OHT-ÉSO ALL PARTNERS MEETING – SUMMARY REPORT

SEPTEMBER 25, 2023

EXECUTIVE SUMMARY

61 participants, including OHT-ÉSO partner organizations, client partners, and primary care providers, participated in the All-Partners' Meeting on September 25, 2023. The goal of the meeting was to offer an opportunity for partners to re-engage on priority topics for the OHT-ÉSO, and provide guidance, feedback, and suggestions on how to meaningfully progress work across all OHT-ÉSO areas of work.

There were three key themes that transcended discussion topics throughout the day:

1. Partners believe the role of the OHT-ÉSO is to facilitate strategic connections, alignment, and collective impact amongst work already happening to address key system challenges. Rather than focusing exclusively on leading independent initiatives, the OHT-ÉSO should help partners understand how their work contributes to collective goals, and providing supports and guidance to partners that help them ensure their work has an impact at the system level.
2. The intersectional nature of health and wellbeing needs to be consistently emphasized in all areas of OHT-ÉSO work. The social determinants of health, and intersecting health challenges, impact how individuals interact with health and social care systems. Partners need help to support their patients and clients with all their health and social needs rather than siloing organizations and clients into restrictive and reductive categories.
3. There is appetite and interest from OHT-ÉSO partners to contribute to system transformation efforts, but engagement and implementation opportunities need to be tailored to different levels of capacity, in recognition of the ongoing strain organizations and individuals are under. Clear, tangible action plans will help organizations determine how they can be involved and support the achievement of collective goals.

MEETING SLIDES

OHT ESO All Partner Meeting_Pre

MENTAL HEALTH AND SUBSTANCE USE

The morning session of the All-Partner meeting was focused on advancing work in the OHT-ÉSO's Mental Health and Substance Use portfolio. The OHT-ÉSO is ready to embark on new initiatives in this portfolio, and used this opportunity to engage with partner organizations, primary care practitioners, and client partners on where they feel the OHT-ÉSO should focus their work to have maximum impact.

Participants were provided a data package in advance that summarized available data on mental health and substance use system performance and asked to share their reflections on this data in advance to inform discussion topics, which were: housing, mental health, and substance use, the toxic drug crisis, emergency department utilization for mental health and substance use, and culturally competent mental health and substance use care. Partners were invited to participate in two breakout discussion groups on identified themes.

HOUSING, MENTAL HEALTH, AND SUBSTANCE USE

Participants shared that access to housing was one of the most impactful social determinants of health for their patients and clients, and individuals with mental health or substance use health require targeted supports to obtain and retain adequate housing. It was also reflected that the current system is under-resourced but also highly fragmented; continued investment of resources without addressing issues of fragmentation is not believed to produce highly impactful results. Participants shared that there is a lot of activity in the housing and supportive housing area and the greatest need is for support from the OHT-ÉSO to strategically connect and align existing efforts and activities to promote leveraging learnings, scaling promising practices, and helping partners understand the collective impact of their individual efforts.

THE TOXIC DRUG CRISIS

There is a high-level activity amongst organizations serving this population to continue to respond to the increasing severity of the toxic drug supply, and its impact on people who use drugs. Partners recognize the need for the system to be able to meet this population where it is with the right intensity of support, no matter where they choose to access service. An example shared by a partner is the challenge faced by clients in accessing health care services when under the influence of drugs or alcohol, and the lack of safe spaces for clients to stabilize in order to receive the needed care. Partners flagged the opportunity for the OHT-ÉSO to support the health system to build its collective capacity to provide high quality care to people who use drugs and address stigma directed towards this population within the health system. Another opportunity for OHT-ÉSO support would be connecting and aligning existing efforts with a particular focus on evaluating the collective impact of the system's toxic drug supply response.

CULTURALLY COMPETENT MENTAL HEALTH AND SUBSTANCE USE CARE

Understanding the landscape of culturally competent mental health and substance use care for different population is impeded by the lack of high-quality data on the ways that different equity-deserving communities are accessing mental health and substance use care. Partners recommended that the OHT-ÉSO consider supporting a mapping exercise to understand currently available data sources on how equity-deserving communities are currently accessing care and what culturally adaptive services are currently available in our community. Partners also felt that a common definition of culturally competent care is important, and that organizations and individuals

will need change management support to move from current practice to more culturally competent care. The importance of engaging community organizations and individuals from equity-deserving communities in these efforts needs to be acknowledged in any work undertaken by the OHT-ÉSO in this area.

EMERGENCY DEPARTMENT UTILIZATION FOR MENTAL HEALTH AND SUBSTANCE USE

There were two primary themes in the discussions of emergency department utilization for mental health and substance use concerns – how to divert clients away from the emergency department who need support but are not in crisis, and how to provide a better care experience in the emergency department for those with mental health and substance use concerns. Finding ways to better support primary care practitioners to address basic mental health and substance use concerns was seen as a strategy to divert traffic from emergency departments, as well as increased system navigation supports to help people find the right services for them, as opposed to resorting to the emergency department. Additional system navigation resources located in the emergency department, with an emphasis on connections to social support, may be a way to prevent repeat visits by the same client. Partners also offered ideas for how to improve the care experience in the emergency room, including improved information transfer between emergency department and other health service providers as well as with the client, address stigma towards mental health and substance use within emergency department staff, and providing additional specialized resources to emergency department staff (e.g., addiction medicine), to ensure the client gets connected right away to appropriate treatment supports.

NEXT STEPS

The OHT-ÉSO Mental Health and Substance Use Co-Leads, in partnership with the Collaborative Leadership Group, will review the feedback shared by partners and re-engage with all participants about next steps in the process of selecting new initiatives in this portfolio.

For questions concerning this portion of the meeting, please contact Ayan Barre at a.barre@pqchc.com.

CELEBRATING OHT-ÉSO PROGRESS, FIRMING OUR FOUNDATION

Please see accompanying slide deck for details on this presentation.

For questions concerning this portion of the meeting, please contact Michelle Hurtubise at mhurtubise@centretownchc.org or Honorata Bittner at hbittner@toh.ca.

OHT-ÉSO CAPACITY BUILDING

Partners were invited to participate in 2 breakout sessions on four areas of capacity development currently underway within the OHT-ÉSO.

PRIMARY CARE ENGAGEMENT

The OHT-ÉSO is working to engage primary care providers around solutions on the issue of unattached patients within our community; there are currently estimated to be 130 000 individuals in the Ottawa area who do not have

access to a primary care provider. The issue is projected to worsen in the coming years, as our population ages and many providers move towards retirement. Participants shared that this challenge has impacts far beyond just the primary care sector and is truly systemic in nature; clients are blocked from accessing certain speciality services (i.e., acquired brain injury, specialized geriatric programs) without a referral from a primary care provider. There may be opportunities for the wider system to support primary care by offering easier access to services that support the social determinants of health needs of patients, thereby decreasing the complexity of care the primary care practitioner needs to provide.

For questions concerning this portion of the meeting, please contact Aleksandra Milosevic at a.milosevic@pqchc.com.

CLIENT PARTNER ENGAGEMENT

Participants were offered the opportunity to share what client engagement currently looks like at their organization, and what goals they have for how they want to advance and intensify engagement in the future. Partners shared that they often experience constraints (i.e., funding, timelines) to doing the kind of engagement work they aspire to, but they have developed creative solutions to these challenges, including collecting feedback on existing programs to seed future co-design initiatives. They also shared the importance of understanding different types of client engagement, and when to emphasize each one – client experience feedback, participation in service and system planning, and client engagement in their own care planning.

For questions concerning this portion of the meeting, please contact Aleksandra Milosevic at a.milosevic@pqchc.com.

PERFORMANCE MEASUREMENT

OHT-ÉSO partners are excited about the opportunity to align performance measurement indicators through the OHT-ÉSO, aligned with the Quadruple Aim and a strong health equity focus. There are opportunities for the OHT-ÉSO to advocate for structural changes that will facilitate this work, like seeing sociodemographic data collected through existing reporting tools partners are already using. Partners are also seeking support in understanding and interpreting the data they currently collect, potentially through collective resources like communities of practice.

For questions about this portion of the meeting, please contact Liam McGuire at l.mcguire@pqchc.com

DIGITAL HEALTH AND INFORMATION MANAGEMENT

Partners expressed challenges with navigating the current landscape of having multiple digital health platforms in use that don't integrate with one another. They shared the importance of advancing digital health and technology use in a client-centred way and the need to implement these new tools in a way that prioritizes the needs and experience of the client. An example shared was clients receiving test results via patient portals before their provider had reviewed them and being left to interpret their results alone. Partners also emphasized the issue of

digital equity, and the importance of supports for clients to learn and use digital health tools in order to participate fully in their care.

For questions about this portion of the meeting, please contact Liam McGuire at l.mcguire@pqchc.com.

NEXT STEPS

Feedback shared during these sessions will be provided to the Primary Care Partner Table, Client Partner Table, Performance Measurement Working Group, and Digital Health and Information Management Strategic Leadership Team. OHT-ÉSO partners can expect follow up discussions on these topics at future All-Partner Meetings.

FRAIL OLDER ADULTS

The afternoon session was focused on understanding how we can advance the Community Health Teams model within the OHT-ÉSO, leveraging existing networks, partnerships, and collaborations. Partners were asked in small group discussions to reflect on the potential benefits of Community Health Teams for their clients and community, potential challenges that may arise bringing this model to their community, existing partnerships and collaborations that could be leveraged, and segments of the older adult population that may not be well-served by this model.

Partners were excited by the potential for resource optimization presented by the Community Health Teams model and appreciated the upstream approach to care. In particular, the Social Health Facilitator role was appreciated for its ability to connect clients to needed social supports, which is currently a gap in our system. Partners also felt that the interdisciplinary nature of the Community Health Teams model would offer opportunities for increased relationship building amongst partners, and help clients and caregivers build trust in the system. Perceived challenges included the complexity of the current primary care landscape and the challenges primary care providers face in making good referrals. Efforts would need to be made to streamline the referral process for primary care and make it as easy as possible for providers to access Community Health Teams if we were to see a high volume of referrals. Partners also felt that there was a need for increased education across the system on the Rockwood Clinical Frailty Scale so that providers could understand its uses and how to interpret results consistently. There was a common concern that the current lack of sufficient funding for community-based services would also present a challenge in adopting new models of care.

There are opportunities to leverage existing partnerships to extend the reach of Community Health Teams into new areas of the system. Some ideas proposed included leveraging hospital-based social workers as Social Health Facilitators, engagement with paramedics to support clients leaving hospital or emergency departments and integrating palliative care services into the model. Participants flagged a few segments of the older adult population that may not be well served by Community Health Teams, including those unattached to primary care, clients with mental health or substance use issues that result in challenging behaviors, and clients living in rural areas.

Ottawa Health Team
Équipe Santé Ottawa

NEXT STEPS

Partners identified the following next steps as promising steps forward:

1. Pursue a better understanding of currently available services by frailty level and by geographic location,
2. Understand opportunities to integrate palliative care services into the model,
3. Explore digital health tools that may assist in Community Health Teams implementation,
4. Broader system education on the Rockwood Clinical Frailty Scale.

For questions about this portion of the meeting, please contact Shaina Smith at s.smith@pqchc.com.