KW4 OHT Strategic Plan
Meeting #1 with Members and Invited Guests

Results Summary

December 7, 2023
5:00-8:00 p.m.
RIM Park, Manulife Financial Sportsplex Centre, Waterloo

Project Overview

KW4 OHT is currently developing its first-ever strategic plan to guide its work and decision-making over the next five years. To inform the process, KW4 OHT has undertaken a number of foundational steps, including PESTEL and SWOT analyses, a community survey, and discussions with funders, resulting in an early draft of strategic priorities.

KW4 OHT has engaged Dr. Rebecca Sutherns of Sage Solutions to facilitate three engagement sessions with members to gather input on the emerging strategy.

Approximately 75 members and invited guests attended the first facilitated session (refer to Appendix A (page 9) for a list of attendees). The purpose was to build awareness about system-level planning, increase understanding of the evolving role of the OHTs in the health eco system and identify initial strategic priorities for implementing the OHT mandate throughout KW4 over the next five years.

Opening presentations included a project overview from Ashnoor Rahim, KW4 OHT Executive Director, followed by additional context and an updated case for support by Steering Committee Co-Chairs Ron Gagnon and Cathy Harrington. Slides from these presentations can be found in Appendix B (pages 10-54).

Participant Feedback

Rebecca led the group through a series of questions where participants had brief table discussions then provided individual input using Mentimeter on the draft

strategic priorities and goals (see Appendix B pages 48-51). Full results from Mentimeter are captured in Appendix C (pages 55-82) and a summary of feedback is provided below.

Feedback on Draft Strategic Priorities

- There was strong member alignment about local needs (scoring averages of 8.0-8.5 out of 10) and with the strategic priorities of member organizations (7.7-8.7 out of 10); the fourth priority (Enhanced OHT governance model and processes) scored an average of 6.4/10 on both of those questions.

Draft Priority	Aligned with local needs	Aligned with organizational needs
1. Improve system navigation in support of a coordinated and collaborative integrated care system	8.5	8.7
2. Improve delivering of proactive, evidence-based care through early detection/intervention, with an ongoing focus on quality improvement and evaluation	8.0	7.7
3. Implement enhanced approaches to partnering with patients, families, and caregivers to ensure meaningful engagement and system co-design principles	8.3	8.5
4. Develop and implement an enhanced governance model and processes	6.4	6.4

- Regarding what additional priorities people would want to add, the theme of providing more integrated care and services and improving collaboration and coordination between organizations figured prominently in 18 responses of the roughly 55 participants answering. Throughout the responses, the need for better access to primary care emerged as a strong, necessary priority.
- Other suggestions for additional priorities (that generated 5 to 8 responses each) included:
    - Mental health and addictions supports
    - Adequate, sustainable and integrated funding

- Better access to primary care
- Access to interpretation/translation services
- Addressing health human resources (equity, retention, optimization)
- Digitally-enabled healthcare
- Health equity

Feedback on Draft Goals

Participants also shared their feedback on the draft goals within each priority, noting where KW4 OHT should focus its attention and where to start.

Participant feedback indicated that some of the draft priorities were more foundational or operational elements rather than a strategic priority (i.e. governance, technology) and should be considered as strategic enablers instead. Participants felt that the priorities should be focused on the patient/client.

There was also strong support for making them clearer and more succinct (i.e. more plain language and less wordy).

1. Improve system navigation in support of a coordinated and collaborative integrated care system.

Within the goals for **system navigation**, members feel that most attention should be focused on **Goal 1.3: Implement supports for unattached patients**, which scored roughly double Goal 1.1 (models of integrated home care) and Goal 1.4 (patient access to health information), with Goal 1.2 (standardized patient navigation system) generating the least support. In response to where to start, participants ranked these goals in the same order and roughly with the same proportions, with Goal 1.1 increasing relative to 1.2 somewhat.

Draft Goals	Where to focus (% of points)	Where to start (rank)
1.1 Develop, implement and expand on new innovative models of integrated home care planning and prepare for the eventual delivery of home care	25%	2nd

Draft Goals	Where to focus (% of points)	Where to start (rank)
1.2 Implement a standardized patient navigation solution that integrates with Health 811 and Provincial Health Service Directory (PHSD)	14%	4th
1.3 Implement supports for unattached patients	41%	1st
1.4 Implement solutions to ensure patients can access their own health information, including digitally	21%	3rd

Participants then provided specific suggestions for improving the goals, including which ones to add or remove. One repeated theme was to remove goals that are dependent on, or the responsibility of, the province. Others included a stronger emphasis on integrated care pathways, team-based primary care and shared electronic medical records.

2. *Improve delivery of proactive, evidence-based care through early detection/intervention, with an ongoing focus on quality improvement and evaluation.*

Within the goals for **early detection/intervention**, **Goal 2.2 (integrated clinical pathways in mental health and addictions and palliative and end-of-life care)** is where members want KW4 to focus and start. This was followed by Goal 2.3 (initiatives and solutions tailored to unique populations) and Goal 2.1 (integrated clinical pathways for four conditions) at roughly two thirds the level of 2.2. Goals 2.4 (population health interventions) and 2.5 (digital health solutions) were seen as least critical.

Draft Goals	Where to focus (% of points)	Where to start (rank)
2.1 Implement integrated clinical pathways for four conditions including congestive hear failure, diabetes, chronic obstructive pulmonary disease, and stroke	21%	2nd

Draft Goals	Where to focus (% of points)	Where to start (rank)
2.2 Subsequently, implement integrated clinical pathways in the areas of mental health and addictions and palliative and end-of-life care	30%	1st
2.3 Advance local initiatives and solutions tailored to KW4 OHT's unique populations to enhance care planning, care delivery and outcome	23%	3rd
2.4 Design and implement population health interventions across the continuum of care for additional target populations in KW4 to achieve better patient and population outcomes	14%	4th
2.5 Use digital health solutions to support effective health care delivery, ongoing quality and performance improvements, and better patient experience	12%	5th

Several participants suggested combining goals 2.1 and 2.2, and others found 2.3 and 2.4 quite unclear. Some thought 2.5 should be removed.

Ten people suggested including prevention in these goals, with an emphasis on proactivity and upstream interventions.

A variety of other specific suggestions were made, including specific diseases (e.g. cancer, dementia) and populations (e.g. homeless, refugees) to add.

3. Implement enhanced approaches to partnering with patients, families, and caregivers to ensure meaningful engagement and system co-design principles.

The votes for where to focus and start within the two goals for **partnering with patients and carers**, were split fairly closely with **Goal 3.1 (implementation of the patient, family and caregiver strategy)** receiving 55% of the "focus points" followed by Goal 3.2 (population health management and equity plan) at 45%.

Draft Goals	Where to focus (% of points)	Where to start (rank)
3.1 Continue implementation of the Patient, Family and Caregiver Strategy	55%	1st
3.2 Further develop and implement a Population Health Management and Equity plan	45%	2nd

Repeated suggestions for improvement included a stronger emphasis on vulnerable groups that may or may not be represented by PFAC groups, a significant need for greater detail in this section, and a possibility of removing both goals since they are seen either as tactics or ways of working.

4. Develop and implement an enhanced governance model and processes.

Within the goals for **governance**, members want KW4 to focus on and start with **Goal 4.2 (establish a primary care network)**, followed by Goal 4.1 (create a not-for-profit), Goal 4.3 (implementation plan for an operational support provider) and Goal 4.4 (OHT designation) at significantly lower levels.

Draft Goals	Where to focus (% of points)	Where to start (rank)
4.1 Create a not-for-profit organization for the purpose of managing and coordinating OHT activities to support integrated clinical and fiscal accountability	21%	2nd
4.2 Establish a primary care network (a clinical network of primary care clinicians within an OHT working together in new ways to support provincial and local primary care priorities, providers and the care of patients)	48%	1st
4.3 Select and execute on an implementation plan for an operational support provider that will provide certain back-office functions in support of OHT activities on an ongoing basis including communications, project management,	16%	3rd

Draft Goals	Where to focus (% of points)	Where to start (rank)
procurement and contract management, financial management, decision support, and analytics.		
4.4 Work towards OHT designation under the Connecting Care Act 2019	14%	4th

Suggestions for improvement indicated a sense that these goals are too operational overall (i.e. "should be left to lawyers"), and that 4.4. will be an outcome of having achieved the other three.

Taken together, how well do these priorities and goals…

Members were then asked to rank their level of agreement for the four statements below, using a scale of 1-5 with 1 being strongly disagree and 5 being strongly agree.

Note: Participants clarified that the low score related to capacity reflects a feeling that there are too many goals, reflecting too much to accomplish.

Next Steps

The KW4 OHT strategic planning team will continue to gather input from members through smaller group discussions in between the strategic planning workshops that will help to refine the strategy further. Specific topics requiring further discussion will be the focus of the second in-person planning workshop on January 29, 2024.The final plan will be shared with members at a digital meeting in March, with a discussion of performance measures, before its approval (April) and roll-out in May.

Appendix A

KW4 OHT Strategic Plan
Meeting #1 Attendees

Amanda Demmer
Ann Bilodeau
Brian May
Catherine Burns
Cathy Harrington
Corey Neumeister
Deanne Gillies
Diane Dalbello
Mayor McCabe
Elliott McMillan
Fauzia Baig
Greg Barratt
Dr. Hsiu-Li Wang
Ian Kaufman
Janet Redman
Janine Barry
Jenn Metzloff
Jennifer Yessis
Jennifer Breatson
Jenny Flagler-George
Dr. Joe Lee
John Neufeld
John Riches
John Colangeli
Judy Nairn
Dr. Karen Cameron
Karen Hobbs
Karyn Lumsden
Kathy Payette
Kristina Eliashevsky
Leanne Terry
Lee-Ann Murray
Linda Kenny
Linda Brooks
Lori Palubeski
Meredith Gardiner
Michelle Martin
Mike Harris
Mike Hribar
Mike Martin
Mohamed Alarkhia
Paul Singh
Patricia Beretta
Dr. Peter Potts
Rhonda Nicholls
Ron Gagnon
Sandra Hanmer
Sarah Farwell
Selena Hazlitt
Stephen Gross
Steve Keczem
Tanya Verburg
Stephanie Mancini
Tara Bedard
Thepikaa Varatharajan
Tim Jackson
Tim Louis
Toby Harris
Wajma Attayi
Will Pace

OHT Staff: Ashnoor Rahim, Brenda Vollmer, Nicole Naccarato, Rebecca Petricevic, Ronke Saba

Sage Solutions: Rebecca Sutherns, Laurie Watson

KW4 OHT Strategic Planning Event

December 7, 2023

Land Acknowledgement

We gather today virtually from many parts of what is now called Waterloo Region. Traditionally this area was a gathering place for many nations. I acknowledge that our meeting today is situated on the Haldimand Tract, land that was promised to the Haudenosaunee of the Six Nations of the Grand River, and is within the traditional territory of the Neutral, Anishinaabeg, and Haudenosaunee peoples. We are grateful for the opportunity to live, meet, and work on this territory. We reflect on the principles of reconciliation and strive to incorporate them into our work.

December 6

National Day of Remembrance and Action on Violence Against Women

Welcoming and Opening Remarks

KW4 ONTARIO HEALTH TEAM

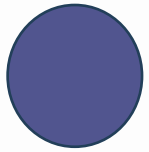
Today’s Agenda

- Welcome and Opening Remarks
- Context Setting, Updated OHT Case for Support
- Initial Feedback on the Draft Strategic Priorities
- Break
- Refinement of Priorities and Clarification of Expectations within KW4
- Closing Remarks and Next Steps

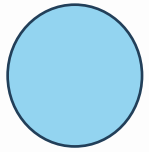
Strategic Planning Working Group

Name	Organization
Aaron Willmott	Traverse Independence
Ann Bilodeau	KW Habilitation
Ashnoor Rahim	KW4 OHT
Bonnie Camm	Grand River Hospital
Brenda Vollmer	KW4 OHT
Cathy Harrington (chair)	Community Care Concepts
Elliott McMillan	Grand River Hospital
Helen Fishburn	CMHA WW
Jenny Flagler-George	University of Waterloo
Kathy Payette	Community Member, CCDC
Leanne Terry	Waterloo Region Nurse Practitioner Led Clinic
Lee-Ann Murray	Home & Community Care Support Services WW
Neil Naik	Primary Care
Sarah Farwell	St. Mary's General Hospital
Steve Keczem	Patient and Family Advisory
Tara Groves Taylor	Community Healthcaring KW
Wajma Attayi	Centre for Family Medicine
Will Pace	Community Support Connections
Supports	
Suellen Robertson	KW4 OHT
Nicole Naccarato	KW4 OHT

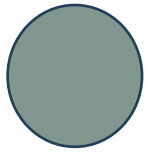
Approach To Our Discussion- The OHT is all of us



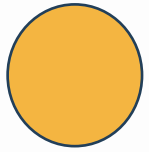
State views and ask questions



Use specific examples and agree on what important words mean



Explain reasoning and intent



Focus on interests, not positions

Jointly design next steps

Discuss undiscussable issues

Harvard Business Review 2016

Context Setting

KW4
ONTARIO HEALTH TEAM

What are we hoping to achieve today?

- Clarify where we have choice and where we do not
- Establish if Members contributions should be used to support OH priorities and/or more hyper-local priorities that may or may not align with OH priorities
- Determine areas of focus as they relate to OH priorities (i.e., what should we focus on in year 1 vs. 2), based on work already underway
- Confirm that the OHT priorities selected by this group should ideally be included in individual organizational strategic priorities and goals

The Ontario Health Team Model

- Introduced in 2019, Ontario Health Teams (OHTs) are a model of integrated care delivery where **groups of health care providers and organizations work together as a team to deliver a full and coordinated continuum of care for patients**, even if they are not in the same organization or physical location.
    - At a minimum, OHTs must have hospital, home and community care, and primary care partners.
- The goal is to provide better, more integrated care across the province.
- Ontario Health is a partner in OHT planning, implementation, and oversight.

OHTs Integrate Care Around Patients

Organizations and providers work together as an OHT, with patients as partners to ensure integrated and coordinated care.

Ontario Health Priorities

KW4
ONTARIO HEALTH TEAM

Ministry/Ontario Health Priorities

Strategic Priorities

Reduce health inequities

Improving care with and for those who need it most;

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

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

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

Transform care with the person at the centre

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

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

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

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

Enhance clinical care and service excellence

Putting the holistic health and wellbeing of people in Ontario first in everything we do;

Advancing positive health outcomes for all; and,

Improving experiences across the health care system.

Maximize system value by applying evidence

Strengthening the capacity to collect, share, integrate, analyze and react to data and evidence; and,

Achieving the best possible quality and value for public investments.

Strengthen Ontario Health's ability to lead

Building a strong organizational culture that unifies and empowers Ontario Health team members across the province;

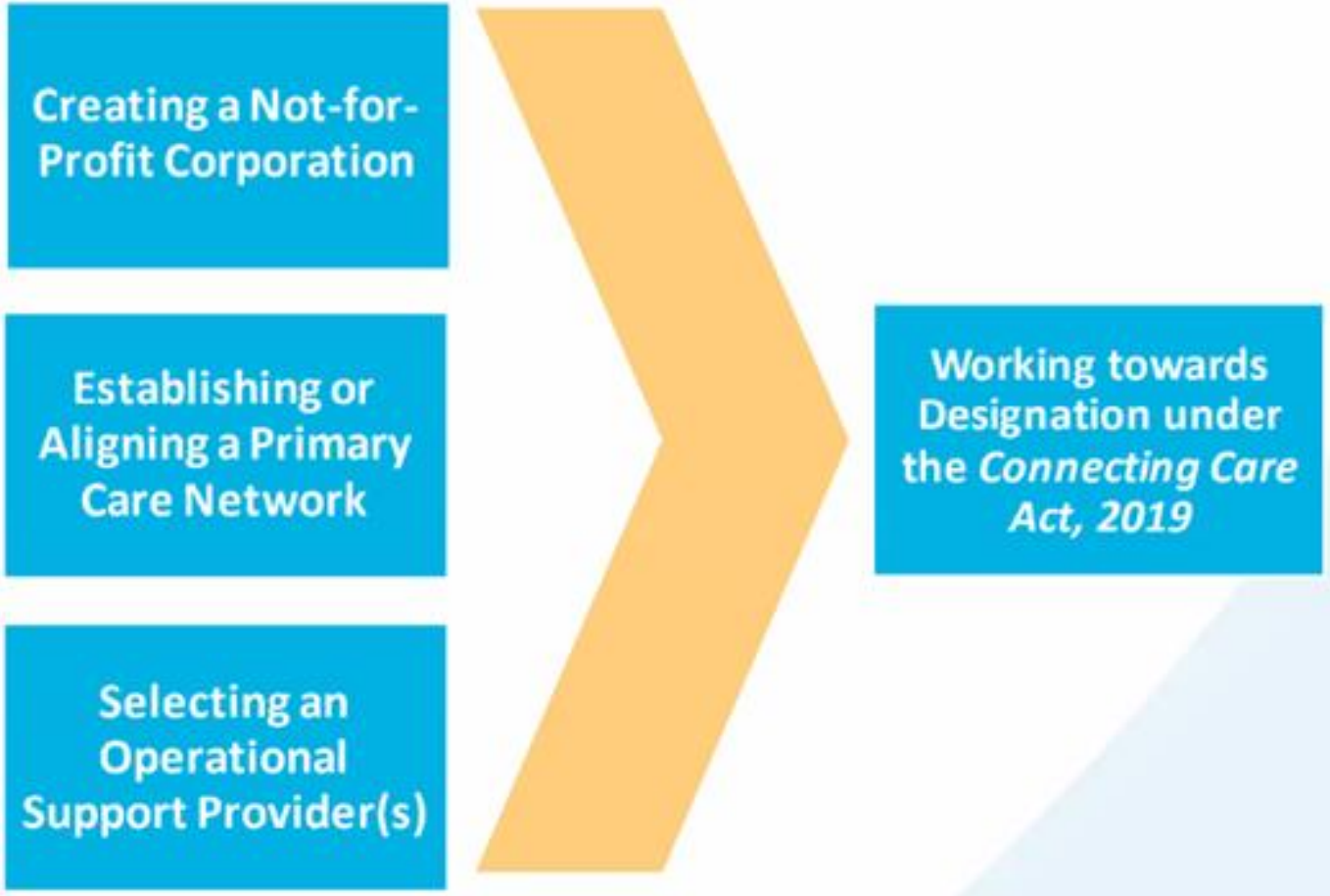
Investing in our people and committing to our own continuous improvement;

Continuing to establish ourselves as a reliable leader and partner;

Challenging the status quo and embracing transformation in order to continuously strengthen our organization and the health system;

Leading by example both locally and provincially, with all of our teams providing valued contributions.

Building OHTs to Last



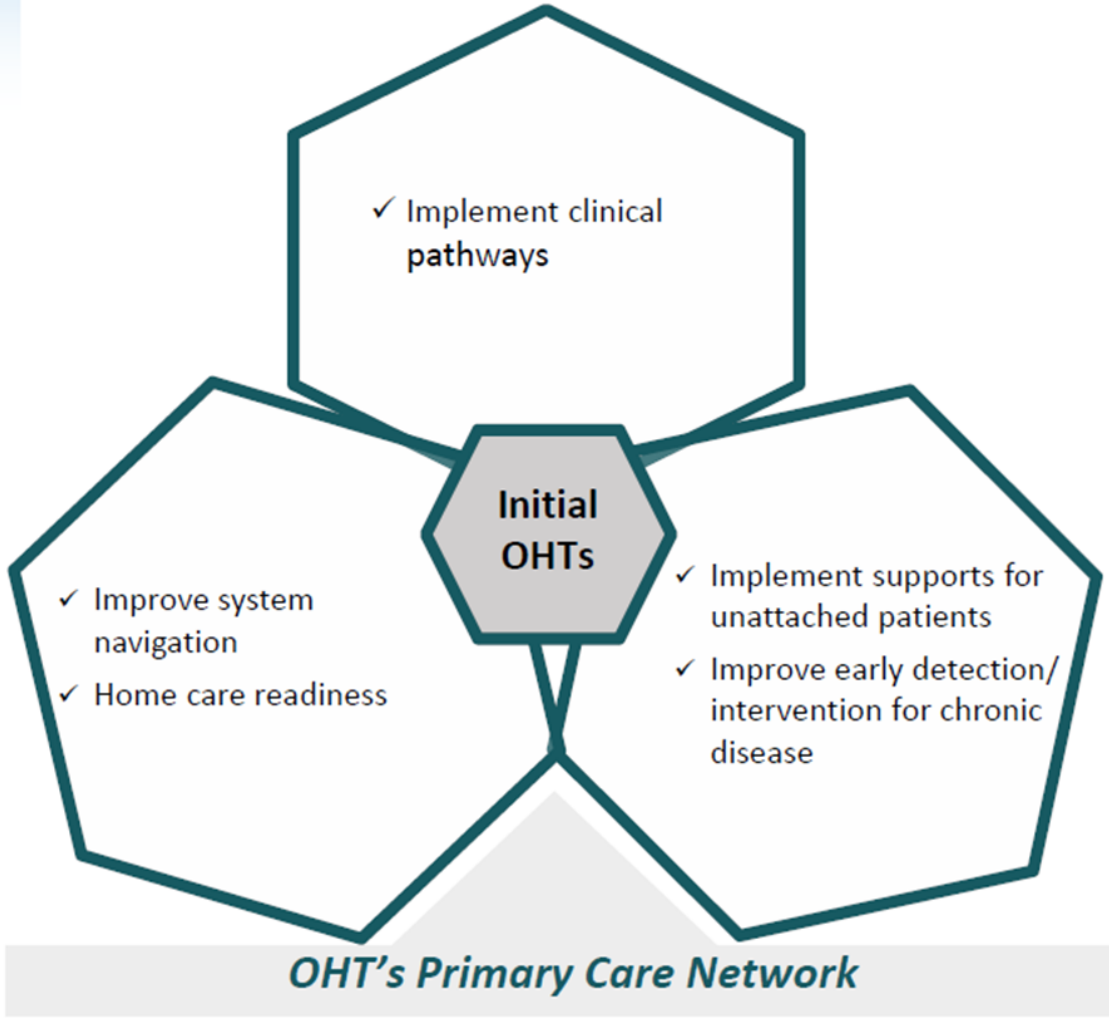
Under the CCA, a designated OHT is eligible to receive an integrated funding envelop and enter into an accountability agreement with Ontario Health.

Work ahead:

- In early 2024, the ministry will consult with stakeholders and OHTs to inform designation requirements to be established in a future regulation under the CCA.
- This regulation will, if approved, outline the requirements that an OHT would need to meet to permit a designation by the Minister of Health.
- The first OHTs will be considered for potential designation starting in December 2024.

Improving Patient Outcomes through OHTs

Initial OHTs will be asked to advance provincial clinical priorities and demonstrate improvements to patient experience and outcomes



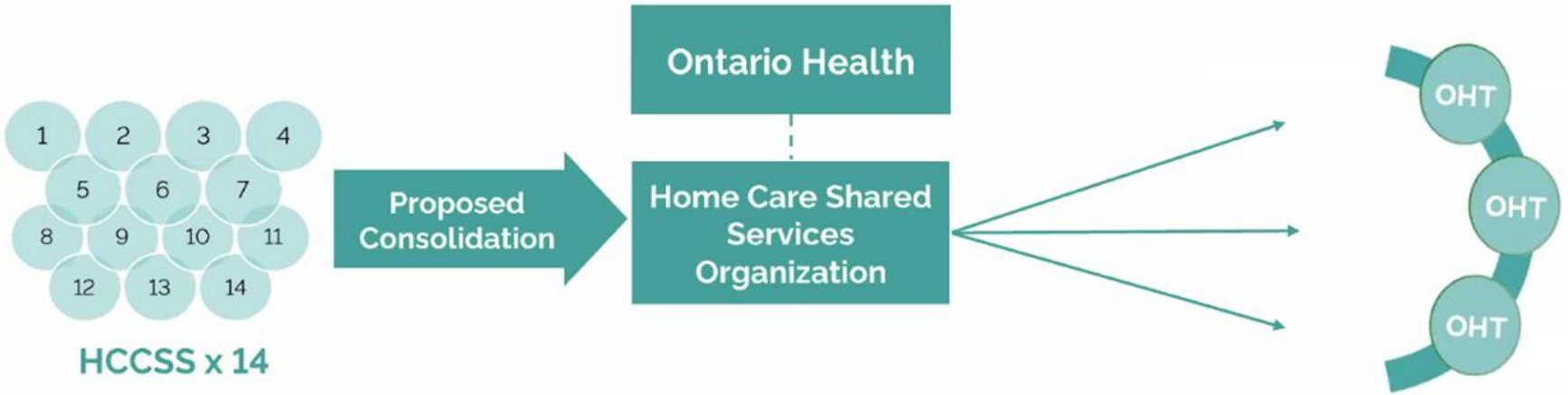
Improved Patient Outcomes

- Increased early detection of chronic disease
- Improved chronic disease outcomes
- Reduced acute care utilization
- Increased access to primary care services for unattached patients
- Improved system navigation support to find and access care
- Increased access to integrated team-based models of care

Modernizing Home Care

Modernizing Home Care
Proposed Consolidation

Proposed Consolidation of the 14 HCCSS Organizations into a **Single Shared Services Organization** (SSO)



HCCSS Consolidation

- **Create a shared services organization (SSO)**
- HCCSS staff, assets, liabilities **consolidated** into the SSO
- **Repeal** the *Local Health System Integration Act, 2006*

Shared Services Organization

- Provides **home care services** until OHTs assume home care delivery, **long-term care home placement,** and **shared services to OHTs**
- **Employs care coordinators** who work in new models in OHTs
- Supports **consistency** and **efficiency** of home care

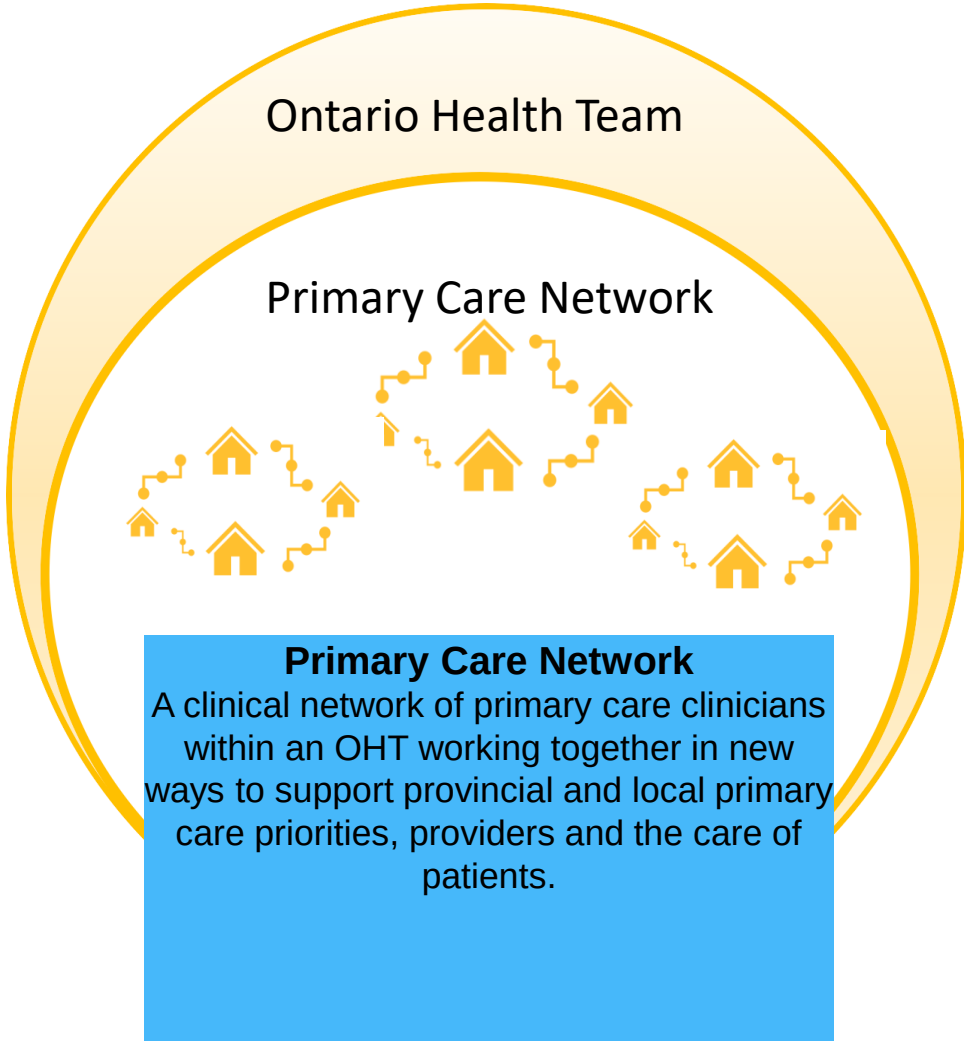
OHTs

As OHTs mature, they will:

- Be accountable for **integrated** home care **planning** and **delivery**
- Continue to spread **new models** of care delivery

Primary Care Advancement: Foundation for Change

Together **Primary Care Networks** form the foundation of an advanced and integrated health system.



Ontario Health

ANNUAL BUSINESS PLAN

2023/2024

KW4 ONTARIO HEALTH TEAM

2023/24 ABP PRIORITIES	GOALS
01 *Integrated Care through Population Health Management and Equity Approaches*	• Enhance care planning and delivery and outcomes for initial target population(s) based on local drivers. • Design and implement population health interventions for additional target populations aligned with provincial direction and built on broadened OHT partnerships. • Implement enhanced approaches to partnering with patients, families, and caregivers in execution of the Population Health Management and Equity plan.
02 *Patient Navigation and Digital Access*	• Implementing patient navigation supports and report on patient utilization. • Report on progress expanding access to Online Appointment Booking (OAB) in primary care settings. • Report on progress enhancing virtual care maturity and access.
03 *Collaborative Leadership, Decision Making and Governance*	• Report on progress implementing Patient, Family and Caregiver Strategy. • Develop and implement an enhanced governance model and processes that align with provincial direction(s) (additional indicator added by OHT) Initiatives.
04 *Primary Care Engagement and Leadership*	• Develop and implement a model and process(es) to enable primary care providers to have a collective voice in OHT activities and Ontario Health (OH) tables. • Develop and implement a plan to connect additional primary care providers and other clinicians to the OHT.
05 *COVID-19 Response and Recovery*	• Develop and implement a plan for COVD-19 response and recovery in alignment with provincial direction.
06 *OHT Sustainability*	• Create a sustainable OHT that will continue to meet the needs of the KW4 community and support system transformation.

KW4 OHT 2023/24 Collaborative Quality Improvement Plan (cQIP) Update

KW4 ONTARIO HEALTH TEAM

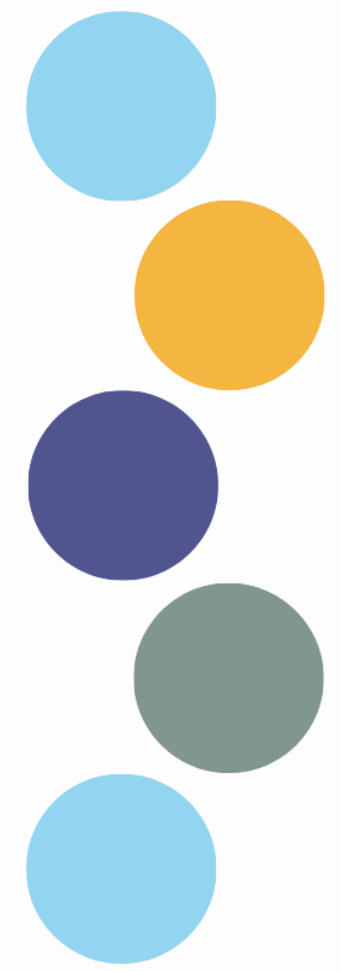
2023/24 cQIP Areas of Focus

1. Improve overall access to care in the most appropriate setting.	Associated Indicator: Alternative Level of Care Days
2. Increase overall access to community mental health and addictions (MHA) services.	Associated Indicator: ED First Point of Contact for Mental Health and Addictions Care
3. Increase overall access to preventative care	Associated Indicators: Preventative Screening in Primary Care (mammogram, colorectal, pap tests)

Performance

#	Indicator	2023/24 Target	Current Performance	
1	% ALC Acute Days (lower is better)	21.6	17.8% (April 1, 2023 – July 31, 2023)	
2	ED first contact for mental health and addictions (lower is better)	22.6	25.7% (April 1, 2023 – August 31, 2023)	
3	% up-to-date with Pap test (higher is better)	56.5	59.6% (April 1, 2023 – June 30, 2023)	
4	% up-to-date with mammogram (higher is better)	58.7	58.6% (April 1, 2023 – June 30, 2023)	
5	% up-to-date with colorectal cancer screening (higher is better)	64.5	64.9% (April 1, 2023 – June 30, 2023)	

Initiatives



Improve overall access to care in the most appropriate setting (ALC)

- Patient personas, journey maps and integrated care pathways
- Complex Care Program (CCP), Integrated Care Team (ICT) for Older Adults, and GeriMedRisk project
- SCOPE (Seamless Care Optimizing the Patient Experience)
- Let's Go Home (LEGHO)
- Recognizing delirium early in the Emergency Department

Increase access to community mental health and addictions services

- Patient personas, journey maps and integrated care pathways
- Transitional Age Youth Clinic
- Planning for the creation of Youth Wellness Hubs in Waterloo region
- Alternate Destination Model for Paramedic Services
- Ontario Structured Psychotherapy (OSP) Program

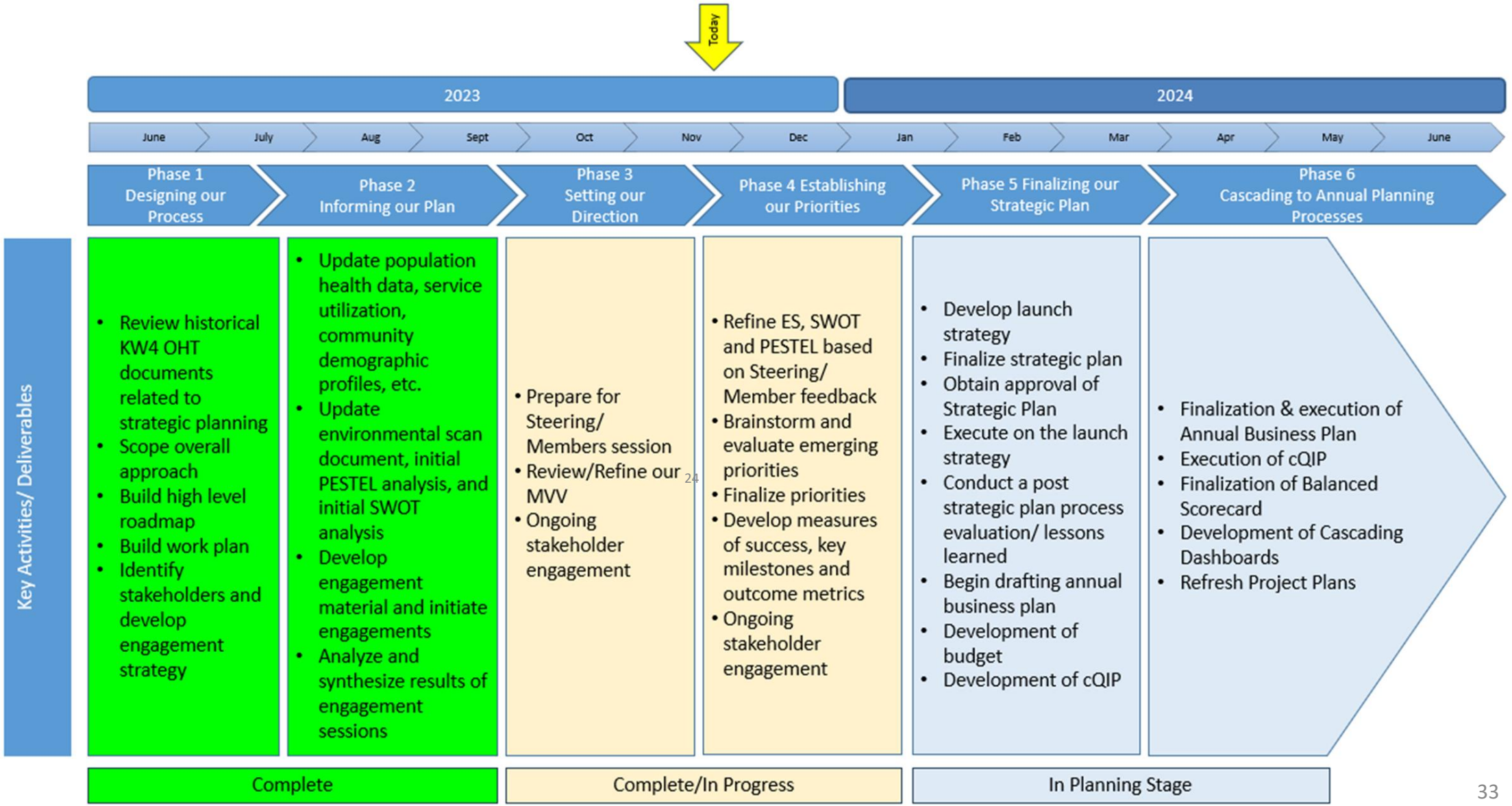
Increase overall access to preventative screening

- Increase public outreach and education
- Address the administrative burden faced by primary care providers

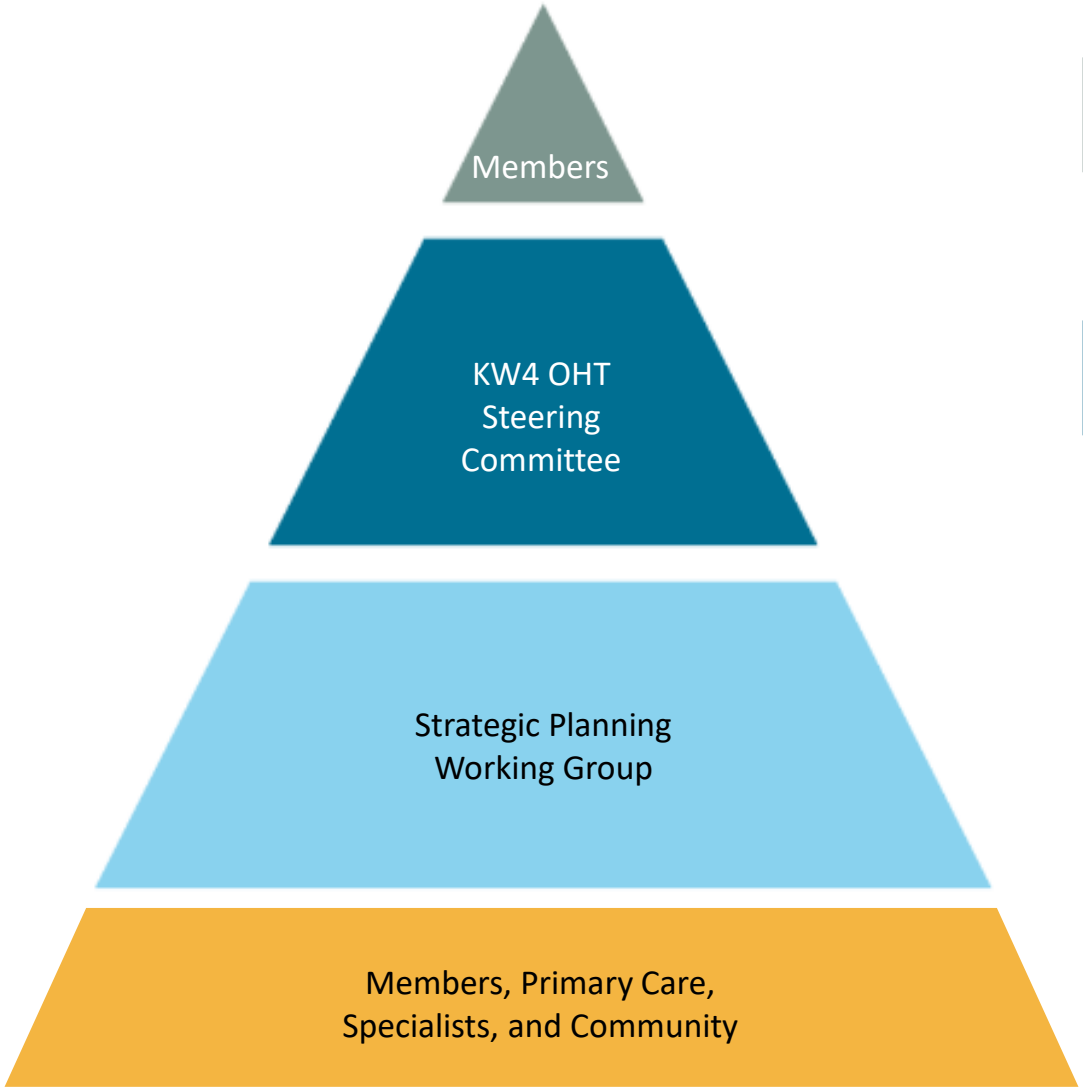
Strategic Planning Roadmap

KW4
ONTARIO HEALTH TEAM

Strategic Planning Overview



Strategic Plan Oversight



Responsible for approving the strategic plan and ensuring alignment between the KW4 OHT Strategic Plan and their organizational plans.

Responsible for overseeing the strategic plan development and developing an annual work plan consistent with the strategic plan.

Responsible for facilitating the development of the strategic plan including reviewing, advising on and considering relevant info and data regarding emerging trends, risks and opportunities and factors affecting healthcare and our community, advising on and assisting in planning, coordinating, and facilitating partner and public engagement and consultation activities, advising on communication strategies, and providing recommendations on key performance indicators (KPI) to be measured and monitored to ensure progress is being made towards the plan.

Responsible for providing input into the strategic plan and the future of health and wellness in the KW4 region.

Updated OHT Case for Support

KW4
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Together We Can Have Greater Impact


Individually we are one drop.
Together we are an ocean.
RYUNOSUKE SATORO

Facilitated Discussion

KW4
ONTARIO HEALTH TEAM

Tonight's Objectives

- Build buy-in through a refreshed case for OHT support
- Frame expectations regarding system-level planning
- Identify initial strategic priorities for implementing the OHT mandate throughout KW4 over the next five years

Vision (no changes made)

A community where everyone thrives, and no one is left behind.

Proposed Revised Mission

Advancing shared strategic priorities and the collaborative integration of health and social care services that maximize collective impact, optimize patient, family and provider experiences, and achieve better health and wellbeing for residents in Kitchener, Waterloo, Wellesley, Wilmot and Woolwich.

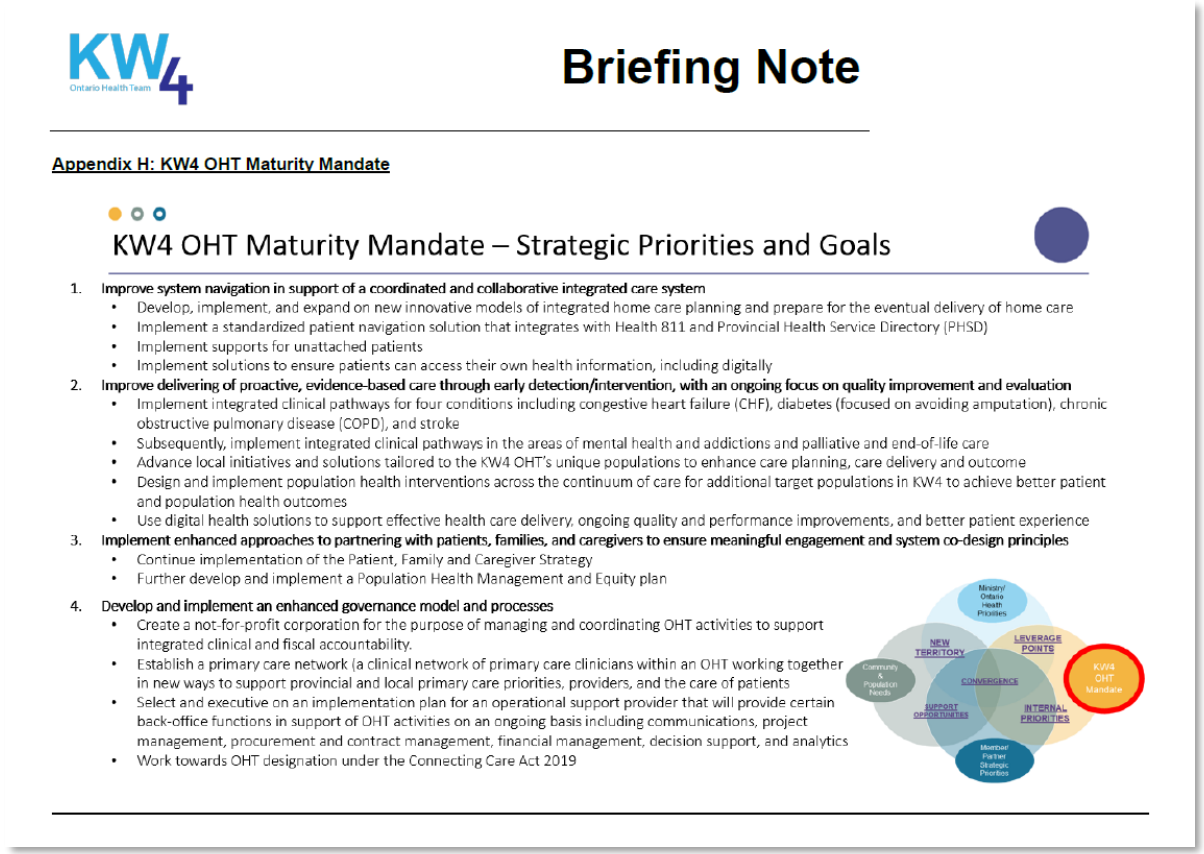
Proposed Revised Values

- We will be partners. Our team includes patients, families, caregivers and the community in partnership with health and social service providers.
- We will be inclusive. We work with diverse populations and urban and rural communities.
- We will pay attention to the social determinants of health, prevention and health promotion.
- We will be adaptable, courageous, evidence-informed and innovative.
- We will value relationships. Our culture is built on empathy and trust and will be demonstrated through our decisions and actions.
- We will be accountable for improving value in the health system, owning the decisions we make and embracing mistakes as opportunities for growth and learning.


Ministry/Ontario Health Priorities
Community & Population Needs
KW4 OHT Mandate
Member/Partner Strategic Priorities

Key Resource

Appendix H: KW4 OHT Maturity Mandate (page 14 of pre-read package)



KW4 Ontario Health Team

Briefing Note

Appendix H: KW4 OHT Maturity Mandate

KW4 OHT Maturity Mandate – Strategic Priorities and Goals

1. **Improve system navigation in support of a coordinated and collaborative integrated care system**
   - Develop, implement, and expand on new innovative models of integrated home care planning and prepare for the eventual delivery of home care
   - Implement a standardized patient navigation solution that integrates with Health 811 and Provincial Health Service Directory (PHSD)
   - Implement supports for unattached patients
   - Implement solutions to ensure patients can access their own health information, including digitally
2. **Improve delivering of proactive, evidence-based care through early detection/intervention, with an ongoing focus on quality improvement and evaluation**
   - Implement integrated clinical pathways for four conditions including congestive heart failure (CHF), diabetes (focused on avoiding amputation), chronic obstructive pulmonary disease (COPD), and stroke
   - Subsequently, implement integrated clinical pathways in the areas of mental health and addictions and palliative and end-of-life care
   - Advance local initiatives and solutions tailored to the KW4 OHT's unique populations to enhance care planning, care delivery and outcome
   - Design and implement population health interventions across the continuum of care for additional target populations in KW4 to achieve better patient and population health outcomes
   - Use digital health solutions to support effective health care delivery, ongoing quality and performance improvements, and better patient experience
3. **Implement enhanced approaches to partnering with patients, families, and caregivers to ensure meaningful engagement and system co-design principles**
   - Continue implementation of the Patient, Family and Caregiver Strategy
   - Further develop and implement a Population Health Management and Equity plan
4. **Develop and implement an enhanced governance model and processes**
   - Create a not-for-profit corporation for the purpose of managing and coordinating OHT activities to support integrated clinical and fiscal accountability.
   - Establish a primary care network (a clinical network of primary care clinicians within an OHT working together in new ways to support provincial and local primary care priorities, providers, and the care of patients
   - Select and executive on an implementation plan for an operational support provider that will provide certain back-office functions in support of OHT activities on an ongoing basis including communications, project management, procurement and contract management, financial management, decision support, and analytics
   - Work towards OHT designation under the Connecting Care Act 2019

KW4 OHT Maturity Mandate: Strategic Priorities

1. Improve system navigation in support of a coordinated and collaborative integrated care system
2. Improve delivering of proactive, evidence-based care through early detection/ intervention, with an ongoing focus on quality improvement and evaluation
3. Implement enhanced approaches to partnering with patients, families and caregivers to ensure meaningful engagement and system co-design principles
4. Develop and implement an enhanced governance model and processes

How well aligned are the KW4 priorities with local needs?

*Rank on a scale of 1-10 with **1 being not at all aligned** and **10 being strongly aligned***

How well aligned are the KW4 priorities with the strategic priorities of your organization?

*Rank on a scale of 1-10 with **1 being not at all aligned** and **10 being strongly aligned***

What other priorities would you want to add?

KW4 OHT Maturity Mandate: Goals

1. Improve system navigation in support of a coordinated and collaborative integrated care system

   1.1 Develop, implement and expand on new innovative models of integrated home care planning and prepare for the eventual delivery of home care

   1.2 Implement a standardized patient navigation solution that integrates with Health 811 and Provincial Health Service Directory (PHSD)

   1.3 Implement supports for unattached patients

   1.4 Implement solutions to ensure patients can access their own health information, including digitally

KW4 OHT Maturity Mandate: Goals

2. Improve delivering of proactive, evidence-based care through early detection/intervention, with an ongoing focus on quality improvement and evaluation

   2.1 Implement integrated clinical pathways for four conditions including congestive heart failure, diabetes, chronic obstructive pulmonary disease, and stroke

   2.2 Implement integrated clinical pathways in the areas of mental health and addictions and palliative and end-of-life care

   2.3 Advance local initiatives and solutions tailored to KW4 OHT's unique populations to enhance care planning, care delivery and outcome

   2.4 Design and implement population health interventions across the continuum of care for additional target populations in KW4 to achieve better patient and population outcomes

   2.5 Use digital health solutions to support effective health care delivery, ongoing quality and performance improvements, and better patient experience

KW4 OHT Maturity Mandate: Goals

3. Implement enhanced approaches to partnering with patients, families and caregivers to ensure meaningful engagement and system co-design principles

   3.1 Continue implementation of the Patient, Family and Caregiver Strategy

   3.2 Further develop and implement a Population Health Management and Equity plan

KW4 OHT Maturity Mandate: Goals

4. Develop and implement an enhanced governance model and processes

   4.1 Create a not-for-profit organization for the purpose of managing and coordinating OHT activities to support integrated clinical and fiscal accountability

   4.2 Establish a primary care network (a clinical network of primary care clinicians within an OHT working together in new ways to support provincial and local primary care priorities, providers and the care of patients)

   4.3 Select and execute on an implementation plan for an operational support provider that will provide certain back-office functions in support of OHT activities on an ongoing basis including communications, project management, procurement and contract management, financial management, decision support, and analytics.

   4.4 Work towards OHT designation under the Connecting Care Act 2019

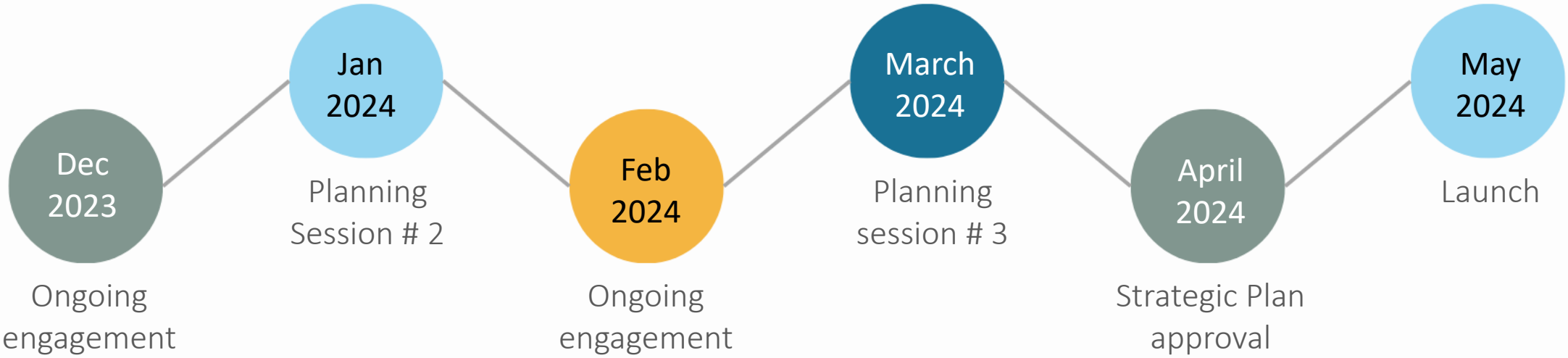
Within the goals for each priority, where should KW4 OHT focus? Where should KW4 OHT start?

Divide 100 points between the goals of each priority for where to ***focus*** *and where to* ***start***

Next Steps

KW4
ONTARIO HEALTH TEAM

Next Steps


Dec 2023
Ongoing engagement
Jan 2024
Planning Session # 2
Feb 2024
Ongoing engagement
March 2024
Planning session # 3
April 2024
Strategic Plan approval
May 2024
Launch

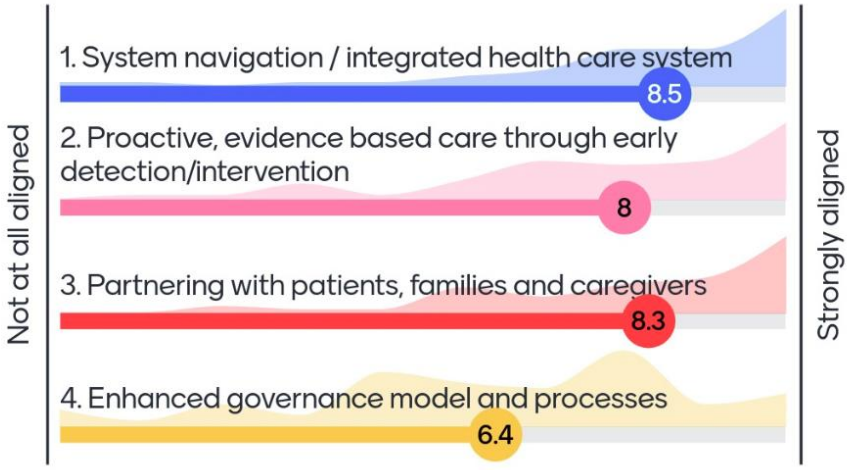
Appendix C
KW4 OHT Strategic Plan
Detailed Member Feedback

Feedback on Draft Strategic Priorities

Rebecca then led the group through a series of questions where participants provided individual input using Mentimeter on the draft strategic priorities (provided on page 14 of the pre-read package). Results were projected on the screen for participants to view in the room. Full results from Mentimeter are captured below (number of responses for each question is noted); narrative feedback has been provided verbatim but synthesized into themes by the consulting team.

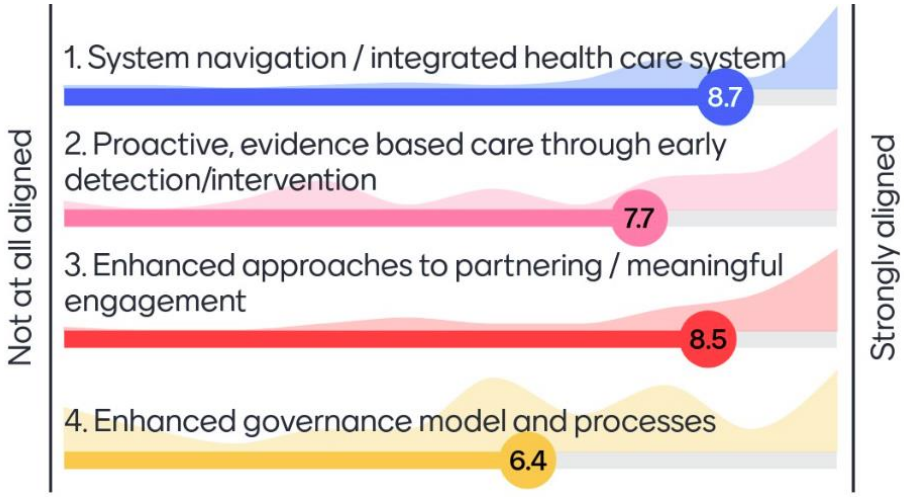
How well aligned are the KW4 OHT priorities with local needs?

61 responses



How well aligned are the KW4 OHT priorities with the strategic priorities of your organization?

57 responses



What other priorities would you want to add?

Integration / coordination/collaboration/community supports (18)

- Integrated care
- Improve continuity of care between partner organizations
- Improved coordination/navigation through the system from a patient/user lens
- More integrated services dual diagnosis inclusion
- Digital integration of care across providers.
- Integrated health and housing (2)
- Connected and integrated care pathways.
- Integrated services
- Integrated care models to support vulnerable populations
- Continuity of care
- Collaboration across sectors
- Public health collaboration
- Collaborative systems
- Partnerships with human serving organizations. The health care system does not need to do it all. Sharing of resources and respond with all working to their strengths.
- Enhance/ strengthen partnerships between member organizations

- Expanded focus on overall wellbeing in coordination with community and social support services
- Explicit inclusion of community support services as part of addressing the social determinants of health

Interpretation (8)

- Accessible translation/interpretation services
- Access to interpretation and other enabling tools for effective care

Digitization (7)

- EHealth enablers to facilitate whole of person care
- Innovating and digitizing health care
- Integrated digital tools for client tracking and care
- Digital enabled healthcare
- Common digital intake across orgs and ties back to primary care
- Digital tools to support shared care models
- Digitally enabled care

Funding (7)

- Adequately fund existing programs before developing new ones
- Sustainable funding for programs and services
- More efficient use of limited healthcare funds.
- Getting more funding for our work
- Integrated funding model development
- Integrated funding envelopes
- Effective alignment and deployment of financial resources

Human Resources (6)

- Provider experience & human resource optimization.
- Equity for healthcare workers across sectors
- Forming more primary care team; Decreasing clinician burnout
- Create a system that attracts and retains skilled HHR.
- A plan to address HHR
- Human Resources retention

Mental health / addictions (6)

- Mental health support.

- Focus on prevention of mental health struggles.
- Early intervention w mental health and addictions.
- Community accessible supports for mental health and addictions.
- Mental health
- Integration of mental health and addictions across sectors

Access (6)

- Better access to primary care
- Enhanced access to specialized care
- Accessibility to access services/ health care
- Family care for all
- Access specialists, fast
- Prioritize access to a seamless primary care system

Health equity (5)

- Lens of health equity
- Health equity
- Responding to urgent local equity issues.
- Focus on a health equity lens
- Stronger focus on health equity.

Children and youth (4)

- Early Childhood health development.
- Participating in the Education System to improve children and youth access to evidence-based health information
- Children's health
- Specific reference that pull out children's needs.

Primary care (3)

- Primary care teams
- Primary care team based care
- Primary care capacity and attachment

Dementia (2)

- Dementia care.
- Where is Alzheimer's?

Seniors (2)

- Specific reference that pull out seniors needs.
- Senior friendly care

Culturally safe (2)

- Provide culturally safe care
- Culturally safe care

Provider experience (2)

- Improving the experience of providers
- Improving provider experience

Other

- Solutions for the unattached patients in the region—this number is growing very fast and includes newborn babies and complex vulnerable seniors. We need a solution easy to access and navigate
- Nutritional support
- Enhanced support for CSS services
- Consideration of social determinants of health
- Healthcare modernization
- Alternate care pathways that reduce demand on EDs and the traditional bricks and mortar hospital based care system
- Figure out right care at right place at right time. And how that all connects back to primary care
- Shifting care to the best service provider
- Flexibility for changing needs
- Addressing sub clinical issues before they develop into full disease
- Improve trust patients have in doctors (patient do ne share all from disbelief)
- Enhanced upstream interventions
- None. There are sufficient for now.
- The real life ability to follow through with care priorities
- Enhanced commitment to addressing social determinants of health and barriers to optimal response to health care
- Health education—system as well as specific illness
- Sustainability
- Increased outreach for the underhoused
- Acknowledging the roles that complimentary care has in healthcare.

- Care capacity building and engagement of care providers for complex populations
- Integrated dining model development
- Faster wait times
- More patient education including lifestyle
- Welcoming non health partners to the table
- Expand primary care team based capacity
- Community engagement
- Homeless and precariously housed
- How safety and security around housing and food impact health
- What is meant by the word navigation.
- Develop a Holistic range of health and social services
- Priorities listed on p16 of package reflect the voice of the patients (from survey) and should be used, rather than p14 which wording is too general. E.g. focus on increase access to primary care is #1"
- Cross geographical solutions
- EDI
- Truth and reconciliation calls to action
- Complex population focus, i.e. refugees and others
- Planning for future population needs
- Disaggregated data collection to better understand needs
- Obesity clinics
- No other systems identified other than health. i.e. health education social services sectors etc.
- Nothing shared about priority populations shared. How and where do the specific priority populations fit when they were identified earlier years of the OHT.

Additional Observations from Table Conversations

Rebecca then invited each table group to take a few minutes and have a conversation on the priorities, and to share their observations based on those discussions. Responses were more limited here, as the group was heading into a break and were also invited to provided written feedback if preferred.

Social Determinants of Health (2)

- Social determinants of health continue to be barriers to care and proactive and preventative health. Removing these barriers will result in better health outcomes
- Social Determinants of Health prevent response to care

System navigation (2)

- Frustration with system navigation challenges is increasing dramatically.
- Need for system "reconfiguration" vs. "navigation"

Sustainable funding (2)

- Need for sustainable funding that matches operational increases e.g. inflation, gas, product costs
- More sustainable funding to community

Vulnerable populations (2)

- These priorities seem very top-down. We need a local nuance and focus on vulnerable populations like refugees, homeless, ABI who are struggling and underfunded.
- Vulnerable population focus

Other

- Rapid rate of population growth not matched with health Human Resources growth
- We need a model of care
- Need an inventory/database of all available services and their intake model and reporting back to primary care
- Wellbeing of staff put them also at the Centre of planning.
- The objectives are too homogenous and don't offer a way to capture community urgencies and diversity—these are how are we the same. What about how do we cultivate our diversity?
- Needs to define prevention—right care right place before hospital
- Individual Structures of Governance reinforces territorial approach to practice which is a barrier to success
- What is the role of the municipalities (i.e. paramedics)?
- There is a need to overlay a health equity lens over all priorities
- Creating integrated team based care in primary care teams

- Investing in Preventative care vs reactive care should be prioritized.
- Team based primarily care is the number one priority we should be focusing on. Access to primary care would solve so many issues downstream.
- Enabler: move the funding within the OHT to the right spots as an enabler.
- Increased attachment to primary care

Feedback on Draft Goals

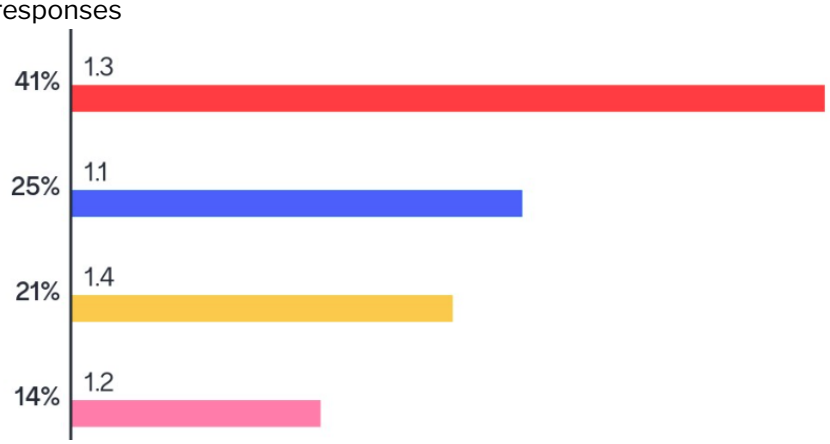
In this section, the group was shown the draft goals under each of the four priorities, and was asked the same four questions in Mentimeter for each.

1. **Improve system navigation in support of coordinated and collaborative integrated care system**
   - 1.1 Develop, implement and expand on new innovative models of integrated home care planning and prepare for the eventual delivery of home care
   - 1.2 Implement a standardized patient navigation solution that integrates with Health 811 and Provincial Health Service Directory (PHSD)
   - 1.3 Implement supports for unattached patients
   - 1.4 Implement solutions to ensure patients can access their own health information, including digitally

Within the goals for system navigation, where should KW4 OHT focus?

Participants were asked to divide 100 points between the goals for each priority to identify where KW4 OHT should focus its attention.

50 responses

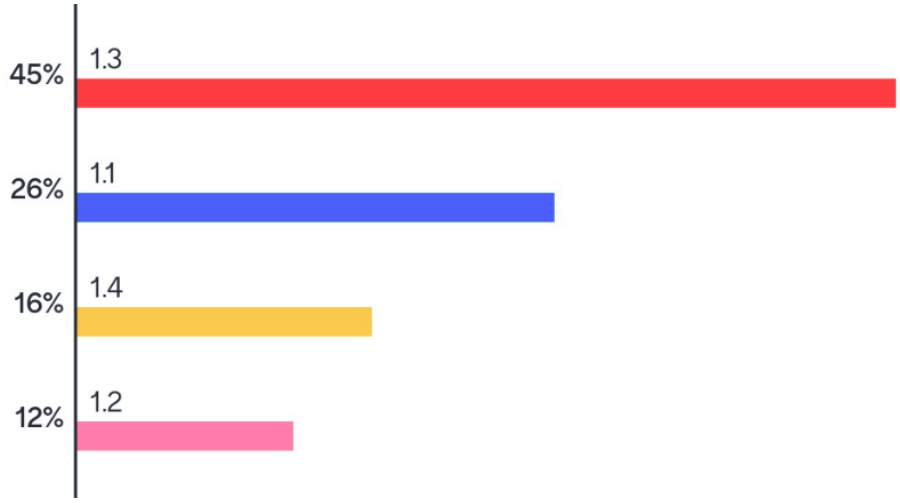


41% of the allocated points went to Goal 1.3: Implement supports for unattached patients. Goal 1.1 (models of integrated home care) received 25% of the points, followed by Goal 1.4 (patient access to health information) with 21% of the points. Goal 1.2 (standardized patient navigation system) received the remaining 14% of the points.

Within the goals for system navigation, where should KW4 OHT start?

Participants were asked to divide 100 points between the goals for each priority to identify where KW4 OHT should start.

53 responses



Participants ranked the goals in terms of priority/urgency in the same order as where to focus, with the highest urgency being supports for unattached patients.

Which system navigation goals should be added or removed?

1.1

- Remove 1.1, 1.2 add integrated service models
- Have the focus of integration on more than homecare.
- Innovative model of care should involve all sectors not just home care
- Expand 1.1 to include all community based programs. i.e CSS. Right now it reads as just HCCSS
- Integrate community care services along with home care supports

1.2

- 1.2 and 1.4. should be removed because they are dependent on the province
- Remove provincial related items
- Remove health 811
- Remove 1.2.
- Remove 1.1, 1.2 add integrated service models
- Remove 1.2 or “fix it”
- Don’t understand the 811 priority
- Teaching people to navigate the system is akin to teaching them how to fish vs feeding them fish. Replace with goal related to care system focused digital infrastructure for coordination, referral and navigation"
- We should really not be focused on aligning Health 811. It’s not organized and creates more admin burden. We should working on aligning Health811 only where it makes sense locally.
- Not clear what 1.2 is saying
- Health 811 will not solve system navigation. Do not invest energy in that product.
- Ai navigation
- Much of 1.2 and 1.4 are limited in who will actually use these
- Remove the PHSD acronym

1.3

- Expand 1.3 by adding access to primary care for unattached individuals
- 1.3 should reference increased primary care capacity
- 1.3 needs to be re- focused - should not come from a starting point of having unattached patients
- The "support" for unattached patient IS access to team based primary care
- 1.3 — yes please. (says 'no support’ then an arrow to ‘attach’)

1.4

- 1.4 should be removed
- 1.2 and 1.4. should be removed because they are dependent on the province
- Remove 1.4 - elevate to OH to address provincially
- 1.4 removed
- Remove 1.4
- Change 1.4 to digital access for care providers to share health records. Patients should have access to health records but so should all care providers to provide good care

- Digital tools aren't accessible to all/most of those in need.
- The access to health information needs to be a provincial strategy. If each OHT does its own thing we will end up with 57+ different systems
- Remove access to digital health as all OHTs should collaborate
- Creating access to digital patient records should be managed and paid for by the province to ensure standardization
- Much of 1.2 and 1.4 are limited in who will actually use these
- 1.4 — 57 different solutions — stay with Ontario Health

Other comments

- Access provided by GRH for newborn babies with no primary care provider
- Tech solutions to support a universal emr like in other provinces
- Shared EMR across all health and community support providers
- Shared electronic record across providers
- Stress as part of the strategic plan support for primary care, it is the way forward
- Common patient record
- Use p16 to define goals. e.g family care for all
- Timely access to specialist and imaging
- As a patient, governance is an organizational choice that has less priority. It is a means, not an end"
- None. They are sufficient.
- More focus on team based primary care
- Understand and implement a health equity and culturally safe care framework
- Health system integration, to evaulate the patient care experiences by the end users especially those without a family md
- Digital health needs to be provincial not local
- Create partner collaborations for integrated pathways.
- Patient advocacy—who can manage patient files to ensure efficient navigation through the system?
- Focus on health equity
- Coordinated navigation across sectors
- System navigation should not be all virtual. We need the human touch.
- Ensure primary care providers and supports would not be required
- Homecare planning should involve tests of change.
- Add more Community Health Centres across all communities—they are a complete and wholistic model of primary care
- Common intake across providers

- Add implement service delivery models that provide care at point of need
- Implement more then just supports for the unattached.
- Build an integrated system that includes EMS and Public Health
- Develop and/or expand family health team(s) as a model to support people
- Integration of barriers to care
- Shared access to health records
- Consider increase use of all primary care providers e.g. NPs
- Health care is not a linear pathway
- Health care experience is a continuum and it loops
- Not done proactively

Specifically how would you make the wording of the system navigation goals stronger?

1.1

- Homecare can mean community based program and supports
- Not home Care planning but home care delivery (2)
- Add the words tests of change to Homecare planning.
- 1.1 community based programs NOT just home care

1.2

- Clarify 1.2
- Reword 1.2 so we better understand what is meant.
- System navigation should be system change or reconfiguration
- Remove the PHSD acronym
- 811 and PHSD is not useful to everyone...youth, seniors, new comers etc.

1.3

- Change 1.3 to: All patients are attached to primary care
- "Implement supports for unattached patients" should be changed to "Attach patients"
- Attach the unattached people
- Not sure implement supports for unattached patients is the right framing. Should be about team based primary care for all KW4 residents
- Change unattached to people facing equity challenges

Language (7)

- Simplify it. Less words!

- Plain language
- Shorten the goals! Too wordy
- Simply goals
- Less lingo and more concrete language that everyone can understand especially the users of the system
- Less amorphous
- Use plain English vs buzzwords.

Too many goals (4)

- Too many to focus on. Lofty goals!

Focus on the person (2)

- Need more person focus. All reads as system focus

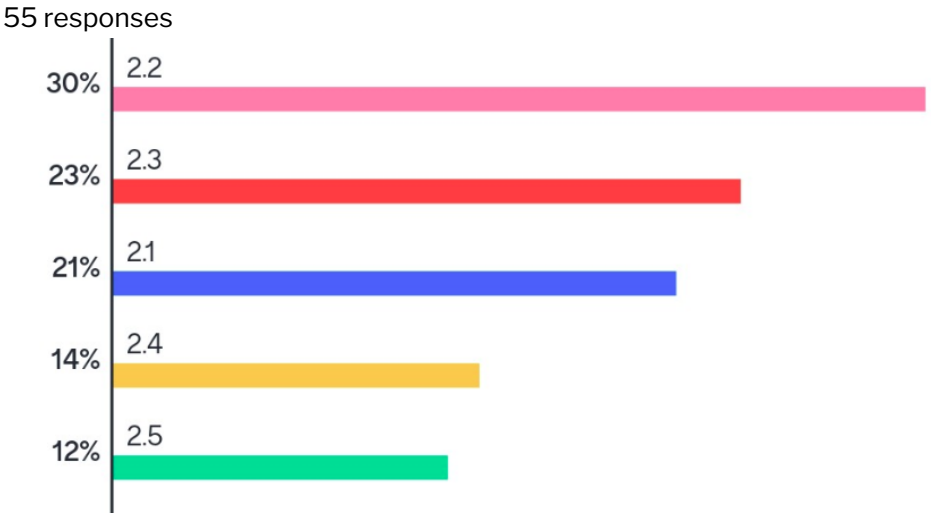
Other

- Be more objective in the goal statements
- Using SMART format
- Write goals in the context of how it impacts people.
- Digitally enabled model of care for those that can use that. Leaves more time for those that can't
- No patient needing health are denied due to lack of access
- Integrated care pathways should include alternative / integrative medicine, prevention beyond screening and vaccination), and patient education and lifestyle programs (nutrition, stress mgt, exercise)
- Leave it as ...develop, implement and expand new innovative models of care. ...expand on what is working in all sectors not just home care
- Less clinical focus so that the goals apply to social service and mental health, not just health care focused.
- Ensure goals are achievable and once achieved can be scaled to other projects
- Add Chronic conditions like long covid, fibromyalgia, chronic pain / fatigue. These are not easily clinically categorized and patients are not well supported
- Not sure anyone outside the system understands what this is all about
- Pure medical focus. Need more collaborative wholistic proactive approach

2. **Improve delivering of proactive, evidence-based care through early detection/ intervention, with an ongoing focus on quality improvement and evaluation**
   - 2.1 Implement integrated clinical pathways for four conditions including congestive hear failure, diabetes, chronic obstructive pulmonary disease, and stroke
   - 2.2 Subsequently, implement integrated clinical pathways in the areas of mental health and addictions and palliative and end-of-life care
   - 2.3 Advance local initiatives and solutions tailored to KW4 OHT's unique populations to enhance care planning, care delivery and outcome
   - 2.4 Design and implement population health interventions across the continuum of care for additional target populations in KW4 to achieve better patient and population outcomes
   - 2.5 Use digital health solutions to support effective health care delivery, ongoing quality and performance improvements, and better patient experience

Within the goals for early intervention, where should KW4 OHT focus?

Participants were asked to divide 100 points between the goals to identify where KW4 OHT should focus its attention.



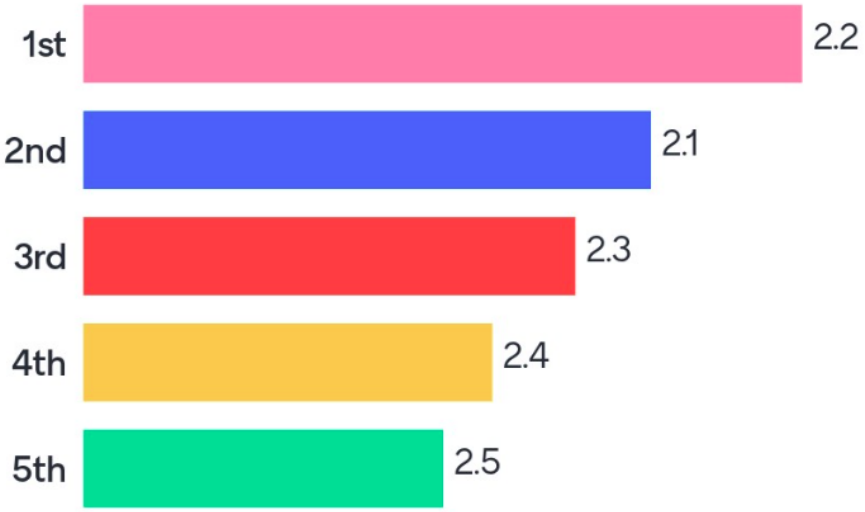
30% of the allocated points went to Goal 2.2 (integrated clinical pathways in mental health and addictions and palliative and end-of-life care). Goal 2.3 (initiatives and solutions tailored to unique populations) received 23% of the points, followed by Goal 2.1 (integrated clinical pathways for four conditions) with 21% of the points.

Goal 2.4 (population health interventions) received 14% of the points and Goal 2.5 (digital health solutions) received the remaining 12% of the points.

Within the goals for early intervention, where should KW4 OHT start?

Participants ranked the goals in order of priority/urgency.

54 responses



Participants ranked the goals in terms of priority/urgency in the same order as where to focus, with the exception of 2.1 and 2.3, which switched places but still ranked in the top three.

Which goals should be added or removed?

2.1

- Combine 2.1 and 2.2 (2)
- Prevention should be added to 2.1
- Integrated care pathways for complex (medically and/or social) patients.
- Clear pathways for all and any illness/issue
- Add Chronic pain, long covid, fibromyalgia
- If 2.1 is mandated in our funding agreement then it has to be a priority
- Don't focus so much on heart failure, diabetes, etc
- Add cancer
- Reduce waiting lists when patient access 2.1 and 2.2
- Dementia care must be incorporated into pathways.

2.2

- Combine 2.1 and 2.2 (2)
- 2.2 palliative and end of life care should be built into all chronic disease pathways
- Reduce waiting lists when patient access 2.1 and 2.2
- End of life should include dementia and frailty
- Palliative and end of life is not a pathway. It happens to everyone
- Centralized intake for Medical Assistance in Dying

2.3

- 2.3 and 2.4 seem very similar. Could be combined. (3)
- 2.3
- Need more detail on 2.3 and 2.4
- 2.3 and 2.4 very unclear
- "Advance local initiatives and solutions"--too broad , what does this mean ?
- "2.3 should be threaded through the approach to 2.1 and 2.2 - not a separate goal
- Vulnerable population focus, ie refugees, unhoused etc
- Named focus on homeless/at risk and refugees
- Focus on refugee health and homeless/at risk
- Please add homelessness, housing, dementia and a focus on welcoming refugees in all areas to KW4 broader than just a traditional health care definition

2.4

- Remove 2.4 (2)
- 2.3 and 2.4 seem very similar. Could be combined. (3)
- 2.3 can be rolled up into 2.1 as that priority is mandated by OH.
- 2.3 and 2.4 very unclear
- Need more detail on 2.3 and 2.4
- How many yrs does the strategic plan span? Would not tackle 2.4 until some of others well under way."

2.5

- Remove 2.5 (2)
- Remove digital health eg all OHT initiative
- 2.5 does not fit, should go in 1.
- 2.5 is critical but we need more detail. No more paper and fax!!!

Prevention / upstream care (10)

- Prevention so we don't need the other five.
- Prevention is missing
- Upstream care rather than waiting for crisis
- Upstream care
- Add preventions, upstream interventions, etc
- Prevention for the population as a whole
- Invest in prevention - upstream, upstream, upstream
- Pathway for dementia detection/ intervention/ prevention
- Upstream preventative care
- Focus on prevention

Too many (4)

- Too many to achieve in one plan
- Too many goals . Less is best
- Too many goals to be successfully implemented well. Should reduce focus to what is manageable
- Too many goals

Other comments

- Those two goals are actually activities - very important activities
- Connect housing, immigration, health
- Consider none of these programs will be accessible if population demand is not met with interpretation alongside.
- Simplicity
- Incorporate Person Centred Care into pathway development
- Include in the development of actions a strong focus on the social determinants of health
- All-of-person care ie wholistic, coordinated care for a person that has multiple diagnoses/complex needs rather than diagnosis-specific care pathways that aren't integrated with each other
- Wrap the services around the patient
- Add dementia
- Increased engagement from specialists
- Think in a wider determinants of health approach. These are all too clinically focused.
- Very medical, needs to be more community based
- Integrated /intersecting pathways
- Broader social determinants of health as a framework

- Improve delivering proactive e.b. care through early detection with a focus on Q1 and evaluation

Specifically how would you make the wording of the goals stronger?

2.1

- Why just clinical pathways? Where is lived experience? Disconnect between vision and this

2.2

- 2.2 add dementia and frailty
- Remove subsequently from 2.2
- #2 need to first develop clinical pathways for integrated mental health and addictions
- Remove "subsequently"
- Why just clinical pathways? Where is lived experience? Disconnect between vision and this

2.3

- Combine 2.3 and 2.4 to reflect proactivity, wholistic care, community care
- Focus on population health goals – Label the priority populations specifically in the goals to help organizations supporting these folks better focus and be more accountable to their patients. Thereby be better allies to OHTs.

2.4

- Combine 2.3 and 2.4 to reflect proactivity, wholistic care, community care
- 2.4 is incredibly vague

2.5

- Digital health tools need to be accessible across sectors to include community services and. It just clinical and acute care services
- More detail needed for digital
- Keep non digital solutions for people not comfortable with phone and computers. Digital should be an addition to person to person, not a substitute

Language

- Goals too wordy
- Fewer words!

- Simplify wording. Too many words too remember.
- Fewer words. Plain language. People focus.
- Too wordy
- Uses a lot of the same words
- To much jargon.
- These are all very hard to understand the meaning of them and how they would apply to different organizations. Make less wordy and more focused
- Simpler wording.
- Fewer clearer words
- Plain language.
- Clear and succinct
- Please make the goals more focused and understandable
- Goals are too vague

Other comments

- Collaboration
- Increase co-design with community members with lived experience
- Why? Why is this hard?? 🤰
- Person focused.
- Need to evaluate implementation
- None of this will work as desired without sustainable funding. Province has to stop wasting time “remaking” the system and focus on implementation.
- Define family and what rights parents have and what rights children have. With mental health it is very hard to help ones children after an age like 16
- Too medical.
- How will we know we’re successful in achieving these goals?

3. **Implement enhanced approaches to partnering with patients, families, and caregivers to ensure meaningful engagement and system co-design principles**
   - 3.1 Continue implementation of the Patient, Family and Caregiver Strategy
   - 3.2 Further develop and implement a Population Health Management and Equity plan

Within the goals for partnering with patients and carers, where should KW4 OHT focus?

Participants were asked to divide 100 points between the goals to identify where KW4 OHT should focus its attention.

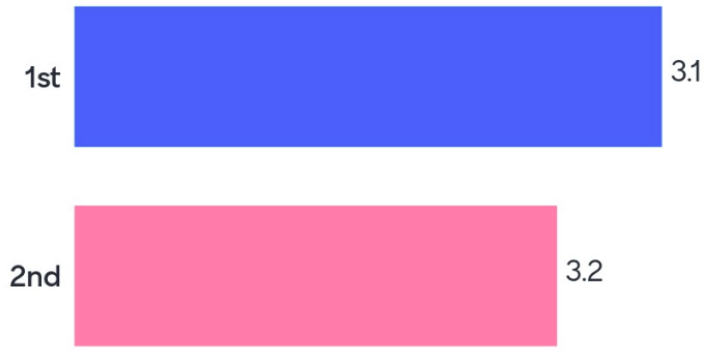
48 responses

55% of the allocated points went to Goal 3.1 (implementation of the patient, family and caregiver strategy). 45% of the points went to Goal 3.2 (population health management and equity plan).

Within the goals for partnering with patients and carers, where should KW4 OHT start?

Participants ranked the goals in order of priority/urgency.

38 responses



Participants ranked the goals in terms of priority/urgency in the same order as where to focus, with the highest urgency being the patient, family and caregiver strategy.

Which goals should be added or removed?

3.1

- What does the 3.1 initiative refer to ?? Patient /Family/Caregivers initiative
- A health equity strategy would include a patient, family and caregiver engagement strategies. Where is indigenous focus and engagement in any of this?
- Patients, caregivers should be at all tables
- Integrate a voice for vulnerable groups that aren't captured through PFAC type groups
- Increase the voice of the patient and client in all aspect of their experience. Increase the voice of diverse patients and clients in all aspect of their experience

3.2

- Provide more definition to a population health and equity lens - in addition responsible partners need to be part of the support process.
- Change from a typical PFAC model, so a goal to use different and creative methods of engagement. Meet people where they are at!
- Improve access with an equity lens - ie. How can homeless people feel welcome at the hospital

Other comments

- Detail/description needed (11)
    - Definitions would be helpful
    - The goals are poorly worded and need to be clearer
    - They need to be more specific to answer this.
    - Better explanation of each 3.1 and 3.2
    - Need more detail on goals. Too broad
    - More specificity
    - Reword goals to be more understandable to people.
    - Clarification of how the two goals relate (to the strategy) or more clear definition
    - Not clear goals
    - Goals should be more specific

    - The wording of the goals need to be actually defined . What do this refer to?
- Remove both (7)
    - These aren't goals. These are ways we should work. We need the population data and we need pfac
    - Remove both. They are tactics not goals.
- Activities not goals (2)
    - These are activities vs goals but necessary as some organizations won't think of doing these if not stated.
    - These are important activities but not goals as they are worded
- Need both
- Both goals need to be outcome focused. What's the expected impact by implementing the strategies?
- People with lived experience should be part of all design initiatives
- Include disabilities both developmental and physical in all areas especially access and plain language
- Evaluate community engagement using OH framework to determine next steps
- Engage patients and caregivers that have more of an EDI lens. Be more intentional with this engagement.
- Articulate health equity, EDI, culturally safe care more clearly in the priority and goals
- Less theoretical more practical measurable goals
- Goals should be reworded. Implementing a plan isn't a goal
- Add co-design.
- Implementation
- Add 100% of members are using and OH/OHT designed engagement model or framework
- 1001 members using framework
- If the wording is "continue to implement" and "further develop" it's clear the initiative ls are not working and need to be changed.
- Equity diversity inclusion and anti racism. Make sure the spaces are brave spaces as it is already hard for these folks.
- Add disaggregate data collection to understand disparities and equity needs
- Keep both but focus on the patient before you start trying to tackle the broader community
- Requirements – though need to be included should be separated from specific local goals

- Add have a shared commitment statement adopted by 100% of members
- Work with community organizations, grassroots organizations and community leaders to understand local needs, co design and co-power solutions

Specifically how would you make the wording of the goals stronger?

3.1

- The patient/family is more of a principle. This is how we work.

3.2

- Address reconciliation as well as equity
- Equity and access - not an equity plan. Plans are words. Make it action.

Language

- Be more clear to make these smart goals.
- The goals are too high level and jargon based - patients and families would not know what they mean. More specificity.
- Also 'plan' in 3.2 should be capitalized

Definitions

- Do we have a definition of what meaningful engagement actually means
- I don't know what the Strategy or Plan is. Take a half sentence to provide description.

Other comments

- Speak to engaging patients and clients where they are. Move away from committees and formal meetings to different engagements to understand patients needs.
- Prefer to see the essence of each strategy captured
- Dig into the voices that are harder to get
- As a patient, I see OHT being a corporation or not as a means, not a goal or end, so not as relevant as long as patient care is good
- Enhanced approaches? Take out. Implement partnering with people with lived experience, families, caregivers... do you think they will understand "system co-design principles. Make it simple
- Prefer to see the essence of the strategy captured

- Primary care should be a very top priority. See survey results of p16, where access to primary care is a top priority

4. Develop and implement an enhanced governance model and processes

4.1 Create a not-for-profit organization for the purpose of managing and coordinating OHT activities to support integrated clinical and fiscal accountability

4.2 Establish a primary care network (a clinical network of primary care clinicians within an OHT working together in new ways to support provincial and local primary care priorities, providers and the care of patients)

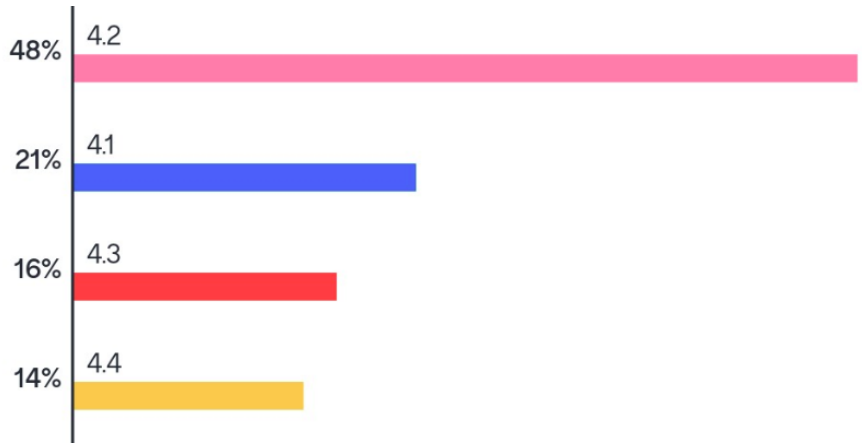
4.3 Select and execute on an implementation plan for an operational support provider that will provide certain back-office functions in support of OHT activities on an ongoing basis including communications, project management, procurement and contract management, financial management, decision support, and analytics.

4.4 Work towards OHT designation under the Connecting Care Act 2019

Within the goals for governance, where should KW4 OHT focus?

Participants were asked to divide 100 points between the goals to identify where KW4 OHT should focus its attention.

44 responses

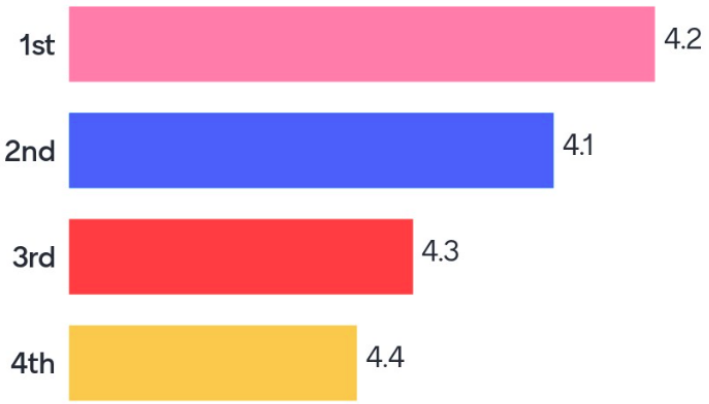


48% of the allocated points went to Goal 4.2 (establish a primary care network). Goal 4.1 (create a not-for-profit) received 21% of the points, followed by Goal 4.3 (implementation plan for an operational support provider) had 16% of the points and the remaining 14% of points went to Goal 4.4 (OHT designation).

Within the goals for governance, where should KW4 OHT start?

Participants ranked the goals in order of priority/urgency.

34 responses



Participants ranked the goals in terms of priority/urgency in the same order as where to focus, with establishing a primary care network identified as the highest urgency, followed by the creation of not-for-profit to manage and cordite OHT activities.

Which goals should be added or removed?

4.1

- 1 and 4 feel like something we just need to pay lawyers to complete

4.2

- Need focus to be on forming PCN
- Primary care needs to be priority
- Focus on primary care network and wrapping supports around primary care

4.3

- As a patient, I see 4.3 as an operational aspect, that is not a priority for me to think about. A must have, a mean, but not a goal

4.4

- Designation can occur once well established
- Remove 4.4
- 4.4 will be achieved if the other 3 goals are met

- Designation is a goal not a tactic. Governance should include the region
- 4.4 is the outcome of the other 3
- Drop 4 as it is an effect of achieving the other 3
- Need to clearly understand benefits and risks to member organizations of incorporating and achieving "designation"
- 1 and 4 feel like something we just need to pay lawyers to complete
- Remove 4.4 and move it to the priority statement
- 4.4 is also an operational process, a enabler, a mean, and not a strategic goal
- Add H&CC modernization

Other comments

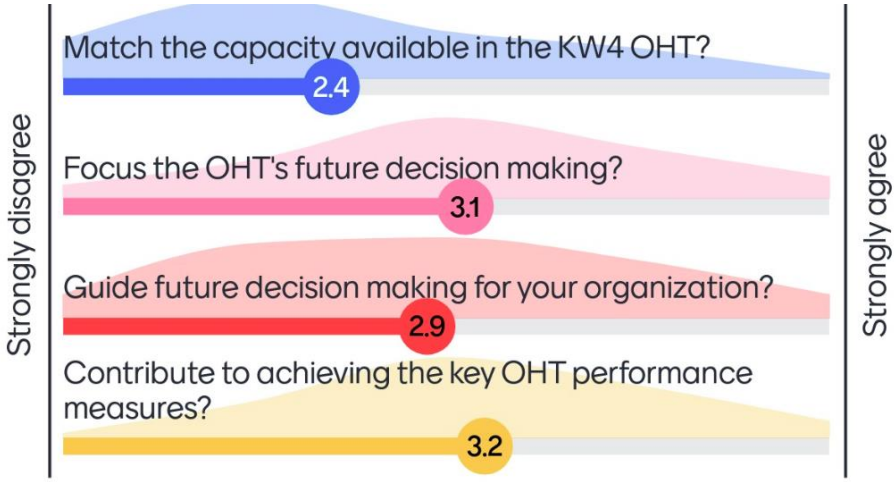
- Keep all the goals (2)
    - All the goals are valid.
- Good list of goals – they are appropriately overlapping
- I think they come as a package
- Remove everything except for 4.2
- Already too many goals ! 1-2 per priority
- Seem to be activities to complete
- Add develop a home a community care delivery model aligned with OH direction.
- Board members should be separate from the KW4 OHT members – holding OHT accountable for schools goals
- Explore the expansion of the network vision around wider determinants of health – help us to think outside of traditional health care.
- Add find a more meaningful contribution process for OHT members
- Enhanced partnership

Specifically how would you make the wording of the goals stronger?

- Fewer words

Taken together, how well do these priorities and goals:

Rank on a scale of 1-5 with 1 being strongly disagree and 5 being strongly agree



Note: Participants clarified that the low score related to capacity are because they feel that there are too many goals/too much to accomplish.

Additional comments

Participants were encouraged to make notes throughout the session. Shared comments are captured here.

- Health equity lens need to be overlayed over all priorities and goals
- Adequately fund successful existing before starting new ones
- HHR wage stabilization across sectors
- Funding disparity
- Add dementia to integrated pathways
- Community paramedicine
- Patient advocacy
- Shared services – who is accountable?
- Where is the upper tier municipalities?
- Areas of focus – access to preventative care
- Not necessarily closest hospital – CAMH
- Rapid rate of growth not matching human health resources (HHR) needs
- First few years of OHT focused on priority populations. What happened to those groups and relation to the Ministry/OH
- Nothing shared about the priority population

- What is primary care prevention?
- Fund existing resources that work
- More primary care
- System reconfiguration/system navigation
- Primary care – NPs
- Meaningful patient engagement
- Include a higher proportion of community members in co-design
- Interpretation
- Digital
- HHR
- Primary Care Teams
- Team-based primary care
- Focus on health equity, vulnerable residents
- Needs local nuance
- Enabler – money in the right spots!
- Too much!
- Resources beyond pathway don't exist
- Meet people where they are.