GHHN Health Equity REPORT

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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:
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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.

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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

Liaisons with GHHN Executive Council
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
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- 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

Liaisons with GHHN Executive Council
- Bernice King, Patient Advisor
- Melissa Farrell, St Joseph's Health Care

GHHN Staff Team
- 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.

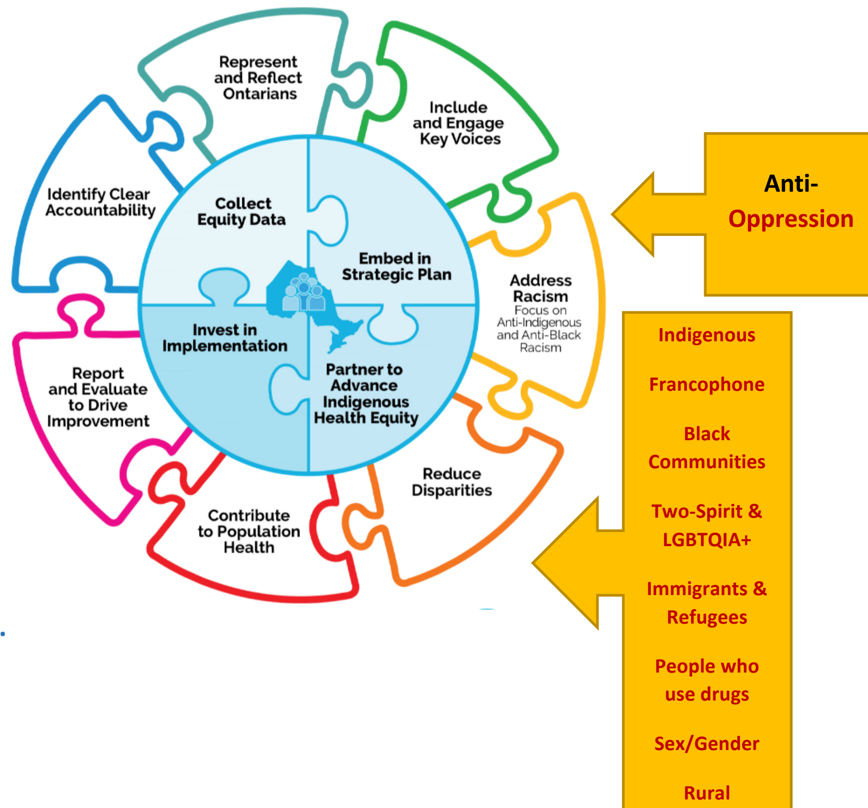
Alignment with Ontario Health's Equity Framework[1]

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



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[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

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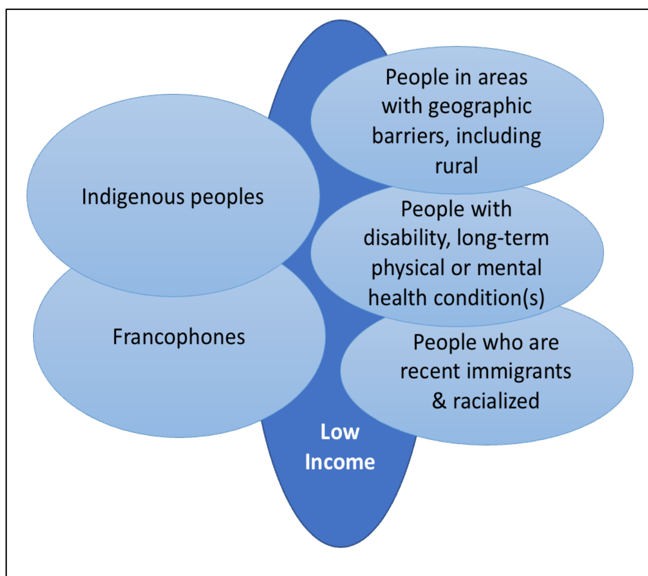
[2] Health Quality Ontario, November 2019.
[3] Ontario Health's Equity, Inclusion, Diversity and Anti-Racism Framework, Ontario Health, 2020.
[4] Black Experiences in Health Care, Symposium Report, 2019 http://accho.ca/wp-content/uploads/2019/04/SHS-BEHC-report-FINAL-aoda-final.pdf
[5] Kindig & Stoddart.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

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.

> *"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."*

[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).

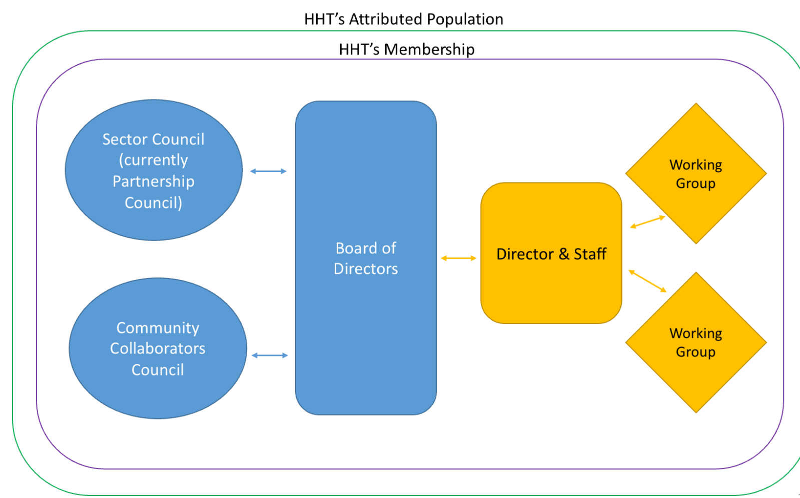
The governance structure for GHHN needs to reflect and support these two shifts in mindset. Throughout the governance structure, at all levels, appropriate content and context experts need to be engaged.

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
Perosn 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

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[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

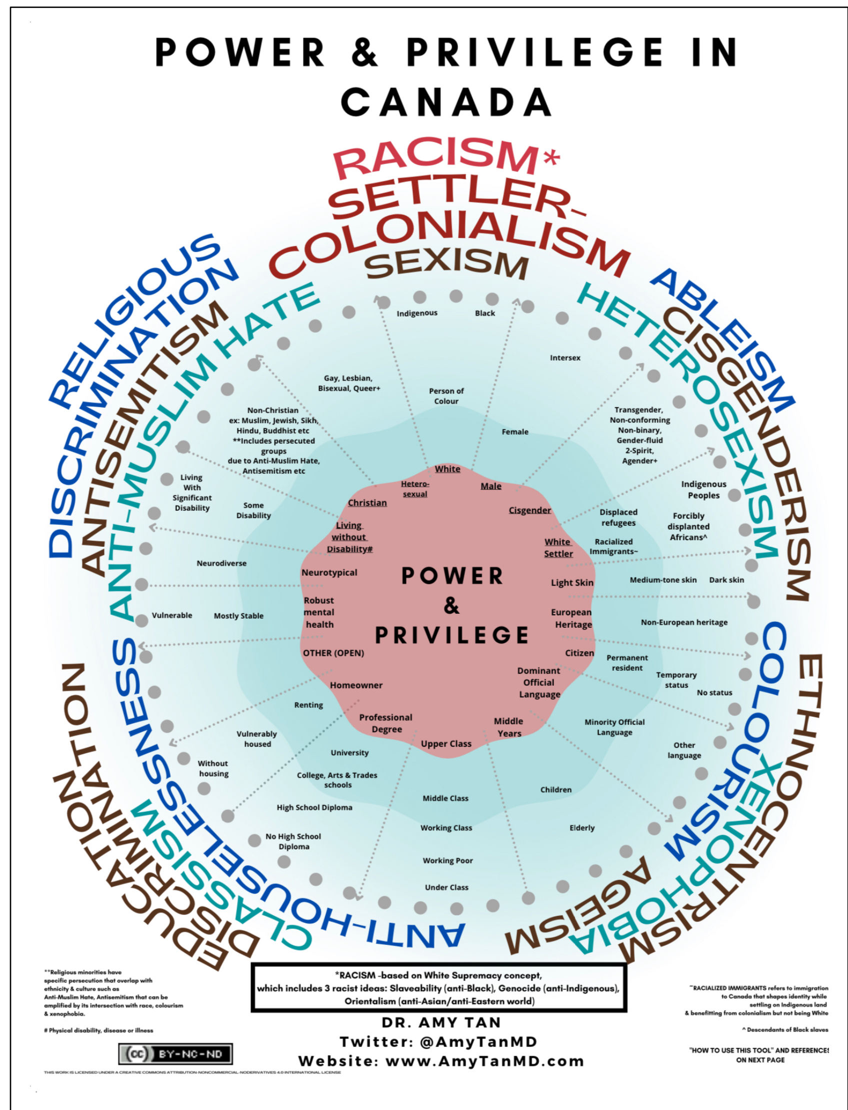
[18] Anti-Oppression Framework, Marigold Capital https://marigold-capital.com/marigold-capital-anti-oppression-framework/#:~:text=The%20six%20main%20lenses%20of,is%20intersectionality%20within%20oppressed%20groups
[19] Kindig & Stoddart. American Journal for Public Health (AJPH) 2002; 93(3):380-3
[20] 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

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[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.

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