OTTAWA HEALTH TEAM – ÉQUIPE SANTÉ OTTAWA QUARTERLY UPDATE – Q1 2023/2024

Questions? Please contact Leslie Wells @ l.wells@pqchc.com

	Initiative	What do we want to accomplish in the 2023/2024 fiscal year?	How does this work connect to the OHT-ÉSO strategic goals and objectives?	Who is leading this work?	What have we accomplished during Q1?
Mental Health and Substance Use	**Counselling Connect** is a web-based platform that provides access to virtual brief counselling supports for all ages, with specific service streams designed to meet the needs of Indigenous, African Caribbean and Black, and LGBTQ+ communities	Increase service options through additional languages and additional group counselling options	**Goal:** Support our attributed population to live healthy and well in community **Objectives:** 1. Increase access to preventative care, primary care, and community-based services 2. Address health inequities and the social determinants of health 3. Increase access to system navigation support. 4. Establish clear service pathways amongst partners **Goal:** Leverage technology to support accessible, integrated care for clients **Objective:** Increase the use of digital health tools to support integrated care	**Co Leads**: Tamara Chipperfield (CCHC), Natasha McBrearty (Crossroads) **Backbone Support:** Ayan Barre, Project Coordinator	• Made available adult counselling appointments in Cantonese.
		Sustainability Planning through partnership with additional mental health and substance use providers, OHTs, and coordinated access mechanisms (e.g., AccessMHA)			• Met with Ottawa-based OHTs to explore opportunities to collaborate on expanding Counselling Connect reach into rural areas surrounding the city and advance common messaging on importance of Counselling Connect within the regional mental health system. • Presented Counselling Connect model and achievements to Champlain Mental Health, Addictions, and Substance Use Health Network to support increased regional support and alignment
	The launch of a **New MHSU Initiative** will allow the OHT-ÉSO to support new initiatives that improve care for individuals with mental health or substance us concerns	Partner engagement to inform selection of new MHSU improvement initiative(s)	TBD	**Co Leads**: Rob Boyd (OICH), Shannon Turcotte (TOH) **Backbone Support:** Ayan Barre, Project Coordinator	• Initial review of mental health and substance use system performance data with co-leads • Initiated planning process for priority setting meeting with partners in fall 2023, including setting goals and objectives, identifying opportunities for partners to share ideas in advance, and recruiting client partners to participate in planning efforts
		Launch of implementation team			N/A
Frail Older Adults	**Home First** seeks to support individuals in hospital to transition back home successfully wherever possible, reducing length of hospitalization and alternate-level-of-care stays.	Implementation and evaluation of "Community Support Services Coach" Position in Emergency Department	**Goal:** Support our attributed population to live healthy and well in community **Objectives:** 1. Increase access to preventative care, primary care, and community-based services 2. Increase access to system navigation supports 3. Establish clear service pathways amongst partners	**Co Leads**: Claire Ludwig (TOH), Carole Green (DSORC) **Backbone Support:** Shaina Smith, Project Coordinator	• Finalized job description and requirements for CSS Advisor Position • Received approval for 12 months of funding to support piloting position from Champlain Community Support Network and TOH • Initiated communication planning to educate and engage key stakeholder groups in Home First principles, including hospital staff and physicians, community care providers, clients, and families
	Community Health Teams are a model of community-based care and support to enable older adults with moderate frailty to live at home as long as possible through the provision of integrated	Increase awareness of the CHT model by sharing it with critical stakeholders at the local, regional, and provincial levels	**Goal:** Support our attributed population to live healthy and well in community **Objectives:** 1. Increase access to preventative care, primary care, and community-based services 2. Address	**Co Leads**: Amy Boudreau (Carefor), Kelli Tonner (SEOCHC) **Backbone Support:** Shaina Smith, Project Coordinator	• Re-engaged key stakeholder groups (e.g., community support services, Home and Community Care Support Services, Ontario Health East) to discuss interest, readiness, and

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	health and social care coordination. This model underwent a trial implementation in 2021/2022.		health inequities and the social determinants of health. 3.Increase access to system navigation support 4. Establish clear service pathways amongst partners		capacity to participate in future implementations of CHT model. • Collaborated with frontline staff who participated in initial CHT implementation to identify feasible immediate term goals that would support the application of lessons learned from the trial implementation to the current system
		Continuing education and promotion about the Rockwood Clinical Frailty Scale as a recommended frailty screening tool			• Explored partnership with Ottawa West Four Rivers OHT to continue mapping existing services for older adults by frailty level to support the development of a comprehensive stepped care protocol for older adults
		Support the development of other strategies to reduce avoidable use of hospital resources by adapting the CHT concept to support higher acuity clients			N/A
Other Populations	The OHT-ÉSO **Cancer Screening** initiative seeks to increase screening rates for breast, cervical, and colorectal cancers amongst newcomer and racialized communities.	Implementation of 3 cancer screening clinics focusing on unattached patients facing barriers to regular screening	**Goal:** Support our attributed population to live healthy and well in community **Objectives:** 1. Increase access to preventative care, primary care, and community-based services 2. Address health inequities and the social determinants of health.	**Co Leads**: TOH, OPH, SWCHC, SEOCHC **Backbone Support:** Ayan Barre, Project Coordinator	• Conducted 2 cancer screening clinics for attached patients who are facing barriers to receiving screening. • Supported recruitment for a nurse practitioner at TOH who can support screening for unattached patients Initiated planning for community town halls promoting preventative cancer screening in newcomer and racialized communities and linking individuals to OHT-ÉSO cancer screening clinics
		Adapt cancer screening educational materials to increase cultural competency			• Continued to collect feedback on outreach toolkit to inform planning on updates and improvements
	The **Lower Limb Preservation** integrated care pathway seeks to reduce avoidable, non-traumatic lower limb amputations by increasing the integration and coordination of hospital and community-based services.	Improving care coordination for individuals at risk of lower limb amputation by bringing specialists to environments where people are already receiving care and implementing a common digital wound tracking software amongst partners	**Goal:** Support our attributed population to live healthy and well in community **Objectives:** 1. Increase access to preventative care, primary care, and community-based services 2. Address health inequities and the social determinants of health. 3. Establish clear service pathways amongst partners	**Co Leads**: Natalie Leroux (TOH), TBD **Backbone Support:** Marley Pickles White (TOH), Nicholas Kerr (TOH)	• Supported partnership between TOH vascular surgery and the Ottawa Mission clinic to increase access to comprehensive wound assessment in the community. • Identified common wound assessment software for implementation and began procurement discussions
		Equip care teams to better care for individuals at risk for lower limb amputation in the community by providing increased training in wound prevention and identification and improving the referral pathway from community partners to vascular surgery			N/A
		Support clients and families to participate in self-management by ensuring consistent, high-quality, and culturally appropriate education resources are			• Began process of reviewing potential client-facing resources to make available within partner organizations

		available in clinical settings of partner organizations			
Digital Health and Information Management	The **Online Appointment Booking** initiative seeks to increase utilization of online appointment booking solutions within primary care settings	Enhance patient and caregiver access to online appointment booking by aiding with funding and implementation support to our primary care network. This will involve facilitating the adoption and implementation of online appointment booking while simultaneously promoting the growth of their digital health capabilities.	**Goal:** Leverage technology to support accessible, integrated care for clients **Objectives:** Increase the use of digital health tools to support integrated care	**Backbone Support:** Ernest Ling, Digital Health Lead	• Sustain Cohort 1 online appointment booking implementations (Troubleshoot, workflow, questions) • Develop Provider Survey for feedback. • Update Ocean online appointment booking to solicit Patient Survey for feedback. • Submit FY2324 funding proposal for new providers and sustainment funding for current providers two new clinics joining our OHT OAB CoP (Ascent Medical Centre & Rideau FHT)
	The **Digital Health and Information Management Strategic Leadership Team** is responsible for advancing digital health and information management maturity within the OHT-ÉSO	Conduct an assessment to understand the current needs and priorities of OHT-ÉSO partner organizations to inform the creation of short-, medium-, and long-term action planning	**Goal:** Leverage technology to support accessible, integrated care for clients **Objectives:** 1. Ensure digital equity is embedded into planning and implementation processes 2. Increase the use of digital health tools to support integrated care 3. Increase clients' access to their health information	**Co-Leads:** TBD **Backbone Support:** Ernest Ling, Digital Health Lead	• Conducted six focus groups with partner organizations on digital health needs, barriers, and priorities Began process of translating focus group feedback into proposed short-, medium-, and long-term goals with DHIM members
		Represent the OHT-ÉSO in local, regional, and provincial discussions on digital health strategy to amplify local needs and priorities			• Continued involvement in local and regional digital health advisory committees and working groups
Performance Measurement	The **Sociodemographic Data Collection** initiative is focused on increasing capacity of the OHT-ÉSO and its partners to collect and use sociodemographic data for health-equity drive planning and decision support	Create a common list of socio-demographic data (SDD) indicators for recommended use by partners along with a resource toolkit to support the implementation and strengthening of organizational SDD collection & use strategies.	**Goal:** Increase capacity to collect, share, and use performance data for planning and decision support **Objective:** Scale up best practices of data collection, storage, and sharing amongst partners	**Co-Leads:** TOH, OPH, CCHC **Backbone Support:** Liam McGuire, Performance Measurement Lead	• Creation of project team to support advancement of this initiative, including project charter and stakeholder engagement plan. • Hold two in-person planning retreats to develop selection criteria, select areas of measurement, and confirm first draft of recommended core socio-demographic indicators with supporting technical specifications. • Develop first draft of recommended core socio-demographic indicators, and share with sub-group members for internal review at their own organizations
	Development of an **OHT-ÉSO Performance Measurement Framework** will help us understand the impact of our work at the system level, across all domains of the Quadruple Aim.	Identify key evaluation themes to define & measure integrated health care performance using the Quadruple Aims framework. Select indicators used across multiple sectors to build initial version of performance indicator framework.	**Goal:** Increase capacity to collect, share, and use performance data for planning and decision support **Objective:** Develop a performance measurement strategy for the OHT-ESO	**Lead:** Aideen Reynolds (OPH) **Backbone Support:** Liam McGuire, Performance Measurement Lead	• Conduct environmental scan of performance measurement tools currently available. • Work with Performance Measurement Working Group to identify key principles for measuring integrated care in an OHT environment. • Started process of selecting evaluation themes for the first selected Quadruple Aim area: Patient/Client and Caregiver Experience

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Health Equity	The **Sociodemographic Data Collectio**n initiative is focused on increasing capacity of the OHT-ÉSO and its partners to collect and use sociodemographic data for health-equity drive planning and decision support	Create a common list of socio-demographic data (SDD) indicators for recommended use by partners along with a resource toolkit to support the implementation and strengthening of organizational SDD collection & use strategies.	**Goal:** Increase capacity to collect, share, and use performance data for planning and decision support **Objective:** Scale up best practices of data collection, storage, and sharing amongst partners	**Co-Leads:** TOH, OPH, CCHC **Backbone Support:** Liam McGuire, Performance Measurement Lead	• Creation of project team to support advancement of this initiative, including project charter and stakeholder engagement plan. • Hold two in-person planning retreats to develop selection criteria, select areas of measurement, and confirm first draft of recommended core socio-demographic indicators with supporting technical specifications. • Develop first draft of recommended core socio-demographic indicators, and share with sub-group members for internal review at their own organizations
	The **OHT-ÉSO Health Equity Collective Impact Framework** will set shared, actionable equity goals based on the OHT-ÉSO Health Equity Charter, and support partners in aligning their internal efforts to support greater system impact on addressing health inequalities	Identify and build consensus around common health equity goals to support internal equity planning efforts within partner organizations	**Goal:** Support our attributed population to live healthy and well in community **Objectives:** Address health inequities and the social determinants of health. **Goal:** Strengthen and expand the culture of co-design within the OHT-ESO **Objective:** Build trust amongst partners through transparency and accountability	**Co Leads:** Aideen Reynolds (OPH), TBD **Backbone Support:** Aleksandra Milosevic, Engagement Specialist	• Received endorsement for collective impact approach to advancing health equity planning from OHT ESO Collaborative Leadership Group and Partner Organizations. Began recruitment for working group to support initial advancement of this initiative
Primary Care Engagement	Continue growth and development of **OHT-ÉSO Primary Care Table to** provide leadership amongst the primary care sector to support effective engagement and planning that align with the vision and commitments of the OHT-ESO	Support ongoing recruitment, support, retention, and capacity building needs of Primary Care Partner Table members to ensure they are equipped to engage in strategic planning and leadership discussions on behalf of the OHT-ESO	**Goal:** Strengthen and expand the culture of co-design within the OHT-ESO **Objectives:** 1. Build trust amongst partners through transparency and accountability 2. Facilitate and support the active involvement of key stakeholders in integrated care design and delivery	**Co-Leads:** Dr. Ben Robert, Hoda Mankal, NP **Backbone Support:** Aleksandra Milosevic, Engagement Specialist	• Recruited and onboarded one new member to the Primary Care Partners Table. • Attendance at OttawaU Department of Family Medicine's Annual • Refresher Course to engage and increase awareness of OHTs amongst primary care community
	The **Primary Care Pain Points** committee represents a collaboration between TOH and primary care to address common challenges in communication and client information sharing between hospital and primary care	Take action to address challenges in referral pathways, discharge summary communication, and EPIC	**Goal:** Strengthen and expand the culture of co-design within the OHT-ESO **Objectives:** 1. Build trust amongst partners through transparency and accountability 2. Facilitate and support the active involvement of key stakeholders in integrated care design and delivery	**Co-Leads:** Dr. Ben Robert, Hoda Mankal, NP **Backbone Support:** Aleksandra Milosevic, Engagement Specialist	• Discharge summaries coming from TOH to primary care have been shortened, decreasing the administrative burden for primary care, and improving communication with hospital partners.
	The OHT-ÉSO has been a collaborator on a regional **Unattached Patient Strategy** that provides guidance and actionable steps to address the current lack of access to primary care in the Ottawa region, particularly for equity-deserving populations.	Continue engagement and discussion with local, regional, and provincial stakeholders to introduce the Strategy and advocate for resources necessary to implement. Support primary care practices to align funding requests to the achievement of the Strategy	**Goal:** Strengthen and expand the culture of co-design within the OHT-ESO **Objectives:** 1. Build trust amongst partners through transparency and accountability 2. Facilitate and support the active involvement of key stakeholders in integrated care design and delivery	**Co-Leads:** Dr. Ben Robert, Hoda Mankal, NP **Backbone Support:** Aleksandra Milosevic, Engagement Specialist	• Met with Ontario Health East to increase awareness of Strategy and advocate for resources to support implementation. • Supported primary care practices to align interprofessional team-based care funding applications with Strategy through the provision of OHT endorsement and letters of support for proposals that support the Strategy's achievement
		Continue learning about gaps, needs, and priorities for primary care practitioners in the region			• Collection of interprofessional team base care funding applications from local primary care practices to increase

					understanding of current needs and gas
Client Partner Engagement	Continue growth and development of **OHT-ÉSO Client Partner Table** as a vehicle to advance the implementation of equity-based co-design, and client-centered planning within all aspects of the OHT	Develop processes and structures that embed client voice in decision-making structures within the OHT- ÉSO	**Goal:** Strengthen and expand the culture of co-design within the OHT-ESO **Objectives:** 1. Build trust amongst partners through transparency and accountability 2. Facilitate and support the active involvement of key stakeholders in integrated care design and delivery	**Co-Leads:** Tim Hutchinson, Pierrette Leonard **Backbone Support:** Aleksandra Milosevic, Engagement Specialist	• A logical model developed to support work planning. • Planning retreat to support relationship building amongst client partners and development of work plan
		Developing a capacity building plan to ensure all client partners working with the OHT-ÉSO have the necessary tools to succeed in their role			• Client partner orientation package updated. • 2 new members were onboard. • Educational and self-management resources shared with client partner and through OHT-ESO newsletter
		Develop a structure and process for advocacy opportunities arising from client partners.			• Consensus building around advocacy needs and constraints to support guideline development
Collaborative Governance	The **OHT-ÉSO Collaborative Leadership Group** provides strategic vision, direction, guidance, and decision-making support to the OHT-ESO as a whole.	**Participation in Leadership Structures:** Strengthen and renew membership in OHT-ESO Collaborative Leadership Group	**Goal:** Strengthen and expand the culture of co-design within the OHT-ESO **Objectives:** 1. Build trust amongst partners through transparency and accountability 2. Facilitate and support the active involvement of key stakeholders in integrated care design and delivery	**Co-Leads:** Honorata Bittner (TOH), Michelle Hurtubise (CCHC) **Backbone Support:** Leslie Wells, Director	• Updating CLG Skills and Experience matrix to support greater representation of equity-deserving groups. • Call for new expressions of interest for CLG membership to fill 2 vacant seats
	OHT-ESO **Partner Organization Engagement Sessions** provide an opportunity to discuss opportunities, challenges, and emerging questions with the OHT-ÉSO as a whole and receive direction and guidance on next steps.	**Increasing Meaningful Engagement of OHT-ESO Partner Organizations:** Implement updated organizing structure for OHT-ESO partners as new priorities and opportunities are identified.	**Goal:** Strengthen and expand the culture of co-design within the OHT-ESO **Objectives:** 1. Build trust amongst partners through transparency and accountability 2. Facilitate and support the active involvement of key stakeholders in integrated care design and delivery	**Backbone Support:** Leslie Wells, Director; Aleksandra Milosevic, Engagement Specialist	• Consensus received on updated organizing framework that will be trialed with new initiatives anticipated for fall 2023
Patient Navigation	Part of the OHT-ÉSO vision and mission is to **simplify and increase access to care.** We are working to demonstrate how this vision, and all associated initiatives, are **supportive of provincial efforts to improve patient navigation services.**	**OHT-ÉSO Navigation Monitoring Framework:** Establish monitoring framework that demonstrates how OHT-ÉSO initiatives contribute to improving domains of patient navigation.	**Goal:** Support our attributed population to live healthy and well in community **Objectives:** 1. Increase access to system navigation supports 2. Establish clear service pathways amongst partners	**Co-Leads:** Crossroads Children Centre, CMHA Ottawa, South-East Ottawa CHC, Regional Geriatric Program of Eastern Ontario Backbone Support: Shaina Smith, Project Coordinator	• Reviewed OHT-ÉSO navigation performance measures in existing projects • Identified gaps in the navigation performance measures in collaboration with working group. • Developed communication/touchpoint strategy for OHT-ÉSO backbone staff to monitor navigation work within individual projects