KW4 ONTARIO HEALTH TEAM

KITCHENER | WATERLOO | WELLESLEY | WILMOT | WOOLWICH

TRANSFORMING TOGETHER

2024/25 Annual Business Plan

Members Meeting – May 22, 2024

Background

In early 2019, the OHT model of care was introduced as a signature initiative for health care transformation, enshrined in legislation through the Connecting Care Act, 2019 (CCA).

OHTs enable patients, families, communities, providers and system leaders to work together, innovate, and build on what is best for Ontario's health care system.

OHTs have been tasked with working towards a common vision of more integrated and better coordinated care across the province and are enabled to achieve shared improvements according to the principles of the Quintuple Aim:

- enhancing patient experience,
- improving population health outcomes,
- enhancing provider experience,
- improving value, and
- advancing health equity.

Furthermore, OHTs play an important role in the mobilization of their partners to respond to local, regional, and provincial priorities. (Ontario Health, May 2024)

Introduction to the Annual Business Plan

In May 2024, KW4 OHT launched their inaugural five-year strategic plan aimed at transforming health and social care delivery in our community. Grounded in our vision of "A community where everyone receives integrated health and social care, delivered by providers who share responsibility for the outcomes of their patients/clients' care," the strategic plan provides an ambitious roadmap for the future of healthcare.

Annually, KW4 OHT will develop a business plan, aligned to the strategic plan, to articulate in more detail the planned work that will be undertaken in collaboration with our partners in that specific year.

The annual business plan is also aligned with the requirements as outlined in Schedule B of the 2024/25 – 2026/27 Ontario Health Team Agreement with Ontario Health. The funding provided through this agreement will enable KW4 OHT to continue advancing towards maturity at which time they will provide a full and coordinated continuum of care to our attributed population.

Initiatives, performance indicators/milestones and targets for 2024/25 have been identified in the annual business plan to allow us to measure and report our progress.

This detailed plan has been produced for the KW4 OHT Steering Committee, Members and Member Boards to articulate the KW4 OHTs planned work, in collaboration with our partners, over the 2024-25 fiscal year. A shorter summary document will be produced for public audiences.

Priorities and Goals

KW4 OHT has identified three strategic priorities which provide general direction on what we will focus on over the next 5 years to achieve our vision. The work KW4 OHT will undertake in 2024-25 related to these priorities and goals includes the following:

Keep people well by implementing strategies that focus on wellness, prevention and early interventions

Goal	Initiative	Performance Indicator/Milestone	2024/25 Target
Promote culturally appropriate healthy lifestyles and preventative measures to empower individuals to make informed health decisions	Continue to increase public outreach and education of cancer screening through various channels and in various languages.	- # of presentations - # of audience members for presentations - # of languages material translated to - Reach of ad campaign	- 10 presentations - 800 audience members - 15 languages - Reach of ad campaign - TBD
	Explore cross-regional opportunities to collaborate on all 3 cancer screening indicators.	- # of cross-regional opportunities identified and initiated by March 31, 2025	- 2 cross-regional opportunities identified and initiated by March 31, 2025
	Increase opportunities for unattached individuals to receive cervical screening through the addition of extra screening appointments each week and/or through the planning and implementation of collaborative cervical cancer screening clinics in various locations around the region.	- # of pap test administered to unattached patients - % of abnormal results from pap tests for unattached patients resulting in follow-up with an NP. - patient satisfaction with the clinic care	- This year will be used to gather baseline data for targets in future years.
Enhance community-based healthcare, beginning in priority neighbourhoods	Improve care for individuals experiencing a mental health crisis through the opening of an integrated crisis centre and strengthen pathways from the centre to community resources to support ED diversion.	- # of patients diverted from the ED - # of walk-in clients - # of police drop-offs - # of ambulance drop offs - # of referrals - # of clients discharged from care	Targeted opening of phase 1 (use of existing resources) is the summer of 2024, pending due diligence.
	Monitor and support expanded Walk-in services at Counselling Collaborative of Waterloo Region.	-# of days walk-in available - waitlist times - utilization of service - # of individuals attending workshops while on waitlist	- Walk-in services expanded to 5 days/week - Waitlists for ongoing counselling reduced by an average of 10-days from 40 days to 30 days by March 31, 2025 - Walk-in utilization increased by an average of 20 individuals per week from 30 individuals per week to 50 individuals per week - 40 individuals attend a newly developed workshop deigned for those on the waitlist for counselling

Reduce the incidence and impact of chronic diseases through evidence-based prevention, early detection, and effective management	Continue to expand the KW4 Integrated Care Team for older adults (ICT) to support older adults living with complex and chronic conditions through advanced care planning, system navigation, and complex case management.	- # of patient appointments - % of patients followed up for ongoing care and case management - # of family health organizations and individual providers added to the initiative - % of patients/care partners who indicate the ICT made them more confident in managing their health - % of patients/care partners who indicate they were very satisfied or satisfied with their experience with the ICT - % of primary care providers who indicate they were very satisfied or satisfied with their experience with the ICT - % of ICT members who indicate they were very satisfied or satisfied with their experience as part of the ICT	Pending approved funding, over the course of 2024/25: - 2,170 patient appointments (10% increase) - 75% of patients followed up for ongoing care and case management - 15 new FHO physician practices added - 80%+ of patients/care partners who indicate the ICT made them more confident in managing their health - 75%+ of patients/care partners who indicate they were very satisfied or satisfied with their experience with the ICT - 80%+ of primary care providers who indicate they were very satisfied or satisfied with their experience with the ICT - 80%+ of ICT members who indicate they were very satisfied or satisfied with their experience as part of the ICT
	Support improved access to diabetes care for high-risk patients in KW4 through timely access to endocrinologists and diabetes education programs for patient referrals meeting urgent criteria.	- % wait times within standard for Diabetes Education Programs (DEP) and Endocrinology appointments - Total # of urgent referrals within pilot project timeframe - # and % of urgent referrals initially received with request for Endocrinology consult - % of referrals from urgent care services with medication orders - % of referrals from urgent care services with orders to adjust medications	- Wait time of 48- 72 hours for endocrinology appointments - Baseline for other indicators will be determined during the pilot project.
	Support diabetes prevention and management with Indigenous older adults	Participate in a Working Group comprised of Certified Diabetes Educators (CDEs), Indigenous Older Adults and health and social service professionals who interest with these groups to: - Identify knowledge gaps in local diabetes health care management for Indigenous Older Adults - Produce education materials that will situate CDEs to be a key stakeholder in enabling Indigenous older adults to live a safer and connected life.	Targets to be established once scope of work finalized.
	Pending funding approval, continue with the DREAM (Dementia, Resource, Education, Advocacy, Mentorship) initiative at GRH for people living with dementia to prevent hospital admissions and look to expand to SMGH.	- # of clients who received system navigation and referral support - # of clients diverted safely home with respite and other supports initiated - % of repeat visits to ER due to caregiver burnout	- We will use 2024/25 to establish baseline data. Our aim per Hospital is: - 250 interventions - 100 Diversions - % of repeat visits to the ER – goal of less than 25%

Collaborate with community organizations to address local social determinants of health challenges (i.e., housing/shelter, food insecurity, etc.)	Monitor and support the launch of on-site programming at Supportive Housing locations across the Region of Waterloo through the Supportive Housing Health Initiative (SHHI) Program. This team will include Nurse Practitioners, Peer Support Workers, and Addictions Counsellors who provide Primary Care and addictions care.	- MOU finalized - Staff recruited - Program launched	- MOU finalized by April 1, 2024 - Staff recruited by June 30, 2024 - Program launched and being successfully being delivered by December 31, 2024
	Monitor and support provide long-term housing alongside dedicated holistic direct support for individuals navigating a concurrent disorder and at risk of homelessness upon exiting incarceration through the Region of Waterloo and Justice Mental Health Project.	- # of supportive housing units provided through the program	- 6 dedicated subsidized apartment units secured and occupied by March 31, 2025
	Develop opportunities to utilize the Social Determinants of Health Framework to reduce the impact of the social determinants of health for priority populations (https://www.ontariohealth.ca/system-planning/social-determinants-of-health-framework).	- Review the framework and accompanying resource guides and identify opportunities where we can apply this framework in our population health framework.	Population Health Management approach developed for our priority neighbourhoods, leveraging the work of our Members. Analyzing new and existing initiatives with a health equity lens to determine how best to address the social determinants of health.

Transform our health and wellness system to ensure people can access the right care, at the right time, and in the right place

Goal	Initiative	Performance Indicator/Milestone	2024/25 Target
Improve access to primary care and team-based models of care	Support the awareness of new funding opportunities for increasing team-based resources in primary care and facilitate the application process to chosen funding opportunities.	- # of completed Funding Opportunity Gating forms - # of funding opportunities shared with OHT Members - # of funding submissions completed	Complete review of gating form in 72 business hours.
	Support the two successful KW4 OHT Expanding and Enhancing Interprofessional Primary Care Team Implementation Plans	- # of patients attached to a most responsible provider (patient has been identified the practice (i.e. through an enrollment/registration) as having a longitudinal relationship for comprehensive primary care at the practice with a designated MRP) - # of patients who have access to a team (have at least one visit in the year for primary care services offered by the team)	We are currently working with Ontario Health to set the targets number of patients who will be served by the new/expanded team.
	Continue to provide access to primary care services for unattached patients who reside in the four priority neighbourhoods (N2H, N2M, N2G, N2C) through the Rapid Access to Primary Care (RAP) Clinic while reducing the use of the emergency room department for non-emergency conditions.	- # of clients served through the RAP clinic - % of unattached patient who report that ED would have been their first point of contact - Client satisfaction rates with model of care	This is a pilot initiative, and we will use this period to collect baseline information for some of our indicators: - 40 clients served per month through the RAP Clinic. - 80% of patients report the ED would have been their first point of contact - 85% client satisfaction rates with model of care
Optimize care coordination and system navigation among providers and services	Continue with the LEGHO program, leveraging existing services and providers within our OHT to support ED Diversion, Admission Avoidance, and Hospital Discharge	- # of patients referred - # of patients supported - # of patients diverted safely back to the community - # of rides provided - # of meals provided - # of care hours provided - # of ED visits while on LEGHO - # of hospital admission while on LEGHO - patient experience	Target still to be determined
	Pending funding, continue to expand the reach of the SCOPE (Seamless Care Optimizing the Patient Experience) program, connecting primary care providers with a nurse navigator to	- # of calls/month - # of new pathways/services added - # of marketing/engagement opportunities - # to PCPs utilizing service - PCP satisfaction	- Increase the number of calls per month to 60 by March 31, 2025 - Develop 6 new pathways or services by March 31, 2025

	connect patients to appropriate community resources in a timely way.	- % of ED visits diverted	- Conduct 2-4 in-person visits or lunch and learns per month to increase awareness and utilization of the SCOPE program - Increase the number of PCPs utilizing services to 200 by March 31, 2025 -Increase primary care provider's reported satisfaction with the SCOPE program. - Maintain percentage of ED visits diverted to 100%
Support the ongoing implementation of online appointment booking, electronic referrals and centralized intake	Support the ongoing implementation of online appointment booking for primary care providers	- # of providers offering Online Appointment Booking (OAB) - % of patient's overall satisfaction with OAB - % of provider's overall satisfaction with OAB - # of patients with access to book appointment online	If there is funding: - We aim to increase the number of providers offering OAB, by 3%, from 121 to 125 providers by March 31, 2025. - We aim to increase the percent of patient's overall satisfaction with OAB, by 3%, from 87% to 90% satisfaction by March 31, 2025. - We aim to increase the percent of providers overall satisfaction with OAB, by 3.75%, from 80% to 83% satisfaction by March 31, 2025. - We aim to increase the number of patients with access to book appointments online by 2.87%, from 139,161 to 143,161 patients by March 31, 2025.
	Support the ongoing implementation of eReferral to allow clinicians to send a referral electronically rather than by fax, putting patients before paperwork and improving wait times	% active use rate of senders on eReferral* *Ontario Health Referral VOR expected to significantly impact performance	63% active use rate of senders

Integrate services across health and social partners to serve the needs of our community

Goal	Initiative	Performance Indicator/Milestone	2024/25 Target
Build and foster creative partnerships that enable integrated care and system excellence	Continue to support the ongoing development and expansion of the Community Support Service Navigation Team at the Boardwalk.	- # of providers/FHO participating in pilot - # of clients connected to services - Client satisfaction - Provider satisfaction	Target still to be determined

Spearhead the development of new and innovative approaches to care delivery, using a system thinking approach and leveraging local partnerships	Monitor and support the continued roll-out of Ontario Structured Psychotherapy (OSP) to adults with depression and anxiety-related concerns. OSP services are based on cognitive-behavioural therapy approaches which teaches people how to change their patterns of behaviour and thinking.	- # of presentations to social service/health agencies -# of referrals - # of views of OSP referral page on partner agency websites - patient experience - % satisfied with the OPS program - Patient outcomes - pre and post measures (Patient Health Questionnaire-9 (PHQ-9) and Generalized Anxiety Disorder Questionnaire (GAD-7))	- Provide referral presentations/resources to 15 Waterloo-based social service/health agencies by March 31, 2025 -increase the number of Waterloo Region residents referred to OSP to 150% of the caseload for two FTE's by March 31, 2025 -Increase views of OSP referral page by 100% from 40 views per month to 80 views per month by May 1, 2024 - 80% of patients indicated they were very satisfied or satisfied with their experience with the OPS program - 70% of patients enrolled in the OSP program reported lower PHQ-9/GAD-7 scores after completing the program
	Monitor and support the exploration the establishment of Youth Wellness Hubs that provide high-quality integrated youth services to support the well-being of young people aged 12 to 25, including mental health and substance use supports, primary health care, community and social supports, and more. The aim of this Community Collaborative is to offer a model that combines recreation, school support, mental health services, and connection, all designed with input from youth and led by the community.	- EOI for consultant issued and consultant hired - Approach to the wellness hubs initiative determined - Framework that meets the needs of Waterloo Region established - Proposal developed and submitted to the Ministry of Health - # and range of diverse group of agencies represented and participating in the planning, potential partnerships, etc.	- Consultant in place by April 15, 2024 - Approach and framework determined by September 30, 2024 - Proposal developed and submitted by March 31, 2025 - 150 people and 30 organizations/agencies engaged in process
	Support the continued implementation of the Palliative Alternate Destination Program for palliative care patients (approved August 2023) led by Waterloo Paramedic Services. This includes: - treat and refer - patient are treated by paramedics on scene for symptom management including for pain or dyspnea, hallucinations or agitation, terminal congested breathing, and nausea or vomiting, and then receive follow up care from their palliative care team or be referred to an appropriate care provider for follow-up care (if the patient does not have one). - alternate destination - Eligible palliative care patients calling 9-1-1 will have the option to be treated by paramedics on-scene as needed. In appropriate situations, individuals with a complete	- # of patients diverted from the ED - # of times pain and symptom management provided in the home - patient and family experience - provider experience - # of patients transported directly to hospice	We will use 2024/25 to establish utilization baseline data and therefore have not set performance targets Our aim for this year will be improved care experience for patient and providers during the end of life trajectory.

	pre-registration may be transported by paramedics directly to a local hospice for wrap-around care.		
	Support the development of a user-centered design social robot prototype to support the health and well-being of Older Adults in LTC. This would be done through co-design with Older Adults and other stakeholders.	-# of engagement sessions -# of participants	-Identification of key areas where social robots can seamlessly support older adults' health and well-being. -Development of social robot prototype
	Rollout of delirium resource toolkit for caregivers, clients and patients in various settings (i.e., Emergency Department) to assist with recognizing the early signs of delirium so that interventions and supports can be initiated sooner.	- # of hospitals Delirium resources distributed to - # of Delirium Education sessions delivered - # of attendees at World Delirium Day webinar	- Kits distributed to 7 hospitals - One Delirium education session to be held on World Delirium Day in March 2025. - Increase registration for the 2025 World Delirium Day webinar by 10% from 245 to 270 people by March 31, 2025.
Implement new innovative models of integrated home care	Launch the St. Joseph's Home Care Hospital to Home Program to help adults who no longer require hospital care to continue their recovery, healing, and rehabilitation at home, while other longer-term community-based services are arranged.	- # of patients participating in program - # of patients enrolled PRIOR to ALC designation - % of patients who indicated they were very satisfied or satisfied with their experience - # of ED visits with patients enrolled in program - # of readmissions	-20 patients per month enrolled starting April 2024 -By March 31, 2025 we will have seen a 10% decrease in ALC LOS for patients in the categories of Home with CCAC and Retirement Home with Supports
	Provide complex transitional care within a patient's home instead of an inpatient unit through the Integrated Transistional Care Team. This team is composed of a GRH Transistional Care Navigator (TCN), HCCSS Care Coordinators, and leads from both Bloom Care Solutions and Community Support Services (CSSs) will collaboratively design an Integrated Transitional Care Plan while the patient is in the inpatient setting. This care plan will be delivered to the patient from the comfort of their home and be composed of coordinated services from Bloom, and where required HCCSS, and CSS. The program can last for up to 3 months in duration and patients can be discharged to existing HCCSS and/or CSS or assisted living options. As the patient progresses and transition from the program is being planned the TCN and Bloom care supervisors will collaborate on a discharge plan from the program and receive support from the HCCSS community coordinators if required.	- # of participants referred to the program - # of participants accepted to the program - # of patients entering the program who were already designated ALC - # of days the patient is in the program - # of patient receiving PSS plus other home services - # of patients requiring ED visit while on program - # of patient requiring re-admission while on program - % patients who said they were satisfied or, very satisfied - Discharge destination from program	- 10-15 participants referred to the program per month - 5-10 participants accepted to the program per month - <50% of patients entering the program designated ALC - <3 months patient in the program - # of patient receiving PSS plus other home services (Baseline needed) - 0 patients requiring ED visit while on program - 0 patient requiring re-admission while on program - >85% of patients satisfied or, very satisfied - Discharge destination from program (Baseline needed)

	Monitor the implementation of Year 2 of the 'Improving Access to Home Support Services in Waterloo' initiative to increase the ability of low income, newcomer, or otherwise vulnerable seniors to age in place. This is a three year initiative, focusing on service expansion with transportation, snow clearing, yard maintenance, and volunteer liaison/service navigation.	- # of seniors identified as low-income, newcomer and otherwise vulnerable registered in AWAH programs/services - % of seniors identified as low-income, newcomer and otherwise vulnerable who report enhanced social inclusion such as a sense of belonging, connection, and inclusion in their communities - # of new services developed and implemented	- Expand delivery of eligible volunteer-based services to seniors identified as low-income, newcomer and otherwise vulnerable by 30 individual seniors by March 31 2025 to help them age at home. - 80% of individual seniors served, identified as low-income, newcomer and otherwise vulnerable, report enhanced feelings of social inclusion such as a sense of belonging, connection, and inclusion in their community following their participation in the program. - Development and implementation of 3 new services for eligible seniors identified as low-income, newcomer and otherwise vulnerable by September 2025.
Grow the number of integrated care model initiatives where the OHT/PCN is the central administrator of funds on behalf of our Members.	Support the implement the Palliative Care Health Service Delivery Framework: a Model of Care to Improve Palliative Care in Ontario (Adults Receiving Care in Community Settings) by supporting care providers in gaining comfort and skills in primary-level palliative care.	- Establish a Steering Committee - Hire a Clinical Coach - Co-create the Regional Delivery Framework implementation plan with Ontario Health - Participate in the Cohort 1 Community of Practice - Engage primary care	Details of the deliverables and reporting requirements associated with this funding will be provided via the issuance of a Transfer Payment Agreement
	AI Scribe - Support the project team's implementation of the AI scribe solution in some family practice clinics	- Deploy AI Scribe solution to some family physicians across the attributed populations of KW4 OHT - Understand how AI Scribes can reduce perceived burnout due to clinical documentation practices -Improve overall provider satisfaction with clinical encounters	As this is an exploratory initiative, the project teams will use 24/25 to establish baseline data.
	Work with Members to identify additional integrated care model initiatives (i.e. Palliative Clinical Pathway)	-Identify one additional opportunity where KW4 OHT would be best suited to be the central administrator of funds	One additional opportunity

Enablers

KW4 OHT has identified three enablers which represent foundational capabilities, capacities, or resources that contribute to our ability to effectively execute our strategic plan. The work KW4 OHT will undertake in 2024-25 related to these pillars includes the following:

Governance

Initiative	Performance Indicator/Milestone	2024/25 Target
Strengthen our leadership capacity to drive collaborative success by creating a not-for-profit organization	Incorporation as a not for profit organization	File for incorporation by March, 2025.
Renew the governance structure of the OHT including establishment of a Board of Directors for the OHT.	OHT Board of Directors in place.	OHT Board of Directors in place by September 1, 2024.
Establish a Primary Care Network	- Finalize Bylaws - Finalize Articles of Incorporation - Create Nominations process - Create Nominations Committee - Appoint first PCN Board - Establish priorities for PCN based on the results of the PCN readiness assessment	PCN Board of Directors in place by September 1, 2024 Priorities developed to advance the PCN closer to maturity by March, 2025
Formalize our operational support provider (OSP) arrangement for back-office functions in support of OHT activities	Complete formal agreement when available from OH	Formal agreement signed within 90 days of guidance documents being released
Increase awareness of the success of the OHT, expand advocacy efforts in order to secure new and sustained funding, and broaden our level of influence	-Continue ongoing engagement with OH, MOH and leaders from all levels of government - Increase OH/MoH awareness through participation at various provincial and regional committees - Invite OH leadership to a KW4 OHT meeting to learn about the region and showcase member agencies - Targeted outreach to MP and MPPs in the region to collaborate and discuss priorities in their ridings - Demonstrate targeted outreach efforts to expand OHT membership to include additional sectors	- OH Leadership to attend KW4 OHT in person engagement events - Min of 3 Presentations of KW4 OHT work at regional and provincial events (RISE, HSPN, etc.)
Lead the engagement of Primary Care providers to increase awareness of OHT work and provide feedback on key initiatives and opportunities to improve access to PC services.	Primary care awareness Newsletter engagement	- Host 2 Clinician Summits by March 31, 2025 - Publish 3 Primary Care newsletters by March 31, 2025 - Publish 3 Specialist newsletters by March 31, 2025 - Increase subscribers for both PC and Specialist newsletters by 15% by March 31, 2025

Tools

Initiative	Performance Indicator/Milestone	2024/25 Target
Develop a comprehensive digital health strategy	Current state digital health assessment developed Current state digital health assessment conducted with KW4 members Assessment results analyzed and draft strategy developed	- Current state digital health assessment developed by July 31, 2024 - Current state digital health assessment conducted with KW4 members by October 31, 2024 - Assessment results analyzed and draft strategy developed Feb 28, 2025 - Curate information about local services across Health811, OHT and member organization websites
Support the implementation of solutions to ensure patients can access their health information, and providers can access a shared medical record	% of Waterloo Region population enrolled for My Connected Care Support the exploration of acute care and primary care data visualization. - Population Health Management Platform RFP completed - Data Visualization in Primary Care and Approach for Data Visualization in Acute Care developed - Business requirements document developed SMGH RCM HF - Total # of unique monitored patients - Average # of patients monitored per month - % of patients overall satisfied - % patients who have a decreased need to visit family doctor/nurse practitioner or walk-in clinic	3% of the population of Waterloo Region are enrolled by March 31, 2025 Support the exploration of acute care and primary care data visualization. - Population Health Management Platform RFP completed by June 30, 2024 - Data Visualization in Primary Care and Approach for Data Visualization in Acute Care by March 31, 2025 - Business requirements document developed by Sept 30, 2025 SMGH RCM HF - 125 uniquely monitored patients (total) - 95 patients monitored on average per month - 95% of patients overall satisfied - 80% patients who have a decreased need to visit family doctor/nurse practitioner or walk-in clinic
Enhance the Harmonized Health Information Management Plan (HIMP) with an emphasis on data governance and data stewardship, to facilitate integrated care and evaluation, while protecting privacy	- % of members that complete annual privacy, security and cybersecurity training Support the exploration of acute care and primary care data visualization. - Population Health Management Platform RFP completed - Business requirements document developed - Data Visualization in Primary Care and Approach for Data Visualization in Acute Care developed	We will use 24/25 to gather baseline Support the exploration of acute care and primary care data visualization. - Population Health Management Platform RFP completed by June 30, 2024 - Business requirements document developed by Sept 30, 2025 - Data Visualization in Primary Care and Approach for Data Visualization in Acute Care by March 31, 2025

Using the OHT Performance Framework as a guide, develop a balanced scorecard for KW4 OHT, and measure and report on OHT performance.	- Scorecard developed - # of reports developed - Utilize a holistic approach to data to enable evidence-based decision making	Quarterly reporting conducted
Development and testing of Newcomer App Prototype; In-field evaluation of working prototype	-# of newcomers participants in field evaluation - # of in-evaluation surveys completed - # of post-study focus group sessions held	- Policy brief to share with community partners - Support transition of initiative to other partners.

Talented People

Initiative	Performance Indicator/Milestone	2024/25 Target
Create a system that attracts and retains skilled health human resources by addressing burnout, succession planning, employee support and wellbeing, and training and development	Training for OHT staff in relation to the topics below: - Indigenous Cultural awareness and safety training; - EIDA-R (Equity, Inclusion, Diversity and Anti-Racism) education and training and, - Active Offer (as per French Language Services Act) - Patient, Family and Caregiver engagement	100% of OHT staff trained by April 2025

Pillars

KW4 OHT has identified two pillars which represent the crucial elements required to deliver on our shared vision and overall strategy in the long term. The work KW4 OHT will undertake in 2024-25 related to these pillars includes the following:

Co-design person-centered models of care by ensuring the diverse perspectives of clients, patients, families, care partners and community are heard, valued, and understood.

Initiative	Performance Indicator/ Milestone	2024/25 Target
Create a collaborative model that supports improved engagement with priority populations to improve health outcomes.	- Adopt and Implement the 'Creating Engagement Capable Environments in Ontario Health Teams' Patient, Family, and Caregiver Capability Framework'	- Community Advisory Council (CAC) and KW4 will complete an assessment of current state and develop an action plan that outlines how the OHT will advance to a minimum of Level 2: Learning and Developing of a Engagement Capable Environment OHT by December 2024
Evolve the governance and composition of the existing Community Council Design Committee (CCDC) to a Community Advisory Council (CAC)	- Revise the Terms of Reference - Create profiles for the Chair, Vice-Chair, and Members based on the 6 competencies listed in the "Creating Engagement Capable Environments in Ontario Health Teams: A Framework for Action". - Create Expression of Interests for the Chair,	- Receive approval from CAC and Steering for the Revised Terms of Reference by June 2024. '- Receive approval for the profiles by June 2024 - Receive approval from the CAC and Sterring for the Expression of Interests for the Chair, Vice-Chair, and Members by June 2024. - Begin recruiting new members in June 2024 with a goal of having 12-15

	Vice-Chair, and Members - Recruit new members to reach target of 12-15 members representing varied and diverse communities - The CAC Chair will hold an ex-officio position on the OHT Board of Directors.	members before September 2024. For continuity, we will seek to have 3 current members continue for an additional 3-year term.
Review/refresh community engagement strategy	-Determine the structures for engagement and ways the CAC will be involved in KW4 OHT activities - Identify how information will be shared back with the communities the CAC represents following engagement activities - Ensure the CAC engagement strategy is collaboratively developed and adopted by KW4 OHT - Embed patient, family and care partners within collaborative decision-making structures - Provide access to training material, supports, tools, and resources to enable patients/clients, care partners and the community to meaningfully contribute in their role as partners/advisors	- The CAC will establish ways of engaging with the communities they serve by November 2024 - The CAC will establish a procedure that will guide how they will share information with the communities they represent by November 2024 - On an ongoing basis, KW4 OHT will engage the CAC in collaborative decision making - On an ongoing basis, KW4 OHT will help to make these resources available to CAC as requested

Integrate equity-driven approaches by embedding an equity, inclusion, diversity and anti-racism lens into our work to reduce health disparities, particularly for underserved populations.

Initiative	Performance Indicator/Milestone	2024/25 Target
Update our understanding of the characteristics of the population including social, economic and health inequities including intersectionality, to inform care and service delivery through data analysis	- Refresh demographic and health outcome data by neighbourhood - Participate in a hospital-led group aiming to implement a standard health equity data set this fiscal year, encouraging the inclusion of other sectors i.e. CHCs, with the intent of developing and implementing processes for the collection of standard socio-demographic data	- Demographic and health outcome data by neighbourhood is refreshed on a semi-annual basis
Support the establishment of an equity measurement framework across Members and begin measuring and reporting on progress	Using the OHT Performance Framework as a guide, work with our Member DEI resources to develop an equity measurement framework	Equity Measurement framework developed