Canadian Red Cross | Croix-Rouge canadienne

Greater Hamilton Health Network

FINANCIALLY ASSISTED SOCIAL PRESCRIBING (FASP)

ANNUAL REPORT 2023

Canadian Red Cross Croix-Rouge canadienne

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LANDÆACKNOWLEDGEMENTA

The City of Hamilton is located on the traditional territories of the Erie, Neutral, Huron-Wendat, Haudenosaunee, and Mississaugas.

This land is covered by the Dish 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.

The City of Hamilton is located next to Six Nations of the Grand River and Mississaugas of the Credit, however most Indigenous peoples live in urban Hamilton.

Our work is guided by the Canadian Red Cross Indigenous Peoples Framework.

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Greater Hamilton Health Network

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Hamilton (Ontario) – Wards 2, 3, 4

Since January 2023, the Canadian Red Cross Society and Greater Hamilton Health Network has set out to co-design a system-wide and sustainable service delivery model that aims to increase health equity informed care and services.

Together with community, we're pleased to introduce Financially Assisted Social Prescribing (FASP), an innovative approach to bringing social prescribing to community organizations in Municipal Wards 2,3, and 4 in Hamilton, ON.

Join Now

Join your community to help build a collaborative network of social prescribing services and referrals. Applications are now open for community organizations and healthcare professionals who are already providing social prescribing, or would like to.

Advantages to members

- Inventory of social prescribing services in wards 2-4.
- Inventory of financially assisted services in wards 2-4.
- Online learning portal for members to access important social prescribing resources.
- Take-home social prescribing training toolkit to train your organization.
- Link worker competency framework.
- Social Prescribing experts and facilitator knowledge.
- Take-home Financial Assistance toolkit to support clients.
- $2M granting available for members only to support clients when accessing social prescribing referrals and/or services.
- Low-barrier grant entry and application process.

For more information
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Croix-Rouge canadienne

Greater Hamilton Health Network

Soutien Financier à la Prescription Sociale (SFPS)

Hamilton (Ontario) – Quartiers 2, 3 et 4

Depuis janvier 2023, la Croix-Rouge canadienne et le Réseau de santé du Grand Hamilton collaborent en vue de créer un modèle de prestation de services durable favorisant une offre de services et de soins de santé équitable dans l'ensemble du secteur.

À l'issue de cette collaboration, nous sommes heureux de présenter l'initiative de Soutien financier à la prescription sociale, une approche novatrice qui permettra d'offrir des services de prescription sociale (PS) aux organismes communautaires des quartiers 2, 3 et 4 d'Hamilton, en Ontario.

Présentez votre demande!

Joignez-vous à cette initiative et participez à la création d'un réseau de services et de références en PS. Les organismes communautaires et les professionnels et professionnelles de la santé qui offrent déjà des services de PS, ou qui aimeraient le faire, peuvent présenter une demande dès maintenant

Avantages d'être membre

- Répertoire des services de PS offerts dans les quartiers 2, 3 et 4.
- Répertoire des services de PS subventionnés dans les quartiers 2, 3, et 4.
- Portail d'apprentissage en ligne comportant des ressources importantes en lien avec la PS.
- Trousse de formation en PS pouvant être utilisée pour former le personnel de votre organisation.
- Cadre de compétence destiné aux agent(e)s de liaison.
- Accès aux connaissances de spécialistes en PS.
- Trousse d'outils pour faciliter l'accès des personnes recevant des services à une aide financière.
- Enveloppe de 2M$ pour verser des subventions facilitant l'accès à des services et à des références en lien avec la PS.
- Processus de présentation de demandes de subvention simplifié.

Pour plus d'informations
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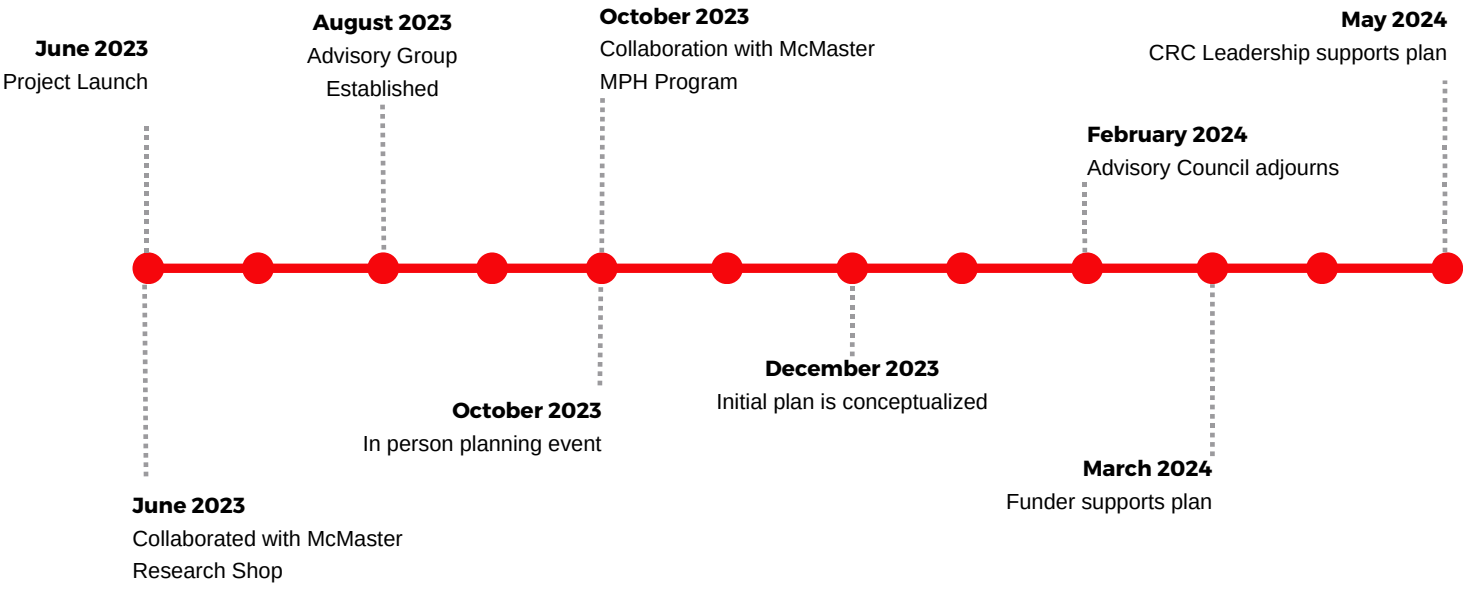
THANK YOU FOR YOUR SUPPORT

We have had the pleasure of learning from so many people. Over the past year, we had...

890+ **Conversation hours**

150+ **Community consultation hours**

500+ **Student/volunteer hours**



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Amber Dice
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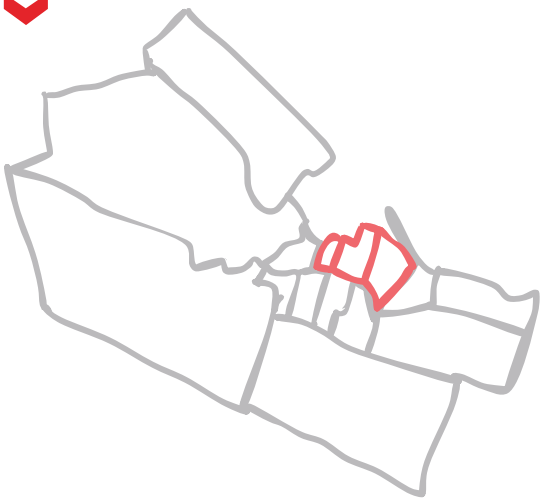
Shane Johnson
Shawna McGhan
Shawna Mutton
Sonia Hsiung
Tammy Hwang
Tanya Elliott
Tatum Sandercock
Terry Ramirez
Tracey Browne
Tracey Carr
Tom Cooper
Victoria Bui
Vivien Underdown
Yulena Wan

Read our Community Engagement Report to learn more about how community was involved during the decision making process

CLICK HERE

CITYÆOFA HAMILTONA

Located in Southern Ontario, the City of Hamilton is home to over 700,000 people, and growing. Each of its 15 municipal wards are represented by an elected member on Hamilton's city council. In 2010, the landmark **Code Red Report** was published. This report highlighted significant health disparities in the City between the wealthiest and poorest, particularly in neighbourhoods found in municipal wards two, three and four.



People living in lowest income neighbourhoods

13 x more likely to visit the Emergency Department

Two neighbourhoods, only five kilometers away from each other have a

21 YEAR

difference in life expectancy

Did you know?

Greater Hamilton Health Network is one of the *first* Ontario Health Teams (OHT) established, and is one of the 12 selected OHTs in the province to accelerate to maturity and deliver home care by 2025. Burlington, ON and London, ON were also selected within the Ontario Health West region.

Hamilton is seeing patients with chronic disease like hypertension and diabetes most often. Many times these patients are unattached to primary care physicians that support their on-going health needs. Services that seamlessly transition people with chronic disease through primary care, hospital, and home and community care, are the priority of our health care system.

IMPACTÆOFA INCOMEÆONA HEALTHA

Income and social well-being are considered to be some of the most impactful social determinants of health. There is clear evidence that shows that health and income are correlated.

The **Social Determinants of Health** influence an individual's health and wellness beyond traditional biological, physiological, and clinical factors.

Up to **80%** of health outcomes are affected by the social determinants of health, including income and social connections.

Magnan, 2017

Children growing up in low income communities are **1.8x likelier** to perform below average than their peers and have poorer health and social outcomes later in life.

Public Health Agency of Canada, 2019

44% of people in the lowest income rate their health as fair, bad, or very bad, compared to the **12%** of people in the highest income

The Health Foundation, 2024

Frequent Emergency Department visits are **2.5 times higher** for those living in the poorest neighbourhoods. This signals to the health care system that people are not getting the help they need elsewhere, such as through primary care, or social workers.

Health Quality Ontario, 2016

WHAT IS SOCIAL PRESCRIBING?

Social prescribing is ‘a means for trusted individuals in clinical and community settings to identify that a person has non-medical, health-related social needs and to subsequently connect them to non-clinical supports and services within the community’ (Muhl et al., 2023)

THE SOCIAL PRESCRIBING PATHWAY

1. Enter

Individuals can enter the pathway via referral by:

- self
- community organization
- informally (e.g., through family/friends)
- medical professional

2. Connect

Individuals identify needs and goals through a connection with a:

- link worker or community connector
- social worker
- nurse
- etc.

3. Attend

Individuals can choose to participate in a non clinical prescription that will improve health and wellbeing, such as:

- art classes
- social outings or activities
- cooking lessons
- etc.

4. Follow Up

Individuals can receive check ins and encouragement from link worker role. Data may be collected to track health outcomes

5. Exit

The cycle is iterative, but an individual may exit when:

- their goal is achieved
- a warm hand off/ open ended exit is provided

Bridgeable, 2023

Lessons Learned

Hamilton is a compassionate community

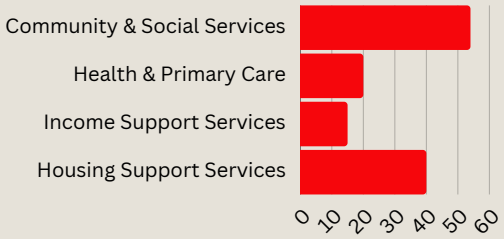
Throughout the consultation process, various service providers in both the health and community and social service sectors had an opportunity to share their insights. While amazing work is being done, there continues to be a high demand for services, and not enough resources to meet the demand.

In a brief scan of available services within wards 2-4, CRC staff identified

180+

health, community, or social services dedicated to serving Hamiltonians

Number of services found in each sector



Key Insights

Hamilton community organizations:

- Have unclear understanding of what other service providers offer, often resulting in duplication of services
- Recognize that smaller organizations do not have the same resources as others, resulting in missed opportunities
- Often share clients, however do not share data and therefore are not encouraged to work together to better support their client collaboratively

In addition, service providers are currently dealing with:

- burn out
- limited capacity
- increased demand
- overly competitive funding opportunities
- power dynamics

Current service offerings for Hamiltonians include (not limited):

- housing support
- financial literacy
- employment supports
- meals
- transportation
- mental health and addictions support
- safer use spaces/harm reduction
- mobile health clinics
- personal hygiene supplies
- clothing and basic needs

Navigating Financial Support is challenging

Understanding how various public and private financial assistance programs work led to the discovery that existing financial assistance is an overly complex, inconsistent and often opaque process.

Key Insights

Clients are required to:

- Manage excess amounts of paperwork with varying levels of financial literacy
- Keep up with several case workers when employee turnover is high
- Navigate supplementary forms, including medical, adding additional people, and time, to the process
- Wait years to get approval or find out they've been rejected with no explanation of next steps
- Be aware of ever-changing policies that threaten claw-backs for clients if they become employed or self-employed, participate in any subsidies, or receive financial gifts

OW	OW – Previous				OW – As of July 2023			
Family Type	Basic Needs	Max Shelter	Max OCB	Total	Basic Needs	Max Shelter	Max OCB	Total
Single	$343	$390	$0	$733	$343	$390	$0	$733
Single Parent - 1 child	$360	$642	$125.75	$1,127.75	$360	$642	$133.91	$1,135.91
Single Parent - 2 children	$360	$697	$251.50	$1,308.50	$360	$697	$267.82	$1,324.82
Couple	$494	$642	$0	$1,136	$494	$642	$0	$1,136
Couple - 1 child	$494	$697	$125.75	$1,316.75	$494	$697	$133.91	$1,324.91
Couple - 2 children	$494	$756	$251.50	$1,501.50	$494	$756	$267.82	$1,517.82
ODSP	**ODSP – Previous**				**ODSP – As of July 2023**			
Family Type	Basic Needs	Max Shelter	Max OCB	Total	Basic Needs	Max Shelter	Max OCB	Total
Single	$706	$522	$0	$1,228	$752	$556	$0	$1,308
Single Parent - 1 child	$849	$821	$125.75	$1,795.75	$895	$875	$133.91	$1,903.91
Single Parent - 2 children	$849	$889	$251.50	$1,989.50	$895	$947	$267.82	$2,109.82
Couple	$1,018	$821	$0	$1,839	$1,085	$875	$0	$1,960
Couple - 1 child	$1,018	$889	$125.75	$2,032.75	$1,085	$947	$133.91	$2,165.91
Couple - 2 children	$1,018	$964	$251.50	$2,233.50	$1,085	$1,027	$267.82	$2,379.82

Amounts given to people through Ontario Works (OW) and Ontario Disability Support Program (ODSP) varies considerably based. This table shows an approximation of amounts received after a policy change in 2023.

Table borrowed from Income Security Advocacy Centre

Barriers to Financial Assistance Services

- Lengthy application processes
- Restrictive and vague eligibility criteria
- Support that is not reflective of the costs of day to day living (e.g. below living wage, not accounting for inflation)

Health Equity is central to every discussion

"Health equity is attained when individuals have the fair opportunity tor each their fullest health potential"

Public Health Ontario

Health equity encompasses various goals that the health and social care systems work toward. Our work builds upon the Ontario Health Equity Framework. Read more here.

Data collection is key

Stakeholders note data gaps on service usage and users as barriers to improvement. At the same time, data collection must be done in a thoughtful manner to avoid misuse of data.

People know what they need

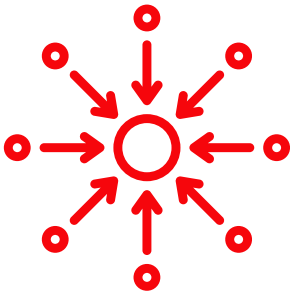
Frontline workers and service users are experts in what would best suit their needs. Extensive engagement and involvement with people with lived experience is needed throughout the process.

Look for who is missing

We recognize that power dynamics can result in some voices being louder than others. We need to take the time to recognize who isn't at the table and ensure that we make space for everyone in the community.

OUR PLAN

We carefully analyzed our past experiences and identified key takeaways to form the foundation of our strategy moving forward. By leveraging the insights gained from our learnings, the CRC team developed a comprehensive plan that addresses potential challenges and maximizes opportunities for success. This proactive approach will guide our actions and ensure that we are well-prepared to tackle any obstacles that may arise, leading us towards achieving our goals effectively and efficiently.



Connecting the community

With so many passionate people and organizations in Hamilton, the potential of connecting services through the establishment of a service coordination collective is significant. The collective will provide opportunities to learn from each other, identify gaps, and build a strong network of support for service providers.

Result

A community with fewer duplicated services, greater collaboration across sectors, and a location to foster innovative systems level thinking

Investing in the community

Limited capacity for professional development and additional funding to support clients was amongst the highest needs identified by community. A new Canadian Red Cross community health grant for social prescribing will allow service coordination collective members to offer financial assistance to their clients.

Result

Community organizations with greater capacity to support their clients

Learning more about the community

Together with our team of staff, volunteers, advisory committee, working groups, and collective members, we aim to maintain an inventory of services in the community.

Result

A comprehensive database of health, social, and community services that will be kept up to date to inform future program development

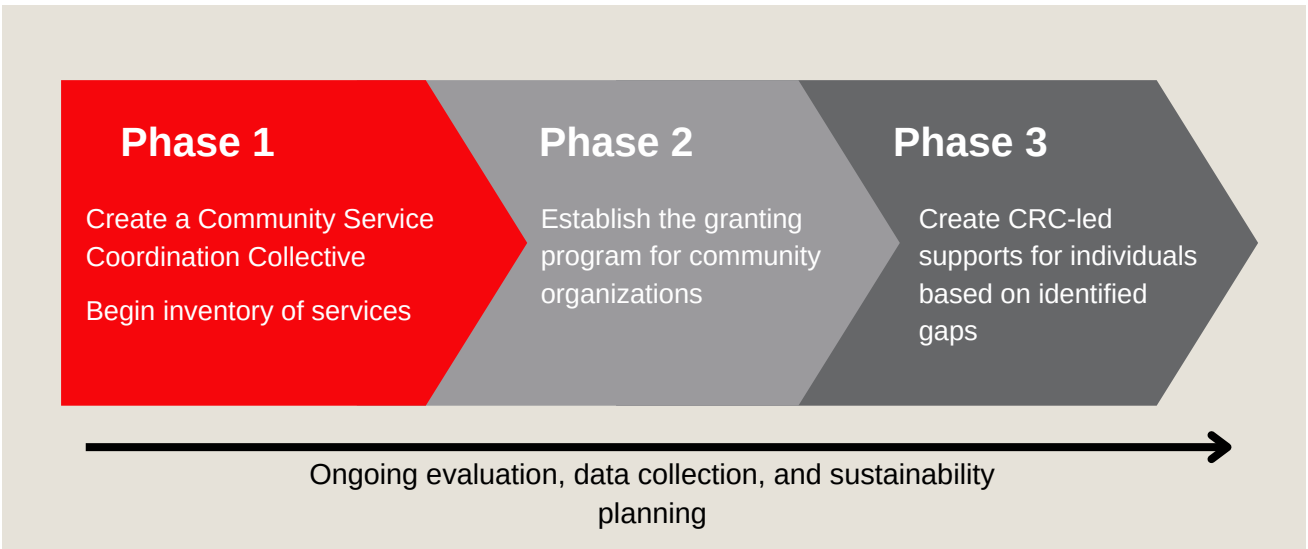
Supporting the community

Through the work we do, we want to recognize opportunities for innovative models of service delivery that CRC can provide.

Result

An evidence informed, community-led CRC service delivery model

Project Phases



GET INVOLVED

Help pilot this initiative with your insights, leadership and strategic connections

Join the advisory committee

Do you currently provide social prescribing, or would like to, within Municipal wards 2,3, and 4 in Hamilton ON?

Join the community service coordination collective

Share your passion and time to help illustrate a new path for financial assistance

Join a working group

Support with your time, passion and skills while we shape the future of financially assisted social prescribing in Hamilton, ON

Join the volunteer team

Contact Us

for more information, partnership opportunities or how you can support

E: mirela.marceta@redcross.ca