HSPN Health System Performance Network

Developmental Evaluation of Ontario Health Teams Invited Symposium

Hart House, University of Toronto

September 21, 2022

OHT Presentations Part 1: Couchiching, Chatham Kent, East York Region North Durham

HSPN

COUCHICHING

Couchiching
Ontario Health Team

Couchiching Ontario Health Team

Presentation for the HSPN DE Symposium

Sept 21, 2022

Who is the Couchiching OHT?

Our Ontario Health Team is made up of over 30+ community organizations – spread across Orillia, Oro-Medonte, Ramara & Severn +.

Our Shared Purpose:

We are one community that is committed to improving health and wellness. Together we will achieve our goal through system co-design, in a culturally safe and meaningful way.

All my relations | Tous lies | Mitakuye-Oyasin

Couchiching OHT – Joint Executive Team

County of Simcoe

Community Connection – connecting people to services

211 Central East Ontario

CarePartners

Helping Hands Orillia

ProResp Inc. – Community Respiratory Therapy

Co-Designed in partnership with COHT PFAC Patient and Family Advisory Committee

Soldiers' Memorial Hospital Orillia

Primary Care Council

Couchiching Family Health Team

Huronia Nurse Practitioner-Led Clinic

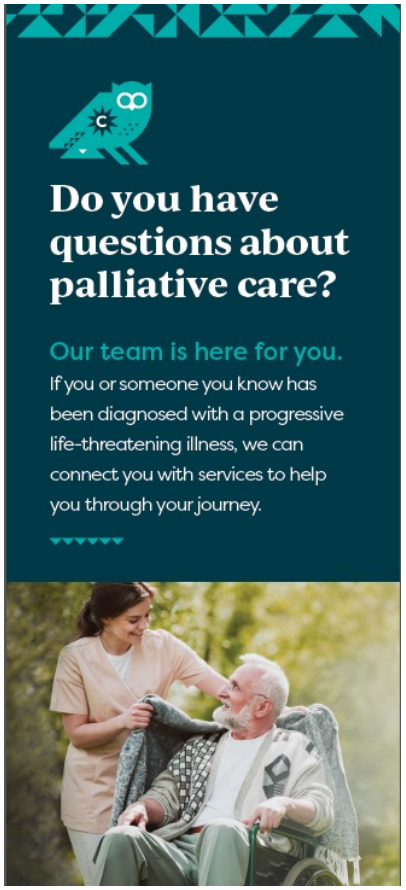
Home and Community Care – North Simcoe Muskoka

The Lighthouse

We'd Say – We're Good at…

- Operating as "One Community"
- Being *both* Patient Focused & Partner Focused – relationships are paramount
- Creating local approaches to health care access inequities, i.e.

Strong System Navigation: Palliative care, Seniors care, High-Intensity Supports at Home (HISH), COVID Clinical Pathways and outreach, COVID-at-Home, NP Clinic for Unattached Patients,



Our Current Challenges *(only opportunities in waiting)*

- Keeping our future state growth and development at pace with our capacity/HHR; moving farther ahead into the desired future state
- Time to meaningfully engage, consult and develop work with Providers, Patients and Caregivers is at a premium

Our Short Term Goals

Integrated Care Planning

&

Coordinated System Navigation

Improved Digital Health Infrastructure

Shared Decision Making

&

Accountability

Effective COVID Response, Recovery and Repurposing Efforts

Human Health Resources & Capacity Building

Shared Purpose – Better Care

All my relations | Tous lies | Mitakuye | Oyasin

CHATHAM-KENT

Chatham - Kent OHT
ONTARIO HEALTH TEAM

Chatham-Kent Ontario Health Team

HSPN Symposium

Developmental Evaluation

September 21, 2022

www.ckoht.ca

info@ckoht.ca

Welcome to Chatham-Kent!

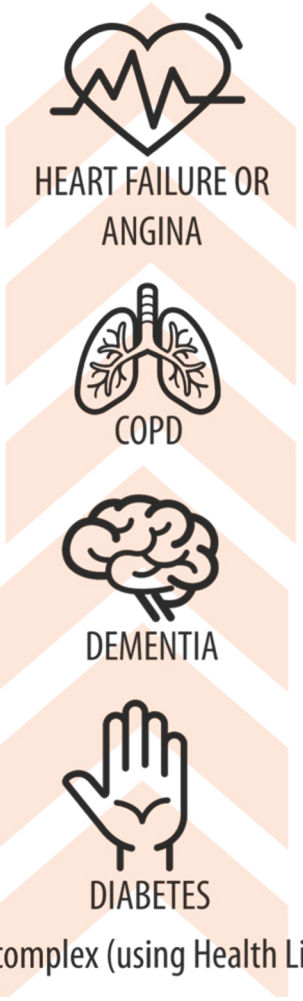
About Our Population

At maturity, the CKOHT will serve the

105,241

residents of Chatham-Kent, Walpole Island, and surrounding areas

Adults **(55+)** with at least **one** of the following criteria:



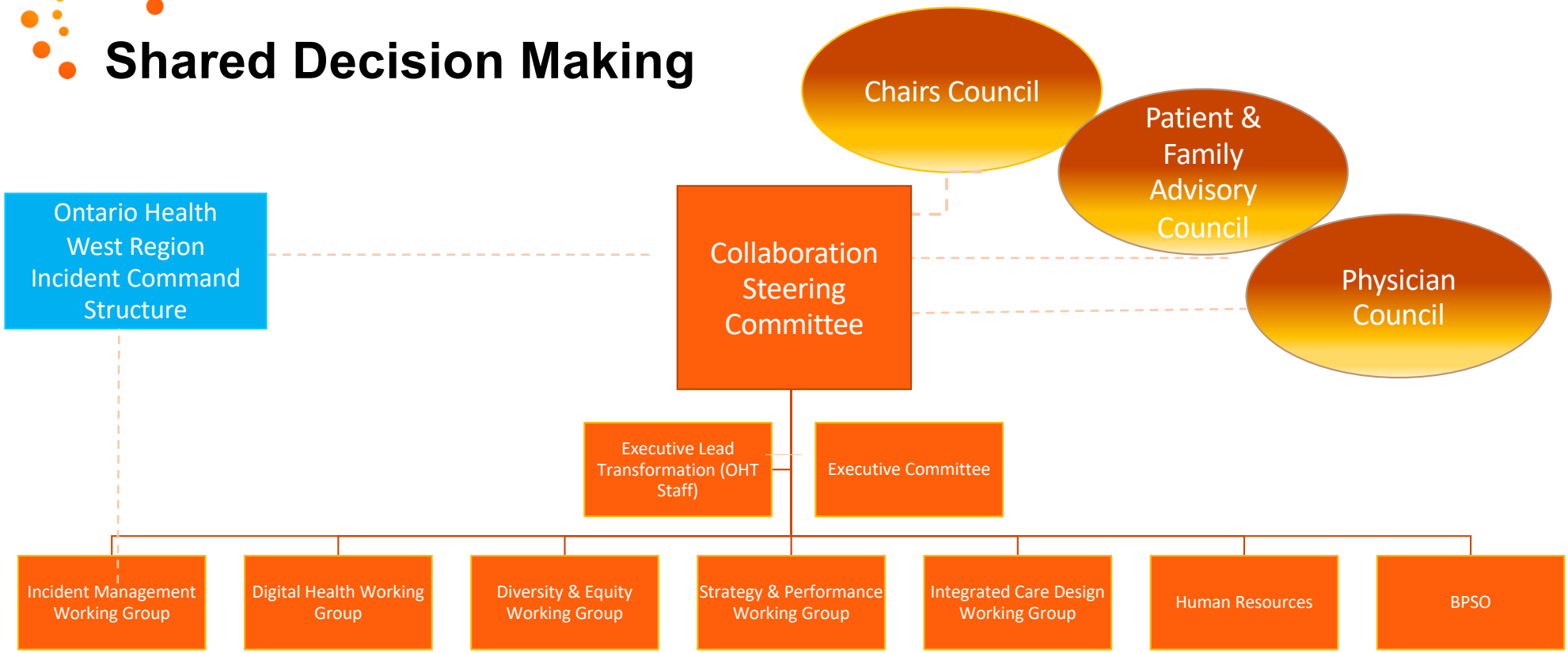
and/or are complex (using Health Links definition)

Year One Population
approximately
11,000 patients
enrolled

www.ckoht.ca

info@ckoht.ca

Shared Decision Making



CKOHT Strategic Goals and Objectives 2021-2024

Population Health and Well-being

We will transform the health care journey for the CKOHT population.

- Transform the health system experiences and outcomes for the CKOHT priority population.
- Establish a plan to address mental health and addictions in Chatham-Kent as an expanded priority population of the CKOHT.
- Coordinate a COVID-19 recovery strategy for the health system.

Health Equity

We will achieve a health system that is safe and equitable for everyone.

- Support First Nations, Inuit and Métis Peoples and communities in improving Indigenous health
- Increase the number of patients able to access primary care.
- Eradicate all experiences of racism, oppression, inequity and stigma in CK.

CKOHT Maturity

We will deepen and grow our partnerships to accelerate maturity.

- Expand the involvement CKOHT partners, particularly in the social, community, and support services sectors.
- Establish a Health and Human Resource Working Group for the CKOHT.
- Mature the CKOHT governance model

Community

We will always remember our purpose and be ready to tell our story.

- Increase knowledge and awareness of the CKOHT.
- Ensure person centered care in all aspects of our work.
- Share best practices between partners within and beyond the CKOHT.

Performance

We will be innovative and accountable in achieving system performance.

- Deepen our shared accountability framework.
- Become a leader of OHTs in implementing evidence-based practices.
- Approve and Implement the Digital Health Road Map.

Population Health and Well-being

"We will transform the health care journey for the CKOHT population."

- Successes and focus areas of CKOHT
  - COPD & CHF Co-design Initiative
  - System navigation for 24/7 access to navigation
  - Mental Health and Addiction Expansion of service in anticipation of expanded priority population
  - HCCS Modernization Leading Project for Palliative Care
  - Covid-19 Response and Recovery
- Next Steps include advancing all of the above initiatives from co-design to implementation

Health Equity

"We will achieve a health system that is safe, equitable, and free of stigma for everyone in CK, including Indigenous, Black, People of Colour, Francophone, immigrant, LGBTTQ, and temporary foreign workers."

- Successes and focus areas of CKOHT
  - Cultural Safety and Sensitivity training with personalized initiatives and campaigns to ground learnings in Chatham-Kent contexts:
    - Indigenous Cultural Safety Training
    - Anti-black Racism Training with University of Windsor
    - Rainbow Health Training
  - Digital Divide Partnership with Chatham-Kent Public Library
- Opportunities & Next steps
  - Mental Health & Addictions Anti-Stigma
  - Building relationships with Indigenous Communities neighboring CK and equity deserving groups in CK will be our priority

CKOHT Maturity

"We will deepen and grow our partnerships to accelerate maturity."

- Successes and focus areas of CKOHT
  - Health Human Resources Working Group established to discuss recruitment and retention issues, and HR initiatives.
  - Identifying best practices in governance models across OHTs with larger membership structure in preparation for expansion plan and sustainability efforts.
  - Formal connections made between Social/Community Sector and CKOHT
- Opportunities & Next steps:
  - CKOHT partnership and governance expansion

Community

"We will always remember our purpose and be ready to tell our story."

- Successes and focus areas of CKOHT
  - Strong PFAC – Patient and Family Engagement Strategy
  - PFAC membership represented across CKOHT partners
  - “Nothing about us without us” means engagement at every step of the OHT process
- Opportunities & Next steps
  - Co-developing Toolkit of resources with PFAC to strengthen PFAC recruitment, onboarding, etc.
  - Patient facing elements of the website

Performance

"We will be innovative and accountable in achieving system performance."

- Successes and focus areas of CKOHT
  - Successfully implementation of CDMA
  - BPSO accreditation in progress
  - cQIP submission and engaged cQIP task team
- Opportunities & Next steps
  - Continued progress with cQIP and BPSO
  - Sustainability for CKOHT

Performance

"We will be innovative and accountable in achieving system performance."

- Successes and focus areas of CKOHT
  - Digital Health Road map implementation
    - Remote Care Monitoring, Surgical transitions, Online appointment booking, among other regional initiatives.
    - RSOC funding
- Opportunities & Next steps
  - Sustainability and multi-year funding for Digital Health initiatives
  - Patient Portals (in alignment with region)
  - Looking for ways to better regionalize and integrate across local, regional, provincial systems

Overall Challenges to Date

- There are challenges and opportunities to being a “wave one” OHT
- Balancing Covid-19 recovery with OHT priorities
  - Resourcing and staffing across partners and a strained healthcare system.
- Competing priorities and the introduction of new priorities
  - OHTs need to be at the table, but have limited resources
  - Timing of funding and new initiatives may not always align with budget cycle
  - Patient and physician engagement is paramount to success, but limited resources are available

What Do We Want to Learn Today

- How are other OHTs are thinking about governance, expansion and sustainability planning?
- How can we gain more clarity on working relationships within the system (ie OH region and OH central/Ministry)?
- How we can advocate for patient voice in end user and regional initiatives?
- How we can approach metrics and impact from a system perspective – as our OHTs matures, we want to understand how we can capture benefit to our investment and initiatives across OHT partners?

Chatham - Kent OHT
ONTARIO HEALTH TEAM

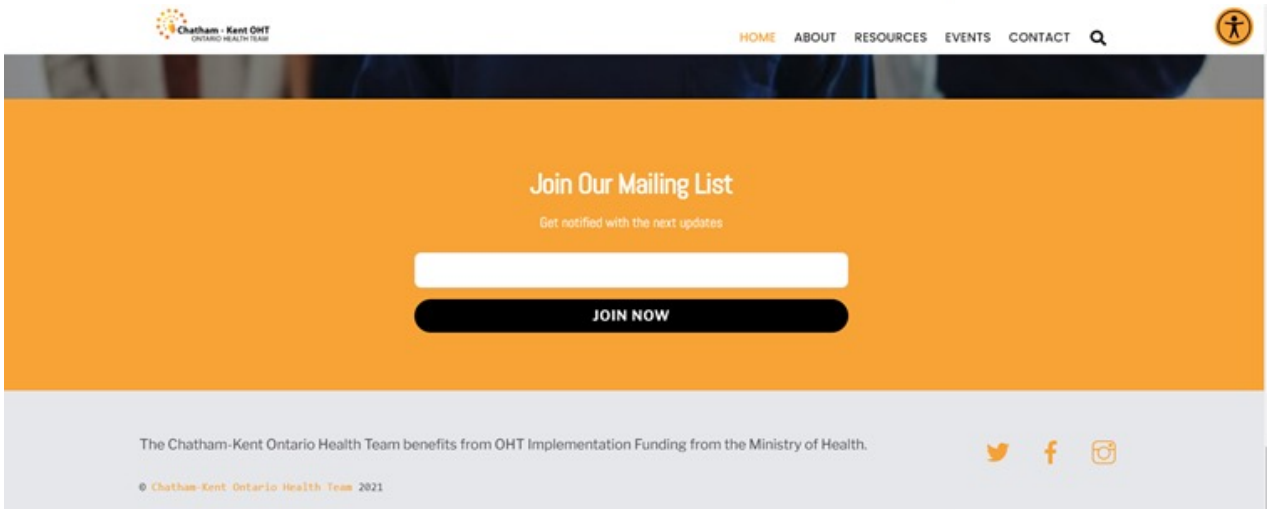
Check us out!

www.ckoht.ca

ck_oht

CK_OHT

ChathamKentOHT



EAST YORK REGION
NORTH DURHAM

EASTERN YORK REGION NORTH DURHAM OHT

Date: September 21st, 2022

Presented by: Elena Pacheco & Dr Cristina Popa

Eastern York Region North Durham
EYRND ONTARIO HEALTH TEAM

AGENDA

1 OVERVIEW

2 STRENGTHS

3 CHALLENGES

4 LEARNING OBJECTIVES

5 WHAT'S NEXT?

MISSION & VISION

MISSION:

Our commitment is to establish a person-centred culture and create an improved coordinated access healthcare model for clients, families, caregivers, and service providers.

We are aiming to achieve this by supporting the four objectives of the Provincial Quadruple Aim:

- Improving the patient and caregiver experience
- Improving the health of populations
- Reducing the per capita cost of health care
- Improving the work life of providers

VISION:

Our vision is to improve the health of the communities we serve and foster an improved individual and provider experience.

STRATEGIC PLAN

Eastern York Region North Durham
EYRND ONTARIO HEALTH TEAM

OHT OVERARCHING STRATEGIC PLAN

QUADRUPLE AIM

Improved Patient Experience
Improved Patient Outcomes
Lower Cost of Care
Improved Provider Experience

MINISTRY OF HEALTH CQIP INDICATORS

Improving overall access to care in the most appropriate setting
1. INDICATOR. Alternate Level of Care Days

Increasing overall access to community mental health and addictions (MHA) services
2. INDICATOR. Rate of Emergency Department visits as first point of contact for MHA-related car

Increasing overall access to preventative care
3. INDICATOR. Percentage of screening eligible patients up-to-date with Papanicolaou (Pap) tests
4. INDICATOR. Percentage of screen-eligible patients up-to-date with mammogram
5. INDICATOR. Percentage of screen-eligible patients up-to-date with colorectal screening

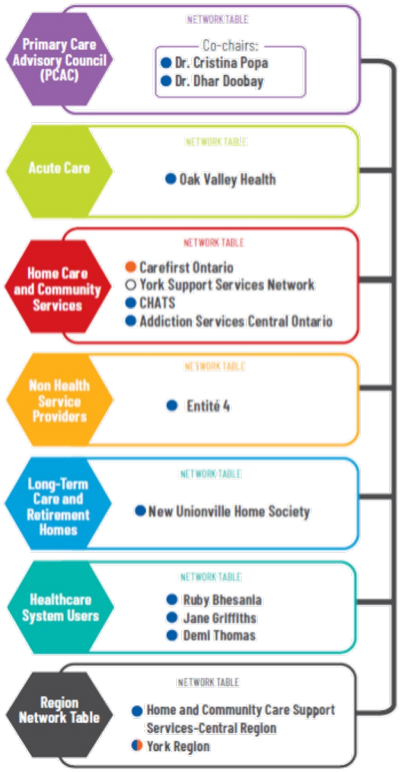
STRATEGIC GOALS

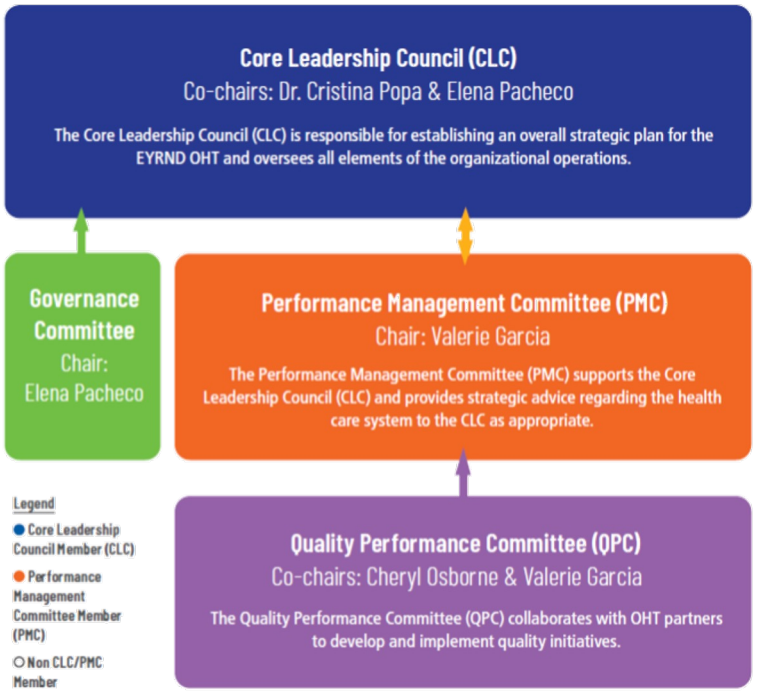
GOAL 1. Revolutionize 24/7 access and system navigation experience
GOAL 2. Increase access to mental health and addictions resources and community supports
GOAL 3. Strengthen the role of primary care providers
GOAL 4. Deliver client centered integrated care within an appropriate setting

ENABLERS

Collaborations
Communications
Digital Tools
Health System Users
Privacy (Data Sharing Agreement)
Equity and Inclusivity

GOVERNANCE STRUCTURE





OUR TEAM & EYRND OHT PARTNERS

360° kids

Addiction Services Central Ontario

Alzheimer Society York Region

Canadian Mental Health Association York and South Simcoe
Mental health for all

Carefirst

CHATS
Community & Home Assistance to Seniors

East Markham Family Health Organization

Entité 4

Health for All

Krasman centre

Markham Family Health Organization

New Unionville Home Society

Health

S·R·T· MedStaff

York Region

York Support Services Network

Oak Valley Health

OUR PROJECTS

IMPLEMENTATION TPA PROJECTS	OTHER PROJECTS
First Link	Online Appointment Booking
Streamlined Access	Early Warning Network
SCOPE	Care@Home
Access & Navigation	Care@Home +
Mental Health and Addictions Wellness Centre	Sunrise Short Stay Program
Primary Care Association Town Hall	COVID, Cough, and Clinical Assessment Centre
Seniors Home Support	Youth Mental Health & Addictions Virtual Navigation
	E-Referral for Surgical Wait Time Management
	Hospice@Home
	Patient Portal

WHAT WE DO WELL

- Broad and comprehensive sector engagement
- Development of strong, foundational, and equitable relationships with primary care
- Deep involvement of community partners, service users, and service providers in co-design of services and programs
- Service of high priority, minority, and vulnerable populations with a health equity lens

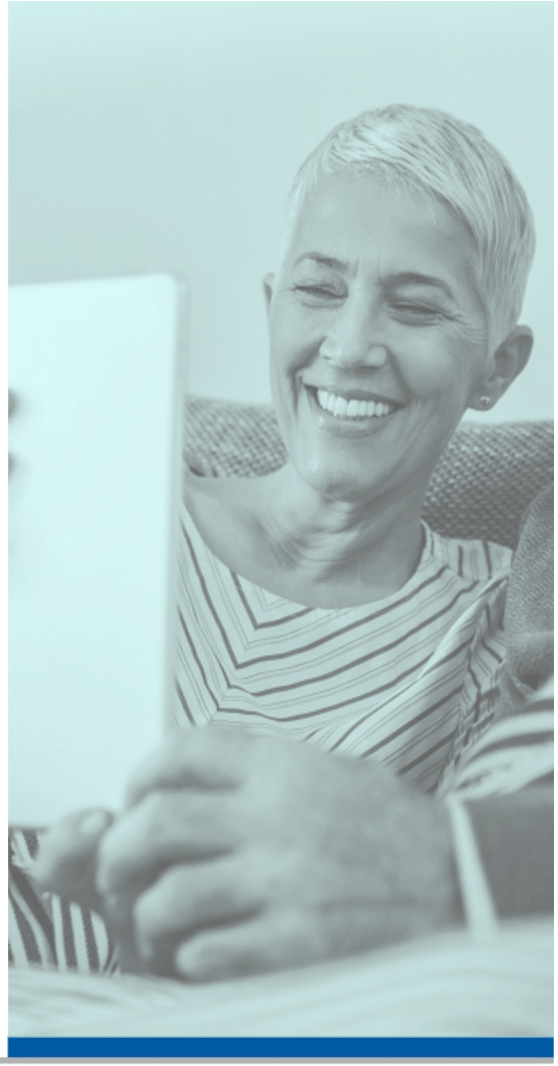
WHAT WE CAN IMPROVE

- Accessibility and levels of awareness of EYRND OHT programs, initiatives, and partnerships
- Volume of informational events & scale of promotions
- Future funding solutions in response to increased demand of in-kind services
- Physician and other clinician engagement & involvement
- Collaboration, cross-promotion, and data/information sharing among OHTs

WHAT'S NEXT?

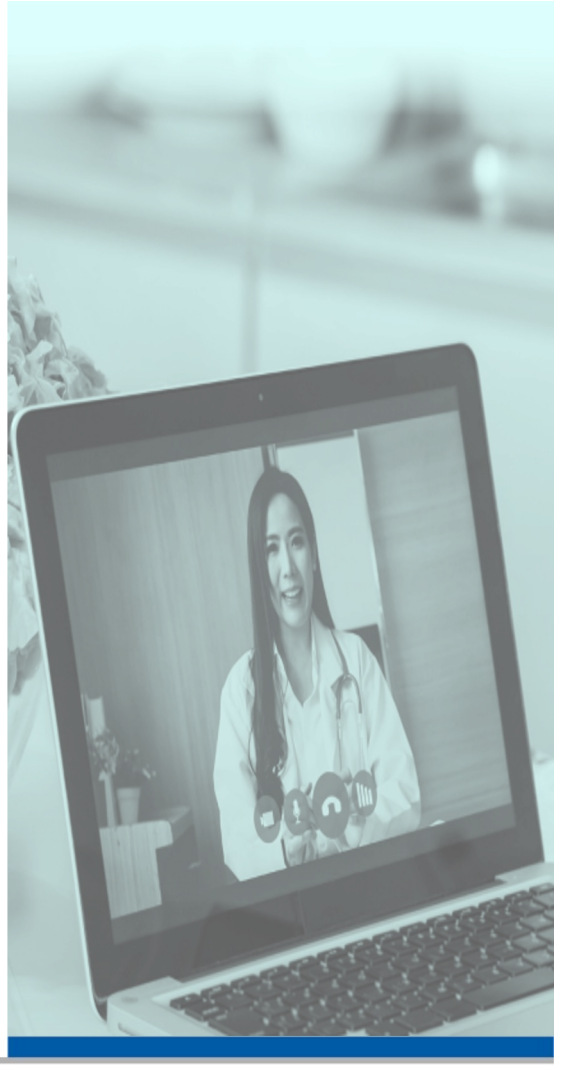
LEARNING OBJECTIVES

- How best to engage, involve, and communicate with vulnerable, minority, and remote communities
- How best to engage solo practice family physicians and support their practice
- Best methods for engaging and involving Long Term Care Homes, retirement homes, and congregate settings in grassroots planning for Alternate Level of Care
- Most effective strategies for standardizing cultural safety training



SHORT TERM GOALS

- Develop multi-year plan for OHT project sustainability, scale, and spread
- Engage in effective and purposeful data collection/analysis with the goal of data-driven, evidence-based, and well-evaluated initiatives
- Continue to engage meaningfully with primary care/other service providers, service users, communities, and subject matter experts
- Continue to collaborate with other OHTs and find work parallels to streamline



THANK YOU

For further information please contact:

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Eastern York Region North Durham
EYRND ONTARIO HEALTH TEAM

OHT Presentations Part 2:
North York Toronto, Greater Hamilton

NORTH YORK TORONTO HEALTH PARTNERS

NORTH YORK TORONTO HEALTH PARTNERS
COMPASSIONATE NORTH YORK

NYTHP "at-a-glance"

HSPN Developmental Evaluation Symposium
September 21st, 2022

Shared Purpose: *Compassionate North York*

- 3 priority populations: **MH&A, Palliative Care, Seniors**
- **Urban setting**, among the fastest growing areas of Toronto
  - 59.9% visible minority
  - 60% not born in Canada
  - High % of seniors and living alone
- Advancing integrated care through a **Collective Impact** approach
- Released our first 3-year **Strategic Plan** in Spring 2022

Strengths

Team Climate

- Shared leadership & cross-sectoral representation
  - Strong Primary Care leadership and engagement
  - Large Stewardship Council with very active members
- Flexibility to act and ***"go for it"***
  - Supported by a Backbone Team
- Willingness to contribute resources (e.g., pandemic response)

Patient & Family Engagement

- **Patient & Caregiver Health Council (PCHC)**, council members involved in major committees & working groups
- Council members are willing to ***ask the hard questions***
- Currently reviewing the structure/functions of the council to effectively support NYTHP

Challenges & Opportunities

Operationalizing our frameworks & strategies

- Patient and family engagement strategy, Equity framework
- Path from current state to the vision of OHTs at maturity

Pandemic response & recovery

- Partnerships strengthened during pandemic; built trust with our communities
- Shifted focus from priority projects; inevitably slowed achievement
- Community needs/priorities may have changed; focus on **what matters** to the community
- Burnout, HHR challenges ahead

"Context of Uncertainty"

- What is the purpose of the OHT Model? (Integration? Efficiency? Quadruple Aim?)
- OH/ministries/funding streams are not structured to support OHT work
- Local drivers vs. provincial priorities … how do we balance?

Goals

Mature our governance model

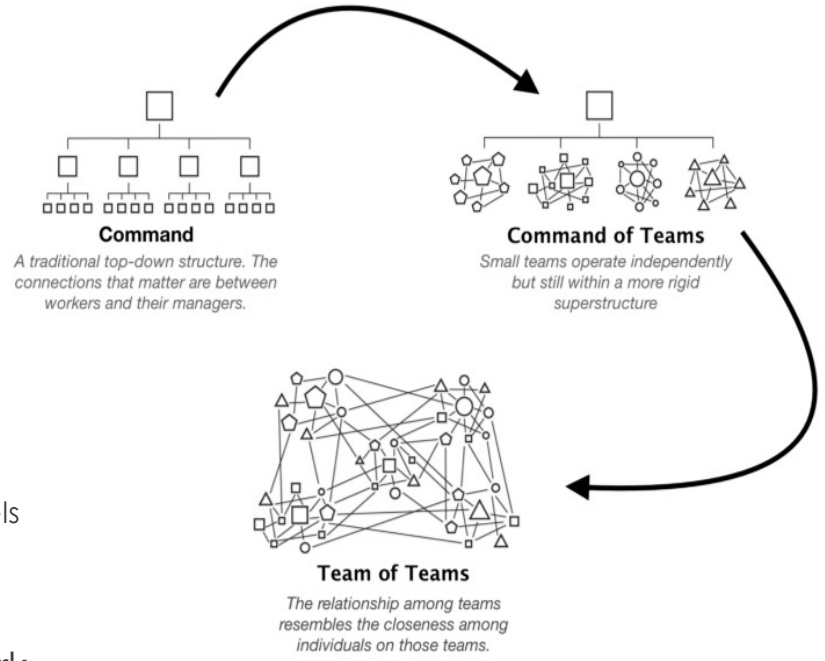
- Develop tools to support decision-making
- Creation of a new Operations Committee
- Strengthen and support Backbone Team
- Strengthen and support our PCHC
  - Recruit new members
  - Clarify roles & responsibilities at various engagement levels

Advance our strategic goals

- Expand access to team-based care in North York
- Implement our Equity framework

Develop evaluation framework

- Evaluation Hub
- Core Outcome Metrics
- Population health analytics (future planning)
- Capacity-building activities



NORTH YORK TORONTO HEALTH PARTNERS
COMPASSIONATE NORTH YORK

Thank you!

NYTHP@nygh.on.ca

www.northyorktorontohealthpartners.ca
www.nythp-pca.ca

GREATER HAMILTON HEALTH NETWORK

HSPN


Greater
Hamilton
Health
Network
Building Community Health Together
September 21, 2022

The Greater Hamilton Health Network

- The Greater Hamilton Health Network is one of Ontario's 51 Ontario Health Teams
- The Greater Hamilton Health Network serves a catchment of: Hamilton, Haldimand and Niagara Northwest
- Attributed population: approximately 620,000 residents
- GHHN supports individuals from the Mississaugas of the Credit and Six Nations of the Grand River – considerations for on reserve and urban Indigenous care

Population characteristics:

- Mix of rural and urban communities
- Very high areas of material deprivation – high risk wards, Hamilton has one of the highest concentrations of urban poverty within Canada
- Hamilton is home to more seniors than youth and by 2041, the number of seniors will nearly double
- Hamilton is designated under the FLS Act and is home to a large number of Francophones.
- Mental health and addictions is a significant local health burden, these concerns have been exacerbated by the pandemic
- Lack of access to supportive housing environments for vulnerable, low-income individuals continues to be a significant stressor

Meet the team


Melissa


Jeff


Kiran


Sarah


Ceara

Greater Hamilton Health Network


Megan


Mia


Veronica


Anna


Marijke


Heather

Building Community Health Together

The GHHN has made significant advancements to the OHT model in the last few years

Relationships, collaborations, support and care for vulnerable populations have all expanded because of the OHT

The GHHN continues to grow and shape local health system planning – health partners, social organizations, advocacy groups see the OHT as the vehicle for change

GHHN Integrated Strategic Plan
2022-2023

Integrated Population Health

Living Healthy in Congregate Care – GHHN providing integrated care where people live

Long-term care homes:

- Reorganization of LTCH home tables to align with GHHN
- LTC-Cares virtual model of care: proof of concept during first wave of COVID connecting LTCHs with ED physicians virtually
- All LTCHs are matched with an acute hospital site for support, has gone beyond just COVID
- Prioritize cornerstones of service, research, and education
- Standardize and improve pathways using Continuous Quality Improvement

Women's homelessness:

- Integrated, multidisciplinary and low barrier women's health drop-in days started focusing on homeless women. Co location of providers: primary care, cancer screening, STI/HIV testing, housing, Ontario Works, vaccinations, contraception, naloxone kits and training, food, giveaways, engagement activities
- Asset mapping of outreach models for women who are homeless – identified opportunities for improvement
- Action plan created for women who are pregnant experiencing homelessness
- Current work in progress: discharge pathways for those who are homeless being discharged from the ED, exploration of a transitional bed model for women who are homeless

Residential care facilities:

- Wrap around integrated care pilots started in 3 RCF's in Hamilton that house vulnerable populations
- Created interdisciplinary teams to work with operators on resident needs
- Goals include avoidance of ER visits, prevention of hospitalizations and improved management of chronic medical and psychiatric conditions

What we have accomplished – 8 half days, 4 seasons

310 women served over 8 days	50 pap smears	100 COVID vaccines
23 flu vaccines	110 Naloxone kits distributed	75 women tested for STI/HIV/POC HEP C
2 individuals supported for trans health care	10 wound care consults	15 peer support workers
40 NRT kits distributed + smoking cessation education	16 contraception consults	Giveaways: food, gift cards, medicine bundles, clothing, feminine hygiene products

Digital Care

Aligning with OH Digital Health Strategy

Virtual care

- Body Brave enrolled over 750 clients on a virtual platform for disordered eating.
- We are a leader in virtual urgent care through LTC-CARES and the Virtual ED.
- We are a leader in remote monitoring for surgical, COVID, and internal medicine.

Online appointment booking

- We are participating in a regional rollout to offer online appointment booking to 500 GHHN primary care providers in partnership with Ontario Health West.

Digital access for patients

- We have a patient portal navigator that offers patients online access to their health data, which will be expanded and offered to all GHHN patients. Additional tools and data sources are also being incorporated into the portal.
- The GHHN has over 3,100 active users on the Patient Portal Navigator.

Connected tools from different sectors

- HHS went live with the Epic hospital information system in June 2022 and SJHH and HHS have connected their Epic systems through Happy Together.
- We have also integrated the Ocean eReferral platform with Epic.
- SJHH is supporting Project AMPLIFI to connect LTC & hospital EMRs.

Predictive analytics for population health

- We are exploring expanding IDS to all of our primary care teams to increase the availability of data for population health analytics. We have onboarded EMS and community organizations onto IDS and have conducted a pilot with community mental health that had positive results.

Quick Facts

- The GHHN was the recipient of over **$2M** in digital funding in FY21-22.
- The GHHN's **Digital Health Secretariat** has three co-chairs and over two dozen active members, with representation from primary care, community organizations, hospitals, and patient advisors.

Success Factors:

- Strong **leadership**, **governance**, and **processes** have enabled effective communications and collaboration across one of the largest OHTs in the province.

Governance

GHHN is the first OHT to be legally incorporated as a not-for-profit corporation (June 2022)

Why did we move towards incorporation?

- More structure and accountability
- Autonomy in operations (procurement, hiring, service delivery)
- Management of shared risk

The governance work is an accumulation of:

- Ernst and Young work started almost two years ago
- Health equity consultation report
- Partner consultations throughout the summer 2021

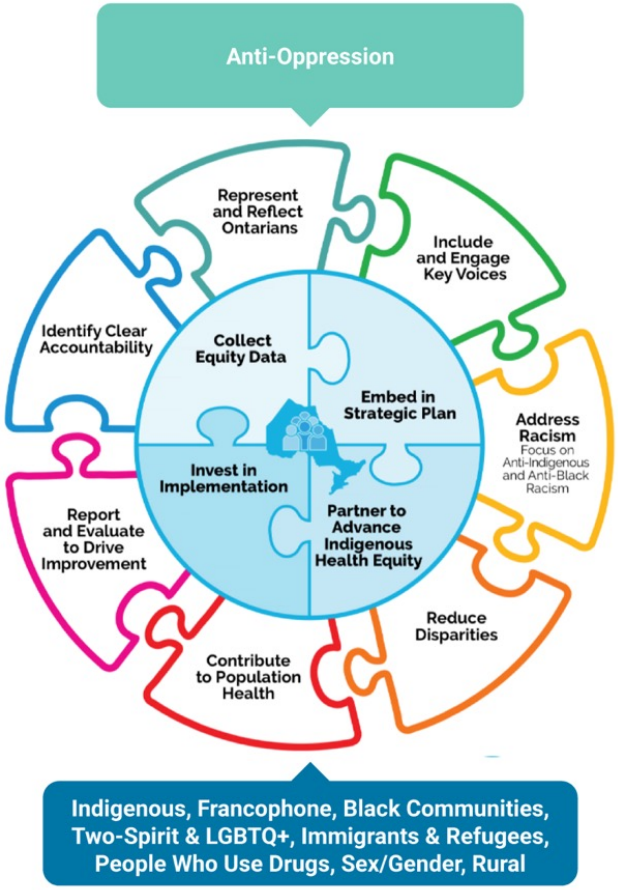
Primary Care Engagement

Primary Care in the GHHN

- Primary Care Governance structure developed in Fall 2021 – new leadership network developed to ensure primary care has a unified voice in GHHN planning
- Primary Care embedded into all working groups under the GHHN. Primary Care practitioners lead and chair multiple working streams
- Continuous engagement through town halls, newsletters, online engagement tools and working group meetings

Overarching Priority Areas for the GHHN

Health Equity Work Plan: Bringing It Together



- GHHN Health Equity Council formalized in January 2022
- Work with communities to understand who is accessing care and address systemic barriers to equitable care through the collection of socio-demographic and race-based equity data
- In collaboration with Entité 2, launch pilot project to assess and provide steps to improve GHHN partners' French language capacity
- Increase health care service in the preferred language of the patient
- Expand the number of Positive Spaces to enable improved accessibility of health services to 2SLGBTQ+ communities
- Decrease the number of opioid overdoses and deaths through harm reduction initiatives and safe supply
- Continue to identify opportunities to educate staff and partners by promoting training and organizing information sessions and panels on equity issues

GHHN/Haldimand Partnership

Early 2021, Ministry recommends Haldimand and GHHN form one OHT

Haldimand and GHHN begin to explore this idea

Cooperative planning journey toward improved integrated care opportunities for patients in Hamilton and Haldimand County begins

July 2021, branding is reflective of all three geographical areas

August 2021, Haldimand and GHHN approach the Ministry for integration funds to support the transition

September 2021, Haldimand is embedded in most secretariats. The Executive Council and regular meetings to plan for integration/partnership are taking place

October 2021, work is done to bring Haldimand and GHHN together to offer joint communications to the partners and community

November 2021, Ministry provides one year funding for integration supports

August 2022, Haldimand stakeholders will start convening as the Haldimand Stakeholder Council and will be fully integrated into the overall GHHN governance structure

Environmental Sustainability

GHHN is the first OHT in Ontario to incorporate environmental sustainability in strategic planning

GHHN has begun research to explore environmental sustainability in healthcare among our partners.

Summary of Recommendations

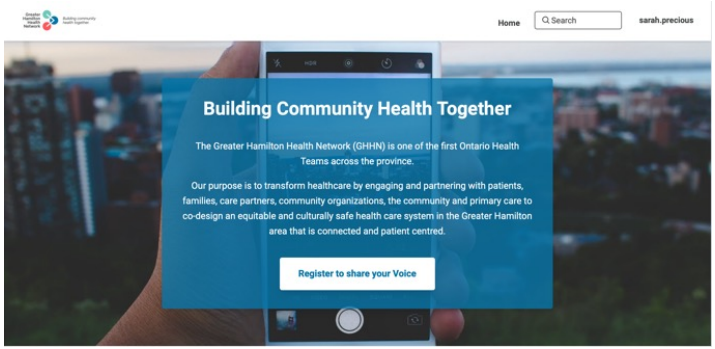
1) Build capacity through education and funding
2) Perform baseline audits of current sustainability practices
3) Embed sustainability within Quality Improvement accountability framework
4) Collaborate both externally and internally (e.g. GHHN community of practice)


GHHN Engagement

GHHN Engagement

Co-designed with over 15 Patients, Families and Care Partners across the GHHN

Locally refined and approved by over 15 Patients, Families and Care Partners across the GHHN



Engage GHHN launched in December 2021. This tool will support engagement with Hamilton, Haldimand and Niagara Northwest. Including private channels for Primary care and community partners.

Opportunities

- Evaluation/performance/accountability support
- Relationship based collaboration takes time and needs to be acknowledged Unknown and inconsistent maturity path of the OHT
- Impacts of pandemic on HHR, staff capacity and ability to shift change
- Small staff team with complex and comprehensive mandate requirements
- Culturally Safe Care training as a foundation to OHT work and a commitment from member organizations to training
- Need more formal engagement mechanisms between the OHT and Ontario Health
- Funding Resources
  - Permanency needed (recruitment and retention)
  - Difficult to plan in one year planning cycles
  - Funding is disproportionate to our attributed population (size)
  - RFP process for Digital funding (short cycles, not sustainable, prescriptiveness)

Questions/ Comments

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Manager of Engagement & Communications
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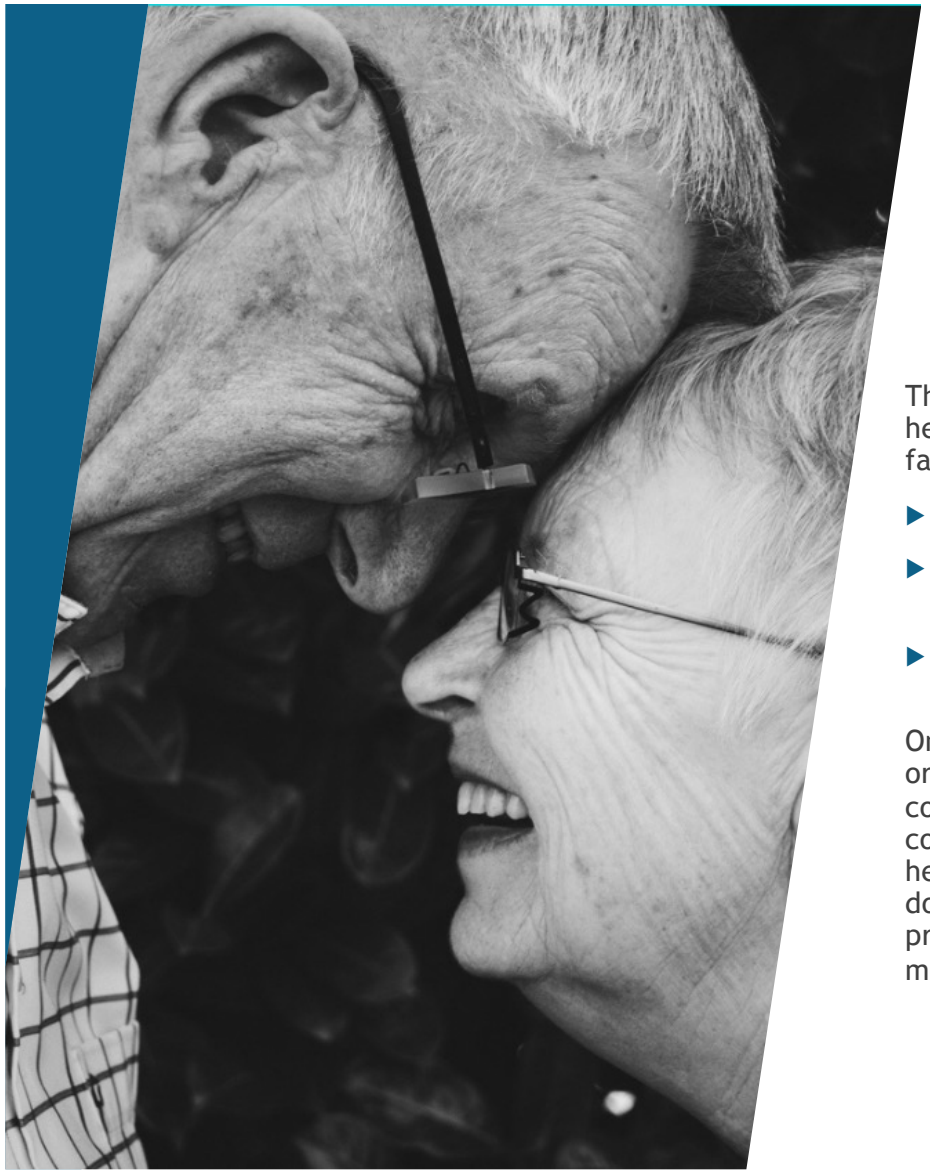
Appendix



What is an Ontario Health Team?

The Ontario government is building a connected health care system centred around patients, families and caregivers to:

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

Ontario Health Teams provide a way of organizing and delivering care that is more connected to patients in their local communities. Under Ontario Health Teams, health care providers (including hospitals, doctors and home and community care providers) work as one coordinated team - no matter where they provide care.

Governance

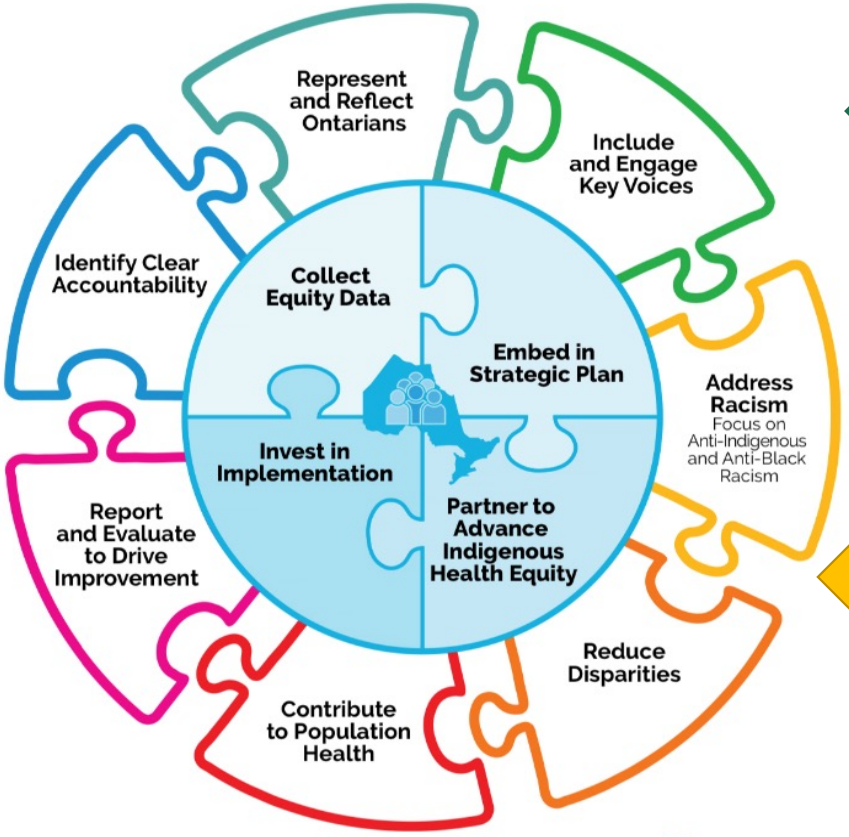
Collective Decision-Making Agreement (CDMA)- Sept 2020

Developed by Executive Council and approved by Partnership Council. It is based on Project Charter and Full Application, with some additions as required. The following topics are covered:

- Resource Allocation
- Information Sharing
- Financial Management
- Inter-team Performance
- Dispute Resolution
- Conflict of Interest
- Transparency
- Measuring impact on populations
- Quality Improvement
- Expansion to additional populations
- Procurement

In general, the Executive Council has the authority and responsibility to oversee and approve new resources, as well as the responsibility to consult with and take feedback from the Partnership Council relating to these decisions. It is a transitional document, while longer term strategies are confirmed.

GHHN Health Equity Framework – Modified from OH



Anti-Oppression

- Indigenous
- Francophone
- Black Communities
- Two-Spirit & LGBTQ+
- Immigrants & Refugees
- People who use drugs
- Sex/Gender
- Rural

- GHHN'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