Annual Business Plan

2023/24

Ontario Health

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Executive Summary

Created in 2019 by the Government of Ontario, Ontario Health is in a unique position to effect change in the health care system. As the government's agency responsible for connecting health care organizations and providers across the province, we have the opportunity and mandate from the Ministry of Health (MOH) and Ministry of Long-Term Care (MLTC) to transform how care is delivered, ensuring it is patient-centred, of high quality, and available when and where people need it.

This annual business plan outlines our roadmap to delivering on the government's important change agenda that will improve health system stability and recovery in the immediate term and for decades to come. Designed to deliver against MOH and MLTC identified priorities, it focuses on clinical excellence, integration and bold health system transformation. Informed by provincial priorities and guided by our new vision, mission and values, we will use our position as a leader in health and wellness to work together with our partners, including the MOH, MLTC, delivery organizations and patients to achieve provincial goals of a more connected health system.

Our strategic priorities, outlined in our accountability agreement with the MOH, continue to build on our now four years as Ontario Health: reducing health inequities, transforming care with people at the centre, enhancing clinical care and service excellence, maximizing system value by applying evidence, and strengthening Ontario Health's ability to lead. Within each of these is an opportunity to work more closely with the people we serve to ensure patient, caregiver and diverse perspectives are a foundational element of our solutions.

This three-year plan to deliver on the government's mandate is ambitious. Through a focus on system and clinical integration, technology advancements, smarter health care, and investments in care delivered in the community, by the end of fiscal year 2025/26, together, we will have achieved:

- The most integrated health system in Canada as a result of the development of Ontario Health Teams (OHTs) and other integrated delivery networks.
- Faster access to more care at home and in local communities.
- Mental health integrated as part of all health with faster access to integrated mental health and addictions services and the ability to measure care outcomes.
- Elimination of the consequences of the pandemic on waitlists, with improved access to care within clinically recommended wait times.
- Significant digital and technological achievements that improve access to information and care processes for patients including equitable access to virtual care.
- A sophisticated patient, client and family feedback system that truly enables person-centred care.
- A stronger and more resilient workforce.

MANDATE

Ontario Health's mandate is to connect, coordinate and modernize our province's health care system to ensure that the people of Ontario receive the best possible patient-centred care, when and where they need it. Ontario Health oversees health care planning and delivery across the province, which includes ensuring frontline providers and other health professionals have the tools and information they need to deliver quality care in their communities.

Introduction

Health system transformation and clinical excellence in pursuit of improving health outcomes and experiences for the people of Ontario is at the heart of all that we do at Ontario Health. Ontario Health's mandate is to connect, coordinate and modernize our province's health care system to ensure the people of Ontario receive the best possible person-centred care, when and where they need it. With some exceptions, Ontario Health oversees health care planning and delivery across the province, which includes ensuring frontline providers and other health professionals have the tools and information they need to deliver quality care in their communities.

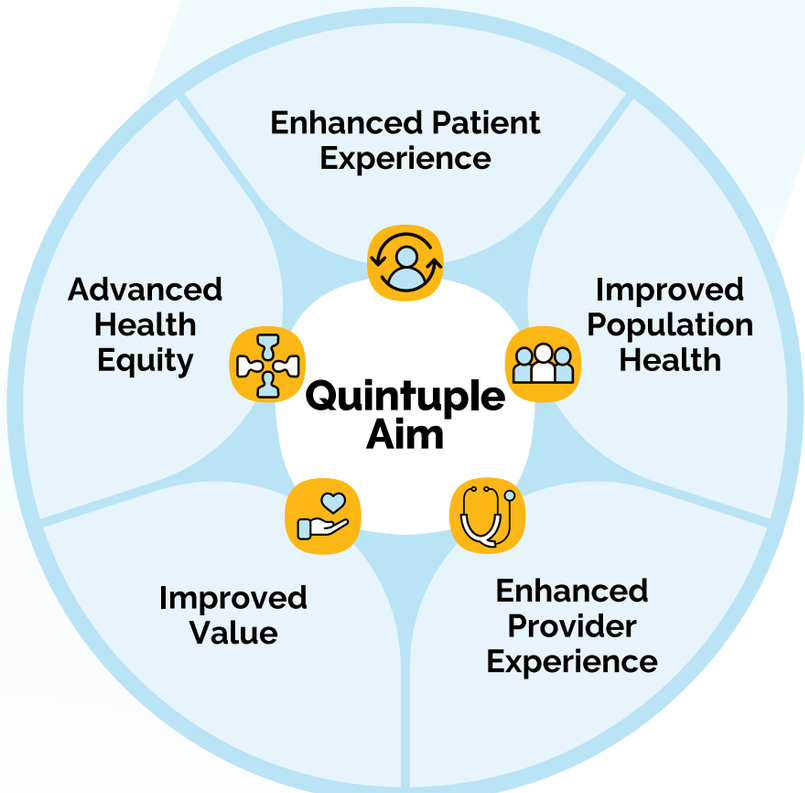
Our Annual Business Plan (ABP) sets out how we will deliver on the governments overarching goals and priorities over the next three years, with a focus on fiscal year 2023/24.

The ABP is aligned with our strategic priorities and ensures delivery against our legislative objectives, our mandate letter from the MOH and our strategic priorities letter from the MLTC. This plan is also informed by the Ontario Government's *Plan to Stay Open: Health System Stability and Recovery*, which acknowledges the critical pressures being felt in the provincial health system as well as the Ministry's new *Your Health: A Plan for Connected and Convenient Care*, released in February 2023.

Finally, the Quintuple Aim is also central to health system planning at Ontario Health. We are firmly committed to the five goals it sets for the design and delivery of an effective health care system:

- Enhancing patient experience
- Improving population health outcomes
- Improving better value
- Enhancing frontline and provider experience
- Advancing health equity

As Ontario Health enters its fifth fiscal year, we look forward to continuing to work with all our partners in advancing our mandate, government priorities and key deliverables as we lead the evolution of a better connected and coordinated health system to help ensure people in Ontario receive the best care possible.



Strategic Priorities

Reduce health inequities

Improving care with and for those who need it most;

Engaging those we serve to understand health and wellness from their perspectives and partnering to take action to make improvements;

Working to address the distinct needs of individuals and communities across the province; and,

Focusing on the full care continuum, including our role and the health system's role in contributing to upstream social determinants of health and preventative care.

Transform care with the person at the centre

Supporting people in Ontario to take an active role in their care, including preventative care;

Collaborating with patients in order to continuously improve planning and delivery of quality care;

Asking how care can be better delivered using both existing and new approaches and tools; and,

Working with Ontario ministries, funded and non-funded partners including municipalities and social services to support and enable more connected and coordinated care.

Enhance clinical care and service excellence

Putting the holistic health and wellbeing of people in Ontario first in everything we do;

Advancing positive health outcomes for all; and,

Improving experiences across the health care system.

Maximize system value by applying evidence

Strengthening the capacity to collect, share, integrate, analyze and react to data and evidence; and,

Achieving the best possible quality and value for public investments.

Strengthen Ontario Health's ability to lead

Building a strong organizational culture that unifies and empowers Ontario Health team members across the province;

Investing in our people and committing to our own continuous improvement;

Continuing to establish ourselves as a reliable leader and partner;

Challenging the status quo and embracing transformation in order to continuously strengthen our organization and the health system;

Leading by example both locally and provincially, with all of our teams providing valued contributions.

Vision, Mission and Values

Since Ontario Health's creation in 2019, we have come a long way in establishing our single, integrated team from 22 separate and distinct agencies and organizations. The foundation of our strong organizational culture is our shared vision, mission and values. More than just words on a screen, our vision, mission and values help define our unified purpose, set the direction for where we are going as an organization and describe how we will work together to get there.

Despite our first years being largely focused on meeting the urgent and challenging needs of a health system under intense pressure from the COVID-19 pandemic, our team worked hard to come together as one organization, harmonizing complex practices, processes and policies.

Our vision, mission and values form the basis for an organizational culture in which we can all feel inspired and empowered to do our best work, valued for our contributions and proud of the difference we are making for the people of Ontario.

Our Vision

(What we aspire to be)

Together, we will be a leader in health and wellness for all.

Our Mission

(Our purpose)

To connect the health system to drive improved and equitable health outcomes, experiences and value.

Our Values

(How we will work together)

- **Integrity**
- **Inspiration**
- **Tenacity**
- **Humility**
- **Care**

Making Progress

Our strategic priorities are achieved alongside our objectives of daily health system operational management, coordination, performance measurement and management and integration. Throughout 2022/23, we worked closely with our health system partners to maintain an ongoing provincial pandemic response while also accelerating a focus on system recovery by improving system access and flow and providing time-sensitive supports to frontline health human resources (HHR) across the province. Working with our delivery partners, we are increasingly connecting these strong response and recovery structures to health system transformations such as OHTs; this will ensure their lasting effect. Below are some key highlights of where we have made progress within our 2022/23 ABP:

Maintained a provincial pandemic response and system recovery

- In the winter of 2022, Ontario's 70+ clinical assessment centres were expanded to include service for influenza-like illnesses and pediatric patients to increase access to primary care in the community during surge periods, diverting traffic away from our emergency departments and preserving emergency care for urgent cases.
- Throughout the fall and winter of 2022, we helped maintain access to surgery despite significant acute care pressures. This was done by managing load sharing across hospitals for high volume specialties, regional coordination of waitlists, providing access to staff training and investing in surgical innovations. More work remains and we will continue to enhance work that has started on central waitlist management, provincial bed management and e-referrals that will provide patients better access to specialist appointments and surgical procedures within clinically appropriate wait times.

Improved system access and flow

- Working with health service providers across the province, we launched over 100 provincial and local initiatives in the fall and winter of 2022. These enabled our system partners to implement actions that enhanced access to long-term care (LTC), complex continuing care, rehab and other community settings to ensure the right care is being provided in the right place. With patients and residents supported in the community, where they prefer to be, hospitals were increasingly able to focus on emergent and surgical care.
- In 2022, in collaboration with the MOH, we successfully transitioned the Telehealth Ontario program over to the new Health811 digital front door, which has increased the number of options Ontarians have to access health information and advice 24/7.

Provided support to frontline HHR

- As of January 2023, our Emergency Department Locum Program maintained zero unplanned emergency department (ED) closures related to physician coverage. To achieve this, the program provided approximately 50,000 hours of urgent physician coverage and averted 400 ED closures by the end of Q2, ensuring Ontarians had access to emergency services when they needed them.
- We also worked with partners to implement an ED peer-to-peer program in six early-adopter rural EDs in October 2022 and expanded to 21 additional sites in December 2022. This successful program then expanded to 27 EDs across the province. This program provides on-demand, real-time support and coaching from experienced emergency physicians 24/7 for patients of all ages and levels of need.
- Through our Supervised Practice Experience Partnership Program and in partnership with the College of Nurses, more than 800 internationally educated nurses were licensed and added to the health care system. The program is expected to exceed its target of 1,200 nurses licensed by the end of fiscal year and is critical in addressing the nursing shortages.

Continued to enhance high-quality clinical care across the province

- Despite the pandemic environment, working with delivery partners, we maintained high-functioning cancer, renal, cardiac, stroke and vascular care throughout the pandemic.
- We introduced new cardiac services funding, scaled Canada's first organized lung screening program, and streamlined access to publicly funded cancer drugs. We also expanded the joint Trillium Gift of Life Network-Ontario Renal Network Access to Kidney Transplantation and Living Donation Strategy to all 27 regional renal programs with the goals of enhancing access and improving patients' experience with kidney transplantations, with a focus on living donations.
- While we continue to focus on establishing foundational supports to enhance access to integrated mental health and addiction services over the longer term, we have more immediately enhanced enrollment in Ontario Structured Psychotherapy.
- In 2022, we recovered cancer screening rates to exceed pre-pandemic levels, and cervical screening remained above pre-pandemic levels for the full year. We also worked with partners to ensure chronic dialysis patients received the COVID-19 vaccine. Rates of vaccination amongst eligible chronic dialysis patients and Multi-Care Kidney Clinic patients are consistently well above the rates, including for the bivalent doses, in the general population.

Clinical Excellence and Health System Performance

This plan aims to improve clinical outcomes and integrated health system performance.

Ontario Health will continue to take a data-driven approach to identifying and addressing areas of improvement that matter to Ontarians and that reduce health inequities. By linking strategic priorities to key system indicators, we can measure our impact.

Key performance indicators within these domains will be used to establish targets, track system performance over time and compare our performance to other jurisdictions. The goal is to identify where Ontario is a leader or lagging, suggesting areas where we can lead nationally and internationally and where we can improve. This data-driven approach will also further our unwavering focus on reducing health inequities by highlighting areas where we have disparities in access and outcomes, which will in turn drive our ongoing prioritization process. These domains and performance indicators are informed by and include the lens of the Quintuple Aim.

OUR PERFORMANCE DOMAINS INCLUDE:

Domain	Description
1. TIMELINESS (ACCESS): • **To preventative and primary care** • **To community and long-term care** • **To surgical and emergent care** • **To integrated care**	• Improved and equitable attachment to primary care and team-based care* • Reduced wait time to home and community care services and long-term care home placement including enhanced supports for caregivers* • Reduced wait time to diagnostic, surgical and emergent care and within clinically recommended times (including for pediatrics) • Improved experience, navigation and flow across the continuum of care (through OHTs)
2. SAFETY AND EFFECTIVENESS	Improved outcomes for mental health, addiction, chronic diseases and palliative care
3. EFFICIENCY	Matching capacity with demand, across the continuum of care
4. A STRONG ONTARIO HEALTH	A diverse, engaged and healthy workforce partnering with communities, health service providers and OHTs
5. EQUITY AND PATIENT CENTREDNESS	Reducing inequities across all domains

*Requires collaboration with MOH and MLTC given ministry accountabilities, as well as Home and Community Care Support Services (HCCSS) for placement services

Spotlight: Aging Care Continuum

Ontario Health is committed to improving the care of older adults. New to our ABP this year, a provincial aging care continuum plan can guide, connect and coordinate person-centred elder care initiatives and improve the care experiences of older adults across the province no matter where they live.

Based on the census, there were more than 2.5 million people 65+ years old living in Ontario in 2021. By 2046, that number is anticipated to almost double to approximately 4.5 million.[1] The fastest-growing age segment is 85 years and older.[2]

With increasing age comes an increased risk of developing chronic diseases, risk of falls, mental health issues and/or social isolation. These often trigger dependencies in activities of daily living (e.g., eating, dressing, grooming, toileting, bathing, walking, etc.) and instrumental activities of daily living (e.g., managing finances, preparing meals, etc.).

A robust care continuum encompasses a broad array of care services intended to help older people live as comfortably and independently as possible, for as long as possible.[3] Services may be as simple as family members providing assistance to elderly relatives who are otherwise independent and aging in their own homes, or as challenging as providing 24-hour nursing care in a long-term care home or hospice.[4] Supports should include physical and mental health care, coordinated and integrated lifestyle, housing and social supports.

An older adult should be able to enter the care continuum at any time or location of care depending on their changing needs.

Initiatives that support an aging continuum are already underway at Ontario Health. In 2023/24, we will work with our ministries and delivery partners to develop a provincial aging care plan that will further connect and integrate many of these efforts and align provincial partner efforts to improve the experience of older people in Ontario.

Spotlight: Indigenous Health

Ontario Health is committed to partnering with First Nations, Inuit, Métis and urban Indigenous peoples to improve health outcomes.

Ontario Health remains committed to working collaboratively with Indigenous communities and partners to learn, grow and together improve the health outcomes for First Nations, Inuit, Métis and urban Indigenous peoples. Through continued and ongoing engagement, we are focused on working together to:

- Establish a partnership approach to engagement with Indigenous partners.
- Build and support capacity to better coordinate Indigenous health initiatives across Ontario Health, including the regions.
- Build health system capacity to address Indigenous health needs.
- Continue to work with health system partners to jointly develop, fund and implement cancer control policies and programs that improve the performance of the cancer system with and for Indigenous people in a way that honours the Indigenous Path to Well-being.
- Develop a First Nations, Inuit, Métis and Urban Indigenous Health Plan for 2024/25 in collaboration with Indigenous partners.
- Continue to support an inventory of Indigenous-related programs, services and funding opportunities across Ontario Health to share with Indigenous leadership and their health teams.
- Help to address anti-Indigenous racism across the health care system.

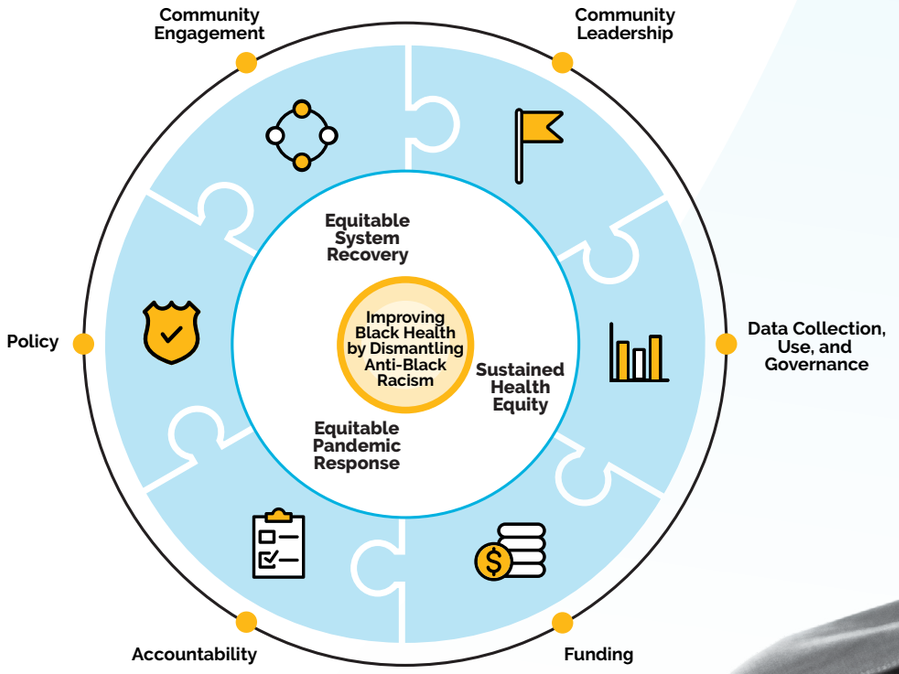
Spotlight: Black Health Plan

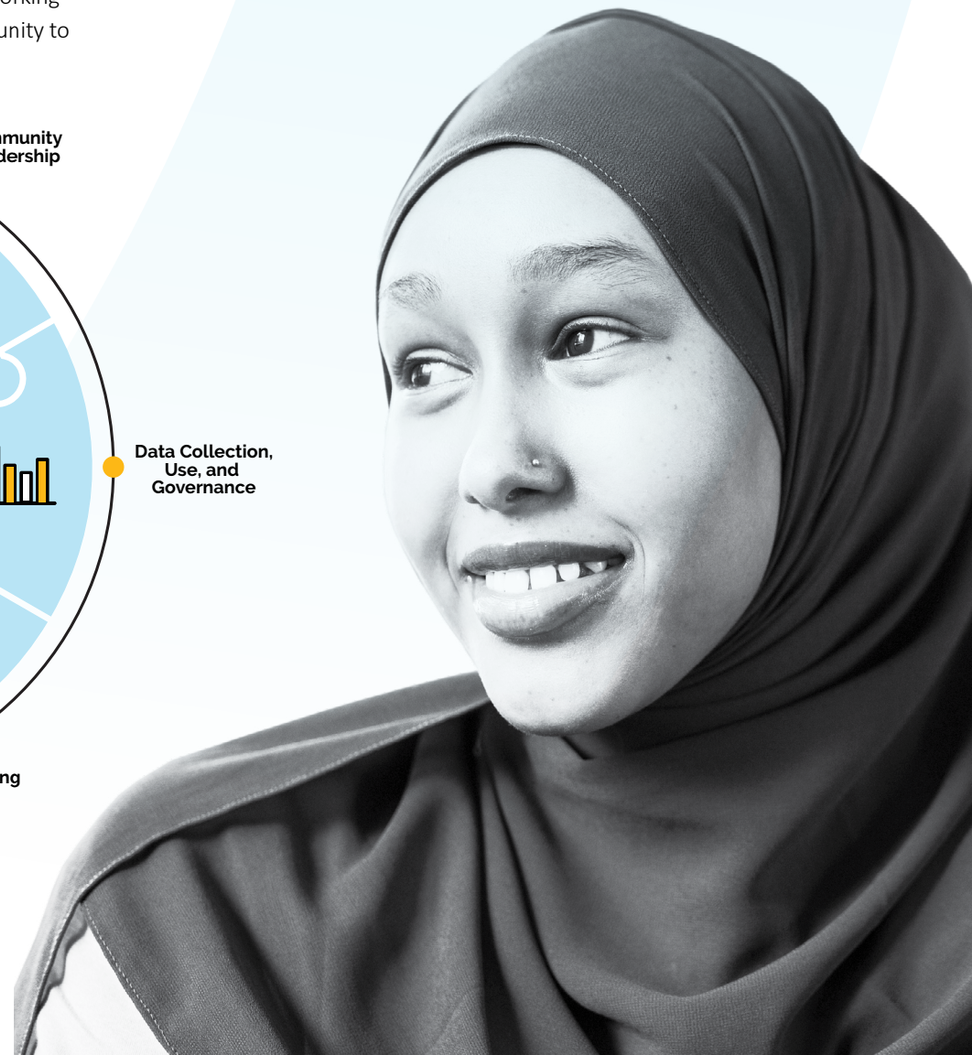
Ontario Health is committed to reducing health inequities, which includes addressing anti-Black racism, through the advancement of our Equity, Inclusion, Diversity and Anti-Racism Framework. We recognize Black communities are more at risk for the harmful effects of the social determinants of health and experience inequities in health care access and experiences.[5] In 2022, led by community and health care leaders, we partnered the Wellesley Institute and The Black Health Alliance to develop the Black Health Plan. This plan sets out a course of action focused on urgent and long-term priorities responding to the diverse needs of Black populations.

The Black Health Plan is now being implemented through partnerships with the Black Physicians Association of Ontario, the Black Health Alliance and the Black Health Plan Working Group, which consists of leaders across the province representing health providers, community-serving organizations, public health units, municipalities and other health system partners.

Black Health Plan efforts currently underway focus on improving access, experiences and outcomes for Black populations. This work includes improving quality of care through the development and implementation of quality standards, enhancing prevention through increased cancer screening, delivering culturally relevant mental health and addictions services, and promoting culturally relevant community engagement.

Through collaboration with community, the Black Health Plan Working Group catalyzes innovative solutions while providing the opportunity to spread and scale promising practices across the province.





Spotlight: French Language Services

Ontario Health is committed to continued collaboration with Francophone partners to improve access to health care services for Francophone people in each region that is consistent with the *French Language Services Act*.

Our business plan outlines a commitment to establishing a French Language Health Strategy in which four priorities were identified, aiming to reinforce our bilingual capacity and internal French language services (FLS) structure, and work in collaboration with health system partners including the French Language health planning entities and health service providers in the development and implementation of actively offering services in French. The objectives of the strategy are to improve a continuum of care providing access to high-quality French language health services and enhance experience and health outcomes for Francophones.

Stakeholder, Partner and Community Engagement

Ontario Health has made considerable progress in establishing and re-establishing meaningful relationships with health system stakeholders, including patients, families, caregivers, clinicians and others. In 2023/24, we will build on the foundational engagement structures and strategies laid out in 2022/23 to support collaboration and partnership throughout our organization.

- We will continue to build and support our patient and family engagement program, which is focused on proactively advancing equity and inclusion in our engagement activities. This includes creating multiple opportunities for health system users to contribute their experiences and insights through regional patient and family advisors' councils, the CEO's Patient and Family Advisors' Council and a patient and family advisors' network. It also means supporting community outreach and partnerships with organizations that work with equity-deserving populations. We will continue to collaborate with the Minister's Patient and Family Advisory Council to support meaningful patient engagement across health transformation initiatives.
- All clinical and regional programs will continue to engage extensively with clinical stakeholders and people with lived experience in the development and delivery of provincial clinical and virtual care programs, and in regional planning, coordination, integration and program implementation.
- We recognize the importance of First Nations, Inuit, Métis and urban Indigenous engagement and the need to develop and implement a framework that will outline a process for engagement and relationship development with Indigenous leadership, organizations, health tables and communities, with a clear focus on respecting governance structures and relevant protocols or political agreements. The framework will emphasize coordination across Ontario Health to avoid duplication and added burden on Indigenous groups. We will work closely with Indigenous leadership to support their priorities and develop joint priorities, ensure that we work with established core Indigenous health tables to seek guidance, and build health system capacity to address Indigenous needs respectfully, successfully and in a culturally safe manner. We will continue to take guidance from the Joint Ontario Indigenous Health Committee on this work.
- We will continue to collaborate with Francophone partners – notably the Minister's French Language Health Services Advisory Council, the French Language Services Office at the MOH and the French language health planning entities – to improve access to health care services for Francophone people in each region that is consistent with the *French Language Services Act*.
- We will continue to prioritize partnerships with organizations that represent underserved populations, to collaboratively implement the elements of our Equity, Inclusion, Diversity and Anti-Racism Strategy and to support work that addresses the social determinants of health across the full spectrum of health services in the community.

Our engagement will help ensure that our actions are guided by a commitment to equity and promotion of equitable health outcomes. The planning, design, delivery and evaluation of initiatives will focus on improving the health care programming and services with and for Indigenous communities as well as improving the availability of health services in French for French-speaking communities.

Implementation Plan and Strategic Map

Ontario Health's ABP provides us an opportunity to articulate our strategic priorities and key activities that will deliver on the government's ambitious mandate of integrating and improving Ontario's health care system over the next three years. Working with the MOH and MLTC, we are focused on ensuring everyone in Ontario receives the best quality health care. This includes patients, families, long-term care residents, community clients, caregivers, volunteers and diverse communities including Indigenous, Francophone, Black and equity-deserving communities and people with disabilities.

The activities in the ABP are informed by the priorities set forth in the MOH's Mandate Letter, the Strategic Priorities Letter from the MLTC, and support what we are required to do as part of our Memorandum of Understanding, Accountability Agreements, the *Connecting Care Act* and/or are key enablers. Ontario Health has also reviewed the audit findings from recent Ontario Auditor General value-for-money audits and is working with its partners to address and implement recommendations and process improvements. The priorities outline what we are doing to change how the system operates– all while focusing on what matters most to Ontarians.

Delivering this ABP will deliver transformational change over the next three years, particularly in the following strategic areas:

- Increased integration of care through the continued development of OHTs, an innovative model of health care delivery that bring groups of providers, organizations and patients together to improve care in their communities
- Integrating and modernizing home care in a timely fashion to ensure continuity of care and high-quality outcomes and experiences for clients, caregivers and service providers
- Sustained gains in reducing alternate level of care (ALC) and enhancing emergency department diversion through improved access to services and programs in the community
- Advancement of key recovery priorities by reducing the number of patients who are considered long waiters beyond the target date considered clinically optimal for surgery and diagnostic procedures
- Development of a person-centred aging care continuum that supports the delivery of health and well-being services to frail older adults, no matter where they live, including LTC
- Expanded access for all Ontarians to high-quality interprofessional primary care
- Continued investment in mental health and addictions with a focus on increasing access to services and clinical pathways by integrating mental health as part of all health

Since our Ontario Health regional teams represent the front door for our health service providers and communities, they play a strong role in managing health system operations and designing and implementing these key initiatives. Our regional teams will continue to play this important role across our health system.

Strategic Map

Reduce health inequities

1.1 Improve equitable outcomes and experiences[M], including a focus on:

- Indigenous people (First Nations, Inuit, Métis, and Urban Indigenous Health Framework)
- Black communities (Black Health Plan)
- Equity-deserving, high-priority, and communities with geographic disparities in access to care
- Older adults
- Children and youth
- Francophone population
- 2SLGBTQIA+ communities
- People living with disabilities

1.2 Improve access to supportive care in housing, including:

- Home care[M]
- Supportive housing
- Assisted living
- Long-term care[L]

1.3 Advance whole person care experiences and outcomes:

- Enhance prevention and a population health approach[M]
- Scale innovative models of service delivery
- Improve health care navigation (Health811)[M]

Health System Operational Management, Coordination, Performance Measurement and Management, and Integration – Areas of Focus for 2023/24

A. Stabilize and transform health human resources (HHR)[M][L]

Bi. Support surge responses and emergency risk management[M][L]

Bii. Support equitable recovery[M]

C. Improve capacity, access and flow (Alternate Level of Care (ALC) across sectors, community paramedicine[M], and clients waiting in crisis in the community)

Transform care with the person at the centre

2.1 Support improved access to high quality mental health and addictions care[M]

2.2 Support improved access and quality of care and life along an aging care continuum, including in LTC homes[L]

2.3 Expand access to high quality integrated care through accelerated implementation of Ontario Health Teams (OHTs)[M]

2.4 Support and expand access to integrated, comprehensive interprofessional primary health care[M]

2.5 Supporting people in the community (support the integration of home care provided by HCCSS into OHTs and points of care[M])

2.6 Digitally enable patient navigation, patient access to data and seamless patient transitions[M]

Enhance clinical care and service excellence

3.1 Advance clinical integration and chronic disease care[M]

3.2 Expand provincial genetic services[M]

3.3 Improve access and quality in cancer care[M]

3.4 Improve access and quality in renal care[M]

3.5 Increase life-saving organ and tissue donations and transplants[M]

3.6 Improve access and quality in cardiac, vascular, and stroke care[M]

3.7 Transform and improve access and quality in palliative care[M][L]

3.8 Expand Provincial Diagnostic Network[M]

3.9 Support informed clinical decision making at the point of care[M]

Maximize system value by applying evidence

4.1 Use data and analytics to enhance equitable access to care and enhance patient health experiences and outcomes

4.2 Advance high-quality and safe care through evidence and continuous quality improvement[M]

4.3 Advance value-add opportunities within the health system[M]

Strengthen Ontario Health's ability to lead

5.1 Enhance Ontario Health's organizational effectiveness through a strong, engaged, connected and accountable workforce

5.2 Strengthen system supports and accountabilities

5.3 Support the government's plans for supply chain centralization[M]

5.4 Implement our Equity, Inclusion, Diversity, Anti-Racism (EIDA-R) strategy

5.5 Drive provincial data exchange, interoperability, and data security through digital leadership

(M) = Denotes work that aligns to the mandate letter provided to Ontario Health by the Minister of Health.
(L) = Denotes work that aligns to the MLTC's strategic priorities.

Reduce Health Inequities

Ontario Health is committed to the Quintuple Aim, which includes improving health equity. To do so, we must understand and respond to the distinct needs of communities. Our ABP focuses on this in three ways: First, we begin our implementation planning by focusing our commitment to reducing health inequities; second, we identify a discrete set of focused activities that will have a measurable impact on reducing inequities; third, in all our activities, we apply a health equity lens to reduce inequities in all our areas of focus. This section highlights the discrete set of focused activities to:

- **1.1.** Improve equitable outcomes and experiences
- **1.2.** Improve access to supportive care in housing
- **1.3.** Advance whole person care experiences and outcomes

1.1. Improve equitable outcomes and experiences

Ontario Health is committed to improving health care access, experiences, and outcomes, and recognizes it is critical to meet the distinct needs of communities. Ontario Health is working to improve the health of First Nations, Inuit, Métis and urban Indigenous individuals, families and communities through equitable access to culturally safe, anti-racist health care. This involves working in partnership with communities and providers to develop the First Nations, Inuit, Métis and Urban Indigenous Health Framework (and related Health Plan). Our focused work in this priority area will also produce a French Language Health Strategy, and deliver on the Black Health Plan, the High Priority Community Strategy and other key initiatives with and for equity-deserving communities.

YEAR ONE: 2023/24

Commit to working with First Nations, Inuit, Métis and urban Indigenous communities, leaders and organizations to improve health outcomes:(M)

- **1.1.1.** Engage with Indigenous partners to develop the Ontario Health First Nations, Inuit, Métis and Urban Indigenous Health Plan 24/25, with the focus on addressing health inequities and outcomes, and supporting their health priorities and strategies.(M)
- **1.1.2.** Work with health system partners to jointly develop, fund and implement cancer control policies and programs that improve the performance of the cancer system with and for Indigenous people in a way that honors the Indigenous Path to Well-being from 2019–24, and start the development of the fifth Indigenous Cancer Strategy.(M)
- **1.1.3.** Provide direction, accountability and a standardized approach to appropriate Indigenous data use at Ontario Health, including working with Indigenous partners to launch and implement the Indigenous Data Governance Matters (IDGM) process.
- **1.1.4.** Work with Indigenous partners to enhance knowledge, build capacity and empower communities with the skills and tools needed to reduce and prevent commercial tobacco use and addiction (including vaping and cannabis use) through the Indigenous Tobacco Program.(M)
- **1.1.5.** Build relationships and continue to engage First Nations, Inuit, Métis and urban Indigenous partners in mapping Indigenous patient journeys to identify gaps and opportunities for potential enhancements to the Health811 service to improve access and navigation of health services with and for Indigenous communities.

Implement the Black Health Plan:(M)

- **1.1.6.** Collaborate with partners to operationalize year one Black Health Plan programs, including culturally specific mental health and addictions services, implementation of the Sickle Cell Disease Quality Standard, Afrocentric screening programs, wellness clinics and anti-Black racism training.(M)
- **1.1.7.** Establish performance indicators, monitor and report on impact.(M)
- **1.1.8.** Form regional Black Health Community Engagement tables to co-develop solutions for Black populations based on local context.(M)

Focus on equity-deserving communities, high-priority communities and communities with geographic disparities in access to care:(M)

- **1.1.9.** Increase access to care for those facing barriers to care, such as rural, remote and geographically isolated populations, via secure virtual care solutions.
- **1.1.10.** Identify and implement priorities focused on reducing health disparities in 2SLGBTQIA+ communities.(M)
- **1.1.11.** Continue the High Priority Community (HPC) Strategy and expand to new communities. Include a focus on increasing access to mental health and addictions programs, cancer and chronic disease screening, and primary care.(M)
- **1.1.12.** Establish meaningful partnerships between HPC lead agencies and OHTs to expand equitable access to care.(M)

Focus on Francophone populations:

- **1.1.13.** Engage and collaborate with French language health planning entities on initiatives aiming to reinforce regional service capacity in French.(M)
- **1.1.14.** Provide regional support to health service providers in the development and implementation of the principle of Active Offer of services in French.(M)
- **1.1.15.** Collaborate with the MOH to collect data related to French language services to support health system planning in French.(M)
- **1.1.16.** Finalize Ontario Health French Language Health Strategy and begin implementation.(M)

YEAR TWO: 2024/25

Commit to working with First Nations, Inuit, Métis and urban Indigenous communities, leaders and organizations to improve health outcomes:(M)

- Implement the Ontario Health First Nations, Inuit, Métis and Urban Indigenous Health Plan 24/25 in collaboration with Indigenous partners and develop the First Nations, Inuit, Métis and Urban Indigenous Health Plan 25/26.
- Complete a final report on the First Nations, Inuit, Métis and Urban Indigenous Cancer Strategy 2019-24 and launch the fifth Indigenous Cancer Strategy.
- Continue to sustain and improve the IDGM process and build health research capacity among Indigenous communities and partners:
  - Conduct annual evaluations.
  - Build data dictionary of Ontario Health databases for Indigenous communities and partners.
- Continue to advance the Indigenous Tobacco Program.
- Continue to partner with Indigenous communities to plan for the inclusion of Indigenous health service information to Health811 directory/data bases (for example, requirements for Health Line to absorb new entries) to improve accessibility of Indigenous-specific information.
- Develop an Indigenous Inclusion Plan that will inform how communities and people will inform design, development, testing, implementation and evaluation of Health811 services moving forward.

Implement the Black Health Plan:(M)

- Collaborate with engagement tables to confirm annual and future year planning.
- Develop mental health and addictions programs across the lifespan of Black populations, including infancy.
- Expand Afrocentric screening programs into other conditions and areas of cancer disproportionately affecting Black populations, including diabetes and hypertension.
- Identify additional communities to expand established programs.

Focus on equity-deserving communities, high-priority communities and communities with geographic disparities in access to care:(M)

- Continue to advance prior year's deliverables.
- Advance priority population focused work with a strategy centring on 2SLGBTQIA+ communities.
- Advance priority population focused work with a strategy centring on people with disabilities.
- Identify other populations of focus.

Focus on Francophone populations:

- Continue to advance prior year's deliverables.
- Continue to engage and collaborate with French language health planning entities.
- Implement Ontario Health French Language Health Strategy.

YEAR THREE: 2025/26

Commit to working with First Nations, Inuit, Métis and urban Indigenous communities, leaders and organizations to improve health outcomes:(M)

- Implement the Ontario Health First Nations, Inuit, Métis and Urban Indigenous Health Plan 25/26 in collaboration with Indigenous partners and develop the First Nations, Inuit, Métis and Urban Indigenous Health Plan 26/27.
- Work with health system partners to jointly develop, fund and implement cancer control policies and programs that improve the performance of the cancer system with and for Indigenous people in a way that honours the Indigenous Path to Well-being from 2024–28.
- Continue to improve, sustain and evaluate the IDGM process and build health research capacity among Indigenous communities and partners.
- Continue to advance the Indigenous Tobacco Program.
- Continue to strengthen relationships and work together with Indigenous community partners to begin to implement the Health811 Inclusion Plan.

Implement the Black Health Plan:(M)

- Continue expansion.

Focus on equity-deserving communities, high-priority communities and communities with geographic disparities in access to care:(M)

- Continue to advance prior year's deliverables.
- Advance priority population focused work in alignment with identified needs.

Focus on Francophone populations:

- Continue to advance prior year's deliverables.

Note: Additional populations, such as older adults, children and youth are captured throughout this business plan.

1.2. Improve access to supportive care in housing

Our regional teams across the province are implementing a targeted strategy to support the transition of people deemed alternate level of care (ALC) to the best level of care and in the most appropriate care settings. This means we are working with the MOH, MLTC and local partners to expand access and flow to community supports (such as assisted living services, supportive housing, adult day programs, and respite supports) and long-term care across the province and in response to local need. This will ensure that people are receiving care at the right time and place and will aim to increase support to people that are vulnerably housed.

YEAR ONE: 2023/24

- **1.2.1.** Target and prioritize capacity expansions and investments in community (assisted living services, supportive housing, adult day programs, and other services including respite) (see area of focus C).
- **1.2.2.** Develop community demand and capacity plans to inform ongoing priorities and investments across regions.

Note: This priority area connects to activities throughout this implementation plan, including but not limited to sections 1.1, area of focus C (patient flow efforts focused on community support services, home care, LTC), 2.1 (support improved access to high-quality mental health and addictions care), and 2.2 (aging care continuum), which ensures people are receiving care, at the right time and place.

YEAR TWO: 2024/25

- Continue to optimize access to community services through the OHT framework.

1.3. Advance whole person care experiences and outcomes

As part of our commitment to the Quintuple Aim, our activities include a focus on improved health system navigation and the collection and use of holistic outcome and experience measures. Whole person care is enabled through comprehensive relationship-based primary care (section 2.4), improving people's ability to navigate the health system and the implementation of a provincially coordinated strategy of patient-reported outcome and experience measurements (PROMs/PREMs). Each of these will be connected to OHT maturity (section 2.3). Our work to enhance Health811 will enable people to more easily access streamlined information, navigate through the health care system and view their health data via secure access.

YEAR ONE: 2023/24

- **1.3.1.** Enhance Health811 to include digital identity, portal access and online appointment booking with an OHT-based user experience.[M]
- **1.3.2.** Align Connex Ontario and other virtual mental health navigation services with Health811.
- **1.3.3.** Expand the patient-reported outcome measures (PROMs) and patient-reported experience measures (PREMs) strategy to OHTs.

YEAR TWO: 2024/25

- Continue to advance Health811 based on user experience and needs.
- Continue the expansion and implementation of PROMS/PREMs across OHTs and provide provincial coordination of patient reported data to elevate patient/caregiver voices.

YEAR THREE: 2025/26

- Evaluate and refine the collection and use of PROMs/PREMs across OHTs and provide health system leadership for patient reported data to advance person-centred care.
- Continue to advance prior year's deliverables.

Health System Performance Monitoring, Management, Coordination and Integration

Our strategic priorities are achieved alongside our daily objectives of health system operational management, coordination, performance measurement and management and integration. In addition to these objectives and our ongoing system supports and issues management, in 2023/24 we will continue to work with the MOH, MLTC and our delivery partners to:

A. Stabilize and transform health human resources

B. Support (i) surge responses and emergency risk management and (ii) support equitable recovery

C. Improve access and flow (Alternate Level of Care (ALC) across sectors, community paramedicine, and clients waiting in crisis in the community)

A. Stabilize and transform health human resources

Advancing the Quintuple Aim includes improving the health care provider experience. Ontario Health aims to foster a system that plans for and adaptively responds to evolving HHR needs. This would support a robust, predictable, sustainable and resilient HHR workforce that enables better person-centred experiences and outcomes. In addition to supporting the MOH's longer term HHR strategy, our actions highlighted below focus on Ontario Health's immediate program-based roles. Specifically, we aim to integrate more internationally educated health professionals into priority areas of the health care system and realize thousands or tens of thousands of days of physician locum coverage supporting crisis response, stabilization, recruitment and retention in rural and Northern communities. We will remain committed to supporting long-term improvements identified by the MOH's longer term HHR strategy.

YEAR ONE: 2023/24

- **A.1.** Collaborate with and inform the MOH and MLTC HHR strategy and the strategic areas for immediate and long-term recruitment and retention (such as within primary care modernization, long-term care, home and community care modernization and the continued evolution of OHTs).[(M)(L)]
- **A.2.** Develop a master provincial data set that measures overall HHR capacity and impact of HHR strategies.
- **A.3.** Expand capacity to deliver programs that directly support frontline delivery, such as:
  - Increasing the recruitment of internationally educated nurses through supervised practice experience partnership.
  - Recruiting to high-need communities through the community commitment program for nurses.
  - Increasing the number of personal support workers (PSWs) working in long-term care and home and community care through PSW return to service and the LTC staffing pool initiatives.[(L)]
  - Scaling the ED peer-to-peer program to additional EDs in appropriate Ontario Health regions.
- **A.4.** Establish a knowledge hub to help identify and disseminate leading practices in HHR across the province and sectors.
- **A.5.** Working with the Ontario Caregiver Organization, define and support the development and implementation of roles, training and supports for essential care partners in LTC homes.[(L)]

YEAR TWO: 2024/25

- Continue refinement and enhancements of data sets along with analytical expertise.
- Provide ongoing programmatic leadership as appropriate.
- Develop and disseminate leading practices in HHR via the knowledge hub.
- Continue to integrate and support essential care partners in LTC.

YEAR THREE: 2025/26

- Continue to advance prior year's deliverables.

B. i. Support surge responses and emergency risk management; and ii. Support equitable recovery

Through the COVID-19 pandemic response, we have established a strong foundation of provincial and regional emergency management and surge response. This foundation is now operationally embedded through our regional model of health system coordination and management and will be applied to ongoing surges and to enhance recovery, with a particular focus in 2023/24 on surgical recovery for adults and pediatrics (reducing wait times for surgery to within clinically appropriate wait times).

YEAR ONE: 2023/24

- **B.1.** Working with the MOH, MLTC, public health, and provider partners including critical care to maintain province-wide monitoring, health care system oversight, coordination, and support in surge preparedness and response.
- **B.2.** Define and scale a long-term Emergency and Risk Management Program.(M)
- **B.3.** Liaise with Infection Prevention and Control (IPAC) Hubs and work with the MOH, MLTC, and public health to define roles and responsibilities for supporting IPAC Hubs.(M)(L)
- **B.4.** Work with hospitals and community-based health facilities on an integrated response to meet demographic demands and provide timely access to surgery and diagnostic procedures; measure and report on equitable access.(M)
- **B.5.** Work with speciality pediatric centres to reduce the number of long waiters for pediatric surgeries.(M)
- **B.6.** Implement a provincial and regional central wait list management tool for surgery, beginning with the high-volume procedures and prioritization of long waiters, including pediatric patients.(M)
- **B.7.** Work with the MOH, hospitals and health care providers to ensure Ontarians continue to have optimal access to effective COVID-19 therapeutics.(M)
- **B.8.** Support ongoing COVID-19 vaccine administration through hospitals, OHTs and other providers, for health care workers, staff, inpatients, and immunocompromised outpatients.(M)
- **B.9.** In collaboration with the MOH, support work to develop and implement patient-centred and evidence-based approaches to care for patients diagnosed with COVID-19 and post COVID-19 condition.(M)

YEAR TWO: 2024/25

- Continue to adapt Emergency Management Framework based on evolving risks and threats.
- Expand central waitlist management and continue to appropriately reallocate volumes that will reduce wait times for surgery.

YEAR THREE: 2025/26

- Continuously improve emergency management.
- Continuously improve equitable access to surgery.

C. Improve capacity, access and flow (Alternate Level of Care (ALC) across sectors, community paramedicine, and clients waiting in crisis in the community)

Ontario Health provides leadership to optimize health system capacity, access and flow within and across regions in order to ensure that patients get the right care, at the right time and place. Through the OHT framework and working with the MOH, we will maximize community-based care delivery.

YEAR ONE: 2023/24

- **C.1.** Maintain and refine a targeted transition and flow strategy to support the transition of people in hospital who need an alternative level of care (ALC) to the most appropriate setting for their needs.
- **C.2.** Advance targeted strategies to ensure better access for people who need specialized supports in long-term care.
- **C.3.** Enable patient flow and capacity balancing across the health system and regions through the advancement and use of a provincial and regional bed management tool.
- **C.4.** Where needed, optimize and create new community and bed capacity in support of ALC reduction initiatives (e.g., as outlined in the MOH Plan to Stay Open).
- **C.5.** Drive local implementation of leading practices that support optimal access and flow and that are aligned with an aging care continuum.
- **C.6.** Support the MOH and the MLTC development of a provincial policy framework for community paramedicine.
- **C.7.** Inform MOH and MLTC capacity planning and investment strategies in order to optimize care in community-based settings.

YEAR TWO: 2024/25

- Continue to build on and expand the impacts of the transition and flow strategy within OHTs and, working with the MOH, optimize community-based capacity across regions.
- Further expand implementation of the provincial bed management system to support a shared understanding of capacity across the system (across all sectors).
- Advance integration opportunities for community paramedicine programs with health delivery partners.

YEAR THREE: 2025/26

- Continue to optimize health system capacity, access and flow through OHT advancement.
- Continue to advance development of community paramedicine as part of integrated mobile health teams and support optimization of community paramedicine at the community level.

Transform Care with the Person at the Centre

Our business plan focuses on advancing six major transformation initiatives of the government that will fundamentally advance health system integration and care for patients and caregivers:

2.1. Support improved access to high-quality mental health and addictions care

2.2. Support improved access and quality of care and life along an aging care continuum, including in LTC homes

2.3. Expand access to high-quality, integrated care through accelerated implementation of OHTs

2.4. Support and expand access to integrated, comprehensive, interprofessional primary health care

2.5. Support people in the community (support the integration of home care provided by HCCSS into OHTs and points of care)

2.6. Digitally enable patient navigation, patient access to data and seamless patient transitions

2.1. Support improved access to high-quality mental health and addictions care

The Mental Health and Addictions (MHA) Centre of Excellence aims to enhance the access to and quality of mental health and addictions services and supports for people living in Ontario. Our dedication rests on building a comprehensive and connected mental health and addictions system, creating system management processes, supporting quality improvement initiatives, disseminating robust evidence and establishing achievable service expectations. While forging trusting relationships with varied stakeholders and people with lived experience, we strive to improve mental health and addictions services and supports so they are delivered consistently across the province, are of high quality, integrated within the broader health care system (as part of all health), accessed faster and more easily than they are today and responsive to the needs of the people we serve.

YEAR ONE: 2023/24

Improve access to and quality of equitable care for people experiencing depression and anxiety-related disorders, schizophrenia, psychosis, eating disorders and substance use disorders:(M)

- **2.1.1.** Expand the Ontario Structured Psychotherapy (OSP) program and align program quality and performance expectations and funding.(M)
- **2.1.2.** Develop new in-person and virtual provincial programs for people with depression and anxiety-related disorders across the full spectrum of care.(M)
- **2.1.3.** Develop new in-person and virtual provincial programs for people experiencing schizophrenia, psychosis, eating disorders and substance use disorders.(M)

Improve system strategy and operations with a foundational principle of equity:

- **2.1.4.** Improve access to mental health and addictions services through:
  - Planning and implementation of mental health and addictions provincial coordinated access to ensure seamless, easy-to-navigate, and equitable access to the right mental health and addictions care at the right time.(M)
  - Implementation and evaluation of mobile mental health and addictions clinics.
  - Supporting implementation and accountability of Roadmap to Wellness investments.
- **2.1.5.** Implement the Indigenous mental health and addictions engagement plan and begin program planning for clinical priorities identified with Indigenous partners.
- **2.1.6.** Implement and evaluate a provincial mental health and addictions oversight model that will advise on the development of provincial mental health and addictions program and drive transparency and accountability.
- **2.1.7.** Expand the provincial mental health and addictions data and digital initiative (DDI) to collect data from community and hospital outpatient mental health and addictions providers.(M)
- **2.1.8.** Develop and utilize a provincial performance measurement framework for mental health and addictions and develop processes and tools to enable data-informed planning, monitoring and funding, including an inventory of funded mental health and addictions resources in Ontario.

YEAR TWO: 2024/25

Improve access to and quality of equitable care for people experiencing depression and anxiety-related disorders, schizophrenia, psychosis, eating disorders and substance use disorders:[M]

- Increase access to the OSP program and monitor quality and performance expectations and outcomes.
- Begin phased implementation of new in-person and virtual provincial programs for people with depression and anxiety-related disorders across the full continuum of care, including screening through primary care and OHTs and neurostimulation procedures.
- Begin phased implementation of new in-person and virtual provincial programs for people experiencing schizophrenia, psychosis, eating disorders and substance use disorders.

Improve system strategy and operations with a foundational principle of equity:

- Advance the multi-year implementation of mental health and addictions provincial coordinated access.
- Improve access to and quality of mobile mental health and addictions clinics and make recommendations on the future model.
- Develop and implement programs for Indigenous clinical priorities through ongoing engagement with Indigenous partners.
- Refine and improve the provincial mental health and addictions oversight model.
- Further expand the provincial mental health and addictions DDI by collecting data from remaining health service providers and developing provider- and system-level analytics and reporting for planning and monitoring.
- Building off the Roadmap to Wellness, develop a four-year system plan for mental health and addictions, incorporating a foundational principle of equity.
- Refine the performance measurement framework and implement processes and tools for planning, monitoring and funding, including the launch of the MHA Provincial Asset Inventory.

YEAR THREE: 2025/26

Improve access to and quality of equitable care for people experiencing depression and anxiety-related disorders, schizophrenia, psychosis, eating disorders and substance use disorders:[M]

- Further increase access to and improve quality of the OSP program.
- Advance ongoing implementation and begin evaluation of in-person and virtual provincial programs for people experiencing depression and anxiety-related disorders, schizophrenia, psychosis, eating disorders and substance use disorders.

Improve system strategy and operations with a foundational principle of equity:

- Advance and evaluate the multi-year implementation of provincial coordinated access to mental health and addictions services.
- Advance implementation of programs for Indigenous clinical priorities through ongoing engagement with Indigenous partners.
- Advance the provincial DDI and improve provider- and system-level analytics and reporting.
- Launch the four-year system plan for mental health and addictions, in alignment with the Roadmap to Wellness.
- Evaluate and improve processes and tools for data-informed planning, monitoring and funding.

2.2. Support improved access and quality of care and life along an aging care continuum, including in LTC homes

Ontario's older adult population is growing rapidly. Ontario Health is committed to working in collaboration with the government and provincial partners to help build a person-centred aging care continuum that supports the delivery of health and well-being services to frail older adults, no matter where they live.

Care provided in a LTC home is one pillar of an aging care continuum. Approximately 100,000 Ontarians live in LTC homes each year; there are steps we need to take to improve their experiences and quality of life. Ontario Health, in collaboration with the MLTC and provincial partners, will continue to work to ensure timely, equitable access to LTC for those who need this level of care, spread innovative care delivery initiatives, and better integrate LTC in the care continuum. Through these actions, we aim to increase access and reduce wait times for various levels of support along an aging care continuum (home care, supportive housing, LTC) while reducing the volume of avoidable ED visits from LTC home residents as well as hospital visits for ambulatory sensitive conditions.

YEAR ONE: 2023/24

- **2.2.1.** In collaboration with MLTC, MOH, Ministry of Seniors and Accessibility (MSAA), and system partners, outline an aging care continuum plan to support improved health outcomes, experience, value, staff well-being, and equity in aging care (aligned with 1.2).
- **2.2.2.** Support the implementation of service models that improve living conditions for older adults, enabling them to age at home including through partnerships with OHTs, home and community services and housing providers, Behavioural Supports Ontario, community paramedicine and hospital service providers (aligned with 1.2 and C).[L]

Work with the MLTC to implement further LTC quality initiatives, including:

- **2.2.3.** Championing innovation and excellence in long-term care and supporting implementation of the MLTC Quality Framework and performance measures for LTC.[L]
- **2.2.4.** The development and implementation provincial standardized resident and family/caregiver experience surveys.[L]
- **2.2.5.** Expanding access to appropriate diagnostic services for LTC residents.[L]
- **2.2.6.** Ensuring that long-term care homes are key partners engaged in the transformation of the health system, including the development and implementation of OHTs.[L]
- **2.2.7.** Supporting the development and implementation of long-term care homes' emergency plans[L]

- **2.2.8.** The collection and analysis of data that advances a health equity approach.[L]
- **2.2.9.** Supporting the MLTC with development, redevelopment and LTC home licensing.[L]

YEAR TWO: 2024/25

- Implement priorities related to an aging continuum of care plan.
- Continue the spread and scale of diagnostic services for LTC home residents.
- Support integration between LTC homes and OHTs as appropriate.

YEAR THREE: 2025/26

- Continue to support priorities related to an aging continuum of care plan.
- Support the integration as necessary between LTC homes and OHTs.

2.3. Expand access to high-quality, integrated care through accelerated implementation of Ontario Health Teams (OHTs)

OHTs are integrated delivery systems that bring groups of providers, organizations and patients and caregivers together to improve care in their communities. In 2022, OHTs received refreshed policy direction from the MOH that will strengthen their ability to transform patient care and to establish the governance, membership and operational capacity necessary to advance to the next stage of maturity. Ontario Health will provide guidance and implementation supports to assist OHTs. Within the span of this business plan, OHTs will have developed: networks of primary care providers that strengthen local connections to advance improved access to primary care; implemented integrated clinical pathways; supported home care and care coordination modernization; and enhanced patient experience through navigation improvements aligned to the provincial Health811. By implementing clinical care pathways for congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), stroke, and lower limb preservation, we will improve patient and caregiver experience, reduce avoidable hospital admissions/ complications and reduce amputations.

YEAR ONE: 2023/24

OHT strategy:

- **2.3.1.** Align OHT supports to refreshed priorities.[M]
- **2.3.2.** Support the integration of primary care in OHTs, which includes providing guidance for the implementation of local networks of primary care and the involvement of primary care leadership in OHT decision-making.[M]
- **2.3.3.** Support implementation of OHT governance, decision-making, operational support providers and communications requirements.[M]
- **2.3.4.** Working with the MOH, complete a community services review and provide recommendations on optimal ways for community agencies to participate as part of OHTs (beginning with community support services and community mental health and addictions services)[M]

OHT virtual care, digital and analytics supports

- **2.3.5.** Develop, design and standardize integrated virtual care models, aligned with clinical best practice and quality standards, including (but not limited to) remote monitoring, surgical transitions, primary care and urgent care.[M]
- **2.3.6.** Further enhance and roll out the current OHT Data Dashboard to support data sharing, information management and population health planning by OHTs.[M]
- **2.3.7.** Provide OHTs with guidance and support to promote standardized approaches to integrated shared care, population health management and OHT digital priorities.[M]
- **2.3.8.** Implement approved approach(es) to enable OHTs to identify and manage their attributed populations, monitor and report performance.[M]
- **2.3.9.** Provide OHTs with guidance and support to promote data sharing, analytics and information management across OHT health service provider member organizations and between OHTs.[M]

Engagement and supports:

- **2.3.10.** Evaluate the OHT Engagement Framework, refine according to evaluation findings and re-launch.[M]
- **2.3.11.** In collaboration with the MOH and external support partners as appropriate, implement recommendations for revisions to OHT supports that are aligned to the current and future needs of OHTs.[M]
- **2.3.12.** Develop a provincial approach to social determinants of health, providing clear actionable support for OHTs to integrate care that will address the non-medical factors that influence health outcomes.[M]

Performance measurement and reporting:

- **2.3.13.** Finalize and implement the OHT Performance Framework including patient-reported measures.[M]
- **2.3.14.** Support the evolution and implementation of OHT collaborative quality improvement plans (CQIPs).[M]
- **2.3.15**. Identify options for sustainable accountability instruments for OHTs.[M]

YEAR TWO: 2024/25

OHT strategy:

- Explore new sustainable OHT accountability and funding agreements and increase the proportion of home care, community support services, and community mental health and addictions funding that is flowed through the OHT model.
- Support the integration of local networks of primary care in OHTs, in collaboration with the MOH.
- Finalize implementation of OHT governance and decision-making guidance.
- Continue to support applications for OHT designation.

OHT virtual care, digital and analytics supports

- Continue to develop and deliver digital and virtual care standards, programs and services to build OHT digital and virtual maturity.
- Continue to increase access to virtual care models via Health811.

Performance measurement and reporting:

- Continue implementation of the OHT Performance Framework

- Align (and integrate, if appropriate) existing OHT performance measurement programs (for example, OHT Performance Framework, CQIPs, clinical pathway key performance indicators, etc.)

YEAR THREE: 2025/26

OHT strategy:

- Continue oversight of potential new OHT accountability and funding agreement and increase the proportion of overall funding that is flowed through the OHT model.

OHT virtual care, digital and analytics supports

- Continue to advance prior year's deliverables.

Performance measurement and reporting:

- Continue to align (and integrate, if appropriate) existing OHT performance measurement programs.

2.4. Support and expand access to integrated, comprehensive, interprofessional primary health care

Primary care is foundational to a high functioning health system. Working with the MOH, Ontario Health has an opportunity to support and expand access to high-quality interprofessional primary care. High-quality primary care is grounded in seven principles[6] – care that is: accessible, patient centred, coordinated and integrated, continuous, comprehensive and equitable, high value and team based. Within the span of this business plan, we aim to have established local networks of primary care that are connected to all OHTs throughout the province and are relied on for coordinated primary care attachment, planning, delivery, and enhanced and equitable access to team-based care.

YEAR ONE: 2023/24

- **2.4.1.** Finalize and begin implementation of a primary care strategy with priority focus areas including improving primary care capacity, access and the development of local networks of primary care connected to OHTs (see 2.3.1).
- **2.4.2.** Prepare and plan for the transfer of contract management for team-based primary care assets to Ontario Health.
- **2.4.3.** Assess and advise the MOH on provincial opportunities for expansion of team-based care based on population needs.
- **2.4.4.** Align and coordinate primary care indicators and reporting across Ontario Health; implement an integrated Ontario Health primary care audit and feedback practice report aligned to clinical priorities.
- **2.4.5.** Improve, release and promote uptake of guidance for clinically appropriate use of virtual care.
- **2.4.6.** Continue supporting the MOH in its renewed relationship with the Ontario Medical Association by ensuring Ontario Health's actions comply with the MOH's obligations under the Ontario Medical Association Representation Rights and Joint Negotiations and Dispute Resolution Agreement.(M)

YEAR TWO: 2024/25

- Continue implementation of the primary care strategy.
- Develop a provincial performance and quality measurement approach for team-based primary care models (CHCs, FHTs, NPLCs) in collaboration with the MOH.
- Continue to support streamlined meaningful primary care indicators and support the continued adoption and refinement of the new integrated primary care report.
- Evaluate guidance for clinically appropriate use of virtual care and continue to develop, release and promote use of guidance and tools.

YEAR THREE: 2025/26

- Continue implementation of the primary care strategy.
- Implement performance and quality management of team-based primary care.
- Incorporate electronic medical record (EMR) data into the integrated primary care report with bi-directional data flow.
- Continue to develop, release and promote use of Guidance for Clinically Appropriate Use of Virtual Care.

2.5. Supporting people in the community (support integration of home care provided by HCCSS into OHTs and points of care)

To better support people in the community and realize the MOH's vision for a modernized and integrated home and community care sector, Ontario Health will execute in three key areas: supporting the integration of home and community care provided by Home and Community Care Support Services (HCCSSs) with the rest of the health system, enabling innovation through OHTs, and advising on enhanced MOH investments. Actions will better connect home and community care with other elements of the health care system (integration), implement new models of care coordination, delivery and contracting (innovation), and deploy new resources to improve equity, quality and access to home and community care services across all communities (investment). Within the span of this business plan, we aim to have improved home and community care integration in a way that will improve client experience by reducing time to first service, reducing admissions to ED, improving access to post-acute home and community care services, improving workforce experience and reducing caregiver distress. Pending MOH approval, this plan will also ensure all OHTs have home care modernization plans in place and being implemented.

YEAR ONE: 2023/24

- **2.5.1.** Inform MOH investments in home and community care to enhance access, timeliness, equity and improved workforce and caregiver experience.(M)

- **2.5.2.** Following MOH approval, support OHT implementation of home and community care leading projects and the development of OHT-led transformation plans for home care.(M)
- **2.5.3.** In collaboration with MOH, MLTC, HCCSSs and OHTs, plan for and implement approved transitions of resources, functions and responsibilities for home and community care service provision including the management of contracted service providers, referrals and placements.(M)
- **2.5.4.** Support home and community care transition to OHTs / other health service providers.(M)
- **2.5.5.** Work with MOH and HCCSS to develop the provider selection and contracting model that will support high-quality and modern home care service delivery that will support improved workforce experiences, better access to service, and quality performance.(M)
- **2.5.6.** Enhance the Client Health and Related Information System (CHRIS), the electronic point of care system for home care, to support home care modernization within the OHT landscape.(M)

YEAR TWO: 2024/25

- Subject to ministry direction, modernize home care contracts to enable innovation, integration in OHTs, better experience for home care workers and caregivers, and outcome-based performance.
- Support continued development and implementation of OHT-led home care transformation plans.
- Continue to inform MOH investments in home and community care.

YEAR THREE: 2025/26

- Support the transfer to new and modernized home care contracts.
- Ensure all OHTs have begun implementation of OHT-led home care transformation plans, enabled by new contracts.

2.6. Digitally enable patient navigation, patient access to data and seamless patient transitions

Enabling patients to be informed and active participants in their own care is critical to positive outcomes and a positive patient experience. Patients need to be able to easily understand the services available to them and navigate the health care system. They also need to be able to access, see and understand their own health care data. Finally, when multiple provides are involved in care, providers need to have all the necessary information to serve the individual without the patient needing to repeat tests or retell their story.

YEAR ONE: 2023/24

Digitally enable patient navigation and patient access to data:(M)

- **2.6.1.** Integrate patient digital identity with priority health care initiatives such as Health811 and virtual visits (aligned to 1.3).
- **2.6.2.** Enable patient access to view clinical records in the provincial electronic health record (EHR).
- **2.6.3.** Enable patients to authenticate to Health811 via secure sign-on, which will facilitate a personalized experienced through the digital front door to the health care system.(M)

Digitally enable seamless patient transitions and provider to provider communication:

- **2.6.4.** Build, modernize and spread adoption of electronic referral tools enabling seamless transitions for patients between providers and equitable access to referral pathways to all providers.
- **2.6.5**. Operationalize the provincial provider-to-provider secure messaging service which would allow any provider enabled with ONEID access to send secure messages.
- **2.6.6.** Enhance the provincial eConsult service according to user feedback; build additional functionality to enable a more streamlined user experience.
- **2.6.7.** Enable eOrdering in primary care and LTC homes through Ontario Laboratories Information Systems (OLIS), Mobile Order Results Entry (MORE) and direct integration; facilitate lab-to-lab referrals and redirects for Public Health Ontario laboratories using existing functionality in OLIS.
- **2.6.8.** Advance implementation of the surgical centralized waitlist management program, with the objectives of growing visibility to real-time demand and system capacity to support enhanced load-balancing of surgical cases. (aligned with B)

YEAR TWO: 2024/25

Digitally enable patient navigation and patient access to data:(M)

- Continue to enable more patients to access a greater amount of their health care data and better support patients' ability to navigate the health care system and its services.

Digitally enable seamless patient transitions and provider to provider communication:

- Continue to automate workflows that eliminate paper and fax-based processes between providers.
- Continue to advance implementation of the centralized waitlist management program.

YEAR THREE: 2025/26

Digitally enable patient navigation and patient access to data:(M)

- Continue to enable more patients to access a greater amount of their health care data and better support patients' ability to navigate the health care system and its services.

Digitally enable seamless patient transitions and provider to provider communication:

- Continue to automate workflows that eliminate paper and fax-based processes.

Enhance Clinical Care and Service Excellence

As we accelerate major transformations, Ontario Health will continue to pursue the delivery of best-in-class care through the experience and well-established success of our clinical programs. This means advancing new strategies while further improving access, quality and innovation within our traditional clinical leadership areas. An important focus within this aspect of our business plan will be the development of approaches to integrating care that improve outcomes and experiences and address people's physical, psychological, social, cultural, emotional and spiritual needs (consistent with 1.3).
Areas of focus include:

- **3.1.** Advance clinical integration and chronic disease care
- **3.2.** Expand provincial genetic services
- **3.3.** Improve access and quality in cancer care
- **3.4.** Improve access and quality in renal care
- **3.5.** Increase life-saving organ and tissue donations and transplants
- **3.6.** Improve access and quality in cardiac, vascular and stroke care
- **3.7.** Transform and improve access and quality in palliative care
- **3.8.** Expand the Provincial Diagnostic Network
- **3.9.** Support informed clinical decision-making at the point of care

3.1. Advance clinical integration and chronic disease care

Clinical integration is foundational for value-based care, particularly for patients living with chronic diseases. Ontario Health will focus efforts where we can have the greatest impact on chronic disease. This work will include a specific focus on diabetes, but also on other common and overlapping clinical conditions, such as hyperlipidemia (high cholesterol) and hypertension (high blood pressure). In addition to quality treatment and disease management, our work will include a focus on prevention, including ensuring equitable access to high-quality best practice early screening and risk factor management where there is a demonstrable patient impact (aligned to 1.3).

YEAR ONE: 2023/24

- **3.1.1.** Establish a governance and clinical model to oversee a chronic disease prevention and management strategy, starting with diabetes.(M)
- **3.1.2.** Complete and provide an analysis to the MOH that identifies improvement opportunities in diabetes care, including understanding high value services, efficacy and outcomes; quantify improvements.(M)
- **3.1.3.** Support OHT implementation of care pathways for lower limb preservation and the development of a diabetes action plan (see section 4.3 for more details on stroke, COPD, CHF, and lower limb preservation integrated pathway approach).(M)

YEAR TWO: 2024/25

- Implement governance and clinical model to oversee a chronic disease prevention and management strategy.
- Identify and implement improvements arising from prior year analysis and care pathway implementation.

YEAR THREE: 2025/26

- Evaluate impact of adoption of diabetes action plan recommendations.

3.2. Expand provincial genetic services

The provincial genetics program is building a comprehensive and connected system for clinical genetic services in Ontario. This will provide access to timely, high-quality genetic services for the best possible health outcomes and ensure health care providers have the tools and resources they need to provide effective and coordinated genetic services across the health system. This work will also position Ontario as a leader in bringing new genetic technologies into clinical practice to benefit patients and families and improve the health care system.

YEAR ONE: 2023/24

- **3.2.1.** Continue implementation of the provincial genetics program to expand access for delivering and managing comprehensive,

coordinated, evidence-based genetic services for additional domains of care; convene experts to identify additional domains of care.[M]
- **3.2.2.** Establish the design of an integrated digital strategy that will support system planning, monitoring and performance management of genetic services, including genetic testing.[M]

YEAR TWO: 2024/25

- Operationalize the provincial genetics program to continue to improve the delivery and management of comprehensive, coordinated, evidence-based genetic services for additional domains of care.
- Develop an integrated digital strategy that will support system planning, monitoring and performance management of genetic services, including genetic testing.

YEAR THREE: 2025/26

- Continue to operate the provincial genetics program to improve the delivery and management of comprehensive, coordinated, evidence-based genetic services for additional domains of care.
- Initiate the implementation of an integrated digital strategy that will support system planning, monitoring and performance management of genetic services, including genetic testing.

3.3. Improve access and quality in cancer care

Collaborating with regional cancer programs and other health system partners, Ontario Health will continue to work to reduce Ontarians' risk of developing cancer and improve outcomes for those affected by cancer. This includes working to decrease cancer incidence, as well as cancer mortality and morbidity by implementing and overseeing evidence-based programs in prevention and cancer screening. We will continue to improve the experience and outcomes of cancer patients and caregivers across the cancer continuum from diagnosis through to long-term follow up and end-of-life care. This includes increasing timely, person-centred and equitable access to innovative, safe and effective care.

YEAR ONE: 2023/24

Improve access and quality in cancer care: [M]

- **3.3.1.** Extend the Ontario Cancer Plan 5 (OCP5) to implement prioritized initiatives for year five and initiatives in response to the pandemic.[M]
- **3.3.2.** Complete planning for Ontario Cancer Plan 6 (OCP6).[M]
- **3.3.3.** Enable an integrated, proactive and equity informed symptom assessment and management model.[M]
- **3.3.4.** Continue to improve, operate and modernize digital systems supporting cancer screening, prevention, treatment and service planning and delivery.
- **3.3.5.** Plan for expansion of critical resources (infrastructure and health human resources) – including a radiation facility in the west and expansion of positron emission tomography (PET) and complex malignant hematology – to promote improved and equitable access to the standard of care.
- **3.3.6.** Improve and expand access to specialized imaging and related procedures.
- **3.3.7.** Improve the time to list for new cancer drugs funded by Ontario Health (e.g., the New Drug Funding Program).[M]
- **3.3.8.** Collaborate with the MOH to explore options to provide Ontario patients with improved access to publicly funded take-home cancer drugs.[M]

Screening and diagnosis:

- **3.3.9.** Support 29 Sioux Lookout and area communities through fecal immunochemical test (FIT) kits initiative and improve access and equity to colorectal cancer screening in other communities.
- **3.3.10.** Expand access to the Ontario Lung Screening Program through new and existing screening sites.
- **3.3.11.** Continue the multi-year implementation of human papillomavirus (HPV) testing in the Ontario Cervical Screening Program to improve cervical screening and colposcopy in Ontario.

YEAR TWO: 2024/25

Improve access and quality in cancer care: [M]

- Launch OCP6.
- Launch a digital option for cancer screening participant correspondence.

Screening and diagnosis:

- Continue to support the FIT kit initiative in the Sioux Lookout and area communities and expand access.
- Expand access to the Ontario Lung Screening Program.
- Make HPV testing available in the Ontario Cervical Screening Program to improve cervical screening and colposcopy.

YEAR THREE: 2025/26

Improve access and quality in cancer care: [M]

- Expand digital correspondence options for cancer screening participant correspondence.

Screening and diagnosis:

- Continue to advance prior year's deliverables.
- Plan for high-risk ColonCancerCheck initiative (Lynch syndrome) to reduce colorectal cancer incidence and mortality among high-risk individuals through early detection.
- Plan for HPV testing self-sampling pilot in the Ontario Cervical Screening Program to identify ways to improve equity and access to cervical screening.

3.4. Improve access and quality in renal care

More than 12,000 Ontarians with advanced chronic kidney disease require dialysis and an additional 10,000 people in Ontario have advanced chronic kidney disease. Living with this disease can present tremendous challenges

to patients and their caregivers. Ontario Health is the government's advisor on chronic kidney disease and the renal system, and funds, coordinates and provides clinical guidance on the delivery of services to patients with advanced chronic kidney disease. Through collaborative efforts, we are committed to advancing a high-quality and person-centred system of care for Ontarians with chronic kidney disease.

YEAR ONE: 2023/24

- **3.4.1.** Implement the final year of Ontario Renal Plan 3, focusing on quality improvement initiatives, health equity and critical capacity infrastructure to drive excellence in renal care.(M)
- **3.4.2.** Develop Ontario Renal Plan 4 to establish future priorities for the renal system including opportunities to reduce disparities.(M)
- **3.4.3.** Advance a more person-centred and integrated kidney transplant system to increase equitable access to kidney transplantation, with a focus on increasing the number of living kidney donor transplants.(M)

YEAR TWO: 2024/25

- Launch Ontario Renal Plan 4, focusing on quality improvement initiatives, health equity and critical capacity infrastructure to drive excellence in renal care.
- Realize a more person-centred and integrated kidney transplant system to increase equitable access to kidney transplantation, with a focus on increasing the number of living kidney donor transplants.

YEAR THREE: 2025/26

- Continue to implement Ontario Renal Plan 4.
- Continuously improve the kidney transplant system to increase equitable access to kidney transplantation, with a focus on increasing the number of living kidney donor transplants.

3.5. Increase lifesaving organ and tissue donations and transplant

Ontario Health is responsible for delivering and coordinating organ and tissue donation and transplantation services across the province. Currently in Ontario, there are about 1,400 people waiting for an organ transplant. Ontario Health helps save and enhance lives by maximizing organ and tissue donations in partnership with our stakeholders. Our public education and awareness initiatives support efforts to increase donor registration rates by encouraging Ontarians to register their consent for donation.

YEAR ONE: 2023/24

- **3.5.1.** Identify and resolve barriers to equitable transplant services by:(M)
  - Achieving an organ yield of 3.22 and 365 deceased organ donors.
  - Achieving 2,100 ocular donors and 300 multi-tissue donors.
  - Increasing donor registrations by 170,000.
- **3.5.2.** Advance new and leading practices for expanded organ and tissue donation:(M)
  - Implement and evaluate organ specific technologies to preserve and/or improve organ function immediately before recovery and prior to transplant (ex-vivo and Abdominal Normothermic Regional Perfusion technologies).
  - Expand non-perfused organ donation (NPOD) and donation following medical assistance in dying (MAID); NPOD is a protocol that allows for lungs to be preserved for a longer period.
  - Implement new tissue and ocular recovery staffing models.
  - Partner with Canada Revenue Agency and Service Ontario to increase donor registration opportunities.
- **3.5.3.** Operationalize perioperative funding for the new kidney transplant funding model and establish the foundation for the full continuum of care.
- **3.5.4.** Secure clinical information systems that underpin the donation and transplant systems:
  - Integrate the Organ Allocation and Transplant System (OATS) with transplant hospitals; advance procurement of donation management system.

YEAR TWO: 2024/25

- Continue to advance through engagement and achieve:
  - An organ yield of 3.24 and 385 deceased organ donors.
  - 2,400 ocular donors and 360 multi-tissue donors.
  - Additional 200,000 donor registrations.
- Advance new and leading practices for expanded organ and tissue donation:
  - Expand ex-vivo organ technologies and abdominal normothermic regional perfusion.
  - Expand NPOD and donation following MAID.
  - Implement new tissue and ocular recovery staffing models.
  - Partner with Service Ontario to increase donor registration opportunities.
  - Operationalize pre- and post-transplant funding for the new kidney transplant funding model and initiate work to scale the new funding model to other organ transplants including living donation.
  - Optimize OATS and donation management system to support modernization of provincial donation and transplant activities.

YEAR THREE: 2025/26

- Continue to advance through engagement and achieve:
  - An organ yield of 3.24 and 385 deceased organ donors.
  - 2,400 ocular donors and 360 multi-tissue donors.
  - Additional 200,000 donor registrations.
  - Continue advancement of new and leading practices for expanded organ and tissue donation.
  - Evaluate and iteratively improve the new kidney transplant funding model; continue to scale the funding model to other organ transplants including living donation.
  - Optimize OATS and donation management system to support modernization of provincial donation and transplant activities.

3.6. Improve access and quality in cardiac, vascular and stroke care

Ontario Health aims to advance cardiac, stroke and vascular care for all Ontarians by increasing equitable access to high-quality, appropriate treatment options. Ontario Health seeks to increase the number of patients with atrial fibrillation (AF) who receive timely access to a de novo catheter AF ablation, patients with ischemic stroke who receive endovascular therapy, admitted patients with acute stroke who receive stroke unit care, and the total number of patients accessing appropriate community stroke rehabilitation. A simultaneous goal is a decrease in the number of congestive heart failure quality-based procedure (CHF QBP) hospital admissions and percent of non-traumatic major amputations per 100,000 adults.

YEAR ONE: 2023/24

Cardiac:

- **3.6.1.** Improve early identification and management of heart failure through OHT implementation of integrated clinical pathways.
- **3.6.2.** Drive equitable access to AF catheter ablation by increasing volumes for areas of the province with low acceptance rates; disseminate patient eligibility guidelines and facility quality criteria; establish a community of practice; and implement a measurement and reporting framework to track AF catheter ablation procedures.

Vascular:

- **3.6.3.** Scale lower-limb preservation programs to reduce non-traumatic major lower-limb amputations via demonstration programs implemented by vascular centres and OHTs.
- **3.6.4.** Develop a provincial population-based abdominal aortic aneurysm (AAA) screening program to detect AAA early in the at-risk population and reduce avoidable AAA ruptures.

Stroke:[(M)]

- **3.6.5.** Implement collaborative system strategies to improve access and timeliness of hyperacute stroke treatments (tissue-type plasminogen activator, tenecteplase and endovascular therapy) with a focus on appropriate patient selection and quality improvement in established protocols.
- **3.6.6.** Implement supports for adoption and monitoring health service providers' alignment to the new provincial stroke unit definitions and requirements document; ensure initiation of the recommendations to address capacity and ongoing access to quality stroke unit care.
- **3.6.7.** Develop strategies to reduce variation in services and promote standardized programming of community stroke rehabilitation (CSR) to align with the CSR model of care; implement first phase of data strategy recommendations; support implementation with additional funding to stroke service providers.

YEAR TWO: 2024/25

Cardiac:

- Scale heart failure care model implementation through more OHTs and make recommendations to update CHF QBP funding policy to improve quality of care and reduce heart failure emergency department visits and hospitalizations.

Vascular:

- Scale lower-limb preservation programs through more OHTs.
- Implement a provincial AAA screening program for early detection and decrease avoidable AAA ruptures.

Stroke:[(M)]

- Continue to advance prior year's deliverables.

3.7. Transform and improve access and quality in palliative care

Improved access to an efficient, effective, timely and equitable approach to palliative care will result in more Ontarians who are living with a serious illness being able to experience an improved quality of life, better manage their pain and other symptoms and receive high-quality care aligned with their wishes and goals as close to home as possible.

YEAR ONE: 2023/24

- **3.7.1.** Finalize palliative models of care recommendations for pediatric populations in all settings and for adults in hospital settings.[(M)]
- **3.7.2.** Support OHTs and other health service providers with implementation of the palliative models of care for adults within community and LTC homes; align improvements to home care modernization.[(M)(L)]
- **3.7.3.** Engage and support Indigenous communities and organizations to self-determine an approach for implementing a palliative model of care for adults in the community that is culturally appropriate and provides culturally safe care.

YEAR TWO: 2024/25

- Develop plans for implementing palliative models of care recommendations for pediatric populations in all settings and for adults in hospital settings, including a system readiness assessment.
- Continue to advance prior year's deliverables.

YEAR THREE: 2025/26

- Initiate implementation plan for the palliative models of care for pediatric populations in all settings and for adults in hospital.
- Collaborate on the spread, scale and sustainability of palliative model of care implementation for adults in the community and with Indigenous communities and organizations.

3.8. Expand Provincial Diagnostic Network

With a proven model for operationalizing and implementing laboratory testing services and programs for Ontario, the Provincial Diagnostic Network is expanding to optimize delivery of a broader scope of lab medicine services across the province. The goal is to provide all Ontarians with high-quality laboratory medicine services when and where they need them. An established governance framework, informed by advisory committees and expert panels, is in place to ensure evidence-based planning. It defines the roles, responsibilities and funding framework that was determined in strategic alignment with the MOH, Public Health Ontario and laboratory partners.

YEAR ONE: 2023/24

- **3.8.1.** Expand the Provincial Diagnostic Network by working with the MOH to develop an implementation plan for a provincial program delivering all insured and/or publicly funded laboratory and point-of-care testing services, which will support increased equitable access and coordinated operations across the sector and improve delivery of services.[M]

YEAR TWO: 2024/25

- Advance targeted areas of expansion.

YEAR THREE: 2025/26

- Continue to advance expansion.

3.9. Support informed clinical decision-making at the point of care

Ontario Health collects clinical data in the provincial EHR and provincial data repositories so it can be appropriately viewed at the point of care. Enabling clinicians within a patient's circle of care to digitally view existing data can help avoid long waits, repeat tests and fax errors as well as allowing patients to tell their story once rather than multiple times. We are continually working to make available data more useful and robust and to increase the number of clinicians who can appropriately view the electronic data at the bedside, streamlining the experience for all users of Ontario Health digital assets.

YEAR ONE: 2023/24

- **3.9.1.** Add critical data sets to the provincial EHR to support clinical decision making such as improving access to medication data at the point of care, primary care data, mental health and addictions data from community providers and genetic data from labs.

Enable more providers to view and consume clinical data at the point of care:

- **3.9.2.** Enable clinician access to critical medication, lab and acute discharge data through continued deployment of the Digital Health Drug Repository (DHDR), OLIS and Health Report Manager (HRM) in community-based clinician EMRs.
- **3.9.3.** Enable providers access to critical home care, immunization and medication data at the point of care by creating CHRIS, COVAX and DHDR viewlets, tools that allow clinicians to view data from their point of care system.

Enhance the user experience, access to and consumption of clinical data in a way that compliments workflows:

- **3.9.4.** Create a consistent customer experience for providers across digital assets and access channels.
- **3.9.5.** Modernize and consolidate existing provincial clinical viewers enabling improved and more efficient access to patient data for clinicians.
- **3.9.6.** Support hospital information system (HIS) vendors to access EHR data through standardized direct integration interfaces.
- **3.9.7.** Enable sharing of medical images across hospitals and independent health facilities through the expansion of select enabling technologies and shared picture archive and communication systems (PACS) to ensure providers have easier access to better quality images at the point of care.
- **3.9.8.** Create a plan to ensure data sent to primary care via HRM aligns with provider workflows and removes report duplication and existing paper-based processes.
- **3.9.9.** Consolidate Ontario Health service desk to create a streamlined experience and single point of contact for customers of digital assets.

YEAR TWO: 2024/25

- Continue to add data sets and providers as contributors to the provincial EHR.

Enable more providers to view and consume clinical data at the point of care:

- As appropriate, continue to make data accessible to more clinicians at the point of care.

Enhance the user experience, access to and consumption of clinical data in a way that compliments workflows:

- Continue to support a positive user experience by ensuring data is consumable in a manner that aligns with clinician workflow.

YEAR THREE: 2025/26

- Continue to add data sets and providers as contributors to the provincial EHR.

Enable more providers to view and consume clinical data at the point of care:

- As appropriate, continue to make data accessible to more clinicians at the point of care.

Maximize System Value by Applying Evidence

Our approach to system and clinical transformation means we are continuing to improve across several of our core capabilities that maximize system value by applying evidence (e.g., our data, quality and reporting strategies, and value identification). Our priorities include work to:

- **4.1.** Use data and analytics to enhance equitable access to care and enhance patient health experiences and outcomes
- **4.2.** Advance high-quality and safe care through evidence and continuous quality improvement
- **4.3.** Advance value-add opportunities within the health system

4.1. Use data and analytics to enhance equitable access to care and enhance patient health experiences and outcomes

Data and analytics are key enablers to fulfilling Ontario Health's mandate and optimizing the health and health experiences of the people we serve. Ontario Health has multiple roles when it comes to data and analytics: as an operator of some parts of the provincial data infrastructure, as a provider of information for those who need it and as a consumer of data and information. Investing in our infrastructure will enable us to create the foundation that will be used to provide a Provincial Health Data Service (PHDS) in a single window for patients, providers, health system users and researchers to access high-quality data for their respective purposes. We will continue to unlock the potential of key data assets in the province and strive to provide meaningful insights that enable the province to identify and respond to current system challenges and future system planning needs.

YEAR ONE: 2023/24

In alignment with Ontario Health's Data & Analytics strategy, we will partner with system stakeholders to:

- **4.1.1.** Establish the foundation for a PHDS driving purpose-driven data access, compliant with provincial privacy laws.(M)
- **4.1.2.** Create a Health Data Office to unify data governance practices, risk management and drive core Data and Analytics capabilities necessary for operating the PHDS.(M)
- **4.1.3.** Enhance the Ontario Health Data Platform (OHDP) by incorporating additional data assets into Ontario Health's Analytics Data Hub. This provides health system users and researchers access to more high quality data for their respective purposes.(M)
- **4.1.4.** Drive purpose driven access to data and insights generated from Ontario Health data assets to inform system and equity-based planning and decision making through the Health System Insights (HSI) platform, providing a single, secure, and intuitively designed portal for health system users.(M)
- **4.1.5.** Expand secure use of data (provincially, regionally and locally) to inform system and equity-informed planning and decision making.(M)

YEAR TWO: 2024/25

- Continue to expand the PHDS.
- Continue to unify and mature data governance practices, risk management and core Data and Analytics capabilities to support the PHDS.
- Continue to incorporate additional data assets into Ontario Health's Analytics Data Hub.
- Continue to drive efficiencies in internal and external OHT reporting through a single source of data and insights through the HSI platform.

YEAR THREE: 2025/26

- Continue to expand the PHDS.
- Continue to unify and mature data governance practices, risk management and core Data and Analytics capabilities to support the PHDS.
- Continue to incorporate additional data assets into Ontario Health's Analytics Data Hub.
- Continue to drive efficiencies in internal and external OHT reporting through a single source of data and insights through the Health System Insights (HSI) platform.

4.2. Advance high-quality and safe care through evidence and continuous quality improvement

Improving outcomes across emerging and high priority clinical areas requires a strong capacity for advancing health care improvement and supporting knowledge exchange. Based on evidence, including data on variations and gaps in health care, Ontario Health works with patients, providers and organizations across the health system to advance a culture of quality. Our goals include improving outcomes, promoting health equity and patient safety, standardizing care across the province and enhancing patient and provider experiences. As key examples, through the activities outlined below, we aim to increase the percentage of targeted Ontario physicians and hospital organizations with an audit and feedback report and to decrease the rates of surgical site infections and urinary tract infections as key examples.

YEAR ONE: 2023/24

- **4.2.1.** Drive health system and patient care improvements through the development and implementation of clinical and quality standards that are reflective of Ontario Health priorities (aligned with 1.1).(M)
- **4.2.2.** Facilitate continuous health care improvements through clinical quality initiatives and by supporting system level quality planning:
  - Quality Improvement Plans (QIPs) program: Deliver guidance and support for 2024/25 QIPs while also identifying and assessing opportunities for connections with Ontario Health accountability and funding levers where possible.
  - Ontario Surgical Quality Improvement Network (ON-SQIN) program: Encourage additional participation of hospital sites to reach a higher level of surgical cases performed in ON-SQIN hospitals.
  - General Medicine Quality Improvement Network (GeMQIN) program: GeMQIN sites will work towards improving a focused clinical issue through a coordinated provincial campaign.
  - Emergency Department Return Visit Quality program (EDRVQP): Build a learning network with participating EDRVQP sites focused on improving the quality of care in emergency departments.
- **4.2.3.** Provide clinicians across Ontario with access to data, such as through MyPractice reports; support knowledge exchange around focused areas of health care improvement through communities of practice and implementation supports.(M)
- **4.2.4.** Advance a culture of patient safety and prevent incident recurrence through the Patient Safety program and implementing reporting and learning for Never Events.(M)
- **4.2.5.** Continue to align public reporting to system priorities, refreshing data on public reporting products as appropriate, reviewing public reporting impacts and including equity in the reporting and distribution of public reporting products.(M)
- **4.2.6.** Advance high-quality care using evidenced-based health technology assessments to inform public funding recommendations about health care services and other health technologies.

YEAR TWO: 2024/25

- Drive quality as clinical quality priorities evolve.
- Further enhance public reporting based on user feedback and reviewing public reporting impact.

YEAR THREE: 2025/26

- Drive quality as clinical quality priorities evolve.

4.3. Advance value-add opportunities within the health system

As a public service, it is important that Ontario Health works across the system to continuously drive value. Value means improving health outcomes for the same or lower costs, which can be achieved through evidence, quality improvement and system integration. Integrated and evidence-based clinical pathways are foundational for value-based care. They enable shared care accountability, effective transitions between providers and health information exchange as well as provide a structured approach to identifying routinizing process efficiencies. This is core to the work of OHTs. Ontario Health will work with OHTs to implement pathways that reflect the full patient journey to include both upstream services like prevention and screening (demonstrating improvement in primary key performance indicator measures) and downstream services like community management and recovery at home. Through the work outlined below, we aim to reduce heart failure acute care utilization through integrated care and ultimately improve population health. We aim to achieve demonstrable patient impact by reducing avoidable, non-traumatic major lower-limb amputations in Ontario, as well as improving equitable access to high-quality best-practice early screening, risk factor management and integrated lower-limb wound care.

YEAR ONE: 2023/24

- **4.3.1.** Work with select OHTs to implement Integrated Clinical Pathways for four diseases/conditions: lower limb preservation, COPD, integrated stroke and heart failure.
- **4.3.2.** Identify new integrated clinical pathway opportunities for future implementation; scale and spread successful integrated care models.
- **4.3.3.** Advance the Ontario Case Costing (OCC) Program to effectively measure performance, savings and support health system funding models to drive best health care value across the system. Ontario Health will also support the sustainment of existing case costing facilities and expansion into community sectors for prioritized OHTs.(M)

YEAR TWO: 2024/25

- Implement integrated clinical pathways with additional cohorts of OHTs.
- Begin provincial scale up/transition to revised funding approach for heart failure and other integrated clinical pathways.
- Begin implementation for new pathways as identified.
- Scale and spread successful integrated care models.
- Work with the MOH to sustain and expand case costing facilities in OHTs, improving case costing submission practices, and enhancing the use of OCC data.

YEAR THREE: 2025/26

- Scale and spread successful integrated care models.
- Work with the MOH to continue to sustain and expand case costing facilities in OHTs, improving case costing submission practices, and enhancing the use of OCC data.

Strengthen Ontario Health's Ability to Lead

Underpinning all our priority areas is the critical foundation of strengthening Ontario Health's ability to lead, fueled by an engaged, connected and accountable team. This includes focusing on building the internal team at Ontario Health and strengthening our supports to the system and general system accountabilities, giving us the ability to build Ontario Health's reputation among our partners and stakeholders. It involves us being an effective system operator and collaborator and advancing our role in key areas such as primary care.

Our priorities in this area relate to our work to:

- **5.1.** Enhance Ontario Health's organizational effectiveness through a strong, engaged, connected and accountable workforce
- **5.2.** Strengthen system supports and accountabilities
- **5.3.** Support the government's plans for supply chain centralization
- **5.4.** Implement our Equity Inclusion Diversity and Anti-Racism (EIDA-R) strategy
- **5.5.** Drive provincial data exchange, interoperability and data security through digital leadership

5.1. Enhance Ontario Health's organizational effectiveness through a strong, engaged, connected and accountable workforce

Ontario Health's mission cannot be achieved without its people. We are committed to engaging, informing and inspiring our workforce to enable them to do their best work. We will invest in our people through wellness programs and learning and development programs that enable individual growth within Ontario Health. We will recognize the achievements of our people through internal and external channels and enable pride in Ontario Health's successes through strong, open and transparent communications supported by a redesigned Ontario Health website.

YEAR ONE: 2023/24

- **5.1.1.** Implement ongoing improvements including: continued employee engagement and action plans, learning and development opportunities and wellness programs.
- **5.1.2.** Continue to implement Ontario Health's future workplace strategy including a hybrid work operating environment and real estate plan.
- **5.1.3.** Continue to embed Ontario Health's vision, mission and values into our work.
- **5.1.4.** Implement year one of our communications strategy; initiate our web transformation plan to redesign the Ontario Health website and operating model through a multi-phased, multi-year approach.

YEAR TWO: 2024/25

- Continue to advance prior year's deliverables.

YEAR THREE: 2025/26

- Continue to advance prior year's deliverables.

5.2. Strengthen system supports and accountabilities

Ontario Health endeavors to be a reliable leader and partner in our goal to continuously strengthen our organization and the health system. In our pursuit to transform the province's health care system, we will continue to challenge the status quo and fortify our partnerships with health service providers (HSPs) by re-aligning agreements to support the implementation of health system strategies and infusing bi-directional accountability between Ontario Health and HSPs as well as across HSPs within OHTs.

Our capacity planning will provide the ability to prioritize the areas where there are health service gaps to ensure improved, equitable and sustainable access to health services and make sure the right resources are available for the right people at the right time and in the right setting. Furthermore, service accountability agreement (SAA) transformation will enable the province's future health care strategies, including system transformation, integration and OHTs, with a focus on reducing health inequities.

YEAR ONE: 2023/24

- **5.2.1.** Reflect health system priorities and a focus on reducing health inequities in the continued transformation of SAAs; continue to enhance coordinated SAA oversight, operations and performance management.
- **5.2.2.** Inform the MOH's development of a provincial capacity plan; inform equitable and sustainable access to health services to ensure the right resources are available for the right people at the right time in the right setting.(M)

YEAR TWO: 2024/25

- Continue to re-align SAAs to reflect integrated delivery efforts of OHTs and within mental health and addictions.
- In partnership with stakeholders, develop health service capacity plans to meet priorities.

5.3. Support the government's plans for supply chain centralization

Ontario's health sector supply chain enables health care providers to deliver the highest-quality possible care to their patients, in the most appropriate setting. Ontario Health will work with MOH, partner ministries, and Supply Ontario to strengthen the health sector supply chain, delivering better value for taxpayers and improved outcomes for patients.

YEAR ONE: 2023/24

- **5.3.1.** Collaborate with the MOH, partner ministries, and Supply Ontario on the development of an integrated clinical supply chain management model for the health care sector with clear accountabilities.(M)
- **5.3.2.** Develop provincial-wide sourcing strategies for both fecal immunochemical test (FIT) and for hemodialysis that will deliver on improved outcomes for Ontarian participants and renal patients while also delivering on value for money.
- **5.3.3.** Provide clinical guidance and leverage Ontario Health's regional structure to respond to health supply shortages.
- **5.3.4.** Procure a provincial acute care clinical viewer for the new clinical document repository, enabling technology consolidation and improved system performance, clinician and patient experience.
- **5.3.5.** Conclude all medical equipment and supplies (MES) contracts for home care with various service providers that ensure high-quality goods are equitably delivered to either patient homes, clinics or various pick-up locations across the province.

YEAR TWO: 2024/25

- Collaborate with the MOH on continued progress toward an integrated clinical supply chain management model for the health care sector with clear roles and accountabilities.
- Successful completion of provincial wide sourcing strategies such as the fecal immunochemical test (FIT).

5.4. Implement our Equity, Inclusion, Diversity and Anti-Racism (EIDA-R) strategy

We strive to embed equity in everything we do. This includes a commitment to engagement, embedding equity-related analyses into our data and analytic strategies and continuing to promote and build a diverse workforce that represents the communities we serve. We recognize the importance to establish productive relationships built on trust with First Nations, Inuit, Métis and urban Indigenous partners, and we will work to develop sustainable engagement structures with them.

YEAR ONE: 2023/24

Embed equity into our data and analytic work:

- **5.4.1.** Finalize community governance models and principles for engaging communities in how their sociodemographic data is collected, used and stored.
- **5.4.2.** Establish organization-wide standards for a core sociodemographic dataset to ensure consistency in data collected by Ontario Health; explore opportunities to expand sociodemographic data collection into new programs.
- **5.4.3.** Drive the meaningful use of equity-related measurement, including area-level and encounter-based data. Develop, use, and spread tools to support equity-related and analysis across Ontario Health through enabling performance target setting and data-informed planning.
- **5.4.4.** Establish a plan to enhance data capture in community-based settings, to inform ongoing capacity and equity-focused planning.

Build sustainability by embedding equity, inclusion, diversity and anti-racism in everything we do with stable funding over the long-term:

- **5.4.5.** Continue to evolve equity goals and performance indicators into SAAs (aligned with 5.2).
- **5.4.6.** Implement provincial equity funding framework to support equitable funding allocations.

Engage and develop a relationship with Indigenous leadership, organizations, health tables and communities consistent with activities with work in area of focus 1.1.1:

- **5.4.7.** Formalize relationships with provincial Indigenous leadership and their organizations.
- **5.4.8.** Continue to engage Ontario Health Regional Indigenous Health Tables and First Nations, Inuit, Métis and Urban Indigenous Health Networks.

Build and promote a diverse workforce:

- **5.4.9.** Execute year one of the Ontario Health Diversity Action Plan based on 2022/23 diversity survey results.
- **5.4.10.** Continue to build and deliver learning and development curriculum in support of EIDA-R objectives (internal and external).
- **5.4.11.** Continue to support and build communities of inclusion as employee resource groups for equity deserving communities.

YEAR TWO: 2024/25

- Implement and spread community governance model approach.
- Continue to spread and scale a consistent approach to equity data collection and use.
- Continue to expand equity accountability in SAAs.
- Continue ongoing engagement and building on relationships with First Nations, Inuit, Métis and urban Indigenous partners.

YEAR THREE: 2025/26

- Continue to spread and scale consistent approaches and identify gaps for ongoing improvement.

5.5. Drive provincial data exchange, interoperability and data security through digital leadership

In collaboration with the MOH and other critical partners, Ontario Health has a role to define the standards by which health service providers share data between technical systems, interoperate and protect health care data from cyber risk. The sharing of data between providers in the circle of care is critical to both informed care delivery at the bedside and broader system planning.

YEAR ONE: 2023/24

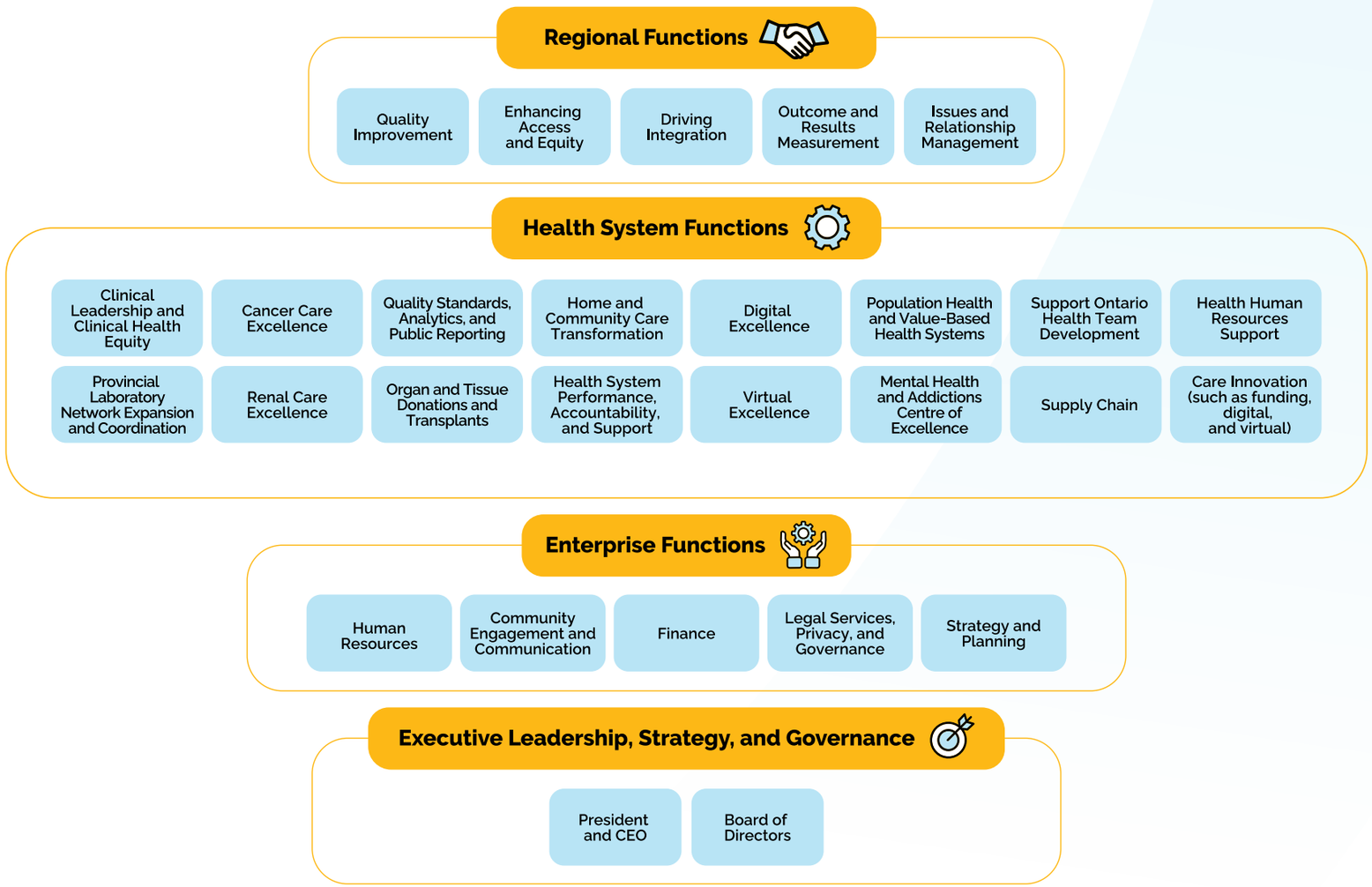
- **5.5.1.** Continue to strengthen the foundation for interoperability and information exchange between systems via the Digital Health Information Exchange (DHIEX) program.
- **5.5.2.** Progress provincial cyber security operating model coverage across the system through the establishment of new local delivery groups and the initial provisioning of provincial health security operations centre services.
- **5.5.3.** In collaboration with the MOH and key stakeholders, co-design a business architecture and operating model that will describe the digital and data capabilities and the roles and responsibilities of stakeholders in delivering digital health solutions across the province.

YEAR TWO: 2024/25

- Continue the prior year's deliverables related to DHIEX.
- Continue to support providers and local delivery groups to improve their cybersecurity posture.

Appendix

Overview of Programs and Operating Model

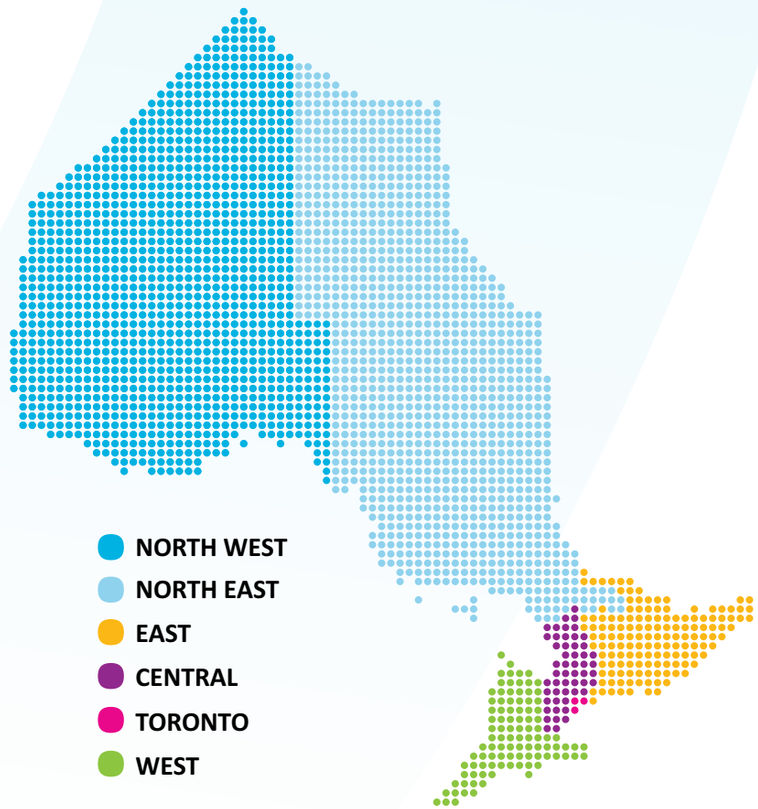


Ontario Health Regional Approach

To ensure we understand and respond to the diverse needs of Ontarians, we have six regional teams which operate as the front door to our communities and health service providers.

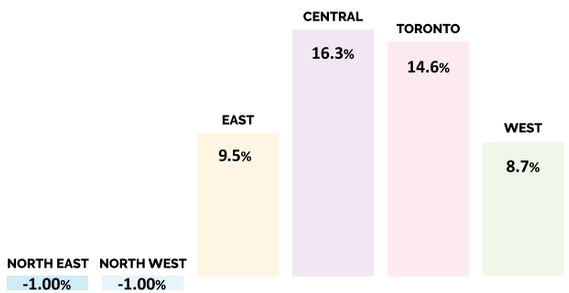
Our regional teams use a population-based health planning approach and hold strong relationships with local and regional health system providers and partners to ensure that the communities we serve have access to the right care and services when they need them. Our regional teams also play an essential role in ensuring that our health system providers have what they need to deliver on the intended health care outcomes of the communities they serve. These teams aim to reduce health disparities and drive health system performance and improvement through the implementation of system-level leadership, funding and monitoring of performance in a way that meets the unique needs of people across the province. For example, with local partners, our regional teams:

- Coordinate and deliver a strong emergency response function, which includes timely access to testing, therapeutics and clinical assessments, which has avoided unnecessary hospital and ED visits.
- Lead and collaborate with health service providers and partners to support health system stability and recovery, with a focus on improved access and flow for patients across the continuum of care, including:
  - Building additional capacity within the community and hospital sectors to ensure patients are receiving the right care in the most appropriate care settings.
  - Supporting surgical recovery to ensure patients waiting for surgeries have improved access to the surgical procedures that they need.
- Facilitate local planning efforts through change management and quality improvement through engagement with provincial and regional expert bodies to drive excellence in clinical care.
- Enhance clinical excellence through innovation and bringing our clinical and primary care teams together to improve access and ensure primary care has the right tools and resources to support patient care.
- Support diverse communities and ensure a strong equity lens is embedded in the various programs and services that we provide, which includes developing programs and services accessible to various populations by addressing factors such as transportation needs, language and cultural barriers.
- Support regional planning with OHTs to better integrate care across community partners and use a population-based health system approach to develop programs that support local needs.
- Ensure that investments in our digital health planning support improvement in patient care outcomes and address the information gap to help our health system providers provide the right care within the right timeframe.

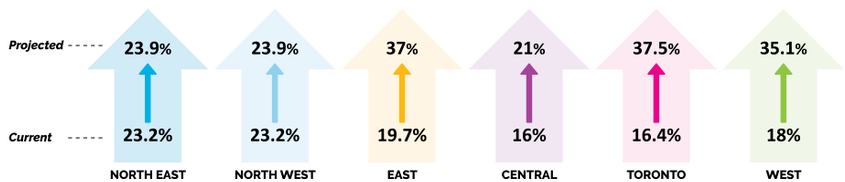


Demographics[7]

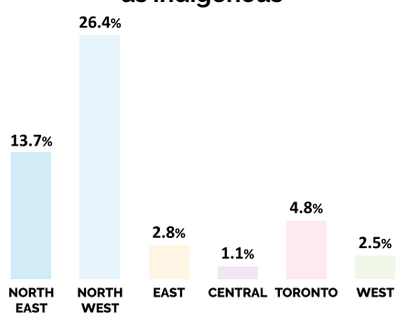
Projected population growth over next ten years



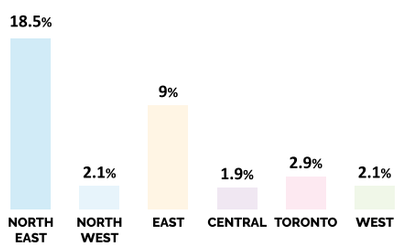
The number of residents over 65 years of age is projected to increase dramatically over the next ten years.



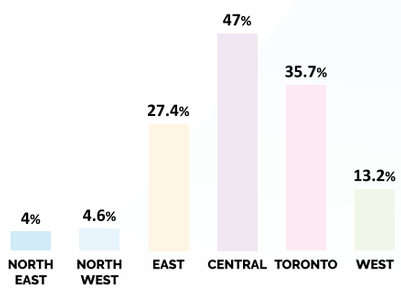
Population that identifies as indigenous



Population that identifies as francophone



Population that identifies as visible minority



HEALTH SERVICE PROVIDERS*

Community Mental Health & Addictions Providers	Community Support Service Providers	Community Health Centres	Public Hospitals
395	532	75	140

Indigenous Primary Health Care Organizations (formerly called Aboriginal health access centres)	Long-Term Care Homes	Family Health Teams
21	627	181

Nurse Practitioner-Led Clinics	Regional Renal Programs	Regional Cancer Centres	Transplant Centres
25	27	14	8

*These are approximate totals that are not inclusive of all providers, such as primary care, specialists, independent health facilities and other sites such as out of hospital premises

North East – Regional Profile

557,220
(population)

13.7%
Identify as Indigenous

18.5%
Identify as Francophone

4%
Identify as visible minority

5.3%
Immigrant population

165
Service Accountability Agreements

7
Designated French-Language Service Areas

Projected population growth over next ten years
-.01%

Projected population over age of 65 in ten years
30%
(23.3% currently)

Number of approved Ontario Health Teams
3

HEALTH SERVICE PROVIDERS

Community Mental Health & Addictions Providers	Community Support Service Providers	Community Health Centres	Public Hospitals	Indigenous Primary Health Care Organizations	Long-Term Care Homes	Family Health Teams	Nurse Practitioner-Led Clinics	Designated Agencies for French Language Services	Palliative Care Centres
47	67	7	24	2	37	28	7	41	7

North West – Regional Profile

232,299
(population)

Projected population growth over next ten years

-.005%

Projected population over age of 65 in ten years

26.5%

(20.5% currently)

Number of approved Ontario Health Teams

4

26.4%
Identify as Indigenous

2.1%
Identify as Francophone

4.6%
Identify as visible minority

6.4%
Immigrant population

100
Service Accountability Agreements

2
Designated French-Language Service Areas

HEALTH SERVICE PROVIDERS

Community Mental Health & Addictions Providers	Community Support Service Providers	Community Health Centres	Public Hospitals	Change to Aboriginal Health Access Centres	Long-Term Care Homes	Family Health Teams	Nurse Practitioner-Led Clinics	Designated Agencies for French Language Services	Palliative Care Centres
37	54	2	12	4	19	14	6	0	2

East – Regional Profile

3,778,440
(population)

2.8%
Identify as Indigenous

6.9%
(French as mother tongue)

7.4%
(French as first official language spoken)

Identify as Francophone

31.8%
Identify as visible minority

25.3%
Immigrant population

328
Service Accountability Agreements

9
Designated French-Language Service Areas

Projected population growth over next ten years
9.4%

Projected population over age of 65 in ten years
24.9%
(20.2% currently)

Number of approved Ontario Health Teams
13

HEALTH SERVICE PROVIDERS

Community Mental Health & Addictions Providers	Community Support Service Providers	Community Health Centres	Public Hospitals	Indigenous Primary Health Care Organizations	Long-Term Care Homes	Family Health Teams	Nurse Practitioner-Led Clinics	Designated Agencies for French Language Services
59	100	21	34	2	165	46	6	38

Central – Regional Profile

5,113,846
(population)

Projected population growth over next ten years
17.6%

Projected population over age of 65 in ten years
21.5%
(16.8% currently)

Number of approved Ontario Health Teams
14

1.1%
Identify as Indigenous

1.9%
Identify as Francophone

47%
Identify as visible minority

48.3%
Immigrant population

274
Service Accountability Agreements

3
Designated French-Language Service Areas

HEALTH SERVICE PROVIDERS

Community Mental Health & Addictions Providers	Community Support Service Providers	Community Health Centres	Public Hospitals	Indigenous Primary Health Care Organizations	Long-Term Care Homes	Family Health Teams	Nurse Practitioner-Led Clinics	Designated Agencies for French Language Services
51	105	9	16	0	124	26	7	2

Toronto – Regional Profile

1,462,821
(population)

Projected population growth over next ten years
14.3%

Projected population over age of 65 in ten years
35.7%
(16.8% currently)

Number of approved Ontario Health Teams
5

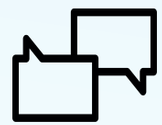
4.8%
Identify as Indigenous

2.9%
Identify as Francophone

35.7%
Identify as visible minority

36.4%
Immigrant population

176
Service Accountability Agreements



1
Designated French-Language Service Areas

HEALTH SERVICE PROVIDERS

Community Mental Health & Addictions Providers
68

Community Support Service Providers
56

Community Health Centres
16

Public Hospitals
14

Indigenous Primary Health Care Organizations
0

Long-Term Care Homes
35

Family Health Teams
16

Nurse Practitioner-Led Clinics
0

Designated Agencies for French Language Services
2

West – Regional Profile

4,133,908
(population)

Projected population growth over next ten years

9.5%

Projected population over age of 65 in ten years

25.71%

(20.5% currently)

Number of approved Ontario Health Teams

15

2.5%
Identify as Indigenous

2.1%
Identify as Francophone

13.2%
Identify as visible minority

18.1%
Immigrant population

429
Service Accountability Agreements

4
Designated French-Language Service Areas

HEALTH SERVICE PROVIDERS

Community Mental Health & Addictions Providers	Community Support Service Providers	Community Health Centres	Public Hospitals	Indigenous Primary Health Care Organizations	Long-Term Care Homes	Family Health Teams	Nurse Practitioner-Led Clinics	Designated Agencies for French Language Services
128	130	20	40	2	236	51	7	5

Environmental Scan

We are mindful of environmental factors in the planning, execution, and delivery of our work. Below is an overview of key external and internal factors.

EXTERNAL FACTORS

Fiscal Environment and Economic Outlook

- In response to the COVID-19 pandemic, the Ontario government has made significant, ongoing response and recovery investments which will continue to place economic pressure on the government for years to come. Our business planning continues to consider new ways to create value for public health investments.

Legislative, Regulatory and Policy Changes

- To respond to the ongoing COVID-19 pandemic, several directives have been issued to support health system capacity to respond to the pandemic and support periods of safe recovery. Ontario Health will continue to work with public health, ministry officials and provider partners to effectively support health system capacity response and recovery.
- Ontario Health is working to ensure the equitable access to quality care for all by ensuring the right care is received in the right place. This is enabled through the *More Beds, Better Care Act, 2022*.

COVID-19 Pandemic, Recovery and HHR Constraints

- COVID-19 brought focus to systemic issues that have been exacerbated by the pandemic, disproportionately impacting access to care in underserved and marginalized populations. While rapid vaccine uptake in Ontario brought hope for a quick recovery of our health care system, the province was further challenged by an early winter surge of respiratory viruses, and ongoing HHR capacity challenges.

Population Growth and Trends

- Ontario's population reached 15,007,816 on April 1, 2022. There were 34,285 births (2.2% increase from 2021) and 33,183 deaths during the first quarter of 2022. Over the past 12 months, Ontario welcomed 214,135 immigrants, up sharply from 85,625 during the previous year. Ontario's population grew by 211,933 or 1.4%, much faster than in the previous year (66,559 or 0.5%), meaning Ontario had the fifth fastest population growth rate in Canada.[8]

SOCIO-CULTURAL AND SOCIAL DETERMINANTS OF HEALTH FACTORS

Mental Health and Addictions

- In Ontario, the prevalence of depression, anxiety-related, substance use and eating disorders continues to grow.
- The COVID-19 pandemic has negatively and disproportionally affected people with a history of mental health or substance use conditions. Accordingly, improving the access to early detection and treatments for mental health illnesses and addictions is critical to mitigating its burden on our health care system.

Seniors and Aging

- By 2041, 25% of Ontario's population is projected to be 65 years old or older.[9]
- Access to home care and long-term care is critical to providing the right care in the right place, yet timely access has declined in recent years. Ontario Health remains ready to support the MOH and MLTC transformations of home care and long-term care.

Virtual Care and Digital Access

- Ontario continues to streamline the approach to virtual and digital health delivery by moving towards standards-based supports for improving access to virtual care, system interoperability, and reducing fragmentation and redundancy.

Cancer Screening

- In Ontario, cancer screening volumes have significantly increased since pandemic-related declines of in-person primary care visits. Continued focus is required to sustain increased cancer screening volumes throughout 2023.

INTERNAL FACTORS

Ontario Health Integration

- Ontario Health has integrated 22 organizations into a unified agency, producing savings of more than $219M. Organizational alignment has been achieved through harmonized payroll, finance, procurement and cyber security systems.

Risk Identification, Assessment and Mitigation

Ontario Health has continued to advance maturity of its enterprise risk management program over the past year. We have established clear parameters for risk tolerance across various risk categories to balance mitigation activities against the need to be innovative and forward thinking when tackling some of our most complex risks and health system challenges.

Our focus in this area over the coming year will be to continue to build enterprise risk management capabilities and capacity within our health system and within Ontario Health. Doing so will ensure that we promote a risk-aware culture that maintains mature processes to proactively identify, assess, manage, monitor and report enterprise risks.

RISK: CLARITY ON ACCOUNTABILITIES

Ontario Health operates in a complex health system environment with many stakeholders involved in the delivery of care to patients across Ontario. This includes federal and municipal jurisdictional partners, health services providers, primary care, provincial ministries and other board-governed Crown agencies. As Ontario Health advances key business transformation programs such as the implementation of OHTs, home care modernization, advancing health equity, delivery of mental health and addictions programs, etc., aligning on accountabilities across partners will be crucial to maximize health system resources, optimize patient experience and more broadly achieve goals of the quintuple aim.

Likelihood and Impact

Likelihood: **Possible**, given Ontario Health's ability to work with health system partners to achieve common goals (as demonstrated through the pandemic response).

Impact: **Moderate**, due to effect on patient experience and utilization of scarce health system resources.

Mitigation

Senior management and the Board will work with the MOH to establish clear governance and accountability frameworks to align with new health service delivery approaches associated with business transformation programs.

Ontario Health is well positioned to engage with health system partners to align on joint goals associated with transformational programs.

RISK: CYBERSECURITY

As Ontario Health continues to advance and rely on digital health platforms to support and enable the delivery of patient-centred care, the organization will inherently be subject to increasing cybersecurity threats from internal and external sources, resulting in potential operational, financial, legal and reputational impacts and downstream effects on patient care.

Likelihood and Impact

Likelihood: **Possible**, given the controls and cybersecurity program in place but challenged by the persistent and evolving external threat landscape.

Impact: **Critical**, given the impact on various aspects of Ontario Health business and stakeholders.

Mitigation

Ontario Health has formally reviewed and validated our privacy and security programs. A robust cybersecurity program is in place, incorporating people, process and technology controls to prevent, detect and respond to cyber threats.

In partnership with provincial health service delivery partners, Ontario Health has developed a provincial cyber security operating model to operationalize the provincial vision for cybersecurity. The goal is for this model to help manage cyber risks and build more robust cybersecurity postures, with alignment across the broader public sector.

RISK: HEALTH SYSTEM CAPACITY

Throughout the course of the pandemic and more recent experience with the 2022/23 fall/winter respiratory virus (RSV, COVID-19, and influenza) season, Ontario's health system has been under significant strain and capacity pressures. Health human resources capacity and health system access and flow challenges have been noted as some of the underlying systemic issues that have contributed to capacity pressures. Unanticipated health emergency events in the future may further exploit this health system vulnerability.

Likelihood and Impact

Likelihood: **Likely**, given the complexity and systemic nature of the risk.

Impact: **Critical**, given direct impact on patients in Ontario.

Mitigation

Ontario Health is supporting the MOH and MLTC in executing the *Plan to Stay Open: Health Stability and Recovery* through strategies and actions described in various sections of this annual business plan. Some highlights include:

- **Improving system access and flow** by increasing capacity in the long-term care and home and community care sectors, working to define new models of care to optimize current health human resource capacity and working with local health service providers to deploy funding aimed at increasing capacity.
- **Preventing ED** closures by deploying capacity balancing techniques within and across hospitals and implementing locum programs to ensure clinicians are deployed, particularly in rural and northern settings.
- **Increasing HHR** capacity through targeted programs; work will also include supporting the MOH's longer term HHR strategy development.
- **Reducing waitlists** by deploying funding to maximize surgical volumes, exploring existing community facility integration and/or partnership opportunities to augment capacity (particularly for low acuity procedures) and exploring opportunities for surgical innovation.

RISK: HEALTH SYSTEM TRANSFORMATION

Health service providers have demonstrated early successes in their drive toward integrated service delivery models through the implementation of OHTs. However, to achieve the OHT vision, further consistency and progress is needed in engaging key sectors such as primary care, home and community care and mental health and addictions in OHT decision making, planning and implementation activities. Provincial direction on mechanisms and structures to coordinate these sectors is needed to enable OHTs to effectively engage them in integrated funding, accountability, governance, and decision making.

Likelihood and Impact

Likelihood: **Medium**, given that clear direction and support is being provided on how best to engage and organize these sectors.

Impact: **High**, given the importance in engaging these sectors in OHT governance and decision making.

Mitigation

The MOH and Ontario Health have been advancing discussions to formalize Ontario Health's leadership role to support and drive implementation of health system transformation programs such as OHTs.

With the MOH's support, Ontario Health will provide leadership and support to OHTs in engaging with the primary care, home and community care sectors. Through this work, Ontario Health will help facilitate appropriate involvement of clinicians, primary care providers and home and community care leaders in their evolving governance structures. To further accelerate OHT development, Ontario Health will continue to advise the MOH on next steps related to home care integration, modernization, and investment.

Human Resources and Staffing

HUMAN RESOURCES PRIORITIES AND DELIVERABLES

To achieve our strategic goals and enable change across the organization, we need the expertise, commitment and enablement of our team members. Ontario Health is creating an environment where people can thrive and are enabled to deliver targeted and sustainable organizational performance. In line with this vision and our strategic goal of continuing to build the Ontario Health team, the following are key human resources deliverables.

1. **Build and deliver Ontario Health's learning and development program, including:**

- Harmonization and integration of the learning management system
- Launch of the Ontario Health leadership development program
- Mandatory training updates (e.g., occupational health and safety)

2. **Continue implementation of our Equity, Inclusion, Diversity and Anti-Racism (EIDA-R) initiatives, including:**

- Execution of our action plan based on 2022/23 diversity survey results
- Continued learning and development curriculum development in support of EIDA-R objectives

3. **Continue implementation of our performance management plan, including:**

- Performance development planning program updates, including updated performance rating criteria calibration processes
- Updated critical role definitions and organizational design and workforce planning strategies to mitigate risk
- Development planning based on organization talent map with succession plans (including critical roles)

4. **Deploy market strategies to support talent acquisition and employee retention.**

5. **Continue delivery of our employee engagement plan, including:**

- Leader level action planning with Pulse surveys to ensure progress
- Onboarding of new employee engagement network members
- Vision, mission and values implementation

6. **Advance our workforce management and analytics plan, including:**

- Organizational design in support of ongoing improvement
- Execution of Workday enhancement plan
- Implementation of phase two of portfolio people dashboard

7. **Advance wellness, health and safety plan including:**

- Execution of year one of the wellness program developed in 2022/23
- Update of our health and safety program (embedding hybrid work environment requirements)

8. **Harmonize talent management and workforce planning in alignment with the 2023/24 budget.**

9. **Implement future of workplace plan as identified in 2022/23.**

10. **Continue harmonization of policies and programs across human resources disciplines.**

11. **Continue with our collective bargaining to establish and strengthen Ontario Health's inaugural agreements.**

In accordance with the Excellent Care for All Act, 2010, Ontario Health employs as the Patient Ombudsman the person appointed by the Lieutenant Governor in Council. Under the Connecting Care Act, 2019, Ontario Health's mandate involves providing support to the Patient Ombudsman, which includes providing the staff necessary to enable the Patient Ombudsman to carry out their functions. Accordingly, Patient Ombudsman staff members are employees of Ontario Health. Although the Office of the Patient Ombudsman is a division within Ontario Health, several measures have been put in place to support the independence of the office and enable it to function separately from the rest of the agency. The ministry works with the Patient Ombudsman to establish the office's budget for its activities separately from the Ontario Health budget process.

Total headcount as of end of Dec 2022	Approximately 3,000
Unionized headcount as of end of Dec 2022* Bargaining Agents: Canadian Union of Public Employees (CUPE), Service Employees International Union (SEIU), Association of Management, Administrative and Professional Crown Employees of Ontario (AMAPCEO)	Approximately 170

Financial Budget

In 000's	2022/23 Budget	2023/24 Budget	2024/25 Budget	2025/26 Budget
Revenue	**$35,624,026**	**$31,847,498**	**$31,784,430**	**$31,745,256**
Government of Ontario (MOH and MLTC)	$35,619,791	$31,843,281	$31,780,213	$31,741,039
Other Recoveries and Revenues	$4,235	$4,216	$4,216	$4,216
Expense	**$35,624,026**	**$31,847,498**	**$31,784,430**	**$31,745,256**
Health Service Provider Transfer Payments	$31,044,489	$28,286,781	$28,254,958	$28,252,780
• Acq Brain Injury	$67,320	$67,320	$67,320	$67,320
• Addictions Program	$343,380	$332,362	$305,597	$305,597
• Assisted Living	$361,758	$361,758	$361,758	$361,758
• Community Health Centres	$512,632	$505,963	$505,963	$505,963
• Community Mental Health	$1,134,374	$995,568	$994,318	$993,568
• Community Support Services	$678,093	$678,093	$678,093	$676,665
• Home and Community Care	$317,273	$319,974	$318,424	$318,424
• Hospital	$23,123,123	$20,547,221	$20,544,962	$20,544,962
• Long Term Care	$4,506,536	$4,478,521	$4,478,521	$4,478,521
Transfer Payments	$3,833,560	$3,023,450	$2,992,205	$2,955,210
Salary and Benefits	$368,745	$344,488	$344,488	$344,488
Information Technology	$198,103	$120,269	$120,269	$120,269
Purchased Services	$132,420	$45,593	$45,593	$45,593
Amortization	$11,230	$176	$176	$176
Office Space	$15,757	$8,184	$8,184	$8,184
Administration, Supplies and Meeting Expenses	$14,300	$14,015	$14,015	$14,015
Travel and Accommodation	$1,259	$1,246	$1,246	$1,246
Patient Ombudsman Office	$4,164	$3,296	$3,296	$3,296

Ontario Health has adopted a hybrid work environment, which has resulted in the a reduced realty footprint where the savings will be returned to the Ministry of Health.

IT and Electronic Service Delivery Plan

Ontario Health manages a vast technology infrastructure that supports our products, managed services, and data stores.
The ongoing operation of this infrastructure is a massive undertaking and critical to system functioning and care across Ontario.

Reduce health inequalities

Virtual Care – Operation and modernization of the existing provincial virtual visit infrastructure and development and implementation of verification standards for virtual solutions across the province.

Transform care with the person at the centre

Home Care – Operation of the provincial digital system for home care services enables the management of four million patient records. System functionality includes document management, service provider referral and billing, supply and vendor management, patient assessments and scheduling, and integrations with other digital assets and point of care systems.

Patient Navigation and Digital Identity – Operation and maintenance of digital tools used by patients to better navigate the system such as Ontario Health websites and Health811 services.

Digital Services Technical Support and IT Service Management – Provision of support services for providers that wish to enroll to use Ontario Health digital products and view clinical data assets. Ongoing operation of the service desk supporting all internal and external users of Ontario Health digital services.

Integrated Care, Seamless Transitions and Provider to Provider Communications – Operation and enhancement of tools and services supporting provider communications, provider consults, secure document exchange, electronic referrals, assessments, lab orders, notifications, and discharge reports.

Enhance clinical care and service excellence	**Cancer Care, Screening, and Prevention** – Operation of electronic communications, screening forms, drug adjudication tools, patient information systems, and administrative systems enabling critical cancer care services, chemotherapy administration, diagnostic imaging, and data collection. **Cardiac Care** – Operation of the digital system that manages of cardiac wait times and procedure efficiencies. **Renal Care** – Operation of the Ontario Renal Reporting System supporting provision of renal care. **Organ Donation and Transplant** – Operation and support for systems enabling the provincial organ allocation and donation system such as the Organ Allocation and Transplant System (OATS) and the Donor Management System (DMS). **Emergency Department Support** – Operation and support for products enabling Emergency Department operation, patient triaging and appropriate level of care. **Provincial Electronic Health Record (EHR)** – Billions of records in provincial data repositories are critical to care at the bedside. These datasets, directories, registries, (e.g., Ontario Laboratories Information System (OLIS), Digital Health Drug Repository (DHDR), Diagnostic Imaging Repositories (DIRs), Acute and Community Clinical Data Repository (acCDR), Provincial Client Registry (PCR), Provincial Provider Registry (PPR)) and the provider identity services, data feeds, viewing applications, that enable viewing of these datasets must be maintained, operated, and supported.
Maximize system value by applying evidence	**Data And Analytics for System, Capacity, Practice, and Waitlist Management** – Operate Ontario Health's 160 data assets and continually manage and modernize the way data is collected, securely stored, and appropriately shared for the purposes of capacity and system planning, practice and waitlist management, and quality improvement.
Strengthen Ontario Health's ability to lead	**Network** – Meeting clinical and transformational goals means building networks, applications and enabling connectivity new ways. Network modernization includes work to move data to the cloud as a priority and consolidation of existing data centres. Modernization must take place while maintaining operations, seeking efficiencies, and reducing of technical debt. **Cybersecurity Defense** – Lead the province in the cyber security space, assist and support providers to raise their overall cyber security posture. **Enterprise IT Services and Solutions** – Ontario Health digitally enables the operations and productivity of staff both in terms of hardware, software, and support for corporate functions.

Initiatives Involving Third Parties

MINISTRY OF LABOUR

Operational funding received for the Occupational Cancer Research Centre, an applied research program for the study and prevention of cancers caused by work. It builds scientific knowledge of occupational cancer through three broad categories of research: surveillance, causation and prevention.

UNIVERSITÉ LAVAL

Ontario Health was part of a group that received funding for a large research grant titled "Personalized Risk Assessment for Prevention and Early Detection of Breast Cancer: Integration and Implementation." The funding period is April 1, 2018, to March 31, 2024. This research study is funded federally by Genome Canada/Canadian Institute for Health Research.

HOME AND COMMUNITY CARE SUPPORT SERVICES

Ontario Health will work closely with HCCSS to implement changes to improve and modernize the province's home and community care sector, including the LTC placement process.

Glossary

Abbreviation	Definition
AAA	Abdominal Aortic Aneurysm
ABP	Annual Business Plan
acCDR	Acute and Community Clinical Data Repository
AF	Atrial Fibrillation
ALC	Alternate Level of Care
CHC	Community Health Centres
CHF	Congestive Heart Failure
CHF QBP	Congestive Heart Failure Quality-Based Procedure
CHRIS	Client Health and Related Information System
COPD	Chronic Obstructive Pulmonary Disease
CQIPs	Collaborative Quality Improvement Plans
CSR	Community Stroke Rehabilitation
DDI	Data and Digital Initiative
DHDR	Digital Health Drug Repository
DHIEX	Digital Health Information Exchange
DIRs	Diagnostic Imaging Repositories
DMS	Donor Management System
ED	Emergency Department
EIDA-R	Equity Inclusion Diversity and Anti-Racism
EHR	Electronic Health Record
EMR	Electronic Medical Record

Abbreviation	Definition
FHT	Family Health Team
FIT	Fecal Immunochemical Test
FLS	French Language Services
HCCSS	Home and Community Care Support Services
HHR	Health Human Resources
HIS	Hospital Information System
HPC	High Priority Community
HPV	Human Papillomavirus
HRM	Health Report Manager
HSI	Health System Insights
HSPs	Health Service Providers
IDGM	Indigenous Data Governance Matters
IPAC	Infection Prevention and Control
IPHCO	Indigenous Primary Health Care Organizations
LTC	Long-Term Care
MAID	Medical Assistance in Dying
MES	Medical Equipment and Supplies
MHA	Mental Health and Addictions
MORE	Mobile Order Results Entry
MOH	Ministry of Health
MLTC	Ministry of Long-Term Care

Abbreviation	Definition
MSAA	Ministry of Seniors and Accessibility
NPLCs	Nurse Practitioner-Led Clinics
NOPD	Non-Perfused Organ Donation
OATS	Organ Allocation and Transplant System
OCC	Ontario Case Costing
OCP5	Ontario Cancer Plan 5
OCP6	Ontario Cancer Plan 6
ODHP	Ontario Health Data Platform
OHTs	Ontario Health Teams
OLIS	Ontario Laboratories Information System
OSP	Ontario Structured Psychotherapy
PACS	Picture Archive and Communication Systems
PCR	Provincial Client Registry
PET	Positron Emission Tomography
PHDS	Provincial Health Data Service
PPR	Provincial Provider Registry
PREMs	Patient-Reported Experience Measures
PROMs	Patient-Reported Outcome Measures
PSWs	Personal Support Workers
QIP	Quality Improvement Plan
RSV	Respiratory syncytial Virus
SAA	Service Accountability Agreement

Endnotes

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[3] Aging Well 2020 Report, Queens University/School of Public Studies. Accessed at queensu.ca/sps/sites/spswww/files/uploaded_files/publications/1%20Ageing%20Well%20Report%20-%20November%202020.pdf

[4] Managing Long-Term Care Facility: Practical Approaches to Providing Quality Care. Edited by Rebecca Perley

[5] Public Health Agency of Canada "Social determinates and inequities in health for Black Canadians: A Snapshot" Government of Canada, 2020.

[6] Epperly T, Bechtel C, Sweeney R, et al. The Shared Principles of Primary Care: A Multistakeholder Initiative to Find a Common Voice. Fam Med. 2019;51(2):179-184. doi.org/10.22454/FamMed.2019.925587

[7] Sources for all statistics in the demographics and regional profile sections include: extracted from IntelliHealth November 2022, Statscan Census (2016 and 2021).

[8] Ontario Demographic Quarterly: Highlights of first quarter. Ontario Government. Accessed at: ontario.ca/page/ontario-demographic-quarterly-highlights-first-quarter

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