CAMBRIDGE NORTH DUMFRIES | OHT

February 2024

Introduction to the Evolving Health System

Photo Credit: Pjrsoap

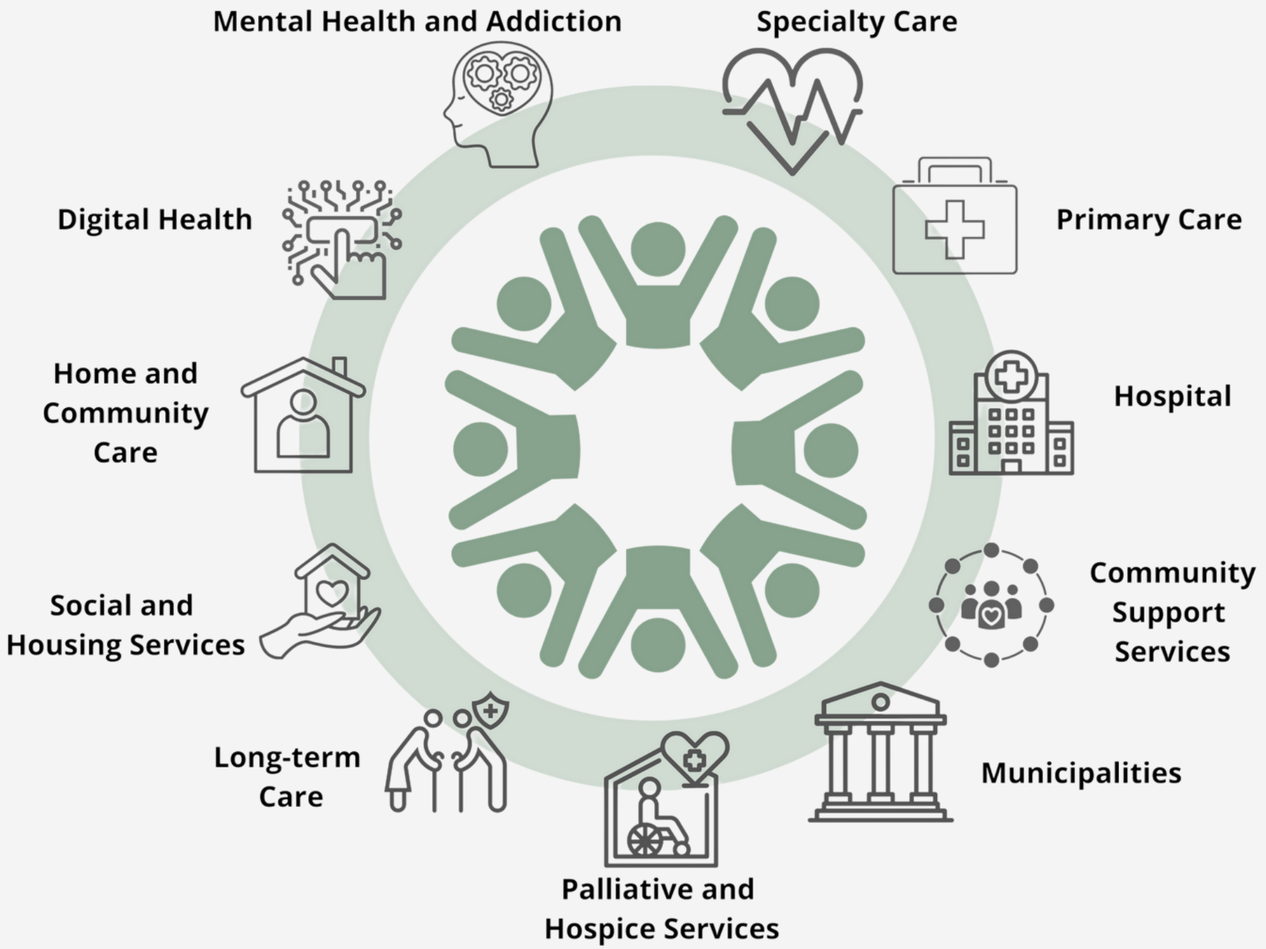
ONTARIO HEALTH TEAMS

Ontario Health Teams are integrating care and using equity-based population health approaches to deliver better health outcomes, and provide better experiences for patients.

What this means for patients:

- Easier transitions from one provider to another
- Improved access to care, including primary care

= **Improved patient outcomes**



Ontario Health Roles

Ontario
MINISTRY OF HEALTH
MINISTRY OF LONG-TERM CARE

HOME AND COMMUNITY CARE SUPPORT SERVICES

Consolidation of formal LHIN home care functions into HCCSS, including one shared service organization provincially.

Ontario Health

Connect, coordinate and modernize our province's health care system

Ontario Health West

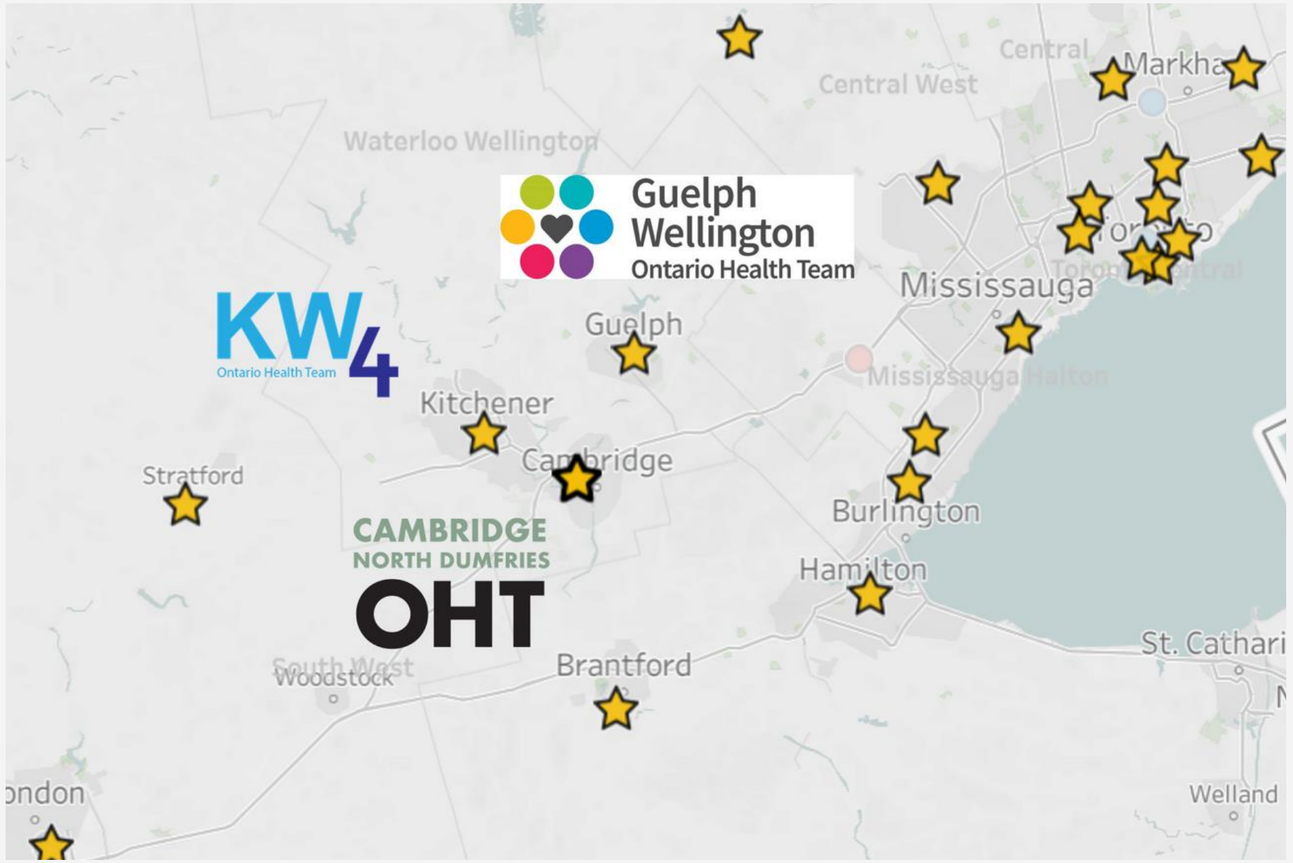
Implementing health system changes, leading the health systems within each region, funding health care providers and monitoring health care performance

CAMBRIDGE NORTH DUMFRIES OHT

Ontario Health Teams

Local health and community care providers work as one coordinated team to provide the right care at the right time for patients

ONTARIO HEALTH TEAMS
BY THE NUMBERS



58

Ontario Health Teams across the province

3

OHTs in Waterloo Wellington area

WE ARE CND OHT

CAMBRIDGE NORTH DUMFRIES | OHT

Our Vision

We envision a community where people access seamless and integrated services to ensure the health and wellbeing of our diverse populations

Our Values

- Inclusive
- Connected
- Accessible
- Adaptable

Our Guiding Principles

- Local Focus
- Safer Space
- Embrace Ambiguity

CAMBRIDGE NORTH DUMFRIES | OHT

2022-2025

STRATEGIC FRAMEWORK

OUR VISION

We envision a community where people access seamless and integrated services to ensure the health and wellbeing of our diverse populations

OUR VALUES

Inclusive | Connected
Accessible | Adaptable

OUR STRATEGIES

CORNERSTONE PRIORITY: Transform the healthcare journey

1. Put patients, families and caregivers at the centre of a re-designed health care experience.
2. Improve collaboration, care coordination and knowledge sharing across all partners.
3. Reduce barriers such as discrimination, stigma, culture and language to improve access to care.

TRANSFORMATION ENABLERS

Innovate, learn and continuously improve

1. Measure and monitor the impact and effectiveness of our OHT, and adapt strategies and priorities as needed.
2. Collaborate with other OHTs to drive innovation and accelerate transformation.
3. Evolve the governance of our OHT to promote transparent and collaborative decision making.

Advance reconciliation and foster diversity, equity and inclusion (DEI)

1. Develop a Reconciliation Action Plan in partnership with Indigenous communities.
2. Eliminate experiences of stigma, racism, oppression and inequity for patients and providers.
3. Improve the experience and outcomes for vulnerable populations.
4. Develop a DEI human resource strategy so our teams best reflect the diversity of our community.

Enable the full potential of our health human resources

1. Optimize the roles and functions of health human resources across our OHT.
2. Collaborate on human resource planning to increase capacity and promote recruitment and retention across all OHT partners.
3. Partner with healthcare providers to improve the provider experience and wellbeing.

ENABLING STRATEGY: Implement digital health tools to increase access to care, improve care coordination and collaboration and to enable evidence-informed planning and decision-making.

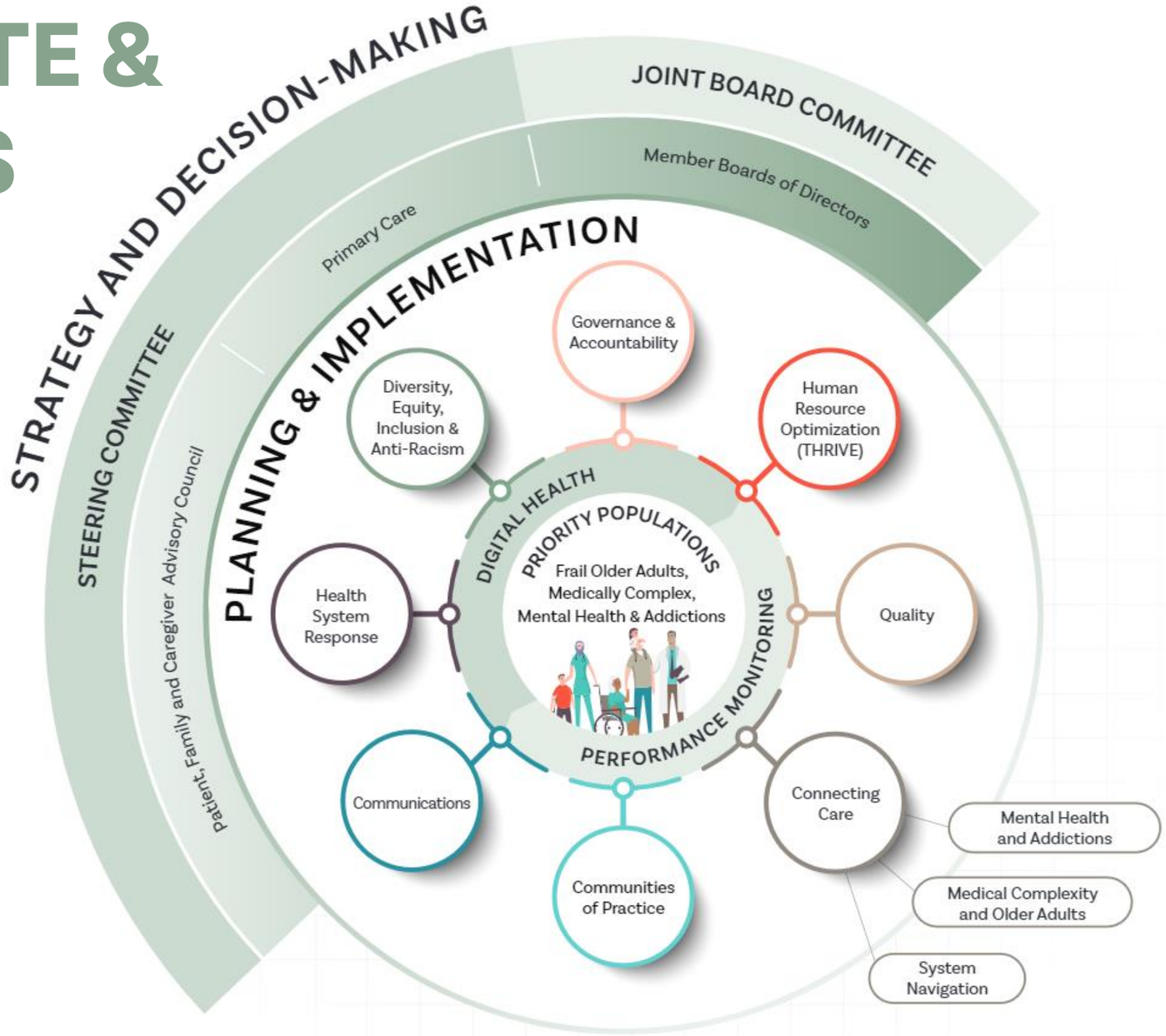
To learn more about the Cambridge North Dumfries Ontario Health Team visit www.cndoht.com

HOW WE OPERATE & MAKE DECISIONS

CND OHT follows a collective impact model with a focus on participatory and collaborative planning, decision making and strategy.

This graphic provides an overview of the various committees and groups that work together to support the OHT.

A small staff support team provides administrative and project coordination support for these groups.



Local solutions to local needs.

COMMUNITY MENTAL HEALTH & ADDICTIONS CLINIC

PILOT PROJECT: MAR - APR 23

Impact

123
Unique Patients

451
Patient Encounters

2
Emergency Department Diversions

11
Connected to a Primary Care Provider

Real-time Feedback Kiosk Survey

50% Said they would have gone to the ED if this clinic didn't exist

92% Felt their needs were addressed

97% Were satisfied with the care that they received

Next Steps

1. Carry out the evaluation framework, aligned with the Quintuple Aim, to inform the next steps of re-launch.

2. Apply lessons learned to the next priority population (frail older adults) and upcoming integrated care pathway work
   - Build upon experiences with **rapid collaboration** during the pandemic.
   - Centre **primary care** in the design and implementation of OHT projects.
   - Leverage partner strengths to embed an **equity** lens.
   - Optimize use of **digital health tools** to facilitate cross-organizational communication and data collection.

Langs Community. Health. Wellness.
TWO RIVERS Family Health Team
Waterloo Region Nurse Practitioner-Led Clinic
PORCHLIGHT Counselling + Addiction Services
Grandview Medical Centre Family Health Team
House of Friendship
Canadian Mental Health Association Waterloo Wellington

CAMBRIDGE NORTH DUMFRIES | OHT

LET'S CONNECT

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KW4 OHT

Tara Groves-Taylor

Who we are

Territory Coverage

The map highlights the KW4 Ontario Health Team (OHT) coverage area including 2/3 cities part of the Waterloo Region. KW4 represents Kitchener, Waterloo, and the Townships of Wellesley, Wilmot and Woolwich. Neighbouring OHTs include Cambridge North Dumfries and Guelph Wellington

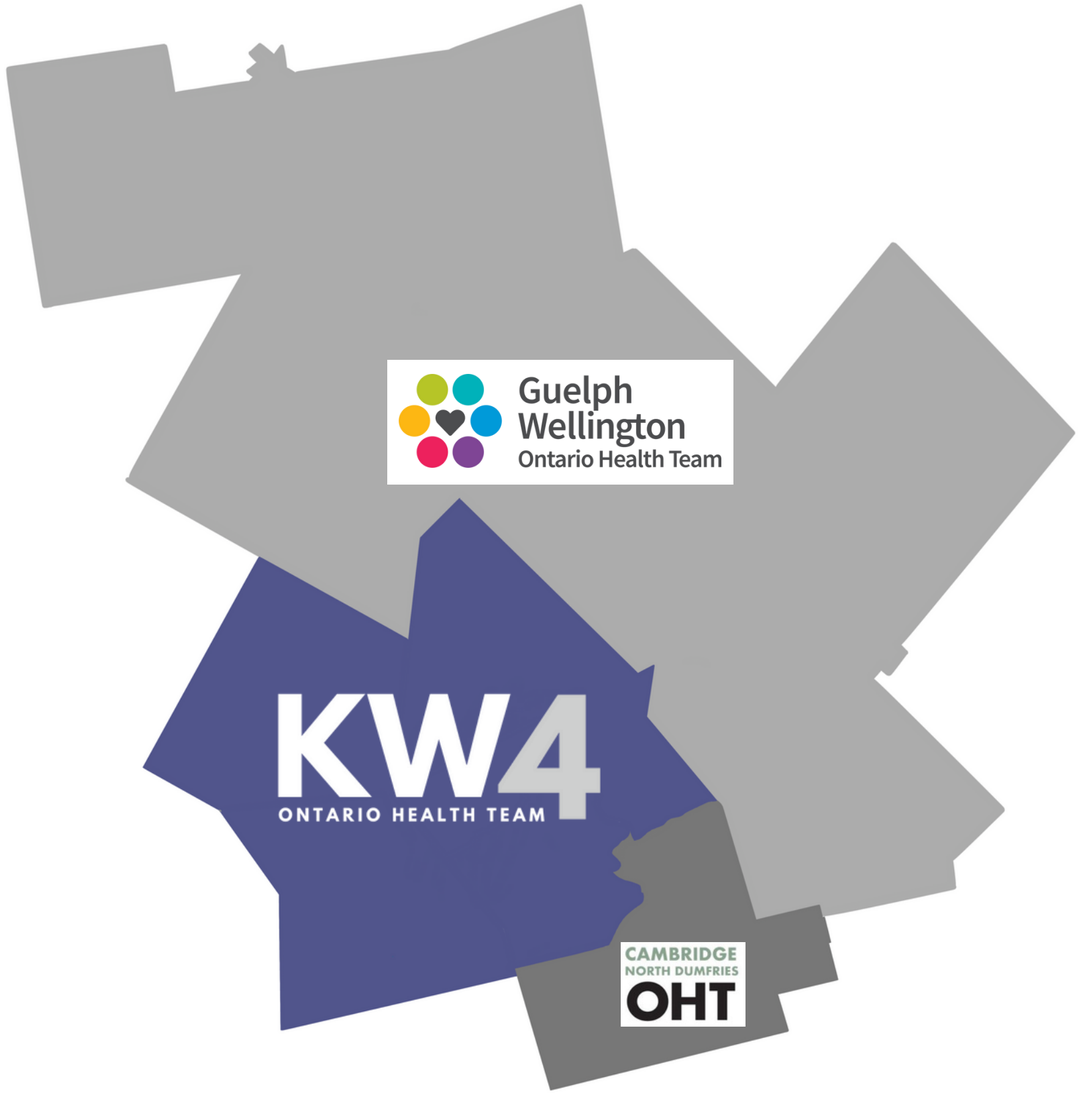
41 Partners

The current partnered organizations (and growing) include:

- Hospital
- Home and Community Care (SPO & HCCSS)
- Mental Health and Addiction
- Community Health Centre
- Long-Term Care Home
- Nurse Practitioner Led Clinic
- Primary Care (FHT)

Cross-Industries Collaboration

Having varying industries vested in a common health care focus, collaboration, and support across the different industries including education, technology, healthcare, grassroots, etc.



The Path Forward:
Integrated Care

Primary Care

Hospital Services

Mental Health & Addictions Services

Long-Term Care

Home & Community Care

Social Service Agencies/Housing

ONTARIO HEALTH TEAMS

Ontario Health

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;

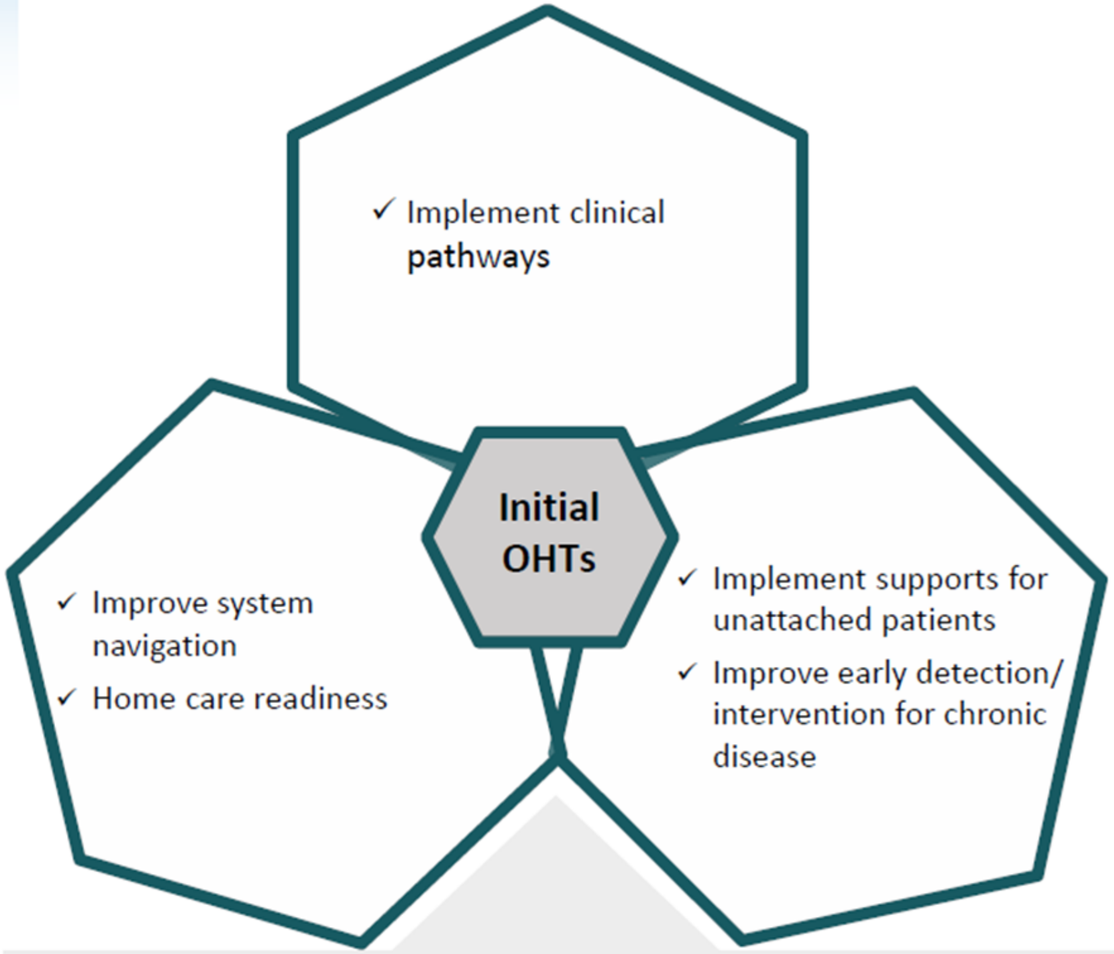
Continuing to establish ourselves as a reliable leader and partner;

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.

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

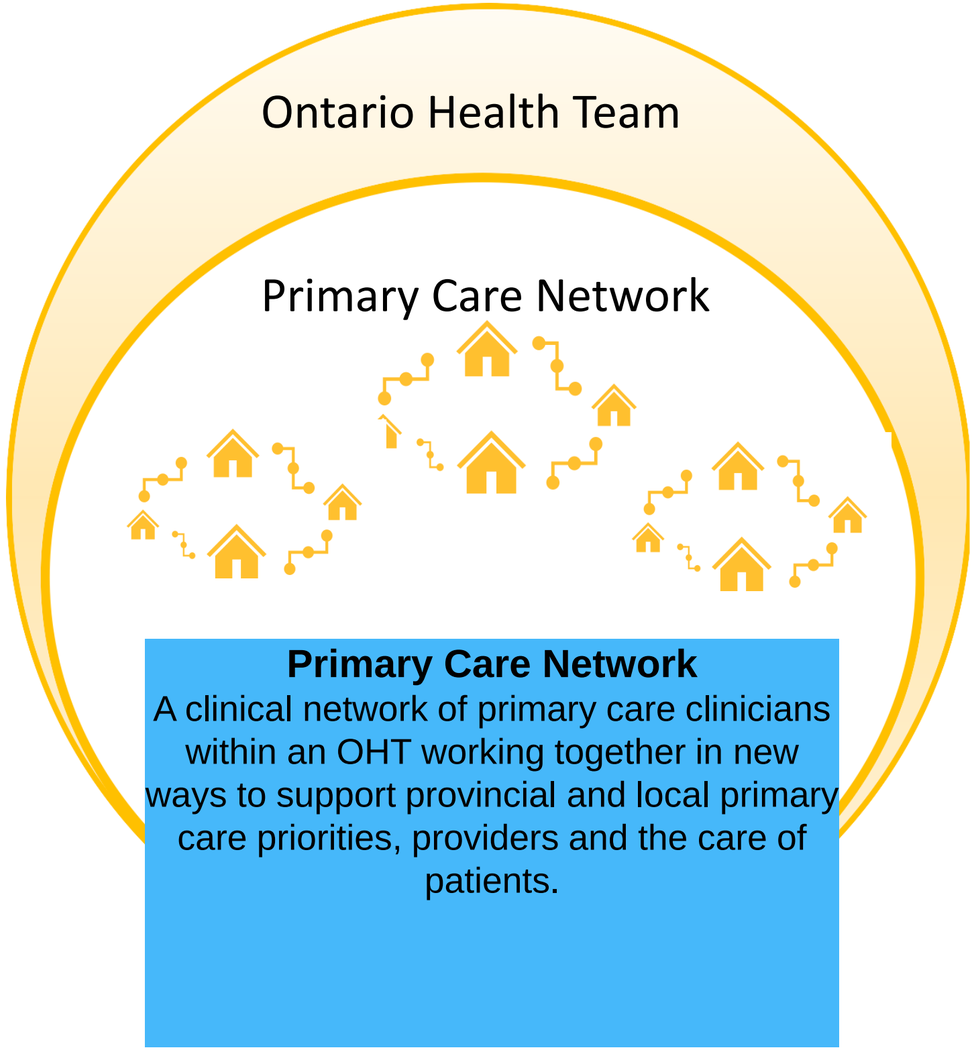
OHTs

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.

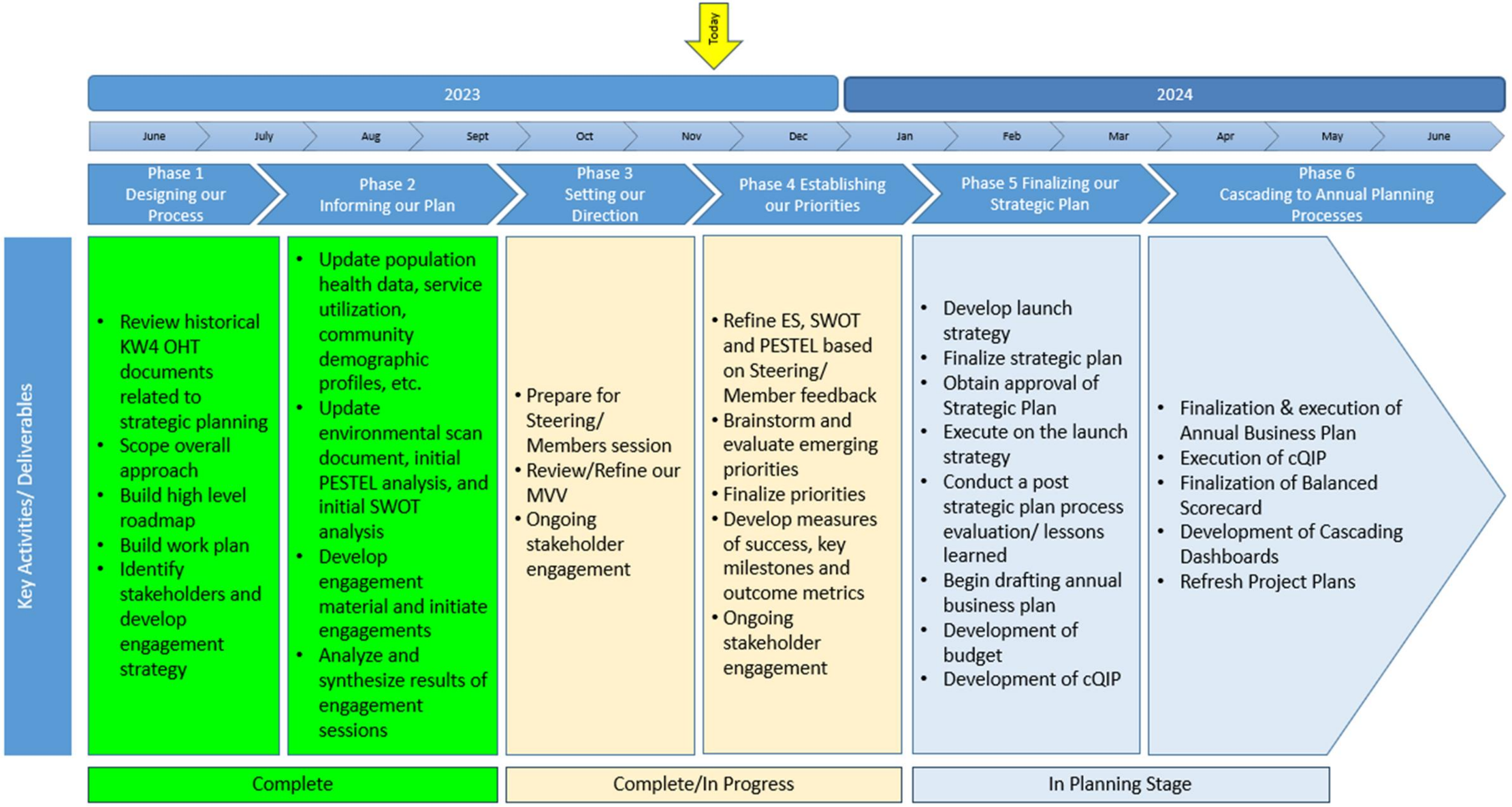


Ontario Health

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
ONTARIO HEALTH TEAM

Strategic Planning Overview



Thank you!

info@kw4oht.com

KW4
ONTARIO HEALTH TEAM