

# OHT- ÉSO COLLABORATIVE LEADERSHIP GROUP

## TERMS OF REFERENCE

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LAST REVIEWED ON	NEXT REVIEW DATE
June 2024	June 2025

### PURPOSE / MANDATE

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The Collaborative Leadership Group’s (CLG) role is to provide a broad sectorial and strategic view of matters of relevance to the Ottawa Health Team – Équipe Santé Ottawa (OHT-ÉSO). The CLG promotes collaboration and integrated care across the OHT-ESO and affiliated partners and ensures OHT-ÉSO engagement in activities that improve patient and population health outcomes, patient and provider experience, value and health equity. In consultation with the member organizations, Client Partner Table and the Primary Care Partner Table, the CLG sets the long term objectives and strategic plan for the OHT-ÉSO.

The CLG will adopt a health equity lens in alignment with the [OHT-ÉSO Health Equity Charter \(see Appendix A\)](#), including in its clinical priorities, with a focus on the needs of equity-deserving populations including First Nations, Inuit, Métis and Urban Indigenous, Francophone, Black and other racialized communities, 2SLGBTQIA+, and other underserved and underrepresented communities. The CLG will also leverage existing equity frameworks and local/ regional resources such as [OH’s Equity, Inclusion, Diversity and Anti-Racism \(EIDA-R\) Framework](#), [Black Health Plan](#), [First Nations, Métis, Inuit, and Urban Indigenous \(FNIMUI\) Framework](#) and [the Social Determinants of Health Framework](#).

The CLG will adhere to the [Patient, Family and Caregiver Declaration of Values for Ontario \(Appendix B\)](#) when working in partnership with clients, patients, families and caregivers.

The CLG will strive to be diverse not only in its representation of sectors but also in its representation of equity deserving communities.

### MEMBERSHIP COMPOSITION

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The Collaborative Leadership Group (CLG) membership reflects the key sectors and diversity involved in advancing integrated care across the full care continuum. Organizations are publicly funded by the Ministry of Health/ Ontario Health and defined in [Appendix C](#).

The CLG shall be comprised of the following voting members, two of whom will be designated as co-chairs:

1. 1 designate from the hospital sector
2. 2 designates from the mental health, substance use health and addictions sector
3. 2 designates from the frail older adult sector
4. 2 co-chairs of the Client Partner Table
5. 2 co-chairs of the Primary Care Partner Table
6. 1 designate from home community care support services (HCCSS) sector
7. 1 designate from community care sector
8. 3 designates from community health sector
9. 1 designate from Ottawa Public Health
10. 1 designate Primary Care Provider with expertise in Digital Health

They will be joined by one non-voting member from the OHT-ÉSO Transfer Payment Recipient.

As the OHT-ÉSO moves along the path to maturity, CLG membership may be revised to reflect new requirements of the OHT-ÉSO.

CLG members commit to a two-year term with the possibility of renewal for one additional term. The terms shall be staggered to ensure succession planning, continuity and in such a manner that no more than one-third (1/3) of providers will end their term in any one year. Members who wish to resign before their term expires shall give advance notice to the CLG Co-Chairs. A comprehensive succession planning and recruitment strategy will ensure that vacancies are filled in a timely way and that the CLG grows and evolves as needed with the maturity of the OHT-ÉSO.

A Team Member may replace its member on the CLG or appoint a temporary alternative at its own discretion for the remainder of their term on reasonable notice to the other CLG members, provided the replacement or alternative has authority comparable to the member being replaced.

The Client Partner Table or the Primary Care Partner Table may replace its member(s) on the CLG or appoint a temporary alternative at its own discretion on reasonable notice to the CLG provided the process followed is acceptable to the CLG.

The CLG, in alignment with the decision-making process outlined below, may require that a CLG member be replaced where the member is not acting in accordance with the guiding principles and in pursuit of the Shared Objectives of the OHT-ÉSO. The replacement member shall be selected through a process approved by the CLG.

## MEMBERS ROLES AND RESPONSIBILITIES

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CLG members are expected to bring their knowledge and experience from their service, occupation, or specialization, recognizing that the member has a duty to the OHT-ÉSO itself, not an individual, or single agency or organization. Members are expected to be senior leaders in their respective organizations with decision making power.

The roles and responsibilities of the CLG members, with support from the OHT-ÉSO backbone team, include:

### **Planning and Priority Setting**

1. Establish an overall strategic plan for the OHT-ÉSO and develop an annual work plan consistent with the strategic plan
2. Identify and measure the impact of re-designed care pathways for the populations of focus for the OHT-ÉSO
3. Develop the name and central brand of the OHT-ESO; and
4. Identify, implement and oversee Action Teams, Resource Teams and Project Charters
5. Support and advocate for the vision, mission and commitments of the OHT-ÉSO to drive change in the health care system
6. Work in collaboration / partnership across the health and social service sector and with other OHTs
7. Endorse and adhere to the OHT-ÉSO Health Equity Charter
8. Use data and a population health management model to support planning for the OHT-ÉSO's attributed populations

### **Quality and Risk Oversight**

1. Review, collaborate on and monitor safety and quality standards and performance and quality improvement for the OHT-ESO
2. Identify risk issues and consider risk allocation, mitigation and corrective actions for OHT-ESO activities.
3. Develop a complaints and significant event process for issues that impact more than one Team Member
4. Develop a risk management process for issues that could negatively impact the OHT-ESO; and
5. Review and approve standards for cyber security risk

### **Resource Allocation and Accountability**

1. Develop guidelines for the allocation and sharing costs and resources, including funding earmarked for the OHT-ESO as well as human resources, capital and facilities and costs related to supporting the work of the OHT-ESO
2. Review and collaborate on financial performance, resource allocation and use, best practice and innovation
3. Develop clinical and financial accountability standards
4. Determine membership fees to be paid by Team Members, if any; and
5. Facilitate and oversee the development of a digital health strategy
6. Declare any actual or perceived conflict of interest
7. Attend monthly CLG meetings and inform the CLG co-chairs of their absence as needed

## **Engagement and Communication Strategy Development**

1. Approve, develop and implement a joint communication strategy, including communication to stakeholders and the community
2. Engage with and see input from Team members,
3. Ensure engagement at the senior leadership level among Team Members
4. Report from time to time to Team Members on the work of the Collaborative Leadership Group and any Action Teams and Resource Teams

## **Leadership and Compliance Oversight**

1. Evaluate and identify areas of improvement in the integrated leadership and governance structure of the OHT-ÉSO on an ongoing basis including the establishment of a standardized process to identify and admit additional Team Members to the OHT-ÉSO
2. Discuss compliance with, and amendments to, these Terms of Reference, the Agreement or a Project Charter
3. Facilitate dispute resolution; and
4. Ensure compliance with all reporting requirements

## **Other**

1. Perform the roles assigned to the Collaborative Leadership Group under the Agreement

## **LEADERSHIP**

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The CLG shall have two Co-Chairs, who shall be elected by a majority vote by the CLG members. At least one co-lead will be Francophone or fluently bilingual in English and French.

Both Co-Chairs participate in deliberations and decision-making of the CLG.

Co-Chairs agree to a two year term and replacement of Co-Chairs will be staggered to allow for transition. Co-Chairs will serve no more than two consecutive terms.

## **LEADERSHIP ROLES AND RESPONSIBILITIES**

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CLG Co-Chairs are responsible for the following, with the support of the OHT-ÉSO Director, as appropriate:

- Provide leadership to the CLG
- Create an environment where all members feel welcome and participate in discussions and decision making
- Establish CLG meeting agendas that are aligned with OHT-ÉSO and Ontario Health goals, work plans and current issues
- Chair meetings (jointly or alternating)
- Provide supervision and coaching to the OHT-ÉSO Director in collaboration with the OHT-ÉSO's designated employer

- Ensure an OHT-ÉSO workplan is developed and implemented for the OHT-ÉSO that includes annual goals and embraces continuous improvement
- Fosters inclusivity and ensures that all members contribute fully to discussions and decision-making
- Provide guidance to working group/ action teams
- Collaborate with neighbouring OHTs in the context of a regional approach to some initiatives/ projects
- Ensure clear communication of required deliverables and timelines
- Represent the OHT provincially, regionally and publicly, as required

Both Co-Leads participate in deliberations and decision-making of the CLG.

## MEETINGS

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The Collaborative Leadership Group will meet at a minimum monthly for two hours on an ongoing basis at a set date and time agreed to by the CLG members or other frequency as agreed to by the CLG. Meetings will be held at the call of the Co-Chair or of four (4) CLG members. Meetings can be any combination of in-person and virtual. The Co-Chairs may determine the meeting procedures. Agendas and meeting materials will be sent out a minimum of four working days prior to the scheduled meeting and indicate if decisions are required. Action Team and/ or working group co-leads may attend by invitation and will be in a non-voting capacity. Guests may attend a meeting upon invitation.

**Minutes:** Meeting minutes will document deliberations and recommendations. Discussion during meetings shall be open, frank and free flowing, and while contents of the minutes will be shared, they will not include attribution of individual contributions made by CLG members. Minutes of the meeting will be sent within a week of the meeting to support CLG members with any follow up action items.

## DECISION MAKING

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Unless otherwise specified in a decision making framework adopted by unanimous approval of the CLG, decisions will be made by consensus ([see Appendix D](#)) by having open table discussions where all voices and opinions are respected. Keeping the OHT-ÉSO strategic plan and priorities front of mind helps steer direction and aid decision making.

Consensus means that 80% of the members present (including designates and proxy votes) is prepared to support the decision or, if applicable, recommend it to their board of directors or organization, as the case may be, even if they do not agree with the decision/ recommendation. If consensus cannot be reached, the CLG Co-Chairs can choose to continue the discussion to address concerns/ barriers, table the decision for discussion at a later date, or not proceed further. CLG members can also ask to speak 1:1 with a co-chair/ OHT-ÉSO director. When assessing consensus, each member will state their position within one of the six levels of consensus.

The CLG may, by unanimous approval of the CLG members, adopt a decision-making agreement that identifies types of decisions where a majority vote or other specified percentage is sufficient to bind all CLG members.

Members will be expected to demonstrate fairness and a commitment to in-depth evaluation of a matter under review and to endeavor to put the persons served by the OHT-ESO and the success and sustainability of the OHT-ESO above their respective organizations.

For key decisions, the co-chairs are responsible for ensuring that all members are aware that a decision will be taking place at the meeting. If the co-chairs determine that key members of the CLG who are critical to the discussion/ decision are not present, the co-chairs can delay the decision to the next meeting or call for a special meeting to make the decision.

The CLG shall consider population health and health equity when developing recommendations or making decisions.

## QUORUM

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Meeting quorum is defined as the minimum number of members required for the meeting to be valid to approve minutes, determine action items and make decisions.

For approving minutes and determining action items, quorum will be 50% +1 of all CLG members present. Members may be present in person or virtually to be counted for quorum.

If a member is not able to attend, the member may (but is not required to):

- a. Send a designate for that meeting, who shall be included in quorum and participate in decision-making;  
or
- b. Consent to the meeting proceeding in the member's absence by so informing the acting Co-Lead in which case the member shall be deemed to have consented to all business transacted at the meeting for which prior notice was given.
- c. Assign a proxy to another member of the CLG to participate in decision making on their behalf. Co-chairs must be informed of a proxy vote prior to the meeting

If quorum is not present, the members present may meet for discussion purposes only and no decisions shall be made.

[Appendix D](#) details the consensus decision making framework followed by the CLG. For consensus to be reached, 80% of the CLG members present (including designates and proxy votes) must be at a level 1-4.

## OHT-ÉSO BACKBONE SUPPORT

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The work of the CLG will be supported by the OHT-ÉSO Director and any combination of the following:

- Administrative - minute taking/ meeting recording, setting the agenda, following up with members on action items between meetings, maintenance of communication lists and website,
- Project management
- Data analysis support and performance management
- Digital health
- Engagement and communication with member organizations

## SUB-WORKING GROUPS

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The CLG may establish one or more Action Teams or Resource Teams to assist it in fulfilling its role. The CLG shall determine the mandate and composition of any such Action Team or Resource Team. Each working group shall have its own Terms of Reference which provide for the selection of a lead or co-leads.

## COMMUNICATION AND INFORMATION SHARING

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The CLG members shall develop a protocol for how information is shared with Team Members and their respective boards of directors or governing bodies, the Client Partner Table, the Primary Care Partner Table, Action Teams and Resource Teams.

The CLG members shall respect the confidentiality of information received by, and discussions of, the CLG.

CLG members and all members of Action Teams or Resource Teams shall each sign an acknowledgement confirming their agreement to respect the confidentiality of information received in their capacity as members of the CLG or one of its Action Teams or Resource Teams as applicable and to adhere to these Terms of Reference and any protocols, policies or procedures adopted by the CLG from time to time.

## COMPENSATION

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Primary care providers and client partners will be financially reimbursed for their work at CLG at the same rate as at their respective Tables.

## FUNDING

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A member of the OHT-ÉSO will be designated as the Transfer Payment Recipient and hold responsibility for ensuring reports, updates and performance data are submitted to Ontario Health as per TPA agreement. This organization is also responsible for receiving, managing, distributing and keeping accurate records of the OHT-ÉSO budget. A financial report will be submitted to CLG on a quarterly basis. Financial records will be retained for at least seven years.

## CONFIDENTIALITY

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Confidentiality is maintained at all times, as per the agreement signed during the onboarding process. Meetings are recorded for accuracy of the minutes only and are deleted once the meeting minutes have been approved.

## REVIEW AND AMENDMENTS

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These Terms of Reference shall be reviewed annually by the CLG and may be amended only with the written agreement of the Team Members.

### Health Equity Charter – Ottawa Health Team - Équipe Santé Ottawa

#### Background

The Ottawa Health Team - Équipe Santé Ottawa recognizes that people in our society face oppressive experiences because of individual and systemic unequal power related to Indigenous identity, race, colour, culture, ethnicity, language preference and linguistic identity<sup>1</sup>, ability, socio-economic class, age (children, youth, seniors), ancestry, nationality, place of birth, religion or faith or other forms of consciously held beliefs, sex, gender (including gender identity and expression), sexuality (including sexual orientation), family status (including marital status), and residency/migratory status. Unequal power dynamics create structures, policies and programs that result in health inequalities and health disparities.

We acknowledge that anti-Indigenous discrimination and racism, both explicit and implicit as well as other systems of oppression, including colonialism, sexism, heterosexism, cissexism, ableism, classism, ageism, and religious persecution, are evident in the health care system and our communities. Individuals may have multiple identities and experience numerous forms of oppression. Colonialization in all forms resulting in oppression and racism needs to be dismantled across institutions, and within the communities, we work with.

#### Purpose

The Ottawa Health Team - Équipe Santé envisions a redesigned health system in which people are healthy, well and supported to live in the community. The Ottawa Health Team - Équipe Santé Health Equity Charter will facilitate shared responsibility for promoting health equity as the foundation for this health system transformation. In order to fight inequities and oppression, it is necessary to examine structures, policies, and programs, and work to ensure that systems are fair and equitable for everyone.

The Health Equity Charter is one of the foundational documents for the Ottawa Health Team - Équipe Santé Ottawa and the endorsement of the Charter is required of all partners.

#### Intent

The Ottawa Health Team - Équipe Santé Ottawa and partners will embed equity in organizational cultures, governance, human resources, service delivery and community engagement.

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<sup>1</sup> Réseau Collecte des données linguistiques, Réseau des services de santé en français de l'Est de l'Ontario

## Guiding Principles<sup>2</sup>

1. **Systemic focus:** We are focusing on proactively removing systemic barriers and root causes of racial and other inequities.
2. **Intersectional approach:** We recognize that working across sectors — not in silos — is required to address systemic inequities, oppression, and racism.
3. **Holistic:** We recognize everyone benefits from removal of systemic barriers faced by the most vulnerable communities. Reducing barriers and disparities leads to a better Ottawa for everyone.
4. **Distinctness and intersectionality of racism:** We acknowledge racism is experienced differently by various groups, and within groups along intersectional lines, including gender identity, creed, class, income, sexual orientation, history of colonization. Oppression does not stand still – it is dynamic and everchanging.
5. **Inclusive:** Those facing inequities must be meaningfully engaged. Their perspectives and guidance inform the strategy and the Ottawa Health Team - Équipe Santé Ottawa decision-making. We recognize that Francophones frequently do not have access to linguistically appropriate services. We respect the unique identities of First Nation, Inuit and Métis peoples and the need for a distinct approach to achieve health equity for Indigenous peoples. We also recognize the disproportionate impact of racism on racialized communities.
6. **Transparent, evidence-based approach:** Our approach will be evidence-based and driven by measurable goals and outcomes and disaggregated data collection, use and disclosure.
7. **Sustainability:** We are setting the foundation for long-term health equity and anti-racism, anti-oppression efforts.
8. **Alignment:** Our work will be strongly aligned with Ontario Health's Equity, Inclusion, and Anti-Racism Framework.<sup>3</sup>

## Objectives<sup>4</sup>

The following long-term objectives are the basis for the development of strategies and actions.

1. Build health equity capacity within our organizations and communities including knowledge sharing and leadership to acknowledge and address institutional racism and bias.
2. Develop and use knowledge and evidence related to health, health equity, and the social determinants of health, including linguistic identity and race-based data disaggregated data to improve decision making and allocate adequate resources to address systemic racism, structural inequities and improve health outcomes
3. Address public awareness, attitudes to increase understanding of inequities, including racism, and grow connections among residents.
4. Utilize the leadership, assets, and knowledge of racialized and other oppressed communities to increase engagement with these communities.

## Accountability

Accountability mechanisms comprise three basic interacting components: shared goals and commitments; ways of measuring and understanding progress; and means of supporting action for change. These

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<sup>2</sup> Adapted from the Ontario Anti-Racism Strategy [Archived - Ontario's anti-racism strategic plan | ontario.ca](#)

<sup>3</sup> Ontario Health *Equity, Inclusion, Diversity and Anti-Racism Framework* [Ontario Health's Equity, Inclusion, Diversity and Anti-Racism Framework](#)

<sup>4</sup> Adapted from the Equity Ottawa Collection Action Plan – Ottawa Local Immigration Partnership (OLIP)

mechanisms will be developed in the first year after the Health Equity Charter is adopted and progress reported annually.

### *Systematic Racism*

A system in which public policies, institutional practices, cultural representations, and other norms work in various, often reinforcing ways to perpetuate racial group inequity. Systemic racism is not something that a few people or institutions choose to practice. Instead, it has been a feature of the social, economic, and political systems in which we all exist. City of Ottawa Anti-Racism Secretariat

### *Anti- Racism*

Anti-racism is the active process of identifying and eliminating racism by changing systems, organizational structures, policies and practices and attitudes, so that power is redistributed and shared equitably (NAC International Perspectives: Women and Global Solidarity).

### *Health Equity*

Health equity is created when individuals have the fair opportunity to reach their fullest health potential. Achieving health equity requires reducing unnecessary and avoidable differences that are unfair and unjust. Many causes of health inequities relate to social and environmental factors including income, social status, race, gender, education, and physical environment. (Public Health Ontario)

### *Health inequalities and health disparities*

Health inequalities and health disparities refer to differences in health status experienced by different groups in society, regardless of their cause. The term ‘health inequalities’ is often used when referring to measured differences in health status.

Health Inequities refer to those health inequalities which are avoidable or remediable differences in health among populations or groups defined socially, economically, demographically, or geographically.

### *Anti-Black racism*

Prejudice, attitudes, beliefs, stereotyping and discrimination that is directed at people of African descent and is rooted in their unique history and experience of enslavement. Anti-Black racism is deeply entrenched in Canadian institutions, policies, and practices, such that anti-Black racism is either functionally normalized or rendered invisible to the larger white society. Anti-Black racism is manifested in the legacy of the current social, economic, and political marginalization of African Canadians in society such as the lack of opportunities, lower socio-economic status, higher unemployment, significant poverty rates and overrepresentation in the criminal justice system.

### *Antisemitism*

Antisemitism is a certain perception of Jews, which may be expressed as hatred toward Jews. Rhetorical and physical manifestations of antisemitism are directed toward Jewish or non-Jewish individuals and/or their property, toward Jewish community institutions and religious facilities.

### *Colonialism*

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<sup>5</sup> Building a Foundation for Change: Canada’s Anti-Racism Strategy 2019–2022. Unless otherwise stated.

A practice of domination, which involves the subjugation of one people to another. Settler colonialism — such as in the case of Canada — is the unique process where the colonizing population does not leave the territory, asserts ongoing sovereignty to the land, actively seeks to assimilate the Indigenous populations and extinguish their cultures, traditions, and ties to the land.

### *Disaggregated data*

In the context of race-based data, this means breaking down composite ("aggregate") categories such as "visible minority" into component parts, such as Black, Chinese, Arab etc.

### *Discrimination*

Treating someone unfairly by either imposing a burden on them, or denying them a privilege, benefit or opportunity enjoyed by others, because of their race, citizenship, family status, disability, sex, or other personal characteristics.

### *Equity*

Fairness, impartiality, even-handedness. A distinct process of recognizing differences within groups of individuals and using this understanding to achieve substantive equality in all aspects of a person's life.

### *Evidence-Based*

Evidence-based means making decisions based on the best available research and is informed by the experience and expertise of practitioners, communities, and those with lived experience. It may also include the knowledge of subject matter experts.

### *Francophones*

The Inclusive Definition of Francophone (IDF) defines Francophones as “persons whose mother tongue is French, plus those whose mother tongue is neither French nor English but have a particular knowledge of French as an Official Language and use French at home.” (Government of Ontario)

### *Homophobia*

Homophobia is fear, hatred, discomfort with, or mistrust of people who are lesbian, gay, or bisexual. Homophobia perpetuates violence, discrimination and stigma against people based on their sexual orientation.

### *Intersectionality*

Acknowledges the ways in which people's lives are shaped by their multiple and overlapping identities and social locations, which, together, can produce a unique and distinct experience for that individual or group, for example, creating additional barriers or opportunities.

### *Islamophobia*

Includes racism, stereotypes, prejudice, fear or acts of hostility directed towards individual Muslims or followers of Islam in general. In addition to individual acts of intolerance and racial profiling, Islamophobia can lead to viewing and treating Muslims as a greater security threat on an institutional, systemic, and societal level.

### *Oppression*

Oppression refers to the use of power by one group to disempower, marginalize, or exert dominance over another group. Dominant groups can maintain their status, privilege, and power over others both intentionally and unintentionally as well as in obvious and subtle ways. Acts of oppression can become institutionalized or systemic, thus becoming hidden and seemingly 'normal'. They can also play out on the personal and interpersonal levels, influencing individual values, beliefs, and actions as well as interactions between people.

### *Race*

Race is a "social construct." This means that society forms ideas of race based on geographic, historical, political, economic, social, and cultural factors, as well as physical traits, even though none of these can legitimately be used to classify groups of people.

### *Racism*

Racism is any individual action, or institutional practice which treats people differently because of their colour or ethnicity. This distinction is often used to justify discrimination.

### *Transparency*

Transparency is the process of being open, honest, and straightforward about the operation of an organization. Clear communications are one of the most important hallmarks of transparency and we will strive to provide the public with information in a reliable, and understandable manner.

### *Sustainability*

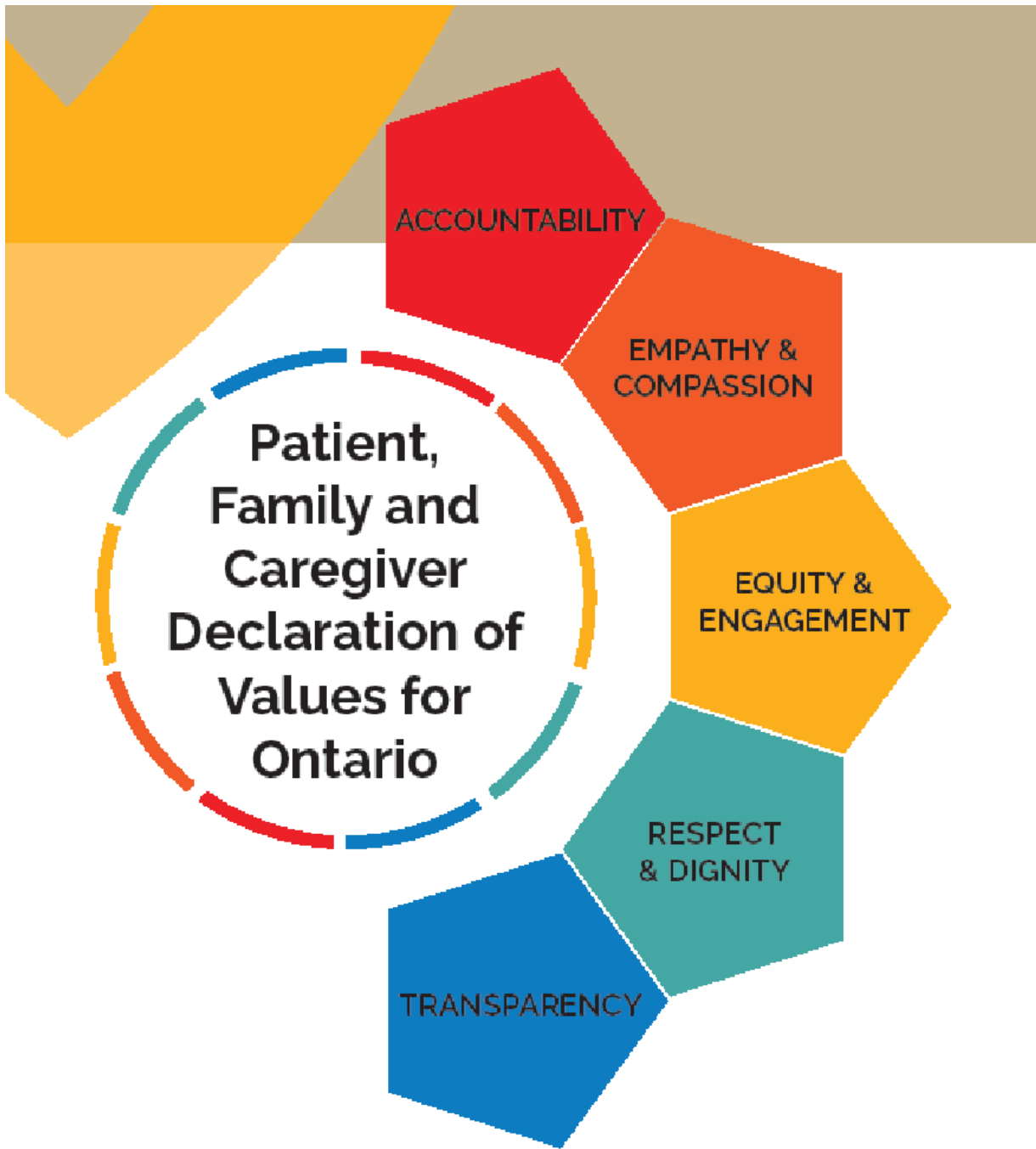
Sustainable health and health care is the appropriate balance between the cultural, social, and economic environments designed to meet the health and health care needs of individuals and the population (from health promotion and disease prevention, to restoring health and supporting end of life) and that leads to optimal health and health care outcomes without compromising the outcomes and ability of future generations to meet their own health and health care needs. (Conference Board of Canada)

### *Systemic or institutional racism*

Consists of patterns of behaviour, policies or practices that are part of the social or administrative structures of an organization, and which create or perpetuate a position of relative disadvantage for racialized persons. These appear neutral on the surface but, nevertheless, have an exclusionary impact on racialized persons

### *Transphobia*

Transphobia is discrimination against trans and gender-diverse people, on the basis of gender identity and gender expression. Transphobia is a systemic issue, meaning that it is embedded in social, political, and economic institutions, as well as throughout communities and cultures.



# Patient, Family and Caregiver Declaration of Values for Ontario

## ACCOUNTABILITY

- We expect open and seamless communication about our care.
- We expect that everyone on our care team will be accountable and supported to carry out their roles and responsibilities effectively.
- We expect a health care culture that demonstrates that it values the experiences of patients, families and caregivers and incorporates this knowledge into policy, planning and decision making.
- We expect that patient, family and caregiver experiences and outcomes will drive the accountability of the health care system and those who deliver services, programs and care within it.
- We expect that health care providers will act with integrity by acknowledging their abilities, biases and limitations.
- We expect health care providers to comply with their professional responsibilities and to deliver safe care.

## EMPATHY & COMPASSION

- We expect that health care providers will act with empathy, kindness and compassion.
- We expect individualized care plans that acknowledge our unique physical, mental, emotional, cultural and spiritual needs.
- We expect that we will be treated in a manner free from stigma, assumptions, bias and blame.
- We expect health care system providers and leaders will understand that their words, actions and decisions strongly impact the lives of patients, families and caregivers.

## EQUITY & ENGAGEMENT

- We expect equal and fair access to the health care system and services for all regardless of ability, race, ethnicity, language, background, place of origin, gender identity, sexual orientation, age, religion, socioeconomic status, education or location within Ontario. We further expect equal and fair access to health care services for people with disabilities and those who have historically faced stigmatization.
- We expect that we will have opportunities to be included in health care policy development and program design at local, regional and provincial levels of the health care system.
- We expect an awareness of and efforts to eliminate systemic racism and discrimination, including identification and removal of systemic barriers that contribute to inequitable health care outcomes (with particular attention to those most adversely impacted by systemic racism).

## RESPECT & DIGNITY

- We expect that our individual identity, beliefs, history, culture and ability will be respected in our care.
- We expect health care providers will introduce themselves and identify their role in our care.
- We expect that we will be recognized as part of the care team, to be fully informed about our condition, and have the right to make choices in our care.
- We expect that patients, families and caregivers be treated with respect and considered valuable partners on the care team.
- We expect that our personal health information belongs to us, and that it remain private, respected and protected.

## TRANSPARENCY

- We expect that we will be proactively and meaningfully involved in conversations about our care, considering options for our care, and decisions about our care.
- We expect that our health records will be accurate, complete, available and accessible across the provincial health system at our request.
- We expect a transparent, clear and fair process to express a complaint, concern, or compliment about our care that does not impact the quality of the care we receive.

Updated: July 2021

**Note:** The purpose of this Patient, Family and Caregiver Declaration of Values, drafted by the Minister's Patient and Family Advisory Council in consultation with Ontarians, is to articulate patient, family and caregiver expectations of Ontario's health care system. The Declaration is intended to serve as a compass for the individuals and organizations who are involved in health care and reflects a summary of the principles and values that patients, families and caregivers say are important to them. The Declaration is not intended to establish, alter or affect any legal rights or obligations, and must be interpreted in a manner that is consistent with applicable law.

Ontario



The CLG shall be comprised of designates from the following sectors, two of whom will be designated as co-chairs:

**Co-Chairs of the Primary Care Partner Table:** These two designates are the co-chairs of the primary care partner table which includes both physicians and nurse practitioners who can speak to various models of care, clinical settings and needs of equity deserving populations

**Co-Chairs of the Client Partner Table:** These two designates are the co-chairs of the client partner table whose membership reflects and can speak to the experience of patients, family and caregivers and needs of equity-deserving populations.

**Co-Chair of the Digital Health Table:** This designate is a primary care provider who is also one of the co-chairs of the Digital Health Table

**Home and Community Care Support Services (HCCSS):** HCCSS is the organization that coordinates in-home and community based care including assessing patient needs, and delivering in home and community based services. HCCSS also provides access and referrals to other community services, and manages Ontario's long term care home placement process

**Community Care Sector:** This includes Community Support Services, Assisted Living Services, and services for people with Acquired Brain Injury

**Public Hospital:** The Ottawa Hospital is the hospital affiliated with the Ottawa Health Team – Équipe Santé Ottawa

**Mental Health, Substance Use Health and Addictions:** this includes not-for-profit organizations funded by the ministry or Ontario Health to deliver mental health, substance use health and addiction services in the community

**Frail Older Adults Sector:** this includes services for adults >55 with medical conditions that reduce their functioning and health and are facing inequitable health outcomes due to the social determinants of health.

**Ottawa Public Health:** the public health agency responsible for promoting and protecting the health of residents in Ottawa. OPH provides a wide range of public health services and programs aimed at preventing diseases, promoting health living and ensuring the safety of the community with the goal of improving the overall health and well-being of the people living in Ottawa

**Community Health Sector:** this includes not for profit organizations with a primary focus on improving the health and well being of populations who have traditionally faced barriers accessing primary health services and addressing the social determinants of health

## APPENDIX D - CONSENSUS DECISION MAKING PROCESS

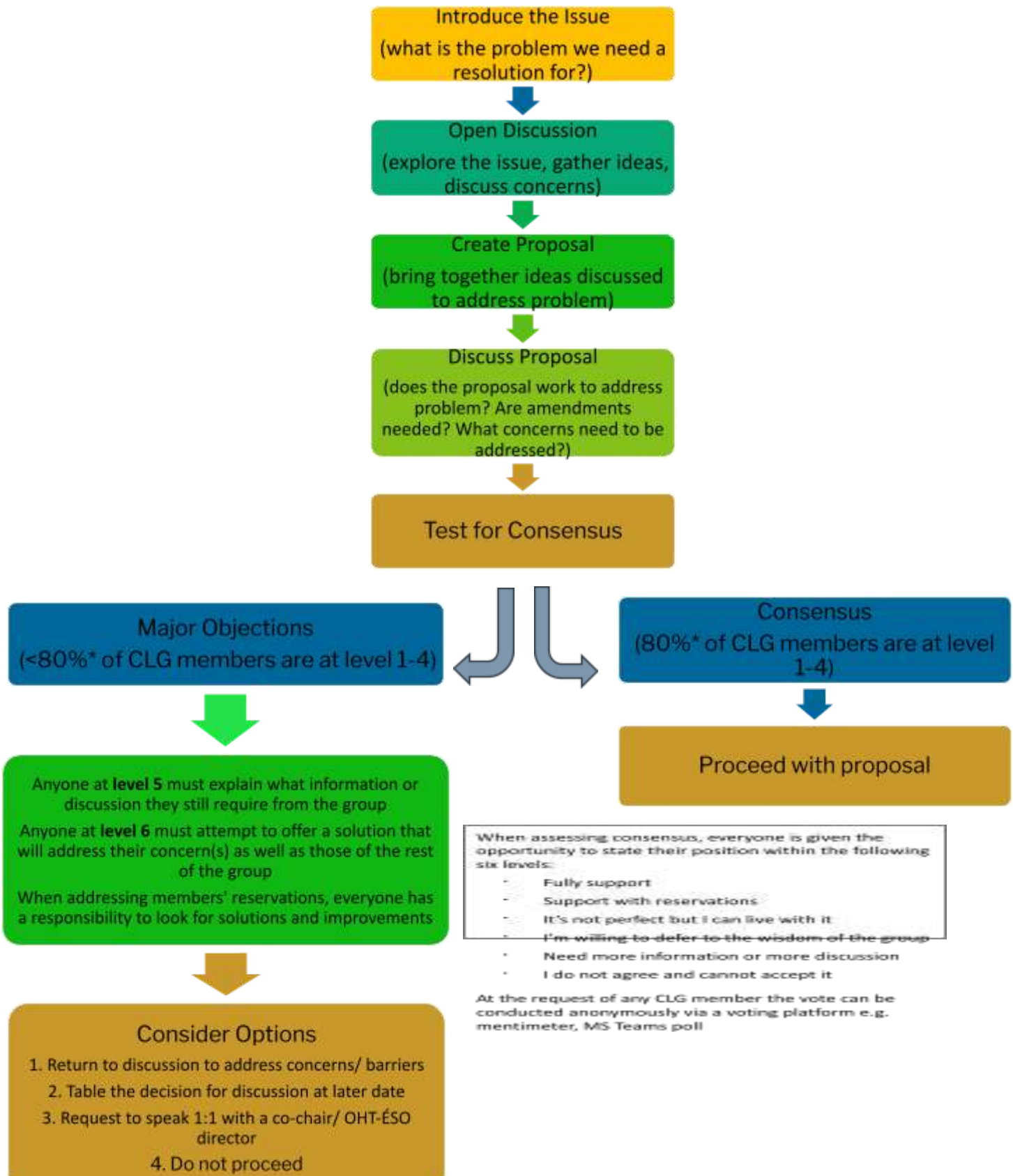
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Groups seeking to generate widespread levels of participation and agreement can use a consensus decision making process. The goals of the consensus decision process include **better decisions**, by including input from everyone and addressing potential concerns, **better implementation**, by generating as much agreement as possible during decision making which increases cooperation in implementing decisions and **better group relationships**, by fostering greater group cohesion and interpersonal connection.

Common elements that define consensus decision making include:

- **Participatory** – all participants are allowed a chance to contribute to the discussion
- **Inclusive** – as many members as possible are involved in group decisions
- **Collaborative** – the groups constructs proposals with input from all interested members
- **Agreement Seeking** – goal is to generate as much agreement as possible.
- **Cooperative** - members are encouraged to keep the good of the whole group in mind. Individual's preferences should be voiced so that the group can incorporate all concerns into an emerging proposal. Individual preferences should not obstructively impede the progress of the group

## Steps in Consensus Decision Making



\*For consensus to be reached, 80% of CLG members present (including designates and proxy votes) but be at a level 1-4.