Northwestern Ontario Integrated Care

Engagement Summary

June 2021

Outline

1.0 Overview and Approach

Beginning in December 2020, the 'North West Integrated Care Working Group' – consisting of approximately 30 cross-sectoral and cross-geography system partners – have worked together to develop recommendations on:

- A local Ontario Health Team (or other more culturally appropriate model of care) coverage model for the North West;
- A coordinated approach to planning for regional specialized services; and,
- What regional-level resources/supports may be required going forward.

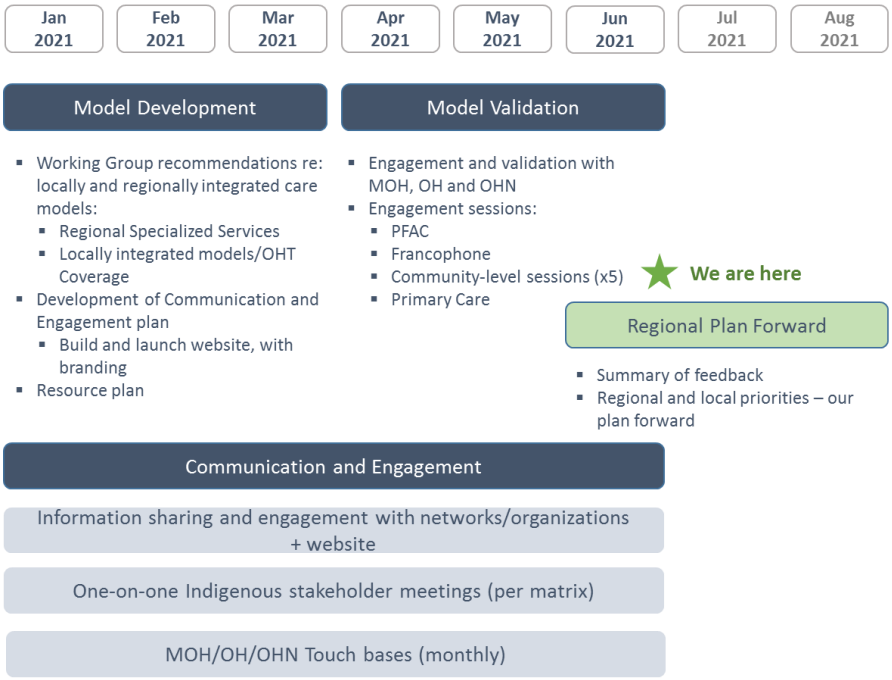
Over April – June 2021 a number of engagement sessions were held with the following objectives:

- To share information regarding the work that is underway by the Northwestern Ontario Integrated Care Working Group (and broader partners)
- To hear from stakeholders on what they think
- To talk about next steps to improve care across our region – including ideas for ongoing co-design, engagement and communication

While engagement throughout the pandemic continued to be a challenge, valuable feedback was gathered.

The feedback has been consolidated within this report (Section 2.0) and has been used to inform next steps related to integrated care/OHT advancement in the North West. The proposed next steps ('A Proposed Plan Forward', Section 3.0) is presented as a strategic roadmap to advance integrated care across the North West, both locally and regionally.

The image below provides an overview of the North West Integrated Care Working Group planning approach to date:



2.0 Engagement Themes

Engagement Overview:
7 Engagement Sessions - **101** Participants
22 Working Group members involved/leading - **13** communities represented

2.1 Summary Themes

The following overall themes emerged from the engagement sessions:

- Overall, **proposed model and Vision is 'directionally right'** – no objections to the proposal model or Vision, though, still many outstanding questions that will need to be answered as the work proceeds
- **Continued engagement is necessary** and **getting more partners engaged will be key to success**
    - Need to get local stakeholders to the table – utilize existing structures (i.e. local service delivery/planning tables to get people engaged) and leverage local leaders so it is meaningful
    - Physician and clinician engagement will be critical
- Need a **parallel Indigenous-led process**, that respects the integrated services that Indigenous providers provide and ensures that Indigenous peoples needs are met in a culturally sensitive way. Need to acknowledge an "equal but different" system/process.
- **Local care delivery and autonomy needs to be protected** in a regionally integrated model
- There are **many areas where we can work together as system partners to improve the system** – locally and regionally
    - Regionally, we need to **begin working together to address key system enablers and priorities**, including: digital, data & information sharing, transitions in care (between regional and local care, as well as between hospital and community), Mental Health and Addictions, transportation, etc.

2.2 Session Themes

The key takeaways/themes from each session are summarized below.

Session/ Stakeholder Group	**Key Takeaways**
Patient Family Advisors (May 19)	1. Participating patient, resident, client, family and caregiver Advisors **want to continue to be involved in this important work**. As a next step, a follow up session will be scheduled to focus on the development of a *Patient/Person Declaration of Values* to guide this work. 2. Need to **respect the important role of care delivery in small communities, and ensure that care is delivered as close to home as possible**. 3. Key **areas for improvement** include: better continuity of care between regional and local services (including better information sharing); improved transportation system/services; and, better access to mental health and addictions services. Opportunities to support this may include: EMR integration; exploring mobile models of care; and, expansion of regional programs/services to meet the needs of the population as close to home as possible.

Red Lake, Dryden & Sioux Lookout (May 25)	1. **Broader engagement is necessary**. Agreement to leverage existing Working Groups and stakeholder groups to continue to advance discussions on the topic. 2. Need to **acknowledge, learn from and build on previous and existing work**. Examples include Regional Wound Central Intake/Referral, NAN transformation, etc. 3. Need to **acknowledge the unique needs of individual communities and articulate how local service delivery models fit with the proposed integrated models at a local, district and regional levels**. Also, need to ensure that small communities (i.e. Ignace, Macchin, Vermillion Bay) do not get lost in this planning.
Kenora (May 26)	1. All Nations Health Partners OHT is advancing their work at a local level. The OHT will also be **connected regionally to plan for regional specialized services** – this includes planning with regional providers in Thunder Bay, as well as Winnipeg/Manitoba as a regional service hub. 2. **Regional approaches to key enablers** such as data and a Health Information System (HIS), as well as advocacy, will be helpful and necessary to enable the All Nations Health Partners OHT. Need to consider regional infrastructure so these important functions/enablers are addressed efficiently, and not done 'off the sides of desks'. 3. Key challenges we must work on as a region/system include: discharge planning, transportation and regional capacity planning to address service gaps (i.e. home and community care).
Thunder Bay & Nipigon (May 27)	1. Need **meaningful engagement with Indigenous peoples** – to envision and plan for a parallel Indigenous-led process, that respects the integrated services that Indigenous providers provide and ensures that Indigenous peoples needs are met in a culturally sensitive way. 2. As providers in Thunder Bay and Nipigon work together, must **ensure that Nipigon as a smaller community is not 'lost'**. The needs, autonomy, nimbleness and local successes must be recognized and built upon. 3. **Regional work should focus on advancing key enablers**, including: data, technology infrastructure, transformation resources, etc.
Marathon, Terrace Bay, Manitouwadge & Greenstone (May 31)	1. **Need further engagement** – local partners needs to be engaged in a meaningful way. Physicians are critical stakeholders and partners in this work. 2. Focus should be on **improving integration of care at the most local level** (vertical integration within communities), and **then a focus on integration across communities** (horizontal) if it makes sense. 3. **Further discussion is needed with partners in Greenstone** to understand where partnerships and integration makes sense to support patient care.
Rainy River District (June 1)	1. Need to **ensure linkage between regional providers and work being done locally**, so regional providers truly understand needs and can be part of solutions. 2. **Regional approaches to key enablers** such as data and digital technologies/infrastructure, as well as advocacy for an all government approach (including municipal) will be necessary to enable the Rainy River District OHT. 3. Key challenges we must work on as a region/system include: health human resource planning.
Francophone (June 9)	1. Need to **ensure the Francophone voice is heard**, not only in the planning phases, but all the way through implementation to ensure that needs are being met. There needs to be follow through and accountability to needs being met. 2. Need to be **culturally sensitive to Francophone patients who may or may not request FLS services**. Language barriers can be harmful and cause added stress.

	3. Specific gaps/challenges related to Francophone needs need to be addressed: services for sexual assault/domestic violence, psychiatry services in French and access to qualified translation services through the continuum of care. These can be addressed by providers thinking creatively and beyond their organizational walls/mandates.

3.0 A Proposed Plan Forward

3.1 Our Regional Vision

Feedback supports advancement towards a regional Vision:

To be a leading integrated care (health and human services) system, where partners work together to achieve the best outcomes and care experience for the people of Northwestern Ontario.

3.2 Values

A number of values/principles have guided our work to date, including:

1. **Status quo is not an option**
2. **Acknowledge the importance of local care delivery in a regional system**

- Any models we pursue must support: integrated delivery of care at the local community level; what is already working well locally; and, improved connection to the broader regional system

3. **Data is important, but it's not everything**

- Our models need to be supported by a reasonable level of data – however, it's not only about existing referral or utilization patterns – it's also about how to do things better and readiness and willingness of partners

4. **We will use an ongoing and evolutionary process – guided by co-design**

- We need to start somewhere – we won't get it perfect, and we may not even get it right at the start
- Iterative and flexible process

The Patient Family Advisory engagement session identified the need and opportunity to develop a *Patient/Person Declaration of Values*, developed by Patients, Clients, Residents and Caregivers. **RECOMMENDATION:** As a next step, it is recommended that another PFA Engagement Session be scheduled for the Fall 2021 to develop a Patient/Person Declaration of Values that will guide ongoing system integration work.

3.3 Regional priorities

Engagement sessions confirmed that we need to begin working together across the system and region to address key enablers, including:

- Digital strategies and technology
- Data and information sharing
- Transitions in care; particularly between regional and local care
- Transportation, etc.

As well, from a service perspective, Mental Health and Addictions was identified as a common priority (and one that aligns with the priority populations of the two approved OHTs in the North West region).

RECOMMENDATION: As a next step, it is recommended that the North West Integrated Care Working Group evolve to focus on advancing the following key regional priorities:

1. Indigenous engagement (advancing a parallel process of engagement and system development)
2. Data & information (immediately, includes: service mapping and data needs mapping; over time, will evolve to population health data management)
3. Improving transitions in care; particularly between regional and local care, and hospital and community
    - Mental Health and Addictions as a regional service planning priority

NOTE: digital strategy and Health Information System renewal is being advanced through an existing regional structure (Digital Health Council) that includes hospital and broader system representation.

RECOMMENDATION: It is recommended that the Digital Health Council Lead (Regional Chief Information Officer, Cindy Fedell) join the North West Integrated Care Working Group to provide regular updates and leverage the Working Group to ensure broader system alignment (across approved and emerging OHTs).

Additionally, the North West Integrated Care Working Group will support the following objectives/functions:

- Communication and engagement
- Information sharing across OHTs
- Facilitating connection between regional specialized providers and OHTs, to ensure effective planning and service provision (where necessary in early stages of model implementation/refinement)
- *With additional resources and funding, regional resources can support project management and facilitation to emerging OHTs to ensure regional alignment, efficiencies and economies of scale. .*

3.4 Community-level priorities

Engagement sessions confirmed that the proposed integrated models/OHTs were 'directionally right' (at least as a starting point). Though, further engagement is necessary and getting more partners engaged will be key to success.

RECOMMENDATION: As a next step, it is recommended that OHT Planning Tables be formed around the proposed integrated models/OHTs:

1. Dryden/Red Lake/Sioux Lookout
2. Thunder Bay/Nipigon
3. Marathon/Terrace Bay/Manitouwadge
4. Geraldton – TBD (further engagement required)

NOTE: further local (community-level) engagement may need to precede the formal development of these Tables.

The focus of their work will be to advance OHT/integrated care planning, with the aim to identify tangible steps to improve patient care for their shared population; as well as align to provincial directions and leverage associated funding opportunities. Key deliverables will include identification of OHT:

- Vision
- Population focus (Year 1 and at maturity) *NOTE: It is recommended that each OHT focus on Mental Health and Addictions as a Year 1 population, to support a shared purpose and efforts regionally.*
- Team/partners
- Collaborative Decision Making Models
- Transformation opportunities and implementation plans

OHT Leads are asked to sit on the Northwestern Integrated Care Working Group to ensure alignment.

3.5 A Proposed Roadmap and Next Steps

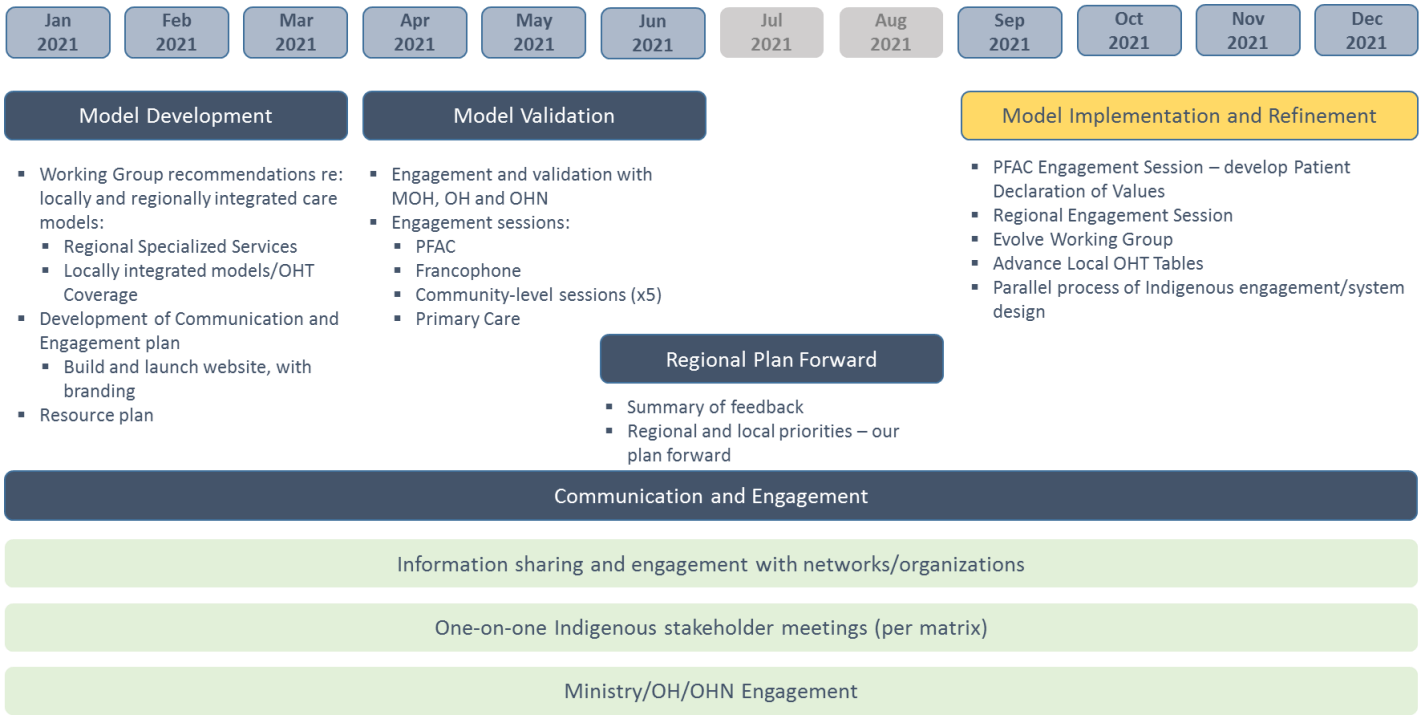
Based on engagement feedback and work to date, the following next steps are proposed:

1. **PFAC Engagement Session to develop draft *Patient/Person Declaration of Values (September 2021)***
2. **Regional Engagement Session (September 2021)**
    - Share engagement session themes and next steps
    - Confirm our shared principles and the *Patient/Person Declaration of Values* to guide regional efforts
    - Launch regional and local work
3. **Launch region-wide parallel Indigenous-led process (September 2021)**
    - Invite all Indigenous stakeholders to engagement session to determine *"what does a parallel process looks like that respects the integrated services that Indigenous providers provide and ensures that Indigenous peoples needs are met in a culturally sensitive way?"*
4. **Renew Northwestern Ontario Integrated Care Working Group (October 2021)**
    - Advance regional system priorities:
        i. Indigenous engagement (advancing a parallel process of engagement and system development)
        ii. Data & information (includes service & data mapping, and eventual population health data management)
            - Include HIS renewal and regional digital strategy as a standing item for information and system alignment
        iii. Transitions in care; specifically between regional and local care *can potentially leverage HQO Quality Standards as a guiding approach
            - Mental Health and Addictions (as a regional service planning priority)
    - Support the following objectives/functions:
        i. Communication and engagement
        ii. Information sharing across OHTs
        iii. Facilitating connection between regional specialized providers and OHTs, to ensure effective planning and service provision (where necessary in early stages of model implementation/refinement)

iv. Pending resources/funding, Project Management, Facilitation and Clinical Leadership

5. Launch local integration/OHT work (October 2021)

- Develop OHT Planning Tables around the proposed integrated models/OHT:
  - Dryden/Red Lake/Sioux Lookout
  - Thunder Bay/Nipigon
  - Marathon/Terrace Bay/Manitouwadge
  - Geraldton – TBD (further engagement required)
- Locally led engagement
- Key deliverables will include identification of OHT:
  - Vision
  - Population focus (Year 1 and at maturity) *Mental Health and Addictions as an overarching regional priority
  - Team/partners
  - Collaborative Decision Making Models
  - Transformation opportunities/plans
  - Implementation plans



4.0 Appendix: Engagement Session Notes (with participants)

4.1 Engagement Session Summary: **Patient and Family Advisors** – May 19, 2021

Attendees:

Session Leads: Jack Christy, Jessica Logozzo, George Saarinen

1. Dan Pieroz - Fort Frances
2. Donna Brown - TBRHSC
3. Linda Ballentine – NOSH
4. Jules Tupker – TB health coalition
5. Carol Ann Brumpton – TBRHSC
6. Wendy Petersen – Kenora
7. Becky Johnson – Marathon
8. Katherine Smith – PFA NW LHIN
9. Diane Clifford – PFA
10. Mirim – Marathon
11. Paul Carr – TBRHSC
12. Jan – TBRHSC PFA and CFP SJCG
13. Lesley Ryan – Marathon
14. Rita Boutette – Kenora PFA LWDH
15. Chantal Chartrand – FLS NW Ontario
16. Theresa Bowen – Kenora
17. Marg Arnone – Thunder Bay
18. Marge Porieir – Kenora
19. Joan Duke – LHIN PFA
20. Keith Taylor – Chair PFAC TBRHSC
21. Dana Lamminmaki – PFA TBRHSC
22. Jessica Saunders
23. Heather Woodbeck – PFA TBRHSC PFAC
24. Maleeha – Red Lake PFAC
25. Debbie Ruuska – Kenora
26. Cindy Cole – PFAC Fort Frances
27. Chief Lorraine Cobiness PFAC in Kenora
28. Wayne – Kenora
29. Craig Kozlowski – OH North
30. Joanna de Graaf Dunlop

Discussion notes:

- Acknowledgement of **great work to date**, and **excitement to be engaged in the process**
    - Appreciate bringing PFAs together across the region.
    - Felt that the example of hospitals working together on a shared leadership role focused on integration is a positive sign.
- Request for **continued patient, resident, client, family and caregiver involvement**
    - It was raised that a **patient declaration of values** from this group to help guide decision makers would be helpful. All agreed. **Agreement that a follow up session will be scheduled to advance this work.**
- Need to **respect the important role of care delivery in smaller communities** – Thunder Bay cannot be seen as the 'centre of healthcare' and **care needs to continue to be delivered as close to home as possible**.
- A participant shared that work underway through All Nations Health Partners OHT has led to better collaboration and innovation. Some key learnings include:
    - Common Vision – all partners are on the same page
    - Ability to leverage existing resources, both federal and provincial, allows them to meet the needs of the population
    - Courage – need to honest about what the challenges are
- <u>Challenges/issues that need to be addressed</u> to improve care for people across the region:
    - **Continuity of care and information** – when patients are discharged out of Thunder Bay and back to community, there are challenges with information being shared with providers/family and there is a lack of follow up care in the community.
    - **Integration** – story shared where a patient from a small community in the North West region was scheduled for three tests in Thunder Bay on three separate days. Noted that

there needs to be more integration/coordination so that patient appointments "make sense".
    - **Transportation** – lack of transportation options in the region; can lead to missed appointments. Two specific examples provided:
        - Ambulance services in the North West being look at for "rationalization" which may mean service to some communities is likely to become limited.
        - Closure of Greyhound bus routes with only limited service provided by Casper and Northland means transport to appointments for medical care has may be (or has been) significantly compromised.
    - **Mental health and addictions** – access is an ongoing challenge, which has been worsening due to the pandemic. Consider ideas such as: safe drug program; services available through school board.
- Opportunities noted:
    - **Electronic Medical Records (EMR) integration** to support better information sharing. *Presenters noted that this is a priority for the region – all hospitals are currently working together to renew the current Health Information System, and are looking at integration/interoperability with the broader health and human services system.*
    - Consider **mobile models of care** to ensure access to services – for example, mobile MRI for the region.
    - Build on **successful regional programs** to address needs – for example, regional stroke prevention team (look at mobile models for ECG, bone density, etc.)
    - Opportunity to look to best practices (i.e. Registered Nurses Association of Ontario Best Practice guidelines) to learn from other organizations/models to advance our work.
- Questions raised:
    - Will hospitals that currently deliver babies still do so in an integrated model?

Key take-aways:

1. Participating patient, resident, client, family and caregiver Advisors want to continue to be involved in this important work. As a next step, a follow up session will be scheduled to focus on the development of a *Patient Declaration of Values* to guide this work.
2. Need to respect the important role of care delivery in smaller communities, and ensure that care is delivered as close to home as possible.
3. Key areas for improvement include: better continuity of care between regional and local services (including better information sharing); improved transportation system/services; and, better access to mental health and addictions services. Opportunities to support this may include: EMR integration; exploring mobile models of care; and, expansion of regional programs/services to meet the needs of the population as close to home as possible.

4.2 Engagement Session Summary: **Red Lake, Dryden & Sioux Lookout** – May 25, 2021

Attendees:

Session leads: Jessica Logozzo, Jack Christy, Marcia Scarrow, Sue LeBeau, Henry Wall

1. Doreen Armstrong-Ross
2. Heidi West
3. Joanna de Graaf Dunlop
4. Linda McNaughton
5. Heather Lee
6. Kieran McMonagle
7. Michael McBride
8. Alice Bellavance
9. Cherie Kok
10. Jennifer Urosevic
11. Daniel McGoey
12. Adam Day
13. Randi
14. Davlin

Discussion notes:

Red Lake Breakout Session:

- Overall, no objections to the proposed model.
- We need a **mechanism to address small volumes** – persons living in small communities matter as much as those living in more populated centers. Care as close to home as possible is important.
- **Technology is a critical enabler**
    - Allows service providers to meet clients where they are at; also allows opportunity to potential reduce stigma
    - In some cases, may result in fewer no shows
- **Primary care needs to be integrally involved** – not at an arms distance
- Need to build a model of care where there is **no wrong door** – to ensure that the care people need is there when they need it
    - Regional Wound Care Central Referral Model could be something to consider translating to other issues
- We **need to address wait lists** so people can access care.
- We **need to look at the broad determinants of health** – activity, income security, housing, etc.
- We **need to be creative.**

Sioux Lookout Breakout Session:

- Need to ensure we **build upon and learn from previous work** (both good and bad) – i.e. existing blueprints and many regional initiatives/programs that are being worked on as we move this forward
- In Sioux Lookout there is both health transformation work taking place, as well as OHT work, which are **very separate systems**. How do we support this work?
- Progress will be developed at the **speed of trust**.

Dryden Breakout Session:

- **Need to engage more broadly** – acknowledged that there are many community partners that need to be engaged in this discussion (only one provider from Dryden and one provider from Ignace in the session/breakout group)

    - Engagement should be led locally and should leverage local work already underway – **agreement to bring Dryden Integrated Health Care Organization (DIHCO) Working Group back together to engage in discussion and advance work**
    - Need to **acknowledge the local work that is already being done, build on that and articulate where it fits**
- Overall, felt that the **model makes sense** and is moving in the right direction; though, **many questions remain**:
    - Where do local services fit with district services?
    - How will we ensure that smaller communities do not get lost? (Ignace, Macchin, Vermillion Bay)
    - How will we ensure that the unique needs of all of the communities are not lost?

Key take-aways:

1. Broader engagement is necessary. Agreement to leverage existing Working Groups and stakeholder groups to continue to advance discussions on the topic.
2. Need to acknowledge, learn from and build on previous and existing work. Examples include Regional Wound Central Intake/Referral, NAN transformation, etc.
3. Need to acknowledge the unique needs of individual communities and articulate how local service delivery models fit with the proposed integrated models at a local, district and regional levels. Also need to ensure that small communities (i.e. Ignace, Macchin, Vermillion Bay) do not get lost in this planning.

4.3 Engagement Session Summary: **Kenora** – May 26, 2021

Attendees:

Session leads: Jessica Logozzo, Jack Christy, Henry Wall

1. Alice Bellavance
2. Rob Kilgour
3. Daniel McGoey
4. Kevin Queen
5. Sara Dias
6. Deborah Everley
7. Rossana Tomashowski
8. Kieran McMonagle
9. Ryan Bhopalsingh
10. Lynn Moffatt
11. Cynthia Stables
12. Marc Demers
13. Jenn Urosevic
14. Call in – Patricia Garden Supportive Housing – Dryden

Discussion notes:

- All Nations Health Partners OHT is well established and is advancing important work at a local level. Following the path of the patient, the OHT will also be connected regionally to plan for regional specialized services to ensure that people receive the care they need, and that it is seamless as they transition through the system.
    - When thinking about regional services and regional integration, need to think not just about Thunder Bay, but also **Winnipeg/Manitoba as a regional service hub**.
- While All Nations Health Partners OHT work happens locally, there are also components we can/should begin to build capacity around regionally. Need to consider **regional infrastructure** so these important functions/enablers are addressed efficiently, and not done 'off the sides of desks'.
- <u>Opportunities noted</u>:
    - **Data** – need to look at data and information regionally, to show where inequities exist so we can plan together and put forward business cases on how to fill those gaps.
        - Most of the data that is readily available in the system relies on OHIP billing. As such, this excludes important services offered through FHTs, CHCs, Nurse practitioner led clinics, etc., that do not utilize these billing models.
        - Collecting data that represents the full continuum of services and needs is something that should be worked on regionally.
        - Opportunity to identify quality indicators for the region.
    - **Regional advocacy** – opportunity to utilize our collective regional voice to advocate to the Ministry to ensure appropriate funding models for OHTs in Northwestern Ontario; to address existing inequities and to ensure that OHTs are funded sufficiently to get the work done (clinically and administratively). Also need to advocacy to remove barriers related to existing "mandates" and eligibility criteria – need to be able to focus on the client and provide services without mandates/criteria getting in the way.
    - **Regional Health Information System** – needs to consider not only hospitals, but the broader system.
- More direction/definition is needed on what is 'regional'.
- <u>Challenges/issues that need to be addressed</u> to improve care for people across the region:

- **Discharge planning and transitions in care (regional)** – story shared regarding a patient that was discharged from TBRHSC without a wallet or identification. Need to do better in supporting people in getting back to their home community. Key to this is ensuring that proper discharge plans are in place and information is shared with local service providers.
- **Transportation** – those coming from rural or remote communities need medical transport and not every patient has access.
- **Inappropriate usage of LTC** – noted that there are significant social admissions (with light behavioural issues) in LTC that should more appropriately be placed in supportive housing – we need to ensure the right people are receiving the right care in the right place.
- **Local service capacity** – need to address gaps in local community resources. Key gaps is in **home care service capacity** in communities. Need to ensure that appropriate local services exist – regional services can be provided, but if there aren't services in place locally when transitioned back to community, it all falls apart.

Key take-aways:

1. All Nations Health Partners OHT is advancing their work at a local level. The OHT will also be connected regionally to plan for regional specialized services – this includes planning with regional providers in Thunder Bay, as well as Winnipeg/Manitoba as a regional service hub.
2. Regional approaches to key enablers such as data and a Health Information System (HIS), as well as advocacy, will be helpful and necessary to enable the All Nations Health Partners OHT. Need to consider regional infrastructure so these important functions/enablers are addressed efficiently, and not done 'off the sides of desks'.
3. Key challenges we must work on as a region/system include: discharge planning, transportation and regional capacity planning to address service gaps (i.e. home and community care).

4.4 Engagement Session Summary: **Thunder Bay & Nipigon** – May 27, 2021

Attendees:

Session leads: Jessica Logozzo, Jack Christy, Nancy Chamberlain, Diane Walker, Alice Bellavance, Rhonda Crocker Ellacott, Bill Bradica, Juanita Lawson, Nathanial Izzo

1. Joanna de Graaf Dunlop
2. David Newman
3. Daniel McGoey
4. Cathy Eady
5. Deborah Dika
6. Randi
7. Tiffany Stubbings
8. Jennifer Wintermans
9. Ken Ranta
10. Dan Levesque
11. Nicole Lator
12. Kerrie
13. Jodie
14. Trish Malmborg
15. Joanne Lent
16. Bobbi Jo Smith
17. M M
18. Michael Dawthorne
19. Diane Lajambe
20. Natalie P
21. Kiirsti Stilla
22. Tina B
23. Shannon Cormier
24. Megan Waque
25. Lisa Tyrrell
26. Melanie Maunula
27. Pam
28. Terry Tilleczek
29. James Anderson

Discussion notes:

Thunder Bay Breakout Session:

- **Everyone needs to be included in the planning and delivery of the plan**.
  - Need to determine who 'everyone' is (group didn't feel it was clear)
- What would the Vision look like if it included **Indigenous system partners**?
  - Indigenous partners have communicated with Ontario Health that they have not been consulted in a meaningful way and are still waiting for this dialogue. They want a separate process.
- **System partners need to service our demographics** which includes a large Indigenous population.
- How do we understand what a **culturally sensitive**, integrated system would look like?
  - Start with knowledge to build capacity.
  - Non-Indigenous need to step up and recognize that our current health system is a Western, colonial system.
- **Equity is paramount**. We need to rethink our health service design. **Engage with Indigenous partners in a parallel process.**
- **Technology** will be really important and may in fact, make it hard to move ahead.
- We need to **recognize and resolve the tension between the city and the District**.
- **Non-health care partners have value to be added to the planning and delivery**. They are often connected to the people using the health care system and whatever happens to the healthcare system will also impact non health care providers
- **Community based services are key to an inclusive, equitable, health care system.**

Nipigon Breakout Session:

- Need **meaningful engagement with Indigenous peoples** – to envision and plan for a **parallel Indigenous-led process**, that respects the integrated specialized services role that Dilico, and other

Indigenous providers, have. Need to ensure that the needs of Indigenous people are met in a culturally appropriate way.

- Need to ensure that the **autonomy, nimbleness and efficiency** that exists in Nipigon is not lost. Need to respect and build on it. This is not about losing services, but **improving services and building on partnerships**.
- Regionally, the following opportunities exist:
  - Building a proper **data and technology infrastructure** to support local and regional service planning and population health management. Needs to focus on the **determinants of health** and look at data on those that do not access services.
- Recognition that we cannot transform the system off the side of our desk. We **need to invest in the resources/capacity for transformation** so we are successful.
  - System planning structures need to acknowledge that partners cannot be part of various groups
- Overall, partners feel the proposed model is **moving in the right direction**. Some questions remain:
  - How will provincial services (i.e. Canadian Hearing Services) be engaged with local OHTs and ensure needs are being met?

Key take-aways:

- Need **meaningful engagement with Indigenous peoples** – to envision and plan for a **parallel Indigenous-led process**, that respects the integrated services that Indigenous providers provide and ensures that Indigenous peoples needs are met in a culturally sensitive way.
- As providers in Thunder Bay and Nipigon work together, **must ensure that Nipigon as a smaller community is not 'lost'**. The needs, autonomy, nimbleness and local successes must be recognized and built upon.
- **Regional work should focus on advancing key enablers**, including: data, technology infrastructure, transformation resources, etc.

4.5 Engagement Session Summary: **Marathon, Terrace Bay, Manitouwadge & Greenstone** – May 31, 2021

Attendees:

Session leads: Jessica Logozzo, Jack Christy, Bill Bradica, Jocelyn Bourgoin (delegate for Debbie Hardy)

1. Joanna de Graaf Dunlop
2. Alice Bellavance
3. Daniel McGoey
4. Darryl Galusha
5. Anne Harrison
6. Cori Watson
7. Donna Jaunzarins
8. Ryan Bhopalsingh
9. Roland Smith
10. Kerrie
11. Valerie
12. Randi Doggett
13. Peter Ruel
14. Adam Brown

Discussion notes:

Manitouwadge/Marathon/Terrace Bay Breakout Session:

- It is important, as this discussion moves forward, to **not lose sight of the good work that has been done in each local area** to improve services.
    - Many efficiencies have already been found at the local level.
    - Already gained on IT and red tape efficiencies.
    - Partnership between Peninsula Manor in Marathon and TBDSSAB in providing rent supplements was noted by Marathon participants as a positive partnership
- Focus should be on **improving integration of care at the most local level** (vertical integration within communities), and **then a focus on integration across communities** (horizontal) if it makes sense.
- Need to **ensure physician engagement** in this work going forward.
    - Physicians must be supportive of horizontal integration; or it will not work.
    - No physicians in attendance at the session which may signal this lack of support.
    - Physicians have been supportive of vertical integration at the local level. There is currently no perceived incentive for physicians to buy into horizontal integration.
- There did not appear to be clear support for Manitouwadge to be included in an OHT with Marathon/Terrace Bay.
- If we proceed, there is **concern about a negative impact on the work that has already been done and potential impact on small communities**.

Greenstone Breakout Session:

- Need to do **more engagement** and have focused discussion with the stakeholders in the Greenstone/Long Lac area given they were not at the table. Only one local Greenstone provider was in attendance.
- Noted that there is **good cooperation among providers in the community** already. This works needs to build on that, and **must not negatively impact**.
    - Also need to build on the virtual/remote models/successes that have been achieved through the pandemic.

- Noted that **natural referral patterns and travel patterns are towards Thunder Bay** (not associated with Manitouwadge/Marathon/Terrace Bay). This should be considered in proposed OHT model.

Key takeaways:

1. **Need further engagement** – local partners needs to be engaged in a meaningful way. Physicians are critical stakeholders and partners in this work.
2. Focus should be on **improving integration of care at the most local level** (vertical integration within communities), and **then a focus on integration across communities** (horizontal) if it makes sense.
3. **Further discussion is needed with partners in Greenstone** to understand where partnerships and integration makes sense to support patient care.

4.6 Engagement Session Summary: **Rainy River District** – June 3, 2021

Attendees:

Session leads: Jessica Logozzo, Jack Christy, Dan McCormick, Karen Lusignan, Jorge VanSlyke

1. Rob Kilgour
2. Alice Bellavance
3. Kristan Miclash
4. Shanna Weir
5. Joanna de Graaf Dunlop
6. Kiirsti Stilla
7. Raiili Pellizarri
8. Deb Ewald
9. Char Strain
10. Lloy Schindler
11. Jenn Osesky
12. Andrew Hallikas

Discussion notes:

- Rainy River District OHT is advancing work locally to improve care. While this work advances locally, **need to ensure linkage between regional providers and work being done locally, so regional providers truly understand needs and can be part of solutions**. Feedback on this included:
    - "Working separately is not working" – need local insights to inform regional services.
    - Example shared – how do we ensure that referrals are getting through and needs will be met?
    - **Opportunity to work together to address HHR challenges and meet population needs**. Regional providers are often challenged to recruit and retain staff due to the regional nature of jobs (i.e. travel) and wage disparities. May be opportunities to work with contract service providers locally to fill gaps closer to home.
    - **Regional providers need to be 'part of' every OHT in the North West.** *Noted that the regional structure of the Northwestern Ontario Integrated Care Working Group can support regional providers in staying connected and accountable to the needs of each OHT/community.*
- **Need active engagement of physicians** in this work. *Rainy River District OHT has developed a Primary Care Advisory Council to engage physicians.*
- **Need active engagement of Indigenous partners.** *Rainy River OHT has been co-led by Indigenous partners.*
- A number of opportunities on how we need to work together regionally include:
    - **Digital technologies** – need to get all of our programs/organizations 'speaking' to each other to support seamless and connected patient care
    - **Data** – need to look at data and information regionally, to show where inequities exist so we can plan together to address needs and gaps.
        - Data needs to be balanced and interpreted based on the needs of the organization/sector/provider.
- Questions to be answered include:
    - From a municipal perspective – how do you get an all of government approach to care everywhere? Discussed housing supports and need for advocacy to get support in these areas.

Key takeaways:

1. Need to ensure linkage between regional providers and work being done locally, so regional providers truly understand needs and can be part of solutions.
2. Regional approaches to key enablers such as data and digital technologies/infrastructure, as well as advocacy for an all government approach (including municipal) will be necessary to enable the Rainy River District OHT.
3. Key challenges we must work on as a region/system include: health human resource planning.

4.7 Engagement Session Summary: **Francophone Partners** – June 9, 2021

Attendees:

Session leads: Jessica Logozzo, Jack Christy, Chantal Chartrand

1. Angele Brunelle
2. Jodie Quesnel
3. Denyse Herry
4. Alexandra Mauro
5. Elodie Grunerud
6. Anita Jean
7. Diane Breton
8. Rose Viel
9. Laila Faivre

Discussion notes:

- **Need to ensure voices are heard, there is follow through and there is an end result**.
    - The Francophone voice and needs to be considered not only in the planning phases, but all the way through implementation to ensure that needs are being met.
    - Previous initiatives have ended engagement and consultation once programs were off the ground, with no follow through.
    - Providers and partners need to be willing and ready to think outside of their organizations/mandates; need to be supported by removing barriers and silos. Success story shared where a FLS resource was hired that moved across multiple organizations/agencies. Funded by a number of providers to provide services across the continuum.
- **Need to be culturally sensitive to Francophone patients who may or may not request FLS services**. Language barriers can be harmful and cause added stress.
    - Cannot make assumptions that Francophone who speak English are fluent. In healthcare situations specifically, many Francophones are not comfortable with English slang/terminology and this can affect their experience and outcomes.
- <u>Challenges/gaps noted:</u>
    - **Lack of services for sexual assault/domestic violence** survivors in French
    - **Accessing psychiatry services** in French has always been a challenge; however, with increased capacity in Thunder Bay as well as the possibility to now access psychiatry virtually has been incredibly helpful with language and wait times.
    - Access to **qualified translation services**. Example shared where patient was contacted by oncology nurse re: diagnosis and treatment options, in English. Patient was experiencing stress due to the nature of the conversation and the nurse offered to have them speak to a nurse that was able to communicate in French (conversational level, though not adept in clinical terminology). Unfortunately, incorrect translation was given which caused additional stress to patient.
- <u>Opportunities/questions noted:</u>
    - How can we better capture existing resources/capacity (i.e. physicians or other HHR) that speak French in the system?
    - OHTs should be required to do active training, as well as have resources and staff embedded to support patients through each part of their care journey. *Centrelles noted that Social Work services are provided for first 12 months of service, but if no follow up care in community/OHT then it falls apart.*

    - How will this be different from previous transformation initiatives? Have seen many initiatives to streamline/improve care – what is different this time? Need to incentivize providers to transform and integrate.
- Need to make sure that if a patient receives care in Thunder Bay, that their care plan follows them back home to the region and their specific community. Concern that if hubs are created (grouping of communities) that the patient's care plan is still shared with his or her local medical professionals.

Key takeaways:

1. Need to ensure the Francophone voice is heard, not only in the planning phases, but all the way through implementation to ensure that needs are being met. There needs to be follow through and accountability to needs being met.
2. Need to be culturally sensitive to Francophone patients who may or may not request FLS services. Language barriers can be harmful and cause added stress.
3. Specific gaps/challenges related to Francophone needs need to be addressed: services for sexual assault/domestic violence, psychiatry services in French and access to qualified translation services through the continuum of care. These can be addressed by providers thinking creatively and beyond their organizational walls/mandates.