SUMMIT
Shaping the Future of Health Care Together in Hastings Prince Edward

Curriculum

Supported by:

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Jodeme Goldhar, Principal
Meghan Perrin, Associate

#HPEOHTShapingOurFuture

MAINTENANCE OF CERTIFICATION

Attendance of this program entitles certified Canadian College of Health Leaders members (CHE/Fellow) to:

- Governance and Leadership sessions:
  - **1.75 Category II credits** for each session (Nov 5, Nov 28)
- 3-Day Summit (Nov 20,21,22)
  - **8.25 Category II credits**
- 1 Day Symposium (January 2025)
  - **3.25 Category II credits**

towards their maintenance of certification requirement

This 1 Group Learning program has been certified by the College of Family Physicians of Canada and the Ontario Chapter for **1.4 Mainpro+ credits**

Speaker Disclosure: Jodeme Goldhar

Vice Chair Board of Directors and Co-Founder International Foundation for Integrated Care (IFIC) Canada at University of Toronto

Co Director McMaster University Health Leadership Academy Programs

Relationships with financial sponsors : NONE

Grants/Research Support | Speakers Bureau/Honoraria | Conflicts of Interest

Working collectively is critical to healing our people and our planet

No single organisation can achieve meaningful progress in the complex health and social care environment alone. Working collaboratively is the only viable way to solve the urgent challenges of our time.

Yet even the best collective efforts rarely transform systems because they don't know how to shift the values, mindsets, power dynamics, and relationships that underpin our systems.

Transformative practices do exist that can catalyze shifts in mindsets and values, but they remain peripheral to social and environmental problem solving.

The next frontier of systems change is bringing those practices from the periphery to the mainstream, so that everyone working to shift our systems for the better can work in more transformational ways!

Adapted from: Collective Change Lab

- Equip health and social change leaders to pursue **transformative systems change approaches**
- Elevate transformative practices **from the periphery to the mainstream**
- **Influence the dialogue** on how systems change actually happens

THEN THERE WILL BE:

- A **new narrative** about how transformative system change happens
- A growing number of health and social change **leaders who integrate transformative practices into their work**
- Promising results from those "early adopters" that **builds further momentum**

SO THAT EVENTUALLY:

- A majority of health and social change leaders **shift their beliefs** about how systems change happens
- A majority of health and social change leaders **shift their behaviour** by integrating transformative practices into how they do the work of systems change

Adapted from: COLLECTIVE change lab

What Is Brave Space

A brave space is a supportive place where peoples feel comfortable learning, sharing honestly and equally, and growing individually and together.

Sensemaking in a Complex World

Sensemaking is a key skill for leaders. It means being an explorer rather than an expert, constant experimenting, & sound judgment.

SIX WAYS TO MAKE SENSE
- HAROLD JARCHE -

BE CURIOUS
CURIOSITY ABOUT IDEAS CAN FOSTER CREATIVITY
CURIOSITY ABOUT PEOPLE CAN DEVELOP EMPATHY
WE GET new IDEAS FROM new PEOPLE

DEAL WITH AMBIGUITY
AMBIGUOUS SITUATIONS DEMAND SOLVING PARADOXICAL and COGNITIVE DILEMMAS ENABLING INNOVATIVE SENSEMAKING

SEE WITH SEVERAL LENSES
ACTIVELY ENGAGE IN COMMUNITIES of PRACTICE TO DEVELOP SHARED UNDERSTANDING WITH OTHERS

EXPERIMENT
TAKE CONTROL of YOUR LEARNING and WORK TO BE UNIQUE AND CREATIVE

BROADEN YOUR KNOWLEDGE CIRCLES
CREATE OUR OWN EMERGENT PRACTICES THROUGH DIVERSE CONNECTIONS and CONVERSATIONS

SHARE YOUR WORK
SEEK → WISE NETWORK
SENSE → REFLECT and MAKE MEANING
SHARE → IDEAS and RESOURCES
LEARN COLLECTIVELY

"OUR ECONOMIC VALUE WILL BE IN DOING WHAT MACHINES CAN'T DO."

"UNLIKE MECHANICAL SYSTEMS, HUMAN SYSTEMS THRIVE ON VARIETY and DIVERSITY"

Sketchnote: Tanmay Vora
@tnvora
QAspire.com

Source: via Helen Beven (LinkedIn)

What is Integrated Care and Population Health?
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Defining Integrated Care

> Integrated Care has been defined in many different ways that converge on a common set of shared principles and practices for care.
>
> In the broadest sense, integrated care includes changes that enhance teamwork and patient centeredness across the dimensions of policy, health systems, organisations, and health care provider practices.

Wankah, P., et al. (2023). Equity Promoting Integrated Care: Definition and Future Development. International journal of integrated care, 23(4), 6. https://doi.org/10.5334/ijic.7614

Through the Lens of Patients and Caregivers

> My care is planned with people who work together to understand me and my carer(s), put me in control, co-ordinate and deliver services to achieve my best outcomes.

National Voices UK, 2021

Through the Lens of Clinicians

Integrated Care and Population Health are interconnected, addressing both individual patient needs and broader population health goals

- Integrated Care

- **Patient-Centered** and **Patient-Directed Care**
- Interdisciplinary, cross-organisational and sectoral-spanning **collaboration** to create a holistic view of patient needs.
- **Inter-operable** electronic medical records facilitate access to patient information, promoting better decision-making across providers.
- Focus on **continuity and smooth transitions** between different levels of care, reducing gaps that can lead to adverse outcomes.

- Population Health

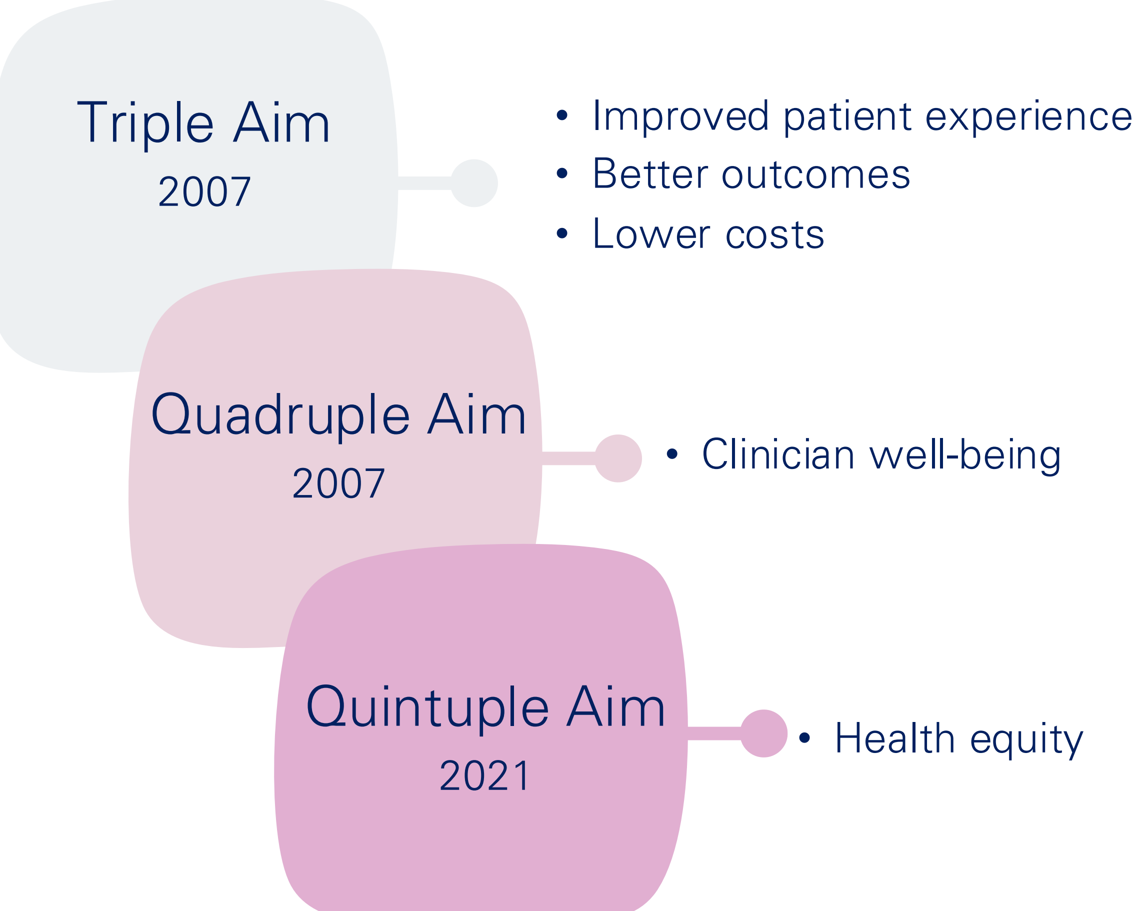
- **Shift in focus to community** - including health equity and the social determinants of health
- Shift to **using population health data** to inform clinical practice and support targeted interventions.
- Shift towards **greater interprofessional preventive care** in **equal partnership with patients and communities**

Equity-Promoting Integrated Care

> The effort to promote health equity through the implementation of integrated models of care begins with a clear understanding of the ways in which social, political and historical systems generate health inequities in the first place.
>
> **A clear understanding of these root causes** provides a crucial input to the effort to design models of care with higher potential to intervene in the pathways through which health inequities are produced.

Wankah, P., et al. (2023). Equity Promoting Integrated Care: Definition and Future Development. International journal of integrated care, 23(4), 6. https://doi.org/10.5334/ijic.7614

Quality Improvement Aims
Quintuple Aims are Converging



Health systems around the world are converging on their aims (population health) but differ on their ‘how to’ and the stage of implementation.

What is Population Health?

"…shift our focus from problem solving, disease-specific approaches to assuming accountability towards a territorially defined population."

"…focus on addressing the root causes – the determinants of health and the reduction of health disparities."

Source:
IFIC Knowledge Tree: Population Health and Wellbeing

Creating Transformative Impact

Cumulative evidence from systematic reviews, peer-reviewed research, case studies and evaluations

Understanding your ambition

Creating an enabling environment

Learn more:
International Foundation for Integrated Care (IFIC) // Nine Pillars of Integrated Care
International Journal for Integrated Care (IJIC)

Three Horizons: The Patterning of Hope

Bill Sharpe

How can people work together to create the transformational change in the face of an uncertain future?

There are two main sorts of change:

- Continue the pattern of how we are doing things today
- Start a new pattern for the future we want and need

Source: Sharpe, Bill. Three Horizons: The Patterning of Hope. (2nd edition, 2020)

The Three Horizons: Patterning of Possible Futures and Hope

Value

New Patterns
Ambiguous
innovation

Horizon 3
Emerging paradigms, ideas, innovations

Horizon 2
Incremental adjustments, transformational experiments

Horizon 1
Current paradigms, assumptions, data, infrastructure

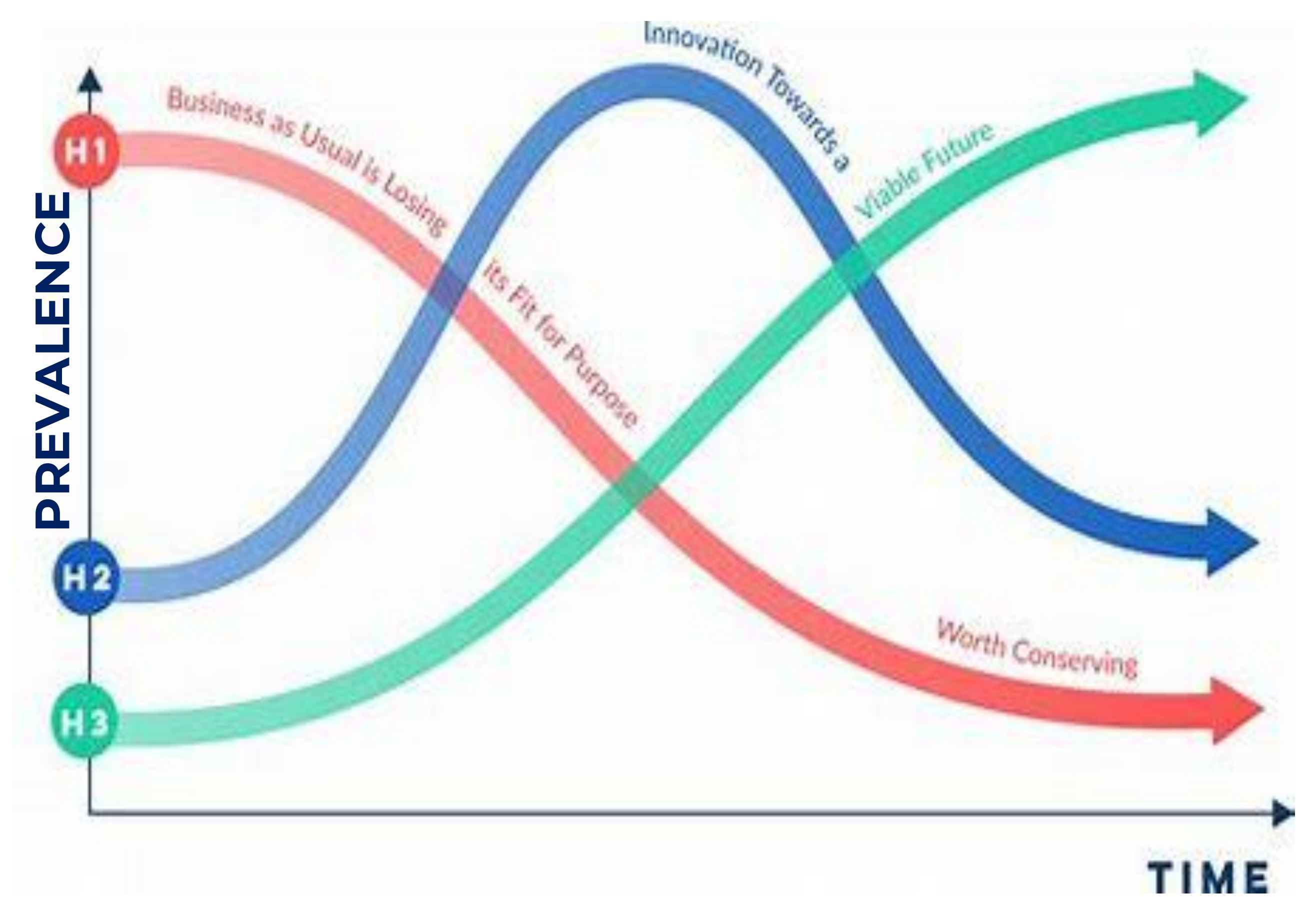
Pockets of the future found in the present

Now | Near Future | Far Future

Source: Sharpe, Bill. Three Horizons: The Patterning of Hope.

Thinking about our future direction using Bill Sharpe's "Three Horizons" model

- **Horizon 1:**
  What are our current ways of working (context, focus, methods, patterns, structures etc)? What is viable/not viable for the future?
- **Horizons 2:**
  How can we build a path between where we are now and where we would like to be in future? What actions should we take?
- **Horizon 3:**
  What could we do differently in the future in radically different ways to achieve our ambitious goals? Where are the emerging opportunities?



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Source: Sharpe, Bill, et al. "Three Horizons: A Pathways Practice for Transformation

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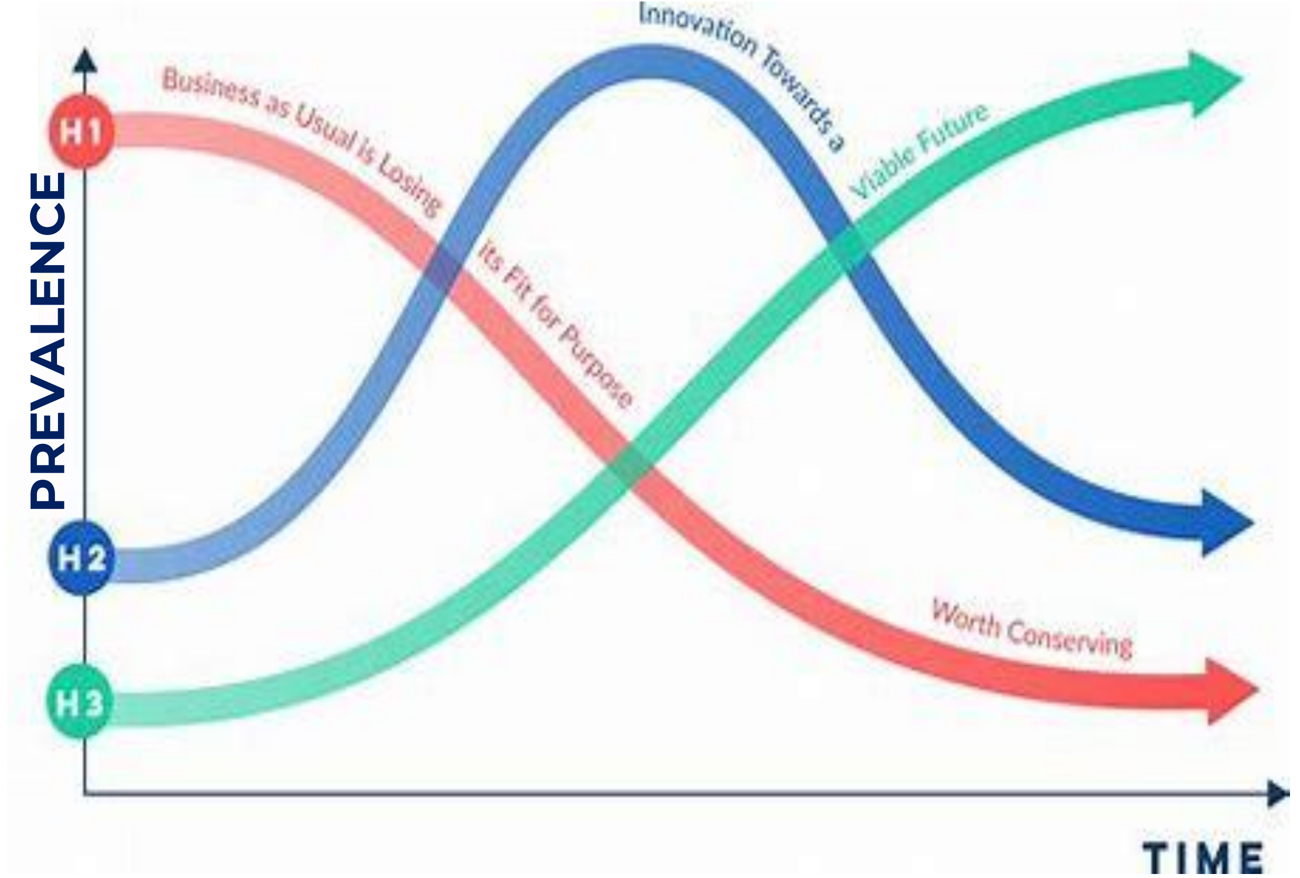

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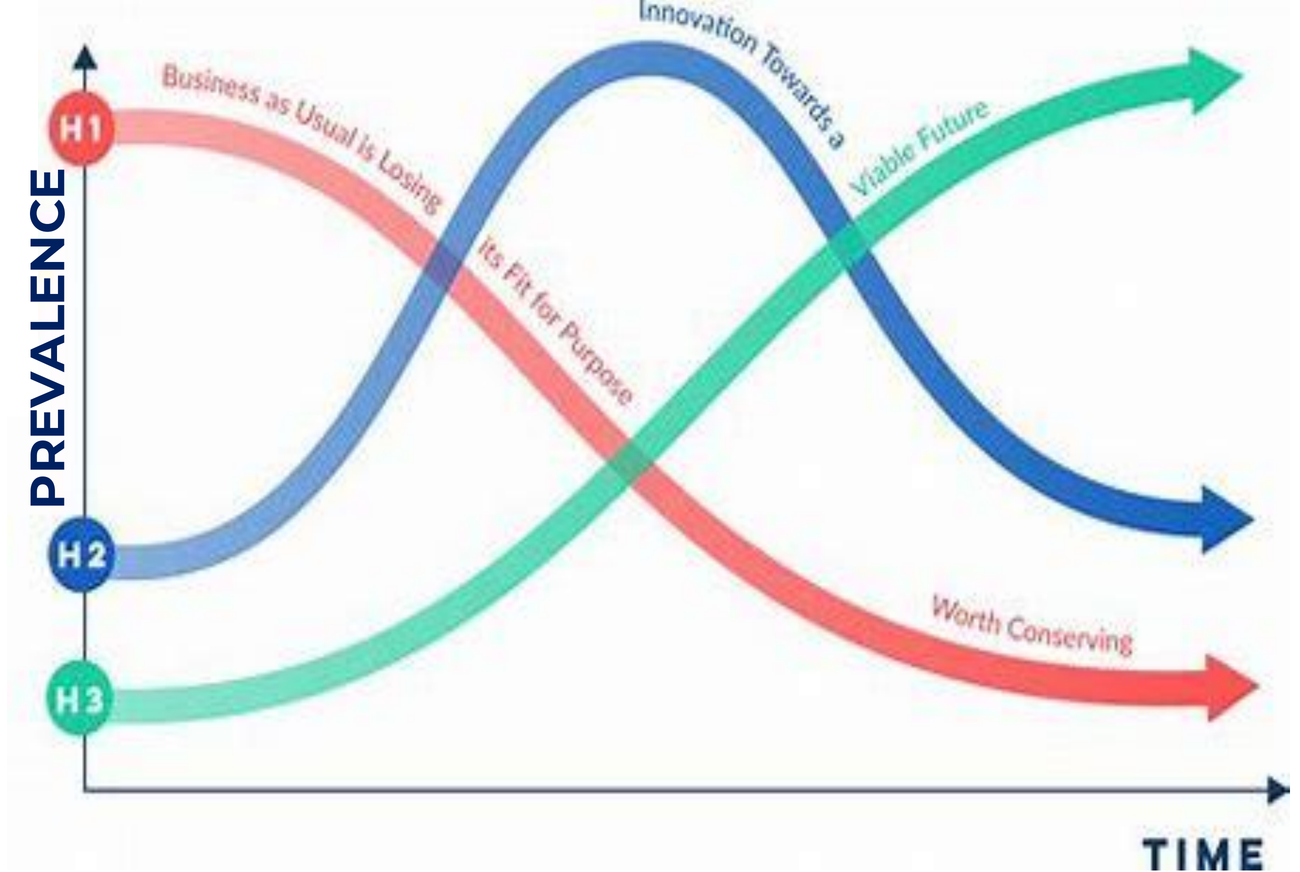

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Source: Sharpe, Bill, et al. "Three Horizons: A Pathways Practice for Transformation

Tomorrow belongs to those who can hear it coming

-David Bowie

Trust as the Foundation of Collaboration

THE COLLABORATION SPECTRUM

COMPETE	CO-EXIST	COMMUNICATE	COOPERATE	COORDINATE	COLLABORATE	INTEGRATE
Competition for clients, resources, partners, public attention	No systematic connection between organizations and/or individuals	Information is shared between organizations and/or individuals	As needed, often informal, interaction on discrete activities or projects	Systematically adjust and align work with each other for greater outcomes	Shared mission, goals, decision-making, and/or resources	Fully integrated programs, planning, funding

TURF

TRUST

Adapted from Weaver, Tamarack Institute

Frameworks Collection by finegood@sfu.ca | Illustrated by sam@drawingchange.com | © CC BY-NC-ND

The Neuroscience Behind Moving at the Speed of Trust

We are in the process of realizing that
we communicate through our nervous systems as much as our intellects.

In the past few years, the theory has spread to the broader wellness and health and care communities.

As individuals, we become better, more compassionate communicators as we understand how human connections are formed.

As a society we can glean a new paradigm for providing care, whether the care be given in an institution, in community, in a classroom or home.

@Polyvagal Institute

Polyvagal Theory

AROUSAL INCREASES

FREEZE
Body collapse
Immobility

Dissociation
Numbness
Depression
Conservation of energy
Helplessness

DORSAL VAGAL

Shame
Shut-Down
Hopelessness
Preparation for death
Trapped

OVERWHELM
"I CAN'T"

FLIGHT
Movement away
Panic
Fear
Anxiety
Worry & Concern

FIGHT
Movement towards
Rage
Anger
Irritation
Frustration

"I CAN"

SYMPATHETIC

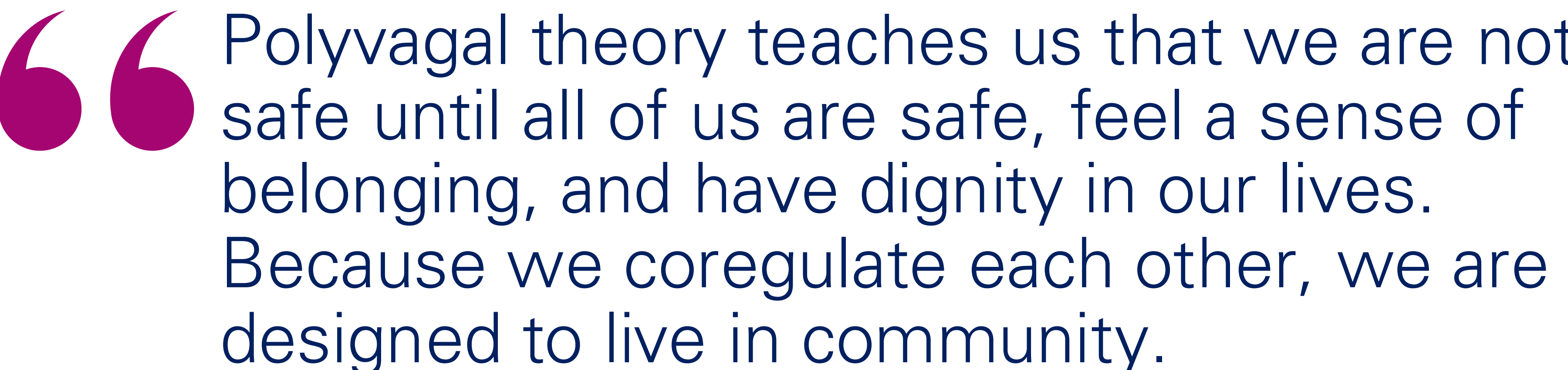
DEACTIVATION

Joy
In the Present
Groundedness

SOCIAL ENGAGEMENT
Connection • Safety
Oriented to the Environment

Curiosity/Openness
Compassion
Mindful

VENTRAL VAGAL



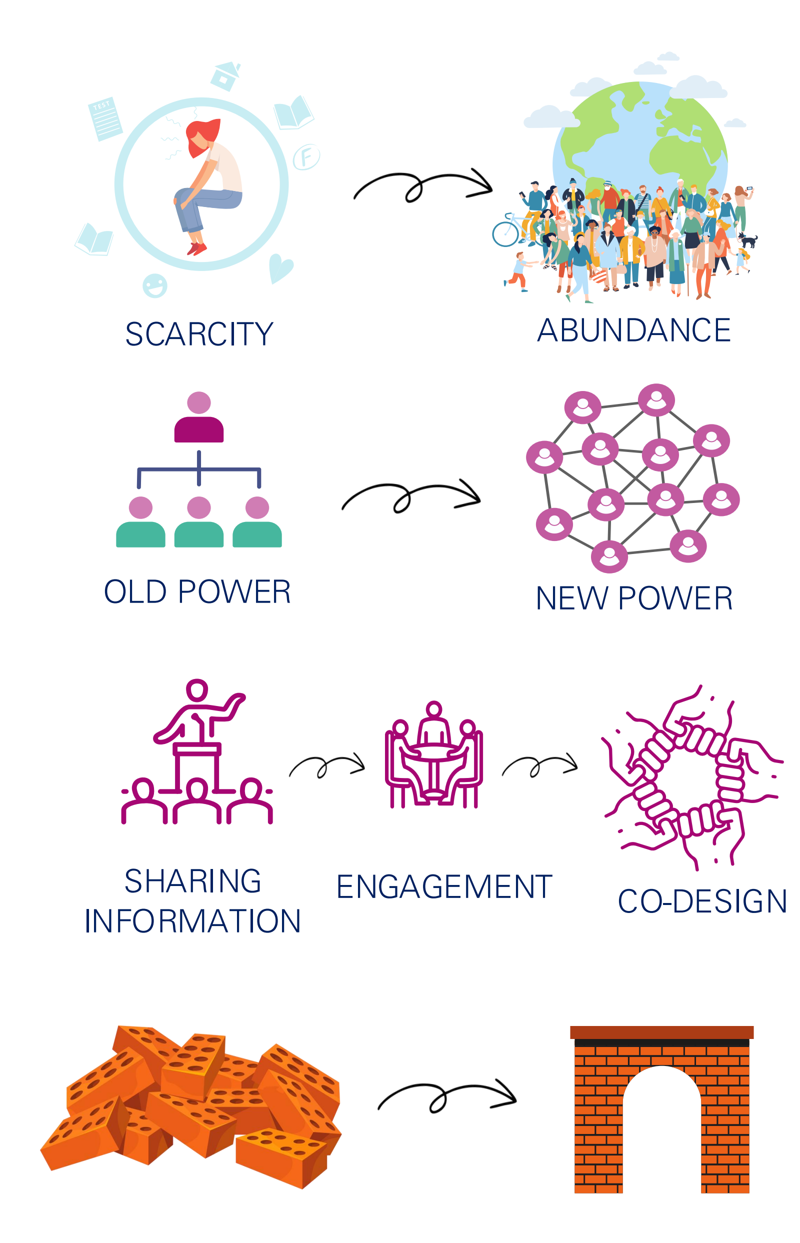
Jan Winhall

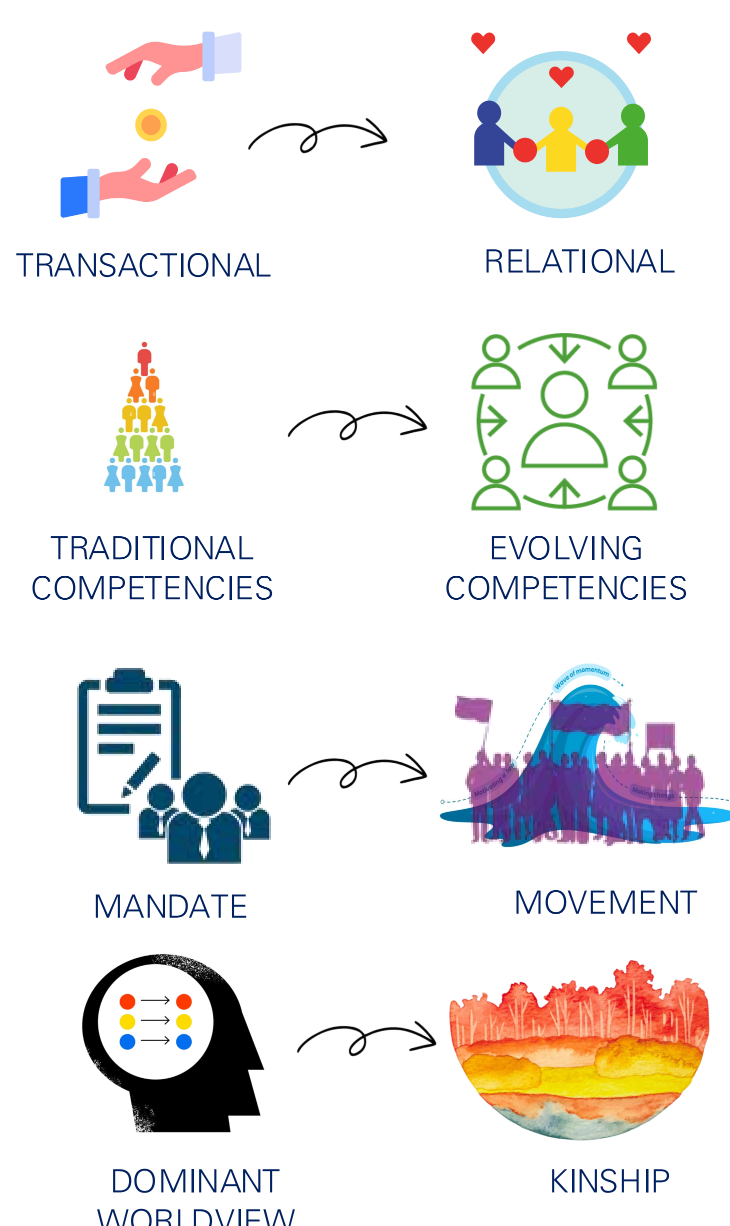
> We do not see things as they are.
>
> We see things as we are.

- Anaïs Nin

Deeper Dimensions: Mindset and Behaviour Shifts

Mindset and Behaviour Shifts





From Mission to Shared Purpose

MISSION

SHARED PURPOSE

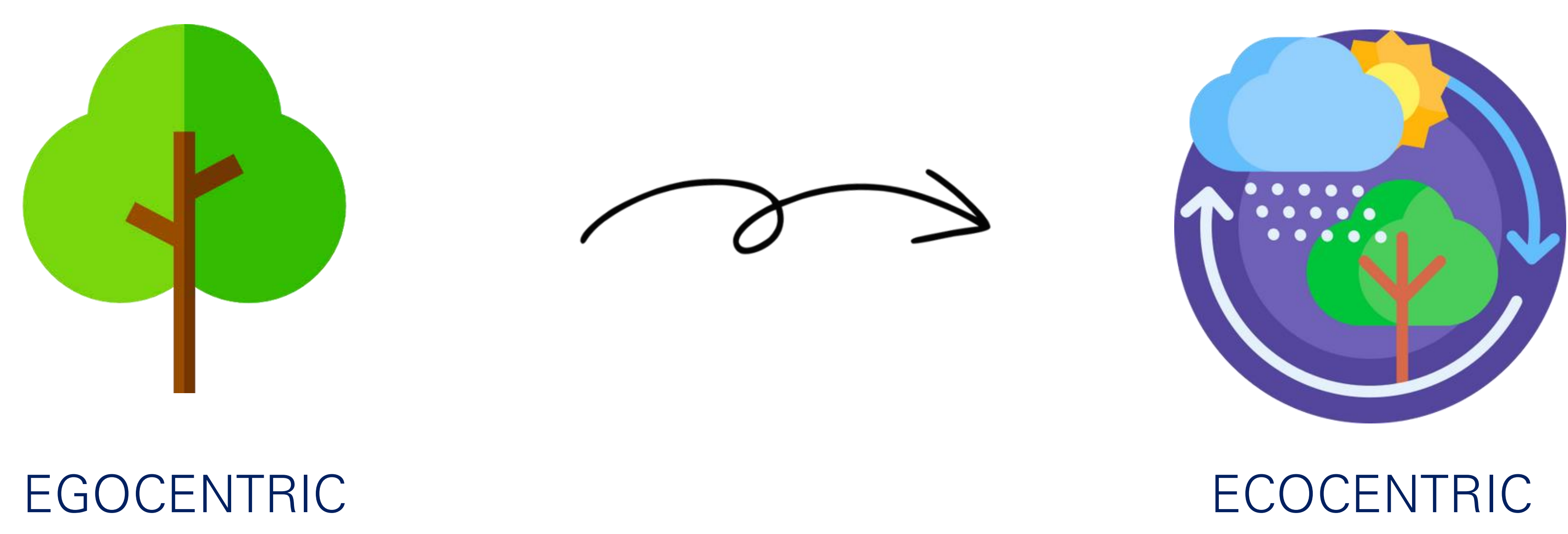
From organisational to Collective Impact

organisationAL IMPPACT

COLLECTIVE IMPACT

Learn more : Tamarack Institute: Collective Impact

From Egocentric to Ecocentric



From Shame and Blame to Strengths- Based

Seek to Understand

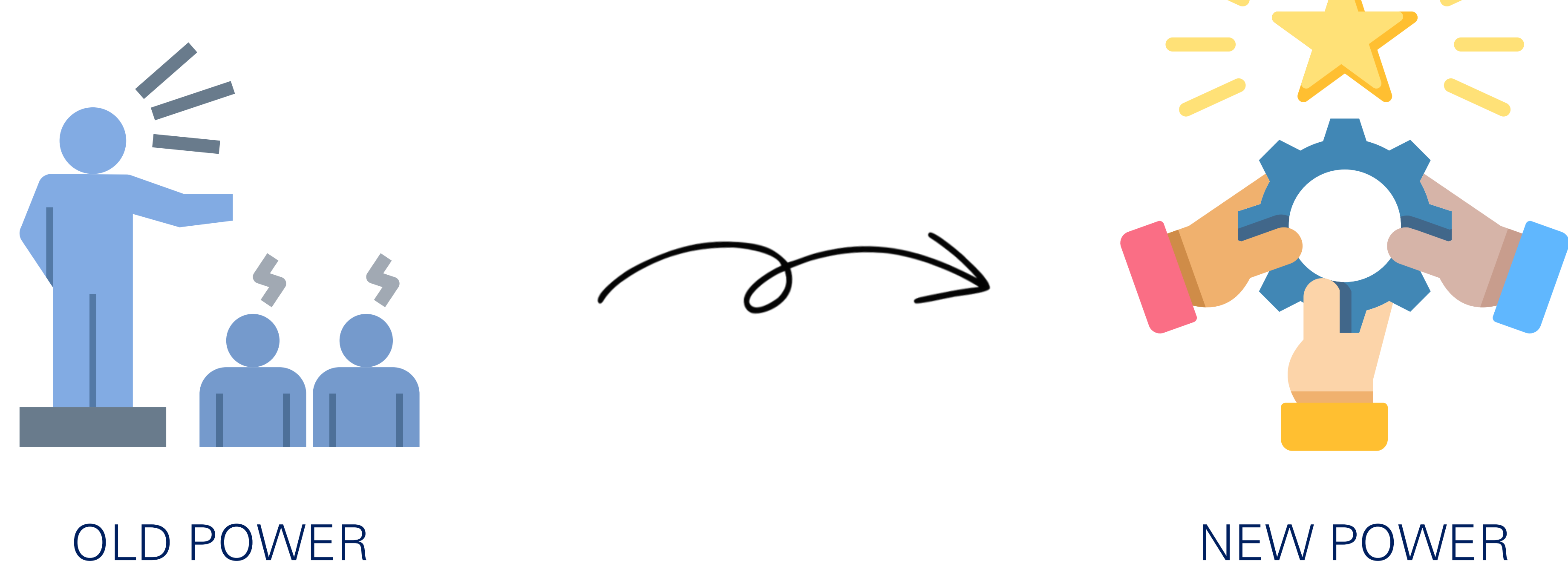
STRENGTH BASED

From Scarcity to Abundance

SCARCITY

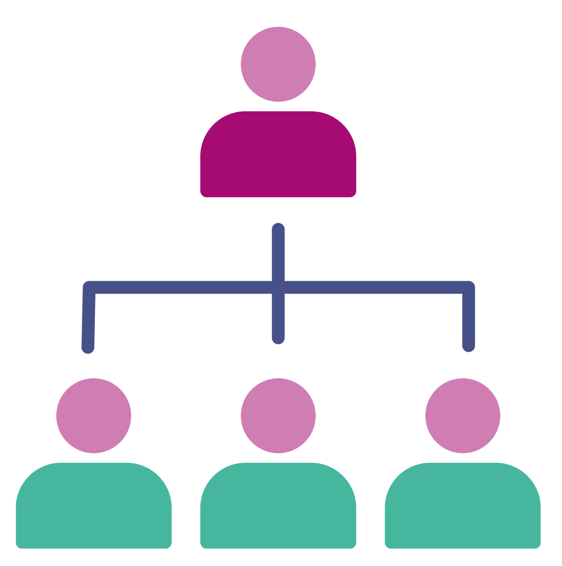
ABUNDANCE

From Old Power to New Power

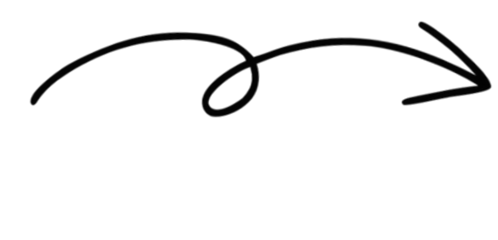


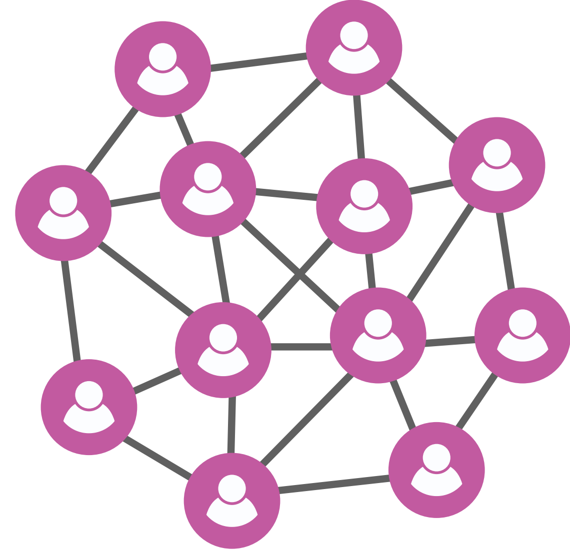
Learn More:
New Power https://thisisnewpower.com/ (Jeremy Heimans and Henry Timms). : Article (HBR) | Book

From Formal Leaders to Super Connectors



FORMAL LEADERS
'Designed for Division'

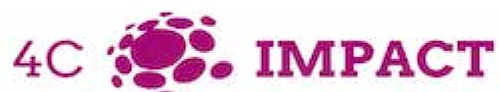




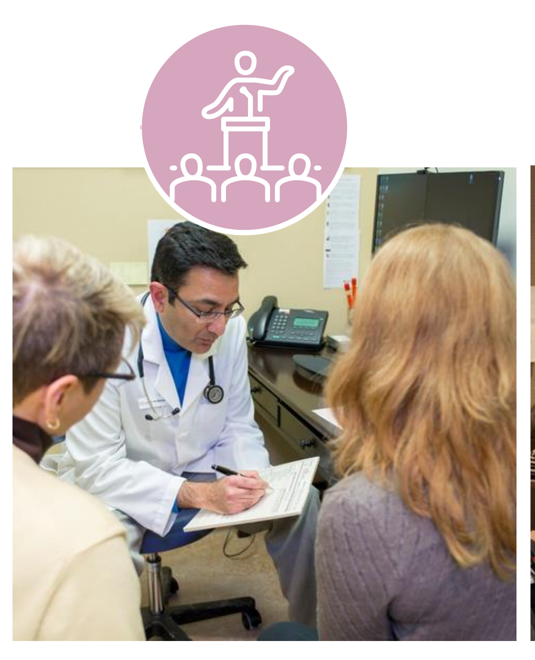
SUPER CONNECTORS
'Designed for Connections'

Source: Understanding "New Power". Harvard Business Review

Learn more: https://thisisnewpower.com/ Jeremy Heimans and Henry Timms



From Sharing Information to Co-Design



Era One:
Sharing Information

Power differential between provider(s), patients and caregivers

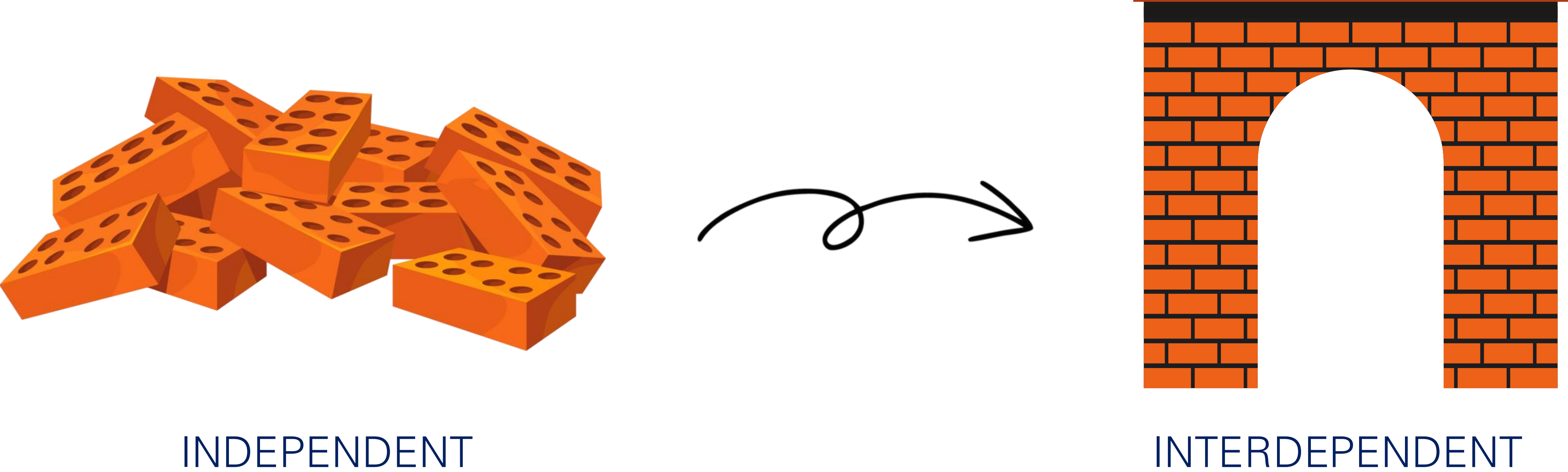
Era Two:
Engaging Patients and their Families

Shifting power differential between provider(s), patients and caregivers

Era Three:
Co-Define and Co-Design

Power is shared between provider(s), patients and caregivers

From Independent to Interdependent



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From Transactional to Relational

TRANSACTIONAL

RELATIONAL

Learn more:
A New Approach to Contracts: How to build better long-term strategic partnerships, Harvard Business Review, 2019
The Relational Work of Systems Change, Stanford Social Innovation Review, 2022

From Traditional to Evolving Competencies

TRADITIONAL COMPETENCIES

EVOLVING COMPETENCIES

Facilitators, brokers and convenors

Source: Giles, Sunnie. The Most Important Leadership Competencies According to Leaders Around the World. Harvard Business Review.

A social movement begins by motivating a few individuals, which creates a wave of momentum. This collective action can then drive significant change.

Based on Registered Nurses' Association of Ontario's Leading Change Toolkit. Image developed by The Center for Implementation, © 2024 | 2024.01 | For full citation: https://thecenterforimplementation.com/toolbox/social-movement

From Mandate to Movement

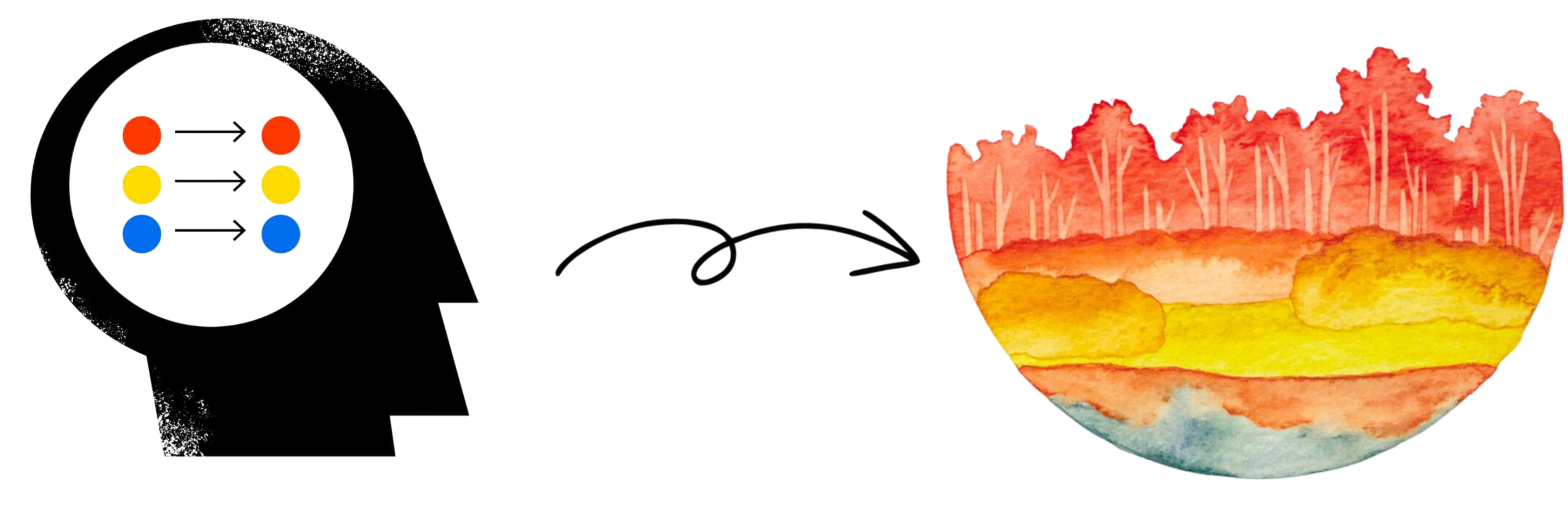
MANDATE

requires buy-in

MOVEMENT

creates investors

From Dominant Worldview to Indigenous Worldview



DOMINANT WORLDVIEW

KINSHIP

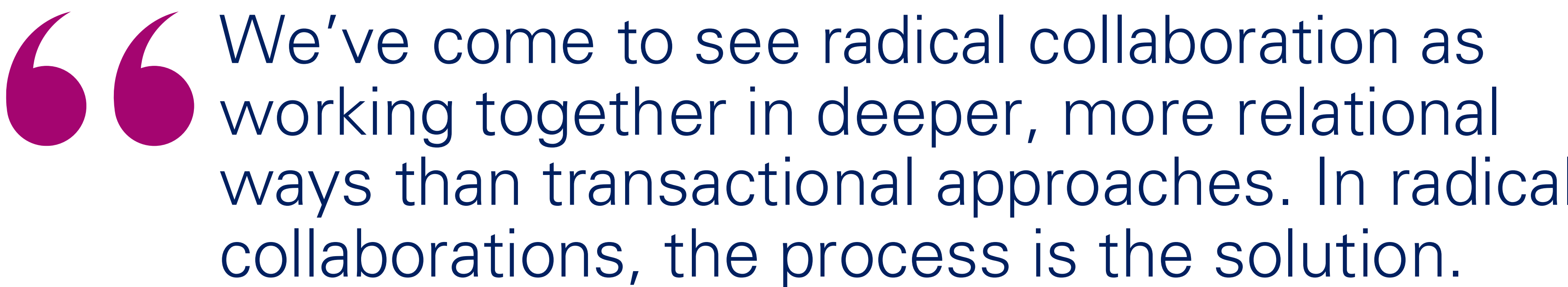
Source: Excerpts from Wahinkpe Topa (Four Arrows), Darcia Narvaez (2022)
Restoring the Kinship Worldview: Indigenous Voices Introduce 28 Precepts for Rebalancing Life on Planet Earth

Common Dominant Worldview Manifestations →	Common Indigenous Worldview Manifestations
Rigid hierarchy	Nonhierarchical
Focus on self and personal gain	Emphasis on community welfare
More head than heart	Emphasis on heart over head
Earth as an unloving "it"	Earth and all systems as living and loving
Minimal empathy, humility, and gratitude	Strong emphasis on empathy, humility, and gratitude
Words used to deceive self or others	Words as sacred, truthfulness as essential
Truth claims as absolute	Truth seen as multifaceted, accepting the mysterious
Rigid boundaries and fragmented systems	Flexible boundaries and interconnected systems
Unfamiliarity with alternative consciousness	Regular use of alternative consciousness
Disbelief in spiritual energies	Recognition of spiritual energies
Disregard for holistic interconnectedness	Emphasis on holistic interconnectedness
Minimal contact with others	High interpersonal engagement
Emphasis on theory and rhetoric	Inseparability of knowledge and action
Acceptance of authoritarianism	Resistance to authoritarianism
Time as linear	Time as cyclical
Acceptance of injustice	Intolerance of injustice
Emphasis on rights	Emphasis on responsibility
Ceremony as rote formality	Ceremony as life-sustaining
Learning as didactic	Learning as experiential and collaborative

Source: Excerpts from Wahinkpe Topa (Four Arrows), Darcia Narvaez (2022) Restoring the Kinship Worldview: Indigenous Voices Introduce 28 Precepts for Rebalancing Life on Planet Earth

Matching Complexity with Competency
Connection is the Correction

Radical Collaboration



Katherine Milligan & Cynthia Rayner

What does Radical Collaboration Really Mean

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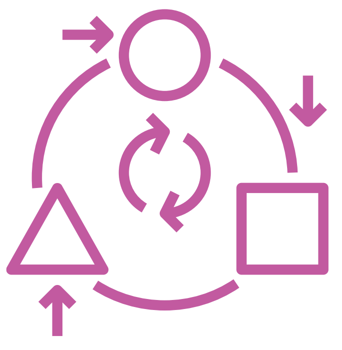
Radical Collaboration for System Change

Collaborative Alliances
Stakeholders shift from being unwilling or unable to work together, to building their capacity to work together across differences.

Systemic Insights
Stakeholders shift from seeing and understanding only part of what's going on, to broadening and deepening their understanding of what's happening and could happen.



Transformative Actions
Stakeholders shift from acting in a way that keeps things the way they are, to acting in a way that fundamentally changes what's happening

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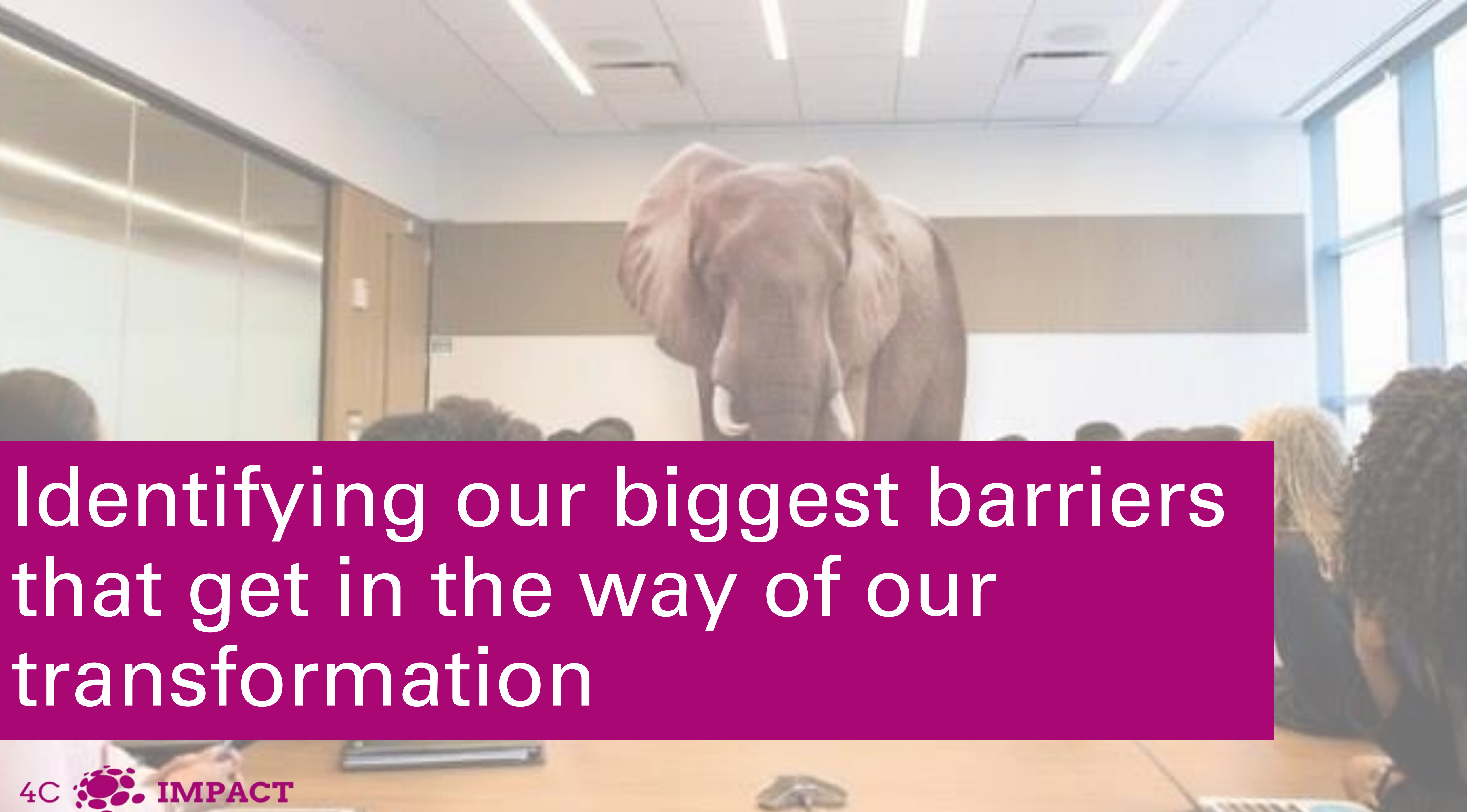

Identifying our biggest barriers that get in the way of our transformation
4C IMPACT

> Any innovation, change or transformation process is **much more likely to succeed if key tensions are addressed**. These tensions typically aren’t apparent at developmental stages but are fully exposed at implementation.
>
> \- Helen Bevan

Embracing The Nine Interrelated Elements Required For Large-scale Change

Recurring and interrelated themes in approaches to enabling large scale change

Moving together towards a shared direction

Changing yourself as a resource for change

Co-producing change: “with” & “by”, not “to” or “for”

Shaping networks to shape opinions

Setting up systems for experimental learning & unlearning

Creating the conditions for emergent change

Leading people through transitions in situations of uncertainty

Developing leaders everywhere: sustainable systems of distributed leaders

Building power: a spectrum of allies AND working through pillars of formal power

Source: Global assessment of change concepts by Helen Bevan (England) and Goran Henriks (Sweden) reviewed by 500 change leaders (2024)

Recurring and interrelated themes in approaches to enabling large scale change

Moving together towards a shared direction	This theme emphasizes the importance of aligning the vision and goals of everyone involved in the change process. It is about creating a common purpose that guides collective action, ensuring that all stakeholders are moving in sync toward the desired outcomes.
Changing yourself as a resource for change	Leaders and participants in the change process need to be adaptable and willing to evolve personally. This concept underscores self-reflection and growth, encouraging individuals to cultivate their skills, attitudes, and mindsets to better support the change effort.
Creating the conditions for emergent change	Instead of imposing a rigid plan, this approach involves setting up a flexible environment where change can naturally evolve. By establishing the right conditions, leaders can enable adaptive and responsive shifts that emerge organically in response to challenges and opportunities.
Leading people through transitions in situations of uncertainty	Change often brings uncertainty, and leaders need to guide people through these transitions by providing support, clarity, and reassurance. This theme highlights the importance of empathetic and resilient leadership during times of ambiguity.

Each of these themes is interconnected and reflects a comprehensive approach to managing and enabling large-scale change, focusing on adaptability, collaboration, distributed leadership, and continuous learning.

Recurring and interrelated themes in approaches to enabling large scale change

Co-producing change: "with" & "by," not "to" or "for"	Effective change is co-created with the people involved rather than imposed upon them. This approach values collaboration, engagement, and empowerment, ensuring that everyone has an active role and feels ownership over the change process.
Developing leaders everywhere: sustainable systems of distributed leaders	Leadership should be distributed across the organisation, with individuals at all levels equipped and empowered to lead. This theme emphasizes building a sustainable network of leaders who can support and drive change in different parts of the organisation.
Setting up systems for experimental learning & unlearning	Change often requires learning new things and unlearning old habits or assumptions. This concept encourages a mindset of continuous improvement, experimentation, and reflection to make informed decisions and take the most effective next steps.
Building power: a spectrum of allies AND working through pillars of formal power	Successful change initiatives leverage a broad coalition of support, both formal and informal. This involves building alliances across different stakeholders and working within established structures of authority to achieve impactful results.
Shaping networks to shape opinions	Change leaders need to actively engage with and influence networks to build support for the change. By shaping conversations and opinions within key networks, leaders can foster a supportive environment and drive momentum for the change.

Each of these themes is interconnected and reflects a comprehensive approach to managing and enabling large-scale change, focusing on adaptability, collaboration, distributed leadership, and continuous learning.

Co-Design Fundamentals

Shaping the Future of Health Care Together in Hastings Prince Edward

Hastings Prince Edward Ontario Health Team

Kerry Kuluski, MSW, PhD

Dr. Mathias Gysler Research Chair in Patient And Family Centred Care, Institute for Better Health, Trillium Health Partners, Associate Professor, University of Toronto

November 20, 2024

Learning Objectives

- Co-Design Fundamentals
- Why Co-Design Matters
- Co-Design with an Equity Lens
- Co-Design Methods

3 approaches to interacting with people

Say- Listening to what someone says in an interview

Do- Watching how people use products and services

Make- In creative workshops, people exploring and *making* solutions

Sanders, E. B. N. (2002). From user-centred to participatory design approaches. In J. Frascara (Ed.), Design and the social sciences: Making connections (pp. 1-8). London: Taylor &Francis.

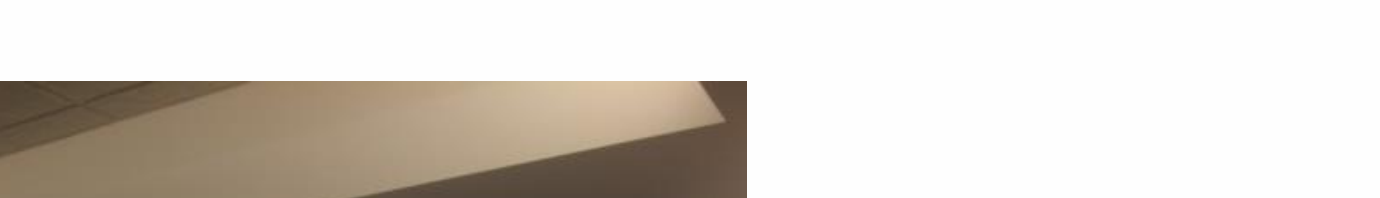
Different Ways to think about Engagement

- Instrumental in nature- 'action focused' including committee work or co-design activities which strives for a tangible outcome.

- Democratic- patients, caregivers and communities *have the right* to influence health care)

- Narrative form- dialogic communication, sharing, learning, re-learning and influencing one another

Rowland P, Johannesen J. Patient Engagement and Compassionate Care In: Brian D. Hodges, Gail Paech, Bennett J, eds. Without Compassion, There Is No Healthcare: Leading with Care in a Technological Age Kingston, Ontario: McGill-Queen's University Press 2020:60-77.



What is Co-Design to you?

Co-Design

1. A process for **developing solutions** to complex problems

2. **Privileges lived expertise**, actively involves people affected by an issue as expert collaborators, along with other partners

3. A shift in healthcare improvement approaches **from consultation to more equitable involvement** and decision-making

Thorburn, K., S. Waks, B. Aadam, K. Fisher, C. Spooner and M. Harris (2024). CoDesign: 1-18.

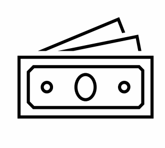
Consider Soni's engagement journey

Meet

Soni

Soni is a 34-year-old who is part of the Thorncliffe Park Community. As an immigrant, she has faced many challenges including finding affordable housing, gainful employment and access to primary care. She is the primary caregiver for her three children and mother. Her mother is 79 and has had a number of falls over the last few months resulting in a broken hip (in addition to having diabetes, high blood pressure and at risk for stroke). Her youngest son has been working closely with a psychologist and is being assessed for developmental delays. Soni also has been diagnosed with anxiety trying to cope with everything that she's managing.

New Country



Income

Caregiving

Food Security

Mental Health

Housing

Credit to: Ontario Health Community Engagement and Co Design Working Group and Allison Needham, Director, Anti-Racism, Equity and Social Accountability, Unity Health Toronto

The Patient Engagement Journey

INFORM	CONSULT	INVOLVE	COLLABORATE	EMPOWER
Learning about info	Providing feedback	Providing advice	Working partnership	Making decisions
Soni visited the community Hub to learn more about services available for her mother.	Based on her son's experience, Soni participated in a feedback meeting and completed surveys.	Soni was invited to sit on the PFAC but given her work and family commitments, is unable to attend regular meetings. She is frequently invited to provide ad hoc advice on particular initiatives	Soni participated in a 2-day working session where she was compensated for her time with multiple partners of the Hub to develop a solution for increasing access to care. Majority of the recommendations were adopted	As a Community Ambassador, Soni provided live feedback to the Hub regarding COVID-19 vaccination hesitancy. This information was used to make real-time changes to service delivery. Working together, vaccinations rates increased.

INCREASING DEGREE OF DIFFICULTY AND IMPACT

Note: there are appropriate times for all levels of engagement

Stages of engagement adapted from IAP2's Spectrum of Public Participation https://cdn.ymaws.com/www.iap2.org/resource/resmgr/pillars/Spectrum_8.5x11_Print.pdf

Stages of Co-Design

Engage- build relationships, take steps to understand the problem

Plan- stages of the work, logistics, assess needs, goals, methods to use, etc.

Explore- learn about experiences and priority areas

Develop- co-design/co-redesign improvement (intervention, process, product)

Decide- what to prioritize and refine/seek additional feedback

Change- turn improvement ideas into action

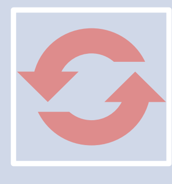
Kiss, N., H. Jongebloed, B. Baguley, S. et al. JNCI Cancer Spectr 8(4).

Co-design involves:

- People affected by the problem
- Those in a position to do something about the problem

Relationship Building Phase

Activity Phase



Looping Back/Ongoing Engagement Phase

Bammer, G. (2013). Disciplining interdisciplinarity: Integration and implementation sciences for researching complex real-world problems, ANU Press.

Why does co-design matter?

Benefits

For the project- improving the creative process, developing better service definitions and organizing the project more effectively;

For the service's customers or users- better fit between the service offer and the person's needs, a better service experience;

For the organization(s) involved- fostering a learning culture, cooperation between different sectors, units, people, communities, enhance capability for innovation.

Helps us Move from Technical to Adaptive Solutions

"The single biggest failure in leadership is treating adaptive challenges like technical problems." Ron Heifetz

Technical Challenges	Adaptive Challenges
Easy to identify	Difficult to identify
Straightforward solution	Requires changes in ways of working
Solved by experts	People with the problem need to do the work of solving it
Requires a limited number of changes	Requires many changes
Typically bound by an organization	Typically crosses organizations
People generally receptive	People may resist the change(s)
Solutions implemented quickly	Solutions require a trial-and-error approach

A Vehicle For Collective Impact

"An intentional way of working together and sharing information for the purpose of solving a complex problem."

- National Council of Nonprofits

"The complex nature of most social problems belies the idea that any single program or organization, however well managed and funded, can singlehandedly create lasting large scale change."

-Fay Hanleybrown, John Kania, & Mark Kramer

Collaboration

The Relational Work of Systems Change

Collective impact efforts must prioritize working together in more relational ways to find systemic solutions to social problems.

CITE SHARE COMMENT PRINT ORDER REPRINTS

By Katherine Milligan, Juanita Zerda & John Kania | Jan. 18, 2022

(Illustration by Hugo Herrera)

"Relationships are the essence and fabric of collective impact. What's critical for those who facilitate collective impact efforts is to **support relationship development** in ways that **build true empathy and compassion** so that **authentic connections** happen, particularly between diverse participants. These deeper connections can form new avenues for innovation to address the social problem at hand."

Katherine Milligan and colleagues

Co-design with an Equity lens

The Ethics of Co-Design

Collective thinking, Collective benefits, Creation of partnerships

But make sure you…

- Know the population/context
- Address power imbalances
- Empower people to participate (skill building)
- Be inclusive
- Be transparent
- Consider timing and resources (compensation, etc.)
- Start before decisions are made and continue after the activity is over

Sendra, P. (2024). "The ethics of co-design." Journal of Urban Design 29(1): 4-22.

"Collective thinking, creating partnerships, and addressing power imbalances – are essential for this transition from consultation to co-design. First, co-design needs to achieve moments of 'collective intelligence', which implies that people think collectively rather than as individuals." (Sendra 2024, p.8)

Readiness of self and context

Explore readiness of self and of organization/system. Ask yourself:

1. How does my position impact others?

2. How do I make others feel?

3. Am I creating a safe space?

4. Is the organization ready to take on the change that we want to achieve?

Moll, S., M. Wyndham-West, G. Mulvale, S. et al. BMJ Open 10(11): e038339.

Sustained advantage for already-privileged groups

Lost learning opportunity

Wasted resources

Harm

Deepening inequities and mistrust

Challenging assumptions

- Who are we engaging with?
- Whose voices are missing?
- Who is excluded?
- Why does that happen?
- What can we do?

Sayani A. et al (2021). Building Equitable Patient Partnerships during the COVID-19 Pandemic: Challenges and Key Considerations for Research and Policy. *Healthcare Policy*, *17*(1).

Co-Design Methods

Co-design method examples

- Persona development
- Journey mapping
- World café

Persona Development Worksheet

My name is:

I am ___ **years old**

My gender identity is:

- ☐ Man
- ☐ Woman
- ☐ Transgender
- ☐ Non-binary
- ☐ Gender fluid
- ☐ Gender non-conforming/ gender queer
- ☐ Two Spirit
- ☐ Questioning or Unsure

Employment Status

- ☐ Full time
- ☐ Part time/casual
- ☐ Retired
- ☐ Not employed at this time

I was born in:

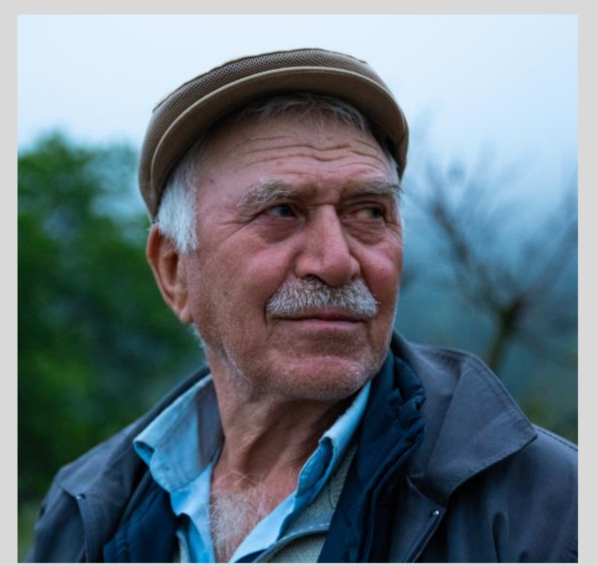
I identify as (check all that apply):

- ☐ First Nation
- ☐ Inuit
- ☐ Métis
- ☐ Indigenous/Aboriginal
- ☐ Arab
- ☐ Black (North American, Caribbean, African, etc.)
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Latin American
- ☐ South Asian (East Indian, Pakistani, Sri Lankan, etc.)
- ☐ Southeast Asian (Vietnamese, Cambodian, Malaysian, Laotian, etc.)
- ☐ West Asian (Iranian, Afghan, etc.)
- ☐ White (North American, European, etc.)
- ☐ Other (please specify)

You can develop personas using existing data combined with community engagement to fill in the missing pieces.

These personas can be used as the basis for designing new pathways and services.

Persona Example



Asad

Age: 87

Gender: Man

City: Mississauga

Birth Country: Middle East

Languages: Arabic, English

Employment: Retired

Marital Status: Widowed

Asad is 87-years old and speaks Arabic as his first language. He lives alone in his own home in a middle-income neighborhood and does not have sufficient funds to meet his daily living needs. He has a caregiver (his daughter) who lives in the same city as him and is experiencing burnout/stress.

He is showing signs of short-term memory problems (difficulty recalling names and appointments) but still demonstrates good judgement, can follow instructions, and express himself clearly. He can feed himself independently, but with difficulty. He uses the toilet independently but needs help with personal hygiene activities and bathing (but actively participates). He can walk independently and get in and out of a chair and bed. He has no history of falling. He needs some cuing and a bit of set-up help when dressing and needs help administering his medications. He requires help with housework, managing finances, and getting into and out of a vehicle. He is able to use the telephone independently and communicate in English but prefers to speak in Arabic. He can prepare light meals or heat prepared meals and relies on others to do his shopping.

Sometimes he feels lonely. Asad is of Islamic faith and prays 5 times a day, which helps his mental health.

Journey mapping

- Used to understand barriers, facilitators, experiences, and interactions that patients and caregivers have
- Outlines various phases (such as entering an emergency room, getting admitted to a hospital, getting access to treatments, and then leaving the hospital) of a healthcare journey
- Typically, these phases may be described as ‘key moments’ or even ‘pain points’

Davies, E. L., D. Pollock, A. Graham, R. E. Laing, V. Langton, L. Bulto and J. Kelly (2022). JBI Evid Synth 20(5): 1361-1368.
Engagement Methods Working Group. Engagement Methods Workbook. OHT Patient, Caregiver & Community Engagement Learning Series. 2022

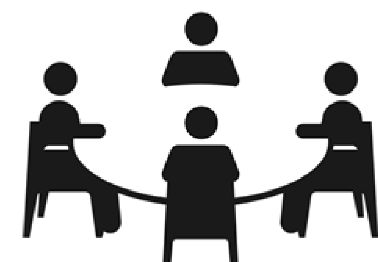
Participant ID #:________
(to be filled out by the research team)

Experiences with ALC (alternate level of care)

	Active Acute Care	Things Got Different....Why?	Leaving Hospital	Community: Awaiting Placement	Active Rehab/CCC Care	Things Got Different...Why?	Leaving Hospital	Community: Awaiting Placement
Step 1: *Circle the words that best describe your feeling at each stage or write your own words on the line below.*	Frustrated Powerless Uninformed Stressed Guilty Rushed Fearful Hopeful Safe Valued Supported Understood Grateful Relieved __________	Frustrated Powerless Uninformed Stressed Guilty Rushed Fearful Hopeful Safe Valued Supported Understood Grateful Relieved __________	Frustrated Powerless Uninformed Stressed Guilty Rushed Fearful Hopeful Safe Valued Supported Understood Grateful Relieved __________	Frustrated Powerless Uninformed Stressed Guilty Rushed Fearful Hopeful Safe Valued Supported Understood Grateful Relieved __________	Frustrated Powerless Uninformed Stressed Guilty Rushed Fearful Hopeful Safe Valued Supported Understood Grateful Relieved __________	Frustrated Powerless Uninformed Stressed Guilty Rushed Fearful Hopeful Safe Valued Supported Understood Grateful Relieved __________	Frustrated Powerless Uninformed Stressed Guilty Rushed Fearful Hopeful Safe Valued Supported Understood Grateful Relieved __________	Frustrated Powerless Uninformed Stressed Guilty Rushed Fearful Hopeful Safe Valued Supported Understood Grateful Relieved __________
Step 2: *Write in the boxes what it was about this stage that made you feel this way (use the back if necessary)*								

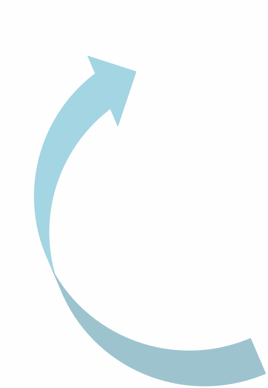
WORLD CAFÉ METHOD

Rotating Discussions



Station 1:
[Topic/Question]

Station 2:
[Topic/Question]



Station 3:
[Topic/Question]

How do older adults with chronic health conditions experience their first virtual care visit with their primary care provider?

Journey Stages Which step of the experience is the patient describing?	Virtual Care Appointment Check-in	Visit with Primary Care Provider	Check-out Process	Post-visit Follow-up
Actions What does the patient do? What information do they look for? What is their context?	Speaks with a nurse Check in using an app on smartphone	Experience with previous diabetes medication Sharing diet and exercise Reviewing blood sugar log	Agreeing to referrals for support Receiving new prescription Paying for medications Learning how to administer new medications	Updating on diet and exercise Reviewing improved HbA1c results Discuss preventative screening
Pain points What does the patient perceive to be a challenge?	Logging into app Being able to see the app functions Being in a public location for WiFi	Missing blood sugar information Not taking medication regularly Hearing provider speak	Lost job Financial insecurity New medication regimen Finding time for visits with HCPs	Small changes to diet Mammogram over due
Touchpoints What part of the service do they interact with?	Nurse	Primary care provider	Pharmacist Social Worker Dietitian	Primary care provider
Emotions or Feelings What is the patient feeling?	Anxious Worried	Overwhelmed	Uncertain Shame	Motivated Proud
Bright points What is working well? What could be done to enhance the experience?	Receiving instructions over the phone before the appointment	Receiving support	Taking care of grandchildren Access to a drug benefit plan	Motivated to make changes to diet and walk more Motivated to make changes to diet and walk more

Reflection

- How do you see yourself using co-design methods?
- What challenges do you anticipate with using these methods?
- What burning questions do you still have?

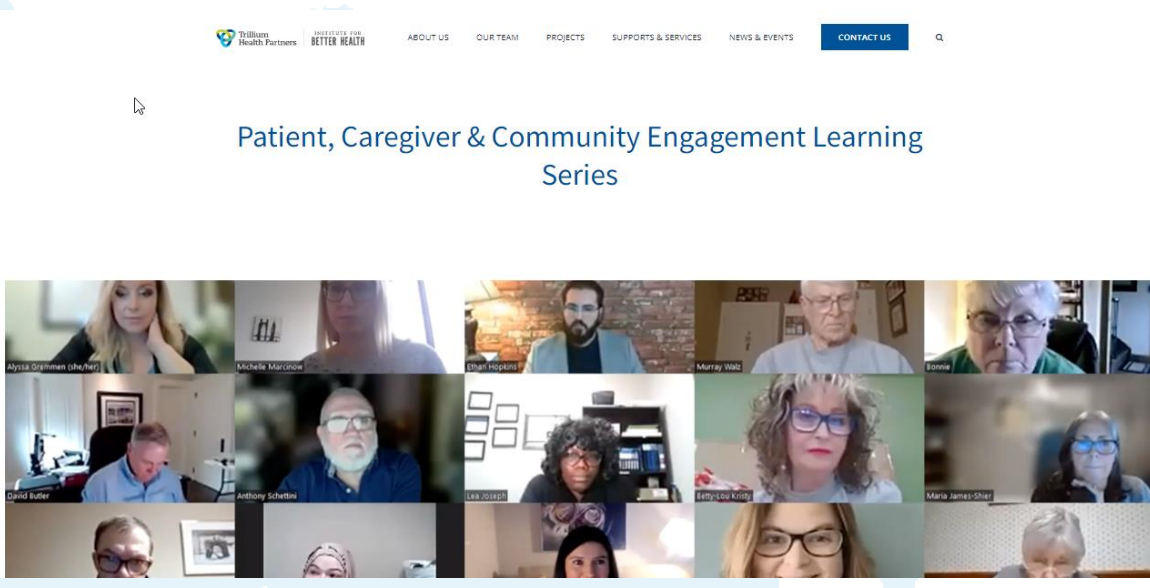
Conclusions

- Relationship building is critical and ongoing
- Honor diversity of expertise and acknowledge differences in decision making power
- Involve people impacted by the problem as well as those who are invested in making the changes
- Think long-term (opportunity to build capacity and a learning culture)

Check out our Engagement Series Learning Library!

7 in-depth engagement webinars and workbooks!

https://www.instituteforbetterhealth.com/portfolio-items/patient-caregiver-and-community-engagement-learning-series/



Thank you!

Kerry Kuluski

kerry.kuluski@thp.ca

Indigenous Ways of Knowing and Being

A source to inform our guiding principles for how we work together

Susan Barberstock, Director of Community Wellbeing, Mohawks of the Bay of Quinte
Tera Osborne, Executive Director, Tsi Kanonhkhwatsheríyo Indigenous Primary Care Team

HEALING WHEEL CONTINUUM

HPE Ontario Health Team
November 21st, 2024

WHAT IS THE HEALING CONTINUUM WHEEL?

Is the integrated continuum of care and supports necessary for community wide healing to take place. Focuses on the promotion of understanding of violence, community prevention measures, crisis intervention, curative and rehabilitative strategies, the promotion of stability in communities and training both at the community and service provider level.

THE HEALING CONTINUUM WHEEL

The Healing Continuum Wheel identifies specific program and service needs of individuals in the life cycle and the programmes and services required to wholistically address family healing

THE HEALING CONTINUUM WHEEL

Training
- development of necessary knowledge, skills and attitudes

Supportive Resources
- resource development
- community infrastructure
- wide range of supports

Promotion of Stability
- networking of services
- resource coordination
- outreach

Promotion
- primary prevention strategies
- community awareness
- leads to social well-being

Elders

Infants

Grand-parents

Toddlers

Spiritual

Emotional

Physical

Mental

Parents

Children

Young Adults

Youth

Rehabilitation
- family/community reintegration
- follow up
- after care

Prevention
- secondary prevention (aimed at high risk groups)
- tertiary prevention (aimed at the already infected)

Curative
- palliative care
- treatment
- counselling
- professional and para-professional

Crisis Intervention
- immediate
- cannot wait for services to be developed

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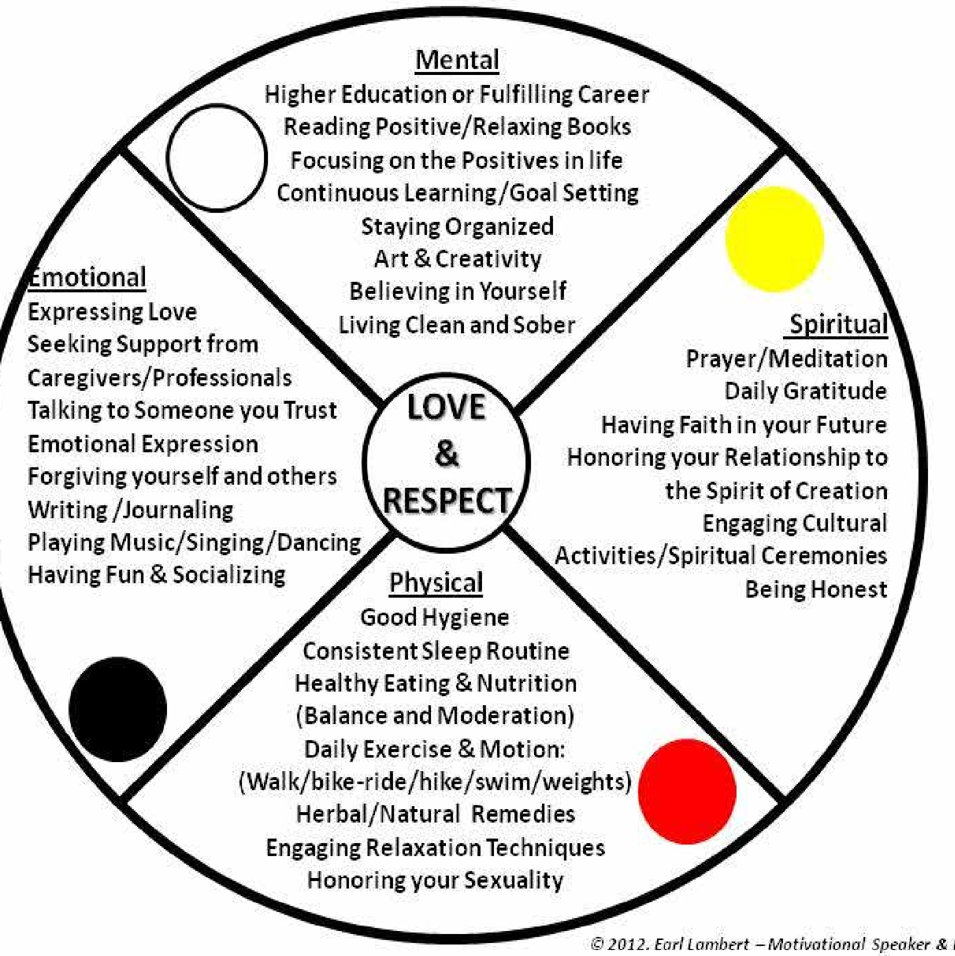
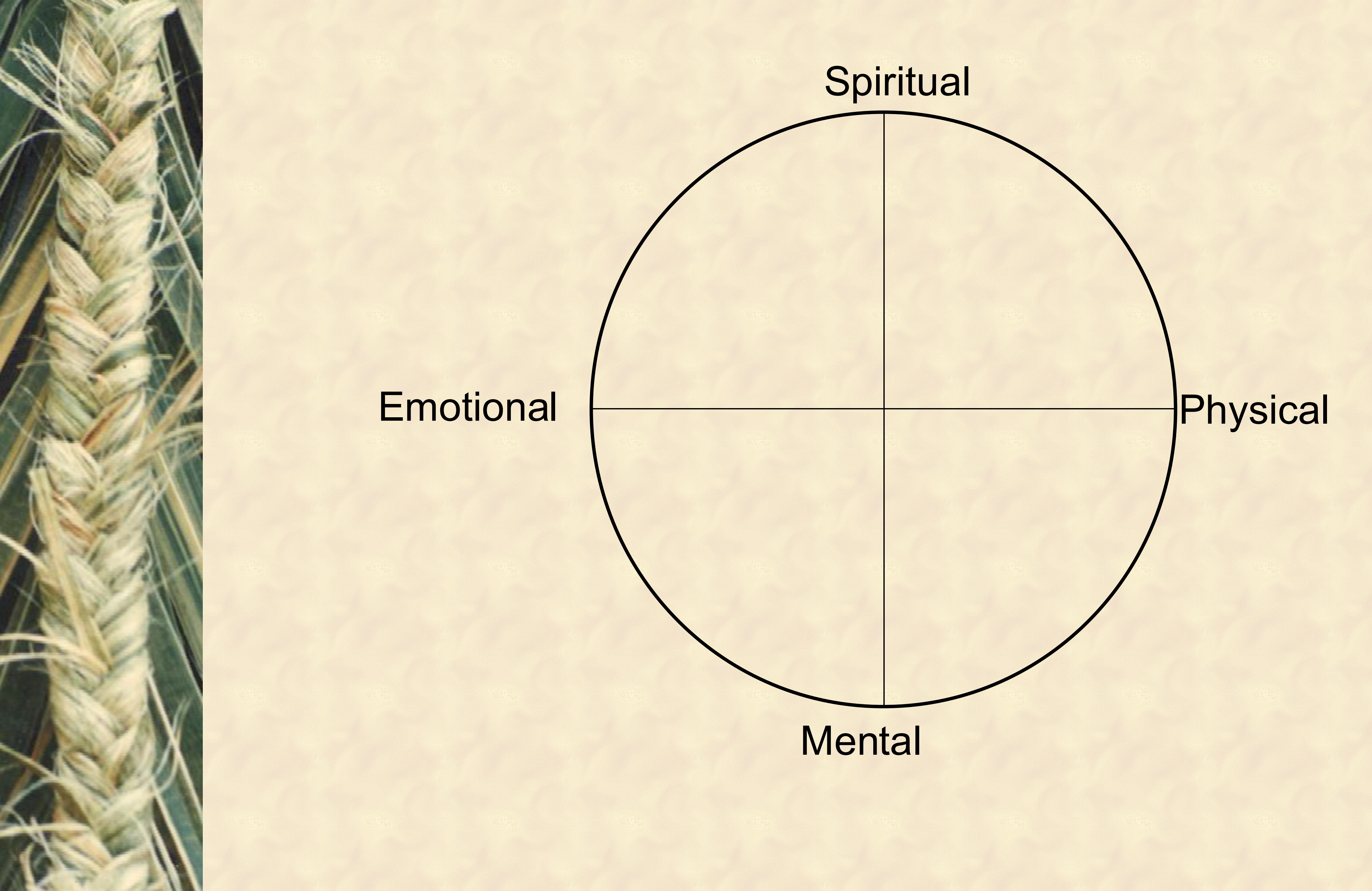
THE HEALING CONTINUUM WHEEL

The Healing Continuum Wheel acknowledges that the physical, mental, emotional and spiritual aspects of our nature must be addressed to achieve a state of wellness.

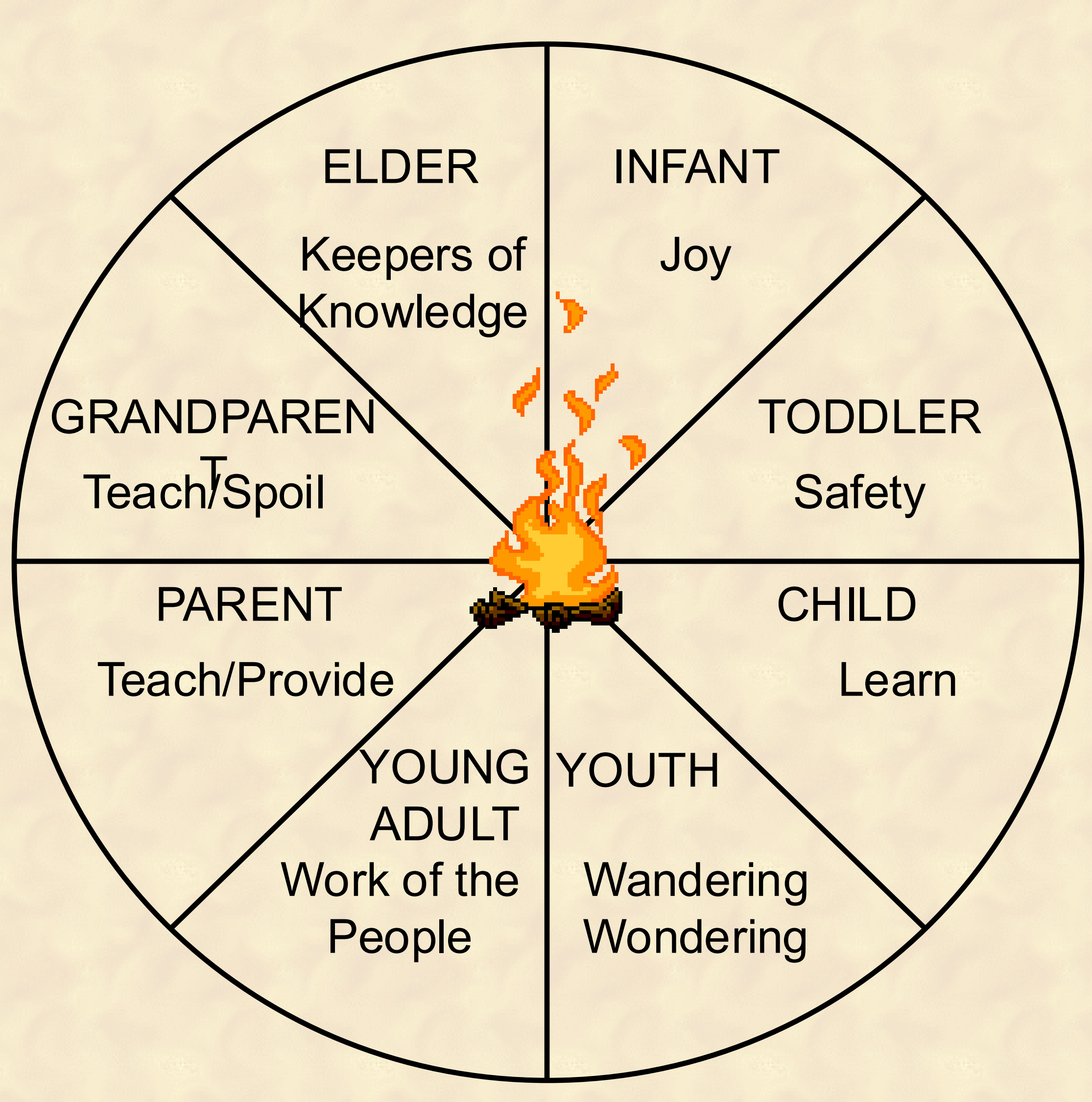

Medicine Wheel: A Holistic Model for Personal Wellness
Mental
Higher Education or Fulfilling Career
Reading Positive/Relaxing Books
Focusing on the Positives in life
Continuous Learning/Goal Setting
Staying Organized
Art & Creativity
Believing in Yourself
Living Clean and Sober
Emotional
Expressing Love
Seeking Support from
Caregivers/Professionals
Talking to Someone you Trust
Emotional Expression
Forgiving yourself and others
Writing /Journaling
Playing Music/Singing/Dancing
Having Fun & Socializing
LOVE
&
RESPECT
Spiritual
Prayer/Meditation
Daily Gratitude
Having Faith in your Future
Honoring your Relationship to
the Spirit of Creation
Engaging Cultural
Activities/Spiritual Ceremonies
Being Honest
Physical
Good Hygiene
Consistent Sleep Routine
Healthy Eating & Nutrition
(Balance and Moderation)
Daily Exercise & Motion:
(Walk/bike-ride/hike/swim/weights)
Herbal/Natural Remedies
Engaging Relaxation Techniques
Honoring your Sexuality
© 2012. Earl Lambert – Motivational Speaker & Inspirational Storyteller


Spiritual
Emotional
Physical
Mental

THE HEALING CONTINUUM WHEEL

The Healing Continuum Wheel recognizes the ages and stages of development from birth to death

THE LIFE CYCLE TEACHINGS



LIFE CYCLE TEACHINGS

INFANTS: Bring the gift of JOY and love from the time of conception to birth. Each member of the family and community share in the love and joy of new life and awaiting the new birth. It is believed infants share the closest union with the Creator. Infants are regarded highly as gifts from the Creator on loan until such time the Creator requests its return. The Eastern direction celebrates infants, toddlers and children in the same vein as a new day

LIFE CYCLE TEACHINGS

TODDLERS: Bring LOVE, curiosity and exploration of new surroundings. Parents must take on the role of teaching toddlers to their new surroundings. Elders, family and community participate in the wonder of curiosity of toddlers whose experience is new and whose learning capacity is great. Toddlers learn by observing. The East represents peace and light as a gift brought on by the toddlers

LIFE CYCLE TEACHINGS

CHILDREN: Bring the gift of LOVE, respect, caring and sharing to their families and community. It is a learning stage and character building stage where teachers of aunties and uncles should all be around. Their movement is closer to the southern direction where the season of planting and growth are signified. There is a need for children to experience people in the most positive way since the experience will continue in these formative years. This is a time for moulding in the child's formative years. South represents warmth and growth.

LIFE CYCLE TEACHINGS

YOUTH: Bring activity and zest for life in their preparation for the maturing season built already through teachings, parents and community. They are now regarded and trained to be future leaders and respected for their vision. Young boys are recognized for their strength and are prepared by their teachers to realize their vision quest. Young girls are respected for their upcoming role as life givers and taught to prepare for their future role in life. Youth are signified in the southern direction where the season of growth and fruition occurs

LIFE CYCLE TEACHINGS

YOUNG ADULTS: Bring CARING and respect for life and are moving toward the western direction which signifies maturity and action. Their characters are already in place from the preceding teachings. It is now time for their self responsibility, self teaching for change and for testing their characteristics. The end of the day is honoured in this direction to indicate that their childhood is moving toward the harvesting season. They are reminded by Elders that they too are beginning the harvest of their youth and to travel their own path. They begin the journey as products of their own characters and ready for parent hood. This is aso a journey of many paths off the main road. West represents introspection

LIFE CYCLE TEACHINGS

PARENTS: Bring LOVE, hope, caring, sharing and teaching to carry on the traditions picked up in the journey from the Elders. Their roles are emerging as they pick up their parents role as caregivers. It is their turn to parent their young and care for their Elders. They will experience the responsibility to prepare their own children as they were prepared. They are designated to work for the growth of their children in recognition of the blessing from the Creator. They will experience the same aches in seeing their children homed and see the product of their parenting skills. Their roles are to assist the meaning of life and make clear the vision of life for future generations.

LIFE CYCLE TEACHINGS

GRANDPARENTS: Bring WISDOM, ove and greater spiritual understanding and are slowly shifting to the northern direction and the stage of wisdom. They bring teachings through the practice of example and role modelling. They are the Aunties and Uncles to many children. They have experienced life in all the stages and should be respected depending on their journey in life. They are responsible for teaching the younger generation to live together in harmony, cooperation and caring for each other. They are picking up the bundles that may be passed on by their Elders because now they have no restrictions and are free to carry on the teachings

LIFE CYCLE TEACHINGS

ELDERS: Bring greater WISDOM, love and spiritual meaning in their role as healers, counsellors and keepers of the teachings and ceremonies. The community values their wisdom and provide for them as they have provided for their children and grandparents. They are seen as the strength for the building of their communities through their teachings. Elders need to remain strong. They signify the Northern direction where spiritual strength and purity are symbolized. It is considered a time for meditation and contemplation with the spirits. It is a time to pass on their knowledge to youth since they are considered to master the joy and sorrow and have encountered many tribulations. The North signifies purity, strength and the beginning of greater spiritual teachings.

IDENTIFIED COMMUNITY NEEDS AND PRIORITY

PROMOTION
PREVENTION
CRISIS INTERVENTION
CURATIVE
REHABIITATIVE CARE
PROMOTION OF STABILITY
TRAINING
SUPPORTIVE RESOURCES

THE HEALING CONTINUUM WHEEL

Training
- development of necessary knowledge, skills and attitudes

Supportive Resources
- resource development
- community infrastructure
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- outreach

Elders
Infants
Toddlers
Children
Youth
Young Adults
Parents
Grand-parents

Spiritual
Physical
Mental
Emotional

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IDENTIFIED COMMUNITY NEEDS AND PRIORITY

PROMOTION:

The promotion of Aboriginal family healing leads to social well being in Aboriginal communities. It includes primary preventive strategies aimed at the whole community to enable individual and family, wherever they may live, to enjoy a healthy and balanced life. Raising community awareness is essential to move past the denial of family violence and to begin community-based healing processes.

IDENTIFIED COMMUNITY NEEDS AND PRIORITY

PREVENTION:

Is identified as a primary prevention strategy, in the Continuum, secondary prevention strategies include those programmes and services aimed at high risk groups while tentiary prevention strategies are defined as those programmes and services directed to those already affected by family violence. From the Aboriginal perspective, the need to keep families in their communities and working toward healing is a fundamental principle of prevention.

IDENTIFIED COMMUNITY NEEDS AND PRIORITY

CRISIS INTERVENTION:

Crisis Intervention is identified specifically and included under treatment services. Is the most immediate and distressing time within a situation of family violence and as such cannot wait for services to be developed. Resources have to be available within the community at the site and time of crisis.

IDENTIFIED COMMUNITY NEEDS AND PRIORITY

CURATIVE CARE:

Curative care encompasses strategies such as treatment centres, counselling services, professional and para professional care. Effective wholistic treatment helps break the cycle of violence.

IDENTIFIED COMMUNITY NEEDS AND PRIORITY

REHABILITATIVE CARE:

Is that which assists individuals and their families within the healing continuum and the larger Aboriginal community to become fully functional within all aspects of their lives through follow up, after care and family/community reintegration opportunities after the initial problem has been identified and treated.

IDENTIFIED COMMUNITY NEEDS AND PRIORITY

PROMOTION OF STABILITY:

The promotion of stability in individual communities and the larger Aboriginal community in the province occurs when services are networked and resources are coordinated throughout the continuum of healing.

IDENTIFIED COMMUNITY NEEDS AND PRIORITY

TRAINING:

Training is a fundamental requirement of any programme and must be consistent, planned and ongoing so that it can provide for the incremental healing for all stages of the Life Cycle. Training is required to develop the necessary skills, knowledge, attitudes and values needed to develop, implement, deliver and evaluate effective and justice healing responses and opportunities to individual, families and communities in a coordinated manner. Effective training programmes that provide for initial basic training as well as ongoing professional development are required.

IDENTIFIED COMMUNITY NEEDS AND PRIORITY

SUPPORTIVE RESOURCES:

A wide range of supports must be in place if the services, programmes and supports identified in the healing continuum are to be implemented in an effective and efficient manner.

Aboriginal Family Healing Joint Steering Committee, For Generations to Come: The Time is Now A Strategy for Aboriginal Family Healing, September 1993

Strategic Planning Wheel

Movement
Create Change

Reason
Plan of Action

Vision

Time
Relationship

Examine
the needs

TRC Calls to Action
Addressing the legacy/health

18. We call upon the federal, provincial, territorial, and Aboriginal governments to acknowledge that the current state of Aboriginal health in Canada is a direct result of previous Canadian government policies, including residential schools, and to recognize and implement the health-care rights of Aboriginal people as identified in international law, constitutional law, and under the Treaties.

TRC Calls to Action
Addressing the legacy/health

19. We call upon the federal government, in consultation with Aboriginal peoples, to establish measurable goals to identify and close the gaps in health outcomes between Aboriginal and non-Aboriginal communities, and to publish annual progress reports and assess long-term trends. Such efforts would focus on indicators such as: infant mortality, maternal health, suicide, mental health, addictions, life expectancy, birth rates, infant and child health issues, chronic diseases, illness and injury incidence, and the availability of appropriate health services.

TRC Calls to Action
Addressing the legacy/health

20. In order to address the jurisdictional disputes concerning Aboriginal people who do not reside on reserves, we call upon the federal government to recognize, respect, and address the distinct health needs of the Metis, Inuit and off-reserve Aboriginal peoples.

TRC Calls to Action
Addressing the legacy/health

21. We call upon the federal government to provide sustainable funding for existing and new Aboriginal healing centres to address the physical, mental, emotional and spiritual harms caused by residential schools and to ensure that the funding of healing centres in Nunavut and the Northwest Territories is a priority.

TRC Calls to Action
Addressing the legacy/health

22. We call upon those who can effect change within the Canadian health care system to recognize the value of Aboriginal healing practices and use them in the treatment of Aboriginal patients in collaboration with Aboriginal healers and Elders where requested by Aboriginal patients.

TRC Calls to Action
Addressing the legacy/health

23. We call upon all levels of government to:

    i. Increase the number of Aboriginal professionals working in the health-care field.
    ii. Ensure the retention of Aboriginal health-care providers in Aboriginal communities.
    iii. Provide cultural competency training for all health-care professionals.

TRC Calls to Action
Addressing the legacy/health

24. We call upon medical and nursing schools in Canada to require all students to take a course dealing with Aboriginal health issues, including the history and legacy of residential schools, the *United Nations Declaration on the Rights of Indigenous Peoples,* Treaties and Aboriginal rights, and Indigenous teachings and practices. This will require skills-based training in intercultural competency, conflict resolution, human rights, and anti-racism.

Joyce’s Principle

Joyce's Principle aims to guarantee to all Indigenous people the right of equitable access, without any discrimination, to all social and health services, as well as the right to enjoy the best possible physical, mental, emotional and spiritual health.

Microsoft Word - Joyce's Principle brief — English_Revised.docx

Nye: wye

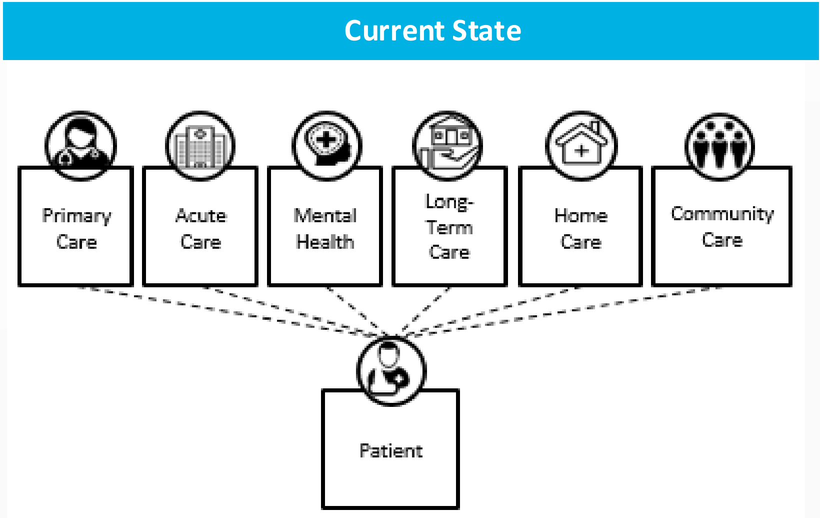
Ontario Health Team Policy

Ontario Health Teams: An Overview

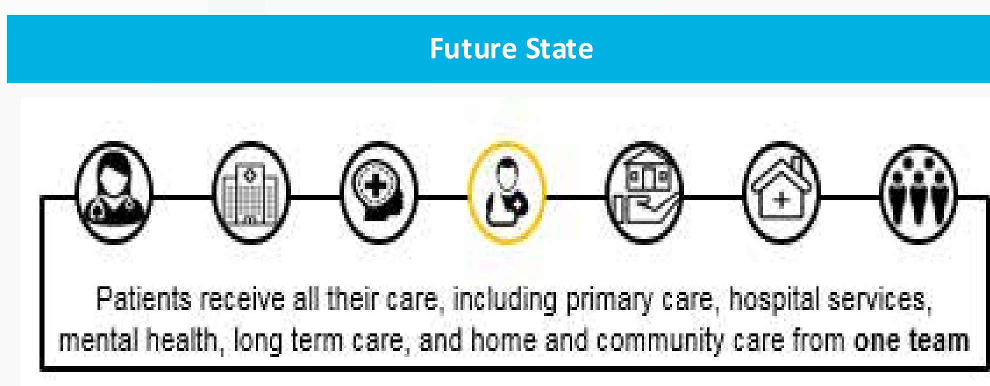
In April 2019, *The People's Health Care Act, 2019* received Royal Assent. The legislation enacts a new statute (the *Connecting Care Act, 2019)* which establishes Ontario Health Teams as a new model of health care organization, funding and delivery.

- Ontario Health Teams (OHTs) are a new model of integrated care delivery where patients, families, communities, providers and system leaders can build on what is best in Ontario's health care system.
- Through this model, groups of health care providers work together as a team to deliver a full and coordinated continuum of care for patients, even if they're not in the same organization or physical location.
- As a team, they work to achieve common goals related to improved health outcomes, patient and provider experience, and value.
- The goal is to provide better, more integrated care across the province.

Current State



Future State



Ontario Health Teams and a Transition to Population Health Management

Ontario Health Teams (OHTs) will transition from siloed, sector-based approaches, to managing the health of a population.

- OHTs will work to achieve specific targets related to the care experiences and health outcomes for their year 1 priority populations.
- They will then build on these experiences by **steadily expanding** their reach in later years, with the goal of eventually optimizing care experiences and outcomes for their full population.

Common areas of focus for year 1 populations

Seniors with greatest need: complex, frail, co-morbid	Chronic conditions and complex care needs	Mental Health & Addictions	End of Life and / or Palliative Care

Health Risks, Costs, & Complexity

- High Risk (OHT Year 1 Pop)
- Emerging Risk, At Risk (OHT Out-Year Populations)
- Usual Care, Self-Care, Prevention (OHT Full Population at Maturity)

Modified Kaiser Permanente Population Health Management Pyramid

- 5% of Ontario's patients account for 65% of health care spending
- They can have **16+ different** health care providers who are often siloed and disconnected
- OHTs will better connect care to improve experiences and outcomes for these patients

There are 58 approved OHTs across Ontario

NORTH WEST
≈248,000
4

NORTH EAST
≈550,000
7

CENTRAL
5,032,410
14

EAST
3,742,520
13

WEST
4,095,589
15

TORONTO
1,440,644
5

NORTH WEST
NORTH EAST
EAST
CENTRAL
TORONTO
WEST

Hastings Prince Edward OHT

is surrounded by 5 neighbouring OHTs:

To the west

- Northumberland OHT
- Peterborough OHT
- Kawartha Lakes Haliburton OHT

To the north / east

- Ottawa Valley OHT
- Frontenac, Lennox & Addington OHT

13 OHTs in East Region

Ottawa Valley OHT
Archipel OHT
Ottawa West Four Rivers OHT
Ottawa OHT
Great River OHT
Kawartha Lakes Haliburton OHT
Hastings & Prince Edward OHT
Frontenac, Lennox & Addington OHT
Lanark, Leeds & Grenville OHT
Peterborough OHT
Northumberland OHT
Durham OHT

Population Health Management Approach

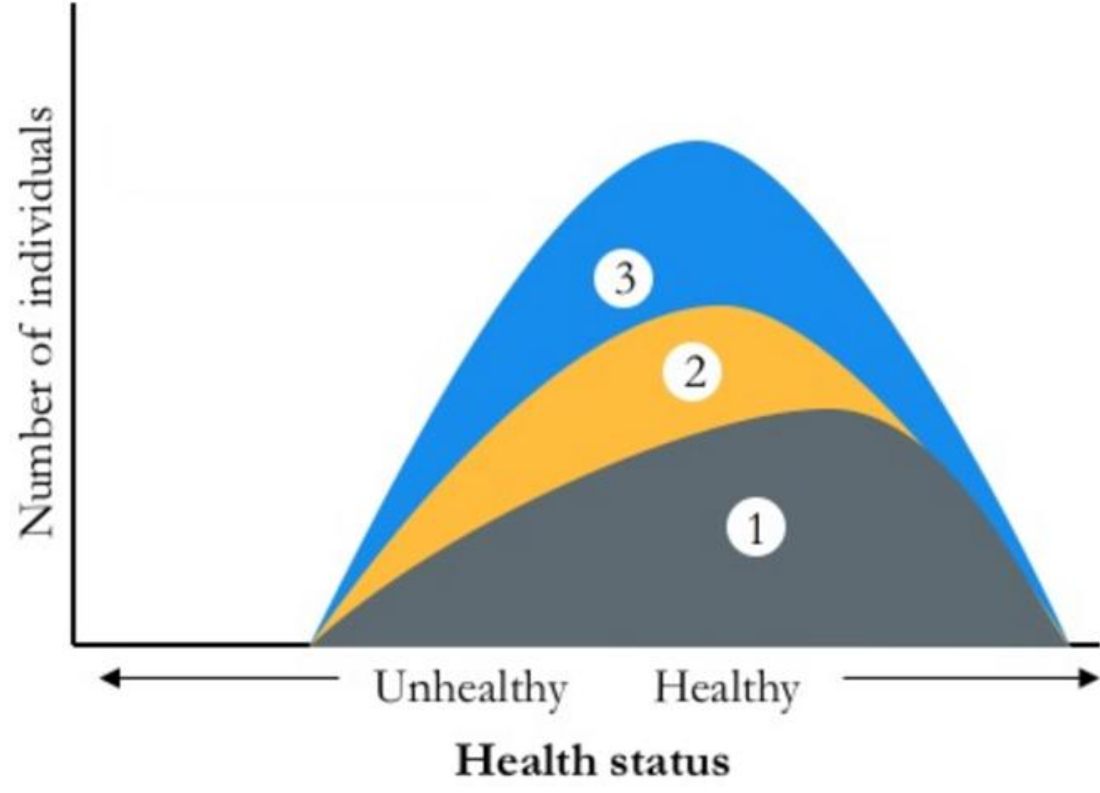
Ontario Health Teams' Philosophy

Work collaboratively to improve the health of the entire population within OHT, while reducing disparities among different population groups - so no one is left behind

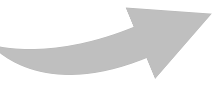
Done using a **Population Health Management Approach (PHM)**

Why a PHM approach? Based on data & evidence; proactive, benefits the entire HPE population, involves collaboration across multiple organizations, and it's the **right thing to do**

Shifting to a PHM approach involves moving:



1 From responding reactively to the subset of patients seeking care from OHT partners…



2 …to anticipating population and sub-population needs and collaborating across partners to intervene proactively…

3 …to focusing on upstream health and social factors and improving overall population health and wellness

Image credit: RISE (Rapid Improvement & Support Exchange)

Population Health Management

Key Considerations

Data Informed

Use data from all sources to **understand your entire population as well as priority segments**: their traits and needs; health conditions and risks, socioeconomic conditions & more → this information helps us to **prioritize our areas of focus**

Use data to measure and share the impacts of your work!

Co-Design of Interventions

Co-Design interventions that are **collaborative; based on best practices & designed to meet needs of the population**

Ensures that perspectives of all providers involved in care are included, and the patient is at the centre of OHT work and their voice is central to planning - **Nothing About Us Without Us**

Advancing Health Equity

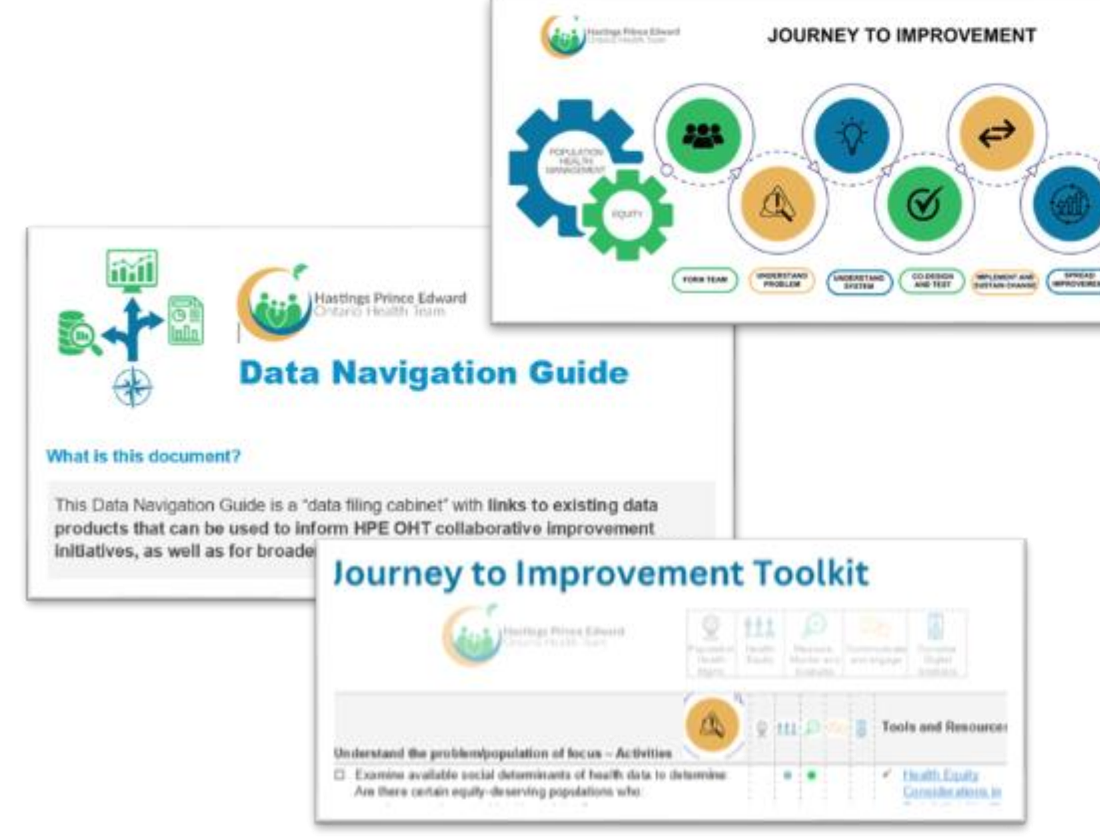
Identify those who may experience barriers to accessing or benefitting from interventions; identify and understand those barriers - and **ensure strategies to remove/mitigate barriers are included in planning**

Goal: The entire HPE population has access to the same opportunity for optimal health and wellbeing

Population Health Management and the HPE OHT

Why a PHM approach? Based on data & evidence; proactive, benefits the entire HPE population, is collaborative and it's the **right thing to do**

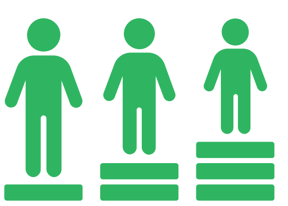
As an OHT, we have been co-designing and working towards how we will incorporate a PHM approach in all the work that we do



Our OHT work today, and looking forward: thinking from a population health management perspective

What does the data tell us about our population – their health needs, barriers, and risks?

Where are there opportunities to transition to more proactive and collaborative care for our population?



Are there certain equity-deserving groups who experience barriers to care, or who have worse health outcomes?

Our OHT work today, and looking forward: thinking from a population health management perspective

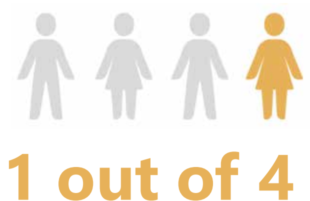
We continue to see relatively high and/or increasing numbers of people within our existing priority population groups:

WHO

- **Population: Unattached to Primary Care**
- **Population: At risk of hospitalization, at risk of Long-Term Care admissions**
- **Population: Chronic Conditions**
- **Population: Mental Health & Addictions, people experiencing homelessness**
- **Population: Respiratory Illness**

Our OHT work today, and looking forward: thinking from a population health management perspective

Based on population characteristics, there may be *other potential priority populations* across the lifespan:



1 out of 4

are ages 65+

(25%, vs 18.7% for Ont.)

Related: relatively high rates of frailty, those at end of life

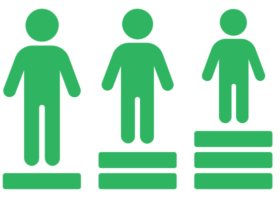
Compared to the province overall, those in HPE have **higher rates of health risks and behaviors** (such as smoking and high blood pressure) **and chronic conditions**, including ones beyond our current priority populations:

- **Heart failure**
- **Stroke**
- **Cancer** (particularly breast, prostate, and lung cancers)

Maternal and child health - higher rates of:

- Mental health concerns and substance use during pregnancy,
- Risk factors for healthy childhood development

Our OHT work today, and looking forward: thinking from a population health management perspective



We know there are equity-deserving groups in HPE who experience barriers to care, and who have worse health outcomes:

Health Care Challenges and Opportunities

Themes identified through engagement with providers, patients, clients, and caregivers

Challenges

November 2023

2 Social Determinants of Health

- There are limited transportation resources available especially in the evenings and on weekends for much of rural HPE. This limitation makes it nearly impossible for patients, clients and caregivers to attend medical appointments, pick up prescription medication and access health care when they need it most.
- The cost of transportation to go to scheduled appointments, medication pick-up, or visits to the hospital is unaffordable.
- A lack of social supports can make it challenging for people to manage their illnesses and access care.
- The cost of private medical services, medications, and other medical supplies can create a barrier to receiving care for those with lower income levels.
- Transportation is particularly an issue for residents who do not have access to housing, earn low income, those with disabilities, and the elderly.

6 Systemic Factors

- Stigma experienced by people who are unhoused, experiencing mental health and/or substance use illnesses.
- There are cultural barriers that need to be addressed (lack of knowledge around equity, diversity and inclusivity).
- There is competition among organizations for recruitment.
  - Wage disparities exist between organizations, which exacerbates

SDOH

Social Determinants of Health

HPE residents living in less materially and socially advantaged areas have *higher utilization related* to:

- Alcohol and mental health related emergency department visits
- COPD and CVD hospitalizations

And have *higher premature mortality rates*

HPE OHT Journey and Impact - Moving from our current state to start sensemaking for our possible future

Hastings Prince Edward
Ontario Health Team

The Context: Our Population

Is growing and changing:

+ 5.2%
Population growth

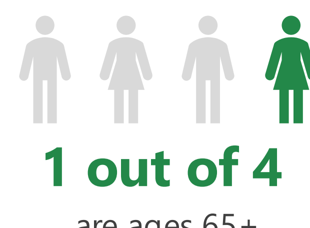
With an increasing **racialized and newcomer population** and seasonal populations

~178,000 people

Is largely rural:

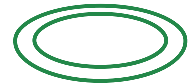
2 out of 3
live in small towns or rural areas

Is relatively older:



1 out of 4
are ages 65+

Has a relatively large segment that is **materially and socially disadvantaged**



Experiences health differently:

Only half report very good or excellent health

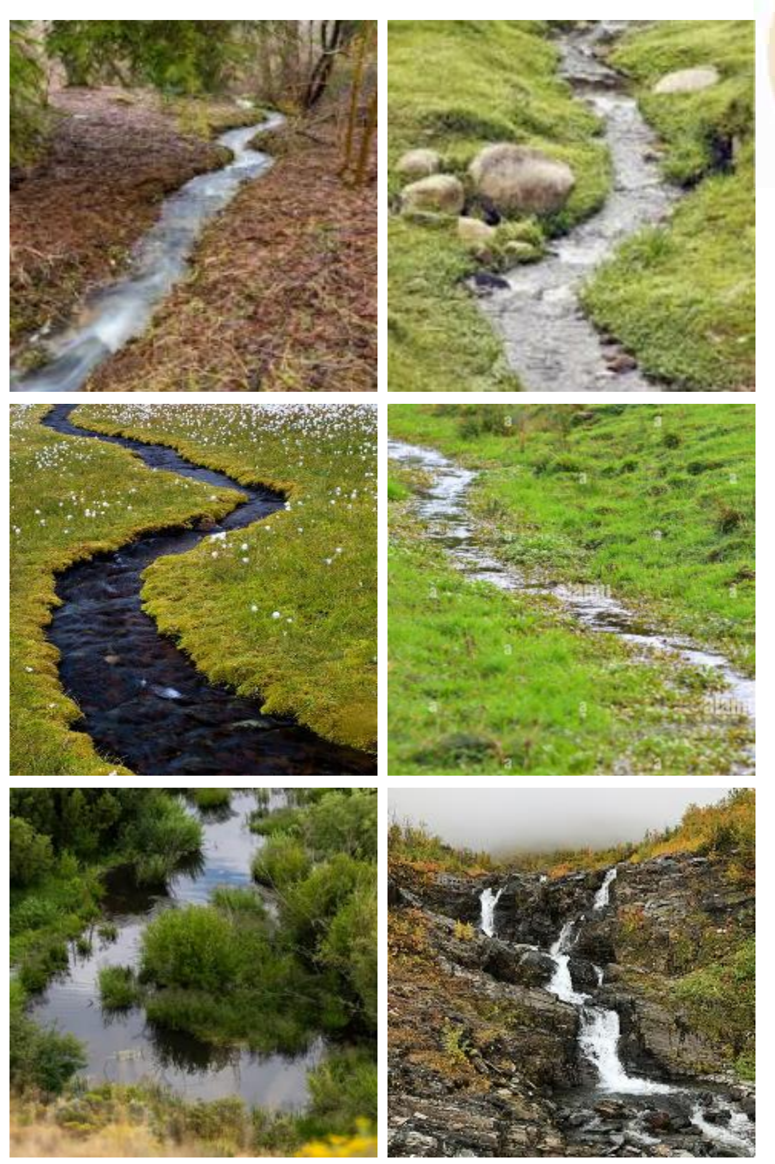
We have higher rates of chronic conditions like diabetes and COPD

People live 2.5 years less on average compared to other Ontarians

The Context: HPE Health and Care Landscape

Community Care
Primary Care
Rehabilitative Care
Long-Term Care
Mental Health & Addictions Care
Seniors and Youth Care
Home Care

Hospital Care
Public Health
Social Services
Specialty Care
Assisted Living
Housing
Emergency Services
And more …



Zooming In…

The Challenge… Zooming Out

A Vision Begins…2021

Introduction of Constellation Model

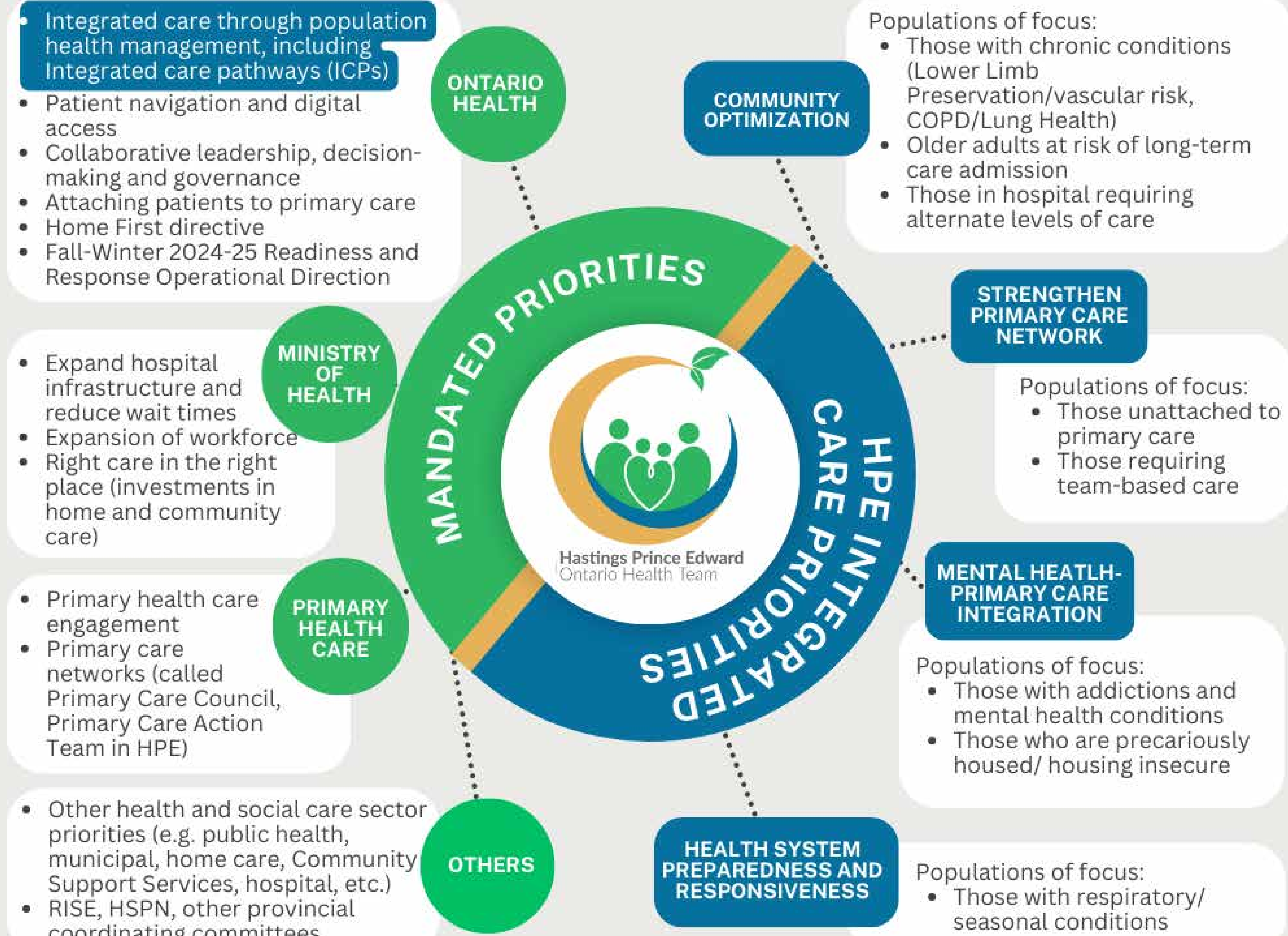
Rural Hastings

Belleville & Tyendinaga

Quinte West

Prince Edward

- To capture nuanced differences across geographic areas in HPE
- Allows for **place-based responses and collaboration** while contributing toward objectives of OHT overall



Integrated care through population health management, including Integrated care pathways (ICPs)
Patient navigation and digital access
Collaborative leadership, decision-making and governance
Attaching patients to primary care
Home First directive
Fall-Winter 2024-25 Readiness and Response Operational Direction
ONTARIO HEALTH
Expand hospital infrastructure and reduce wait times
Expansion of workforce
Right care in the right place (investments in home and community care)
MINISTRY OF HEALTH
Primary health care engagement
Primary care networks (called Primary Care Council, Primary Care Action Team in HPE)
PRIMARY HEALTH CARE
Other health and social care sector priorities (e.g. public health, municipal, home care, Community Support Services, hospital, etc.)
RISE, HSPN, other provincial coordinating committees
OTHERS
MANDATED PRIORITIES
HPE INTEGRATED CARE PRIORITIES
Hastings Prince Edward
Ontario Health Team
COMMUNITY OPTIMIZATION
Populations of focus:
Those with chronic conditions (Lower Limb Preservation/vascular risk, COPD/Lung Health)
Older adults at risk of long-term care admission
Those in hospital requiring alternate levels of care
STRENGTHEN PRIMARY CARE NETWORK
Populations of focus:
Those unattached to primary care
Those requiring team-based care
MENTAL HEATLH-PRIMARY CARE INTEGRATION
Populations of focus:
Those with addictions and mental health conditions
Those who are precariously housed/ housing insecure
HEALTH SYSTEM PREPAREDNESS AND RESPONSIVENESS
Populations of focus:
Those with respiratory/ seasonal conditions

Charting a new path…
Leadership
Collaboration
Integration
Covid, Cold and Flu Clinics
Foundational Supports
Integrated Care Pathways
Patient, Client & Partner Council
Priorities & Populations of Focus
Shared purpose, Principles for Working Together, Declaration of Values
HPE OHT = 50+ organizations strong

Breakthroughs!

Breakthrough:

Partnerships, Collaboration and New Ways of Working Together

Examples:

Population: Chronic Conditions

Lower Limb Preservation (LLP) Demonstration Project

Population: Respiratory Illness

Covid, Cold & Flu Care Clinics

Shining Examples of Success

A Patient Experience

"In winter 2019, my feet first got sick"

"When you are homeless, you don't look after yourself and your feet go by the wayside."

"Once I understood the need for better shoes and to stay off my feet, I was able to get quick healing"

"Finally, the colour of my feet is coming back."

Breakthrough:

Access to Equitable Team-Based Comprehensive Care

Example:

Population: Unattached to Primary Care

Primary Health Care Strategy

Breaking Through

To be successful in collaboration and integration we have begun activities that will help support the work we need to do:

- ✓ Foundational Supports (Digital, Quality, Performance Management, etc.)
- ✓ Health Equity Working Group
- ✓ "Journey to Improvement" - how quality improvement and population health management can guide our work forward

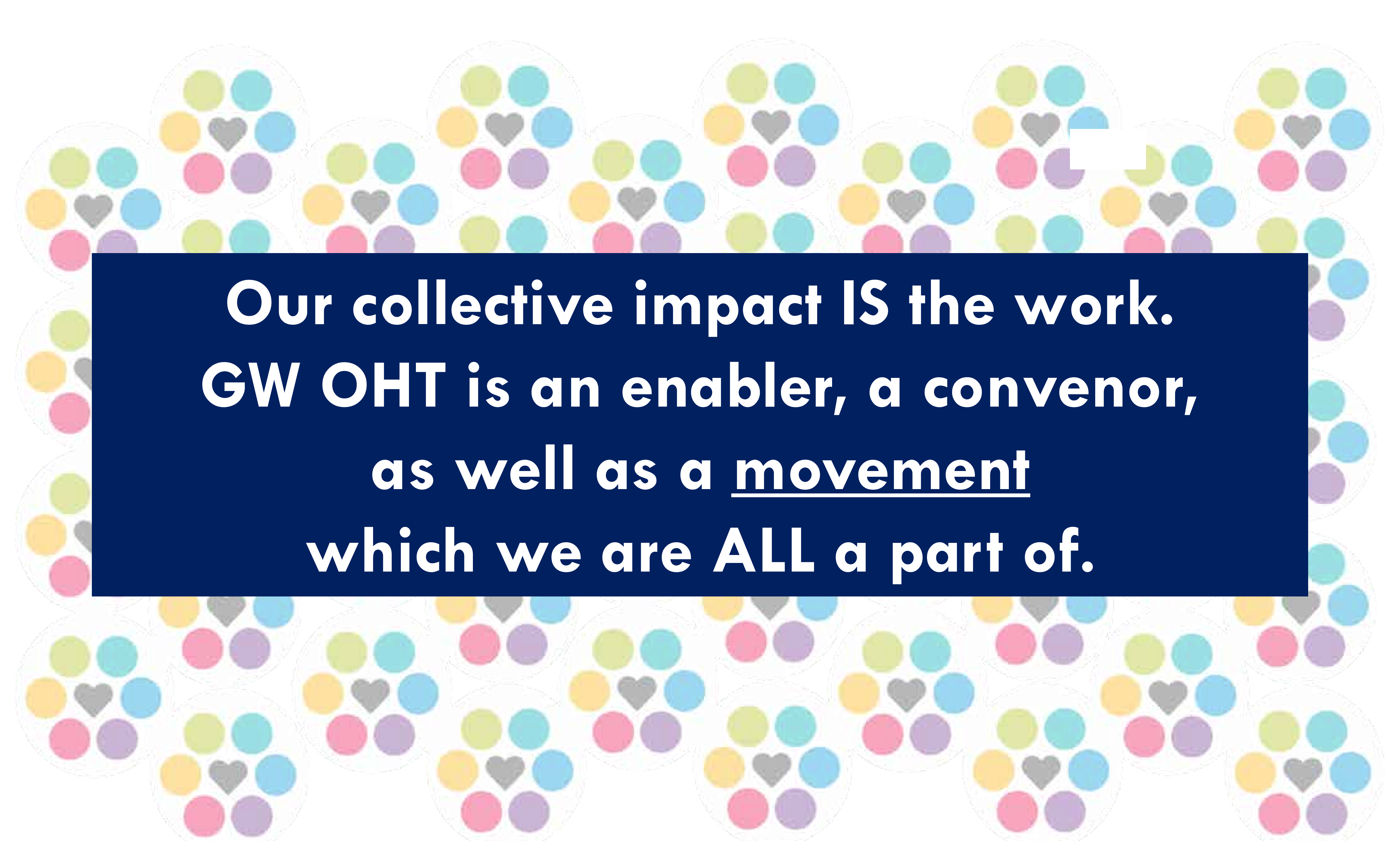
Moving Forward…

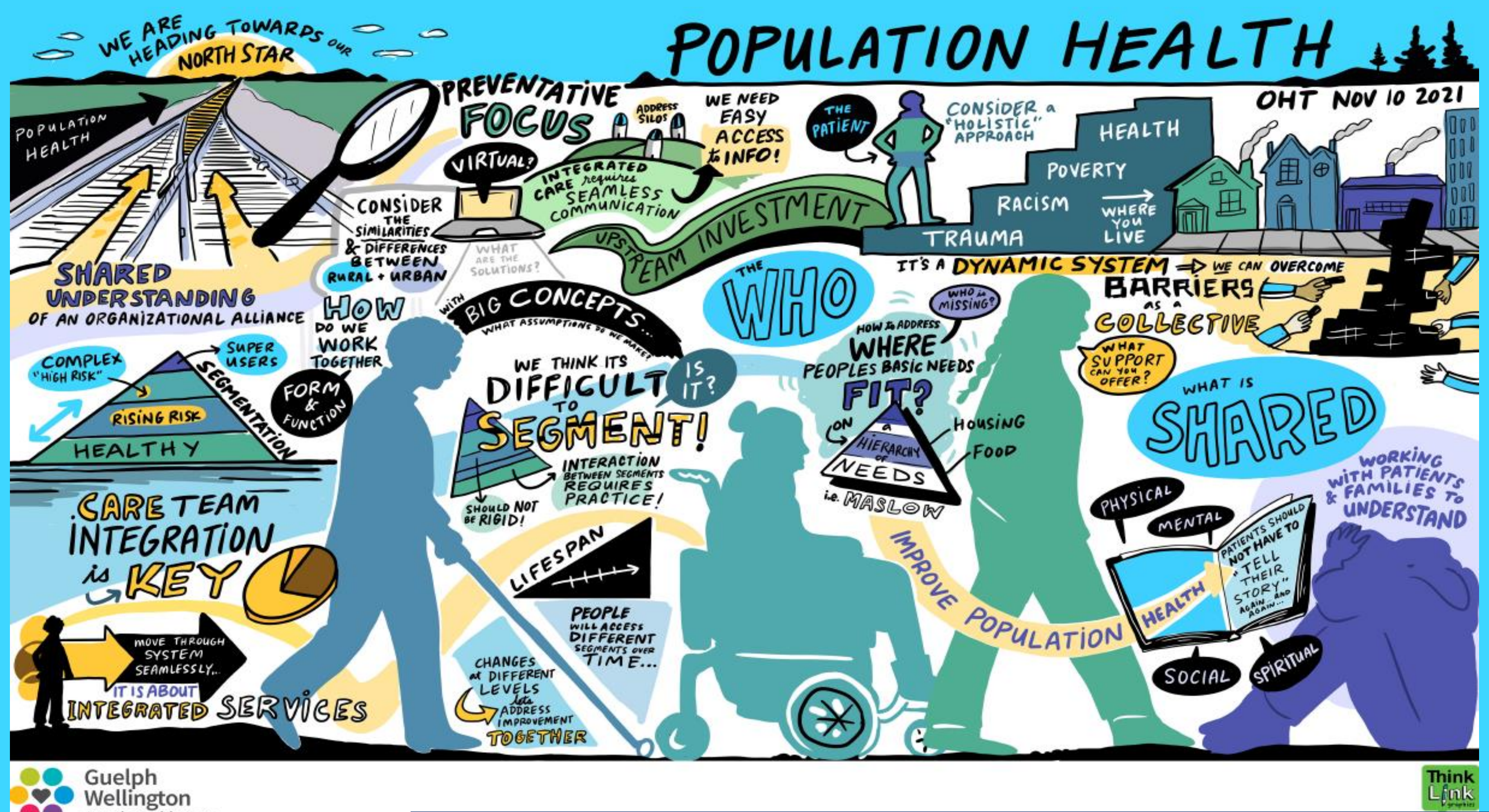
We are all the HPE OHT!
Personal Reflections …

Thank You!

One Team Approach

Emmi Perkins, Director of Transformation
Guelph Wellington Ontario Health Team

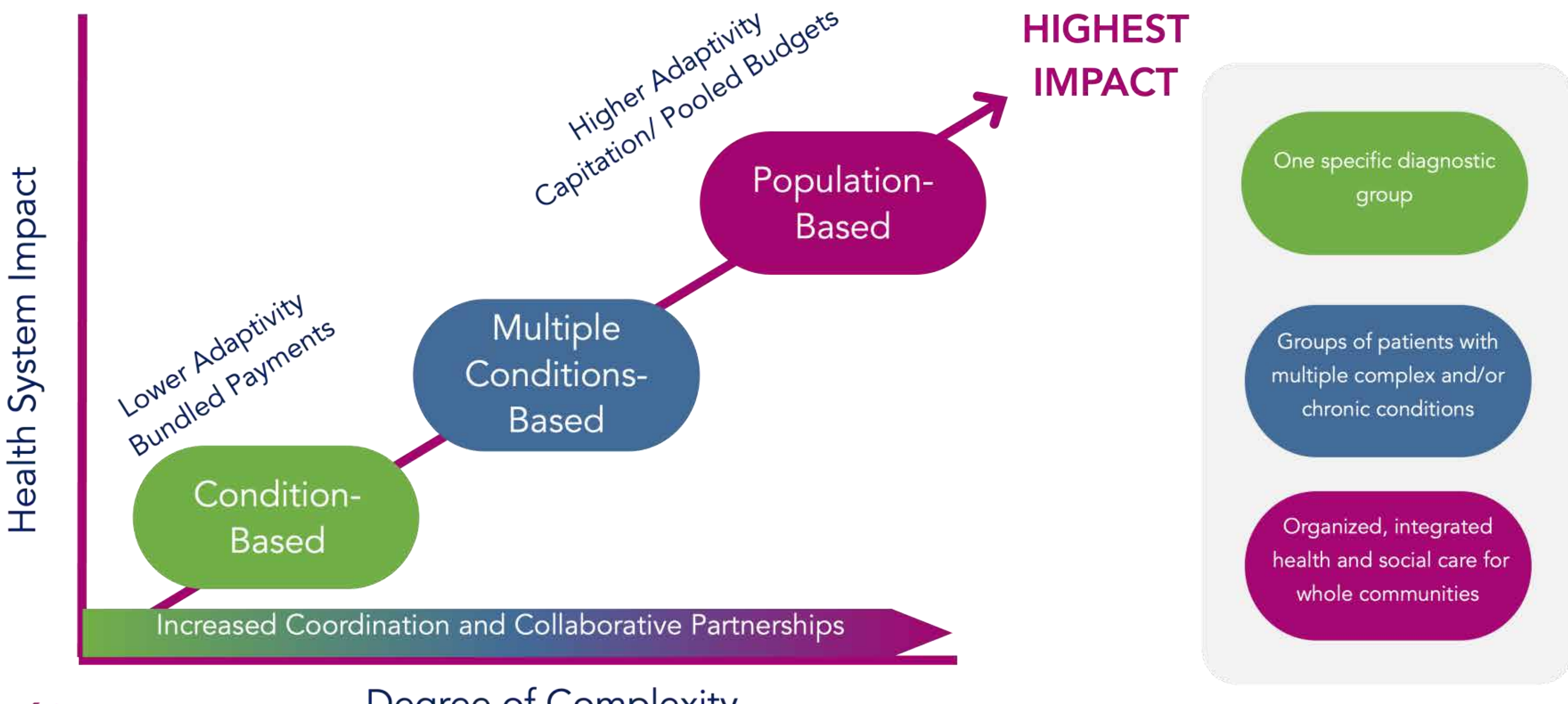

Our collective impact IS the work.
GW OHT is an enabler, a convenor,
as well as a movement
which we are ALL a part of.



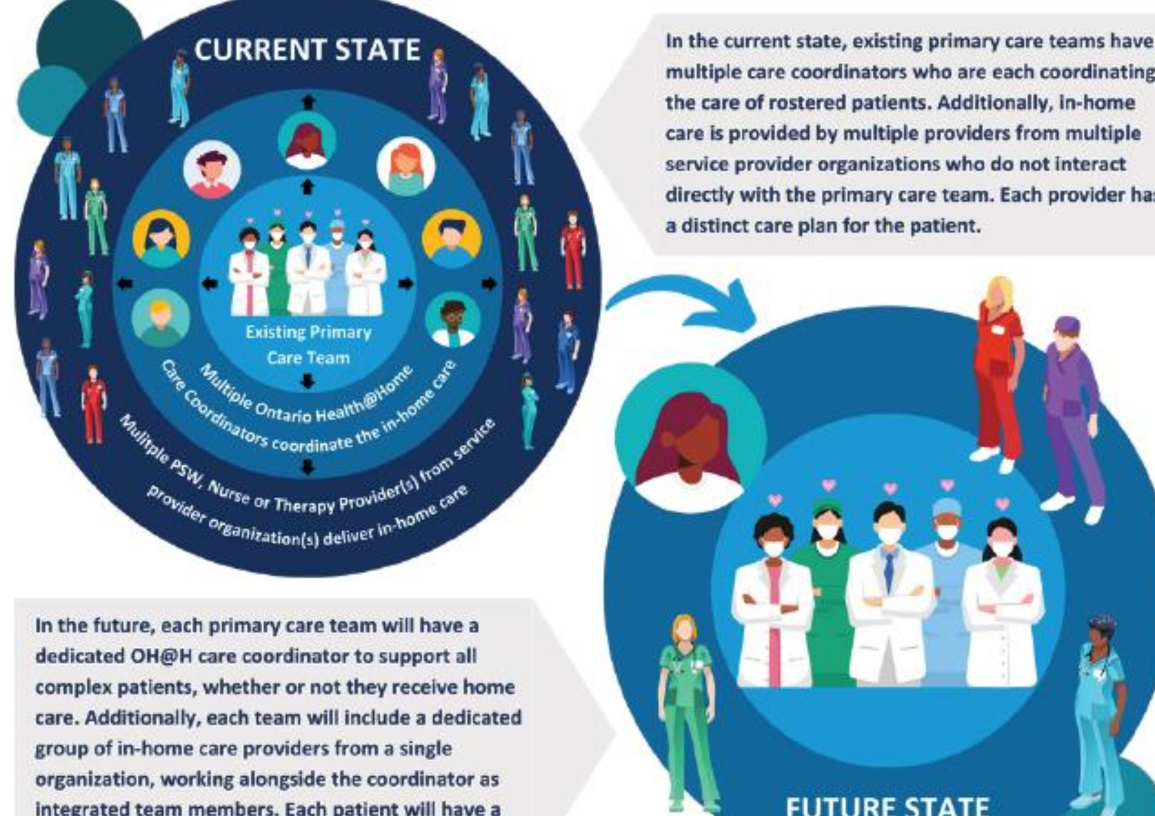
Building on previous collective work, we came together around our shared purpose

Integrated Health Systems

Transition from Health Conditions to Population-Focused



IPCTs as the Vehicle to Advance Integrated Care in Guelph Wellington



Integrated Patient Care Teams (IPCTs) – The Vehicle to Advance Integrated Care in Guelph Wellington

Primary Care Providers at Existing Primary Care Teams/Sites

Patients Served by Existing Primary Care Teams/Sites

A Dedicated OH@H Care Coordinator

Dedicated Nurses, PSWs, Allied Health from a Service Provider Organization contracted to the GW OHT via a modernized contract and funding formula

Integrated Patient Care Teams in Guelph Wellington

Mount Forest FHT
Patients: 11,837
Physicians/NPs: 10

Minto-Mapleton FHT
Patients: 16,926
Physicians/NPs: 14

UGFHT
Patients: 34,264
Physicians/NPs: 37

EW FHT
Patients: 12,300
Physicians: 10

Guelph CHC (Hub)
Patients: 1500
Physicians: 2.5
Physicians/NP

Wyndham House
Patients: 350
NPs: 2

Guelph FHT (3 IPCT Sites)
Patients: 23,785
Physicians: 20

OUR OPTIMAL MODEL OF LEADERSHIP

How do you want to lead together?

- Shift to distributed leadership and work in the grey together
- Embody mindset and behaviours needed for integration
- Have various mechanisms to build trust and connection
- Shared pride and understanding about the impact we are already having and that we can have
- Sit in the place of loving the <u>why</u> we get to work in radically collaborative ways in service of population health and wellbeing
- Focus on what we can collectively achieve and that is within our control
- Being brave enough to shift our organizations and even our own roles in the best interest of the whole
- Do what we say we are going to do

Evolving the Governance Council and Steering Committee to be Fit for our Shared Purpose

What is our Current Purpose?

Advancing integrated care by:

- Supporting achievement of impact within identified 4 priority areas
- Advancing/concluding 'GW OHT 2022/25 Strategic Priorities '
- Guiding development of next set of strategic priorities
- Supporting continued RADICAL COLLABORATION and distributed leadership
- Preparing for designation – PCN, Home Care Readiness, Patient/Caregiver Engagement, coordinating corporation

Evolving the Governance Council and Steering Committee to be Fit for our Current Purpose – Proposal

GW OHT Community Collaborative

- Purpose: Connection, Celebration, Engagement and Idea Generation
- Meets ~4 times per year
- Includes:
  - PFAC reps and executive and/or governor from Core and Community partner organizations
  - Working Groups Leads
  - GW OHT PFAC, AOAT, GWPA, PCN members
  - Others?
- Format: Stories, Celebration of successes, Collect advice re: specific issues/areas of focus

GW OHT Joint 'Integrated Care' Committee

- Purpose/Function/Mandate: Makes key decisions to advance the OHT's shared purpose as informed by the GW OHT Community Collaborative and other stakeholders. Supported by revised CDMA.
- Meets in months between 'Community Collaborative' meetings
- Co-chaired by a GW OHT PFAC rep and/or person with lived experience
- Includes: The executive and governor and/or patient/caregiver/PWLE from each core partner organizations who commit to GW OHT partnership as a vehicle to advance integrated care
- Sub-group to be created to guide the incorporation process

By the End of 2024-25

we want to focus on the following 4 areas,
building on the work that is already being done by the collective and by working groups

Focus Area	**1. Anchor IPCT as the approach for how we advance integrated care**	**2. Strengthen collaborative leadership at all levels**	**3. Align & leverage our current resources to work better together**	**4. Leverage the collective voice of GW OHT for advocacy around key issues**
Measure(s) of Success	• # of IPCT sites & their level of maturity (measured through IPCT Maturity Scale) • # of community members benefitting from an IPCT • # of front-line staff & PCP working as part of an IPCT	Reach 'One Team Approach' (OTA) high performance as measured through 'One Team Approach' Self-Assessment	• OHT work is part of what we do, not what we do on the side of our desks • Shared, clear measurable outcome indicators • People/patients & community at the centre of all work, decisions & priorities • Aligned strategic priorities across all partners	• We have coalesced around key areas for joint advocacy that align with our shared purpose. • We have made collective advocacy efforts (joint letter, joint meetings with MPP, MOH etc)

ONE-TEAM APPROACH

One-team Approach Definition

The one-team approach is a culture where individuals and groups work in an integrated way to put people at the centre, regardless of their functional or organizational boundaries. The approach emphasizes the importance of open communication, transparency, continuous improvement, equitable sharing of information and resources, with mutual support to achieve goals and objectives. Each member seeks to understand each other's strengths and differences, their roles and how they contribute to the success of the "one-team". This approach will promote greater efficiency, higher levels of innovation, and a more positive work environment while prioritizing compassionate, responsive care.

the "how"

Assumption: A "one-team" approach for GW OHT will provide the foundation for a more integrated, person- centred health care system

"One-team" culture/approach

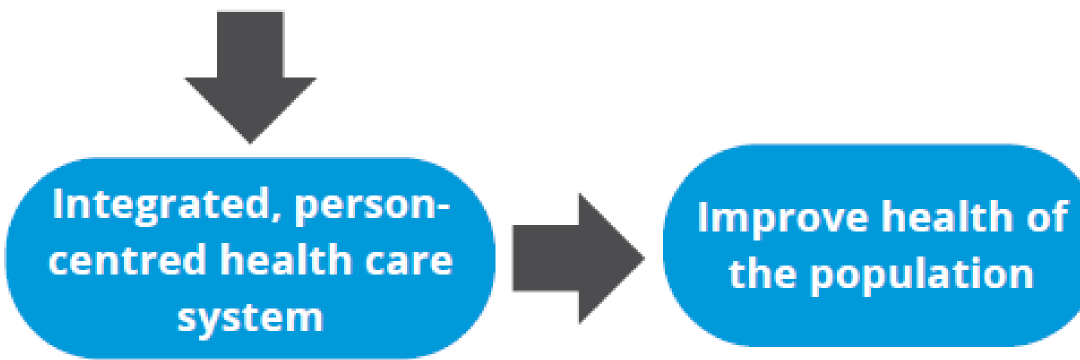
Integrated Patient Care Teams (IPCTs)

Integrated, person-centred health care system

Improve health of the population

One-Team Approach

- Partners & Common Agenda
- Leadership Alignment
- Shared Protocols/ Operations/Resources
- Community/Stakeholder Communication & Engagement
- Shared Data & Measurement
- Sustainability



Domain	Outcome Statements
Partners & Common Agenda The appropriate partners and a common agenda are in place	GW OHT is composed of a broad range of partners including organizations that address the social determinants of health (e.g., equity-deserving groups, children/youth, food insecurity, poverty, etc.) and are responsive to the needs of the community.
	All GW OHT partners understand and endorse the purpose of the GW OHT and are working collaboratively towards the strategic priorities.
Leadership Alignment Leadership and core support are there to align and coordinate the work	GW OHT leadership structure is adaptive and invested in ongoing learning and improvement.
	Core staff effectively model and guide GW OHT's strategic priorities
	Core staff collaboratively work towards alignment of GW OHT's activities with the strategic priorities
Sustainability Able to continue the work over the long-term	Sufficient funding (including permanent base funding) and resources are available to support the GW OHT over the long-term (i.e., 10 years).
	GW OHT has broad community/stakeholder support.
	Resource allocation is highly flexible to respond to population needs
	Sufficient investment in health human resources to recruit and retain staff.

Domain	Outcome Statements
Community/Stakeholder Communication & Engagement Building trust and strengthening relationships	GW OHT partners have implemented shared internal and external communication plans to support the OHT with clear roles and responsibilities.
	GW OHT partners have implemented a shared community and stakeholder engagement plan that incorporates an equity, diversity and inclusion (EDI) lens.
	GW OHT partners have a shared understanding of EDI and now it applies to the GW community.
Shared Data and Measurement Tracking progress, continuous learning, and accountability	GW OHT partners have collaborated in the design and management of a shared measurement framework.
	Quality data based on a set of meaningful indicators is accessible to all GW OHT partners and the community.
	A shared measurement framework is used for key decision-making, performance monitoring, and system planning.
Shared Protocols/Operations/ Resources Activities are integrated to maximize impact	GW OHT partner organizations have equitably shared functions and resources to support the OHT (e.g., clinical, back office).
	GW OHT partners are following shared protocols (e.g., communication)

The Stage of the OTA within the GW OHT

Baseline (1): GW OHT has not integrated any elements of a one-team approach

Starting (30): GW OHT has started to develop some elements of a one-team approach

Progressing (50): GW OHT has integrated some elements of a one team approach into our practice

Advanced (80): GW OHT has integrated most elements of a one team approach into our practice

Maturity (100): GW OHT has fully integrated the one team approach

Responses	Min	Max	Mean
19	6	85	45.63