ÉQUIPE SANTÉ
ALGOMA ONTARIO
HEALTH TEAM

Monthly board update

March 2024

2024 Goals	Activities	Current status
Strengthening care in Algoma		
The following three programs are strengthened and expanded across Algoma: • Coordinated Access to Geriatric Services • Early Frailty Identification • Post-fall Pathway • Establish a renewed Healthy Aging Strategy	**Healthy Aging** • Increase uptake of the coordinated access referral form among primary care providers • Increase early identification of frailty in primary care. • Support the implementation of the post-fall pathway into communities and services • Conduct consultations to ensure the Algoma COVID-19 Pandemic Recovery Plan for Older Adults and their Caregivers reflects 2023 community needs	**Actively manage health outcomes for the attributed population**
• Identify a priority initiative, and initiate a project to improve clinical pathways for ambulatory care-sensitive conditions • Develop a multi-year plan to address complex chronic disease needs in Algoma • Establish a Mental Health and Addictions System Planning Table • Strengthen and expand the Community Wellness Bus project	**Complex Chronic Disease** • Bring partners together to conduct a community scan of the current state and opportunities related to complex chronic disease management • Establish an Advisory Committee **Mental Health and Addictions** • Implement integrated community-based mental health and addiction planning recommendations. Recommendations will have a focus on governance and structure • Strengthen and increase partnerships within the health system and expand the scope of services provided to bus visitors, including improving access to primary and preventative care	**Deliver a full continuum of care for all but the most highly specialized conditions** **Seamless transitions through the health and social service systems**
• System navigation supports across priority areas are implemented to improve health system navigation for providers and the community	**System Navigation** • Develop an Algoma OHT 24/7 system navigation support platform, coordinating with the provincial digital front door, Health 811 • Support the development of a Mental Health and Addictions Resource Guide/Roadmap for providers and the community	**24/7 coordination and system navigation**

2024 Goals	Activities	Current status
Community partnership and engagement		
• The adoption of the foundational values for care and the principles for advancing integrated care is increased among AOHT partners • Algoma's primary care delivery priorities are communicated and incorporated into future planning • Caregiver ID is expanded across Algoma, increasing the recognition of caregivers as an essential part of the care team • Tangible steps to improve equity, diversity, and inclusion are identified and planned for	**Community Engagement** • Develop and share a roadmap to implement AOHT's Guiding Values and Principles • Meaningfully engage community voices by forming a Primary Care Patient and Family Advisory Council • Compile, analyze, and share data from Phase 2 of Caregiver ID from the Caregiver Focus Groups • Adopt and implement a framework for equity, diversity, and inclusion	**Meaningfully partner and engage with community voices to build a health system that is designed by and for the communities we serve**
Building a foundation for collaboration		
• Knowledge and expertise of digital health champions to advance digital health maturity is leveraged and aligned with Ontario Health's digital health strategy and digital health maturity objectives • The current AOHT digital health capabilities and performance status of digital health systems are understood • Implement key objectives in our AOHT Harmonized Information Management Plan (2022)	• Strengthen the Digital Health Committee and Privacy Officers' Community of Practice • Create a performance-based measurement of AOHT digital health systems across partner organizations • Develop a work plan on privacy, security, and data-sharing with partner organizations to create an Algoma OHT Privacy Toolkit • Develop the program design for the Virtual Episodic Access to Care programs for unattached patients in Northeastern Ontario in collaboration with other OHTs	**Digital health solutions support delivery of care, ongoing quality and performance improvements, and patient access to information when and where they need it**
• Increase access to preventative screening for unattached patients • Based on collaborative Quality Improvement Plan (cQIP) indicators, develop indicators that measure AOHT performance	**Performance Measurement and Evaluation** • Continue to host a series of cervical screening clinics • Develop and implement a performance measurement framework based on research to measure overall success	**Provide care according to the best available evidence and clinical standards**
• Develop and implement a path to not-for-profit incorporation • Strengthen the foundation of our OHT through renewed structures, increased involvement, and communication with key stakeholders	**Leadership, Governance, and Partnerships** • Establish a Board of Directors • Develop Collaborative Decision-Making Agreements among our partners • Establish a framework for expanding AOHT membership • Develop a communications protocol to improve engagement and understanding of AOHT priorities and identification of partners • Build and strengthen relationships with rural and Indigenous organizations and neighbouring OHTs	**Operate through a single clinical and fiscal accountability framework, including an integrated funding envelope based on care needs of attributed population**