KW4 ONTARIO HEALTH TEAM

KITCHENER | WATERLOO | WELLESLEY | WILMOT | WOOLWICH

TRANSFORMING TOGETHER

2025/26
Annual Business Plan

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 develops 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 2025/26 have been identified in the annual business plan to measure and report on our progress. The KW4 OHT Operations Committee will review and monitor progress against the detailed process measures identified for each initiative and the Governance Table and Members will review and monitor overall performance using the following Performance Framework.

Indicator	Current Performance	2025/26 Target
Ontario Health OHT Performance Framework Validated Measures		
Admissions per 100 patients with heart failure (HF)	56.30	53.50
Admissions per 100 patients with chronic obstructive pulmonary disease (COPD)	25.10	23.90
Number of hospitalizations for ambulatory care sensitive conditions (ACSC)	26.20	24.90
Percentage of screen-eligible people who are up to date with breast cancer screening	54.50	57.20
Alternate level of care (% ALC days)	17.80	17.00
% of patients within the OHTs-attributed population who are attached to a primary care physician	87.10	TBD *
Additional Proposed Measures		
Frequent emergency department visits for mental health and addictions–related care	13.80	13.14
% of patients within the OHTs-attributed population who have access to team-based care	18.96	TBD *

* Target to be set once outcome of KW4 OHTs EOI proposals determined as part of the province's Primary Care Action Plan.

This detailed plan has been produced for the KW4 OHT Operations Committee, Steering Committee, Members and Member Boards to articulate the KW4 OHTs planned work, in collaboration with our partners, over the 2025-26 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 2025-26 related to these priorities and goals includes the following:

Notes:

*cQIP Indicator

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

Strategic Goal	Initiative	Performance Indicator/Milestone	2025/26 Target
Promote culture-based healthy lifestyles and preventative measures to empower individuals to make informed health decisions	In collaboration with Waterloo Wellington Regional Cancer Program and Primary Care, continue to increase public outreach and education regarding breast cancer screening through various channels and in various languages with a focus on our priority neighbourhoods. *	- # of local partners who shared public outreach material - # of in person and virtual events held in KW4 - # of attendees at outreach events in KW4	- 8 partners - 10 events with >50% in priority neighbourhoods - 600 attendees
	In collaboration with the Waterloo Wellington Regional Cancer Program and other partners, provide Primary Care Provider education regarding updated best practice for accessing mammograms in order to increase screening rates of their patients. *	- # of provider education events held educating providers on best practice for mammogram access - % of low screening providers who attended educational sessions - % of providers with KW Habilitation Aging in Place model trained in best practices for mammogram access.	- 4 educational events - 75% of low screening providers attend - 100% of providers involved with KW Habilitation Aging in Place trained.
Enhance community-based healthcare, beginning in priority neighbourhoods	Work with CAC members and grass roots community agencies that serve the priority neighbourhoods to determine how best to engage communities.	- # of engagements with grassroots agencies serving priority neighbourhoods and populations - # of initiatives that included community members (including CAC members) as part of the project co-design process for the priority neighbourhoods	- Conduct 5 engagement sessions with grassroots agencies related to OHT priorities - 75% of initiatives include at least one community member in the co design process

Strategic Goal	Initiative	Performance Indicator/Milestone	2025/26 Target
	In collaboration with the Waterloo Region MHA System Transformation Team and Primary Care consider the circumstances of individuals who are frequently visiting the ED for MHA, including a deeper dive in neighbourhoods that are disproportionally impacted, and implement strategies to address these gaps. *	- deep dive to consider the circumstances of individuals who are frequently visiting the ED for MHA conducted by FSA - % of chart reviews for patients with 10 or greater ED visits for MHA in a year - % of patients with greater than 10 visits who are asked to participate in longitudinal (cross sector) data sharing - % of patients that access ED via 911 response due to being unattached or lack of viable alternate care pathways	- deep dive complete - 80% of charts reviewed - 80% of patients asked - baseline to be collected through Paramedic Services data
	As part of the Pediatric Recovery Funding – Mental Health Supports for Black Children and Youth, facilitate increased access to community-based mental health/outreach supports, counselling services, youth/children's groups, crisis response, and service navigation and foster relationships to improve health equity in a culturally responsive and sensitive manner.	Indicators and milestones to be finalized once funding letter received from Ontario Health	TBD
	Enhance access to care for Black communities through the Seamless Care Optimizing Patient Experience (SCOPE) Black Health Plan Initiative by co-designing locally informed, culturally responsive care pathways with the Black community based on identified gaps.	- Total number of client interactions - Percent of clients reporting that the services provided are helpful to them - Total number of unique clients served - Total number of clients seen in wellness and mobile events - Total number of events held - Total number of locations - Total number of referrals by type (community agencies, hospitals, social services, etc.) - Quarterly updates identifying potential pressures or what clinicians are seeing in terms of notable gaps or areas of need [provider reported] - Racial groups served	- 48 client interactions - 80% clients reporting that the services provided are helpful to them - 48 unique clients served - N/A - 1 event held per quarter - N/A - 80% of referrals to be made by type - 1 gap or area of need identified per quarter, based on provider feedback - Black (e.g., African, Afro-Canadian, Afro-Caribbean, Afro-Egyptian etc.)

Strategic Goal	Initiative	Performance Indicator/Milestone	2025/26 Target
		- Percent of clients who find the services non-discriminating and culturally responsive	- 95% clients who find the services non-discriminating and culturally responsive
Reduce the incidence and impact of chronic diseases through evidence-based prevention, early detection, and effective management	Collaborate with Primary Care and Community Partners to connect more patients at risk of developing cardiovascular disease, COPD, and/or diabetes with a multidisciplinary team for education and coaching on healthy lifestyle interventions to reduce the risk, and to assist patients and care partners in being able to self-manage their disease, with a focus on priority neighbourhoods. *	- # of referrals to the SMGH Community Airways Clinic for Asthma and COPD - # of referrals to the CHC Rapid Respirology Clinic - # of asthma education/self-management appointments through SMGH contracted RRT services with University of Waterloo - # of referrals to the SMGH Integrated Comprehensive Care (ICC) program - # of referrals to the SMGH PREVENT Clinic - % of patients who feel that the PREVENT program has helped them lead healthier lives (using the quality-of-life QOL measure) - % of patients in the PREVENT program who feel empowered to make good decisions around their health, exercise routines or nutrition options - # of self-referrals to the Regional Coordination Centre diabetes education program - group convened to conduct a review of current wellness and chronic disease self-management offerings, and to explore opportunities to more effectively and efficiently use our collective resources to expand our reach - # of local community organizations Public Health provides COPD referral information to for distribution to diverse communities through peer health workers - SCOPE pathway developed for existing COPD, CHF, and Diabetes services - # of primary care providers benefitting from the free eHealthCe change management support for the implementation of the EMR-integrated COPD management tool	- 10% increase - 10% increase - 10% increase - 10% increase - 10% increase - > 90% of patients - > 90% of patients - 10% increase - group convened, review conducted - 14 organizations - SCOPE pathways developed - 5% of primary care providers (pending refresh happening provincially and dependent on funding) - > 10 partners - ongoing use of interRAI tools

Strategic Goal	Initiative	Performance Indicator/Milestone	2025/26 Target
		- # of partners who distribute and post educational information - OH atHome will continue to support connecting at risk patients through the standard use of the interRAI suite of tools	
	Collaborate with Primary Care and Community partners to identify older adults with complexity that require coordinated care planning to prevent hospitalization and reduce ALC risk through early intervention and community support management. *	<u>Hospital</u> - % of older adults, 70+ visiting the ED with a completed AUA screening - % of high-risk older adults referred to GEM nurse/team - % of patients inked to appropriate community resources <u>ICT for Older Adults</u> - % of patients/care partners who indicate the ICT made them more confident in managing their health <u>LEGHO</u> - # of patients diverted safely back to the community with support initiated. <u>DREAM</u> - # of clients diverted safely home with respite and other supports initiated <u>CHC</u> - # of times social prescribing used to reduce isolation <u>Naturally Occurring Retirement Communities (NORC) in Waterloo</u> - # of time education is provided - # of NORC ambassadors in place - # of times service navigation is provided - increase in one's perceived ability to age at home - increased sense of belonging and connection to the community <u>KW Seniors Day Program</u>	<u>Hospital</u> - targets to be finalized <u>ICT for Older Adults</u> - >85% <u>LEGHO</u> - 350 patients (based on base funding) <u>DREAM</u> - 100 clients per hospital/per year will be diverted safely home <u>CHC</u> -collecting baseline <u>Naturally Occurring Retirement Communities (NORC) in Waterloo</u> - 5-7 times - 3 ambassadors - 45 times - 80% agree or strongly agree - 80% agree or strongly agree <u>KW Seniors Day Program</u> - capacity planning on bi-weekly basis. <u>Alzheimer's Society</u> - 250 older adults per hospital/per year. <u>Ontario Health atHome</u> - Ongoing use of the ED and admission avoidance protocol. <u>KW Habilitation</u> - Annual screening of anyone over the age of 40.

Strategic Goal	Initiative	Performance Indicator/Milestone	2025/26 Target
		- regular sharing of capacity planning data to Ontario Health atHome to ensure day program spaces are allocated effectively and efficiently. <u>Alzheimer's Society</u> - % of times timely access to counselling, system navigation and other support provided in relation to DREAM and ALC. <u>Ontario Health atHome</u> - Ongoing use of the ED and admission avoidance protocol developed by OH atHome to support discharge from the ED and ED avoidance. <u>KW Habilitation</u> - Ongoing use of the NTG-Early Detection Screen for Dementia (NTG-EDSD) tool for the early detection screening of adults with an intellectual disability who are suspected of or may be showing early signs of mild cognitive impairment or dementia.	
Collaborate with community organizations to address local social determinants of health challenges (i.e., housing/shelter, food insecurity, etc.)	In collaboration with the Waterloo Region MHA System Transformation Team support the creation of Hart Hub model, ensuring services connect into the broader system of services while also exploring different access points for the most vulnerable in our community. *	- governance structure established including a Strategy and Accountability Table, an Implementation Table, a Living and Lived Experience Table, and a Community Advisory Table - positions to support the HART Hub's initial launch posted - Scaled start-up initiated - # of partners providing service - # of referral pathways developed - # of clients served in 2025/26 - Submit proposal to become an approved Alternate Destination Clinic (ADC) for Paramedic Services 911 patients and include Paramedic Treat and Refer to system partners as part of the work.	- Tables/ Committee established by Spring 2025 - all positions filled - Initial start-up on April 1, 2025 - > 12 partners providing service - core pathway developed by April 1, 2025 - X clients - Review and analyze 911 patients that could be considered for ADC or Paramedic Treat and Refer and submit proposal

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

Strategic Goal	Initiative	Performance Indicator/Milestone	2025/26 Target
Improve access to primary care and team-based models of care	As part of Ontario's 'Connect Every Person in Ontario to a Family Doctor and Primary Care Teams' initiative, work with the KW4 OHT Primary Care Network to develop a proposal(s) for our area to connect more people to comprehensive, convenient, and connected care through a publicly funded family doctor or primary care team.	Number of proposals submitted	A minimum of 1 proposal submitted
	Support the Refugee Health Integrated Care Team in continuing to attach refugee patients with team-based primary care while evaluation and sustainability plans are developed.	Evaluation complete Sustainability plan developed Successful transition to operations	Evaluation complete Sustainability plan developed Successful transition to operations
	Support the two successful KW4 OHT Expanding and Enhancing Interprofessional Primary Care Team Implementation Plans (Woolwich CHC and WRNPLC)	- # of new incremental patients attached - # of new incremental patients who have access to a team	Targets to be finalized once direction from Ontario Health is received
	Collaborate with Partners to ensure more patients hospitalized or treated in the emergency department for heart failure, COPD, and/or diabetes receive a follow-up appointment with a health care provider within 7 days of leaving the hospital. *	- OH atHome will continue to collaborate with GRH/SMGH to support coordinating appointments prior to discharge with multidisciplinary team. - % of appointments coordinated prior to hospital discharge - # of referrals for unattached patients to the RAP Clinic - # of referrals to the KW4 OHT Older Adult Integrated Care Team (ICT) from ER and community - # of providers offering online appointment booking (OAB)	- support for coordinating appointments - > 50% - 10% increase, dependent on funding - 10% increase, pending funding - 5% increase (dependent on funding) - at least 1 proposal submitted - 5% improvement - 5% improvement - Community Paramedicine targets to be determined

Strategic Goal	Initiative	Performance Indicator/Milestone	2025/26 Target
		- submit Primary Care Action Plan proposals to expand access to team-based primary care in KW4 - 7-day follow-ups after being discharged home following an ED visit 7-day follow-ups after being discharged home following an inpatient hospital stay - # of referral to the Community Paramedicine program for medically complex clients with COPD, CHF, Diabetes in community. - # of clients with COPD, CHF, Diabetes receiving Community Paramedicine program support - # of clients with COPD, CHF, Diabetes supported with remote patient monitoring.	
	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 unique patients served per month 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	Targets will be finalized when funding is confirmed Targets for 24/25 were: - 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 supported - # of patients diverted safely back to the community with supports initiated - # of rides provided - # of meals provided - # of direct contacts for service coordination	Targets are based on base funding - 350 patients - 350 patients - 1,050 rides - 4,900 meals - 2,100 contacts
	Continue to expand the reach of the SCOPE (Seamless Care Optimizing the Patient Experience) program, connecting primary care providers with a nurse navigator to connect patients to	- # of calls/month - # of new pathways/services added - # of marketing/engagement opportunities - # to PCPs utilizing service - PCP satisfaction - % of ED visits diverted	- 75 calls/month - 2 new pathways/services added - 6 marketing/ engagement opportunities completed - 250 PCPs utilizing service - 85% PCPs satisfied

Strategic Goal	Initiative	Performance Indicator/Milestone	2025/26 Target
	appropriate community resources in a timely way.		- 95% ED visits diverted
Streamline processes and address bottlenecks to reduce wait time for services	Work with the KW4 OHT Primary Care Network to develop a business case for the creation and implementation of an OBGYN central intake model.	Business Case Developed	Business Case Developed Feasibility evaluated and Decision made to proceed or not.
Support the ongoing implementation of online appointment booking, electronic referrals and centralized intake	Pending funding, support the ongoing implementation and use 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	-120 providers offering OAB - 90% of patients satisfied with OAB - 83% of providers satisfied with OAB - 130,00 patients with access to book appointments online
	Support phase 1 of Patients Before Paperwork (PB4P) focused on improving utilization of digital health tools such as eReferral and the Ontario Laboratories Information System (OLIS).	Awaiting provincial and regional guidance. Proposed draft measure below. - % active use rate of senders on eReferral	Awaiting provincial and regional guidance. Proposed draft target below. - Maintain 55% active use rate of senders on eReferral

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

Strategic Goal	Initiative	Performance Indicator/Milestone	2025/26 Target
Build and foster creative partnerships that enable integrated care and system excellence	Support the expansion of the Community Support Service Navigation Team at the Boardwalk.	- # of providers/FHO participating - # of clients connected to services - Client satisfaction - Provider satisfaction	Targets to be set post expansion decision. Target in 24/25: 100% of FHO providers in The Boardwalk participating.
Spearhead the development of new and innovative approaches to	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	- Ethics review - Structured interviews and focus groups held with LTC providers and older adults - Iterative design process for the social robot	- Ethics review completed, and approval obtained - Interviews and focus groups conducted

Strategic Goal	Initiative	Performance Indicator/Milestone	2025/26 Target
care delivery, using a system thinking approach and leveraging local partnerships	through co-design with Older Adults and other stakeholders.		- Initial design guidelines from interviews and focus group developed - Final design guidelines with the functionalities of the robot outlined
Implement new innovative models of integrated home care	Continue with programs that support the transition from hospital to home to improve patient flow and to help adults who no longer require hospital care to continue their recovery, healing, and rehabilitation at home. *	- # of patients participating in the Hospital to Home program - time to SPO service initiation for the H2H program - re-admission/ED visit rate for those in the H2H program - % of ALC leading practices implemented by hospitals - expansion of Hospital to Home program to include Mental Health - Aging in Place program established at KW Habilitation - OH atHome Care Coordination will continue to be part of the multi-disciplinary team who develops care plans for discharge home and will continue to collaborate on determining the most appropriate programs that will support safe discharge. - Paramedic Services / Community Paramedicine support for discharge planning / ER Rounds, home visits and remote patient monitoring to keep patients safely at home post discharge - # of patients diverted back to the community through the Home At Last program - # of patients supported through Home At Last service coordination	-20 patients/ month - same day - less then 12% - program expanded to include MH - Aging in Place program established - Development of care plans - support from Paramedic Services - 220 patients diverted back to the community through the Home At Last program - 220 patients supported through Home At Last service coordination
Grow the number of integrated care model initiatives	Continue to support the implementation of the Palliative Care Health Service Delivery Framework: a Model of Care to Improve Palliative Care in Ontario (Adults Receiving Care in Community Settings) by	- # of Community Organization Assessment Tool (COATS) completed - # of health care providers participating in Pallium education	Tentative Targets - 5 COATs completed - 12 health care providers participating in Pallium education

Strategic Goal	Initiative	Performance Indicator/Milestone	2025/26 Target
where the OHT/PCN is the central administrator of funds on behalf of our Members.	supporting care providers in gaining comfort and skills in primary-level palliative care.	- # of health care providers who have completed the palliative care competency assessment by clinical setting - # of health care providers trained (i.e., case-based education or mentoring sessions) by clinical coaches by clinical settings (Community Organizations, Long-Term Care Homes, Indigenous Organizations)	- 27 health care providers who have completed the palliative care competency assessment by clinical setting - 25 health care providers trained by clinical coaches by clinical setting

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 2025-26 related to these pillars includes the following:

Governance

Initiative	Performance Indicator/Milestone	2025/26 Target
Strengthen our leadership capacity to drive collaborative success.	CDMA Review Policies Developed	Complete CDMA Review Policies developed and approved to guide good governance
Support the Primary Care Network Board of Director Governance	Policy Manual Development Set-up of financial accounts Annual General Meeting Governance Education and Training	- Policy manual completed and approved by the Board - First Annual General Meeting held Q1 for 24/25 - Governance Education and Training Session held in Q2
Maintain operational support provider (OSP) arrangement for back-office functions in support of OHT activities	Ongoing discussions with GRH as merger with SMGH evolves.	TBD
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	- 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.)

Initiative	Performance Indicator/Milestone	2025/26 Target
	- 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	
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, 2026 - Publish 3 Primary Care newsletters by March 31, 2026 - Publish 3 Specialist newsletters by March 31, 2026 - Increase subscribers for both PC and Specialist newsletters by 15% by March 31, 2026

Tools

Initiative	Performance Indicator/Milestone	2025/26 Target
Continue to expand awareness of My Connected Care.	- # of departments that order communications materials - # of times communication was sent to hospital staff to increase awareness	Data, including baseline, to be collected and reported in 2025/2026.
Using the OHT Performance Framework as a guide, develop a balanced scorecard for KW4 OHT, and measure and report on OHT performance.	- Scorecard developed	Quarterly reporting conducted

Talented People

Initiative	Performance Indicator/Milestone	2025/26 Target
In collaboration with project partners, support the implementation and evaluation of AI scribe in primary to help address administrative burden and burnout and improve primary care satisfaction.	- # of providers that implement AI Scribe in KW4 OHT - % of providers who report a decrease in overall stress/burnout when using AI Scribes -% of providers overall satisfaction with clinical encounters when using AI Scribes	Data, including baseline, to be collected and reported in 2025/2026. Targets to be determined. Proposed draft targets below: - 40 providers implement AI Scribe in KW4 OHT - 60% reduction in overall stress/burnout when using AI Scribes

Initiative	Performance Indicator/Milestone	2025/26 Target
		- 55% of providers satisfied with clinical encounters when using AI Scribes
Develop a KW4 OHT Primary Care Network Member peer-led education series to empower primary care with the knowledge to streamline processes, reduce administration burden., and enhance the provider experience.	# of participants % of participants who felt the session was valuable % of participants who felt the session was beneficial to their practice # of non PCN members who sign up to be PCN members after participating in an event # of downloads	40% of total membership participation Increase of participation by 10% from one session to the next > 80% of participants feeling the session was valuable > 80% of participants feeling the session was valuable to their practice 20% of non-members who attended the session sign-up for PCN membership 30% of attendees subsequently download resources. > 80% of members feel a greater sense of support and connection. > 80% of members feel the education sessions have assisted in improving care.
Under the guidance of Ontario Health and the 'Integrated Capacity and Health Human Resources Plan for Ontario' begin to analyze current and anticipated regional gaps in the health human resources.	Continue to monitor and support local and regional Health Human Resource planning dependent on funding availability	Annual meeting with Director Health Care and Physician Recruitment, Greater Kitchener Waterloo Chamber of Commerce to discuss potential opportunities for OHT support

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	2025/26 Target
Support the Community Advisory Council (CAC) to achieve engagement goals outlined in the OHT Engagement Capable Framework	- # of engagement activities conducted by the CAC in collaboration with clients, patients, families, care partners, and the community	- 12 engagement/co design sessions with CAC involvement per annum

Initiative	Performance Indicator/ Milestone	2025/26 Target
In collaboration with GRH provide access to DEIA courses as the first step in strengthening community engagement with specific groups including Indigenous groups and the Black community.	- # of community members, including CAC members, community agency leadership and their board members who complete DEIA courses	- 75% of CAC members complete at least 1 course - 60% of OHT member organizations have at least 1 or more staff person complete at least 1 course

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	2025/26 Target
Continue to expand 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	- Demographic and health outcome data by neighbourhood is refreshed on a semi-annual basis
Participate in a hospital-led initiative to standardize the collection of standard socio-demographic data to inform care and service delivery through data analysis.	Completion of sociodemographic data collection at GRH and SMGH starting with baselined data collection for identified priority areas	100% of priority areas identified in hospitals 80% completion of consenting patient surveys in priority areas