2024–25

ANNUAL PLAN

ÉQUIPE SANTÉ
ALGOMA ONTARIO
HEALTH TEAM

Letter from the tri-chairs

The release of our 2024–25 Annual Plan not only marks the beginning of our fifth official year as an Ontario Health Team, but more notably, five years since our partners made a public commitment to build a network where Algoma residents have access to the right care, right team, and right care setting when they need it.

Together as partners, the Algoma Ontario Health Team (AOHT) did not waver from the goals we set out to achieve by the end of 2023–24. Our dedication and focus resulted in meeting and surpassing our community driven objectives, bringing us closer to an integrated healthcare system. We made advancements in care for older adults and their caregivers, complex chronic diseases, and mental health and addictions; launched our inaugural patient and family advisory council focused on primary care; and welcomed six new partners from across Algoma district.

While we celebrate our successes, we recognize the journey that lies ahead. In the past four years we've grappled with repercussions of the COVID-19 pandemic and its stages of recovery, and today, we feel the exacerbated effects of the province-wide primary care provider shortage in Algoma. The challenges Algoma residents face navigating and accessing care remind us of the importance of working together towards our shared vision of integrated health and social services in Algoma.

Our 2024–25 Annual Plan was built in consultation with partners and stakeholders — including clinicians, patients, caregivers and families - to support a more holistic and effective approach to service planning and delivery in Algoma. We also carefully considered how our goals and activities can productively contribute to new and evolving primary care initiatives. This plan is our commitment to being part of collaborative, innovative, and sustainable solutions to long-term, multi-faceted challenges that cannot be solved overnight.

Given the challenges we are facing in our community, the AOHT is at a critical juncture. We will continue to rely on trusting relationships we've built, the collective expertise of our member organizations, and lessons we've learned to move forward with optimism. While we've come a long way together, we remain in pursuit of a health system where no one is left behind.

S Parniak

Stephanie Parniak
AOHT Tri-Chair

D Noel

Dominic Noel, NP
AOHT Tri-Chair

I Watson

Ila Watson
AOHT Tri-Chair

The Algoma Ontario Health Team (AOHT) is a team of local health professionals, organizations, and community members working to create a network where citizens will have access to the right care, right team, and right care setting when they need it. We want individuals to experience seamless transitions throughout their care journey in a system that is understandable, digitally-enabled, and collaborative.

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VISION: An integrated health system focused on the unique needs of Algoma residents, where people receive seamless, effective care where and when they need it.

MISSION: The Algoma OHT will collaborate in a model of care that is person-centered, efficient and simplified for both individuals and providers.

Guiding values and principles

We have adopted the Patient, Family and Caregiver Declaration of Values for Ontario. This means that we strive to uphold the following values when providing care:

- Accountability
- Empathy and compassion
- Equity and engagement
- Respect and dignity
- Transparency

We have also adopted principles for advancing integrated care, which guide how we work with others to improve Algoma's health system.

- Patient-centred and culturally safe
- High quality
- Universally accessible
- Community-led
- Strengthens population health with primary health care

Integrating care in Algoma

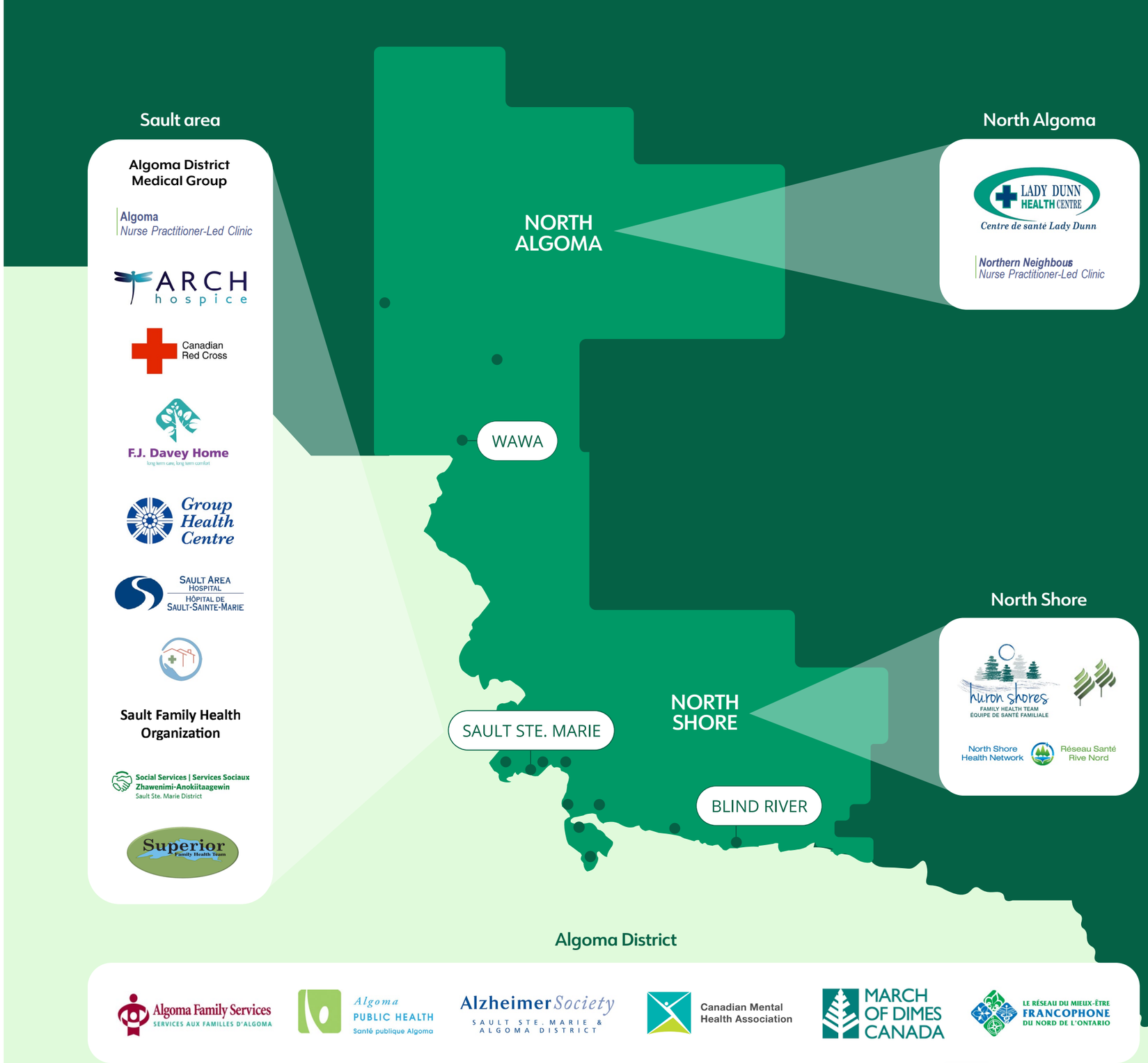
Our attributed population includes residents in 21 municipalities spanning 32,000 km. While our vast geography and sparsely populated region contributes to challenges accessing and delivering health and social services, Algoma is home to residents who are innovative, resilient, and optimistic.

We aim to build a healthcare system that reflects the uniqueness of our region and harnesses the qualities of our communities and the providers that serve them.

We actively partner and collaborate with organizations, primary care providers, and community representatives to improve and unify healthcare system planning and service delivery in Algoma. Significant efforts will continue to broaden membership across sectors and geography to support our entire attributed population.

In 2024–25, our team will continue to leverage regional opportunities to support our initiatives including engagement with neighbouring OHTs across the North East and frequent engagement with Maamwesying OHT, given the communities we share.

> Through this network, we make our rural voices heard and strengthen collaborative partnerships across Algoma. Becoming an official member of the AOHT means we are one step closer to designing a healthcare system that provides equitable access to care for Algoma residents, regardless of the community they live in.
>
> **Alyssa Spooney, Executive Director of Huron Shores Family Health Team**



Population health

Health and well-being can be influenced by ethnic distribution, Indigenous status, household size and costs, education, employment, income, and access to health care. In Algoma, several of these indicators are notable when compared to Ontario as whole. This includes a higher number of Indigenous and Francophone community members and a higher percentage of residents with low income. Because Algoma is a diverse and widespread community, these population characteristics help underpin the importance of taking an equity-focused approach and emphasize the value of culturally appropriate care within our priority populations. **Prioritized based on impact and feasibility, we are focusing on the following four populations.**

Older adults

As of 2021, 26.5% of Algoma residents are over the age of 65, compared with only 18.5% in Ontario. This number is expected to increase to 29.2% by 2026[1].

Over 7,000 older adults in Algoma are living with frailty, characterized by reduced strength, endurance, and physical function. Without intervention, an estimated 11,000 individuals will be living with frailty in Algoma by 2040[2]. Maintaining older adult independence improves quality of life, decreases the amount of time spent accessing care, and reduces the overall cost to the healthcare system.

Over the past five years, we forged a path to advancing integrated care for older adults and their caregivers through implementation of the post-fall pathway, early frailty identification, and coordinated access to geriatric services. This year, we will build off of our progress and continue to bring together local and regional health professionals to co-design improved care pathways for older adults living with frailty.

Complex chronic disease

As Algoma's population ages, more citizens will be living longer with chronic conditions.

Many Algoma residents are already living with chronic diseases such as chronic obstructive pulmonary disease (COPD), diabetes, and heart disease[3]. It is common for individuals who have one chronic condition to have others. If not well managed in the community, having multiple chronic conditions can drastically reduce quality of life and use substantial healthcare resources.

Algoma has higher rates of COPD hospitalizations than Ontario as a whole. This year, we aim to improve capacity to diagnose COPD and improve the care journey in the community.

Mental health and addiction

Mental health and addictions challenges emerged widely as being influential on chronic disease risk factors and outcomes and are increasingly being considered a life-long chronic condition[4].

Compared to all of Ontario, Algoma has a significantly higher rate of emergency department visits for mental health and substance use (554 vs. 184 per 100,000)[5]. Algoma has seen an increase in unattached patients that are diagnosed with a mental health challenge from 2020 to 2022[6]. Algoma also continues to experience significantly higher opioid-related ED visits, hospitalizations, and deaths when compared to Ontario[7].

This year, through our Mental Health and Addictions System Planning Table, we aim to integrate more psychosocial supports into primary care services and improve coordinated access and navigation to mental health and addictions services.

Primary care

Primary care is a cornerstone of the healthcare system. While areas of Algoma may have been sheltered from primary care provider shortages in the past, our entire region is now affected and unattachment rates are soaring.

We will take a coordinated, solution-focused approach to increasing access to primary care services through multiple avenues, including the primary care network of providers and the patient and family advisory council. Our Leadership Council commits to supporting improvement initiatives. Our communities depend on it.

[1] Census Profile 2021. The District of Algoma Health Unit, Ontario. Statistics Canada; 2021. Population (estimates 2011-2021 and projections 2022 onwards). Intellihealth, editor. 2023.

[2] Chronic obstructive pulmonary disease Hospitalizations Health Equity Snapshot. Public Health Ontario. (2024, January 19). https://www.publichealthontario.ca/en/Data-and-Analysis/Health-Equity/Chronic-Obstructive

[3] Mental health and substance use emergency department visits health equity snapshot. Public Health Ontario. (2024b, January 19). https://www.publichealthontario.ca/en/Data-and-Analysis/Health-Equity/Mental-Health-ER-Visits

[4] CCO & Ontario Agency for Health Protection and Promotion (Public Health Ontario, 2019). The burden of chronic diseases in Ontario: key estimates to support efforts in prevention. Queen's Printer for Ontario.

[5] CCO & Ontario Agency for Health Protection and Promotion (Public Health Ontario, 2019). The burden of chronic diseases in Ontario: key estimates to support efforts in prevention. Queen's Printer for Ontario.

[6] INSPIRE. (2023). Primary care, 6 data reports.

[7] Algoma Public Health. (2024). Local data: Opioid related health harms in Algoma.

Milestones: How did we get here?

Expanding frailty ID
Expanded frailty identification efforts along the North Shore.

Primary care PFAC
Onboarded 17 PFAC members focused on primary care initiatives.

Mental Health and Addictions System Planning Table
Established a Mental Health and Addictions System Planning Table to facilitate the advancement of mental health and addiction priorities in the Algoma district.

Regional approach to EVAC
Participated in a regional approach to implementing virtual care appointments, collaborating with Maamwesying Ontario Health Team.

Onboarding partners
The AOHT onboarded eight new members in 2023–24 from across the district.

> I want to use my skills and knowledge to advocate and improve primary health care for Algoma and the North, so that all have optimal access to primary care that is time sensitive, comprehensive and coordinated, including easy access for patients to their health care information.
>
> **Denise Maki, Primary Care PFAC member**

Planning for 2024–25

With provincial guidance putting OHTs on an accelerated path to maturity over the next three years, we pledge to remain steadfast in the commitment we've made to our local communities.

Through extensive consultation and co-design, we are proud to present our 2024–27 logic model to you (see next page). This logic model is a visual representation of our program goals and objectives, built with shared understanding with our partners. It will serve as our plan for the next three years, with updates to be made to the activities each subsequent year.

Strengthening care closer to home

	Activities (by 2025)	Outputs (by 2027)	Outcomes at maturity
Healthy aging (older adults)	**Early frailty identification in primary care** • Implement and provide ongoing support for early frailty identification program along North Shore • Sustain and expand existing early frailty identification program in Sault Ste. Marie **System translation** • Implement system navigation tools to support residents and providers • Host a series of healthy aging community education sessions	Approaches to care focus on prevention. Access to primary health care increased. Residents and healthcare system providers are equipped with the tools necessary to navigate the system. Algoma residents are actively managing their complex chronic conditions through support in the most appropriate settings. Integrated supports are built into primary care teams to increase access for those seeking mental health and addictions services. Residents are housed with appropriate levels of support.	Actively manage health outcomes for the attributed population Deliver a full continuum of care for all but the most highly specialized conditions Access to 24/7 coordination and system navigation Seamless transitions through the health and social service systems
Conditions better managed in the community	**Chronic obstructive pulmonary disorder (COPD)** • Increase community capacity to diagnose COPD • Develop localized COPD pathways • Explore digital health opportunities to support COPD self-management		
Mental health and addictions	**Integrate psychosocial supports in primary care** • Explore opportunities to embed psychosocial supports into primary care **Coordinated access and system navigation** • Support development of coordinated access to community mental health and addictions programs • Launch roadmap to connect individuals with appropriate services		
Residents unattached to primary care	**Increase access to primary care services** • Support NE OHT Regional Collaborative to implement Episodic Access to Virtual Care Clinic in the Northeast • Explore opportunities for alternative primary care models to support unattached individuals • Increase capacity and pathways to support unattached newborns **Preventative screening** • Collaborate with primary care partners to deliver cervical screening clinics for unattached individuals • Collaborate with partners to increase preventative screening education (resource: North East Regional Cancer Program) **Community Wellness Bus** • Expand scope of services, including harm reduction and preventative care • Increase opportunities to access primary care services in the community		

Community partnership and engagement

Activities (by 2025)	Outputs (by 2027)	Outcomes at maturity
Caregivers • Increase uptake of the Caregiver ID **Primary care patient and family advisory council** • Embed primary care PFAC members into various AOHT-level work (Resource: Community Partnership Toolkit) **Advancing social equity** • Complete Phase I of the system equity research project • Disseminate and support diversity, equity and inclusion training and education opportunities	Approaches to care fcus on prevention. Access to primary health care increased. Residents and healthcare system providers are equipped with the tools necessary to navigate the system. Algoma residents are actively managing their complex chronic conditions through support in the most appropriate settings. Integrated supports are built into primary care teams to increase access for those seeking mental health and addictions services. Residents are housed with appropriate levels of support.	AOHT meaningfully partners and engages with community voices to build a health system that is designed by and for the communities we serve.
Digital health • Explore opportunities to reduce barriers related to information sharing • Develop a renewed AOHT digital health strategy **Leadership and governance** • Expand and strengthen OHT partnerships, including OHT-to-OHT level partnership agreements • Continue to onboard new members to reflect full sector representation **Recruitment and retention** • Explore digital health solutions to increase capacity within primary care • Lead a community approach to increase Nurse Practitioner recruitment	All sectors are aligned on an integrated approach to implementing digital health solutions. Consistent information sharing among AOHT partners is leveraged. All sectors and geographies are represented within the AOHT. Consistent and transparent governance is in place. Increase in capacity within the system to support all Algoma residents.	Digital health solutions support delivery of care, ongoing quality and performance improvements, and patient access to information when and where they need it. AOHT provides care according to the best available evidence and clinical standards. AOHT operates through a single clinical and fiscal accountability framework, including an integrated funding envelope based on care needs of the attributed population.

Building a foundation for collaboration

Measuring impact

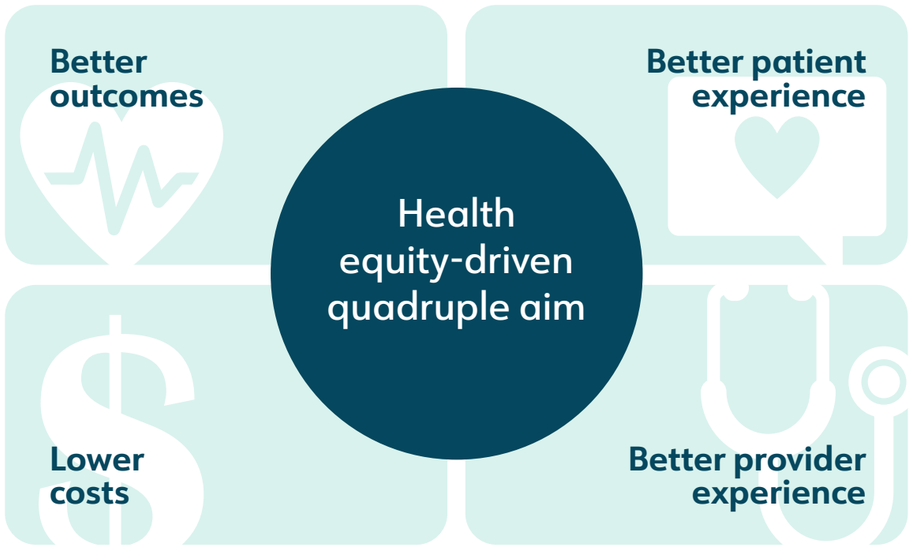
Quality improvement is all about delivering the best possible care and achieving the best possible outcomes for healthcare system users.

An important component of integrated care is performance measurement – setting goals and measuring what matters to support rapid improvement in care delivery. To operationalize our annual plan, we need to demonstrate the healthcare system changes of AOHT integration activities. Our team will measure performance through a series of indicators that align with the health equity driven quadruple aim (otherwise known as the quintuple aim) and essential elements of an integrated healthcare system.

"The Quadruple Aim is a framework to guide the redesign of health care systems and the transition to population health that is centered on four overarching goals: improved population health outcomes, improved care and patient experience, improved provider satisfaction, and lower costs / better value."[1]

The quadruple aim is centered around health equity, as it is the lens through which the AOHT plans for all.

[1]Institute of Health Services and Policy Research. (2021). Accelerate health system transformation through research to achieve the quadruple aim and health equity for all.



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