender-based analysis, is inclusive of the principles of inclusion and diversity, and explicitly addresses systemic barriers, power imbalances, and inequitable distribution of resources at all levels. The GHHN Health Equity framework is aligned with Ontario Health’s Equity, Inclusion, Diversity and Anti-Racism Framework.

3. That GHHN adopt a segmented approach to population health that designs policies and practices to meet the unique needs of Indigenous, Francophone, racialized with a focus on the black communities, immigrants and refugees, Two-Spirit and LGBTQIA+, people who use drugs, people with disabilities, and rural communities while recognizing that poverty is the overall determinant of health. The GHHN Health Equity Framework would use a gender-based analysis and recognize the intersectionality of these population segments.

4. That the GHHN engage with sector and community partners and people with lived/living experience, including patients and users of the system, to provide input and finalize a Health Equity Declaration of Commitment so that it is co-owned by the membership. This Declaration could be a requirement of membership and participation in the GHHN.

II. Governance and Corporate Culture of the Greater Hamilton Health Network

Building trust, including enhancing reliability, accountability, and integrity, will be critical to the success of the GHHN and an important foundation to setting the corporate culture.

Corporate Culture Recommendations:

To continue to build trust in the GHHN and its initiatives through a health equity lens, it is recommended that the GHHN:

1. Adopt and officially announce the GHHN's Health Equity Framework and develop a plan with appropriate resources to implement the prioritized recommendations.

2. Demonstrate accountability on an ongoing basis by reporting regularly on its health equity actions to the diverse people, communities, and community organizations within the GHHN's attributed population. This includes publicly releasing the GHHN Health Equity report and its implementation plan.

3. Commit to inclusion and diversity at all levels of the organization, ensuring voices of the diverse communities and the organizations and agencies that serve the diverse communities are engaged at decision making and co-design tables in sufficient numbers to ensure their voices are heard.

4. Develop processes and mechanisms to ensure the voice, participation and knowledge of marginalized populations and the community organizations that serve them are engrained in the GHHN.

5. Commit to accountability to the diverse communities in its attributed population through public, effective, continuous communication, and discourse, as well as rules for interaction at decision-making and co-design tables that clearly create expectations and mechanisms to support reliability, accountability, and integrity amongst all participants.

Health Equity Informed Governance Recommendations.

1. Adopt collaborative governance model during its short to mid-term stage of development.
    a. Adopt the proposed collaborative governance model that includes a Sector Council and a Community Collaborators Council.
    b. The Community Collaborators Council should intentionally call for members with lived/living experience in its open call.
    c. Develop a strategy for broader engagement of specific population health communities.
    d. Add the specific engagement strategy with primary care once their structure is determined.

2. Develop Terms of Reference for the Community Collaborators Council and the Sector Council that reflect the Health Equity Framework and Declaration of Commitment and other specific requirements.

3. Expand the membership of the Executive Council as soon as possible.

4. Develop a diversity matrix for the composition for the GHHN Board. Incorporate matrix in the bylaws and in policy and issue an open Call for Nominations for a transparent process.

5. Meet with the Coalition of Hamilton Indigenous Leaders (CHIL) and the Indigenous Primary Health Care Council (IPHCC) to begin the development of an ally governance relationship.

6. Formalize a partnership agreement between French Language Health Planning Entité 2 (FLHPE) and GHHN to design and implement an GHHN FLS plan.

7. Approve a Health Equity-informed Governance implementation plan.

8. Approve an Executive Council Governance Policy: Commitment to Health Equity that outlines processes for accountability. (See Appendix A for consideration.)

9. Develop a Strategic Plan that incorporates the commitment to Health Equity.

10. Transition the GHHN EDI ARAO Steering Committee to the GHHN Health Equity Committee:
    a. Rename the committee: GHHN Health Equity Steering Committee.
    b. Refresh/revisit current membership (commitment of current members was to May 31, 2021); and
    c. Develop Terms of Reference for two-year commitment.

III. Health Equity Informed Care and Services

***Recommendations*:**

1. Through a process of engagement, engage community members, population-specific organizations, users, patients and people with lived/living experiences and health and

community organizations and providers to adopt the Principles for Health Equity Informed Care and Services that would guide the work of GHHN.

2. Develop a plan and metrics to apply the principles to the GHHN initiatives.

3. In consultation with the advisory Councils, review and prioritize the seven proposed strategic initiatives for transforming the delivery of care from the perspective of Health Equity.

IV. Operations from the Lens of Health Equity

***Recommendations*:**

1. The Executive Council/Board establish the Director's Executive Limitations to ensure they incorporate the commitments to health equity.

2. The Director develop an operation development plan that incorporates health equity in the organization's policies. Priorities are identified in the report.

GHHN HEALTH EQUITY ACTION PLAN – Draft Short Plan

GHHN Health Equity Committee

1. That the GHHN EDI ARAO Steering Committee be transitioned to the GHHN Health Equity Committee with a refreshed mandate and membership for a two-year term to oversee the transition and implementation of this work.

   Metrics:
   - Terms of Reference are approved by Executive Council
   - GHHN Health Equity Committee membership is confirmed.

2. Current members to assist the GHHN with the public statement regarding Health Equity and the commitment to ARAO.

   Metrics:
   - Executive Council adopt the terms of reference for the revised GHHN Health Equity Committee.
   - GHHN Health Equity committee membership is revised.
   - Current members support the public statement as reflective of both reports.

Health Equity Framework: an anti-oppression, anti-racism, sex/gender-based and intersectional approach.

3. That the GHHN adopt the Health Equity Framework using an anti-oppression, anti-racism, sex/gender-based and intersectional approach.

4. That the GHHN issue a public statement to all members that it is committed to doing Health Equity work with a commitment to ARAO and sex/gender-based analysis and that it is starting immediately to begin the long journey to address health inequities. The statement would invite all members/partners to join in this work – that GHHN cannot do it in isolation.

   Metrics:
   - GHHN passes a resolution to adopt the Health Equity Framework.
   - GHHN issues a public statement with the endorsement of the GHHN EDI ARAO Steering Committee.
   - GHHN does a presentation to the current Partnership Council to invite their participation and to identify areas of collaboration.

5. When the GHHN engages in their Strategic Plan, it is informed by the Health Equity report and its' Supplementary Report with a focus on Population Specific Communities. The timing for the Strategic Plan for GHHN is to be determined.

Metrics:

- The Strategic Plan and its strategic directions reflect the commitment to Health Equity through an ARAO, sex/gender based and intersectional approach and is informed by the findings in both reports.

GHHN Health Equity Declaration of Commitment

6. The Declaration of Commitment be presented to the current Partnership Council, any emerging councils or networks and Working Groups for feedback. The revised version to be voted on by the Executive Council and its Council(s). Signing the Declaration of Commitment could be a condition of membership/partnership.

   Metrics:

   - Council participants are engaged in the process.
   - The number of Council participants that signed the Declaration of Commitment by April 1, 2022

Governance:

7. That the Executive Council be immediately refreshed/expanded to include:
   a. An appointment of an Indigenous Director in an ex officio role with the De dwa da deh nyes and the Coalition of Hamilton Indigenous Leaders (CHIL).
   b. A nomination from the French Planning Entité 2 and the FLS designated organization for a Francophone Director.
   c. Cross membership be confirmed with the GHHN Health Equity Steering Committee (#s TBD)
   d. Revisit any current Executive Council members who may be open to change (e.g. physician representation, lived experience representation).

   Metrics:

   - Expanded membership of the Executive Council to be implemented by the September Executive Council meeting.

8. That the Executive Council review the recommendations regarding Governance and develop an action plan to implement the recommendations.

   Metrics:

   - Action plan to be presented to the Partnership Council at the fall meeting for review and input.
   - Recommendations are implemented.

9. That the Executive Council adopt the Governance Policy - A commitment to Health Equity

   Metrics:

   - Executive Council adopt the Governance Policy on Health Equity (see draft Appendix A)

10. That the GHHN develop an ally relationship agreement with the Indigenous leaders in Hamilton and the Indigenous Primary Health Care Council.

    Metrics:

    - Ally relationship agreement is signed.

11. That the GHHN develop a partnership agreement with the French Language Planning Entité 2.

    Metrics:

    - FLPLE2 partnership agreement signed.

Education:

12. That the GHHN approach this work with humility and a deep commitment to listen, learn and unlearn. This includes but is not limited to seeking education and training on leadership fragility, impact of micro-aggressions, power, and privilege and how it plays out in the health systems and historical discriminations and its impact on health outcomes for specific populations. It also includes continuous learning on the health equity-informed population health approach and its specific impacts on the population segments within the GHHN, and the community and the population-specific organizations that serve them. The GHHN Health Equity Steering Committee to provide input to support the development of this plan.

    Metrics:

    - An Education Plan is implemented for September 2021 to April 2022 for Executive Council and other Council(s).

Delivering Care through a Health Equity Len

13. That the Partnership Council adopt the principles for Health Equity-Informed Care

14. That the GHHN Director develop an action plan based on the priorities identified in the delivering care through an equity lens and the supplementary report with a focus on the congregate settings working groups.

    Metrics:

    - The Working Groups have reviewed the principles and made recommendations for adoption.
    - The revised principles for Health Equity-Informed Care be adopted by the Partnership Council.
    - The GHHN Director report back to the Partnership Council on the progress of implementing the principles in the Congregate setting work.

Health Equity-Informed Engagement Plan:

15. That the Partnership Council adopt a Health Equity Informed Engagement Plan

    NOTE: Consultations, being led by the GHHN staff team, are currently underway for an engagement plan.

Metrics:

- The Health Equity-Informed Engagement Implementation Plan is presented to the GHHN Health Equity Committee for review and input.
- The Health Equity-Informed Engagement Implementation Plan be presented to the Partnership Council for adoption.
- The community service organizations, community organizations representing population specific groups, communities of interest, patients, users of the system, people with living/lived experience feel engaged and part of the process.

Operations

16. That the GHHN Director develop a year one action plan to develop operational policies through a health equity lens

17. That the GHHN submit a budget to the Executive Council to support the implementation of the Year 1 Health Equity plan.

18. That the GHHN develop a plan beyond April 1, 2022, that is consistent with the Collective Decision Making Agreement (CDMA) and is contingent on the GHHN mandate and funding.

Metrics:

- Policies are developed as per plan.
- Executive Council approves budget for 2021-22 to support the work.
- Executive Council approve a Health Equity Plan with resources effective April 1, 2022.

Chapter One

Setting the Stage

Ontario Health Teams (OHTs) were introduced by the Ministry of Health to improve the delivery of integrated and patient-oriented care. The vision is that, at maturity, Ontario Health Teams will build a connected health care system centred around patients, families, and caregivers to:

- strengthen local services,
- make it easier for patients to navigate the system, and
- create seamless transitions between providers.

The Greater Hamilton Health Network (GHHN) was one of the first Ontario Health Teams to be approved by the Ministry of Health and represents a partnership of more than 30 organizations spanning the health care and community service continuum. In the Full OHT application, this partnership mapped out an ambitious and challenging strategy to improve the experience patients will have when accessing care. These innovative strategies included early intervention, new digital technologies, enhanced bundled care programs, and increased coordination for medically complex patients.

In its application, the GHHN committed to be grounded in population health approaches:

- The Ministry of Health identified Indigenous people and the Francophone population as two priority populations for all OHTs to develop specific engagement, consultation, and service delivery strategies.
- The GHHN application also recognized that “substantial numbers of Hamiltonians are likely to experience poorer health outcomes than the general population: people living in poverty, racialized groups, newcomers, people with mental or physical disabilities, and some members of the Two Spirit and LGBTQIA+ communities.” In their application, GHHN committed to developing approaches for marginalized and disadvantaged populations who experience higher rates of health issues.

GHHN also committed to being “focused on the social determinants of health”. This is very important as determinants of health such as racism and discrimination, food security, and social isolation are key determinants of health that fall within the mandate of the health care system. However, other determinants of health such as income and housing will require a multi-system approach when developing pathways to care and other initiatives. To ensure the impacts of determinants of health, such as housing and income, are taken into consideration in the development of the GHHN initiatives, GHHN is committed to engage and partner with organizations and partners whose mandates are to address determinants of health (e.g., municipal housing).

In order to develop a comprehensive approach and response to population health inclusive of the determinants of health, the Greater Hamilton Health Network identified the need to develop an Equity, Diversity, and Inclusion (EDI) Framework.

The project was asked to address three general topic areas:

1. delivering care to patients from a lens of health equity,
2. the operations of the Greater Hamilton Health Network (staff level), and
3. the governance and corporate culture of the Greater Hamilton Health Network.

By committing to do this work, the GHHN is recognizing that this important Health Equity work is the beginning of an ongoing journey and foundational to building a connected health care system. It is a continuation of GHHN's ongoing conversation and commitment to Health Equity and will support the GHHN in making health systems changes. It will also serve as an example and supporting document for GHHN partners to consider within their own work.

This report is the culmination of five months of consultations, reviews of reports, seven population specific focus groups, discussions with the Executive Council, regular meetings with the GHHN EDI ARAO Steering Committee and GHHN staff.

This project was undertaken with the current members of the Greater Hamilton Health Network. As the work of the GHHN expands to include more partners and more geographies, including the expansion to include the Greater Hamilton area, a continued dialogue and process will be required to ensure the Commitment to Health Equity can be responsive and applicable to all GHHN members.

A special thanks to all the members of the GHHN EDI ARAO Steering Committee. Their commitment and diligence were deeply appreciated during these remarkably busy times.

GHHN EDI ARAO Steering Committee:

- Clare Freeman - Dr. Bob Kemp Hospice
- Comfort Afari – Hamilton Black Community Leaders Forum, Chair
- Connie McKnight - De Dwa Da Dehs Nye>s
- Haider Saeed (MD)- Hamilton Family Health Team, member of the HFHT EDI Committee
- Kyle Weitz - Compass CHC
- Laura Cattari - Hamilton Roundtable for Poverty Reduction
- Lisa Jeffs – Youth Wellness Centre, St. Joseph's Health Care
- Medora Uppal – YWCA Hamilton
- Nhlaloenhle (Nala) Ndwana - Hamilton Urban Core CHC
- Nora Melara-Lopez - Compass CHC, Co-Chair, Racial Justice, Inclusion and Diversity Committee
- Sunjay Sharma, MD – Hamilton Health Sciences, Co-Chair, President's Task Force on EDI
- Tara Galitz – Centre de Santé Communautaire Hamilton Niagara
- Tim McClemont - The AIDS Network, Executive Director

<u>Liaisons with GHHN Executive Council</u>

- Bernice King, Patient Advisor
- Melissa Farrell, St Joseph's Health Care

<u>GHHN Staff Team</u>

- Melissa McCallum, Director
- Jeff Wingard, Senior Manager, Partnerships and Development
- Sarah Precious, Manager, Engagement and communications

Chapter Two

The Proposed Greater Hamilton Health Network's Health Equity Framework: an Anti-Racism, Anti-Oppression, Sex/Gender based, Intersectional Approach.

The vision of the GHHN is "to provide an equitable and seamless continuum of care that actively improves population health while meeting the individual needs of the community".

Recommendations:

To be resolute on the journey toward fulfilling the vision of the Greater Hamilton Health Network and achieving equitable health outcomes, it is recommended:

1. The GHHN acknowledges that oppression, including racism and hatred in all its forms, makes people sick. GHHN commits to addressing systemic racism and oppression, challenging the status quo, addressing systemic barriers, and changing practices.

2. The GHHN adopt a Health Equity Framework that is inclusive of anti-Indigenous and anti-Black racism and anti-oppression strategies, ensures provision of French Language Services, uses a sex/gender-based analysis, is inclusive of the principles of inclusion and diversity, and explicitly addresses intersectionality, systemic barriers, power imbalances, and inequitable distribution of resources at all levels. The Health Equity Framework is aligned with Ontario Health's Equity, Inclusion, Diversity and Anti-Racism Framework.

3. The GHHN adopt a segmented approach to population health that designs policies and practices to meet the unique needs of Indigenous, Francophone, racialized with a focus on the black communities, immigrants and refugees, Two-Spirit and LGBTQIA+, people who use drugs, people with disabilities, and rural communities while recognizing that poverty is the overall determinant of health. The GHHN Health Equity Framework would use a gender-based analysis and recognize the intersectionality of these population segments.

4. The GHHN engage with sector and community partners and people with lived/living experience, including patients and users of the system, to provide input and finalize a Health Equity Declaration of Commitment so that it is co-owned by the membership. This Declaration could be a requirement of membership and participation in the GHHN.

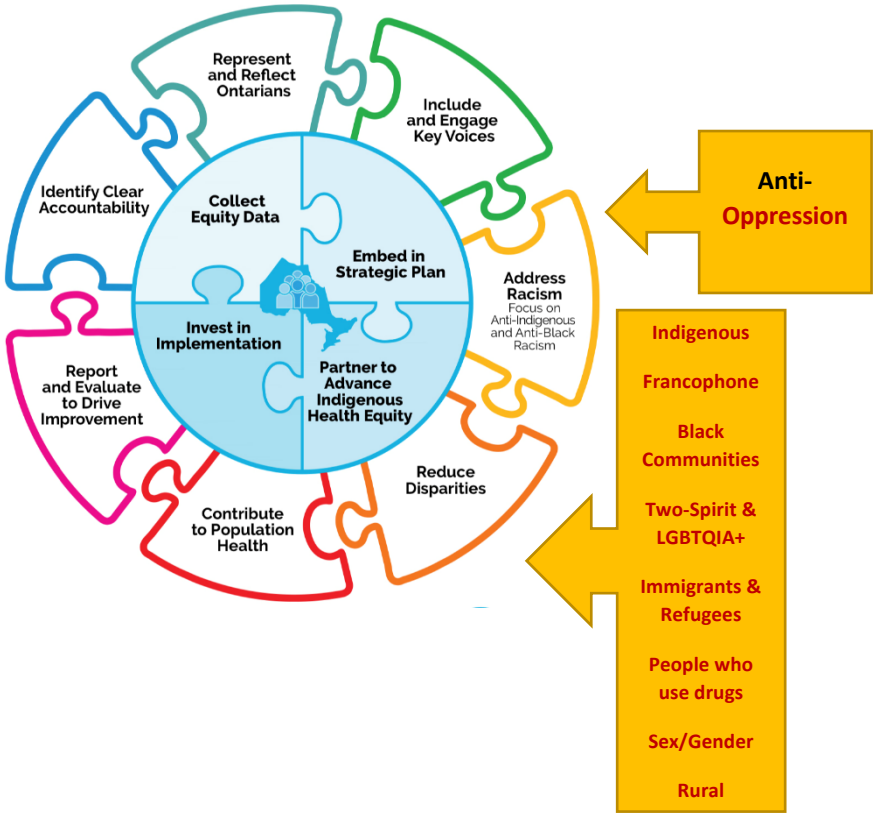
Alignment with Ontario Health's Equity Framework[1]

The GHHN EDI Steering Committee reviewed the Ontario Health Equity Framework. While there was support for the framework, there was significant feedback that the Ontario Health framework was exclusive of key populations and that the GHHN framework needed to be expanded to include anti-oppression.

While it is recognized that Indigenous and Black populations experience significantly poorer health outcomes than any other population or marginalized community, a framework that focuses on anti-racism is seen to be exclusive of other marginalized populations including Two Spirit and LGBTQIA+, immigrants and refugees, people who use drugs, people with disabilities, and rural communities. Each of these marginalized communities experience oppression and systemic barriers resulting in poorer health outcomes as compared to the general population. It also does not address poverty as the key determinant of health, or provide a gender-based analysis, or address the intersectionality of these identities.

Therefore, it is recommended that the GHHN align with the Ontario Health framework by adopting the Ontario Health Equity Framework and adding the commitment to address oppression in all its forms.

Greater Hamilton Health Network's Health Equity Framework: an anti-oppression, anti-racism, sex/gender-based, intersectional approach. Adapted from Ontario Health's Health Equity, Anti-Racism, Diversity and Inclusion Framework



[1] Ontario Health's Equity, Diversity, and Anti-Racism Framework, Ontario Health, October 2020.

GHHN's Health Equity Framework (Proposed)

The GHHN acknowledges that oppression, including racism and hatred in all its forms, makes people sick. GHHN commits to addressing systemic racism and oppression, challenging the status quo, addressing systemic barriers, and changing practices so that all people have access to equitable health outcomes.

Therefore, it is recommended that the GHHN adopt a Commitment to Health Equity that is inclusive of anti-Indigenous and anti-Black racism and anti-oppression strategies, ensures provision of French Language Services, is inclusive of the principles of inclusion and diversity, uses a sex/gender-based analysis and explicitly addresses systemic barriers, power imbalances, and inequitable distribution of resources at all levels.

As a result of adopting the Health Equity Framework, the GHHN aims to develop a system that:

- Enables people to reach their full health potential and receive high-quality care that is fair and appropriate to them and their needs, no matter where they live, what they have, or who they are.[2]
- Achieves equitable outcomes by providing differential treatment and redistribution of resources to provide a level playing field among diverse individuals and communities.[3]
- Addresses lack of access to health care services, gaps in care, and inequities in outcomes through the provision of accessible, affordable, high quality, culturally and linguistically appropriate, gender affirming and trauma and violence informed care in a timely manner.[4]
- Serves all people better by focusing on those who are the most marginalized.

Improving Population Health

The vision of the Greater Hamilton Health Network (GHHN) is to "provide an equitable and seamless continuum of care that actively improves population health and meets the individual needs of GHHN's community."

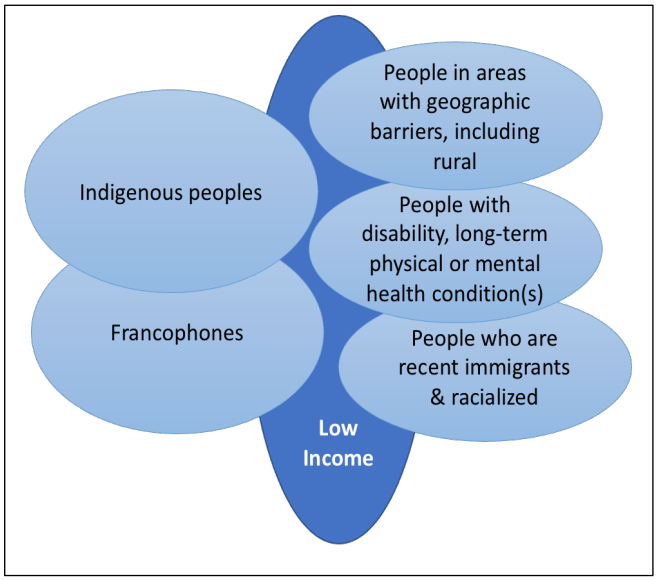
According to the literature, population health is defined as "the health outcomes of a group of individuals, including the distribution of such outcomes within a group."[5] Addressing the distribution of outcomes within a group is often referenced as a segmented population health approach.

Studies have illustrated that about 20-22 percent of the people in Ontario have significant barriers to health care. This has been validated through the Ministry of Health work related to Health Links. By addressing the needs of this 22 percent of the population, research illustrates that the entire population's health outcomes will improve. By targeting local population health barriers, we can

[2] Health Quality Ontario, November 2019.
[3] Ontario Health's Equity, Inclusion, Diversity and Anti-Racism Framework, Ontario Health, 2020.
[4] Black Experiences in Health Care, Symposium Report, 2019 http://accho.ca/wp-content/uploads/2019/04/SHS-BEHC-report-FINAL-aoda-final.pdf
[5] Kindig & Stoddart. American Journal of Public Health, 2002;93(3):380-3.

achieve more equitable health outcomes. For example, if we can plan for how a Muslim woman who wears a hijab might experience the health care system, it will likely be better experience for all women. If we plan for how we communicate with a person with a developmental disability, our communication will be better for everyone. Care will improve. Patient and provider experience will improve. And improved outcomes will be anticipated.

Emerging thinking is the need to add 'equity' – the need to address health disparities - as a fifth aim of the Quadruple Aim, making it a Quintuple[6] Aim.



Towards Equity in Access to Community-based Primary Health Care: A Population Needs-Based Approach (2013)

Overall Finding: 22% of people in Ontario experience significant barriers to good health outcomes with poverty as the overall driver. However, there is significant multiple intersections that contribute to the 22% finding.

Data: 2006 Census & 2009 Indian Registry
Note: There was Insufficient data to include Two Spirit and LGBTQIA+LGBTQIA+

It is well documented that poverty is an effective indicator for health outcomes. In Hamilton, Code Red neighborhoods, and the diverse people who live there, need to remain a priority, as identified in the GHHN's full application. Immediate actions are needed for the GHHN to collect and use socio-demographic and race-based data to better understand the diversity of populations within these communities.

Using an intersectionality approach with poverty, the consultations in the discovery phase of this report identified important gaps in population health for specific populations within Hamilton. These include:

i. Indigenous
ii. Francophone
iii. Racialized with a focus on the Black communities
iv. Immigrants and refugees
v. Two Spirit and LGBTQIA+
vi. People who use drugs
vii. People with disabilities

[6] https://www.ahrq.gov/ncepcr/tools/workforce-financing/white-paper.html#tab2

viii. Rural communities

GHHN has already committed to developing specific strategies for the Indigenous and Francophone populations. Within GHHN initiatives, it will be important to also develop specific strategies to meet the unique needs of all eight identified sub populations, recognizing that these populations have a high degree of intersectionality, including the need for gender-based reanalysis in each initiative.

Taking a Segmented Approach to Population Health

To achieve population health, it is recommended that GHHN apply an equity-informed, segmented population approach to its work, by ensuring that programs and services are tailored to meet the unique needs of groups of people with largely similar characteristics within a larger group. The creation of these sub groups is known as segmentation. Segmentation divides a population into distinct groups—each with specific needs, characteristics, or behaviours—to allow care delivery and policies to be tailored for these groups.[7]

An example: The GHHN priority initiative for shelters

The GHHN priority initiative for homelessness is focusing on cis gender and trans women who are homeless and vulnerably housed. There will be unique needs, for example, for people who use drugs, who do not speak English, who are from different cultures, who are from Two Spirit and LGBTQIA+ communities, and experience homelessness sin rural communities. A population segmented approach would require tailored approaches to be designed to meet the unique needs of this population from both in-reach and out-reach lens.

The GHHN commitment to population health using an equity-informed, segmented approach recognizes that “one size fits all” planning does not improve health outcomes for all and that deliberate strategies to address specific populations will be required in each GHHN initiative.

Therefore, it is recommended that the GHHN commits to adopting a population health approach with a focus on those that face the highest barriers to health. This includes intentionally incorporating intersectionality of population specific groups in all GHHN initiatives, while recognizing that poverty is the overall driver for poor health.

For GHHN, the population segments would include Indigenous, Francophone, racialized people with a focus on black communities, immigrants and refugees, Two Spirit and LGBTQIA+, people who use drugs, people with disabilities, and rural communities. GHHN has already committed to developing specific strategies for the Indigenous and Francophone populations.

[7] S.I. Vuik, E.K. Mayer, A. Darzi. Patient Segmentation Analysis Offers Significant Benefits for Integrated Care and Support. Health Affairs. Vol. 35, No. 5. May 2016. https://doi.org/10.1377/hlthaff.2015.1311

Within GHHN initiatives, it will be important to also develop specific strategies to meet the unique needs of the eight identified sub-populations as required, recognizing that these populations have a high degree of intersectionality, including the need for gender-based analysis in each initiative.

GHHN's Health Equity Declaration of Commitment

The GHHN Health Equity Framework requires a Declaration that outlines the commitments, values and beliefs that will guide this work.

A proposed, draft Declaration of Commitment is presented as a starting point for discussion. It will be important that the leadership at all levels of the GHHN, including sector and community partners and people with lived/living experience, including patients and users of the system, participate in the development of this Declaration so that it is co-owned by the membership.

Adoption by the members would be a significant milestone and signing the Declaration could be an important requirement of membership and partnership in the GHHN.

GHHN's Health Equity Declaration of Commitment: **(DRAFT)**

The Greater Hamilton Health Network is committed to achieving equitable health outcomes for all. To achieve this vision, the members of the Greater Hamilton Health Network collectively agree to the following beliefs, recognitions, and commitments to action.

As communities of Indigenous, Francophones, diverse communities, and leaders in the delivery of health and community care services, acknowledging our beliefs, recognitions and commitments will inform the way we come together; the way we honour and respect each other; and the way we will build a collective responsibility to transforming health care. This Declaration is a way to set out our shared way of working together.

TOGETHER, WE BELIEVE:

- Everyone deserves equitable health outcomes to reach their full health potential no matter where they live, what they have, or who they are.

- Racism, oppression, and hatred in all its forms makes us sick and that we need to explicitly address power imbalances, system barriers, gender inequities and inequitable distribution of resources,

- High-quality care must be free of racism, oppression and hatred in all its forms and that care and services must be accessible, affordable, high quality, culturally and linguistically appropriate, gender affirming, and trauma- and violence informed care.

- To improve health outcomes for all we must address the unique health care needs of the people facing the highest barriers to health, with poverty as the overall determinant of health. Together, we must address barriers due to poverty, and other geographical, linguistic, sex/gender, race, religious, cultural, mental health and addiction, physical and digital barriers.

- Within the GHHN attributed population, we acknowledge the distinct needs of Indigenous, Francophone, racialized with a focus on Black communities, immigrants and refugees, Two-Spirit and LGBTQIA+, people who use drugs, people with disabilities, and rural communities.

TOGETHER, WE RECOGNIZE:

- The Canada Health Act and the rights to universal, accessibility, portable, comprehensiveness, health care for all people.

- The Canadian and Ontario Human Rights that prohibit discrimination based on "race, national or ethnic origin, colour, religion, age, sex, sexual orientation, gender identity or expression, marital status, family status, genetic characteristics, disability, and conviction for an offense for which a pardon has been granted or in respect of which a record suspension has been ordered be imbedded in all aspects of health care work".

- Indigenous health equity stands apart from the broader commitment to health equity and is shaped by inherent rights, specific histories and current realities of First Nations, Inuit, and Métis peoples in Canada. We recognize that Indigenous health equity is rooted in treaty rights and mutual commitment to reconciliation, meaningful ally relationships, and Indigenous people's rights to self-determination, which includes the commitment to Indigenous Health in Indigenous Hands.

- Francophone communities have specific needs and constitutionally protected rights. Language and culture play an essential role in the provision of health care services, and Francophone populations require equitable access to quality health services in French to achieve optimal health and wellbeing.

- Anti-Black racism and racial stereotypes persist in the health care system and those racial inequalities, discrimination, and the lasting effects of trauma have negatively and disproportionately impacted the health and wellbeing of black individuals and communities.

- Two Spirit and LGBTQIA+ people face homophobia, heterosexism, cissexism, and transphobia based on sexual orientation, gender identity, and/or gender expression, which negatively affect the health and wellbeing of Two Spirit and LGBTQIA+ individuals and communities.

- Other marginalized and minoritized communities, including people who use drugs, immigrants and refugees, people living with disabilities, and some rural communities, require health care services designed to meet their unique needs.

- The historical and current impacts of racism, oppression, systemic discrimination, and hatred towards communities of people and interpersonal violence in the lives of those we serve, including Indigenous peoples, Francophones, Black communities, people who are Two Spirit and LGBTQIA+, and those who identify across multiple identities. Cis-gender females, trans females and males, girls, and gender diverse bear high risk of being targets of violence. Discrimination,

stigma, and hate continue to be experienced by people from variety of religious backgrounds, people who are psychiatric consumers, vulnerable populations with developmental disabilities and other marginalized communities that have been othered or shamed. Experiences of trauma, violence, and institutionalization affect individuals, families, and communities and impact physical, mental, emotional, and spiritual health, and wellbeing.

- Digital equity – a state whereby people and communities can readily and effectively access and use information technology to fully participate in society – is intricately bound to health equity and must be a right realized for everyone in the growing digital world. We recognize that certain populations, including but not limited to some rural communities, people living in poverty, those experiencing homelessness, and seniors, lack the necessary tools and devices, services like broadband connection and electricity, and/or digital literacy skills to participate in digital health care.

With these shared beliefs and recognitions, WE COMMIT TO:

- Shared responsibility to work in a way that will engage diverse communities and voices and that works collaboratively with health and community service providers within an open and collaborative spirit of change.

- Ground our work in anti-oppression and anti-racism and to confront homophobia, heterosexism and transphobia, Islamophobia and anti-Muslim hate, ableism, sexism and all other forms of oppression and hatred.

- Ground our work in human rights-based strategies, acknowledging the treaty rights of Indigenous peoples, the constitutional and legislative rights of Francophones, and the legislative rights of Two Spirit and LGBTQIA+ people, people with disabilities, people who use drugs, recent newcomers and refugees, people with disabilities, women and girls and people living in rural communities to receive high quality health care that is free from discrimination.

- Inclusion and diversity at all levels of Greater Hamilton Health Network, ensuring members of Hamilton's diverse communities and the organizations and agencies that serve diverse communities are engaged at decision-making and co-design tables in manners that enable their voices to be meaningfully heard.

- Meaningful sustained change that dismantles systemic racism and oppression across the continuum of the healthcare system through the rigorous application of the principle of "nothing about us without us."

- Apply an equity-informed, segmented approach to population health and to co-design policies and practices that meet the unique needs of these population groups. Within the GHHN attributed population, we commit to the Indigenous, Francophone, racialized with a focus on black communities, immigrants and refugees, Two Spirit and LGBTQIA+, people who use drugs,

people with disabilities, and rural communities. We commit to the use of gender-based analysis and to honour their intersectionality.

- Commit to an ongoing education program focused on equity, anti-oppression, anti-racism, and population health with a particular focus on Indigenous, Francophone, racialized with a focus on black communities, immigrants and refugees, Two Spirit and LGBTQIA+, people who use drugs, people with disabilities, and rural communities in order to enhance GHHN members' understanding and continually improve their abilities to act as allies in the collective work of achieving equitable health outcomes for all.

- Collect, share, and use socio-demographic and race-based data to inform GHHN's co-design, planning, and decision-making. A community data governance table will guide this work. This information gathered and collated must be informed through a lens of ARAO and the communities must be involved in providing input to the data.

- Develop digital inclusion strategies that ensure diverse people and communities who are impacted by the digital divide have access to digital tools and resources (e.g. devices, internet, electricity) and can meaningfully adopt them (e.g. accessible and effective training and education).

Chapter Three

The Governance and Corporate Culture of the Greater Hamilton Health Network

Building trust, including enhancing reliability, accountability, and integrity, will be critical to the success of the GHHN and an important foundation to setting the corporate culture.

Corporate Culture Recommendations:

To continue to build trust in the GHHN and its initiatives through a health equity lens, it is recommended that the GHHN:

1. Adopt and officially announce the Health Equity Framework and develop a plan with appropriate resources to implement the prioritized recommendations.
2. Demonstrate accountability on an ongoing basis by reporting regularly on its health equity actions to the diverse people, communities, and community organizations within the GHHN's attributed population. This includes publicly releasing the GHHN Health Equity report and its implementation plan.
3. Commit to inclusion and diversity at all levels of the organization, ensuring voices of the diverse communities and the organizations and agencies that serve the diverse communities are engaged at decision making and co-design tables in sufficient numbers to ensure their voices are heard.
4. Develop processes and mechanisms to ensure the voice, participation and knowledge of marginalized populations and the community organizations that serve them are engrained in the GHHN.
5. Commit to accountability to the diverse communities in its attributed population through public, effective, continuous communication, and discourse, as well as rules for interaction at decision-making and co-design tables that clearly create expectations and mechanisms to support reliability, accountability, and integrity amongst all participants.

The Current Climate:

The consultation process in preparing this report identified some learning opportunities and recommendations to build a health equity informed corporate culture at the GHHN.

The process revealed many long-standing issues that need to be addressed on an ongoing, systematic basis to move forward in an environment of growing trust that builds a strengthening commitment to health equity. Through the series of interviews with the Executive Council, members of the GHHN EDI Advisory Council, 25 individuals, and seven population-specific focus groups, common themes repeatedly emerged. Many of these themes were years in the making and existed prior to the establishment of the GHHN. However, they provide meaningful insights into the environment in which the GHHN is currently working.

One recent example related specifically to the GHHN during the development of the GHHN full application and the partnership council membership. While the community and population specific organizations recognized the incredibly compressed timeframe given by the Ministry of Health to develop the full application for the GHHN, an unintended consequence was that the community and

population specific organizations, felt excluded resulting in feelings of lack of transparency and exclusion.

Therefore, it will be even more important moving forward, that the work of the GHHN is built on principles of engagement, transparency, and inclusion – and to value the diverse voices of community organizations and people served by the GHHN.

Reflections and Themes: "Without meaningful action, there will be no trust"[8]

1. Commitment to Sustained Action

It is positively acknowledged that doing the work of developing a Health Equity Framework and Report with recommended actions using dedicated resources is a first, significant step in demonstrating the commitment to do this work.

However, a strong theme of overall skepticism emerged from the dialogue with individuals, the Steering Committee, and the population specific discussions that this project is an exercise only, and, like other past reports in Hamilton, there will not be lasting change or commitment.

It was also stated that it would be important that all leaders in the GHHN, especially at the Executive Council, are seen to be actively integrating and undertaking ongoing health equity work at their level of the GHHN and in their own organizations.

2. Power and Marginalization

Change requires a long view, often generations. Historically and to date, the balance of power is perceived to be with large institutions. It is important that larger institutions demonstrate collaborative leadership competencies and not appear to be turf-oriented.

In general, the community partners and organizations that serve specific populations feel that there is a lack of understanding of "the community", its services, capacities, and strengths, but there is also a recognition by health care actors that solutions to many health care issues lie in "the community".

> *"Community is often blamed for lack of coordination and for people falling through the cracks. The narrative that communities have 'failed' needs to stop."*
>
> *"Community agencies understand the communities; they have skills and know the solutions but they do not have the resources. This is not acknowledged."*
>
> *"Often you are the only one and are afraid to rock the boat. There is a need for a minimum of three people with diverse views on the Council and on each working group."*

However, due to their experiences in the Hamilton health system, community organizations that work with marginalized populations often feel themselves marginalized. Community organizations have fewer resources, especially staff to participate in decision making tables. This means they feel they are often a lone voice, which reinforces feelings of not being heard or listened to. Individuals shared how difficult it is to speak as the only person at the table from the perspective of marginalized people – especially if one is racialized, from a vulnerable population, and/or from a marginalized organization.

[8] Collaborative Governance. Tamarack Institute, 2019

Further to this point, there was a theme from the consultations, that the “Same Ten People” were at all the health leadership tables in Hamilton, reinforcing the reflection that these tables are not representative of the diversity of community groups and people the GHHN serves. The expression “Same Ten People” did not mean 10 specific individuals. An example was shared that the leadership of the Two-Spirit and LGBTQIA+ did not always include the diverse racialized voices at a variety of tables and it was often the same people who were the ‘go to’ people for decision makers. Individuals who identify as, and organizations that work with, Francophones, racialized people, refugees, new immigrants, people who use drugs, and Two Spirit and LGBTQIA+ want to be meaningfully engaged at all relevant tables. Some will bring system perspectives and are potential partners at governance decision-making and advisory tables, while others bring lived experiences of specific health system issues, gaps, and assets that need to be co-designed with their context expertise through working groups. Women’s organizations also need to be included and are critical to supporting the successful integration of a gender-based analysis within the work of the GHHN.

Indigenous partners stand ready to build an allied relationship with the GHHN based on Indigenous Health in Indigenous Hands.

It was recognized that the GHHN took an especially important first step when they used an open and transparent process, with a diversity matrix, to select the members of the GHHN EDI Steering Committee.

With commitment to health equity starting at the executive governance level, diverse and representative leaders on the Executive Council will immediately begin to build trust and transparency. Terms of Reference and other ground rules for governance bodies must support courageous conversations that address issues of trust, especially with community members and groups. The more public the discourse is and the more effective, continuous communication mechanisms that integrate health equity are regularly employed, the more accountable the GHHN will be to the diverse communities and community groups that are part of its sector and community ecosystem and its attributed population.

3. <u>Trust with a focus on Reliability, Accountability, Integrity</u>

Trust is essential in doing health equity work and to the achievement of the overall goals of GHHN. However, the general lack of trust in the decision-making process and inclusion of the experience of community organizations in Hamilton is a theme that has emerged during this work and is an important context for the GHHN as it continues to do its work.

Trust is key to collaboration. The Ministry of Health has identified trust as the most important ingredient for successful OHTs.

"For OHTs that are comprised of multiple, separate organizations, building shared governance and accountability relationships requires trust and may take time to establish."

Ontario Health Teams: Guidance for Health Care Providers and Organizations, Page 24

Trust is a word that is easy to say but a concept that is difficult to describe. Through her research, Dr. Brené Brown created an acronym called B.R.A.V.I.N.G. that describes seven elements that, cumulatively, create or erode trust between people and between organizations.[9] The strength of this framework to understanding trust is that it makes the nebulous, emotional, and value-laden concept of trust more specific and actionable. Particular areas for improvement can be identified, discussed, and actioned by the GHHN in order to continually cultivate a culture of trust between everyone in the GHHN ecosystem. One of the deliverables of this project is to embed a commitment to health equity in the culture of GHHN. Understanding the current culture and barriers to trust is an important step in understanding how to move forward with solutions.

Responses from consultations indicate that the three most important elements of trust to nurture and support on an ongoing basis in the GHHN are: reliability, accountability, and integrity.

Reliability: Consistently Meeting Commitments

Reliability emerged as the biggest factor contributing to lack of trust in the process. Historically, marginalized community members and agencies have been asked to participate in an initiative. They have put in lots of time, effort, and commitment. The resultant reports were then not acted upon. Participants were told that change was too difficult; that there were no resources; sometimes there was no response. They were often told to wait until other priorities were met.

"The history of reports is like a health system focussed only on diagnostics. Diagnoses are made, problems defined, but there is no treatment. No follow through on recommendations."

Government decision-makers and other decision-making bodies have put out large proposals and projects intended to help rectify and address inequalities and biases against racialized and marginalized communities, but they often turned out to be a band aid solution. "It feels like it was just intended to check the boxes," commented one participant.

Cumulatively, this had led to the feeling of fighting the same fights over and over again. Community members and agencies need to be able to have the confidence and power to say that they cannot participate if they do not have time or resources. Community agencies need access to resources. Community members need the ability to co-create a health system they can access, navigate, and within which they can achieve good health outcomes and where they feel that their voices are meaningfully heard.

[9] B.R.A.V.I.N.G. stands for Boundaries, Reliability, Accountability, Vault, Integrity, Non-Judgment, and Generosity. For brief definitions of each element: https://daretolead.brenebrown.com/wp-content/uploads/2018/10/BRAVING.pdf For a longer explanation (video): https://brenebrown.com/videos/anatomy-trust-video/

Accountability: Apologizing, Owning and Addressing Mistakes

Some community members identified that the broader health system has a history of accountability, recommendation, recommendations being watered down, shelved, or not addressed in past reports including the "Mapping the Void" – the 2018 report on "Two Spirit and LGBTQIA+ issues in Hamilton. As the GHHN works in this system, it will need to show strong principles of accountability and implementation.

Developing governance structures and supportive tools and resources, including agreements, communications mechanisms, Terms of Reference, and policies, will help to demonstrate GHHN's commitment to accountability to the broader community and the diverse people who live in the GHHN catchment area.

Integrity: Walking the Talk

To demonstrate an ongoing commitment to improving trust, GHHN leaders and partners need to actively role-model integrity (choosing courage over comfort and practicing values not just professing them). People from groups that have historically had more power and privilege need to practice being more comfortable with the anger/frustration/hurt sometimes expressed by historically marginalized groups and individuals when talking about experiences of racism, heterosexism, and other oppressions that come from a history of hurt, feeling ignored, and having to fight to access care. This is hard work and needs to start from a place of humility, of unlearning on identifying opportunities to make systemic changes. It is important to cultivate courage over comfort in conversations about uncomfortable topics like these since the inability to have difficult conversations only broadens and deepens feelings of mistrust for health care.

Giving appropriate credit and resourcing appropriate organizations are keyways to clearly role-model integrity. Historically, institutions have been funded to provide programs and services that the community had identified as solutions and/or that could have been better provided by community agencies and/or community members using peer-driven approaches.

> *"Recently our team — Black Leaders Health Forum — proposed the idea of Vaccination Ambassadors to the COVID-19 Taskforce. They loved it so much they adopted and implemented it but it seems that Public Health has taken the idea and not given any credit to the Black Leaders Health Forum."*

Health Equity Informed Collaborative Governance

Recommendations for Governance:

1. Adopt collaborative governance model during its short to mid-term stage of development.
    a. Adopt the proposed collaborative governance model that includes a Sector Council and a Community Collaborators Council.
    b. The Community Collaborators Council should intentionally call for members with lived/living experience in its open call.
    c. Develop a strategy for broader engagement of specific population health communities.
    d. Add the specific engagement strategy with primary care once their structure is determined.
2. Develop Terms of Reference for the Community Collaborators Council and the Sector Council that reflect the Health Equity Declaration of Commitment and other specific requirements (TBD).
3. Expand the membership of the Executive Council as soon as possible.
4. Develop a diversity matrix for the composition for the GHHN Board. Incorporate matrix in the bylaws and in policy and issue an open Call for Nominations for a transparent process.
5. Meet with the Coalition of Hamilton Indigenous Leaders (CHIL) and the Indigenous Primary Health Care Council (IPHCC) to begin the development of an ally governance relationship.
6. Formalize a partnership agreement between French Language Health Planning Entité 2 (FLHPE) and GHHN to design and implement an GHHN FLS plan.
7. Approve a Health Equity informed Governance implementation plan.
8. Approve an Executive Council Governance Policy: Commitment to Health Equity that outlines processes for accountability. (See Appendix A for consideration.)
9. Develop a Strategic Plan that incorporates the commitment to Health Equity.
10. Transition the GHHN EDI ARAO Steering Committee to the GHHN Health Equity Committee:
    a. Rename the committee: GHHN Health Equity Steering Committee.
    b. Refresh/revisit current membership (commitment of current members was to May 31, 2021); and
    c. Develop Terms of Reference for two-year commitment.

When the GHHN governance structure was originally designed, it was designed with the vision that within three to five years, the OHT would be an integrated system with one funding envelope. This determined to an extent, who was seen to be needed at the Executive Council and the future design of the Board.

Fast forward three years to 2021 and on the continuum of integration, the OHT is, for the foreseeable future, on more of a path of collaboration than integration. This is evidenced by the Ministry of Health's requirement to sign "Collaborative Decision-Making Agreements (CDMA).

The shift to collaboration is significant and needs to be acknowledged. This shift and the commitment to Health Equity needs to inform the governance structure for Greater Hamilton Health Network.

Governance in its broadest form is how groups organize to make decisions. It determines who has power, who makes decisions, how other players' voices are heard and how accountability is rendered.

The premise behind Collaborative Governance is that "if you bring the appropriate people together in constructive ways with good information, they will create authentic visions and strategies for addressing the shared concern of the organization or community." (David Chrislip, The Collaborative Leadership Field book).

Collaboration is the most intense level of working together. It is a structure and process for creating change. A collaborative effort is driven by partners who agree to share information, activities, resources, influence, power and decision-making authority to achieve common goals, goals that no one single partner or program could achieve by acting alone.

Trust is key to collaboration.

Collaborative governance using a health equity framework requires two important mind shifts:

1. Rethinking who is involved.
    - Supporting "collective seeing" and processes that promote co-ownership by all participants (including balancing the relational and the rational)

> Collaborative Governance is a governing arrangement in which leaders from different organizations drawn from multiple sectors engage in collective decision-making process that is deliberate, consensus-oriented, and directed to the achievement of a shared Goal – for OHTs the quadruple aim. (RISE)

> Collaborative Governance is a formal agreement in which participants representing different interests are collectively empowered to make decision or make recommendations to a final decision maker who will not substantially change consensus recommendations. (Tamarack)

2. Reconsidering whose eyes are on the system/program and needing both content and context experts.
    - Content: subject matter experts, including from different sectors, providers, clinicians, and organizations that work across the health care system.
    - Context: people with lived experiences, including patients, clients, users, residents, families, and caregivers that represent the diversity of GHHN's attributed population; and community organizations and agencies that work directly with specific populations. This may include racial or ethno-specific organizations, geographic communities (e.g., rural) or communities of interest (e.g., people who use drugs).

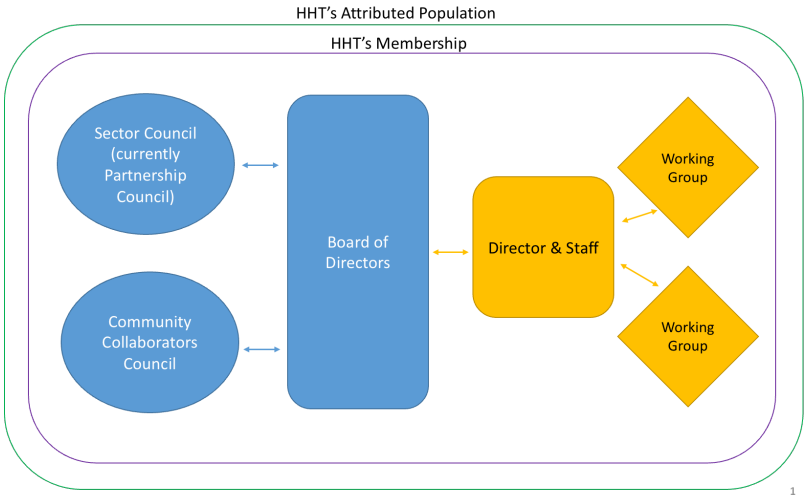
The governance structure for GHHN needs to reflect and support these two shifts in mindset. Throughout the governance structure, at all levels, appropriate content and context experts need to be engaged.

Proposed Collaborative Governance model applying the Health Equity Framework

Building on the work of Ernst and Young, the following collaborative governance design for GHHN is being proposed.

NOTE: Currently the GHHN is in the process of engaging with patients, caregivers, clients, users of the system and people with lived experience to determine an engagement process and structure. Once this consultation is complete, it will need to be incorporated into the model.

In addition, primary care providers in Hamilton are currently in discussion about the form of a primary care structure. Once this work is complete, the relationship between the GHHN and this primary care structure will need to be incorporated as well.



Membership: Creating Accountability to GHHN's Attributed Population

According to the Ministry of Health, the Greater Hamilton Health Network is accountable for its attributed population. Through a health equity lens, this would mean that, when the GHHN takes on its initiatives within its mandate, that it needs to consider the impact on the attributed population, with a focus on those facing the biggest barriers to health.

Within a policy governance approach, this makes the attributed population, with a focus on populations facing the biggest barriers to health who they are ultimately accountable to. While this does not mean that the GHHN will impact every individual in the GHHN, it is understood that the attributed population with a focus on populations facing the biggest barriers are who the GHHN is "acting on behalf of" and who GHHN needs to find ways to be accountable to and report back to on an ongoing basis.

Building on the recommendation of the Ernst and Young report, the membership, with a goal of about 500 members, would be the proxy for the attributed population.

It is understood that the Executive Council has determined that the membership will be an open membership with a low bar for criteria to become a member. By virtue of this open membership, members will be a mix of content and context experts.

Members could include:

- ✓ Users of the system, families, caregivers, people with lived experience

- ✓ All health and social services providers
- ✓ Municipalities
- ✓ Researchers and academics
- ✓ Allies and supporters of transforming the system
- ✓ Alliances and coalitions
- ✓ Population specific community groups

Through a health equity framework, it is recommended that the following criteria be considered for GHHN membership:

Rights and Responsibilities (proposed):

- ✓ **Support the GHHN mission and vision.**
- ✓ **Sign the Health Equity Declaration of Commitment.**
- ✓ Inform the Strategic Plan as required.
- ✓ To be kept informed (i.e. through newsletters, website) and to provide input into ongoing direction or the GHHN (i.e. surveys).
- ✓ **Nominate and elect members of the Board of the GHHN.**
- ✓ **Nominate members for the Councils and Working Groups.**
- ✓ Bring information to your own organization and network to enhance understanding of the GHHN and its commitment to health equity.

Sector Council (former Partnership Council)

The Sector Council would consist of the content experts across the health and social services system. It would include health services providers funded through the Ontario Ministry of Health (including Ontario Health) including but not limited to home care, community support services, long-term care, hospices and other residential/congregate settings, acute and specialized care, mental health and addictions, and primary care. There is a strong call for the membership of the Sector Council to be open to all community agencies that serve the diverse populations in the GHHN, even if they do not receive any funding from the MOH.

While the Executive Council is determining the criteria for participation in the Sector Council, from a health equity perspective, the following criteria are recommended:

1. That the organization is a member of GHHN and be committed to the GHHN vision, mission, values and Health Equity Declaration of Commitment.
2. That all organizations begin their own journey on health equity with a commitment to developing their own organizational plan.
3. That all organizations develop an AR/AO education plan to ensure leaders from the Board to executive to front line begin their own education journey.
4. That all organizations commit to collect socio-demographic and race-based data.

The Sector Council would be advisory to the Executive Council/Board including informing vision, mission, strategic directions and holding the Board accountable for systems-level and GHHN outcomes including implementation of the Health Equity Commitment and Action Plan(s).

The Sector Council would nominate sector representatives to the Board of Directors and be expected to participate in Working Groups on the co-design of relevant parts of the system.

NOTE: Currently the primary care providers are engaged in a conversation to develop a primary care structure. Once this work is completed, its relationship with the Sector Council and the Executive Council will need to be determined. To support understanding and consensus among the diverse funding and delivery models involved in primary care, this group will provide advice on behalf of primary care, including nominating sector voices to the Board of Directors and participating in relevant Working Groups to co-design parts of the system.

Community Collaborators Council (PROPOSED NEW)

The Community Collaborators Council is a proposed new Council that is being recommended to advise the Executive Council/Board. This Council will be a representation of Hamilton's diverse community and include in its membership persons with lived/living experience, alongside organizations, agencies, coalitions, alliances, and networks that serve and/or represent diverse populations within GHHN's attributed population, including potentially geographic and population-based communities. Relevant academics who do research in population health and specific population groups may be interested in joining as participants in the Council.

It will be important that a deliberate outreach process is undertaken to ensure this Council includes diverse voices of the priority populations served by the GHHN. It must include supports to ensure full participation of persons with lived/living experience and smaller community-based organizations without barriers: accessibility, transportation, childminding, financial and other.

The Community Collaborators Council will play an important advisory role to the Executive Council/Board. During the Discovery phase of this work, the potential members of this Council were the most vocal in identifying issues of trust, lack of representation, and marginalization so it is imperative that the Executive Council/Board has a Council that brings these perspectives and voices to the dialogue.

Criteria for participation in the Community Collaborative Council, from a health equity perspective, would be similar to the Sector Council with the exception that many of the networks and alliances may be less formal structures and may not have the capacity to meet all the same criteria.

Having said that, all Community Collaborative Council participants in the GHHN commit to the following criteria:

1. That the organization or individual is a member of GHHN and committed to the GHHN vision, mission, values and Health Equity Framework.
2. That all organizations begin their own journey on health equity with a commitment to developing their own organizational plan. For individuals, this means engaging in a respectful 'no blame' manner in order to further health equity in the broader community.

If possible, all participating organizations should also:

3. Develop an AR/AO education plan to ensure leaders from the Board, executive to front line begin their own education journey.
4. Support organizations to collect socio-demographic and race-based data.

The Community Collaborators Council would be advisory to the Executive Council/Board including informing vision, mission, strategic directions and holding the Board accountable for population level outcomes including implementation of the Health Equity Declaration of Commitment and Action Plan(s).

The Community Collaborative Council would nominate sector Directors that reflect the diversity of the populations in the GHHN and be expected to participate in Working Groups to co-design relevant parts of the system.

NOTE: It will be important that the Sector Council and the Community Collaborators Council have opportunities to collaborate and learn from each other.

GHHN Director

The Director is the sole employee of the Executive Council/Board. All staff report to the Director. The Director and her team would work with the Working Groups to operationalize the GHHN Strategic Plan and Health Equity Framework and Action Plan(s).

Working Groups

The composition of each Working Group is directly determined by the problem that needs to be resolved. Thinking deliberately about who needs to be involved and whose eyes need to be on the problem will be important in determining who should be at the Working Group. It will be important to ensure a mix of content and context experts, including sector specific representatives, community members, and people with lived experience and to ensure the diverse voices of the populations impacted by the Working Group's common agenda are participating.

Once the Working Group membership has been identified, it will be important that all participants work collaboratively together to determine a shared vision for change, including a common understanding of the problem(s) and a joint approach to solving it through agreed upon actions.

Executive Council/Board of Directors: Collaborative Leadership through a Health Equity Lens

The GHHN Board is accountable to its attributed population.

The GHHN has agreed to a policy governance model. With that commitment, the Board has four main roles. From a health equity perspective, the roles would include:

1. Represent the Ownership:
    - The GHHN Governance model includes an active membership with a goal of over 500 members. This membership could be the proxy for the attributed population.
    - The Community Collaborative Council and the Sector Council would be advisory to the Board and would provide opportunities for joint dialogue and planning. Terms of Reference for Councils, including criteria for participation would need to be developed.
    - Persons with lived/living experience of systemic barriers from identified population groups should be included as context experts on the Board.

2. Lead the Organization:
    - Review the Mission, Vision and Values to ensure they reflect the commitment to Health Equity.
    - Develop a strategic plan that encompasses the commitment to Health Equity.
    - Adopt the Health Equity Declaration of Commitment and commit to an annual Health Equity Action Plan.

3. Evaluate the Operations:
   - Ensure the clear delegation of operations to the Director includes a commitment to Health Equity in its Strategic Directions and executive limitations.
   - Ensure evaluation of the Director includes progress on the Health Equity Action Plan.

4. Exercise Governance Transparency:
   - Ensure Board policies include clear, integrated commitments to Health Equity.
   - Adopt a Governance Policy specific to Health Equity. See proposed draft in Appendix A.

Composition of the Board through a Health Equity Lens

The Ernst and Young report recommended that the Board include 12-18 Directors and that there be a split of Sector Directors and 'Independent' Directors. The report recommended that the Sector Directors be 'elected' by the sectors. No direction was provided on the election process for the 'Independent' Directors.

This section of the report will make recommendations on how to think through the composition and election of the GHHN Board through a health equity lens.

Establish the Board's Diversity Matrix

It is recommended that the GHHN adopt a diversity matrix with a mix of content and context experts that bring a range of perspectives and expertise that the Board wants to achieve on their board as a whole.

The following are components of the matrix that the board should consider. The percentages and balance would need to be determined by the Board.

Sample form GHHN EDI Steering Committee

HHT EDI SC Matrix Summary

WORKED WITH...	C# 1	C# 2	C# 3	C# 9	C# 10	C# 11
Indigenous						
Francophone						
Racialized	x	x		x		
Immigrant and refugees	x	x		x		
2SLGBTQ	x	x				
Person living with disability	x	x	x			
Rural						
Other - poverty, homeless, MH&A	x					
LIVED EXPERIENCE						
Indigenous						x
Francophone						
Racialized	x					x
New Immigrant & Refugees					x	x
2SLGBTQ						x
Person living with disability			x		x	x
Poverty						
Rural						x
MH&A						
Gender						
female		x	x		x	x
Male	x					
gender diverse						
Organization exper with Populations						
Indigenous	x					x
Francophone						
Racialized	x	x		x		
Immigrant and Refugees	x	x		x		x
2SLGBTQ	x	x				
People who live with Poverty	x	x	x		x	x
People who use drugs	x	x			x	
people who struggle with MH&A	x	x			x	
Health System						
Public Health						
primary care	x					x
community sector		x				
mental health & addictions	x	x				
home and Community Care					x	
LTC					x	
acute				x		
academia				x		
patient advocate						
Other			x			
Roles						
executive leader		x		x	x	
Front line provider	x			x		x
board member						
other	x		x			
Assessment Score Average	18	12	21.8	21.3	14	24

- Sector representation: The Ernst and Young report recommended the following sector representatives: primary care, community home care, congregate settings (community care and long-term care), acute care, mental health, and the City of Hamilton.
- It is recommended that the Board consider the following modifications:
  - grouping home and community care
  - separating LTC and Retirement homes from shelters, hospitals, groups homes
  - adding community organizations
- Once the Director is elected, they bring the perspective of the sector as a whole and not their own organization.

1. Population perspectives:
   - That ensures that the following perspectives are included in the Board: racialized with a focus on the black communities, immigrants and refugees, Two Spirit and LGBTQIA+, people who use

drugs, people with disabilities, and rural communities while ensuring that poverty is the overall determinant of health.

2. Gender parity with female and other gender diverse people representing the majority of the group and cis-gender males being less than 50% of the representation.

3. People with lived experience, users of the system, clients and patients.

4. Designated Seats:
    a. One Francophone director to be elected as per the nomination of the French Planning Entité 2 and the designated FLS Health Service Provider organizations in the GHHN.
    b. Municipality to designate their representative.

5. Indigenous Ex-Officio Seat
    a. An Indigenous ex-officio or observer should be included until an allied relationship agreement is completed and defines the relationship.

As a collaborative governance board, the directors as a whole are responsible to be system thinkers and to put people and their communities first. It will require a strong understanding of health equity, anti-racism and anti-oppression and its implications as well as skills in collaborative leadership.

Therefore, the Board should consider the following attributes for each director:

- **Advancing the Greater Hamilton Health Network**: knowledgeable about and dedicated to the GHHN's vision, mission, values and strategic directions.
- **Health Equity**: commitment to and understanding of health equity through an anti-oppression and anti-racism lens.
- **Commitment to population health**: commitment to improving health outcomes for the population in Hamilton facing barriers to health and wellbeing.
- **Understanding of the health system from the perspective of developing an integrated, coordinated, seamless system of care**: understands that health is inclusive of the determinants of health; and
- **Understanding of the GHHN's role in health system transformation**

While each Director may not have the following attributes, it would be important that the Board as a whole has the following expertise:

- **Policy Governance:** experience of governance principles and practices.
- **Strategic Planning**: experience of strategic planning processes.
- **Financial Literacy:** ability to understand the financial position of the GHHN as presented in its financial statements.

Each director could bring multiple attributes to the Board. For example, a physician may work in primary care with a focus on homeless and people who use drugs. The physician may be an immigrant and a member of the LGBTQIA+ community.

Nomination Process

A nomination process is critical so that the Board can review and recommend a slate of candidates to ensure it meets its matrix goals.

Proposed process for consideration.

1. The Board issues an open Call for Nominations reflecting the attributes that it is seeking to fulfil from its matrix criteria. The Call for Nominations is sent to its membership with a specific focus on the Councils that are advisory to the Board.
    a. The Sector Council is requested to nominate more than one sector representative in order to provide the Board with capacity to look at intersectionality to meet the matrix.
    b. The Community Collaborators Council is requested to nominate Directors that bring the perspective of the priority population to the Board.

2. The Board makes the final recommendation to the membership for election.

3. In future years, the Call for Nominations would focus on the matrix gaps of the Board.

4. Once a director is on the Board, they are responsible for the outcomes for the attributed populations, not the organization that they are from. However, it is important that they bring their diverse perspectives to the discussions.

Transition from Executive Council to Board of Directors

Important decisions will be made in the next few months that will determine the GHHN governance structure, especially the transition to the Board and its first-year composition.

It will be important for transparency to immediately expand the Executive Council during this transition.

Terms would be time limited to transition for the Board. There would be no guarantee the new members of the Executive Council would continue on the Board.

Recommendations to consider for the transition:

1. Discuss the appointment of an Indigenous Director in an ex officio role with the De dwa da deh nyes and the Coalition of Hamilton Indigenous Leaders (CHIL).
2. Request a nomination from the French Planning Entité 2 and the FLS designated organization for a Francophone Director.
3. Request nomination(s) from the GHHN EDI ARAO Steering Committee to expand population specific and community perspectives.
4. Revisit any current Executive Council members who may be open to change (e.g. physician representation, lived experience representation).

Starting the Journey:

1. Transition the GHHN EDI ARAO Steering Committee to the GHHN Health Equity Committee:
    a. Refresh/revisit current membership (commitment of current members was to May 31, 2021).
    b. Develop Terms of Reference for two-year commitment.

2. Expand the membership of the Executive Council as recommended as soon as possible (as per above).

3. Develop a matrix for the composition for the GHHN Board. Incorporate this matrix in the bylaws and in policy and issue an open Call for Nominations for a transparent process as timing permits.

4. Meet with the Coalition of Hamilton Indigenous Leaders (CIHL) and the Indigenous Primary Health Care Council (IPHCC) to begin the development of an ally governance relationship.

5. Formalize a partnership agreement between French Language Health Planning Entité 2 (FLHPE) and GHHN to design and implement a GHHN FLS plan.

6. Develop Terms of Reference for the Community Collaborators Council and the Sector Council that reflect the Health Equity Declaration of Commitment. The Terms of Reference to include criteria for participation. (NOTE: The structure for primary care is under development and will need to be incorporated as it matures.)

7. Once the engagement process has been completed, incorporate the directions to include the voices of patients, clients, users of the system and people with lived experience into the collaborative governance model.

8. Develop a Strategic Plan that incorporates the commitment to Health Equity.

9. Approve a Health Equity Action Plan for Year One.

10. Develop an Executive Committee/Board Governance Policy: Commitment to Health Equity that outlines the processes for accountability. (See Appendix A for consideration.)

Chapter Four
Health Equity Informed Care and Services

Recommendations:

1. Through a process of engagement, engage community members, populations specific organizations, users, patients and people with lived/living experiences and health and community organizations and providers to adopt the Principles for Health Equity Informed Care and Services that would guide the work of GHHN.
2. Develop a plan and metrics to apply the principles to the GHHN initiatives.
3. In consultation with the advisory Councils, review and prioritize the seven proposed strategic initiatives for transforming the delivery of care from the perspective of Health Equity.

Principles for Delivering Health Equity Informed Care

From consultations with seven population focused groups including Indigenous, Francophone, black health leaders, organizations working with immigrants and refugees, organizations, allies and member of the Two Spirit and LGBTQIA+ communities, organizations and allies working with people who use drugs, and community support agencies working in rural communities, the following key principles emerged to improve delivery of care through a health equity lens.

1. **"Nothing About Us Without Us"**: Ensure that the GHHN decision making bodies and working groups are representative as a whole of the population groups that are impacted by the initiative including patients, clients, residents, peer workers, people with lived/living experiences, community population groups, community organizations that work with impacted communities, and community agencies who provide supports and services to the impacted populations. Recognize the need for gender parity and ensure this is represented in the Working Groups.

2. **Collect Socio-Demographic and Race-Based Data**: Begin to collect socio-demographic and race-based data in each of the GHHN initiatives. Establish a data governance table to ensure communities that partner or participate in the process have the right to analyze the data and determine distribution in order to ensure appropriate interpretation and context.

3. **Ensure Knowledge about Community Expertise**: Learn about the community and other health service agencies that provide services to segmented populations in each of the initiatives and build on their expertise.

4. **"One Size Does Not Fit All":** Develop strategies for each of the segmented population groups within the initiative to identify the different needs, characteristics and behaviours of these groups to ensure care delivery and policies are tailored to meet the diverse needs; including but not limited, to multi-language interpretation, translation of information, and provision of gender affirming spaces.

5. **Training**: In consultation with specific population informed organizations, determine comprehensive and ongoing anti-oppression and anti-racism training for staff from organizations involved in the GHHN initiatives. Work with partners through the Sector Council to determine how to make this training mandatory.

6. **Integrated Pathways**: Develop integrated pathways for care for segmented population groups who are impacted by the initiative; use peer workers and other support workers from existing agencies to help people to navigate the system.

7. Encourage partners to **look for, engage, hire people** who are already grounded in the work with leadership that reflects the people who are being served by the initiative.

8. Develop strategies to meet the **multi-lingual interpretation and translation** requirements of the people being served; ensure all materials are translated into French and other priority languages for the initiative.

9. Develop strategies to ensure **appropriate pronouns, names and gender identity** are recognized and integrated in all aspects of client service (i.e. Intake forms, front desk uses appropriate names, clinicians' use of names).

10. Ensure **signage for Two Spirit and LGBTQIA+ positive care** with a specific focus on trans-specific care is posted using multi-languages. In consultation with community, conduct external positive space audits before organization puts up signage.

11. Integrate **harm reduction approaches i**n all initiatives, especially congregate settings, aligned with the Hamilton Drug Strategy's harm reduction strategy. Review the "Hospital policy as a harm reduction intervention for PWUD"[10] for the six policy changes that could be adapted to GHHN initiatives.

12. Integrate **rural impacts** in each initiative as appropriate. Do not address rural issues as an afterthought.

13. Embed accountability through **annual reporting of health outcomes of relevant populations within the GHHN initiatives**. Begin to prioritize the collection of socio-demographic and race-based data, and in the meantime, solicit community responses and their experiences as an iterative improvement process.

[10] Hospital policy as a harm reduction intervention in PWUD. To be published in International Journal of Drug Policy, 2021. NOTE PWUD means: People who use drugs.

Recommendations: Adopting and Applying Principles to current GHHN Priorities in Congregate Settings

Over the last three months, as a result of gaps exposed during COVID-19, the GHHN refined its priority populations to focus on congregate settings under a "living healthy in congregate care" strategy.

COVID-19 exposed disparities in access, equity, and housing throughout the City of Hamilton. In response to the pandemic, health and social service providers worked together in new and innovative ways to support people living in Hamilton. One of the key areas highlighted were the gaps in care in the continuum of congregate settings. Many of these congregate care settings require multi-layered responses including but not limited to access to primary care, access to psychiatric and addiction services, specialty services, system navigation, and recreation. Better integrated connections were formed during the pandemic but there is so much work left to be done to create a supportive system for residents, staff, and providers in congregate care.

As a result, the GHHN has refined a congregate care strategy that will focus on:

- Women's Homelessness
- Care in Residential Care Facilities
- Care in Retirement Homes
- Care in Long-Term Care Homes

- Women's Homelessness
    - There is a common understanding that woman's homelessness is a complex issue and that supports, and interventions need to be sensitive to the intersectionality's women face. A joint approach to helping address barriers will require a network of supports that includes reaching out to women and meeting them where they are at, while taking into account the appropriate in reach services being available. Members of the women's homeless working group have agreed to take a deeper look into the barriers, gaps, successes and lived experiences of our current models of care and outreach for women.

- Care in Residential Care Facilities
    - Those living in Residential Care Facilities (RCFs) are some of the most vulnerable individuals in Hamilton and the RCF system remains a critical part of the housing continuum. There is a common understanding that the current system of RCF care requires more intensive person-centered approaches to health and social care. Creating a supportive network to wrap around individualized support for residents has already started in a pilot home and the GHHN is now spreading this model to other homes in highly marginalized areas in the city core. An RCF Secretariat working group is convening to take the lessons learned from the pilot homes and understand more fully the vision for supports in the RCF environment on a broader scale including who is and is not accessing this system.

- Care in Retirement Homes and Long-Term Care Homes:
    - There has been much progress in the collective community and acute care support for those living in retirement home and long-term care over the last year through the pandemic. Ensuring these integrated networks of support continue and thrive is essential as a focus

moving forward. There is a common understanding that there are access gaps in retirement homes and long-term care which include providing culturally appropriate care, mental health and addictions and safe space for diverse and marginalized populations. Led by the community and primary care, work in retirement homes and long-term care will focus on pilot homes working together under collective, evidence-based, and patient-centered mandates. Tailoring supports and continuity of care will be a main driver.

Each of these streams of work were developed using community expertise, consultations, data, and patient experience. The GHHN formally acknowledges and appreciates that certain areas of focus do not have robust data (women's homelessness, residential care facilities, and retirement homes) but that cannot be a limiting factor in deciding where to focus. Experiences from care providers and those living in these environments have identified that there are complex social, medical, and mental health needs that require a person-centered, tailored approach to care.

Using a population health management lens, in-reach and outreach services will be examined to understand the gaps in who is currently receiving care and who is not. This work will and has already started to use the experience of peer workers, those with lived and living experiences, and the expertise of those who provide care to marginalized populations.

Incorporating a health equity approach will be integral to all these foundational working groups and although early steps have been taken, the GHHN is just starting its journey.

A key barrier is that every partner is at a different place when it comes to the following priorities:

- Developing a data collection policy that incorporates socio-demographic and race-based data: This is currently not something signed off by partners of the GHHN yet and each organization has different data points they are currently mandated to collect.
- Developing anti-racism and anti-oppression and trauma-informed care training: Partners of the GHHN are in different stages when it comes to training their own staff and providers.
- Engagement: Organizations and partners have all completed various levels of engagement with peers, persons with lived experience and staff. The GHHN does not want to duplicate this good work but rather build on it for action but organizing this can be challenging.

Health Equity-Informed System Change Initiatives

During the consultations, seven key initiatives were identified as critical to improving care through a health equity lens. Each of these initiatives would transform the system and are long term commitments. The Executive Council/Board, in partnership with the Councils will need to establish priorities for this work.

1. Develop an anti-oppression and anti-racism education and training strategy.

The number one call to action from all population groups was the need to address the constant, harmful, discriminatory micro-aggressions that people experience as soon as they leave the comfort of their own home or their own community focused organization.

Racism, discrimination, and stigma in the form of micro aggressions are experienced across the entire health system, including community agencies that are not designed to meet their specific population needs. Participants in the consultations especially identified that many people experienced micro-aggressions in hospitals as that is the place when people are the most vulnerable and in need of urgent care.

> *"Constant racism and oppressions in the form of micro aggressions and systemic racism makes us sick.*
>
> *I need to get ready each day I walk out the door to prepare myself to be belittled, looked down upon. I am judged and seen as less intelligent before I speak.*
>
> *Just the looks demoralize me every day."*
>
> *a professional black leader*

Calls to Action:

- Acknowledge that racism makes people sick and is a significant determinant of health.
- Require members of the advisory Council(s) as they become formalized, to develop Health Equity Action plans, including investment in education and training to begin their own journey of addressing systemic barriers.
- Action must begin at all levels of the organization from the board to the executive leaders to front line staff.
- In each of the working groups of GHHN, explore whether populations are experiencing micro aggressions in the congregate settings and develop appropriate strategies to address the findings. Monitor progress through patient and user experience surveys and share results with organizations.

Education partners include but are not limited to:

- Indigenous Primary Health Care Council for Indigenous Cultural Safety
- Rainbow Health Ontario on Two-spirit LGBTQIA+ specific and gender affirming care
- French Language Planning Entité on Active offer
- Hamilton Trans Health Coalition for a training primary care partners

Starting the Journey:

1. **Identify education resources that partners could access**: Each organization in GHHN is increasingly looking at how to provide appropriate education for their own organizations that covers a wide range of populations. There are significant resources available but not everyone is aware of them or how to access them.

2. **Determine how much training is currently underway:** Determine if there could be a common strategy among partners to maximize cost effectiveness and efficiency.

3. **Partner with Ontario Health:** In the Ontario Health's Equity plan it states that "OH will select 2-3 areas where they will fund the system to support HSPs to work together to provide consistency of outcomes and achieve economies of scale (e.g. training programs, equity capacity building initiatives)." Approach Ontario Health to develop an AO/AR education strategy for the GHHN.

2. Socio-demographic and race-based data collection

Ontario Health has identified the need for all health service providers to collect socio-demographic and race-based data. They are currently developing common standards and are looking at embedding it in the primary care electronic medical records. (Note: Standardized data collection for SD&RB data is already embedded in the Practice Solutions EMR.) The GHHN Executive Council has committed to the collection of socio-demographic and race-based data for GHHN projects.

Starting the Journey:

1. Establish a community data governance table to oversee the use and analysis of the data.

2. Develop a strategy to collect disaggregated socio-demographic and race-based data across the partners and in GHHN initiatives that include standardized data.

3. Use the OCAP principles for Indigenous Data and the EGAD principles as outlined in "Engagement, Governance, Access and Protection (EGAP): A Data Governance Framework for Health Data Collection from Black Communities in Ontario."

3. Develop a sustainable System Navigator Program

While the health system is still fragmented, develop a sustainable system of peer workers, system navigators, and cultural ambassadors to help people navigate the system. These positions should be anchored in the community and in primary care and help people navigate across the entire continuum of care throughout their life span.

The core mandate of the GHHN is to develop an integrated, coordinated system of care across the continuum of the health system. Currently, the system is fragmented and siloed, leaving patients and users with many barriers to accessing care. In response, many community organizations use

peer workers, community ambassadors, and system navigators to help people navigate the system. However, these roles are often funded as pilots or with other forms of non-sustainable funding.

The advantage of locating these roles in the community organizations is that they know the communities they serve and can help patients and users to move across the continuum of care as required. These roles can be tailored to meet the cultural and linguistic needs of the patients and users.

System navigators and care coordinators for the medially complex could also be embedded in primary care organizations that are grounded in community, are team-based, and are culturally and linguistically accessible.

As funding is identified, the long-term goal would be to develop a sustainable system navigator program anchored in the community and in team-based primary care.

Starting the Journey:

1. In the GHHN initiatives, assess the need for system navigators as part of the strategy and determine the partners' current capacity to provide these services.
2. Determine if there are ways to enhance the capacity through co-operation and collaboration.

4. Interpretation Services

The call for timely access to qualified interpretation services for people who do not speak English was a major theme in the consultations, especially for French Language services and other major languages spoken in Hamilton by new immigrants and refugees. Access to interpreters is limited and not readily available in a timely manner and only in a few settings. In person interpretation is considered the best approach. Most written information is only available in English. Despite Hamilton being a designated FLS area, there is little to no information available in French.

For people who do not speak English, access to the health system is fraught with misunderstandings and anxiety. During the consultations it was reported that children and minors are frequently being used as interpreters to inform parents of often life changing conditions including cancer diagnoses. Other examples include children interpreting diagnoses related to sexual health and children being asked to explain the trauma that their parents experienced, to their provider. This experience is often retraumatizing for the child and parent. Participants expressed concern that using children as interpreters can be dangerous and is unacceptable.

The immigrants and refugees' consultation urged the GHHN and its partners to make it a priority to offer appropriate interpretation to the circumstances. A question was asked: Would the provider have the child in the room if interpretation was not required? If no, then it is incumbent on the provider to find appropriate interpretation services in a timely manner.

In an article published by Dynamic Language[11], it stated that the "dangerous and potentially serious outcomes inherent in relying on underage and untrained bilingual children to interpretation far outweighs the potential benefits of having them take on the challenge of communication on behalf of the parent or the provider. In hospitals or clinic settings where consequences of mistakes can be serious, even life threatening, it would seem inherently obvious that a bilingual minor, no matter how high linguistically, should never operate in the capacity of an interpreter between a medical professional and a family member.

Starting the Journey:

1. Within GHHN initiatives:
   a) Ensure materials are available in French and in the languages of the participants in the initiative.
   b) Assess the need for interpretation and determine the capacity of partners to develop interpretation services.

2. Assess the capacity of interpretation and translation in GHHN initiatives and encourage collaboration among partners to enhance appropriate interpretation services.

3. Conduct a capacity assessment of existing organizations to provide interpretation and translation services in GHHN and discuss a strategy to share resources to develop a cost effective, timely and appropriate interpretation program.

4. Learn more about the Hamilton Immigrant Partnership Council (HIPC), led by the City of Hamilton to develop an interpretation and translation system and determine its applicability to the health system.

5. Home Care

Sometime, in the future, if the OHT mandate is clarified for home care, the GHHN needs to develop a culturally, linguistically and gender affirming home care delivery system that meets the needs of diverse communities to keep their families at home.

During the consultation regarding long-term care and retirement homes, all population groups identified that there were serious challenges in finding culturally, linguistically, Two Spirit and LGBTQIA+ and gender affirming care in these facilities. The call for solutions to LTC and retirement homes always went to the need for a more robust home care delivery system that enables families to keep elders in their own homes.

While the Ministry of Health is currently establishing an Ontario Home Care agency to oversee the evolution of home care, it is the current understanding that the Ontario Health Teams will eventually be a key delivery partner.

As soon as the road map is clarified, it is recommended that the GHHN engage with the new agency to be a leader in developing an equity-informed home and community care system.

[11]The danger of using children as their parent's interpreter. www.home.DLD.

In the meantime, as soon a COVID-19 is under control, continue to advocate for the (former LHIN) care coordinators to be co-located in primary care. Many FHTs and physicians have identified the valuable service to patients for increased access to community care services but also in helping patients navigate the system.

Starting the Journey:

1. In partnership with the Primary Care members in GHHN, develop a strategy to continue to advocate that the former LHIN Care Coordinators be embedded in Primary Care.

2. Evolve the care coordinator role to system navigators (acknowledging that other agencies also have system navigators.)

   A significant resource is "Connecting Care Coordination with Primary Care: Guidance for Ontario's LHINs" from November 2017. This document was guidance provided to the LHINs by the Ministry of Health and used an equity lens.

6. Primary Care:

There is a significant need for the GHHN to develop a primary care system that has a health equity focus. Primary care is the entry point to the system for most people. According to GHHN, 95% of the people in the GHHN attributed population has a primary care provider. However, the lack of access to primary care that is culturally competent and LGBTQIA+ and gender affirming was cited as one of the key concerns through the consultations.

While people may have a primary care provider, they may not have effective access due to language barriers, lack of capacity of primary care provider to provide Two Spirit and LGBTQIA+ and gender affirming care, unwillingness to support people who use drugs, and/or lack of transportation for rural communities. In addition, primary care is increasingly using virtual visits for primary care services. Lack of access to internet, computers, and cell phones are an increased barrier to people in some rural communities and for people who live in poverty.

See the Supplementary Report for recommendations regarding primary care throughout each chapter.

Starting the Journey:

1. To work with the emerging primary care structure to develop a health equity focused primary health care strategy.

7. Mental Health Services

The lack of culturally appropriate and accessible mental health and HIV services was identified across population groups. There was a strong call for mental health and addictions services to be anchored in population focused organizations that understood the culture and spoke the appropriate languages. It was recognized that interpretation is not necessarily the solution as it was equally or more important that the providers understood the culture in order to provide appropriate services.

This is a longer-term initiative to develop a strategy for culturally appropriate mental health and addiction services.

Starting the Journey:

1. Map the capacity of the mental health service providers to provide French Language services, culturally and linguistically appropriate services, and Two-spirit and LGBTQIA+ services in order to immediately make appropriate referrals.
2. Develop a long-term strategy and road map to address the gaps.

Chapter Five

The Operations of the Greater Hamilton Health Network with a Health Equity

Recommendations for GHHN's Operations:

1. That the Executive Council/Board establish the Director's Executive Limitations to ensure they incorporate the commitments to health equity.

2. That the Director develop an operation development plan that incorporates health equity in the organization's policies. Priorities are identified in the report.

Lens

The GHHN staff team is the face of the GHHN's commitment to health equity.

One of the key themes from all the consultations is that the GHHN staff team needs to reflect the diversity of the people it is working with – that they need to 'see themselves' in the organization and in leadership roles. It is critical for the Director to know its authorities and to see in policy the GHHN requirement to do health equity work.

Therefore, it is strongly recommended that, in the first year, the following policies and strategies be developed.

Policies

1.1 The Executive Council/Board establish the Director's Executive Limitations to ensure they incorporate the commitments to health equity. This is the work of the Executive Council/Board to approve.

Direction to the Director

1.2 Develop a recruitment strategy to ensure staff reflect the diversity of Hamilton and the priority populations for the GHHN inclusive but not limited to:
- 1.2.1 Set diversity targets and develop a strategy to achieve the targets;
- 1.2.2 Ensure each job postings has a strong commitment to and experience with EDI & AR;
- 1.2.3 Distribute job postings using non-traditional venues in order to ensure it reaches diverse individuals.

1.3 Develop a retention strategy that will support diverse staff in their roles; addressing any issues related to feeling marginalized in their roles.

1.4 Develop human resources policies that reflect commitments to health equity.

1.5 Develop an annual operating plan that advances the commitments to health equity, including work plans for all staff.

1.6 Develop a performance appraisal system that:
- 1.6.1 Requires all staff to develop health equity in their individual workplans;
- 1.6.2 Monitors progress on achieving their health equity deliverables in their workplans through the annual performance appraisal program.

Starting the Journey:

1.7 Develop an annual education plan for staff that ensures staff continue to grow in its understanding of AR/AO and Health Equity including:
- 1.7.1 An orientation plan of required AR/AO and health equity training.
- 1.7.2 An annual plan for ongoing development.

1.8 Develop a FLS policy that outlines:
- 1.8.1 The degree to which GHHN will deliver FLS services (i.e., what type of documents will be translated, will website be bilingual?);
- 1.8.2 Determine any designated bilingual positions.

1.9 Develop an annual budget that includes appropriate funding to fulfil the deliverables related to the Health Equity Action Plan(s).

Appendix A

DRAFT Governance Policy: Health Equity

The GHHN Executive Council/Board of the Greater Hamilton Health Network is committed to ensuring its policies, processes, and practices are reflective of its Health Equity Framework. It seeks to embed the beliefs, recognitions, and commitments in the GHHN Health Equity Declaration of Commitment in the fabric of the GHHN.

Notwithstanding the generality of the foregoing:

1. The GHHN will develop strategies on health equity that focus on Indigenous, Francophone, and racialized with a focus on the black population, Two Spirit and LGBTQIA+, immigrants and refugees, and people who use drugs, people with disabilities and rural communities. Intersectional lenses including poverty, disabilities, and gender will inform the strategies.

2. The commitment to health equity through an anti-oppression and anti-racism lens, inclusive of diversity and inclusion requires the Executive Council/Board to plan for and evaluate its commitment in all its products specifically by:

    2.1 Ensuring that the strategic plan and annual operating plan reflect a commitment to Health Equity, which includes a focus on anti-oppression, anti-racism, inclusion and diversity.

    2.2 Ensuring that the Executive Council/Board's education plan and orientation for new Directors incorporates sufficient education on anti-oppression and health equity so that the entire Executive Council/Board retains its commitment to health equity.

    2.3 Ensuring that the advisory Councils including the Community Collaborators Council and the Sector Council reflect the GHHN's commitment to health equity by ensuring the participants reflect the diversity of the populations and the priority groups as identified by the GHHN; and that there is an education strategy within the workplans to ensure ongoing education in Health Equity, Anti-oppression and Anti-racism.

    2.4 Ensuring the Executive Council/Board's governance policies and practices reflect its commitment to health equity at the Board level.

    2.5 Ensuring the Executive Council/Board's nomination process results in an Executive Council/Board that is reflective and inclusive of its identified population groups.

    2.6 Ensuring the direction to the Director of the GHHN, through the executive limitations is reflective of the commitment to health equity, including developing an annual Health Equity Action Plan.

    2.7 Ensuring that sufficient resources are identified in the annual budget to support the work identified in the GHHN Health Equity Action Plan.

3. The GHHN will be held accountable to the attributed population through the following mechanisms:

    3.1 The GHHN Executive Council/Board seek the input from the advisory Council(s) and the Working Groups in the development of the annual Health Equity Action plan.

    3.2 The Councils will participate in the evaluation of the progress of the Action Plan and the results will be shared on an annual basis.

    3.3 The final year end progress report of the GHHN commitment to Health Equity will be published annually and distributed to networks and on the website.

Source: Adapted from the Alliance for Healthier Communities GP Commitment to Anti-oppression and Health Equity.

Appendix B
Building a Common Understanding: Glossary of Terms[12]

Anti-Oppression[13]

Anti-oppression asks us to dive deeper in examining power dynamics and structures, and openly challenging the concept of "rightness" of the dominant group. The dominant group is often seen to represent the norms within society. Those who fall outside of the dominant group become invisible as their perspectives and ways of being and living are not considered. They may find themselves misunderstood, unrepresented, isolated, or even completely silenced or unsafe. Anti-oppression begins with how we uproot our own assumptions and prejudices, and call to surface oppression that may be unconscious. By having open conversations about oppression and its impact, it becomes easier for unconscious biases to be identified and addressed.

Anti-Racism

An anti-racism approach is a systematic method of analysis and a proactive course of action. The approach recognizes the existence of racism, including systemic racism, and actively seeks to identify, reduce and remove the racially inequitable outcomes and power imbalances between groups and the structures that sustain these inequities.

Anti-Black Racism

The policies and practices rooted in Canadian institutions such as education, health care, and justice that mirror and reinforce beliefs, attitudes, prejudice, stereotyping and/or discrimination towards Black people and communities.

Anti-Indigenous Racism

Anti-Indigenous racism is the ongoing race-based discrimination, negative stereotyping, and injustice experienced by Indigenous Peoples within Canada. It includes ideas and practices that establish, maintain and perpetuate power imbalances, systemic barriers, and inequitable outcomes that stem from the legacy of colonial policies and practices in Canada.

Collaborative Governance

Collaborative Governance is a governing arrangement in which leaders from different organizations drawn from multiple sectors engage in a collective decision making process that is deliberate, consensus-oriented, and directed to the achievement of a shared goal (in OHTs' case, the quadruple

[12] Other than where otherwise footnoted (including Anti-Oppression, Collaborative Governance, Governance, Indigenous Health in Indigenous Hands, Oppression, Population Segments, Population Health, Power, and Privilege), all definitions were extracted from the Glossary of Terms provided by the Ontario Health Equity and Anti-Racism Framework. Ontario Health used the McGill University Equity, Diversity and Including Strategic Plan (2020-2025); the UHN Anti-Racism and Anti-Black Racism (AR/ABR) Strategy; and the 519 Glossary of Terms around equity, diversity, inclusion and awareness.

[13] Anti-Oppression Framework, Marigold Capital, https://marigold-capital.com/marigold-capital-anti-oppression framework/#:~:text=The%20six%20main%20lenses%20of,is%20intersectionality%20within%20oppressed%20groups

aim.)[14] The premise behind collaborative governance is that "if you bring the appropriate people together in constructive ways with good information, they will create authentic visions and strategies for addressing the shared concern of the organization or community."[15]

Diversity

The range of visible and invisible qualities, experiences and identities that shape who we are, how we think, how we engage with, and how we are perceived by the world. These can be along the dimensions of race, ethnicity, gender, gender identity, sexual orientation, socio-economic status, age, physical or mental abilities, religious or spiritual beliefs, or political ideologies. They can also include differences such as personality, style, capabilities, and thought or perspectives.

Equity

Unlike the notion of equality, equity is not about sameness of treatment. It denotes fairness and justice in process and in results. Equitable outcomes often require differential treatment and resource redistribution to achieve a level playing field among all individuals and communities. This requires recognizing and addressing barriers to opportunities for all to thrive in our society.

Governance

Governance in its broadest form is how individuals and/or groups organize to make decisions. It determines who has power, who makes decisions, how different stakeholders' voices are heard, and how accountability is rendered.[16]

Health Disparities

Differences in health access, experiences, or outcomes in a way that is systematic, patterned, and preventable.

Inclusion

Inclusion recognizes, welcomes, and makes space for diversity. For example, an inclusive organization capitalizes on the diversity of thoughts, experiences, skills, and talents of all employees.

Indigenous Health in Indigenous Hands

Indigenous health in Indigenous hands means that health care must be planned, designed, developed, delivered and evaluated by Indigenous-governed organizations.[17]

Intersectionality

The ways in which our identities (such as race, gender, class, ability, etc.) intersect to create overlapping and interdependent systems of discrimination or disadvantage. The term was coined by Black feminist legal scholar Dr. Kimberlé Crenshaw and emerged from critical race theory to understand the limitations of "single-issue analysis" in regard to how the law considers both sexism and racism. Intersectionality

[14] Rapid-Improvement Support and Exchange (RISE). RISE brief 3: Collaborative governance. August 8, 2019.

[15] David Chrislip. The Collaborative Leadership Fieldbook. Jossey-Bass. July 11 2002.

[16] Institute on Governance. https://iog.ca/what-is-governance/

[17] Indigenous Health in Indigenous Hands www.IPHCC.ca

today is used more broadly to understand the impact of multiple identities to create even greater disadvantage.

Oppression

Oppression is the use of power to marginalize or disempower an entire social group or category, often while it further provides advantages to those in positions of power. Before challenging and mitigating oppression, it is imperative to identify and understand oppression and the consequences it has on society and individuals. Oppression occurs at many levels, such that visible oppression (bullying or physical harm) and invisible oppression (language, laws, mindsets, traditions) are inextricably linked. Invisible oppression can be said to precede visible oppression, as the socialized stereotypes and biases are often the basis of hatred or fear that is displayed as emotional or physical abuse toward oppressed groups. At an institutional level, these beliefs are reinforced by policies and laws. Because it is largely the dominant group that creates policies and laws, those in the dominant group need to become inclusive allies to oppressed groups to help effect change.[18]

Population Health

The health outcomes of a group of individuals, including the distribution of such outcomes within a group.[19] Population health is an approach to health that aims to improve the health of the entire population and to reduce health inequities among population groups. In order to reach these objectives, it looks at and acts upon the broad range of factors and conditions that have a strong influence on our health.[20] In Ontario, approximately 22 percent of the population face the most significant barriers to care. People who live in poverty are the overall driver with intersections of:

- Indigenous communities,
- Francophones,
- Racialized with a focus on Black communities,
- Immigrants and refugees,
- Two Spirit LGBTQIA+,
- People living with disabilities,
- Some rural communities,
- People living with disabilities,
- Within these populations, women (generally) have worse health outcomes than men.[21]

Population Segments/Segmentation

If care is to be truly centered on people, their specific care needs and other characteristics must be addressed. While it is practically impossible to develop care models and intervention programs for each individual, programs can be created for groups of people with largely similar characteristics. The

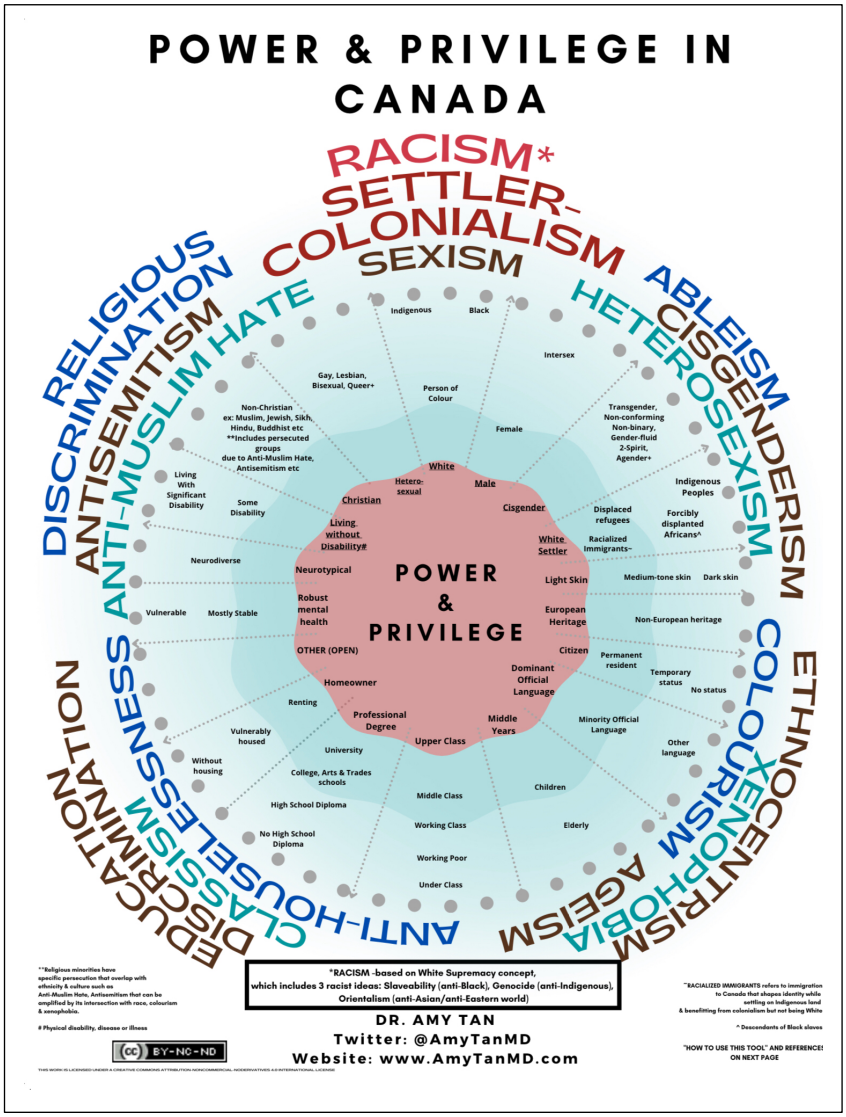
[18] Anti-Oppression Framework, Marigold Capital https://marigold-capital.com/marigold-capital-anti-oppression-framework/#:~:text=The%20six%20main%20lenses%20of,is%20intersectionality%20within%20oppressed%20groups
[19] Kindig & Stoddart. American Journal for Public Health (AJPH) 2002; 93(3):380-3
[20] https://www.canada.ca/en/public-health/services/health-promotion/population-health/population-health-approach.html
[21] Alliance for Healthier Communities. Towards Equity in Access to Community-Based Primary Health Care: A Population Needs-Based Approach. 2013.

creation of these groups is known as segmentation. Segmentation divides a population into distinct groups—each with specific needs, characteristics, or behaviours—to allow care delivery and policies to be tailored for these groups.[22] GHHN's focus on different congregate settings during the COVID-19 pandemic (e.g., shelters, RCFs, long-term care homes and retirement homes), are examples of populations that require a further segmented approach using socio-demographic and race-based data analyses and information from community partners. For example, residents of shelters may require differential strategies and/or tactics to achieve equitable outcomes for Indigenous, Francophones, racialized, women and youth, immigrants and refugees, Two Spirit and LGBTQIA+, people who use drugs, formerly institutionalized and people who live in rural areas. A gender-based analysis approach would also be required.

Power[23]

Power manifests itself in the following:

- Authority: position or role in an organization.
- Knowledge: expertise, knowledge, skills, and information.
- Status: advantages granted or denied because of social identity, racialization, gender, class, religion, nationality, ethnicity, education, physical and mental abilities, and sexual identities or orientation.
- Informal: rank in a group based on degree of belonging. e.g. popularity, seniority, alliances.
- Personal: innate and developed traits, skills and abilities that help one succeed in life.
- Personal: innate and developed traits, skills, and abilities that help one succeed in life.



[22] S.I. Vuik, E.K. Mayer, A. Darzi. Patient Segmentation Analysis Offers Significant Benefits for Integrated Care and Support. Health Affairs. Vol. 35, No. 5. May 2016. https://doi.org/10.1377/hlthaff.2015.1311

[23] Tan, Amy. "Power and Privilege in Canada Graphic Tool".

Privilege

Privilege is unearned advantage given to only a particular group of people in a system/society that is not enjoyed by other groups.[24] Privilege describes benefits that belong to people because they fit into a specific social group or have certain dimensions to their identity. One can have (or lack) privilege because of racialization, gender, sexual orientation, religion, class, among many other characteristics. Having privilege means having an advantage that is out of one's control and that one did not ask for. One may not even notice it until one educates themselves about its existence. Privilege and lack of privilege are how power is distributed.[25]

Sex/gender Based Analysis[26]

Sex and gender-based analysis (SGBA) is a systematic approach to research, legislation, policies, programs, and services that explores biological (sex-based) and socio, cultural (gender-based) similarities and differences between (cis/trans) women, and men, boys and girls. It involves asking additional questions in research and /or policy and program development about men and (cis/trans) women, boys and girls, identifying existing evidence and gaps in evidence. It challenges us to identify how differences will be considered. SGBA applies within the context of a diversity framework, that attends to the ways in which determinants such as ethnicity, socioeconomic status, disability, sexual orientation, migration status, age and geography interact with sex and gender to contribute to exposures to various risk factors, disease courses and outcomes. Using a SGBA lens brings these considerations into focus and can help to formulate research, policies, programs, and legislation that are relevant to the diversity of the Canadian populace.

NOTE: For the purpose of interpreting the above definition, the Two-Spirit and LGBTQIA+ working members of the Steering Committee recommends gender-affirming language to inserted in the definition to explicitly include cis/trans in its definition of gender.

Structural Racism

Structural racism is a system in which public policies, institutional practices, cultural representations, and other norms work in ways to reinforce and perpetuate racial group inequity. It identifies dimensions of history and culture that have allowed white privilege and disadvantages associated with colour to

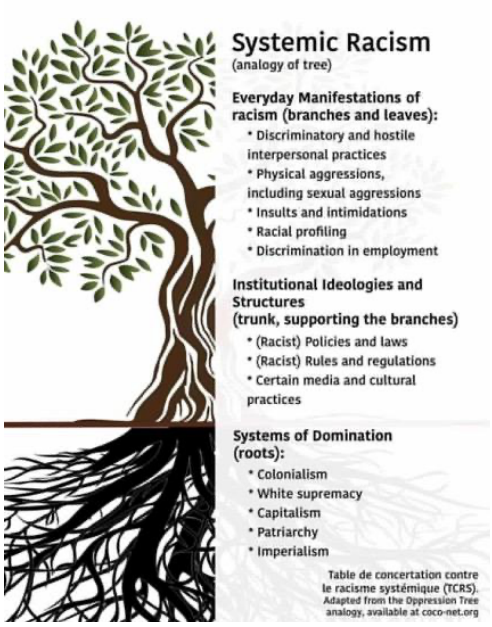
[24] Tan, Amy. "Power & Privilege in Canada Graphic Tool."
[25] Anti-Oppression Framework, Marigold Capital https://marigold-capital.com/marigold-capital-anti-oppression-framework/#:~:text=The%20six%20main%20lenses%20of,is%20intersectionality%20within%20oppressed%20groups
[26] https://www.canada.ca/en/health-canada/corporate/transparency/corporate-management-reporting/health-portfolioe-sex-gnder-based-analysis-policy.html

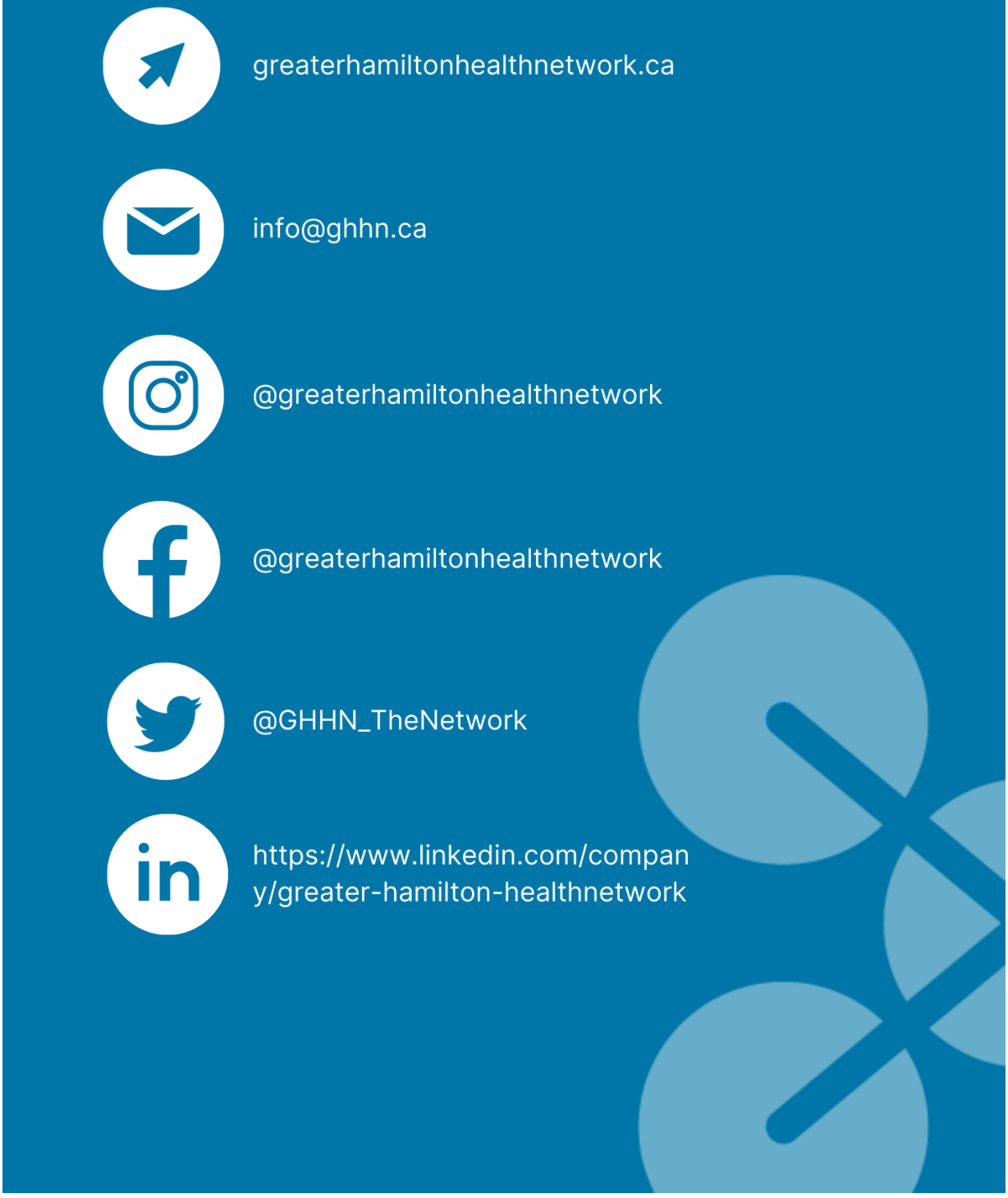
endure and adapt over time. Structural racism is not something that a few people or institutions choose to practice. Instead it is a feature of the social, economic, and political systems in which we all exist.

Systemic Racism

Organizational culture, policies, directives, practices or procedures that exclude, displace or marginalize some racialized groups or create unfair barriers for them to access valuable benefits and opportunities. This is often the result of institutional biases in organizational culture, policies, directives, practices, and procedures that may appear neutral but have the effect of privileging some groups and disadvantaging others.

"Without the roots, the tree would die."
The Rez Project




greaterhamiltonhealthnetwork.ca
info@ghhn.ca
@greaterhamiltonhealthnetwork
@greaterhamiltonhealthnetwork
@GHHN_TheNetwork
https://www.linkedin.com/company/greater-hamilton-healthnetwork

Ad Hoc Working Group for the Transfer of the Physician Recruitment and Retention Program to the Greater Hamilton Health Network

Summary Report Regarding Proposal to Transfer Program into the Greater Hamilton Health Network

Council Direction

At its meeting of January 25, 2023, Council amended Item 3 of Board of Health Report 22-008, August 10, 2022 (originally approved by Council on August 12, 2022), as follows:

3. Physician Recruitment and Retention Steering Committee Report 22-002 - August 5, 2022 (Item 10.1)

(a) Working Group of the Physician Recruitment and Retention Steering Committee Report 22-001 (Item 1)

(i) Proposal to Transfer Program into the Greater Hamilton Health Network & Formalize Existing Funding Relationships (Item 4.1)

(1) That Physician Recruitment and Retention Program (Hamilton Physicians), with the support of the Greater Hamilton Health Network, attached as Appendix A to Physician Recruitment and Retention Steering Committee Report 22-002, be transferred to the Greater Hamilton Health Network (GHHN), as an independent department therein, reporting to the Executive Director of the GHHN, on a date mutually agreed upon and no later than February 28, 2023, attached to Working Group of the Physician Recruitment and Retention Steering Committee Report 22-001 as Appendix B to Physician Recruitment and Retention Steering Committee Report 22-002;

(2) That from the date of the transfer, Physician Recruitment and Retention Program (Hamilton Physicians) staff will become employees of the Greater Hamilton Health Network (GHHN):

(aa) with the same terms and conditions of employment;

(bb) from which time they will adhere to GHHN policies; and

(cc) may have the opportunity to become permanent employees of the GHHN;

(3) That the Key Performance Indicators (KPI) of the Physician Recruitment and Retention Program (Hamilton Physicians) will remain unchanged upon the initial transfer of the Program to the Greater Hamilton Health Network (GHHN) and any future changes will require approval of the

Executive Council of the GHHN and that the GHHN provide an annual report to the Board of Health on the KPIs;

(4) That the following be transferred to the Greater Hamilton Health Network (GHHN):

(aa) All existing property purchased by Hamilton Physicians, including all office furniture, equipment and supplies;

(bb) Administration for payroll and expenses;

(cc) The balance of the City of Hamilton’s current contribution to the Physician Recruitment and Retention Program (Hamilton Physicians) operating budget of $75,000;

(dd) Payments from existing funding partnership arrangements;

(ee) All Physician Recruitment and Retention Program (Hamilton Physicians) surplus funds (as of May 31, 2022, this amount is $515,116.05), net any outstanding liabilities; and

(ff) The Hamilton Physicians brand, which will be maintained by the Greater Hamilton Health Network (GHHN);

(5) That the Greater Hamilton Health Network will commit all budgeted future Physician Recruitment and Retention Program (Hamilton Physicians) funding payments to physician recruitment and retention efforts;

(6) That the Greater Hamilton Health Network (GHHN) will pursue formal funding arrangements with the Physician Recruitment and Retention Program (Hamilton Physicians) current partners and with other stakeholders, including the other municipalities within its mandate;

(7) That an ad-hoc working group, be established, as follows:

(aa) The ad-hoc working group shall consist of one representative from each of the Physician Recruitment and Retention Program stakeholders

(bb) The ad-hoc working group shall report to the Working Group of the Physician Recruitment and Retention Steering Committee;

(cc) The ad hoc working group shall investigate the details of the program transfer from the Hamilton Physicians partnership to the Greater Hamilton Health Network (GHHN) including, but not limited to, those considerations set out in subsections (a) through (f);

(dd) The ad hoc working group shall be disbanded on the successful and final transfer of the Physician Recruitment and Retention Program to the GHHN;

(ee) The Working Group of the Physician Recruitment and Retention Steering Committee shall develop and approve the terms of reference for the ad hoc working group;

(8) That the Physician Recruitment and Retention Steering Committee:

(aa) be established for the 2022-2026 Term of Council; and

(bb) be disbanded upon the transfer of the Physician Recruitment and Retention Program to the Greater Hamilton Health Network; and

(9) That the Executive Director of the Greater Hamilton Health Network, or their designate, be invited to attend the next meeting of the Recruitment and Retention Steering Committee.

(10) That the Medical Officer of Health be authorized to execute any and all agreements, amendments and ancillary documents necessary to transfer the Hamilton Physicians program to the Greater Hamilton Health Network, in a form satisfactory to the City Solicitor.

The Ad-Hoc Working Group has finalized the transfer arrangements which will allow for the successful transition of the Physician Recruitment & Retention Program (Hamilton Physicians) to the Greater Hamilton Health Network (GHHN) by February 28, 2023. The GHHN will formally assume responsibility of the Physician Recruitment and Retention (PR&R) Program on March 1, 2023. The details of the transfer are set out below.

Section 1: Transfer of Funds Currently Held by the City of Hamilton to the GHHN

Each of the five current funding partners of the PR&R Program (Hamilton Health Sciences, St. Joseph’s Healthcare Hamilton, McMaster University, McMaster University Department of Family Medicine, and the Hamilton Family Health Team) were asked to confirm that the portion of their contributions to the funds currently held in surplus for the PR&R Program by the City of Hamilton may be transferred to the GHHN. Consent was obtained via signed consent and waiver agreements from four of these five partners. McMaster University opted to have their contributed portion of the surplus returned, and discussions are currently underway regarding retaining the surplus as well as securing future funding.

Of the remaining surplus funds (less the portion returned to the McMaster University), a portion will be held back to cover anticipated legal costs for the PR&R Program. Any remaining funds following the culmination of the matter will be transferred to the GHHN.

As of February 28, 2023, all funds held by the City of Hamilton for the PR&R Program (less any outstanding expenses, payroll deductions, and liabilities) will be transferred into the GHHN.

The City of Hamilton currently contributes $75,000 per year to the PR&R program and has committed to continue to include this funding in its annual budget. Any approved funding from the City of Hamilton for PR&R initiatives moving forward will be allocated to the Greater Hamilton Health Network. Approval will be conditional on the agreement that all budgeted future funding payments from the City of Hamilton (as well as all funds currently held in surplus) are allocated to physician recruitment and retention efforts within the City of Hamilton.

As of March 1, 2023, future annual funding contributions from the remainder of the PR&R Program’s current funding partners to be negotiated between the GHHN and each funding partner directly.

Section 2 - Transfer of PR&R Staff to GHHN

Contract negotiations to transfer the employment of current PR&R staff to the GHHN are nearing completion. The current staff contract ends on February 28, 2023, and the new contract with the GHHN is expected to take effect March 1, 2023.

The GHHN has agreed administer staff payroll and expenses for the PR&R staff that transfer into the GHHN as of March 1, 2023. Current payroll administration and expense reimbursement for PR&R staff which is currently administered by the Hamilton Chamber of Commerce will conclude February 28, 2023.

Section 3 – Co-Location Agreement with McMaster’s Department of Family Medicine

PR&R Program (Hamilton Physicians) staff currently have office space at the David Braley Health Sciences Centre, which is provided as an in-kind contribution from the McMaster University Department of Family Medicine, under a co-location agreement that extends to December 31, 2023. A new co-location agreement has finalized between the GHHN and the McMaster University Department of Family Medicine effective March 1, 2023 to December 31, 2023.

Section 4 – Transfer of Hamilton Physicians Property

It has been agreed that all property purchased by the PR&R Program (Hamilton Physicians), including office equipment, supplies and furniture will be transferred to the GHHN, effective March 1, 2023. PR&R staff have compiled a list of all program property to be transferred to the GHHN valued at approximately $12,600.

Section 5 – Key-Performance-Indicators (KPIs)

Upon the transfer of the PR&R Program into the GHHN current Key Performance Indicators (KPIs) for the PR&R program will be maintained. Any revisions to the current KPIs must be in the best interests of physician recruitment and retention within the City of Hamilton and will require the approval of the Executive Council of the GHHN.

KPIs will be reported to the Executive Council of the GHHN on an annual basis. The GHHN has committed to invite representatives from any current PR&R stakeholders who are not members of the GHHN Executive Council (currently only the Hamilton Chamber of Commerce) to the annual meeting at which KPIs will be provided.

The GHHN will report annually to the Board of Health on its recruitment activities for Hamilton at a time mutually agreeable to both.

BOH23002

Collective Impact:

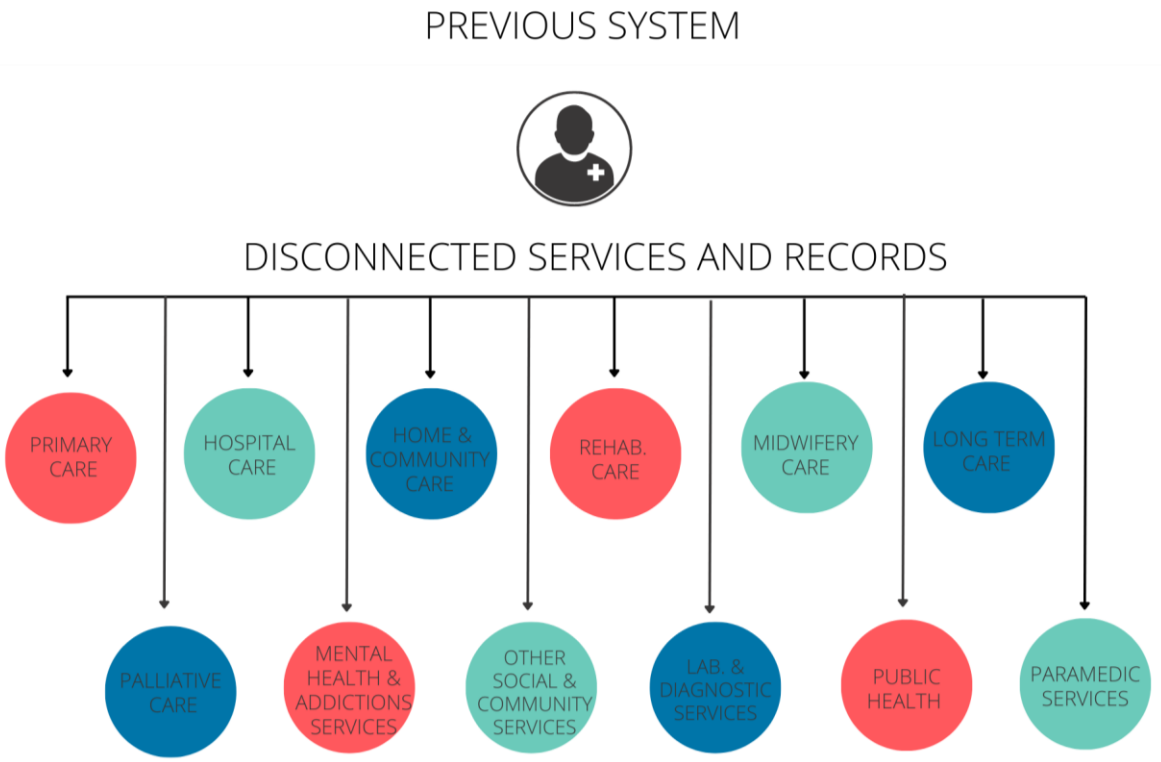
Healthy and Safe Communities and the Greater Hamilton Health Network – 2023 Update

June 12, 2023

Development of Ontario Health Teams

In 2018, the provincial government committed to transforming the healthcare system.

The vision was to create a more connected system that is centred around patients, their families and care providers.



Adapted from Ministry of Health and Long-Term Care (2022)

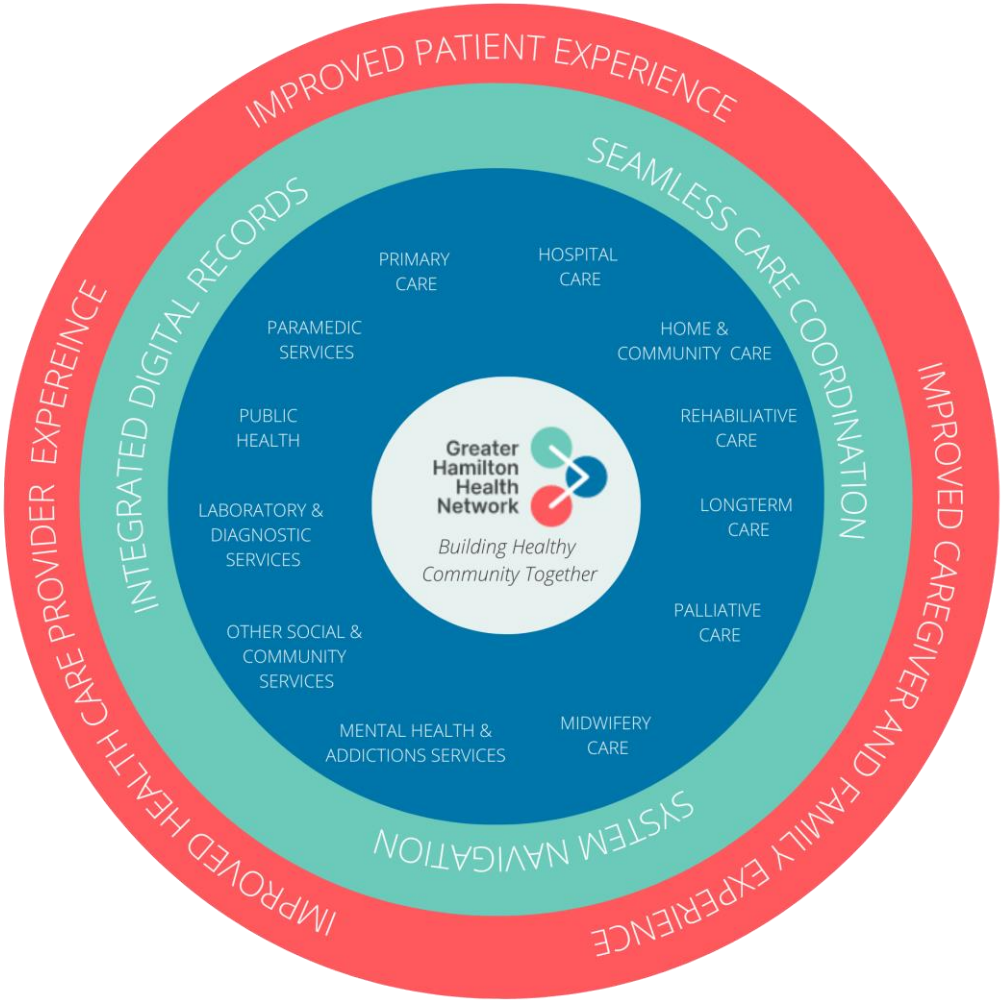
Development of Ontario Health Teams

This new vision was achieved through Ontario Health Teams.

Under Ontario Health Teams, local providers, irrespective of the care they provide or where they provide care, work as **one coordinated team and deliver a full continuum of care** to the populations they serve.

Adapted from Ministry of Health and Long-Term Care (2022)

Development of Ontario Health Teams



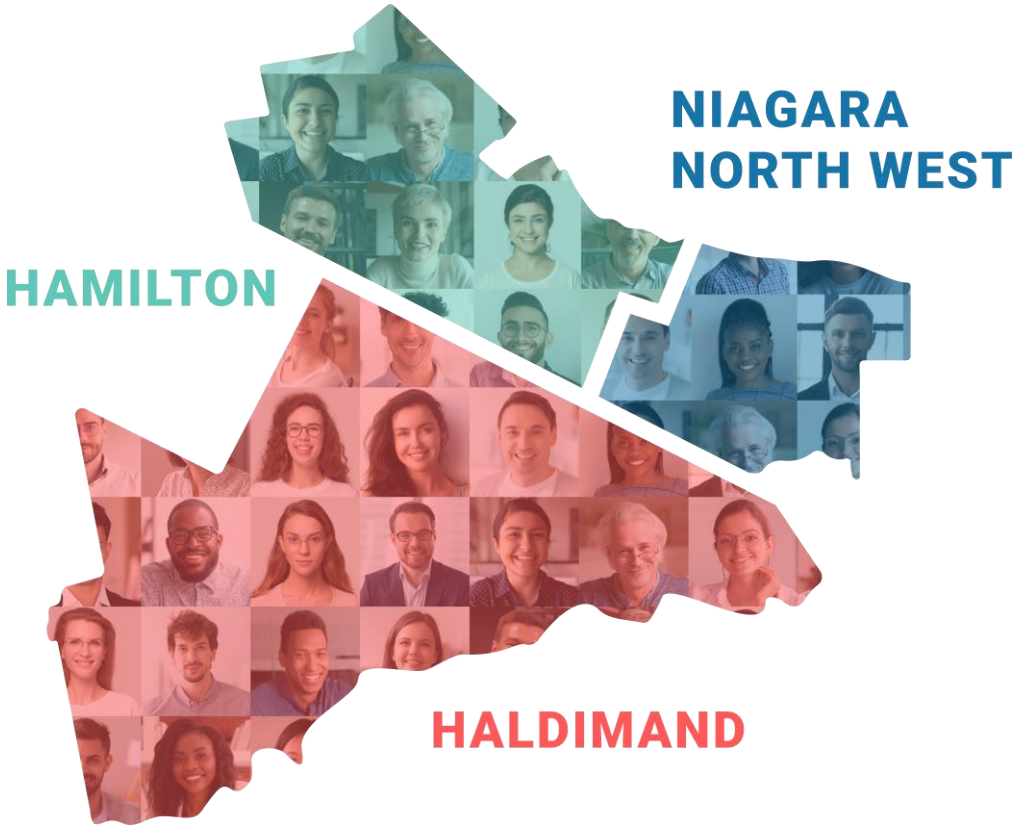
This model allows for easier:

- Patient navigation
- Transitions between providers
- Coordination between providers
- For providers to respond to local needs

Greater Hamilton Health Network Team

With approval in late 2019, the Greater Hamilton Health Network, **was one of the first Ontario Health Teams in the province**.

The team proudly serves residents of Hamilton, Haldimand and Niagara North West.



Greater Hamilton Health Network Team

The Greater Hamilton Health Network (GHHN) Board is comprised of 18 directors, including:

- 15 seats based on sector representation or stakeholder council participation.
- 3 seats based on the skills or competencies required by the Board.

Collectively, the Board developed a governance strategy that resulted in the Greater Hamilton Health Network becoming the first incorporated not-for-profit Ontario Health Team in the province.

In late 2022, the Ministry of Health announced this model as the gold standard model all Ontario Health Teams should adopt.

Board Seats	# of Seats
Primary Care Council *	2
Patient Family and Care Partner Leadership Council*	2
Health Equity Council *	1
Haldimand Council *	1
Home Care Sector	1
Hospital Sector	2
Community Organization (General)	1
Community Organization (Mental Health and Addictions)	1
Congregate Setting/ Long-Term Care Home	1
City of Hamilton – Municipality	1
Indigenous Sector	1
Francophone Sector	1
Independent Seats	3

* Nominated based on GHHN stakeholder council participation

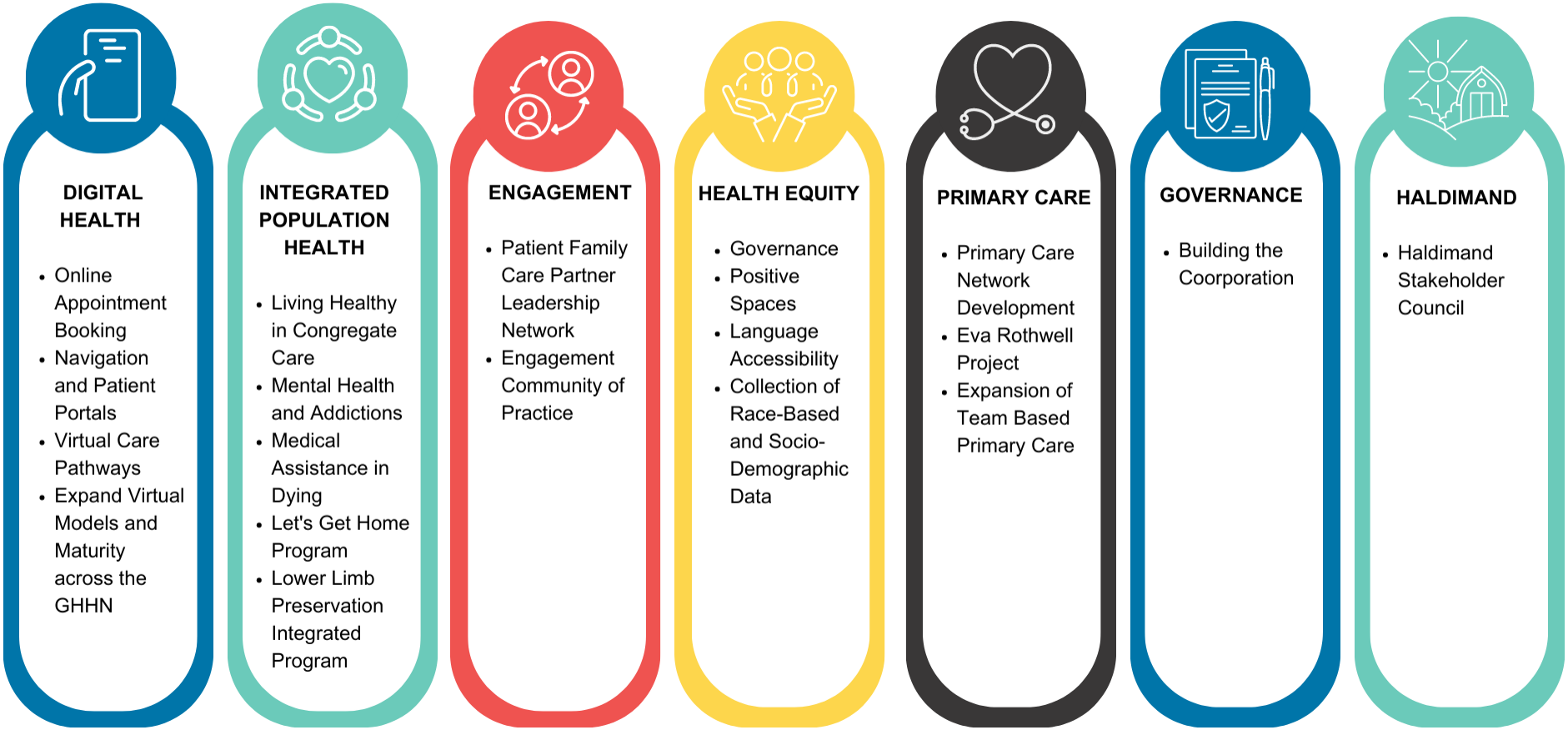
Greater Hamilton Health Network Team

The Greater Hamilton Health Network's Strategic Plan reflects a blend of both local and provincial priorities.

The Greater Hamilton Health Network prioritizes and makes decisions on care pathways based on these 5 core principles and will remain nimble enough to respond to ongoing system and community pressures.

Greater Hamilton Health Network Team

The Greater Hamilton Health Network's strategic priorities:



Greater Hamilton Health Network Membership

The Greater Hamilton Health Network currently includes over 40 local health and social service organizations and continues to incorporate new members.

Each organization is responsible for contributing their unique expertise to guide the overall direction of the Greater Hamilton Health Network.

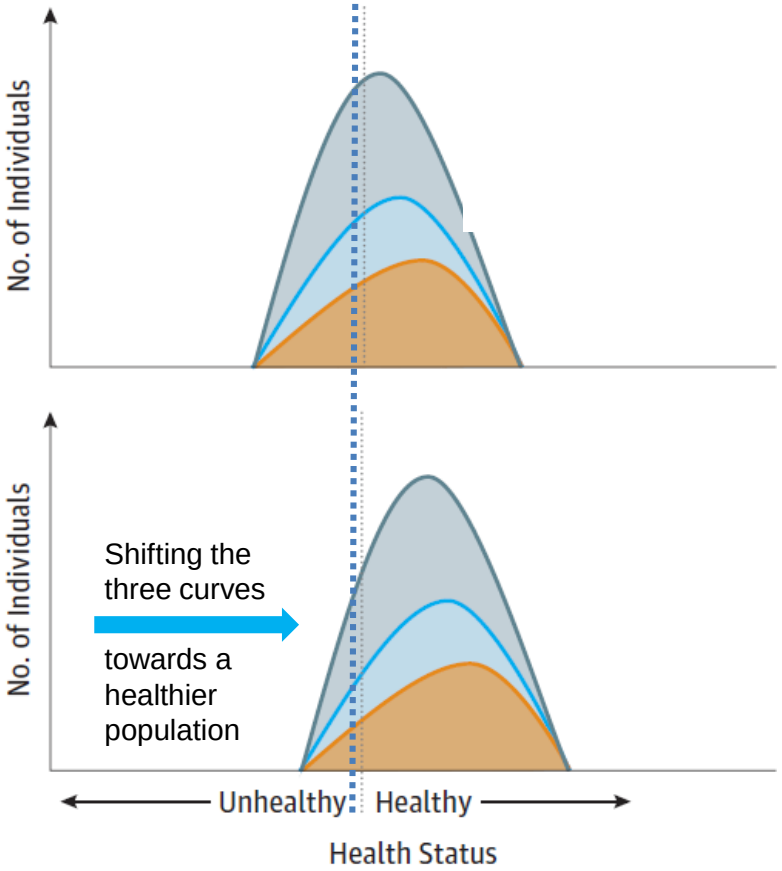
Population Health Approach

Ontario Health Teams use a population health approach to inform local health system planning.

A population health approach intends to:

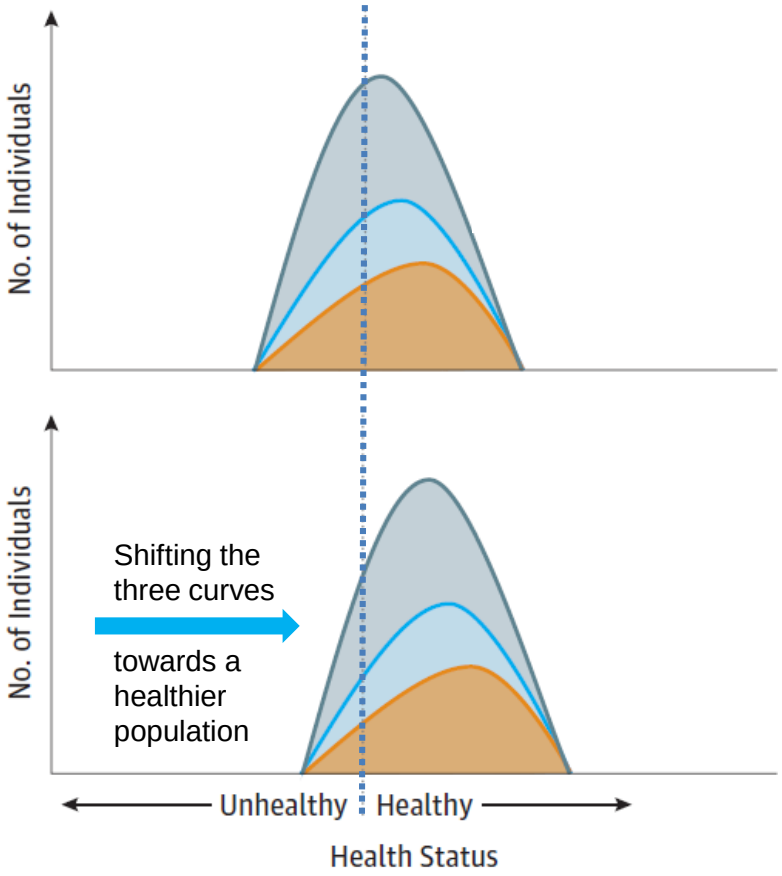
- Improve the health of the entire population
- Reduce the health inequities among priority populations

This is often referred to as “shifting the population health curve” so that there is **better and more equitable health for the whole community.**



Adapted from Washington AE et al JAMA 2016 315(5); 4590460

Population Health Approach



Greater Hamilton Health Network members implementing population-based policies & interventions

Focuses on social determinants of health, health promotion & disease prevention

Greater Hamilton Health Network members providing clinical outreach services for specific populations

Proactive management of behavioural risk factors and chronic health conditions

Greater Hamilton Health Network members providing services to patients seeking acute care issues

Reactive to individual health needs

Adapted from Washington AE et al JAMA 2016 315(5); 4590460

Population Health Approach

Applying a joint population health approach means:

- HEALTH OF THE WHOLE POPULATION, INCLUDING PRIORITY POPULATIONS
- INCREASE INVESTMENT IN UPSTREAM INTERVENTIONS
- EMPLOY EVIDENCE-BASED DECISION MAKING
- APPLY MULTIPLE STRATEGIES TO ADDRESS THE SOCIAL DETERMINANTS OF HEALTH
- WORK WITH PARTNERS ACROSS LEVELS AND SECTORS
- ENSURE PUBLIC INVOLVEMENT TO ENSURE SERVICES ARE ADDRESSING NEEDS
- INCREASE ACCOUNTABILITY FOR HEALTH OUTCOMES

Population Health Approach

Public Health Services (PHS) conducts Population Health Assessments in order to identify and monitor community health needs.

This includes identifying:

- Emerging health issues
- Health inequities
- Priority populations

This information helps to inform the direction of the Greater Hamilton Health Network and their member organizations.

Collective Impact

Collective Impact

GOAL: ENSURE TO THAT PATIENTS HAVE EASY ACCESS TO THE SUPPORTS THEY NEED, WHEN AND WHERE THEY NEED THEM.

Women's Health Drop-In Day Clinics

- Drop-in style clinics specifically designed for women who are homeless
- Offers a variety of health and social service supports using a "one-stop shopping" approach
- Creates a space where women are already accessing and feel comfortable
- Healthy and Safe Communities (HSC) offers service including COVID-19 and flu vaccinations, Sexually Transmitted Infections (STIs) and Blood Borne Infection (BBI) testing and education, naloxone training and kits and housing supports among others.
- To-date, has served over 480 women across Hamilton.
- Won a top award at the 2022 International Conference of Integrated Care in Denmark for an innovative service delivery model.

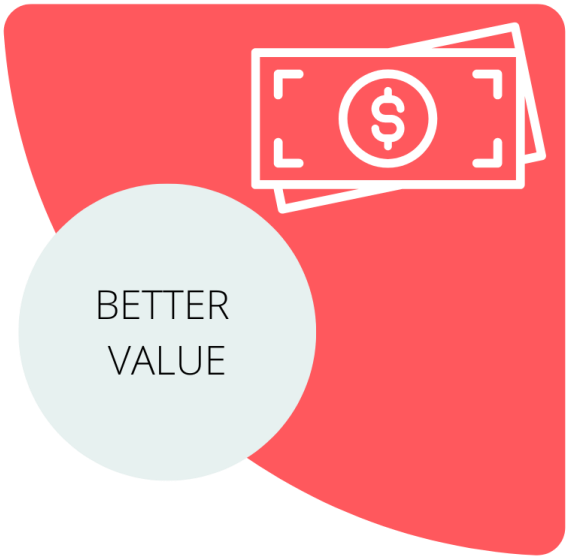
Collective Impact

GOAL: MAKE IT EASIER FOR PROVIDERS TO SUPPORT THEIR CLIENTS AND REDUCE THE TIME AND ENERGY NEEDED TO PROVIDE CARE.

Digital Health Strategy

- Developed an integrated digital health system that connects hospital record systems and integrates a electronic referral platform
- Other initiatives include patient-facing projects that aim to support clients with system navigation and appointment bookings
- Helps to connect patients with Healthy and Safe Communities services and through digital booking and electronic referrals
- To-date, completed 16 digital health initiatives spanning acute and community care
- In 2022, the Greater Hamilton Health Network received over $2M in funding for local digital health initiatives to support this work.

Collective Impact



GOAL: REDUCE THE HEALTH CARE COSTS PER CAPITA, WHILE MAINTAINING THE QUALITY OF CARE AND PATIENT EXPERIENCE.

Let's Go Home Program

- Aims to reduce hospital admissions by connecting patients accessing the emergency department with community supports
- Connects patients to longer term services that better meet their needs
- Community services tend to be less expensive and help to address the root cause the patient is facing

Collective Impact

GOAL: IMPROVE THE HEALTH OF THE ENTIRE POPULATION BY REDUCING THE HEALTH INEQUITIES THAT CURRENTLY EXIST.

COVID-19 Response

- Public Health Services led collaborative planning efforts and response to COVID-19 through the Hamilton COVID-19 Response Table (HCRT) and the Vaccine Readiness Network (VRN). Greater Hamilton Health Network leadership and membership was involved in these planning tables.
- The Hamilton COVID-19 Response Table (HCRT) worked to address issues like monitoring and surveillance, assessment & testing, infection control practices, capacity planning and vaccination among other issues
- The Vaccine Readiness Network (VRN) focused on addressing concerns related to equitable access to both vaccine information and appointments

Key Messages

As the Greater Hamilton Health Network continues to strengthen and expand their partnerships, evolve and take on further responsibilities, this collective impact will continue to grow.

The need for a collaborative, integrated and efficient health care system has never been greater as our region is facing immense pressure to address growing health care shortages and waitlists.

With the complex health and social service issues our community is facing, including housing & homelessness, and mental health & addictions, our health care system requires a coordinated cross-sectoral effort to address the root cause of these issues.

Together, the Greater Hamilton Health Network and Healthy and Safe Communities will continue to prioritize as local health and social service demands increase, while remaining nimble enough to respond to ongoing system and community pressures and work to improve the Ontario Health Team model.

Rather than function as individual organizations, it is important that the Greater Hamilton Health Network and Healthy and Safe Communities continue to work together to improve the health of the community by leading local health system transformation, resulting in a healthier community for everyone.

References

- Dion A, Waddell K, Moat KA, Reid R, Lavis JN. Rapid synthesis: Examining the intersections between Ontario Health Teams and public health. Hamilton: McMaster Health Forum, 30 March 2022.
- Ministry of Health and Long-Term Care. (2018). Population Health Assessment and Surveillance Protocol. https://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/docs/protocols_guidelines/Population_Health_Assessment_Surveillance_2018_en.pdf
- Ministry of Health and Long-Term Care. (2019). Ontario health teams: Guidance for health care providers and organizations. https://health.gov.on.ca/en/pro/programs/connectedcare/oht/docs/guidance_doc_en.pdf
- Premier's Council on Improving Healthcare and Ending Hallway Medicine. (June 2019). A healthy Ontario: Building a sustainable health care system. https://files.ontario.ca/moh-healthy-ontario-building-sustainable-health-care-en-2019-06-25.pdf
- Public Health Agency of Canada. (2012). *What is the Population Health Approach?* Canada.ca. https://www.canada.ca/en/public-health/services/health-promotion/population-health/population-health-approach.html
- Washington AE, Coye MJ, Boulware LE. Academic Health Systems' Third Curve: Population Health Improvement. *JAMA.* 2016;315(5):459–460. doi:10.1001/jama.2015.18550

CITY OF HAMILTON
PUBLIC HEALTH SERVICES
Epidemiology and Wellness Division

TO:	Mayor and Members Public Health Committee
COMMITTEE DATE:	June 12, 2023
SUBJECT/REPORT NO:	Hamilton Opioid Action Plan (BOH23021) (City Wide)
WARD(S) AFFECTED:	City Wide
PREPARED BY:	Melissa Biksa (905) 546-2424 Ext. 6709 Dr. Mark A. Cachia (905) 546-2424 Ext. 1391
SUBMITTED BY: **SIGNATURE:**	Dr. Elizabeth Richardson, MD, MHSc, FRCPC Medical Officer of Health Public Health Services

RECOMMENDATION

(a) That the Hamilton Opioid Action Plan, attached as Appendix “A” to Report BOH23021, be approved;

(b) That the Public Health Services budgeted complement be increased by 1.0 FTE Health Strategy Specialist, with funding for the 2023 costs of $39,048 to come first from any Public Health Services levy funded surplus, then from the Public Health Services Reserve (112219), and that the 2024 operating cost of $116,760 be included in the 2024 Tax Operating Budget;

(c) That a one-year drug checking and surveillance system pilot be implemented at a cost of $118,000 to be funded in 2023, first from any Public Health Services levy funded surplus, then from Public Health Services Reserve (112219), and that the 2024 operating costs of $60,000 be included in the 2024 Tax Operating Budget.

(d) That an 18 month pilot be implemented to provide a supervised consumption site in a men’s shelter by Housing Services through a Call for Applicants, for a total cost of $667,000 and that the cost of $120,000 for 2023 be funded from first from any Healthy and Safe Communities departmental levy funded surplus, then from Public Health Services Reserve (112219), and that the costs of $547,000 be included in the 2024 and 2025 Tax Operating Budget.

(e) That Public Health Services conduct an evaluation of the pilot men’s shelter supervised consumption site and report back in Q4 2024.

(f) That the General Manager, Healthy and Safe Communities Department or delegate be authorized and directed, on behalf of the City of Hamilton, to enter into, execute and administer all agreements and documents necessary to implement the Call for Applicants for a shelter based supervised consumption space, including but not limited to spending caps, benefit frequency limits, or other controls necessary to ensure costs are contained within the approved budget.

EXECUTIVE SUMMARY

Problematic opioid use and an increasingly toxic drug supply continues to be an area of public health concern in Hamilton. Local data continues to highlight an increasing trend of opioid-attributed overdoses in the community. In the first four months of 2023, Hamilton received 336 opioid-related paramedic calls, which was higher than the same four-month period in both 2021 and 2022. In addition, from January to April 2023, there were 62 suspected opioid-related deaths. A total of 42 of these suspect deaths occurred in private residences.

As Hamilton continues to address this public health concern, several local actions have been initiated by the municipality. On February 22, 2023 Council directed staff to engage with a diverse group of community partners to create an evidence-based harm reduction plan including addressing how safer use spaces and other evidence-based harm reduction strategies can be actioned in Hamilton and the homeless serving sector. This Council direction aligned with the February 2023 Hamilton Drug Strategy (HDS) prioritization of the update of an opioid specific action plan as part of the Hamilton Drug Strategy renewal.

In addition to the Council direction in February 2023, the City of Hamilton has continued to advocate for a comprehensive approach to address the harms associated with problematic opioid use. On April 12, 2023 Council directed the Mayor to declare an emergency in the areas of opioids, mental health, and homelessness in Hamilton. This declaration continues to underscore and advocate the need for action at all levels of government.

In March 2023, Public Health Services contracted MASS LBP to support the development of the Hamilton Opioid Action Plan. As part of this process, the Hamilton Drug Strategy steering committee met on March 28, 2023 to review and provide input into the Hamilton Opioid Action Plan development plan. In April 2023, MASS LBP facilitated one-to-one, and group conversations with community members and members of the Hamilton Drug Strategy steering committee. The Hamilton Drug Strategy steering committee then met twice in May to review and finalize recommendations for the plan. The Hamilton Opioid Action Plan in its entirety is attached as Appendix “A” to Report BOH23021.

The recommendations put forward in the Hamilton Opioid Action Plan present a community-driven approach to respond to the toxic drug supply for the municipality. The goals established for the Hamilton Opioid Action Plan are to:

1. Reduce the number of deaths associated with opioid use;
2. Reduce the harms associated with opioid use; and,
3. Increase the access to a spectrum of treatment options.

The Hamilton Opioid Action Plan aims to achieve these actions through:

1. Providing a mix of short and long-term actions;
2. Ensuring actions are tangible and achievable;
3. Improving data collection and evaluation; and,
4. Enhancing collaboration.

Throughout the consultation period participants clearly articulated the need for the Hamilton Opioid Action Plan to be bold and to present recommendations for immediate action. The plan presents 13 recommendations that are evidence-informed, feasible, and will help to achieve the established goals in Hamilton. As the Hamilton Opioid Action Plan is initiated, three recommendations have come forward with requests for funding to the City. This includes project support for the implementation of the plan, scaling up provision of safer consumption spaces in a shelter space through a proposed call for applications, and funding to support the pilot of a drug checking service in Hamilton.

Alternatives for Consideration – See Page 12

FINANCIAL – STAFFING – LEGAL IMPLICATIONS

Financial: Recommendation (b) is requesting approval for a 1.0 FTE Health Strategy Specialist to support the planning and implementation of the Hamilton Opioid Action Plan, at a cost of $39,048 in 2023, and for the cost of $116,760 to be included in the 2024 Tax Operation Budget. In 2023, the position would be funded first from any Public Health Services levy funded surplus, then from Public Health Services reserve (112219).

Recommendation (c) is requesting the authorization of $118,000 on a one-time basis to implement a drug checking service and surveillance system in Hamilton, to be funded in 2023 first from the Public Health Services levy surplus, if any, then from Public Health Services Reserve (112219). These expenditures include $100,000 in one-time capital expenses to purchase necessary equipment to create a drug checking surveillance system, as well as $18,000 in operational expenditures. Public Health Services will explore the possibility of private donation to support this initiative to

decrease the one time financial requirements. In 2024, $60,000 in operational expenditures will be added to the 2024 Tax Operating Budget.

Recommendation (d) requests the authorization of $667,000 for Housing Services to initiate a call for applications to agencies to operate a men's shelter-based supervised consumption site for 18 months. For this recommendation $120,000 would be requested in 2023 to be funded first from any Healthy and Safe Communities levy surplus, then from Public Health Services Reserve (112219), and that the costs of $547,000 be included in the 2024 and 2025 Tax Operating Budget.

Staffing: To support the planning and coordination of the Hamilton Opioid Action Plan, a 1.0 FTE Health Strategy Specialist is required.

Legal: Not Applicable.

HISTORICAL BACKGROUND

Historical reports that outline the Board of Health's approach to a community-response to opioids include:

- Report BOH16035 (September 19, 2016) – "A Comprehensive Public Health Approach to Drug and Substance Misuse";
- Report BOH17006 (March 20, 2017) – "Opioid Response Summit";
- Report BOH17013 (April 20, 2017) – "Hamilton Opioid Response Provincial and Federal Funding Request";
- Report BOH17004(a) (December 4, 2017) – "Hamilton Supervised Injection Site Needs Assessment & Feasibility Study";
- Report BOH18015 (December 10, 2018) – "Hamilton Drug Strategy";
- Report BOH19017 (March 18, 2019) – "Consumption and Treatment Services in Hamilton";
- Report BOH20006 (February 21, 2020) – "Hamilton Drug Strategy Year End Report";
- Report BOH21002 (February 19, 2021) – "Hamilton Drug Strategy 2020 Year End Report";
- Report BOH21009 (October 18, 2021) – "Comprehensive Opioid Response";

- Report BOH22016 (August 10, 2022) – "Decriminalization of Personal Possession of Illicit Drugs";

- Report BOH23002 (January 16, 2023) – "Board of Health Orientation Part 2: Population Health Assessment and Public Health Priorities";

- Report BOH23007 (February 13, 2023) – "Consumption and Treatment Services Site Application"; and,

- Report BOH23008 (February 13, 2023) – "Opioid Emergency Response".

POLICY IMPLICATIONS AND LEGISLATED REQUIREMENTS

The Hamilton Opioid Action Plan aligns with mandated work for Public Health Services as outlined in the Ontario Public Health Standards' "Substance Use and Injury Prevention" program standard. The goal of the standard is to reduce the burden of preventable injury and substance use, and requires health units to develop and implement public health interventions that reduce the burden of substance use through:

- Assessment of population health data;
- Collaboration with community partners, policy-makers, and priority populations; and,
- Persons with lived experienced and the public.[1]

RELEVANT CONSULTATION

MASS LBP was contracted to lead the development of the Hamilton Opioid Action Plan with the Hamilton Drug Strategy Steering Committee. All Hamilton Drug Strategy steering committee members were offered an interview and encouraged to recommend other community members, persons with lived experiences, equity-deserving groups, and health and social services leaders to consult. In total 33 interviews and focus groups were completed during the four-week consultation.

The Hamilton Drug Strategy steering committee met on May 1, 2023 to review initial themes and emerging recommendations. The draft recommendations were circulated to the Hamilton Drug Strategy steering committee and individuals who participated in interviews. Steering committee members were also invited to share with other community members for feedback. Thirty-seven individuals responded to the survey.

[1] Ministry of Health. Ontario Public Health Standards: Requirements for Programs, Services and Accountability. Toronto, ON: Queen's Printer for Ontario; 2021 Jun [cited 2023 May 18]. Available from: https://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/docs/protocols_guidelines/Ontario_Public_Health_Standards_2021.pdf

The recommendations were finalized by the steering committee at a meeting on May 18, 2023. The final report was completed by MASS LBP and sent to the Hamilton Drug Strategy steering committee members for final comment and endorsement on May 26, 2023.

ANALYSIS AND RATIONALE FOR RECOMMENDATION

Problematic opioid use and an increasingly toxic drug supply continues to be an area of significant public health concern in Hamilton. To date in 2023, reports from the Public Health Services weekly surveillance system continue to highlight that there is a highly toxic and unpredictable drug supply in Hamilton that leads to unusual or irregular drug poisoning presentations. Recently, there has been an increased presence of toxic substances such as benzodiazepines and xylazine, which are not responsive to naloxone.

Opioid-Related Paramedic Calls

Opioid-related paramedic calls are defined as calls for which the responding paramedic notes a suspected opioid poisoning. From January to April 2023, there have been 336 opioid-related paramedic calls. This represents more than 19 calls per week or 2.75 calls per day. The number of opioid-related calls in this period was higher than for the same period in 2022 and 2021 (n=239 and n=245), and higher than the previous four-month period of September to December 2022 (n=300). In March 2023, there were 96 opioid-related calls, the highest number recorded since September 2021 (n=103).

While opioid-related calls have been attributed to all wards across Hamilton, most calls have been concentrated in Wards 2 and 3. From January to April 2023, over half of all opioid-related calls came from Ward 2 (56%, n=189) and 20% (n=68) from Ward 3. The Wards with the next highest percentages of total opioid-related calls were Ward 5 (4%, n=15) and Ward 4 (4%, n=13).

Suspect Drug-Related Deaths

Suspect drug-related deaths are deaths where the investigating coroner's preliminary investigation indicates potential drug involvement.[2] Suspect drug-related deaths in Hamilton are defined by the location of incident, and do not necessarily describe all deaths among Hamilton residents. Of note, these data are preliminary and provided to Public Health Services from the Office of the Chief Coroner of Ontario. Data are subject to change and counts for the most recent two to three months are often underestimates.

From January to April 2023, the preliminary data identified that 62 suspect drug-related deaths occurred in Hamilton. This is an average of one death every two days, or 3.6 deaths per week. The number of suspect drug-related deaths presented is lower than in the previous four-month period of September to December 2022 (n=80). This is also

[2] Office of the Chief Coroner of Ontario. Death Investigation System [Data file]. Toronto, ON; 2023 May 11.

lower than the January to April period in 2022 (n=78) and 2021 (n=68). At the provincial level, counts of suspect drug-related deaths in Ontario from January to April have also decreased for consecutive years (n=1,086 in 2023; n=1,205 in 2022; n=1,346 in 2021).

From a geographic perspective, the highest percentage of suspect drug-related deaths in Hamilton has consistently occurred in the forward sortation area (FSA) L8L. The boundaries of this FSA predominantly overlap with Ward 3, and to a lesser extent with Ward 2. More than one in five (23%, n=14) incidents of suspect drug-related deaths from January to April 2023 in Hamilton occurred in L8L. The FSA with the second-highest percentage of the total suspect drug-related deaths in the same period is L8H. Just over one in ten (11%, n=7) suspect drug-related deaths occurred in L8H, an FSA which predominantly overlaps with Ward 4 and to a lesser extent with Ward 5.

Notably, data reports that most suspect drug-related deaths occur in private residences. From January to April 2023, 68% (n=42) of suspect drug-related deaths occurred in private residences, followed by 10% (n=6) in congregate living spaces and 10% (n=6) outdoors.

Further demographic data is available in Appendix “B” to Report BOH23021. The information above provides the Public Health Committee with a quarterly update on opioid-related paramedic calls and opioid-related deaths. The next quarterly update to Public Health Committee will occur in September 2023. Data will continue to guide the actions of the Hamilton Opioid Action Plan and underscores the need for continued action to address the harms associated with opioid use in Hamilton.

Hamilton Opioid Action Plan

To address the on-going harms associated with opioids, the Hamilton Drug Strategy initiated an update of the Hamilton Opioid Action Plan as part of its strategy renewal in 2023. The Hamilton Drug Strategy is a community collaborative of health and social service leaders, persons with lived experience and members of the community that was established following Mayor Eisenberger’s Opioid Summit in 2017. The goal of the Hamilton Drug Strategy is to ensure that residents of Hamilton are free of harm due to substance use and can enjoy the best quality of life. Public Health Services is a partner in this community driven strategy and provides administrative and community engagement support through a Senior Project Manager.

The administrative coordination of the Hamilton Drug Strategy was placed on hold during the COVID-19 pandemic due to the required resources to support the public health response. The Hamilton Drug Strategy steering committee met twice during the pandemic, and the harm reduction working group continued to meet quarterly as a community of practice. In late 2022, the Hamilton Drug Strategy initiated a renewal of the strategy. In February 2023, the Hamilton Drug Strategy approved the update of Hamilton Opioid Action Plan as one of its strategic priorities for 2023 - 2024.

The Hamilton Opioid Action Plan presents immediate, medium, and long-term recommendations to coordinate local action. Through consultation with the community, MASS LBP sought to understand the impact of the drug toxicity crisis and gather input on how to respond. To assist the Hamilton Drug Strategy steering committee members understand the current evidence-base, the Hamilton Drug Strategy Secretariat completed an environmental scan of current drug strategies across the province, and a review of evidence-based strategies to address the harms associated with opioid use. Hamilton Drug Strategy Steering committee members were invited to share information to contribute to the evidence base and were asked to consider the information when completing their interview.

The Hamilton Opioid Action Plan, as appended in Appendix "A" to Report BOH23021, presents 13 actions broken into short, medium, and long-term recommendations with proposed leads. These include:

- **Immediate (0-6 months)**
    1. Establish an Opioid Action Table (Proposed Lead: Public Health Services);
    2. Scale up Supervised Consumption Sites across Hamilton (Proposed Lead: Public Health Services);
    3. Develop "Safer Use" policies in hospitals and care settings (Proposed Leads: St. Joseph's Healthcare Hamilton and Hamilton Health Sciences);
    4. Increase the availability of drug-checking services and resources (Proposed Lead: Public Health Services); and,
    5. Engage and support primary care providers (Proposed Lead: Greater Hamilton Health Network).

- **Medium-Term (6 months)**
    6. Clarify service pathways and options for individuals who use substances, care providers, and first responders (Proposed Lead: Opioid Action Table);
    7. Develop and implement new youth prevention programs (Proposed Leads: City of Hamilton, Community Safety & Well-Being Plan, and Hamilton Youth Strategy);
    8. Expand supports available to families (Proposed Lead: Opioid Action Table); and,
    9. Increase access and support to shelters and drop-ins (Proposed Leads: City of Hamilton – Housing Division, Shelter Partners).

- **Long-Term (12 months)**
    10. Increase the number of physicians able to prescribe opioid agonist therapy (OAT) and safer supply programs (Proposed Leads: Greater Hamilton Health Network, and the Primary Care Sector);

11. Expand the availability of stabilization services (Proposed Leads: St. Joseph's Healthcare Hamilton and Hamilton Health Sciences);
12. Increase access to rapid detox and residential treatment programs (Proposed Leads: Wayside House of Hamilton, Womankind Addiction Service, and St. Joseph's Healthcare Hamilton); and,
13. Develop additional Supervised Consumption Sites throughout Hamilton (Proposed Lead: Opioid Action Table).

To action three of the immediate initiatives outlined above, investment is recommended at the municipal level.

Opioid Action Table

The Hamilton Opioid Action Plan recommends the formation of an Opioid Action Table to drive the implementation of the plan. This action table will include persons with lived experience, health and social service leaders, and other key partners who will be accountable to the Hamilton Drug Strategy Steering Committee. The action table will strike task-oriented working groups to bring together the necessary representatives to implement the respective action item. These working groups will be responsible for establishing goals, monitoring progress, and reporting back to the action table. A key conversation emerging from the Hamilton Opioid Action Plan development was the desire to work collaboratively in a more cohesive and supportive manner. This includes reducing competition for funding and holding the Opioid Action Table accountable for the actions endorsed in this plan. Program support, via a Health Strategy Specialist, is recommended to support the planning, coordination and implementation of the plan.

Supervised Consumption Sites

Supervised consumption sites provide a place for people to use substances while in the presence of trained staff. Using substances in a supervised setting reduces the risk of overdose and death and reduces the spread of blood-borne infections through the provision of sterile harm reduction supplies.

Expansion of supervised consumption sites in Hamilton will increase the availability of safe options for substance use in the community. Expansion of supervised consumption sites in a variety of settings including shelter-based, hospitals and mobile settings was a clear recommendation that emerged from Hamilton Opioid Action Plan consultations, and aligns with the direction from Council in February 2023 to "consider how to implement safer use spaces and other evidence-based harm reduction strategies both in the City and in the Houseless serving sector".

As outlined in Report BOH23007, there are currently three different streams available to operate supervised consumption services in Ontario. Two of the streams, Urgent Public Health Needs sites and Supervised Consumption Sites require only Health Canada approval but do not provide any operational funding for the applicant. The third stream is a Consumption and Treatment Services site (CTS). CTS sites are provincially approved and provide operational and capital funding to the applicant. There is

currently one Urgent Public Health Needs site in Hamilton; currently operated by the YWCA at Carol Anne's Place. In the first year of operation, this site has reported zero deaths.[3] There is one additional supervised consumption space in Hamilton, a provincially funded CTS, which is operated by Hamilton Urban Core Community Health Centre.

To further expand safer consumption services in shelter-based settings, it is recommended that Housing Services initiate a Call for Applicants to provide an onsite safe consumption site located in a men's shelter. The requested funding of $667,000 is an estimate for an 18-month pilot that would provide operational and one-time capital funding to implement a shelter-based service for an 18-month period. This pilot period would allow for the operational site to be set up, an evaluation to be completed, and a report back to the Public Health Committee on its outcomes. Public Health Services would support the successful applicant with an application to Health Canada for approval of an Urgent Public Health Needs site and program evaluation.

Provision of supervised consumption services at a men's shelter site will continue to support people who use substances, reduce harms associated from using in unsupervised settings and further work to connect individuals to services.

In addition to scaling up Urgent Public Health Needs sites within shelters, the Hamilton Opioid Action Plan outlines actions to increase supervised consumption sites both within local hospitals and the addition of a mobile site in Hamilton. To move forward with a mobile option, further planning and consultation will be led by the Opioid Action Table and any subsequent funding request will come forward as part of the 2024 municipal budget process. Hospital led sites will be coordinated by the hospital leads with report back to the Opioid Action Plan. An additional report back on a community evaluation for Supervised Consumption sites in Hamilton will be coming back to Public Health Committee in August 2023.

Drug-Checking

Drug-checking is an emerging harm reduction approach as the drug toxicity crisis worsens. Drug-checking allows for the analysis of the composition of a substance, indicating the presence of particular drugs (e.g. fentanyl or benzodiazepines), depending on the testing method.

A 2021 systematic review on the influence of drug checking on behavioural change found that drug-checking may influence both intended behaviour and, although less researched, enacted behaviour. Intended behaviour included using less, seeking more information about the substance, using with others, and doing a test shot. Using a drug-checking strip was facilitated by individuals having concerns about drug content and

[3] Beattie S. Not 1 person has died at Hamilton YWCA's unique safer use drug space since it opened a year ago [Internet]. CBC; 2023 Apr 22 [cited 2023 May 18]. Available from: https://www.cbc.ca/news/canada/hamilton/ywca-safer-use-drug-space-1.6818362

associated risk of drug poisoning, drug market changes, perceived negative health consequences, central location of services, testing accuracy, and comprehensiveness of results. Reported barriers to using included a lack of concern over drug contents, high trust in sellers, inaccessible location of services, limitations with results, and legal risk of criminalization.[4]

Within Ontario, a drug-checking service has been offered in Toronto since October 2019. This drug-checking service uses laboratory-based testing methods, with a one to two business day turnaround time. The service provides detailed information on drug composition to service users and enables monitoring of substances circulating in the community and broad information sharing to help inform care for people who use substances, advocacy, policy, and research.[5] Other jurisdictions, such as the Region of Waterloo utilize testing strips at their CTS site.[6] Expansion of drug-checking services has also been implemented in British Columbia, and the British Columbia Centre on Substance Use has published implementation guidance to aid organizations in scaling up these initiatives in local communities.[7]

Expanding access to drug-checking services and supplies is recommended to support reducing the harms associated with unregulated substances to individual users and to generate local surveillance data to increase knowledge of the circulating drug supply in Hamilton. Ongoing evaluation of the drug checking service will provide real-time data to further understand the substances circulating in Hamilton and help enable proactive responses by communicating results to the broader community. Finally, offering drug-checking services will provide Hamilton the opportunity to contribute to the developing Canadian evidence-base as the systematic review notes, echoed by the corresponding Public Health Ontario synopsis,[8] that most of the current studies originate from Europe in party settings.

---

[4] Maghsoudi N, Tanguay J, Scarfone K, Rammohan I, Ziegler C, Werb D, Scheim AI. Drug checking services for people who use drugs: a systematic review. Addiction. 2022 Mar;117(3):532-544.

[5] Toronto's Drug Checking Service. About [Internet]. Centre on Drug Policy Evaluation; [cited 2023 May 19]. Available from: https://drugchecking.cdpe.org/about/

[6] Region of Waterloo. Consumption Treatment and Services – CTS Data Dashboard [Internet]. Kitchener, ON: Region of Waterloo; [cited 2023 May 19]. Available from: https://www.regionofwaterloo.ca/en/health-and-wellness/consumption-and-treatment-services.aspx#CTS-Data-Dashboard

[7] British Columbia Centre on Substance Use. Drug Checking Implementation Guide: Lessons learned from a British Columbia drug checking project [Internet]. Vancouver, BC: British Columbia Centre on Substance Use; 2022 Jun [cited 2023 May 24]. Available from: https://drugcheckingbc.ca/wp-content/uploads/sites/2/2022/07/BCCSU_Implementation_Guide_2022.pdf

[8] Ontario Agency for Health Protection and Promotion (Public Health Ontario). Review of "Drug checking services for people who use drugs: a systematic review." Toronto, ON: Queen's Printer for Ontario; 2022 Jun [cited 2023 May 19]. Available from:

The projected cost to implement drug checking strips for individual use and to create a surveillance system in Hamilton for a one-year period is $200,000 and cost sharing opportunities will be explored through private donation to reduce the cost to the levy and reserve. This amount will cover the costs of strips to be distributed to the individual user, and the cost of two point-of-care analysis systems to be located in the community. The point-of-care testing system would allow users to test their substance and enable broader information sharing to the community. Additional analysis through mass spectrometry, which can provide extremely detailed information as compared to testing strips or point-of-care devices, will continue to be investigated with local partners. Further planning and design of this initiative will be done in collaboration with people who use substances to ensure the pilot supports harm reduction practices and the needs of the community.

Investment in these initiatives will support the implementation of these initiatives in 2023. For the other two immediate actions, hospital and primary care-based interventions outlined above, each hospital will take a lead within their organization and report back on progress to the Opioid Action Table. The engagement and support of primary care providers is work currently underway through the Greater Hamilton Health Network.

Next Steps

Progress on the Hamilton Opioid Action Plan will be reported back to the Public Health Committee with established performance indicators and progress in Q1 2024. In addition, the Hamilton Drug Strategy will continue its renewal with the Hamilton Drug Strategy Steering Committee identifying priority areas of actions over the coming months to support the other four substances of concern (alcohol, cannabis, methamphetamines, and cocaine).

ALTERNATIVES FOR CONSIDERATION

If the Public Health Committee does not support Recommendation (b) for the funding a Health Strategy Specialist position, the implementation of the Hamilton Opioid Action Plan will be delayed due to a lack of resources to support planning and coordination of the initiatives, development and monitoring of indicators, and to maintain momentum. Current partners have identified dedicated resources as a key factor to move these initiatives forward.

If the Public Health Committee does not support Recommendations (c) and (d) for funding implementation of the two immediate priority areas of action; safer use spaces

---

https://www.publichealthontario.ca/-/media/Documents/nCoV/Research/2022/06/synopsis-review-drug-checking-services-people-systematic.pdf?sc_lang=en&rev=f101cadb52704c91bc0810cf98c692b7&hash=EB635089F085E834EDEC5BB13C5BBC77

and drug checking will be delayed, and external funding sought by the Opioid Action Table, from other provincial government or charitable sources.

ALIGNMENT TO THE 2016 – 2025 STRATEGIC PLAN

Community Engagement and Participation
Hamilton has an open, transparent and accessible approach to City government that engages with and empowers all citizens to be involved in their community

Healthy and Safe Communities
Hamilton is a safe and supportive City where people are active, healthy, and have a high quality of life.

Our People and Performance
Hamiltonians have a high level of trust and confidence in their City government.

APPENDICES AND SCHEDULES ATTACHED

Appendix “A” to Report BOH23021	Hamilton Opioid Action Plan Report
Appendix “B” to Report BOH23021	Hamilton Quarterly Opioid-Related Impact Update

Hamilton Opioid Action Plan

Prepared by MASS LBP for Hamilton Public Health Services

May 24, 2023

Introduction

This plan was developed in collaboration with several dozen stakeholders and community members in Spring 2023. The plan outlines thirteen immediate actions which can help to reduce the deaths and harms caused by the toxic drug supply in Hamilton. The plan also proposes a series of subsequent actions across a spectrum of prevention, harm reduction, treatment and social justice/ justice to be initiated this year which aim to provide better services and supports to individuals and families grappling with the consequences of the opioid epidemic.

As people who use substances, their families and frontline workers have disproportionately borne the harms associated with the opioid crisis, the plan includes actions to bolster the existing responses in the community.

National, Provincial and Local Context

National

Across the country, the opioid epidemic has had devastating effects on individuals, families, and communities. These related harms are exacerbated by a drug toxicity crisis, where opioids circulating on the streets are frequently mixed with dangerous additives that may be unknown to the user. Due to the rising toxicity of opioids, deaths related to substance use are increasing across the country. This has resulted in a public health emergency, requiring an urgent and coordinated response.

The COVID-19 pandemic has placed additional strain on the resources needed to tackle the opioid crisis. In order to respond to the pandemic, significant resources and capacity were shifted away from harm reduction, treatment and prevention. Two years of combatting the pandemic has also contributed to burnout for frontline workers in a variety of sectors. Concurrently, the pandemic intensified the root causes of substance use such as trauma and precarious housing while forcing people who use substances (PWUS) to use in isolation or with little support.

Federally, the government has been working to address the opioid epidemic by supporting the provinces and municipalities in their efforts. This includes, but is not limited to, dispensing free naloxone kits throughout the country, passing the *Good Samaritan Drug Overdose Act*, and approving supervised consumption sites and overdose prevention sites through Urgent Public Health Needs site applications[1].

[1]https://www.canada.ca/en/health-canada/services/publications/healthy-living/canada-opioid-crisis-fact-sheet.html

Ontario

Ontario continues to experience high rates of opioid-related morbidity and mortality. The province saw a 79% increase in monthly opioid-related deaths in 2020, from 139 deaths in February 2020 to 249 deaths in December 2020[2]. Of these deaths, almost one in six occurred among people experiencing homelessness, and one in ten occurred within shelters or supportive housing[3]. In 2023, the province continues to experience an increase in opioid-related harms as reflected in high numbers of emergency department visits, hospitalizations, and deaths[4].

The provincial government has outlined its strategy to address the opioid crisis in the "Roadmap to Wellness: A Plan to Build Ontario's Mental Health and Addictions System". The strategy calls for the improvement and expansion of mental health services through the development of a "core services framework" that will define standardized support pathways.

The provincial plan focuses on the implementation of the Mental Health and Addictions Centre of Excellence, a coordinated body responsible for identifying service gaps, establishing performance indicators, and identifying the digital needs of service providers.

Hamilton

The data below highlights the impact of the opioid crisis on the City of Hamilton:

- Emergency department visits for opioid overdoses increased 494% between 2016 and 2021[5]
- Deaths have increased 31% from 2020-2021[6]
- From January to October 2022, there were 139 confirmed or probable opioid-related deaths in Hamilton[7]
- Hamilton's opioid death rate has been consistently higher than the provincial rate[8]

[2] https://www.publichealthontario.ca/-/media/Documents/C/2021/changing-circumstances-infographic.pdf?rev=e9cb2312bda146d792ed57e3d09329b7&sc_lang=en

[3] ibid

[4] https://www.publichealthontario.ca/en/data-and-analysis/substance-use/interactive-opioid-tool

[5] Hamilton Paramedic Services, [extracted March 13, 2023
Office of Chief Coroner, 2023]

[6] ibid

[7] ibid

[8] Office of the Chief Coroner of Ontario received January 20, 2023.

- Opioid death rates in Hamilton were 45% higher than in Ontario in 2021, but ranged from 111% higher in 2018 to 30% higher in 2020[9]

The City of Hamilton is working to address the crisis including through continued advocacy to the Province for the nine resolutions proposed by the Association of Local Public Health Agencies:

1. Create a multi-sectoral task force, including PWUS, to guide the development of a robust, integrated provincial drug poisoning crisis response plan
2. Expand access to harm reduction programs and practices, Urgent Public Health Needs Sites, drug testing, inhalation sites, and safer opioid supply
3. Enhance and ensure the sustainability of support for substance use prevention and mental health promotion initiatives, with a focus on early childhood to adolescence
4. Expand the collection, analysis, and reporting of timely integrated epidemiological data initiatives
5. Expand access to treatment for opioid use disorder and support the overall health of PWUS
6. Address the structural stigma, discrimination, and related harms that create systemic barriers for PWUS
7. Advocate to and support the Federal government to decriminalize personal use and possession of substances, paired with increased investments in health and social services
8. Acknowledge and address the socioeconomic determinants of health, systemic racism, and their intersections that are risk factors for substance use and pose barriers to accessing supports
9. Provide funding and other supports to enable consistent community leadership by PWUS and community organizations.

There are many other local initiatives to respond to the opioid crisis, spearheaded by grass roots organizations, people with living/lived experience, academics, health and social service organizations, and harm reduction workers. However, further local coordination and prioritization are needed in order to enhance ongoing local efforts.

[9] Office of the Chief Coroner of Ontario, extracted from the Public Health Ontario Interactive Opioid Tool, January 24, 2023. Retrieved from: https://www.publichealthontario.ca/en/data-and-analysis/substance-use/interactive opioid-tool#/maps

Defining the Crisis

Toxicity

A toxic and unpredictable drug supply is one of the drivers of the current drug toxicity crisis. Potent additives, such as xylazine and benzodiazepines are increasing the toxicity of the unregulated drug supply and their presence and potency are often unknown to the individual. This significantly increases the risk of drug poisoning and is the driving factor in the mounting number of deaths tied to substance use.

The social determinants of health are a factor

The detrimental effects of poverty, intergenerational trauma, mental health disparities, and various other social determinants of health significantly contribute to and exacerbate the impacts of the opioid crisis. Lack of adequate primary care, mental health services, and housing supply creates challenges in providing adequate treatment and resources. In addition, the broader social determinants of health must be addressed holistically in order to prevent problematic substance use among individuals and youth. Intergenerational trauma, stemming from the historical exclusion of equity-deserving groups and the adverse experiences passed down through generations, further contributes to the crisis, perpetuating a cycle of problematic substance use. Understanding the intersection of mental health challenges and problematic opioid use is a necessity for the proper care and treatment of PWUS.

Addressing these underlying social determinants is crucial for effective intervention and prevention strategies. This includes the need for a wide spectrum of integrated treatment and harm reduction options to address the complex needs of some PWUS.

Need for urgent action and collaboration

Complex

The multifaceted nature of societal issues requires an understanding that the root causes, such as poverty, trauma, mental health disparities, and various other factors, which are often intertwined. To effectively address these challenges, comprehensive and coordinated solutions must be implemented that recognize the interconnectedness of these issues. This requires a multi-sectoral response, with an integrated spectrum of services that work in concert to address the complex needs of PWUS.

The fact that addressing these root causes extends beyond the scope of municipal governance adds to the complexity of mounting an effective response. The implementation of evidence-informed solutions requires resources and collaboration from various stakeholders at municipal, provincial, and federal levels. The barriers associated with an inter-governmental response further necessitate the need for local partnerships between relevant stakeholders and people with lived experience to share resources and implement robust solutions. An effective local response depends on the ongoing collaboration of local public health agencies, primary care providers, community groups, harm reduction workers, and people with lived experience.

Alignment

The lack of coordination and collaboration between different sectors, such as healthcare, social services, law enforcement, and community organizations, has hindered the delivery of effective services and treatment for the opioid crisis. This fragmented system has led to gaps in care, duplicated efforts, competition for resources, and missed chances for early intervention. To effectively address the opioid crisis in Hamilton, it is crucial to break down these barriers and promote a coordinated approach among all stakeholders. This means actively working together, sharing information, and collaborating on actions to overcome the challenges Hamilton faces.

Impact

To improve Hamilton's drug policy implementation and tackle the challenges it faces, we can learn from successful approaches used in other jurisdictions. These approaches have been proven to reduce the harm and deaths caused by drug use and improve the health outcomes of people who use substances. By studying and adopting the best practices from these evidence-informed models, Hamilton can improve its own strategies and interventions to help residents and fight against the toxic supply of opioids.

To make a real difference and overcome the obstacles to effective drug policy, it's important to have focused and coordinated efforts across different sectors. This means working together with government agencies, healthcare providers, law enforcement, social service organizations, community groups, and individuals who have firsthand experience with drug use. By aligning funding, sharing resources, and coordinating strategies, Hamilton can create a comprehensive and integrated approach that addresses many of the different aspects of drug policy implementation.

Process / Roles

Board of Health

In light of the persistently high rates of morbidity and mortality associated with opioid use within the Hamilton community, City Council has taken action by declaring three States of Emergency in March 2023. This emergency declaration specifically pertains to the intersecting issues of homelessness, mental health challenges, and substance use. Hamilton Public Health Services has also been tasked with formulating a comprehensive and evidence-informed harm reduction plan.

Hamilton Public Health Services (PHS)

PHS is dedicated to ensuring the well-being of its residents and fostering healthy communities. Recognizing the impact of mental health and addictions in the community, PHS has identified the opioid crisis as one of its departmental priorities for 2023. In line with this commitment, PHS provides secretariat support to the HDS, a collaborative effort that aims to address substance-related issues comprehensively.

In February 2023, the Hamilton Drug Strategy Steering Committee also approved the development of an updated opioid action plan as one of its strategic goals in 2023. In March 2023, PHS hired the services of MASS LBP to facilitate the process and ensure meaningful engagement from stakeholders and community members.

Hamilton Drug Strategy (HDS) Steering Committee

The HDS Steering Committee is a multi-sectoral group designed to provide strategic direction for partnerships and actions related to drug policy and interventions. Since its inception in 2018, the HDS has worked to implement interventions using an evidence-based comprehensive approach to address the impact of substance use in the community. This includes utilizing a four-pillar approach of prevention, harm reduction, social justice/justice and treatment. The committee was tasked with leading the development of a Hamilton Opioid Action Plan and ensuring it meets the needs of the community.

Members of the Steering Committee contributed to the development of the plan by:

- Learning about and contributing to the evidence base, best practices and strategies employed by other jurisdictions to mitigate the risks experienced by people who use substances.

- Contributing their perspective and expertise with respect to different elements of the Hamilton Opioid Action Plan.

- Reviewing the proposed actions that will be included in each version of the Hamilton Opioid Action Plan.

Members were also asked to recommend stakeholders or community members who should be involved in the process and who could help to consult with their communities, especially people who use substances, and other stakeholders.

Who we spoke to

PHS contracted MASS LBP to conduct the public consultation and facilitate several working meetings with the HDS Steering Committee. The consultation consisted of stakeholder interviews, focus groups with people with lived experience as identified by consulted organizations, and a survey on proposed actions.

Members of the steering committee were invited to participate in one-on-one or group interviews with the facilitation team. Participants were also encouraged to refer colleagues, individuals with lived experience, and other relevant stakeholders to the facilitation team to be consulted.

The facilitation team hosted three two-hour meetings. During each meeting, members of the Steering Committee were invited to provide feedback and direction on the elements of the plan. As well, each member was offered the opportunity to lead an element of the plan relevant to their sector. For a list of those consulted, please see **Appendix A**.

Hamilton Opioid Action Plan

The goals of the plan:

1. Reduce the number of deaths associated with opioid use
2. Reduce the harms associated with opioid use
3. Increase access to a spectrum of treatment options

These will be accomplished by:

1. Providing a mix of short- and long-term actions
2. Ensuring actions are tangible and achievable
3. Improving data collection and evaluation
4. Enhancing collaboration

Action Plan Overview

A. Immediate Actions (0-6 months)

1. Establish an Opioid Action Table
2. Scale-up Supervised Consumption Sites across Hamilton
3. Develop Safer Use Policies in hospitals and care settings
4. Increase the availability of drug-checking services and resources
5. Engage and support primary care providers

B. Medium-Term Actions (6 Months)

6. Clarify service pathways and options for individuals who use substances, care providers, and first responders
7. Develop and implement new youth prevention programs
8. Expand supports available to families
9. Increase access and support to shelters and drop-ins

C. Long-Term Actions (12 months)

10. Increase the number of physicians able to prescribe opioid agonist therapy and safer supply programs
11. Expand the availability of stabilization services
12. Increase access to rapid detox and residential treatment programs
13. Develop additional supervised consumption sites throughout Hamilton

Detailed Actions

A. Immediate Actions (0-6 months)

1. Establish an Opioid Action Table
Proposed Lead: PHS

- The Opioid Action Table will be accountable for implementation of assigned action items and will be led by persons with lived experience, health and social service leaders and other key partners appointed by the HDS Steering Committee.
- The Opioid Action Table will create action-oriented task groups consisting of representatives from relevant organizations and identified community members to further plan and implement action items.
- The Opioid Action Table will report back to the HDS Steering Committee every six months on its progress.
- The Opioid Action Table will ensure the implementation of measures to support other actors in the sector:
    - Support the development of culturally appropriate services and strategies based on Indigenous Ways of Knowing.
    - Maintain an up-to-date service map.
    - Strengthen data collection and reporting mechanisms.
    - Develop a sectoral accountability framework.

2. Scale-up Supervised Consumption Sites across Hamilton
Proposed Lead: PHS

- Add Supervised Consumption Sites, prioritizing
    - Men’s shelters

- Mobile sites

3. **Develop Safe Use Policies in hospitals and care settings**
   Proposed Leads: St. Joseph’s Healthcare, Hamilton Health Sciences

   - Support the development of an on-site Safe Use policy.

4. **Increase the availability of drug checking services and resources**
   Proposed Lead: PHS

   - Secure an expanded drug checking program to support harm reduction practices and local surveillance

5. **Engage and support primary care providers**
   Proposed Lead: Greater Hamilton Health Network (GHHN)

   Engage primary care providers through a mentorship network where they are paired with an addictions specialist to learn more about harm reduction, safer supply, service pathways, and other information to improve the quality of treatment.

   - Incorporate peer support and front-line harm reduction workers into the mentorship program to build relationships, support experiential learning, and break down the stigma against PWUS.

B. Medium-Term Actions (6 Months)

6. **Clarify service pathways and options for individuals who use substances, care providers, and first responders**
   Proposed Lead: Opioid Action Table

   - Develop accessible resources for first responders to be able to link PWUS to services.

   - Ensure hospital staff, first responders and other relevant actors are aware of available service pathways to direct individuals who use substances to further treatment /support services.

   - Ensure that individuals who use substances and their support networks are aware of available service pathways.

7. **Develop and implement new youth prevention programs**
   Proposed Leads: City of Hamilton, Community Safety and Well-Being plan, Hamilton Youth Strategy

   - Develop and support additional youth-oriented prevention programs supported by people with lived experience.

   - Ensure reach to younger ages (8-12) with evidence-informed and age-appropriate prevention strategies.

8. **Expand supports available to families**
   Proposed Lead: Opioid Action Table

   Expand existing supports available to families of those who use substances, particularly the children of PWUS.

   - Establish additional services to support the loss and grief of loved ones affected by opioid-related deaths.

     - Create a dedicated, single referral number for families impacted by opioid-related deaths and harms.

     - Provide dedicated resources to families on how to support their loved ones who use substances.

   - Develop intentional supportive housing pathways for pregnant women who use substances.

   - Promote the development of de-stigmatizing practices to health and social service agencies that serve families.

9. **Increase access and support to shelters and drop-ins**
   Proposed Leads: City of Hamilton – Housing Services, Shelter partners

   - Create additional daytime abstinence-positive spaces and programs for those choosing to remain sober.

   - Increase funding to shelters and expand the existing drop-in services available in Hamilton.

C. Long-Term Actions (12 months)

10. Increase the number of physicians able to prescribe opioid agonist therapy (OAT) and safer supply programs
Proposed Leads: GHHN, Primary care sector

- Increase the number of physicians able to prescribe OAT and safer supply programs with sufficient training and support.
- In partnership with relevant stakeholders, collaboratively advocate to municipal, provincial, and federal governments for more safer supply initiatives.
- Support existing safer supply programs.

11. Expand the availability of stabilization services
Proposed Leads: St. Joseph’s Healthcare, Hamilton Health Sciences

- Expand the availability of rapid stabilization for PWUS with high risk (of death) in hospital.
- Extend the capacity and operating hours of existing rapid access addiction medicine (RAAM) clinics.
- Develop youth-specific RAAM clinic pathways and spaces.

12. Increase access to rapid detox and residential treatment programs
Proposed Lead: Wayside House of Hamilton, Womankind Addiction Service, St. Joseph’s Hospital

- Expand the availability of rapid detox programs and residential treatment programs.
- Work to reduce long wait times to access both rapid detox and residential treatment programs.
- Ensure detox programs are equipped with the resources to support clients or have the means to refer clients to resources to bridge the transition to residential treatment programs and afterward.

13. **Develop additional Supervised Consumption Sites throughout Hamilton**
Proposed Lead: Opioid Action Table

- Investigate the long-term expansion of Supervised Consumption Sites through partnerships with hospitals, shelters, and other community organizations in Hamilton.

- Collaborate and support organizations with existing Supervised Consumption Sites to expand their capacity and service offerings.

Appendix A

Organizations that participated in interviews and focus groups:

Steering Committee

- Dr. Elizabeth Richardson, Medical Officer of Health
- Melissa McCallum, GHHN Mental Health and Addictions
- Robin Lennox, Co-Chair GHHN Harm Reduction and Safer Supply Working group, Co-Head of Service of Inpatient Substance Use Service
- Regan Anderson, Wayside House of Hamilton
- Medora Uppal, YWCA Hamilton
- Kristyn Bruce, Wesley
- Sue Phipps, Canadian Mental Health Association
- Michelle Baird, City of Hamilton – Housing Services
- Ron Keenan, Community Member
- Deb Bedini, Hamilton Health Sciences
- Tammy Kerwin, Community Member
- Terry Ramirez, City of Hamilton - PHS
- Chukky Ibe + Sarah Lowe, City of Hamilton - Mayor’s Office
- Paul Hamilton, Hamilton Police Service
- Russell Crocker, Hamilton Paramedic Service
- Dave Thompson, Hamilton Paramedic Service
- Tim McClemont, The AIDS Network
- Cheryl Williams, St. Joseph’s Healthcare Hamilton
- Greg Croft, Mission Services of Hamilton
- Jo-Ann Mattina, De dwa da dehs nye>s Aboriginal Health Centre (DAHC)

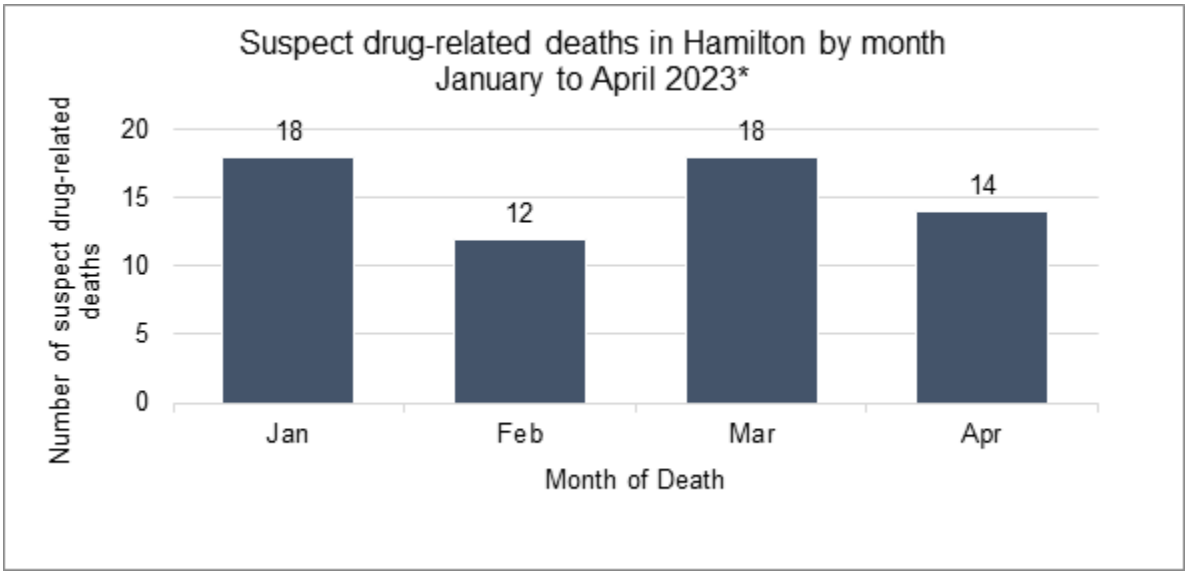
Community Stakeholders

- Staff/Peers + Clients**,** Wayside House

- Indigenous Community Members, DAHC
- Staff, Grenfell Ministries
- Olivia Mancini, Canadian Drug Policy Coalition (CDPC)
- Harm Reduction Working Group, CDPC
- Rudi Wallace, Hamilton Community Foundation
- Nicholas Boyce, CDPC
- Koubra Haggar, Hamilton Centre for Civic Inclusion
- Cathy Risdon + Primary Care Leadership Team
- Staff, St. Joseph’s Healthcare
- Social Navigator Team, Hamilton Police Service
- Marcie McIlveen, Keeping Six
- Katherine Kalinowski, Good Shepherd CentresJames Moulton, Salvation Army

Hamilton Quarterly Opioid-Related Impact Update

Figure 1: Suspect Drug-Related Death in Hamilton, January-April 2023.



Source: Office of the Chief Coroner for Ontario (OCC), Death Investigation System, May 18, 2023.

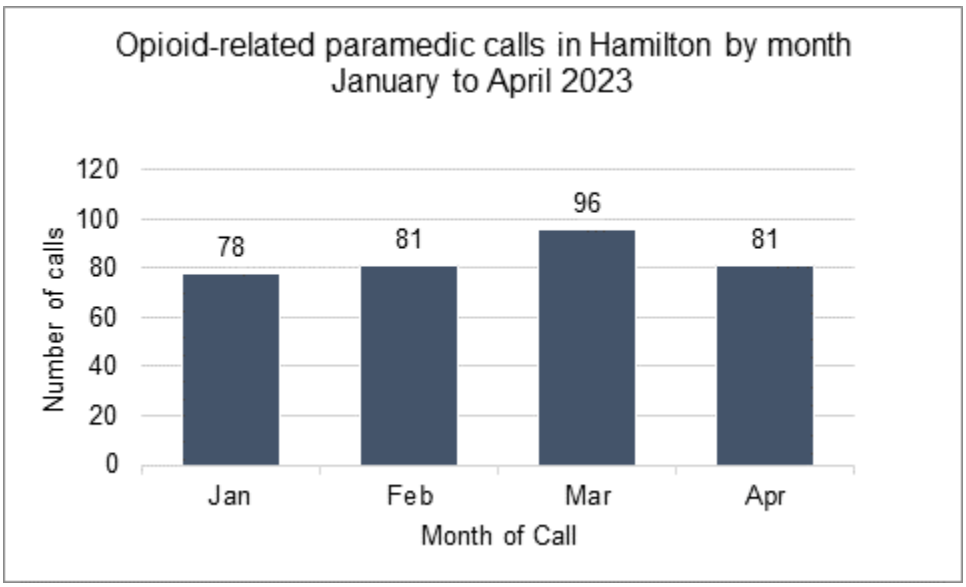
Table 1: Suspect drug-related deaths in Hamilton, January-April 2023, by indicator.

Indicator*	N	Percent
Age Group		
20-29	7	11%
30-39	15	24%
40-49	13	21%
50-59	14	23%
60-69	10	16%
Sex		
Male	44	71%
Female	18	29%
FSA of location of incident		
L8L	14	23%
L8H	7	11%
L8N	6	10%
L8P	5	8%
L8M	5	8%

*****Fields with fewer than 5 suspect drug-related deaths are not reported. Percentages may not add up to 100% due to suppression of small counts.

Source: Office of the Chief Coroner for Ontario (OCC), Death Investigation System, May 18, 2023.

Figure 2: Opioid-related paramedic calls in Hamilton, January-April 2023



Source: City of Hamilton (Health and Safe Communities-Public Health Services) Hamilton Opioid Information System. 2023. Available from: https://www.hamilton.ca/people-programs/public-health/alcohol-drugs-gambling/hamilton-opioid-information-system

Table 2: Opioid-related paramedic calls in Hamilton January to April 2023 by indicator.

Indicator	N	Percent
Age Group		
15-24	23	7%
25-34	115	34%
35-44	109	32%
45-64	81	24%
65+	8	2%
Sex		
Male	254	76%
Female	79	24%

Ward of Call*		
Ward 2	189	56%
Ward 3	68	20%
Ward 5	15	4%
Ward 4	13	4%
Ward 8	11	3%
Ward 1	10	3%
Ward 7	8	2%
Ward 6	7	2%
Ward 13	7	2%

*****Wards with fewer than 5 opioid-related calls are not reported. Percentages may not add up to 100% due to suppression of small counts

Source: City of Hamilton (Health and Safe Communities-Public Health Services) Hamilton Opioid Information System. 2023. Available from: https://www.hamilton.ca/people-programs/public-health/alcohol-drugs-gambling/hamilton-opioid-information-system

Early Warning Qualitative Surveillance Summary – January – April 2023

Through the local Opioid Situation Report, Hamilton Public Health Services (HPHS) receives anecdotal reports from community partners regarding drug poisonings and the illicit drug supply. In recent months, several agencies have reported on severe drug poisonings in the community requiring multiple rounds of Naloxone to reverse. HPHS have also been informed of several drug poisonings occurring in congregate settings like local shelters, with numerous drug poisonings being reported within short periods of time (2-7 days). In February 2023, there were local reports of drug poisonings attributed to “Yellow Down”, which is suspected to be a highly toxic fentanyl or fentanyl-like drug. There were also reports of unusual or irregular drug poisoning presentations involving a “jolting” or “seizure-like” response. Community members have informed local agencies that the current illicit drug supply is particularly potent, and some have indicated that the local supply is also laced or contaminated with substances like Phencyclidine (PCP) and benzodiazepines (benzos). Overall, the anecdotal information shared speaks to the highly toxic and unpredictable illicit drug supply in Hamilton.

BOH23021

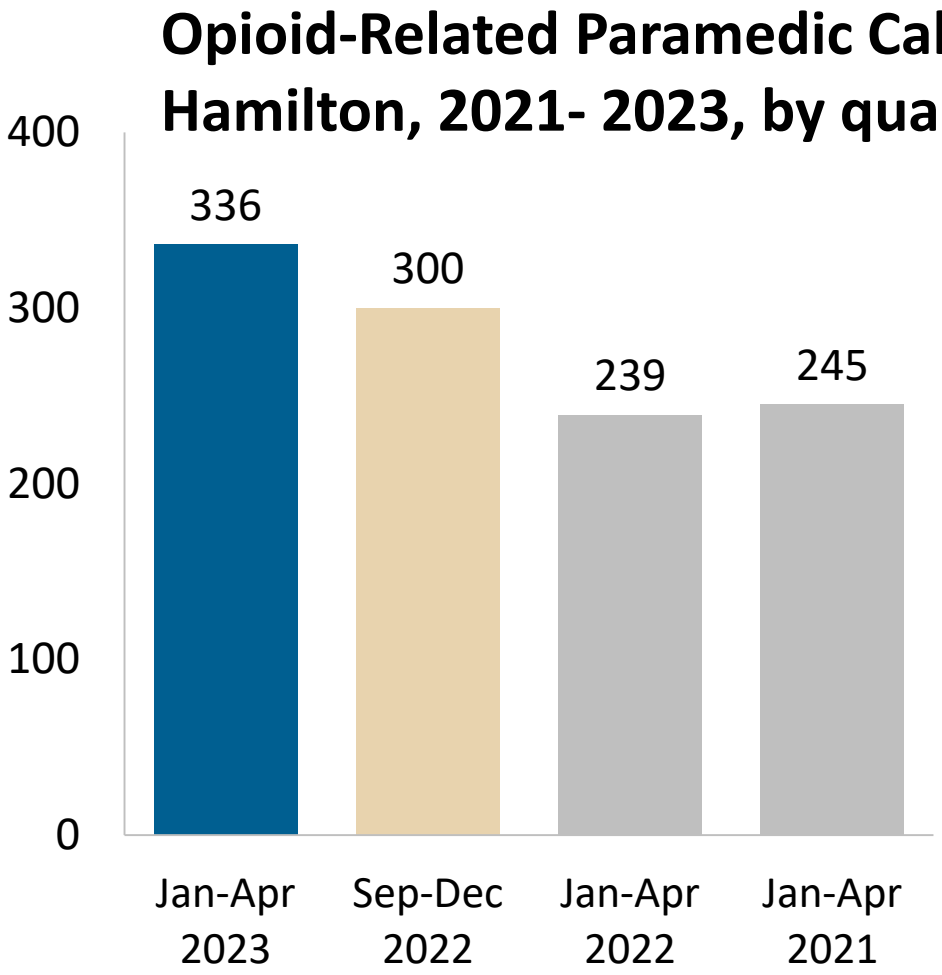
Hamilton Opioid Action Plan

June 12, 2023

Agenda

1. Review of local data
2. Background
3. Hamilton Opioid Action Plan Process and Timelines
4. Community Conversations
5. The Plan
6. Recommendations
7. Immediate Actions
8. Next Steps

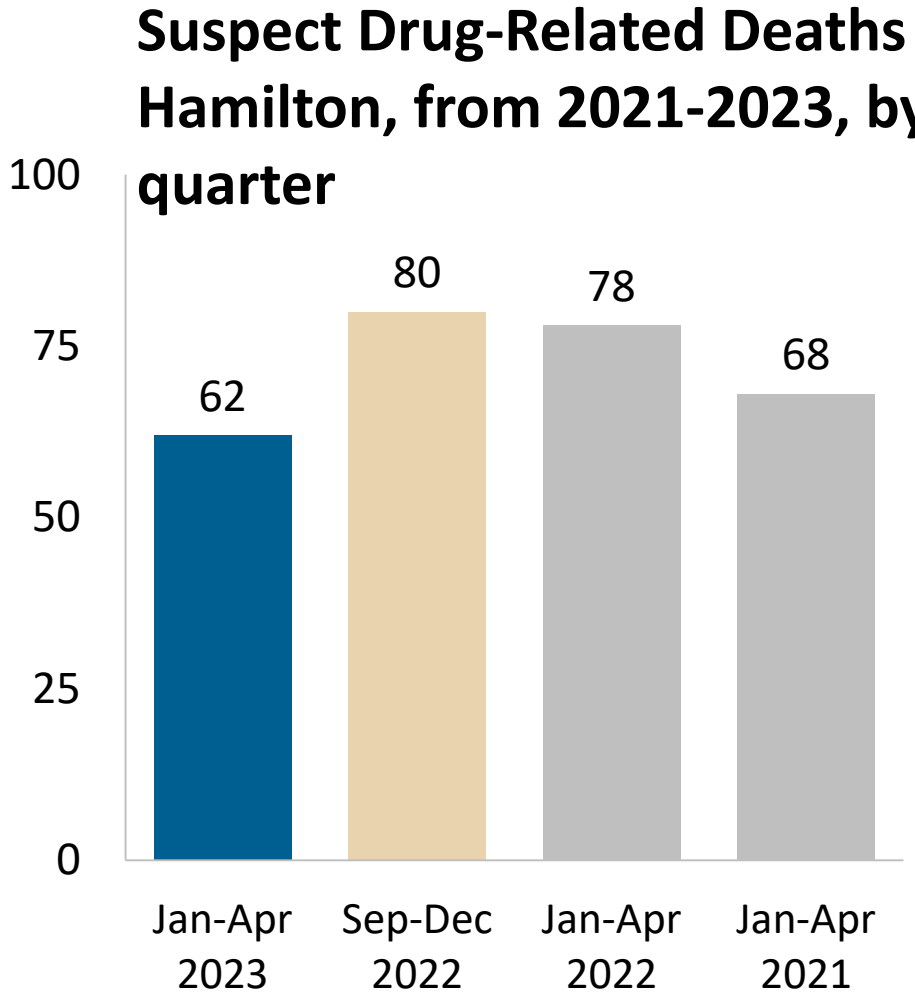
Local Data



Calls across all wards but concentrated in Ward 2 (56%) and Ward 3 (20%)

Source: Hamilton Paramedic Services, May 2023

Local Data

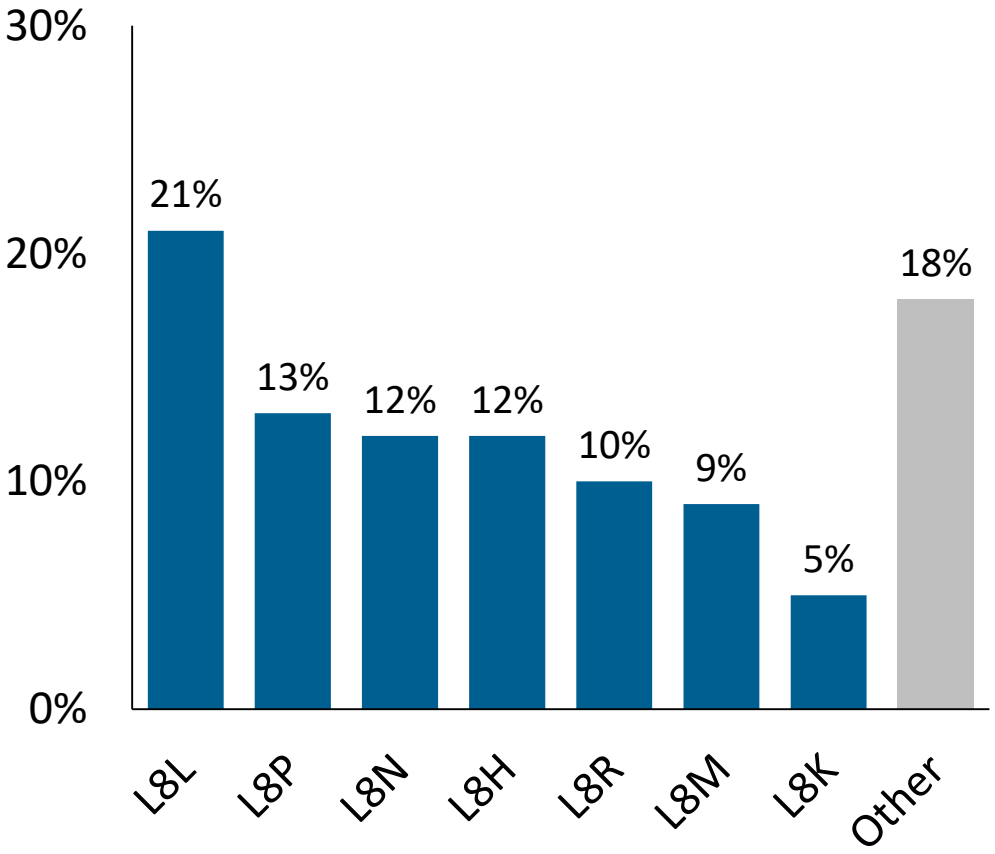


Represents 1 death every two days, or 3.6 deaths per week.

Source: Office of the Chief Coroner for Ontario, Death Investigation System, May 2023
Data are preliminary and subject to change

Local Data

Suspect Drug-Related Deaths by Forward Sortation Area (FSA), 2022-2023



Highest percentage in Forward Sortation Area L8L (21%) and L8P (13%).

Most occur in private residences (73%) followed by congregate living (9%) and outdoors (9%).

Source: Office of the Chief Coroner for Ontario, Death Investigation System, May 2023
Data are preliminary and subject to change

Background

February 2023

- Council directed staff to engage with a diverse group of community partners to create an evidence-based harm reduction plan.

- Hamilton Drug Strategy (HDS) identified the development of a coordinated opioid-specific action plan as part of the Hamilton Drug Strategy strategy renewal and a priority area of action in 2023.

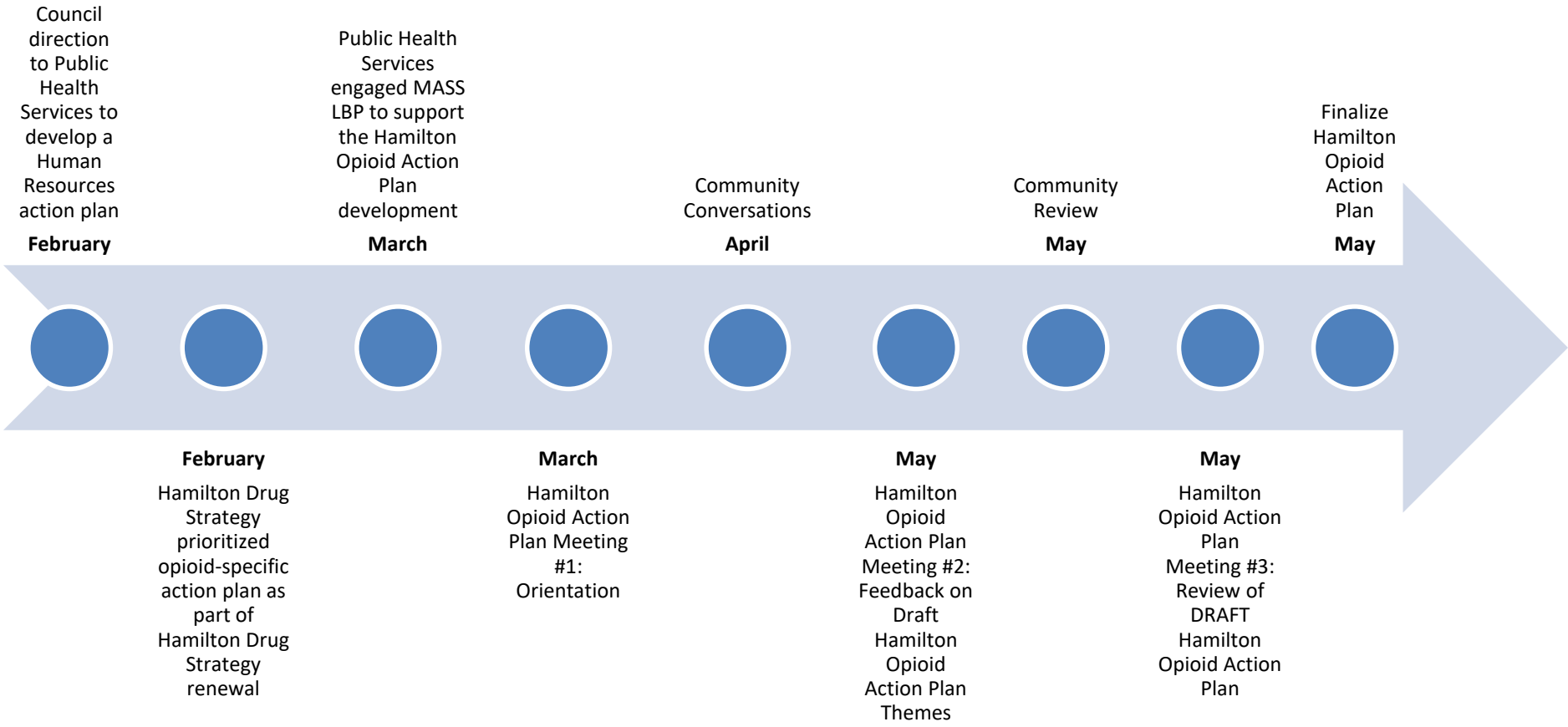
March 2023

- Public Health Services has engaged MASS LBP to support the facilitation of the Hamilton Opioid Action Plan (HOAP) process with the HDS Steering Committee.

April 2023

- Council directed the Mayor to declare an emergency in the areas of opioid, mental health and homelessness in Hamilton

Hamilton Opioid Action Plan Process and Timelines



Hamilton Opioid Action Plan Objectives

1. Reduce the number of deaths associated with opioids
2. Reduce the harms associated with opioid use
3. Increase access to a spectrum of treatment options

Community Conversations – Who We Spoke With

Hamilton Drug Strategy Steering Committee Members

- Community members
- Canadian Mental Health Association Hamilton Branch
- City of Hamilton - Community Services; Hamilton Paramedic Services; Housing Services; Mayor's Office; Public Health Services
- De dwa da dehs nye>s Aboriginal Health Centre
- Greater Hamilton Health Network
- Hamilton Health Sciences
- Hamilton Police Services
- Mission Services of Hamilton
- McMaster Family Practice
- St. Joseph's Healthcare
- The AIDS Network
- Wayside House of Hamilton
- Wesley
- YWCA Hamilton

Community Members & Organizations

- People with living/lived experience
- Indigenous community members
- Canadian Drug Policy Coalition (CDPC)
- De dwa da dehs nye>s Aboriginal Health Centre
- Good Shepherd Centres
- Grenfell Ministries
- Hamilton Centre for Civic Inclusion
- Hamilton Community Foundation
- Harm Reduction Working Group
- Keeping Six
- Primary Care Leadership Team
- Social Navigator Team – Hamilton Police Services
- Salvation Army

Community Conversations – What We Heard

- The crisis is deepening and requires focus and leadership
- Poverty, inadequate housing, overstretched shelter services are exacerbating the crisis.
- Limited coordination between service providers is reducing impact
- "We can get our hands around this" if we concentrate on those most at-risk
- We need to address public stigma
- We need to show results
- We need to hear each other even when advocating for different approaches and treatment modalities
- Families need support
- Primary care providers need support
- Frontline workers are struggling and burning out
- Empathy, community, and skill building are key to meaningful recovery

Hamilton Opioid Action Plan Actions

Immediate Actions: 0-6 months

1. Establish an Opioid Action Table
2. Scale up Supervised Consumption Sites across Hamilton
3. Develop safer use policies in hospitals and care settings
4. Increase availability of drug-checking services and resources
5. Engage and support primary care providers

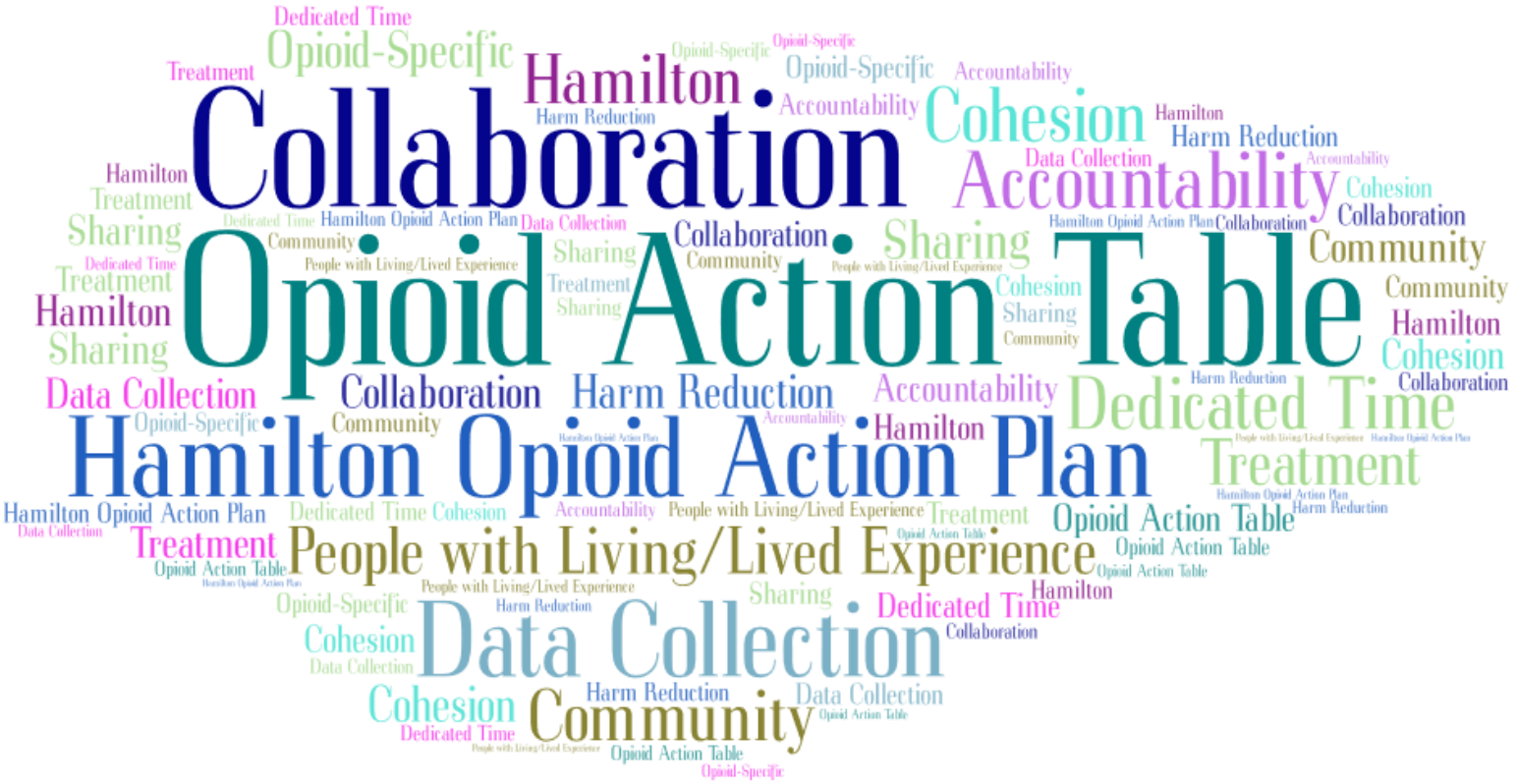
Medium-Term Actions: 6 months

1. Clarify service pathways and options for individuals who use substances, care providers, and first responders
2. Develop and implement new youth prevention programs
3. Expand supports available to families
4. Increase access and support to shelters and drop-ins

Long-Term Actions: 12 Months

1. Increase number of physicians able to prescribe opioid agonist therapy (OAT) and safer supply programs
2. Expand availability of stabilization services
3. Increase access to rapid detox and residential treatment programs
4. Develop additional Supervised Consumption Sites throughout Hamilton

Municipal Support and Investment



Opioid Action Table

Action: Establish an Opioid Action Table

- Oversee Hamilton Opioid Action Plan implementation and increase collaboration.
- Composed of people with living/lived experience & health and social service leaders.
- Reports to the Hamilton Drug Strategy Steering Committee.
- Develops task-oriented working groups.

Supervised Consumption Sites

Action: Scale up Supervised Consumption Site across Hamilton

- Expand supervised consumption sites to shelter-based settings
  - Initiate a Call for Applicants to pilot an 18-month safer use space in a men's shelter.
- Expand supervised consumption sites to other community settings, including exploration of a mobile Supervised Consumption Site and Supervised Consumption Sites within local hospitals.

Drug Checking Services

Action: Increase availability of drug checking services and resources

- Distribute drug checking strips within the community
- Provide two point-of-care drug checking devices for use in the community
- Investigate opportunities for additional analysis through mass spectrometry

Recommendations

a) Endorse the Hamilton Opioid Action Plan.

b) Increase Public Health Staff complement by 1.0 FTE Health Strategy Specialist to support planning and coordination of the Hamilton Opioid Action Plan.

c) Allocate funding for operational costs to initiate a one-year drug checking surveillance system pilot from October 2023 to September 2024.

d) Allocate funding to Housing Services to execute a Call for Applicants to pilot a Supervised Consumption Site for 18-months in a men's shelter.

e) Direct Public Health Services to conduct an evaluation of the Supervised Consumption Sites and report back in Q4 2024.

f) Authorize and direct the General Manager, Healthy and Safe Communities or delegate to, on behalf of the City of Hamilton, enter into, execute and administer all agreements and documents necessary to implement the Call for Applications for a shelter based Supervised Consumption Site.

Next Steps

- Establish the Opioid Action Table
- Initiate task-oriented working groups
- Report back on Hamilton Opioid Action Plan progress and performance measures in Q1 2024

Hamilton

QUESTIONS?

CITY OF HAMILTON
PUBLIC HEALTH SERVICES
Healthy Environments Division

TO:	Mayor and Members Public Health Committee
COMMITTEE DATE:	June 12, 2023
SUBJECT/REPORT NO:	Cold Alert Threshold Review (BOH23005(a)) (City Wide)
WARD(S) AFFECTED:	City Wide
PREPARED BY:	Sally Radisic (905) 546-2424 Ext. 5549
SUBMITTED BY: **SIGNATURE:**	Kevin McDonald Director, Healthy Environments Division Public Health Services

RECOMMENDATION

(a) That thresholds for Cold Alerts issued by the Medical Officer of Health remain at -15°C or -20 windchill; and,

(b) That the City's annual Winter Response Strategy, which is being developed to support individuals experiencing homelessness during winter months be provided independent of Cold Alerts issued by the Medical Officer of Health.

EXECUTIVE SUMMARY

The Office of the Medical Officer of Health issues 'Cold Alerts' for the purpose of notifying community members of the risk to health from exposure to extreme cold temperatures and how to access support for individuals experiencing homelessness and in need of shelter. The Cold Alert threshold value (i.e. trigger) of -15ºC or -20 windchill was designed to warn of times when the risk of cold weather injuries (CWIs) such as acute frostbite and hypothermia from exposure were further heightened, especially for those most vulnerable to its effects, such as individuals experiencing homelessness, older adults (≥65 years of age), and young children.

Although the current thresholds of -15ºC or -20 windchill are largely consistent with Public Health Units in Ontario that employ Cold Alert protocols, research focusing on individuals experiencing homelessness found that most (72%) of cold weather injuries (i.e. hypothermia) occurred at temperatures warmer than -15ºC. Additionally, findings from a City of Hamilton Community Service Provider Cold Alert Trigger and Response Survey found that 86% of responses (12 out of 14 responses) had concerns specific to

the current Cold Alert thresholds since their service users experienced cold weather injuries at warmer temperatures above these thresholds. Furthermore, 71% of responses (10 out of 14 responses) shared that they believed the current Cold Alert thresholds did not meet the health and safety needs of those experiencing homelessness and housing precarity. Subsequently, more than half of responses (57%, or 8 out 14 responses) indicated that they would support an annual Winter Response Strategy that provides low-barrier overnight warming spaces for individuals experiencing homelessness.

At the January 19, 2023 Emergency & Community Services Committee meeting, staff were directed to report back to a Fall 2023 meeting with recommendations for an annual winter response strategy, in response to identified gaps in services for those experiencing homelessness (Report HSC23012).

Therefore, consistent with research evidence, the City of Hamilton Community Service Provider Cold Alert Trigger and Response Survey findings, and above noted staff direction, there is a need to provide an Annual Winter Response Strategy that aims to protect the health and safety of individuals experiencing homelessness during winter months which is independent of the existing Cold Alerts issued by the Medical Officer of Health during extreme cold weather conditions.

Alternatives for Consideration – See Page 10

FINANCIAL – STAFFING – LEGAL IMPLICATIONS

Financial: Not Applicable.

Staffing: Not Applicable.

Legal: Not Applicable.

These implications will be addressed in Housing Division's forthcoming Emergency & Community Services Committee Recommendation Report going forward in September 2023.

HISTORICAL BACKGROUND

Since the 2000/2001 winter season, the Office of the Medical Officer of Health has issued Cold Alerts for the purpose of notifying community members of the risk to health from exposure to extreme cold temperatures and how to access support for vulnerable persons in need of shelter. The Cold Alert threshold value (i.e. trigger) of -15ºC or -20 windchill was designed to warn of times when the risk of acute frostbite and hypothermia from exposure were further heightened, especially for those most vulnerable to its effects, such as individuals experiencing homelessness, older adults (≥65 years of age) and young children. The alerts trigger increased outreach to

individuals experiencing homelessness by community agencies and groups to encourage people to access available shelter services and expanded services offered in anticipation of the potential that more individuals would be utilizing identified services during these times. The Cold Alert triggers and corresponding community response plan have historically been predicated on the understanding that access to warm, dry, safe shelter or housing is essential. More information about the City of Hamilton's Community Cold Response and to access a complete listing of ongoing community resources including emergency shelters, and drop-in locations can be found by visiting https://www.hamilton.ca/cold.

The current thresholds are largely consistent with Public Health Units in Ontario that employ Cold Alert protocols. However concern regarding the potential for these thresholds to protect the health and safety of individuals experiencing homelessness who spend prolonged periods of time outdoors in wet conditions with inadequate clothing, suffer from mental health and substance use disorder which may exacerbate cold weather-related injuries and death and may not have access to warm, dry, safe shelter including overnight spaces, otherwise, has been raised.

Given this concern and approved through the January 19, 2023 Emergency & Community Services Committee Report HSC23012, as a mitigation measure, the Housing Services Division provided one-time funding to the 'The Hub' as an overnight warming space through March 31, 2023. Additionally, Report HSC23012 provides approval related to enhanced access to drop-in warming centres for the duration of the 2023 winter season and a commitment to come back to a Fall 2023 Emergency & Community Services Committee meeting with recommendations for an annual Winter Response Strategy.

Moreover, at the January 16, 2023 Board of Health Meeting, Report BOH23005 was brought forward with Public Health Services staff committing to:

- Conduct a scientific review of the available evidence related to the impact of cold weather events on health;
- Conduct an environmental scan of current Cold Alert thresholds and response protocols for the cities of Toronto, Ottawa, and other Ontario Public Health Unit jurisdictions;
- Work together with Housing Division staff to engage and consult with community service providers with respect to their concerns specific to Cold Alert thresholds and response plans to inform any potential changes in policy; and,
- Bring forward a Recommendation Report detailing specific options and recommendations specifically related to Cold Alert thresholds.

This recommendation report fulfills the commitments from Report BOH23005, outlined above.

POLICY IMPLICATIONS AND LEGISLATED REQUIREMENTS

By approving the recommendations of this report, an annual Winter Response Strategy would operate independent of Cold Alerts issued by the Medical Officer of Health when temperature drops or is expected to drop below -15°C or the temperature feels like -20°C.

RELEVANT CONSULTATION

In February 2023, Public Health Services' staff initiated working together with Housing Services Division staff to engage and consult with Community Service Providers with respect to their concerns specific to Cold Alert thresholds and response plans to inform any potential changes in policy.

An online survey tool was developed via SimpleSurvey with the assistance of Public Health Services' Epidemiology and Evaluation staff. The purpose of the survey was to engage Community Service Providers such that they may share feedback specific to Cold Alert thresholds and response which could be used to inform further policy opportunities and decisions.

Through existing and established working relationships with Community Service Providers, Housing Services Division staff distributed the Cold Alert Trigger and Response Survey via email.

On March 2, 2023 a survey was sent via email to 39 staff (both management and frontline) working in various Community Service Provider organizations including: Emergency Shelter, Street Outreach, Drop-In Program, Shelter Health Network, Homelessness Prevention, Violence Against Women's Shelter, Housing First Intervention, and Supportive Housing. The survey was open for a period of two weeks and closed on March 16, 2023.

A total of 14 participants providing community services in various locations in the city of Hamilton completed the survey, including five Emergency Shelters, two Drop-In Programs, one Homelessness Prevention service, one Violence Against Women's Shelter, one Housing First Intervention, and four "others" such as Supportive Housing. Survey results show 86% of responses (12 out of 14 responses) identified that they support vulnerable individuals within the homelessness serving sector. However, only 43% of responses (6 out of 14 responses) indicated that it was their organization's primary mandate to serve individuals in the homelessness serving sector.

Survey results show 86% of responses (12 out of 14 responses) of Community Service Provider staff indicated that they have concerns specific to the current Cold Alert thresholds which are set for when temperature drops or is expected to drop below -15°C or the temperature feels like -20°C. The concerns raised include cold weather injuries

experienced by their service users at warmer temperatures above the thresholds, other adverse outdoor environmental conditions such as freezing rain, hail, and heavy snow which can exacerbate cold weather injuries, and the use of unauthorized spaces for shelter (i.e. building vestibules) during times when the thresholds are not met which can be a safety issue for both their service users and the public.

More than half of responses (57%, or 8 out of 14 responses) indicated that the current Cold Alert thresholds did not align with their organization's cold response protocols, and 71% of responses (10 out of 14 responses) shared that they believed the current Cold Alert thresholds did not meet the health and safety needs of those experiencing homelessness and housing precarity.

When asked if Community Service Provider staff would support an annual Winter Response Strategy operating from December 1 to March 31, that provides low-barrier overnight warming spaces for individuals experiencing homelessness, more than half of responses (57%, or 8 out of 14 responses) indicated that they would, whereas the other 43% of responses (6 out of 14 responses) had concerns pertaining to their current limited resources (i.e. staffing) and capacity (i.e. space) to support the demands of an annual Winter Response Strategy.

71% of the participants shared that expanding services to include: increased communication, Indigenous Services, more shelter spaces, additional outreach workers, inclusion of faith-based organizations, private sector food donations, warm clothing and blanket supplies, and a medical warming bus should be considered as part of an annual Winter Response Strategy.

On April 11, 2023 a survey summary of feedback responses (Appendix "A" to Report BOH23005(a)) was shared with the 14 participating Community Service Providers via email such that they could review the survey summary responses to ensure that the information was accurate and resonated with the responses provided by their respective organizations. Participants were given a two-week time period until April 24, 2023 to provide further feedback via emailing the Health Hazard Specialist at sally.radisic@hamilton.ca. No additional feedback was received as of April 24, 2023.

ANALYSIS AND RATIONALE FOR RECOMMENDATION

Research identifies that the most prevalent and preventable health risks associated with exposure to cold temperatures, also known as cold weather injuries, include frostbite

and hypothermia.[1, 2, 3, 4, 5] During cold weather exposures, the human body struggles to maintain body temperature and loses heat faster than it can be produced.[6] Cold weather injuries are worsened by wind chill and moisture.[7, 8, 9, 10] Additionally, research indicates that cold weather injuries are a risk for all individuals who do not have adequate knowledge and protective equipment.[2, 6]

Further, when considering risk of cold weather injuries, it is important to understand that there is individual variability between and within populations.[6] Hence some individuals may be at greater risk including:

- Homeless people;[2, 4, 11, 12]

---

[1] Center for Disease Control and Prevention. Prevent Hypothermia and Frostbite. 2019. Available from: https://www.cdc.gov/disasters/winter/staysafe/hypothermia.html

[2] Health Canada. Extreme Cold. 2021. Available from: https://www.canada.ca/en/health-canada/services/healthy-living/your-health/environment/extreme-cold.html

[3] Haney, C. Beyond “Snow Shoveler's Infarction”: Broadening perspectives on winter health risks. Geography Compass, 2020, 14, e12494. Available from: https://compass.onlinelibrary.wiley.com/doi/10.1111/gec3.12494

[4] Heil, K.; Thomas, R.; Robertson, G.; Porter, A.; Milner, R.; Wood, A. Freezing and non-freezing cold weather injuries: a systematic review. British Medical Bulletin, 2016, 117,79–93. Available from: https://pubmed.ncbi.nlm.nih.gov/26872856/

[5] National Health Services (NHS). Frostbite. 2021. Available from: https://www.nhs.uk/conditions/frostbite/

[6] Haman, F.; Souza, S.; Castellani, J.; Dupuis, M.; Friedl, K.; Sullivan-Kwantes, W.; Kingma, B. Human vulnerability and variability in the cold: Establishing individual risks for cold weather injuries. Temperature, 2022, 9, 158–195. Available from: https://www.tandfonline.com/doi/full/10.1080/23328940.2022.2044740

[7] Cappaert, T. A., Stone, J. A., Castellani, J. W., Krause, B. A., Smith, D., & Stephens, B. A. (2008). National athletic trainers' association position statement: Environmental cold injuries. Journal of Athletic Training, 43(6), 640–658.

[8] Castellani, J. W., Young, A. J., Ducharme, M. B., Giesbrecht, G. G., Glickman, E., & Sallis, R. E. (2006). Prevention of cold injuries during exercise (No. MISC06-03). Army Researcg Inst of Environmental Medicine NATICK MA Thermal and Mountain Medicine Division.

[9] Fudge, J. (2016). Exercise in the cold: Preventing and managing hypothermia and frostbite injury. Sports Health, 8(2), 133–139. Available from: https://doi.org/10.1177/1941738116630542

[10] Zafren, K. (2013). Frostbite: Prevention and initial management. High Altitude Medicine & Biology, 14(1), 9–12. Available from: https://doi.org/10.1089/ham.2012.1114

[11] Brown, A.J.; Goodacre, S.W.; Cross, S. Do emergency department attendances by homeless people increase in cold weather? Emerg. Med. J. 2010, 27, 526–529. Available from: https://emj.bmj.com/content/27/7/526

[12] Gasparrini, A.; Guo, Y.; Hashizume, M.; Lavigne, E.; Zanobetti, A.; Schwartz, J.; Tobias, A.; Tong, S.; Rocklov, J.; Forsberg, B. Mortality risk attributable to high and low

- Outdoor workers;[2]
- People living in homes that are poorly insulated (with no heat or no power);[2]
- People with certain medical conditions such as diabetes, peripheral neuropathy, and diseases affecting the blood vessels;[2]
- People taking certain medications;[2]
- Winter sport enthusiasts;[2]
- Infants (under one year old);[2, 8, 9, 13]
- Seniors (age 65 years or older);[2, 8, 9, 13]
- Mental illness;[10, 14, 15, 16, 17, 18] and,
- Drug[18, 19] and alcohol use.[10, 20, 21, 22]

Although frostbite can impact any part of the body, extremities such as hands, feet, nose, ears and lips are most likely to be impacted by freezing temperatures usually below -0.55°C.[2, 4, 5] When exposed to cold temperatures, the body redirects blood flow to vital organs away from extremities so that they get colder to the point that the tissue

---

ambient temperature: A multi country observational study. Lancet 2015, 386, 369–375. Available from: https://www.sciencedirect.com/science/article/pii/S0140673614621140?via%3Dihub

[13] Valnicek, S. M., Chasmar, L. R., & Clapson, J. B. (1993). Frostbite in the prairies: A 12-year review. Plastic and Reconstructive Surgery, 92(4), 633–641.

[14] Imray, C., Grieve, A., Dhillon, S., & Caudwell Xtreme Everest Research Group. (2009). Cold damage to the extremities: Frostbite and non-freezing cold injuries. Postgraduate Medical Journal, 85(1007), 481–488. Available from: https://doi.org/10.1136/pgmj.2008.068635

[15] Murphy, J. V., Banwell, P. E., Roberts, A. H., & McGrouther, D. A. (2000). Frostbite: Pathogenesis and treatment. Journal of Trauma and Acute Care Surgery, 48(1), 171.

[16] Reamy, B. V. (1998). Frostbite: Review and current concepts. The Journal of the American Board of Family Practice, 11(1), 34–40.

[17] Urschel, J. D. (1990). Frostbite: Predisposing factors and predictors of poor outcome. The Journal of Trauma, 30(3), 340–342.

[18] Valnicek, S. M., Chasmar, L. R., & Clapson, J. B. (1993). Frostbite in the prairies: A 12-year review. Plastic and Reconstructive Surgery, 92(4), 633–641.

[19] Brändström, H., Eriksson, A., Giesbrecht, G., Ängquist, K. A., & Haney, M. (2012). Fatal hypothermia: An analysis from a subarctic region. International Journal of Circumpolar Health, 71(1), 18502. Available from: https://doi.org/10.3402/ijch.v71i0.18502

[20] Biem, J., Koehncke, N., Classen, D., & Dosman, J. (2003). Out of the cold: Management of hypothermia and frostbite. CMAJ, 168(3), 305–311.

[21] Conway, G. A., & Husberg, B. J. (1999). Cold-related non-fatal injuries in Alaska. American Journal of Industrial Medicine, 36(S1), 39–41.

[22] Hallam, M. J., Cubison, T., Dheansa, B., & Imray, C. (2010). Managing frostbite. BMJ, 341, c5864. Available from: https://www.bmj.com/content/341/bmj.c5864

fluid in these parts can freeze and crystalize leading to tissue damage and potentially tissue death.[5, 6, 14, 23, 24]

Moreover, frostbite is often linked with hypothermia and is described as a dangerous drop in normal body temperature of 37°C to below 35°C resulting in cardiovascular and central nervous system dysfunction which may lead to death.[2, 5, 25, 26, 27]

Health Canada (2021) describes three stages of hypothermia.[2] The first stage, or mild stage, occurs when body temperature drops 1-2°C and symptoms include initiation of shivering and consciousness. The second stage, also called the moderate stage, occurs when body temperature drops 2- 4°C and symptoms include strong shivering and impaired consciousness. The last stage, which is the severe stage, occurs when body temperature drops below 32°C and symptoms include absence of shivering, loss of consciousness, possible cardiac arrest and death.[27]

Hypothermia can be experienced if individuals are not properly dressed for the cold weather, stay out in cold temperatures for long periods of time, fall in cold water and have wet clothing on;[2, 5] individuals who are experiencing homelessness are susceptible to these circumstances.[4, 28] In a 2019 published study examining cold weather conditions and the risk of hypothermia among individuals experiencing homelessness between 2004 and 2015 in Toronto, researchers found that the risk of hypothermia among individuals experiencing homelessness increased with declining temperature.[29]

---

[23] Regli, I.B.; Strapazzon, G.; Falla, M.; Oberhammer, R.; Brugger, H. Long-Term Sequelae of Frostbite—A Scoping Review. Int. J. Environ. Res. Public Health 2021, 18, 9655. Available from: https://doi.org/10.3390/ijerph18189655

[24] Murphy, J. V., Banwell, P. E., Roberts, A. H., & McGrouther, D. A. (2000). Frostbite: Pathogenesis and treatment. Journal of Trauma and Acute Care Surgery, 48(1), 171.

[25] Herity, B.; Daly, L.; Bourke, G.J.; Horgan, J.M. Hypothermia and mortality and morbidity. An epidemiological analysis. J. Epidemiol. Community Health 1991, 45, 19. Available from: https://jech.bmj.com/content/45/1/19

[26] Baumgartner, E.A.; Belson, M.; Rubin, C.; Patel, M. Hypothermia and other cold-related morbidity emergency department visits: United States, 1995–2004. Wilderness Environ. Med. 2008, 19, 233–237. Available from: https://pubmed.ncbi.nlm.nih.gov/19099327/

[27] Dr. Doug Brown & BC Accidental Hypothermia Working Group. Accidental Hypothermia Clinical Practice Guideline for British Columbia. 2016. Available from: https://www2.gov.bc.ca/assets/gov/health/practitioner-pro/bc-guidelines/bc_hypothermia_cpg.pdf

[28] Brown, A.J.; Goodacre, S.W.; Cross, S. Do emergency department attendances by homeless people increase in cold weather? Emerg. Med. J. 2010, 27, 526–529. Available from: https://pubmed.ncbi.nlm.nih.gov/20466831/

[29] Zhang, P.; Wiens, K.; Wang, R.; Luong, L.; DoAnsara, D.; Gower, S.; Bassil, K.; Hwang, S. Cold Weather Conditions and Risk of Hypothermia Among People Experiencing Homelessness: Implications for Prevention Strategies. Int. J. Environ.

Their study showed that the odds of experiencing a hypothermic event increased 1.64-fold (95% Confidence Interval: 1.30–2.07) with every 5°C decrease in the minimum daily temperature and 1.10-fold (95% Confidence Interval: 1.03–1.17) with every one millimetre increase in rainfall.

Furthermore, Zhang et al., 2019 found that most (72%) hypothermia cases happened when temperatures were warmer than -15°C.[29] Consequently, in an effort to prevent hypothermia among individuals experiencing homelessness, Zhang et al, (2019) concluded that there was a need to provide a seasonal cold weather response in addition to the existing alert-based response during extreme cold weather conditions.[29]

It is important to point out that via an environmental scan of cold weather programs at Ontario Public Health Units, it was identified that at least five Ontario Public Health Units including Hamilton, Toronto, Durham, York, and Simcoe issue cold alerts when daily minimum temperatures are forecasted to reach -15°C or colder (-20 windchill or colder). Cold alerts typically include issuing of public notifications with health messages along with the provision of shelters and other services to reduce cold weather injuries.[30] The exception is Ottawa Public Health which issues Frostbite Advisories at -25 windchill or colder and Warnings at -35 windchill or colder; however, access to spaces where individuals can warm up such as shelters, operate independent of Frostbite Advisories and Warnings in the city of Ottawa.[31]

In an effort to determine the effectiveness of a cold weather program, researchers evaluated the Toronto Cold Weather Program (TCWP) and found that it was not effective in reducing cold related mortality and morbidity. As a result, the researchers pointed out the need to improve existing cold-related policies in Canada.[30]

Therefore, based on both the research evidence review and the City of Hamilton Community Service Provider Cold Alert Trigger and Response Survey findings, there is a need to provide an additional Winter Response Strategy that aims to protect health and safety of individuals experiencing homelessness during winter months which is independent of the existing Cold Alerts issued by the Medical Officer of Health during extreme cold weather conditions.

Res. Public Health 2019, 16, 3259. Available from: https://www.mdpi.com/1660-4601/16/18/3259

[30] Benmarhniaa, T.; Zhaob, X.; Wang, J.; Macdonald, M.; Chen, H. Evaluating the potential public health impacts of the Toronto cold weather program. Environment International, 2019, 127, 381-386. Available from: https://www.sciencedirect.com/science/article/pii/S0160412018327156?via%3Dihub

[31] Ottawa Public Health. Extreme cold weather assistance to people experiencing homelessness. 2023. Available from: https://www.ottawapublichealth.ca/en/professionals-and-partners/extreme-cold-weather-assistance-to-homeless-persons.aspx

ALTERNATIVES FOR CONSIDERATION

The Public Health Committee may choose to increase the Cold Alert trigger temperature criteria above -15ºC to be more protective of individuals experiencing homelessness.

The challenges of setting a protective Cold Alert trigger are highlighted by various cities in Canada and United States (US) with varying thresholds above -15ºC since evidence indicates that frostbite can occur at temperatures below -0.55°C.[2, 4, 5] For example, in Vancouver the threshold is set at -5°C or colder; whereas in the US cities of New York and Chicago a threshold of 0°C (32°F) or colder including wind chill is set while Washington, D.C. uses -9.4°C (15°F) or colder including wind chill.[32]

ALIGNMENT TO THE 2016 – 2025 STRATEGIC PLAN

Healthy and Safe Communities
Hamilton is a safe and supportive City where people are active, healthy, and have a high quality of life.

APPENDICES AND SCHEDULES ATTACHED

Appendix “A” to Report BOH23005(a)	Cold Alert Trigger and Response Process Survey Summary

[32] City of Toronto. Review of policies and procedures related to Warming Centres. April 13, 2023. Available from: https://www.toronto.ca/legdocs/mmis/2023/ec/bgrd/backgroundfile-235826.pdf

Cold Alert Trigger and Response Process Survey Summary

On March 2, 2023 a survey was sent via email to 39 staff (both management and frontline) working in various Community Service Provider organizations including: Emergency Shelter, Street Outreach, Drop In Program, Shelter Health Network, Homelessness Prevention, Violence Against Women's Shelter, Housing First Intervention, and Supportive Housing. The survey was open for a period of two weeks and closed on March 16, 2023. The purpose of the survey was to reach out to Community Service Providers such that they may share feedback specific to Cold Alert thresholds and response plans which could be used to inform further policy.

There were a total of 14 participants providing services in various locations in the City of Hamilton who completed the survey including 5 Emergency Shelter, 2 Drop In Programs, 1 Homelessness Prevention, 1 Violence Against Women’s Shelter, 1 Housing First Intervention, and 4 Others such as Supportive Housing. 86% (12/14) identified that they support vulnerable individuals within the homelessness serving systems. However, only 43% (6/14) indicated that it was their organization’s primary mandate to serve individuals in the homelessness serving system.

86% (12/14) of Community Service Provider staff indicated that they have concerns specific to the current cold alert thresholds which are set for when temperature drops or is expected to drop below -15°C or the temperature feels like -20°C. The concerns raised include cold weather injuries (CWIs) (i.e. frost bite and hypothermia) experienced by their service users at warmer temperatures above the thresholds, other adverse outdoor environmental conditions such as freezing rain, hail, and heavy snow which can exacerbate CWIs, and the use of unauthorized spaces for shelter (i.e. building vestibules) during times when the thresholds are not met which can be a safety issue for both their service users and the public.

More than half 57% (8/14) indicated that the current cold alert thresholds did not align with their organization’s cold response protocols and 71% (10/14) shared that they believed the current cold alert thresholds did not meet the health and safety needs of those experiencing homelessness and housing precarity.

When asked if Community Service Provider staff would support an annual Winter Response Strategy operating from December 1st to March 31st that provides low-barrier overnight warming spaces for individuals experiencing homelessness, more than half 57% (8/14) indicated that they would whereas the other 43% (6/14) had concerns pertaining to their current limited resources (i.e. staffing) and capacity (i.e. space) to support the demands of an annual Winter Response Strategy.

71% of the participants shared that expanding services to include: increased communication, Indigenous Services, more shelter spaces, additional outreach workers, inclusion of faith-based organizations, private sector food donations, warm clothing and blanket supplies and a medical warming bus are to be considered as part of an annual Winter Response Strategy.

CITY OF HAMILTON

M O T I O N

Public Health Committee: June 12, 2023

MOVED BY COUNCILLOR N. NANN

SECONDED BY COUNCILLOR ……

AIR POLLUTION & MENTAL HEALTH IMPACTS

WHEREAS, emerging data points to a connection between air pollution and mental and neurological health impacts;

WHEREAS, Hamilton Public Health does not currently collected data on air pollution and it's links to mental and neurological health outcomes;

WHEREAS, Hamilton Public Health does not currently have the resources to collect, analyze, and report to Public Health Committee on this data; and

WHEREAS, Hamilton Public Health regularly benefits from partnership with academics and other health research institutions where there are intersecting areas of interest.

THEREFORE BE IT RESOLVED:

(a) That Public Health Staff be directed to identify the resources required to develop, in partnership with the Centre for Addictions and Mental Health (CAMH), McMaster University and other local stakeholders, a suite of evidence-informed indicators that can be used locally to monitor the impact of air pollution on mental and neurological health outcomes for future Health Check reports;

(b) That staff report back to Public Health Committee on the identified resources needed by the start of Q4 2023, so that any staffing and/or financial needs can be identified for inclusion in the 2024 Budget; and

(c) That staff include this information in future Health Check reports to Public Health Committee by the beginning of 2025 and annually thereafter.