KW4 Ontario Health Team

Persona, Journey Mapping, and Integrated Care Pathway Support

Final Report

July 11, 2023

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Contents

Purpose of the Document

- This document is the **final report** of Optimus SBR's Neighbourhood Integrated Care Team Patient Persona, Journey Mapping and Integrated Care Pathway (NICT ICP) engagement with the KW4 OHT.

- The document includes all information and outputs from the engagement.

- The document contains:
  - Project Overview
  - Patient Personas and Journey Maps
  - Co-Designed Integrated Care Pathways
  - Recommended Next Steps
  - Appendix

1

Project Overview

Context

- In November 2022, the Ministry of Health released a report (*Ontario Health Teams: The Path Forward*) offering new direction and guidance to Ontario Health Teams
- In the report, the Ministry outlined plans for **phased introduction of integrated clinical pathways** through OHTs
- **Four target pathways** were identified for people living with the following chronic conditions:
    1. Congestive heart failure
    2. Diabetes
    3. Chronic obstructive pulmonary disease
    4. Stroke
- Additional pathways have been planned in the areas of mental health and addictions and palliative and end-of-life care
- Currently, several OHTs are piloting the pathways throughout the province, and new funding is anticipated to enable additional OHTs to implement the pathways in the future
- Given the above direction from the Ministry, Optimus SBR partnered with the KW4 OHT to develop three integrated care pathways for Kitchener, Waterloo, Wellesley, Wilmot, Woolwich (KW4)

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Project Mission and Success

Mission

- To support the KW4 OHT leadership in developing patient personas, journey maps and integrated care pathways for priority populations in KW4

Success

- Three patient personas and journey maps for KW4 priority populations
- Integrated care pathways for three major health/illness related conditions that residents in the KW4 priority neighbourhoods commonly seek care for
- Buy-in and support from partnership and leadership

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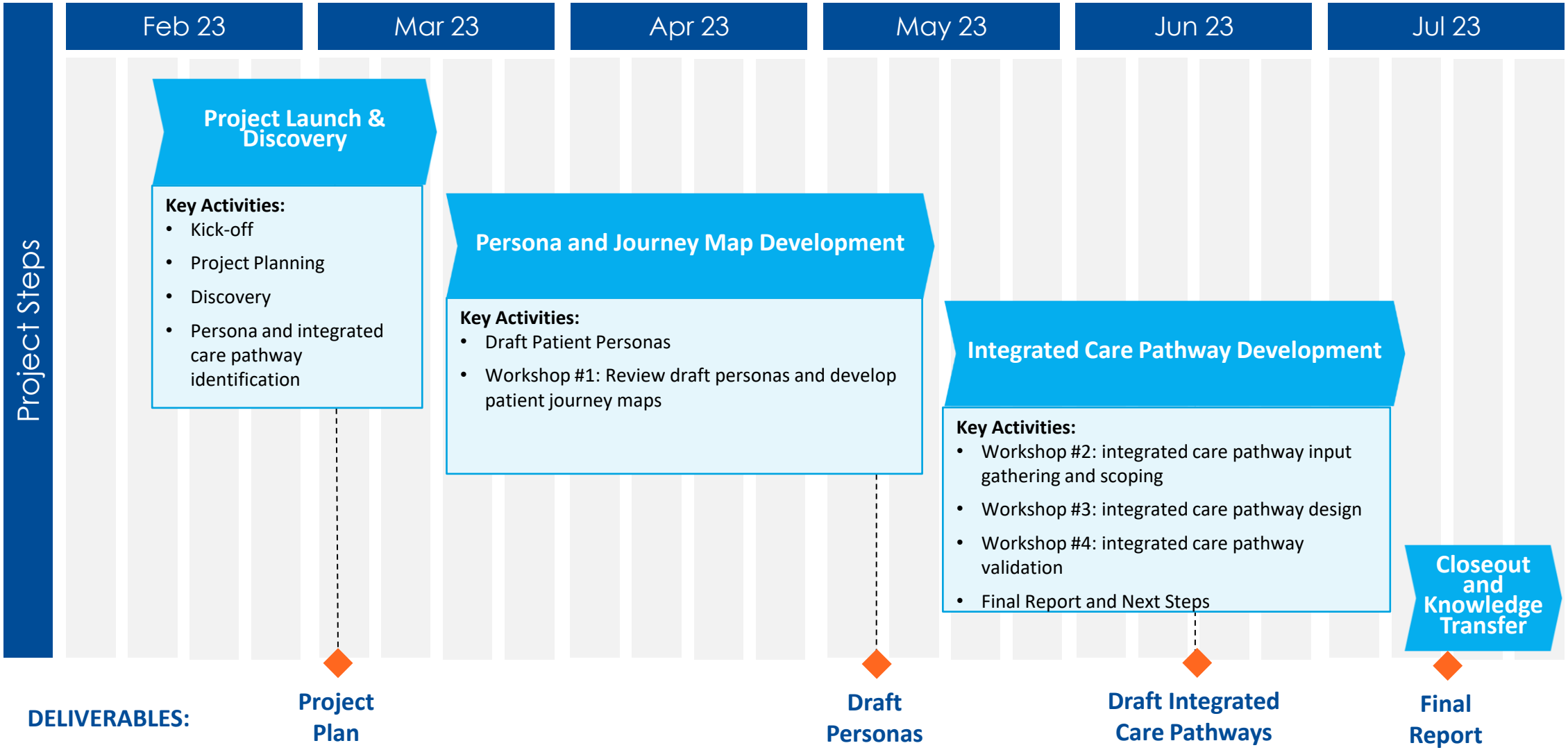
Project Timeline

The project took place over a 6-month time periods from February-July 2023



Project Methodology

The integrated care pathways were informed through a rigorous engagement approach, detailed analysis of data and documents, guidance from Ontario Health, and four in-person co-design workshops.

Our Methodology

5 // Discovery Interviews

Conducted 5 initial discovery interviews with KW4 OHT leadership, members, regional leads, and patient and family representatives to gather insights that would inform the engagement process.

62 // Documents Analyzed

Analyzed 62 documents provided by the KW4 OHT team, workshop/interview participants, as well as Ontario Health to inform the development of patient personas, journey maps, and integrated care pathways.

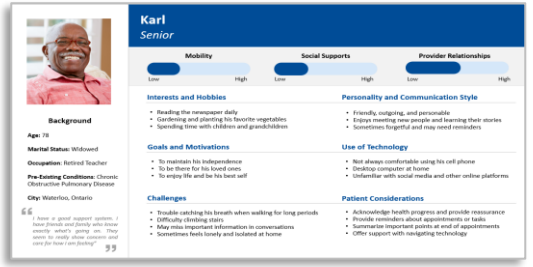
4 // Co-Design Workshops

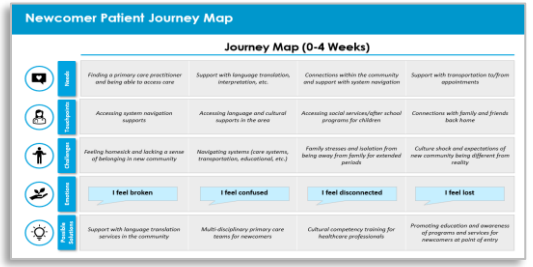
Facilitated 4 in-person workshops with community members, health and social care providers to co-design patient personas, journey maps, and integrated care pathways for 3 priority populations.

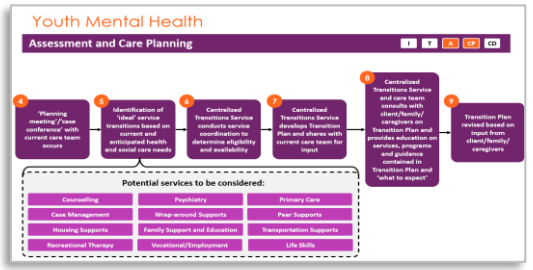
9 // Expert Interviews

Conducted 9 expert interviews to gather insights on relevant services in KW4 and key challenges to address in the design of care pathways for heart failure, diabetes, and mental health and addictions.

Sample Co-Design Outputs







Engagement Highlights

A diverse range of community members and experts were involved in the co-design workshops.

Interviews

9 individual and small group interviews were conducted with key informants from Ontario Health and various health and social service providers in KW4 to inform integrated care pathway development.

Workshops

4 In person workshops with over **60 unique participants** were held to create journey maps and integrated care pathways. Workshop participants included persons with lived or living experience, families, care partners, OHT staff and partners.

Over 70 stakeholders engaged across these activities!

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Workshop Objectives

Optimus SBR facilitated four co-design workshops to develop the integrated care pathways. Each workshop built upon the work and discussion of the previous workshops.

Workshop #1

- Optimus SBR facilitated discussion around three patient personas, based on KW4's priority populations
- **Journey maps for the three personas were developed**

Workshop #2

- Optimus SBR proposed three target populations for the integrated care pathways
- **The target populations for the integrated care pathways were refined** to reflect community need in KW4

Workshop #3

- Optimus SBR facilitated a discussion to **design the integrated care pathways**
- Discussion was centred around five key stages in a person's journey

Workshop #4

- Optimus SBR presented draft versions of the integrated care pathways
- **The integrated care pathways were refined and validated** through discussion

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Patient Personas and Journey Maps

Personas and Journey Maps

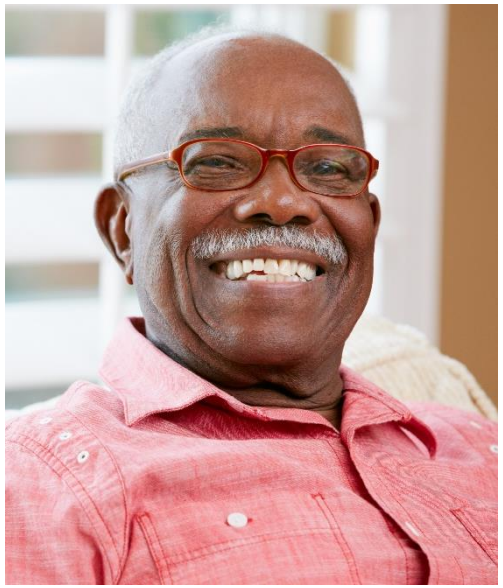
Workshop #1 focused on developing patient personas and journey maps. These are described below.

Personas	○ Personas were the foundation for the patient journey maps created in Workshop #1. ○ Three broad patient personas were used to help depict the experiences, motivations, and goals of patients, as well as the barriers and challenges they face when accessing health and social services.
Journey Maps	○ Three journey maps were developed in Workshop #1: Senior, Adult with Mental Health and Addictions Challenges, and Newcomer. ○ Journey maps allowed the Workshop group to better understand and depict how patients interact with the health and social services health systems throughout their care journey. ○ Note: KW4 OHT had previously developed journey maps for the newcomer population. In Workshop #1, Optimus SBR shared the existing journey maps and asked participants to update/adjust them as appropriate.

Patient Personas and Journey Mapping

In Workshop #1, Optimus SBR facilitated a discussion around three patient personas:

Karl



Persona Profile:
Senior

Objective:
To improve overall access to care for seniors in the most appropriate setting.

Jeffrey

Persona Profile:
Person with Mental Health and Addictions Challenges

Objective:
To improve access to community services for adults with mental health and addictions challenges.

Nadia

Persona Profile:
Newcomer

Objective:
To improve the health and wellness of newcomers within the first two years of their arrival in KW4.

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Summary of Journey Map: Senior

Below is a high-level summary of the journey map created in Workshop #1.

	0 – 4 Weeks	1 – 6 Months	6 Months – 2 Years
Needs	Health literacy education and support with chronic disease management	Support with activities of daily living and continued community engagement	Comprehensive home care including medication management and potential end-of-life support
Challenges	Access to personal health information and wait times to access services	System navigation	Continued independent living in the community, including access to affordable and safe housing
Solutions	Central health information system and frequent communication with care providers	Central contact to support with system navigation and ensure timely flow of information	Comprehensive home care supports

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Summary of Journey Map: Mental Health & Addiction

Below is a high-level summary of the journey map created in Workshop #1.

	0 – 4 Weeks	1 – 6 Months	6 Months – 2 Years
Needs	Supportive environment with appropriate connections to resources	Accessible, timely and coordinated outpatient supports, and maintenance of positive relationships	Accessible, timely, coordinated and consistent access to supports, and maintenance of positive relationships
Challenges	Access to and limited eligibility for the right supports	Lack of motivation, long wait times, multiple service offerings, high costs of some services, and limited eligibility for service	Continued and consistent access to supports as needed
Solutions	Access to education and easy navigation to the right supports in the early stages of care	Increased referral services and strategies to avoid gaps in care	Collaboration between health and social services for the most optimal, patient-centric care solutions

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Summary of Journey Map: Newcomer

Below is a high-level summary of the journey map created in Workshop #1.

	0 – 4 Weeks	1 – 6 Months	6 Months – 2 Years
Needs	Access to a consistent primary care provider	Support with navigating the health and social care systems	Finding stability and security, and achieving a sense of belonging and purpose
Challenges	Finding a primary care provider who can provider culturally safe care	Lack of knowledge and awareness of the health and social care systems	Stigmatization and systemic racism
Solutions	Create a free primary care-based screening program	An orientation tool and educational materials to facilitate system navigation	Ongoing community outreach and events to keep newcomers informed and engaged

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Integrated Care Pathways

Integrated Care Pathways

Integrated care pathways are structured multidisciplinary approaches to providing care for patients with a specific clinical problem. They can be used to help improve patient experiences and flow through the care system.

Common steps to design an integrated care pathway include:

1. IDENTIFY target population(s)

2. DEFINE goals and outcomes for the pathway

3. MAP the ideal future state

4. DEVELOP the revised care pathway

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Integrated Care Pathway Design

The integrated care pathways are structured according to five key stages, listed below. These stages depict how a person flows through the care system.

Intake	Triage	Assessment	Care Planning	Care Delivery
How and where will patients who can benefit from the care pathway be identified?	What important subgroups exist and should be considered in the care pathway?	What assessments should be conducted for each subgroup? By whom?	What services will each subgroup require?	How will services be provided? By whom?

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Ontario Health Guidance

Ontario Health has proposed selection criteria for integrated care pathways, which were considered in the integrated care pathway development.

	Business Case Selection Criteria
A	Active cross-sector collaboration between OHT members
B	Co-designed with the input of patients and family caregivers
C	Plan for the distribution of resources between partners
D	Plan for prioritizing populations who are most at risk and best suited for non-acute care
E	Willing to collect patient reported experience and outcome measures (PREMs and PROMs)
F	Consider digital health

	Proposed Implementation Selection Criteria
1	Conditions which have a significant and/or growing prevalence or are a clinical priority
2	Conditions with a higher acute care utilization
3	Better outcomes are achievable through integrated primary, home or community care
4	Have both strong provincial and local clinical leadership
5	Have clearly identified sources of funding
6	Can support a robust measurement and evaluation framework
7	Pathways have the readiness to be implemented in the short-term

Integrated Care Pathway Populations

Based on KW4 priority populations, guidance for Ontario health and socialization with KW4 Leadership Action Committee, target populations for the integrated care pathways were solidified between Workshops #2 and #3.

Pathway	Initial Target Population		Updated Target Population
Senior Pathway	Senior with congestive heart failure transitioning from hospital care to home.	>	**Senior with Heart Failure**
Mental Health and Addictions Pathway	Adult with mild to moderate anxiety, depression, and substance use disorders.	>	**Youth Transitions to Adult Mental Health Services**
Newcomer Pathway	Newcomer accessing diabetes education and care.	>	**Newcomer with Diabetes**

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Integrated Care Pathways

Senior with Heart Failure

The following slides depict the co-designed integrated care pathway developed with the KW4 community. This pathway is intended to be an 'ideal future state' pathway. It is a starting point for continued Integrated Care Pathway development for KW4 OHT moving forward.

Senior with Heart Failure: Goals and Relevant Services

The goals of the integrated care pathway are listed below, alongside some services that were identified as highly relevant in KW4

	Senior with Heart Failure
Goals	• Provide a clear community-based care pathway for seniors with heart failure that adopts a chronic disease management approach • Support patients to receive ongoing care in the community including unattached patients • Improve communication and establish clear processes for information sharing between providers, the patient, and their care partners • Increase access to information • Offer more comprehensive and holistic care • Improve the patient's quality of life • Engage patients and care partners as members of the care team • Better integrate services across sectors (e.g., health and social services) • Create a community of support around the patient • Integrate palliative care earlier in the patient's care journey
Services that may integrate with this pathway in the future (this is not an exhaustive list)	• Heart Failure Pathway (St. Mary's Hospital and Grand River Hospital) • Integrated Comprehensive Care Program (St. Mary's Hospital) • Geriatric/Complex Care Program (New Vision)

Senior with Heart Failure

Intake

I | T | A | CP | CD

1 **Person experiences symptoms of heart failure:**

- Primary Care
- Community Paramedicine
- Hospital
- Rapid Response Team
- Social Care Organization
- Health811
- Community Agencies
- Family Members/ Care Partners

Family members/care partners, social care organizations, or community agencies (e.g., food delivery drivers, housekeepers, etc.) may be the first to notice when someone is experiencing symptoms of heart failure

2a Person presents to hospital (i.e., 911 call)

2b Person presents to primary care

3 Care Provider treats urgent symptoms to stabilize the person's condition and identifies the person's care partner(s)

4 Person is referred to a Multidisciplinary Community Hub

Notes:

- In general, people are sent to hospital or primary care when they experience symptoms of heart failure. There is an important opportunity to shift this response pattern, so that people are aware of – and comfortable referring to –Multidisciplinary Community Hubs in the future.
- Multidisciplinary Community Hubs use a spoke-hub-and-node model where primary care works collaboratively and is highly integrated with community-based multidisciplinary teams of health professionals and specialists.
- Social care providers, community agencies and translation services should be included in the Multidisciplinary Community Hubs to support heart failure management in the community.

Senior with Heart Failure

Triage

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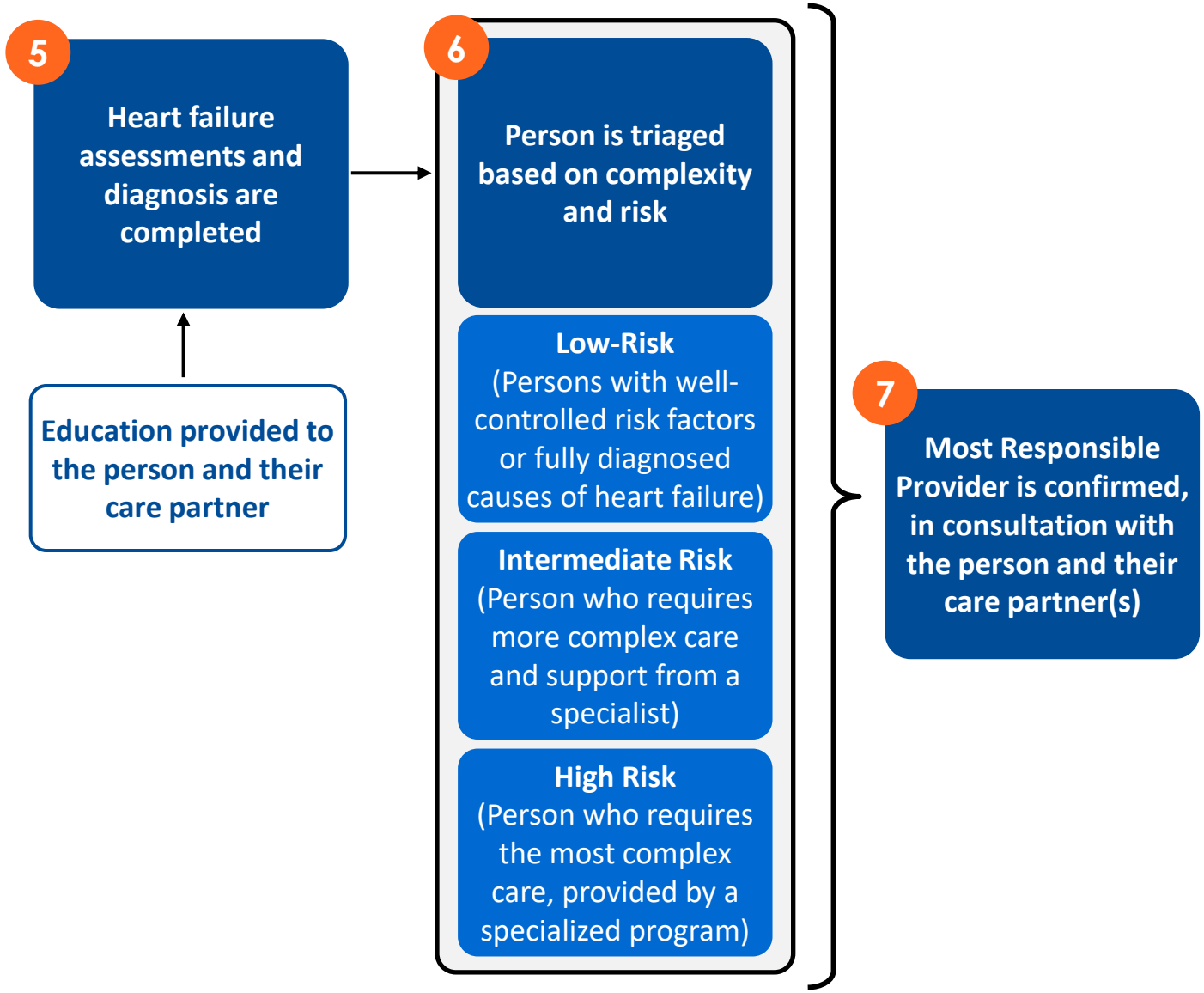

Senior with Heart Failure

Assessment

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8. Most Responsible Provider engages the person and their care partner(s) in discussing goals of care

9. Most Responsible Provider, the person, and their care partner(s) work to identify additional care team members, as needed

10. Multidisciplinary Care Team completes assessments to determine the resources needed to support the person in the community

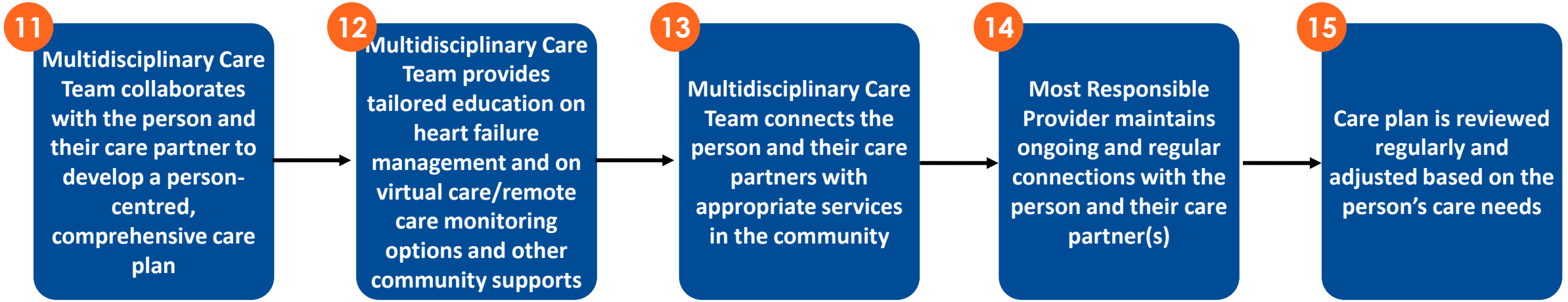
The Care Team may include, for example:

The Person/Patient	Spiritual Care Provider	Specialists
Care Partner(s)	Palliative Care Provider	Primary Care Provider
Most Responsible Provider	System Navigator	Peer Support Workers
Community/ Social Service Provider(s)	Physiotherapist	Pharmacist
Home Care	Nutritionist/Dietician	Intensive Geriatric Service Workers

Senior with Heart Failure

Care Planning and Delivery

I T A CP CD



Notes: Congestive heart failure often becomes a life-long condition, and regular monitoring to minimize risk is required in most cases. Follow-up intervals will vary depending on the level of risk of the individual.

Youth Transitions to Adult Mental Health Services

The following slides depict the co-designed integrated care pathway developed with the KW4 community. This pathway is intended to be an 'ideal future state' pathway. It is a starting point for continued Integrated Care Pathway development for KW4 OHT moving forward.

Youth Transitions to Adult Mental Health Services: Goals and Services

The goals of the integrated care pathway are listed below, alongside some services that were identified as highly relevant in KW4.

	Youth Transitions to Adult Mental Health Services
Goals	• Proactively anticipate and readily provide the services and supports that will be needed • Reduce stigma and create a supportive care environment for the individual • Reduce barriers to accessing care • Ensure that the individual has an ongoing connection to their care team • Create a community of support around the individual • Reduce any potential 'trauma' or 'anxiety' related to service transition • Ensure a smooth transition from youth to adult services • Increase awareness of care services available in the region • Ensure connection to appropriate social supports
Services that may integrate with this pathway in the future (this is not an exhaustive list)	• Here 24/7 (CMHA) • Front Door Program (Lutherwood) • Outpatient Mental Health (Grand River Hospital) • Walk-In Counselling (Camino) • Acquired Brain Injury in the Streets (Traverse)

Youth Transitions to Adult Mental Health Services

Intake and Triage

I T A CP CD

Note: Consider removing labels, and recognizing mental health needs regardless of age. Partner organizations will need to work together to ensure transitions are not disrupted by age-related eligibility criteria. Language translation service should be offered at all points of the process. Where possible, teams and providers should stay consistent; when not possible, warm handoffs should occur between providers.

1

Person is identified with changing mental health needs or concerns:

- Community Agencies
- Primary Care
- Hospital
- Youth Shelter
- School
- Child Protective Services
- Family Members/ Care Partners
- Newcomers (to Canada from abroad as well as those moving from other areas of Ontario/Canada)

2a Person is referred to centralized transition service

2b Person is referred to youth services

Does the person have a primary care provider?

YES

3a Centralized Transitions Service coordinates 'planning meeting'/'case conference' with current care team

NO

3b Centralized Transitions Service connects the person with appropriate care provider and/or team and coordinates a planning meeting

Youth Transitions to Adult Mental Health Services

Assessment and Care Planning

I | T | A | CP | CD

4. 'Planning meeting'/'case conference' occurs with the care team and education is provided

5. Identification of 'ideal' service transitions based on current and anticipated health and social care needs

6. Centralized Transitions Service conducts service coordination to determine availability

7. Centralized Transitions Service develops Transition Plan and shares with care team for input

8. Centralized Transitions Service and care team consults with client/family/ caregivers on Transition Plan and provides education on services, programs and guidance contained in Transition Plan and 'what to expect'

9. Transition Plan revised to ensure that it can be personalized based on input from client/family/ caregivers

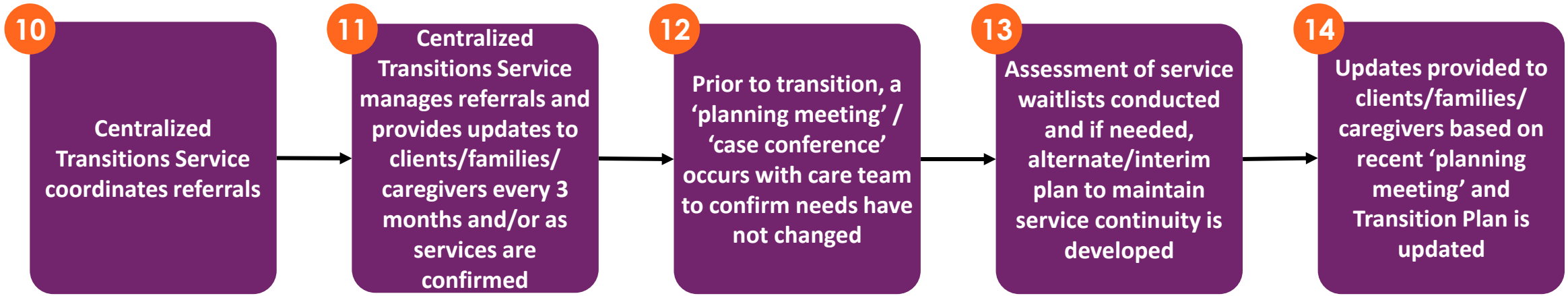
Potential services to be considered, for example:

Counselling	Psychiatry	Primary Care
Case Management	Wrap-around Supports	Peer Supports
Housing Supports	Family Support and Education	Transportation Supports
Recreational Therapy	Vocational/Employment	Life Skills

Youth Transitions to Adult Mental Health Services

Assessment and Care Planning (cont.)

I | T | A | CP | CD



Youth Transitions to Adult Mental Health Services

Care Delivery

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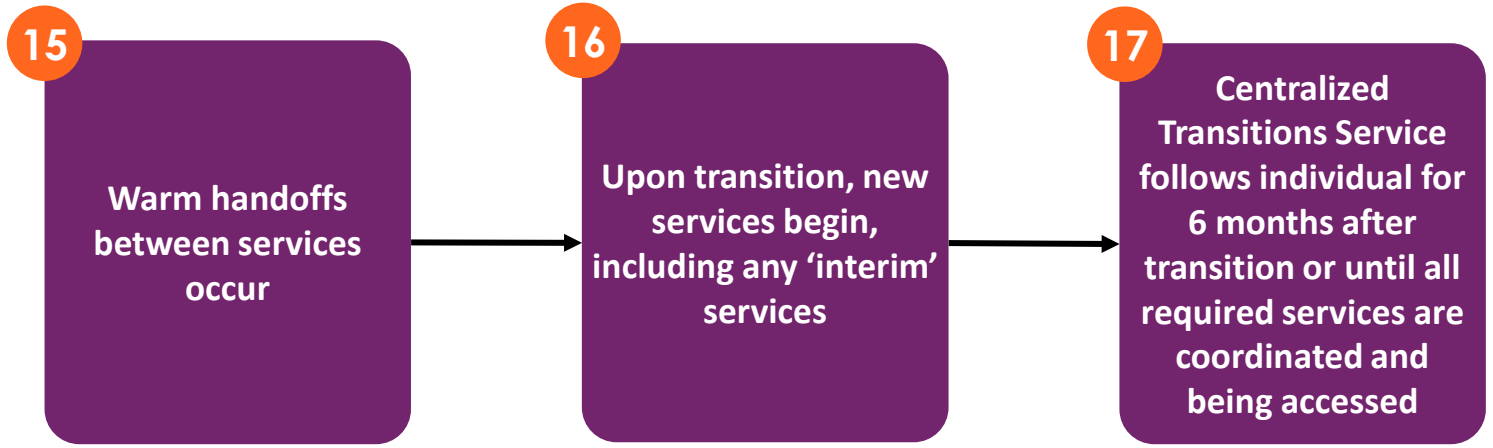

Newcomer with Diabetes

The following slides depict the co-designed integrated care pathway developed with the KW4 community. This pathway is intended to be an 'ideal future state' pathway. It is a starting point for continued Integrated Care Pathway development for KW4 OHT moving forward.

Newcomer with Diabetes: Goals and Services

The goals of the integrated care pathway are listed below, alongside some services that were identified as highly relevant in KW4

	Newcomer with Diabetes
Goals	• Increase knowledge of resources and services available in the KW4 region • Provide strong system navigation • Reduce unnecessary duplication of efforts between providers • Provide a multidisciplinary, team-based approach to care • Establish a clear point of contact for the patient • Provide culturally-sensitive care • Improve chronic disease management in the community • Reduce barriers to accessing care
Services that may integrate with this pathway in the future (this is not an exhaustive list)	• Diabetes Central Intake (Regional Coordination Centre) • Diabetes Program (Community Healthcaring Kitchener-Waterloo) • Refugee Health Integrated Care Program (Centre for Family Medicine) • Primary Health Care, Refugee Health, Community Health and Wellness (Community Healthcaring Kitchener-Waterloo) • Adult Diabetes Education Centre (Grand River Hospital)

Newcomer with Diabetes

Intake and Triage

I T A CP CD

1 **Person presents with diabetes and/or symptoms:**

- Primary Care
- Hospital
- Pharmacy
- Settlement Services
- Community Organization
- **Self-referral** (Waterloo Wellington Diabetes website self-referral form or Newcomer App – once created)

Note: Care provider in this case is refers to anyone with a billing number.

2 **Care provider addresses immediate care needs** (and introduces Newcomer App)

3a **Care provider completes referral to Diabetes Central Intake and, if required, completes a referral to specialist care**

4 **Central Intake Team processes the referral and collects relevant information**

5 **Central Intake Team triages the person based on level of urgency for care or requirements for education**

There are three sub-groups:

- **Urgent** (standard wait time 1-2 days)
- **Semi-Urgent** (standard wait time 7-14 days)
- **Non-Urgent** (standard wait time 14-28 days)

Note: Opportunities to provide education to pharmacy, settlement services, community organizations to support a newcomer to compete a self-referral/access additional resources. Opportunities to flag the newcomer's insurance status early when the referral is submitted.

3b **Person completes self-referral form. Referral form accessibility options:**

1. Newcomer App with direct link to Waterloo Wellington Diabetes self-referral form;
2. Waterloo Wellington Diabetes website self-referral form
3. Paper form printable through Waterloo Wellington Diabetes website

Self-referral form offered in a variety of languages for referral to care and/or to education

Note: Self-Referral forms completed online are supported by OCEAN eReferral and are seen by Central Intake referral clerk immediately (during normal business hours)

Newcomer with Diabetes

Assessment

I | T | A | CP | CD

6 Central Intake Team flow the referral to the most appropriate Diabetes Education Program (DEP) based on their needs and insurance status

7 The respective Diabetes Education Program (Hospital Diabetes Education Program or Community Diabetes Education Program) conducts a full assessment

8 Based on the assessment, the relevant Diabetes Education Program provides education

9a If the person has an existing PCP, the Diabetes Education Program will make recommendations to the PCP for further care. If a specialist is recommended, the PCP will submit a referral

9b If person is not attached to a primary care provider, attempts will be made to link the patient to a provider who will continue to collaborate with the Diabetes Education Program to provide care

10 Primary Care Provider completes assessments, reviews recommendations from the Diabetes Education Program and develops an individualized care plan in collaboration with the person and the Diabetes Education Program

Newcomers' insurance status may limit access to services:

- Short-term visa
- Long-term visa
- Government-assisted refugee
- Self-sponsored

Note: In order to see a specialist, a referral from primary care provider, emergency (hospital) or urgent care is required. Typically specialists involved in care include but are not limited to: endocrinologists, ophthalmologists, nephrologists, chiropodists.

Newcomer with Diabetes

Care Planning and Care Delivery

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11 Primary Care Provider , with support from the Diabetes Education Program connects the person with a Multidisciplinary Care Team and culturally competent supports

→

12 Multidisciplinary Care Team provides continuing culturally competent diabetes education and support with an emphasis on adopting healthy behaviours

→

13 Primary Care Provider and Diabetes Education Program ensures regular follow-up with the person to ensure their diabetes is managed appropriately

Potential providers to include in the care team, for example:

Registered Dietitian	Pharmacist	Counselling
Endocrinologist	Diabetes Educator	Transportation Supports
Multicultural Care Provider	Behavioural Change Specialist	Recreational Therapy
Language/Translation	Podiatrist	Peer Supports
	Wound Care	

Note: Opportunities for additional education to be provided to various service providers about culturally competent resources for newcomers with diabetes and various service options dependant on insurance status.
Opportunities to share additional information about the Waterloo Wellington regional self-management program.
Also, opportunity for translation services at each point of interaction.

→ 5

Recommended Next Steps

Recommended Next Steps

Optimus SBR has identified four recommended next steps for KW4 leadership to move the integrated care pathways forward towards implementation.

1

Share the Integrated Care Pathways with Key KW4 OHT Leadership Groups

- The KW4 Steering Committee and Leadership Action Committee should review and reflect on the integrated care pathways, and discuss opportunities to implement these in KW4, connecting them with existing work
- The care pathways should also be shared with the priority population working groups for further insights

2

Spread Awareness of the Integrated Care Pathways

- KW4 leadership should socialize the integrated care pathways with members
- KW4 leadership should connect with Cambridge North Dumfries OHT to share integrated care pathways and identify opportunities for integration where there may be shared populations between the two regions

3

Connect with Ontario Health

- Optimus SBR has scheduled a meeting for KW4 leadership to connect with Ontario Health. Key KW4 OHT leadership (supported by Optimus SBR) should share the integrated care pathways created and discuss upcoming funding opportunities
- KW4 should develop and submit a business case to Ontario Health for funding support to implement the pathways

4

Assemble a Team to Advance the Integrated Care Pathway Work

- KW4 should work with members to assemble a team for each integrated care pathway to write a funding application and support implementation