

# Moving Ontario's High Priority Communities Strategy from Margins to Mainstream: *Findings from an Evaluation of the South-East Markham HPCS*

Toronto Metropolitan University  
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Freida Chavez, RN DNP.  
Janet Lum, PhD.  
A. Paul Williams, PhD.

# Today's Goals

- Share key insights from our evaluation of the High Priority Communities Strategy (HPCS) in South-East Markham
- Consider how lessons learned can help build healthier, more equitable communities now and in the future

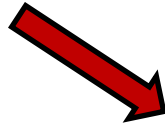
# Acknowledgments & Thanks

- Participants
  - Key informants
  - Front Line Focus Group Participants
  - Clients
- Partners
  - Ontario Health Central
  - HPCS Southeast Markham partner organizations
  - Health Commons Solutions Lab

# Part 1:

## *High Priority Communities Strategy in South-East Markham*

# What the Pandemic Revealed: “The Health of People in Canada was Inequitable Before COVID-19”



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# Ontario Supporting High Priority Communities

Funding will provide community outreach, increased testing and wraparound supports

December 21, 2020

## Office of the Premier

The Ontario government is moving quickly to put in place a targeted High Priority Communities Strategy that will **provide funding to local lead agencies to work in partnership with Ontario Health, public health units, municipalities, and other community partners** to deliver key interventions for the province's hardest-hit neighbourhoods.

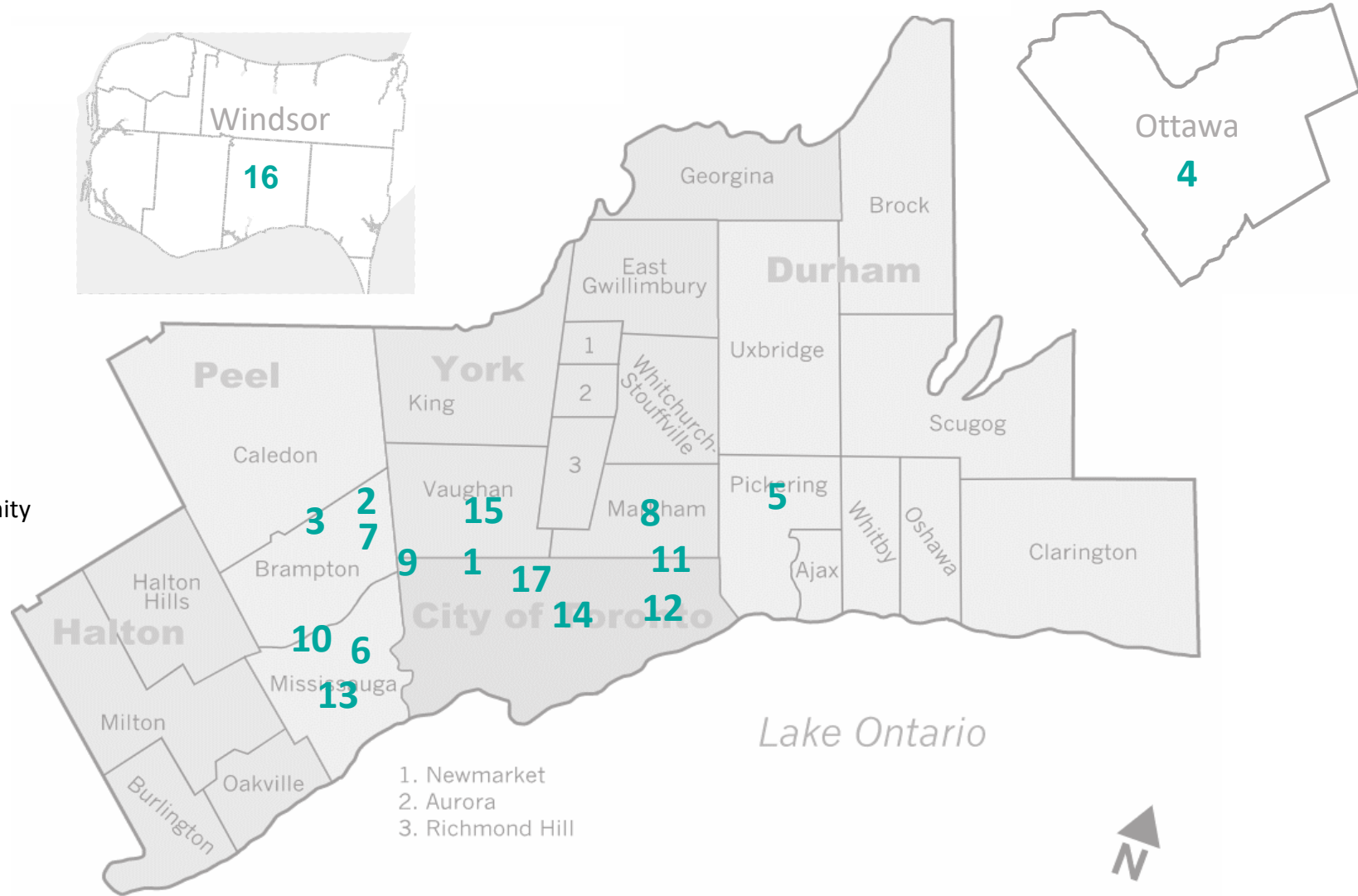
Evidence shows that **racially diverse, newcomer and low-income communities have been impacted more significantly by COVID-19 than others**, and they need specific supports as they are facing complex barriers to accessing services and enacting core prevention measures.

Through this initiative, **\$12.5 million in funding** will be invested to support lead community agencies and community partners in **15 priority neighborhoods in Durham, Peel, Toronto, York and Ottawa. These jurisdictions were selected due to their high-COVID-19 prevalence (current or historical), low testing rates, and sociodemographic barriers to testing and self-isolation.** Additional funding of \$42 million will also be available to establish isolation centres.

<https://news.ontario.ca/en/backgrounder/59793/ontario-supporting-high-priority-communities>

# High Priority Communities Strategy: 17 Local Initiatives

1. Black Creek (Black Creek CHC)
2. Bramalea (Wellfort Community Health Services)
3. Brampton (Punjabi Community Health Services)
4. Central Ottawa (South-East CHC)
5. Durham West (Carea)
6. East Mississauga (Dixie Bloor Neighbourhood) Services)
7. Malton (Wellfort Community Health Services)
8. Markham (Carefirst)
9. North Etobicoke (Rexdale CHC)
10. North-West Mississauga (Indus Community Services)
11. Scarborough North (TAIBU CHC)
12. Scarborough South (Scarborough Centre for Health Communities)
13. South-West Mississauga (Dufferin-Peel Canadian Mental Health Association)
14. Thorncliffe Park (Flemingdon CHC)
15. Vaughan (Vaughan CHC)
16. Windsor (Windsor & Essex County Canadian Mental Health Association)
17. North York (Unison CHC)

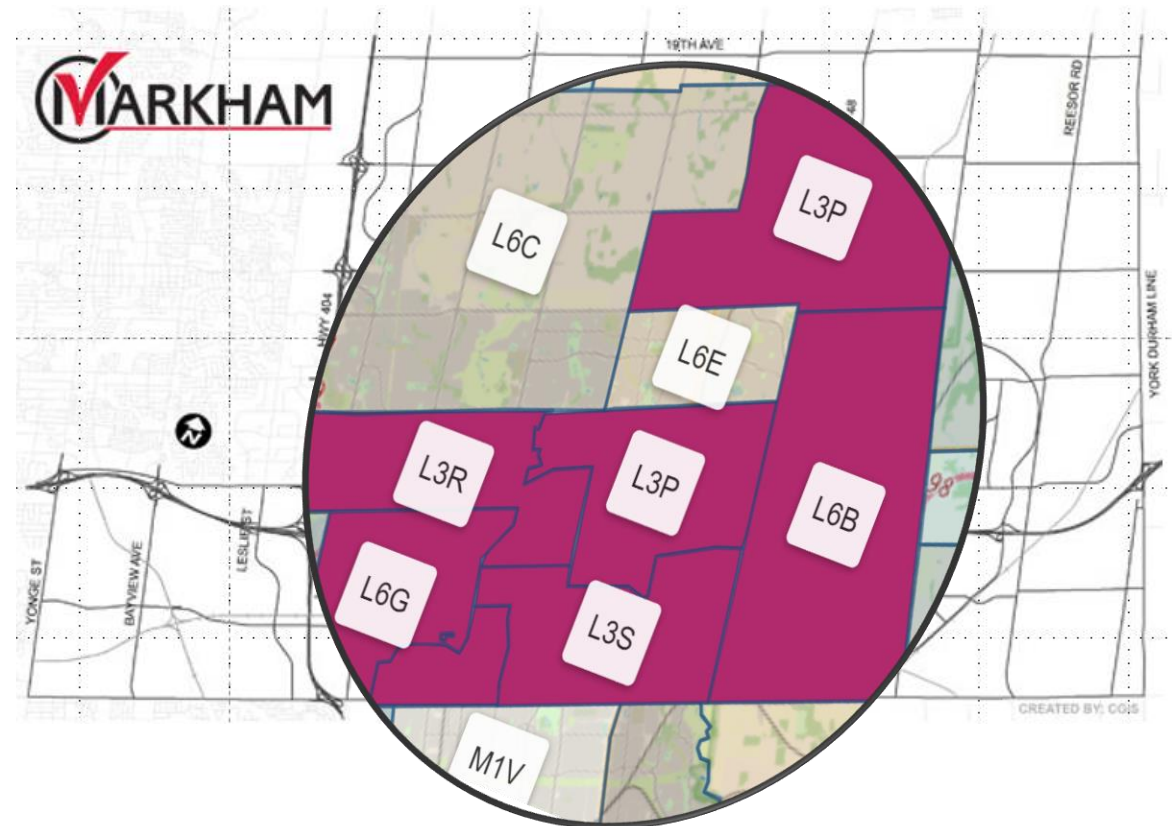




# HPCS South-East Markham: *HPCS-SEM*

Contains postal codes with 3+ dimensions of marginalization:

- Material Deprivation
- Dependency
- Residential Instability
- Ethnic Concentration:  
48% East Asians,  
20% South Asians
- High COVID-19 positivity
- Low testing rate





# HPCS-SEM: *“Made in Ontario” Collaborative Lead Agency Model*

- Lead agency (Carefirst Seniors and Community Services) identified by Ontario Health based on organizational capacity and community connections
  - In turn, lead agency engaged 35+ partner organizations from diverse communities
  - Enabled less-well-resourced partners to “get to the gate” with shared funding, technical, logistical support
  - Partners leveraged their own trusted channels and devised community-appropriate “micro-strategies”
  - Individuals & families received coordinated access to a full range of COVID-related services: education, tests, vaccinations, “wrap-around” health & social care

# HPCS-SEM Lead Agency: *Carefirst Seniors and Community Services*



PACE model: integrated continuum of person-centred health & social care at home, in community hubs and residential care settings



# HPCS-SEM Partnerships: *Health and Determinants of Health*

Healthcare	Community Supports	Faith and Grassroots
<p>Since Jan 21'</p> <ul style="list-style-type: none"> <li>• Scarborough Health Network</li> <li>• Oak Valley Health</li> <li>• Eastern York Region North Durham Ontario Health Team</li> <li>• Scarborough Ontario Health Team</li> <li>• Carefirst Family Health Team</li> <li>• Health-For-All Family Health Team</li> <li>• York Region Community Services and Health</li> <li>• York Region Public Health</li> <li>• Hong Fook Mental Health Association</li> <li>• CMHA York &amp; South Simcoe</li> <li>• Addictions Services Central Ontario</li> <li>• Dynacare</li> </ul>	<p>Since Jan 21'</p> <ul style="list-style-type: none"> <li>• YMCA of Greater Toronto</li> <li>• YMCA of Markham</li> <li>• Social Services Network</li> <li>• Centre for Immigrant &amp; Community Services</li> <li>• The Cross-Cultural Community Services Association</li> <li>• Community &amp; Home Assistance To Seniors</li> <li>• 360°kids</li> <li>• 105 Gibson Centre</li> <li>• Scarborough Centre for Healthier Communities</li> </ul> <p>Since Jun 22'</p> <ul style="list-style-type: none"> <li>• York Hills Centre for Children, Youth and Families</li> <li>• Across U-Hub</li> <li>• York Support Services Network</li> </ul>	<p>Since Jan 21'</p> <ul style="list-style-type: none"> <li>• Islamic Society of Markham</li> <li>• Tamil Civic Action</li> <li>• Markham Chinese Presbyterian Church</li> <li>• Markham Wesley Centre</li> <li>• Ebenezer United Church</li> </ul> <p>Since Dec 22'</p> <ul style="list-style-type: none"> <li>• Council of Agencies Serving South Asians</li> </ul> <p>Other Partners</p> <p>Since Jan 21'</p> <ul style="list-style-type: none"> <li>• Markham City Councillors</li> <li>• Health Commons Solutions Lab</li> </ul> <p>Since Nov 22'</p> <ul style="list-style-type: none"> <li>• Seneca College</li> </ul>

# HPCS-SEM Partnerships: *Agile and Adaptive*

Jan 21' – Mar 22'

**30** partner agencies

- **20,000** interactions via 1-on-1 Ambassador contact, education sessions, webinars, and etc.
- **100,000** RAT kits
- **24,000** PPE kits
- **30,000** COVID swab clinic visits
- **2,300** wraparound support service recipients

Apr 22' – Mar 23'

- **35** partner agencies
  - **42,000** interactions via 1-on-1 Ambassador contacts, education sessions, webinars, and etc.
  - **325,000** RAT kits
  - **3,000** COVID, Cold, and Flu Care Clinic assessments
  - **6,000** COVID vaccine clinic visits
  - **1,400** wraparound support service recipients
- \*\*\*\*\*
- **100** newly attached PHC patients
  - **600** mammogram referrals
  - **1,200** pap smears & referrals
  - **4,600** mental health referrals
  - **1,100** mental health sessions



# Part 2:

## *HPCS-SEM Evaluation Highlights*

# What We Did: *Multi-Stage, Multi-Methods Formative Evaluation*

- Conducted at “arms length” by team of experienced academic researchers/evaluators working “pro bono”
- Methods
  - Review of early evaluation findings
    - Health Commons Solutions Lab evaluation of all Ontario HPCSs (2021)
  - Telephone survey of former clients
  - On-line focus groups with front-line staff
  - Key Informant interviews
  - On-line Partners’ Forum

*Findings “triangulated” to identify robust patterns*



# What We Heard from Clients:

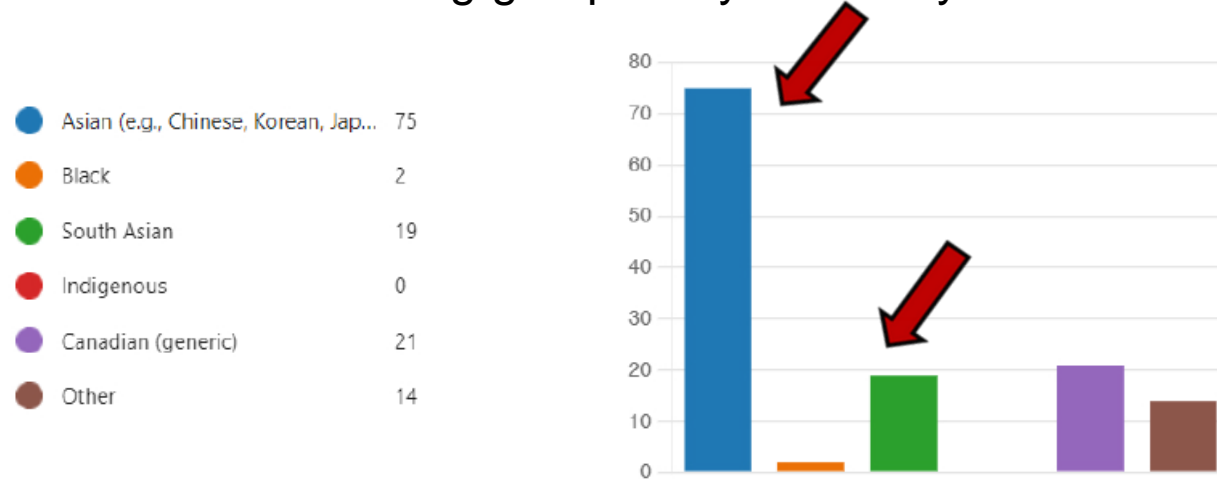
## *Complex Health and Social Challenges*

- A father, new immigrant, with a newborn, depressed, frustrated and hopeless as his wife was hospitalized after confirming positive. Neither had access to primary care
  - A care coordinator helped the father source the right formula for his baby, instructed on how to feed/bathe and take care of the baby and gave on-going emotional support until the wife returned
  - Wrap-around care provided by Carefirst (swab test, food security, essentials delivery), The Cross-Cultural Communities Services Association (care coordination), York Region Health and Community Services (education on infant care), Carefirst Family Health Team (now enrolled as patient)

# What We Heard from Clients:

## *Diverse Communities & Living Arrangements*

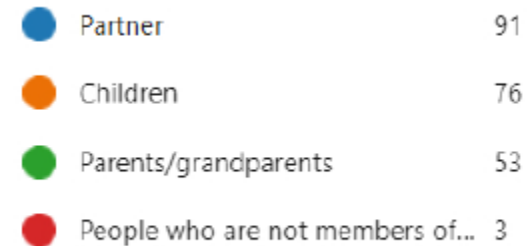
Which of the following groups do you identify with?



*Diverse clients and communities*

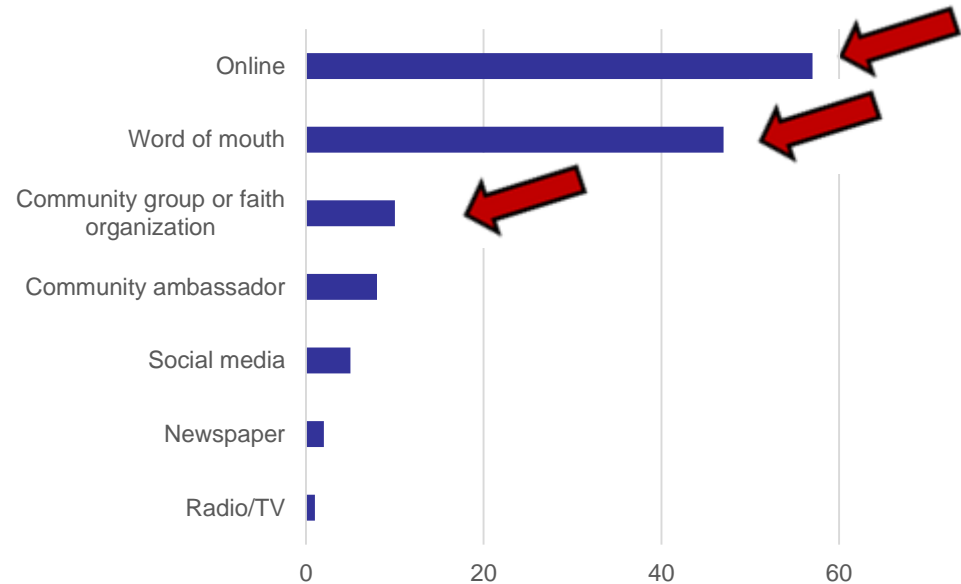
*Individuals and social units (e.g., extended families)*

Which best describes your living arrangements?



# What We Heard from Clients: *Community Connections Matter*

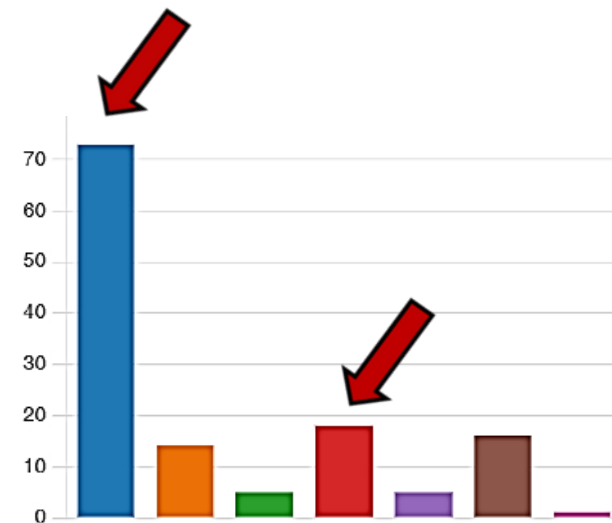
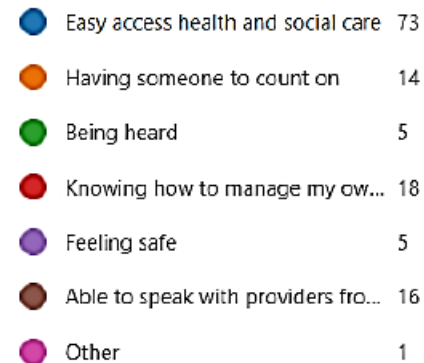
How did you first hear about the program?



*Online (community websites), word of mouth, community & faith organizations*

*Access to care and support for self-care*

What did you value most?



# What We Heard from Front-Line Workers:

## *Community Resources Mobilized*

“...one of my first cases was a family where the whole family got tested positive and their youngest child was already in sick with a high fever ...”

“... I don't want to get onto the bus to come pick up food, what can I do, I still need to eat, right? So, in that type of situation, we mobilized a lot of volunteers with their own vehicle to deliver food at that time ... in a week we almost have 10 drivers ... ”

“They can call me during the day if they have a question and they can speak home language to me and I try to find the answer for them, so they feel more comfortable ... so I feel happy to serve them.”

# What We Heard from Front-Line Workers:

## *Lead Agency Played a Key Role*

- The coordinating/facilitative role of the lead agency was key to creating a collaborative, integrated network
  - Lead agency reached out on peer-to-peer basis to build trust, establish goals, provide funding and logistical support, facilitate collaboration
  - Engaged larger, established organizations (e.g., hospital networks) as well as smaller, volunteer-driven organizations (e.g., faith and cultural groups)
  - Partners concentrated on their core services in their communities
  - If one partner could not provide a service in a culturally-appropriate way, they could reach out to partners to fill gaps

# What We Heard from Front-Line Workers:

## *Collaboration Added Capacity*

- As a network, HPCS-SEM could take on challenges beyond the capacity of single organizations
  - Partners provided an integrated continuum of supports including access to primary care, medications, mental health services, transportation, food hampers, frozen meals, diapers, financial assistance (e.g., rent)
  - Coordinated transportation for those with mobility challenges or fearful of using public transit
  - To accommodate families with children, partners arranged vaccinations for the whole family at the same time thus minimizing child-care challenges and time off work



# What We Heard from Front-Line Workers:

## *HPCS Reached Into the Most Marginalized Communities*

- Leveraged trusted community channels
  - Community websites, word of mouth, community institutions (e.g., churches, mosques, recreation centres, settlement agencies)
- Pro-actively engaged people and multi-generational families
  - Those who did not speak English, did not have a computer/cell phone or internet, did not have an OHIP number (e.g., recent immigrants or refugees)

# What We Heard from Key Informants:

## *Commitment and Resources Shared*

“So, first and foremost, having an organization to take lead, in my opinion has been one of the success factors of this organization. ... we shared the burden, and we shared the resources with a key organization being the foundation from which to build on ... to make this process of success.”

“Then people become familiar with one another and say you know what, anytime there’s an issue with food insecurity, we will direct our clients to this organization ... by channeling clients, channeling funding and channeling support.”

# What We Heard from Key Informants:

## *Lead Agency Played a Crucial Enabling/Integrating Role*

- Approached partners as peers, “did not look down”
- Connected diverse organizations including many not considered “health care” but essential to “health” (e.g., community centres, settlement agencies, daycare centres, houses of worship)
- Supported smaller organizations with vital financial and logistical resources
- Encouraged organizations to focus on their strengths and reach out to partners to fill gaps
- Reduced administrative burden for smaller organizations that did not have to sit at so many “tables”

# What We Heard from Key Informants:

## *Enabling Policy Framework Essential*

- HPCS enabled by a clear policy mandate and “low rules” environment
  - Encouraged collaboration between partners including those with limited resources
  - Allowed flexibility in funding and delivery
- HPCS also stimulated collaboration within government
  - Health
  - Children, Community and Social Services
  - Municipal Affairs and Housing
  - Finance

# Part 3:

## *Take Away*

# Lessons from the Pandemic:

## “Crisis Can Lead to Change: A Health Equity Approach”



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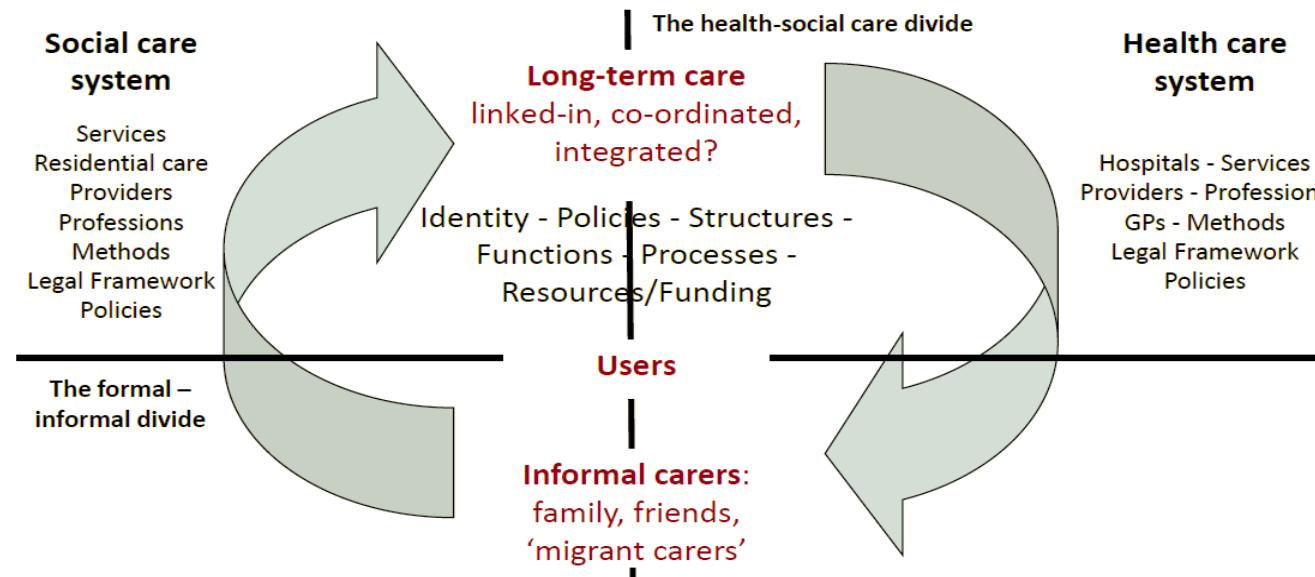




# HPCS Goes Where All Health Systems Want to Go: *Integrating Health and Determinants of Health for Vulnerable Populations*



## Terminology of long-term care



Source: Jenny Billings. INTERLINKS.

<https://www.ryerson.ca/content/dam/crncc/knowledge/eventsandpresentations/integratedcare/healthconnections/Jenny%20Billings.pdf>

# HPCS Advances Key Policy Priorities: *Ontario Health 2022/23 Business Plan*

# Strategic Priorities



## Reduce health inequities

Improving care with and for those who need it most;

Engaging those we serve to understand health and wellness from their perspectives and partnering to take action to make improvements;

Working to address the distinct needs of individuals and communities across the province; and,

Focusing on the full care continuum, including our role and the health system's role in contributing to upstream social determinants of health and preventative care.



## Transform care with the person at the centre

Supporting people in Ontario to take an active role in their care, including preventative care;

Collaborating with patients in order to continuously improve planning and delivery of quality care;

Asking how care can be better delivered using both existing and new approaches and tools; and,

Working with Ontario ministries, funded and non-funded partners including municipalities and social services to support and enable more connected and coordinated care.

# HPCS Builds On Evidence-Based Best Practices: *Neighborhood Networks, Leeds, UK*

Since 2005, each local area in Leeds has had a Neighborhood Network



## Take Away: *HPCS Made Crucial Gains During the Pandemic*

- HPCS-SEM considered an unqualified success by clients, front-line workers and leaders in diverse communities hit hardest by the pandemic
  - Partners enabled to mobilize quickly, work collaboratively, overcome barriers and deliver integrated care to the most vulnerable people, families and communities
  - Within government, HPCS stimulated collaboration between agencies and departments

# Take Away: *Gains No Less Important Post-Pandemic*

- Canada is one of the most diverse countries in the world
  - Diversity spans intersectional dimensions of “sex, gender, racialization, income, housing, employment, and other socioeconomic factors”
  - Yet, pandemic showed that some communities fare worse than others
- On equity/diversity/inclusion grounds, essential to reach out, overcome barriers, promote the health of marginalized persons and communities
- On sustainability grounds, broad-based community collaborations support the health of stretched healthcare systems

# Take Away: *An Enabling Policy Framework and Peer Leadership Are Key Success Factors*

- The HPCS succeeded because policy-makers enabled community organizations to do what they do best – “low rules” environment
  - Established a clear policy direction
  - Identified community leads to facilitate collaboration and accountability
  - Provided flexible resources to support “buy-in” by community partners
  - Encouraged innovative, community-appropriate “micro-strategies”

## Bottom Line:

### *Lessons From the HPCS Should Now Move to the Mainstream*

- HPCS-SEM already “pivoting” to take on persistent health equity and population health challenges
  - Women’s preventive health, mental health, connecting people to primary care
- More broadly, HPCS offers a proven “made in Ontario” model for achieving key health priorities and advancing the work of Ontario Health Teams



# Thank You!

If you have further questions or comments,  
please contact us at:  
[jlum@torontomu.ca](mailto:jlum@torontomu.ca)