FLAOHT
Frontenac Lennox & Addington Ontario Health Team

ÉSOFLA
Équipe Santé Ontario de Frontenac, Lennox et Addington




A five-year plan for

Achieving our best health as people, as providers, as a system.

Ka gashkitoonaa mino bimaadiziwin

Land Acknowledgment

With deep respect and humility, we acknowledge that the Frontenac, Lennox and Addington Ontario Health Team is located on the traditional territories of the Anishinaabe, Haudenosaunee and Huron-Wendat Nations, as well as the territories of other rural and urban Indigenous community members including Métis, Inuit, and other First Peoples from across Turtle Island.

We stand upon land that carries the footsteps of Peoples of Indigenous ancestry who have been here for thousands of years. We have an opportunity to learn from each other, improve relationships and promote respect for the past, present and future. We are thankful to share, learn, work, play and grow on these lands as we work together to build a new health-care system that will be inclusive and equal for all.

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“We are working together to radically re-design the health-care system; to keep people healthy and well and connected with high quality, easy-to-access services.”
Dr. Kim Morrison, Frontenac, Lennox and Addington Ontario Health Team (FLA OHT) Executive Lead.

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“We work in partnership together, health-care professionals and community members, and bring our experience and perspectives to create a robust, responsive health-care system.”

Kerry Stewart, Past co-chair, FLA OHT Community Council

“We are working together to radically re-design the health-care system; to keep people healthy and well and connected with high-quality, easy-to-access services.”

Dr. Kim Morrison, FLA OHT Executive Lead, Family Physician

Great ideas need an action plan

Improving health and wellbeing for everyone in our communities**.** A place for everyone to have a supportive and **fully-connected neighbourhood of health care, social and wellness services.**

That is not the reality in today's health-care system. The ways in which health care is currently funded and operated, through organizational silos, makes collaboration and communication difficult.

This is why we're working together to **radically redesign the health-care system**. Through innovative partnerships, the FLA OHT is changing how care is coordinated across health, social, and wellness services in our communities.

Moving from vision to reality. Based on everything our community said was important about their health care, we created a draft plan and validated with community members and partners that we were on the right track.

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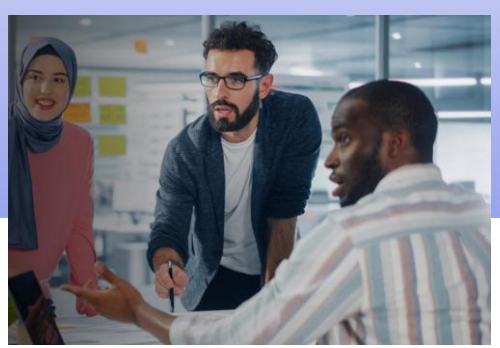
Co-designing the future of health care, together

Plan and understand
(Nov. 2021)

- Community research to understand the people in the communities we serve



Shape the process
(Dec. 2021)

- Worked with Community Council to co-design the engagement approach
- Leadership review

Discovery and exploration
(Jan.- Apr. 2022)

- Empowered, listened and learned from partners about the strengths, opportunities and challenges of the regional health-care system

Co-designing the future of health care, together

Public engagement
(May – July 2022)

- Consulted, gathered insights and ideas from community members to help transform the health-care system

50 hours
of focus group discussions

Create the plan
(Aug. – Dec. 2022)

- Harvested insights, finalized the strategy

1,000+
people engaged

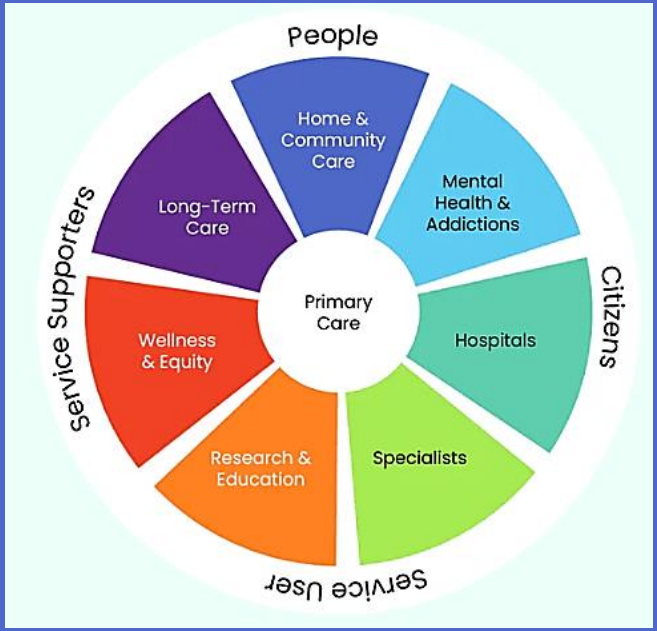
Implement and evaluate
(2023 - 2028)

- Set annual action plans,
- Review progress against performance targets
- Continue work with community

1,800+
online thoughts shared

Our team

Ontario Health Teams are in development throughout the province. They are teams of health, community, and social services providers working together to be professionally and financially responsible for making sure people get the care they need, when and where they need it.



The Frontenac Lennox and Addington Ontario Health Team (FLA OHT) is:

300+
health-care providers & community members

160
family doctors

3
hospitals

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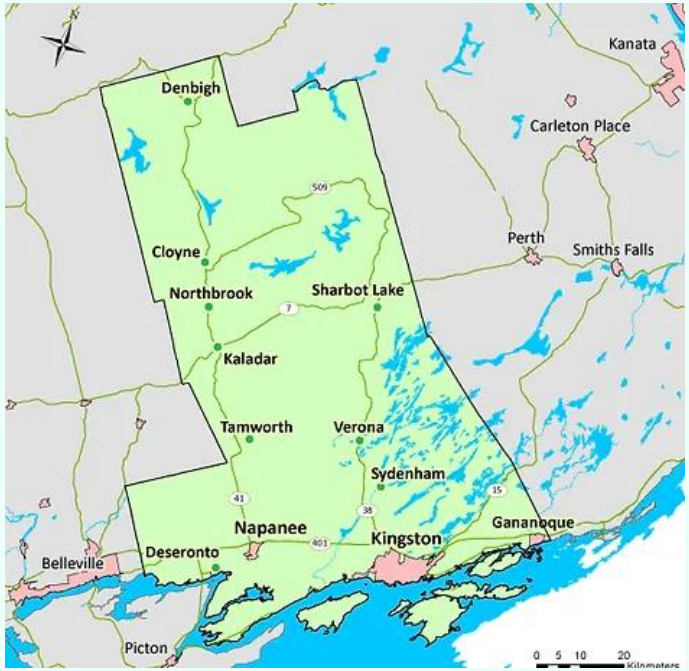
Our region

We are all working together to meet the health and wellness needs of the people in the region.

This area is composed of vibrant urban cities, many small towns, picturesque villages along Lake Ontario and many rural and remote areas – yet many health and wellness challenges exist.



220,000

approximate population of the FLA OHT region

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Who we serve

- We are older than the rest of the province. One in four people is older than 53.
- We have a total population of about 220,000 where one in eight or over 20,000 people do not have a primary care provider. This puts more pressure on emergency departments and hospitals.
- Hospitals in the region are experiencing severe shortages of health-care workers and longer wait times have become normal.
- Mental health and addiction needs in this region are higher than the provincial average.
- The regional Indigenous population is higher at 3.7 per cent compared to the rest of the province at 2.8 per cent.
- More people speak French as their first language at 3.1 per cent compared to the provincial average of .03 per cent, and we are a designated area under the French Language Services Act.

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Our mission

A People-Centred Health Home for everyone in Frontenac, Lennox & Addington counties

Our vision

A healthier community where we all have equitable access to high-quality care, services and supports that empower us toward Achieving our best health

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People-Centred Health Home

People-Centred Health Home

The Health Home is our home base for easy access to all the health care and wellness services we need to achieve our best health.

The Health Home is our front door to the health-care system. It includes a team dedicated to supporting our best health and wellness through every stage of our lives. The Health Home team might be a physical primary care practice, a virtual service or a mobile health-care team that comes to us – whatever works best for each of us.

The Health Home team includes:

- **People** empowered to be partners in their own care, equipped with the knowledge, resources and tools to support their health and wellbeing
- **Primary care doctors, nurse practitioners and/or traditional healers** to support health-care needs and connect people to other health and wellness providers as needed
- **Nurses and allied health professionals** to support preventive care and managing chronic disease
- **Mental health workers** to support mental, emotional and spiritual health
- **Home and community care coordinators** to provide easy access to community health and social services from people's homes
- **Community social support workers** to connect us with the resources we need in our community including housing, food-sharing programs and other community supports
- **Connections** to the broader community of service providers and social supports we may need to achieve our best health

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Our guiding principles

Defining the People-Centred Health Home experience**.**

In order to provide high-quality health care and the best possible experience and outcomes, Health Homes are committed to the seven Guiding Principles that ensure the best possible health care quality, experience and outcomes for all.

Our seven guiding principles

Equitable

- making health care available to everyone in a way that strives to meet their needs, cultural and linguistic preferences and eliminates barriers to care

Accessible

- offering easy access to the care, services and support we need, when, where and how we need it

Holistic

- caring for physical, emotional, mental, social, spiritual needs – not just specific health problems

Connected

- providing smooth connections to all the services and supports that are needed to ensure high-quality care

Continuous

- offering continuity of care across the health and wellness team throughout our entire life spans

Collaborative

- supporting all providers to work together as a team, and with the people they serve, to deliver care and support holistic health and wellness needs

Accountable

- ensuring we all take responsibility for creating the best possible, evidence-based health-care quality, experience and outcomes

Our framework

The new vision for health care in Ontario is well aligned with the Quintuple Aim, a health-care framework with five objectives.

- Improve the person and caregiver experience
- Improve the health of populations
- Improve the work life of providers
- Improve the value of care, reduce the cost of health care
- Improve health equity by understanding the social determinants of health

Our strategic directions

1	2	3	4	5
Promote equitable health and wellness	Improve health-care quality	Empower people to achieve their best health and wellness	Support provider well-being	Deliver value-based care
				

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1

Promote equitable health and wellness

1.1 Deliver culturally and linguistically appropriate, accessible, trauma-informed care for everyone in our FLA OHT
Starting points:

- Listen and learn from equity-deserving populations to identify and address opportunities and barriers
- Create a health equity roadmap, standards and tools to help providers deliver the same level of care for all populations
- Implement income screening to ensure people with low incomes are identified and connected to supports

1.2 Build capacity to support the health and social needs of Indigenous and Francophone communities
Starting points:

- Ensure all providers have Indigenous Cultural Safety training and provide culturally safe spaces
- Implement language translation services in all health-care settings
- Create Health Home connections to the community Traditional Healing Coordinator
- Create navigation pathways for Francophone and Indigenous health services, providers and resources

1.3 Reduce barriers to health and wellness for vulnerable and marginalized populations
Starting points:

- Work with community partners addressing health equity issues to enhance and connect services while co-designing an equitable, barrier-free health system that is available 24/7

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2

Improve health-care quality

2.1 Ensure <u>everyone</u> has access to high quality, team-based care from a People-Centred Health Home throughout their life span

Starting points:

- Implement a Health Home Quality Framework built on best practices
- Create a new team-based clinic model with locations to serve people who do not have a primary care provider
- Implement My Practice reports in all Health Homes to support continuous quality improvement

2.2 Coordinate care in priority areas: aging-well-at home, palliative care, integrated addictions and mental health, coordinated discharge, access to primary care

Starting points:

- Create new roles to connect people with the care they need (EG: embedded care coordinators, care navigators, health & social care integrators, Aging-Well @ Home advocates, community support volunteers, prevention practitioners)
- Implement ‘Access MHA’ 24/7
- Expand shared care mental health rounds for all ages
- Create a health-care service navigation system Deliver high quality, equitable access to palliative care

2.3 Help people stay healthy and well in their homes and communities

Starting points:

- Embed Home Care and Community Support Services within Health Homes
- Proactively identify people who need home care and community-based supports earlier in their health-care journey

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3

Empower people to achieve their best health and wellness

3.1 Promote health, prevent disease and address social determinants of health
Starting points:

- Encourage participation in cancer and other health screening programs
- Develop a health promotion outreach and transportation strategy to connect vulnerable and marginalized people with prevention, health, wellness & social services and supports
- Promote immunizations to prevent serious illnesses in our community

3.2 Empower people to self-manage their preventative care, health, wellness and chronic conditions
Starting points:

- Encourage active living, healthy eating, healthy aging and other health promoting behaviours
- Embed accessible self-management programs into all Health Homes
- Improve digital access to personal health information and educational resources

3.3 Support pandemic response and recovery
Starting points:

- Implement clinics and pathways that improve access and wait times for specialty care
- Bring specialized care out of hospital and into people's Health Homes, homes and communities
- Implement strategies that improve access to prevention, wellness and social services
- Coordinate COVID vaccination opportunities

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4

Support provider well-being

4.1 Create capacity for health and social care providers to provide the highest quality care
Starting points:

- Expand team-based care so all providers have the support and connections they need to provide the best possible care while supporting their own well-being
- Establish community support volunteer models that enhance provider capacity

4.2 Connect all FLA health and social service providers on one common health record
Starting points:

- Initiate primary care pilot of the Lumeo Health Information System to enhance quality, efficiency and service
- Seamlessly integrate digital health information systems across providers
- Embed best-practice guidelines for integrated care into digital health systems and tools
- Promote use of portable devices to support point of care documentation for all providers

4.3 Address regional Health Human Resource challenges
Starting points:

- Develop a collaborative regional health human resources plan
- Work with partners to recruit and retain health-care professionals including Francophone and Indigenous professionals
- Work with education partners to increase training spots for health-care professionals in all disciplines
- Create regional hubs of support for providers' mental, physical, social, emotional, and spiritual well-being so that we have strong, resilient and capable professionals

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5

Deliver value-based care

5.1. Create the space, mechanisms and models for providers to collaborate and integrate services to keep people healthy

Starting points:

- Work with Ontario Health to develop governance guidance for OHTs
- Conduct a formal assessment of our integrated care and governance models to build on our early successes, pin-point next steps in our integrated care journey and inform annual operating plans
- Work with partners to implement a mature, inclusive governance structure to help bring the Health Home model to life as the foundation of the health system

5.2 Work with partners to develop a sustainable, inclusive budget and resource model for FLA OHT

Starting points:

- Secure sustainable support for FLA OHT leadership and administrative supports
- Realign current funding allocations to support integrated, team-based, wrap-around care, services and supports for the people we serve

5.3 Empower FLA OHT care networks to be full, active participants in co-designing the future health-care system.

Starting points:

- Solidify Terms of Reference for each care network
- Develop network action plans connected to the FLA OHT strategy and priority projects
- Increase opportunities to connect more partners to the FLA OHT
- Develop action plans to improve the offer of French language health services, Indigenous health services and services for other unique populations

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Foundations for success

1. Establish People-Centred Health Homes
2. Cultivate a learning health system
3. Advance digital health
4. Communicate, engage, co-design

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1 Establish People-Centred Health Homes

1.1 Support all primary care groupings to become team-based, People-Centred Health Homes
Starting points:
- Co-design Health Home implementation standards, tools, education and a roadmap for delivery
- Promote training opportunities for Health Homes on Active Offer for French language services, Indigenous cultural safety, & trauma-informed care

1.2 Ensure all People-Centred Health Homes deliver core embedded services and connections to community-based, social and specialty health-care services
Starting points:
- Collaborate with FLA OHT partners to identify where each one fits within or as a connection to each Health Home
- Help all Health Homes provide a common basket of services and supports across peoples' life span
- Develop Health Home connection mechanisms including one health record, pathways to health, wellness & social services, multidisciplinary rounds, referral systems and equity-oriented care models

1.3 Create equity-oriented health-care and population health management models to meet the unique needs of Indigenous, Francophone and equity-deserving populations.
Starting points:
- Provide training and tools to Health Homes on equity-oriented, trauma- and violence-informed care, linguistic and cultural safety and harm reduction

2 Cultivate a learning health system

2.1. Cultivate a learning health system that supports continuous quality improvement, education, professional development and builds health human resource capacity
Starting points:
- Create an FLA OHT learning and professional development plan
- Support all FLA OHT initiatives with Quality Improvement methods and tools
- Collaborate with and learn from other Ontario Health Teams

2.2. Collaborate with OHT research and evaluation partners to build and implement an OHT evaluation framework and support research initiatives
Starting points:
- Create logic models for all FLA OHT working groups
- Build an FLA OHT evaluation and strategy performance framework
- Participate in research initiatives that advance our strategic directions and goals

2.3. Apply a population health management approach to all initiatives
Starting points:
- Implement a data and decision support model for working groups and Health Homes
- Apply population segmentations, health status & system utilization data to each working group

3 Advance digital health

3.1 Create one health record that is shared across all people and providers in FLA OHT and is accessible from wherever they are

Starting points:

- Secure a primary care pilot of the Cerner electronic medical record system (Lumeo Project) with governance and support models
- Ensure linguistic preference is reflected in all digital health tools
- Explore digital health connections for home and community support services

3.2 Create a health and social service navigation strategy that supports seamless connections to information and supports for community members and providers

Starting points:

- Engage community members and providers to identify needs and explore navigation models
- Digitize the continuum of service navigation, electronic referral, appointment booking and access to patient health information
- Support Provincial work to create a Patient Portal that enables everyone to access and contribute to their own health information

3.3 Develop a privacy and data sharing framework to inform system planning and population health management

Starting points:

- Participate in the regional information sharing collaborative
- Participate in the PHIPPA modernization consultations
- Support advancement of best privacy policies across all providers

4 Communicate, engage, co-design

4.1 Engage with patients, families and community members to co-design health and social care that meets their needs

Starting points:

- Evaluate and continuously improve our communications & community engagement framework
- Co-design strategic and annual plans, working group initiatives with community members
- Participate with Indigenous Health Council, Comite de Citoyens and other citizen groups
- Collaborate with neighbouring OHTs

4.2 Collaborate with committees tackling social issues in our community that affect people's health

Starting points:

- Provide OHT representation for key community groups tackling social issues (EG: Homelessness Collective Impact Committee, Mental Health System Advisory Committee & others) to promote joint planning and action to address health and related social issues
- Foster cross-sector connections across community committees andFLA OHT projects

4.3 Sustain continuous communication across FLA OHT and the communities we serve

Starting points:

- Continue to grow FLA OHT communication and social media channels
- Work with community partners to leverage communication channels and keep our communities informed and engaged with our work
- Support public education that helps people make the best use of system resources
- Build a robust FLA OHT website that creates one integrated hub for information and access to collaboration and digital health tools

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Five-year outcomes

Achieving our best health is a call to action to all health, social and wellness providers that things need to change and are changing. Together we are making progress now and are building on our work. At the end of five years, we will be able to say that:

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1	2	3	4	5
Everyone in FLA has a People-Centred Health Home that provides team-based care, digital-health solutions, embedded mental-health supports, home care and community supports and 24/7 coordination & navigation services that reflects their cultural and linguistic preferences.	Community members and providers report high satisfaction and better health outcomes with team-based care Health Homes.	FLA OHT partners have built a governance structure that values collaboration, community participation and fosters shared accountability for outcomes that matter to the people we serve and the providers who serve them.	People in our communities are healthier and we have the data, systems and structures to make continuous improvements.	Our OHT is a top performer on measures of system integration.

Achieving our best health

as people, as providers, as a system

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Thank you for joining us on this exciting journey toward **achieving our best health**. To learn more about the FLA OHT and how you can become involved in our work to transform the system of health and wellness care in Frontenac, Lennox & Addington counties.

Follow us on

www.flaoht.ca