High Priority Communities Strategy: Moving to Broader System Goals

May 31, 2023

Overview

To provide an overview of the High Priority Communities Strategy, its successes and lessons learned, and opportunities for alignment with broader health system goals.

1. Understanding the Needs of High Priority Communities
2. The Strategy's Shift to Address Broader Health Needs
3. Key Success Factors
4. Linking High Priority Communities Strategy and Ontario Health Teams

Understanding the Need for the High Priority Communities Strategy

Underserved populations in Ontario face systemic barriers in accessing and interacting with the health system, which directly contributes to **overall poorer health outcomes** based on indicators such as **income, geography and race.**

- **10.4%** of Ontario's population **do not have a family physician**[1] **and Black women in Ontario are 3X less likely to have a family doctor** compared to non-racialized women.[2]
- The **poorest Ontarians are nearly 2X as likely to report multiple chronic conditions** as the richest Ontarians.[3]
- Self-reported **diabetes** in Canada is **almost 2X higher among Black, South and West Asian adults** compared to white adults.[4]
- **Black and racialized patients in Canada may be less likely to receive adequate pain treatment.**[5]
- Health knowledge and awareness may be obstructed **by language barriers, literacy, cultural differences, or limited access to technology**.[6]
- Experiences of systemic **racism in the health system negatively impact the health outcomes** of equity deserving populations.[7]

The HPC Strategy works to address these barriers.

The High Priority Communities Strategy: Supporting Broader Health Goals

Goals of Strategy

Community-informed Population Health and Wellness Models to Address:

Chronic Disease Prevention & Management

Mental Health and Substance Use

Primary Care

Unmet Local Needs

Food security, housing, income/employment supports, transportation, settlement services, and more

The strategy empowers communities to identify local needs that they will address.
Community goals were identified by lead agencies, in partnership with OH, OHTs, and PHUs.

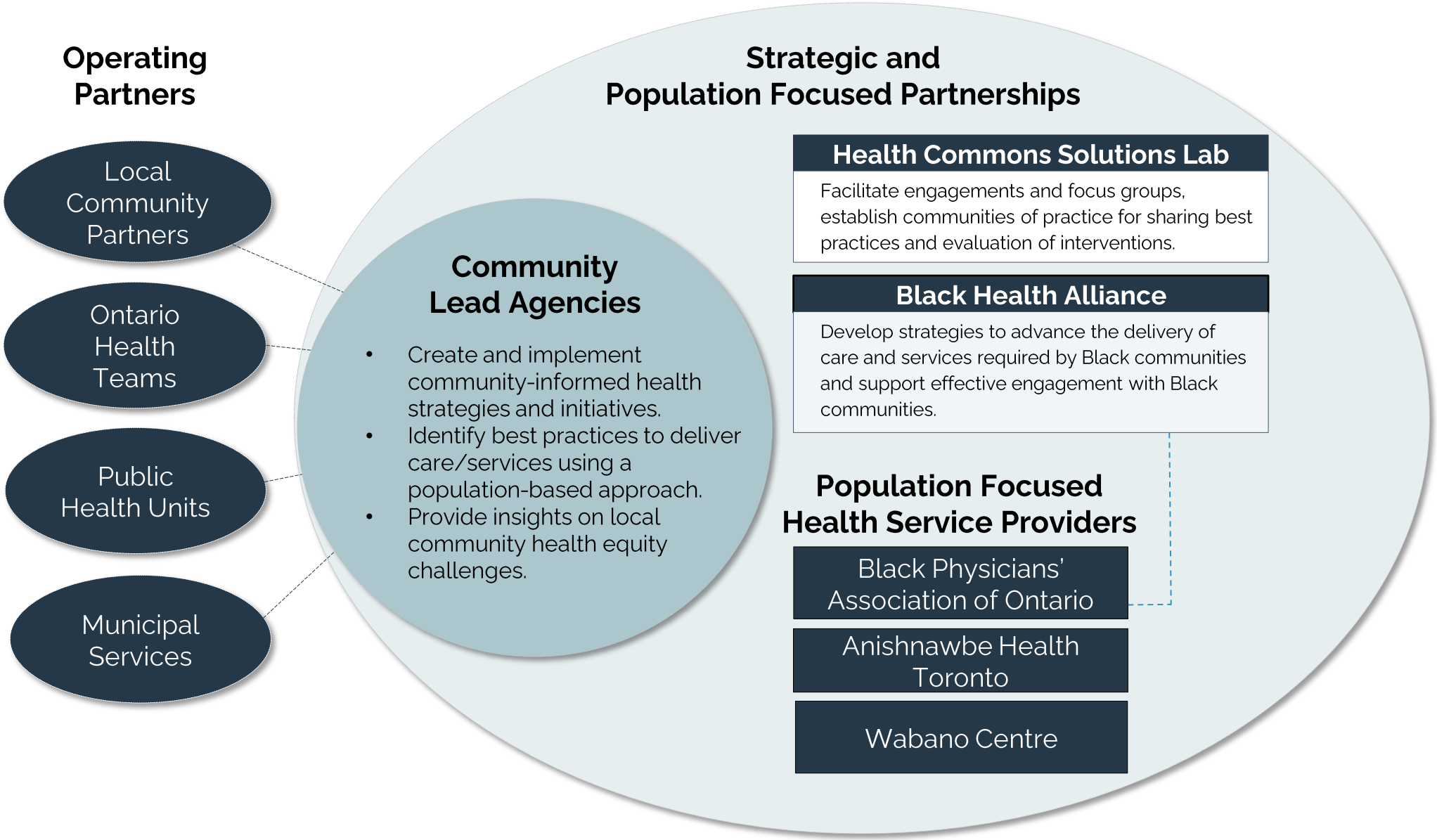
How does the strategy address local goals?

Remove barriers to accessing **health services**

Community-informed **engagement & outreach**

Wraparound supports to **address the determinants of health**

HPC Strategy 2023-24: Partner Roles



HPC Strategy: Progress on Broader Health Goals

Increasing Access to Preventative Services & Mental Health Supports

16,131 individuals were either referred or received direct **mental health and addiction supports.**

Over 17,000 individuals were referred for **breast, cervical, and colorectal cancer screening.**

Nearly 5,000 individuals were either referred or have completed their screening tests for **diabetes.**

Over 3,000 Naloxone kits were distributed to high priority communities.

Increase Access to Wraparound Supports

Nearly 40,000 individuals were either referred or received direct wraparound supports and services (i.e., housing, transportation, income support, etc.)

Partnerships and Community Engagement

1,468 new partnerships across 10 sectors

Nearly 400,000 individuals were engaged using a variety of engagement methods (i.e., community ambassadors, webinars, social media, etc.

Increasing Primary Care Attachment

1,811 individuals were referred to primary care (i.e., physician, Health Care Connect, etc.)

301 individuals were successfully attached to primary care

HPC Strategy Reflections

Key Successes

- Lead Agencies with Community Connections
- Community Ambassadors
- Wraparound Supports
- Barrier Free Health Services
- Partnerships and Collective Impact

Lessons Learned

1. **Value of Community Informed and Community Led Solutions**
   Programs need to be community driven to ensure they are accessible and effective.

2. **Need to Scale**
   Targeted approaches work best – how to provide supports to more people, in more communities.

3. **Health is Bigger than the Health Care System**
   Health equity and progress on health outcomes requires supports that address the determinants of health.

HPC Lead Agencies, a Core Partner in Ontario Health Teams

- HPC lead agencies are working with OHTs in their local health system.
- Ontario Health Teams (OHTs) are a model of integrated care delivery that enable patients, families, communities, providers and system leaders to work together, innovate, and build on what is best in Ontario's health care system.
- Under this model, **groups of health care providers and organizations work together as a team to deliver a full and coordinated continuum of care for patients**, even if they're not in the same organization or physical location.
- The goal is to provide better, more integrated care across the province.

OHTs Integrate Care Around Patients

Patients receive all their care, including primary care, hospital services, mental health, long-term care, and home and community care from **one team.**

OHT & HPCS Alignment

With population health management at the core of OHTs, there is a nature alignment with HPCS. In practice these linkages include **1) advancing health equity** and, **2) leveraging partnerships**.

1. Advancing Health Equity

- Shared commitment to improving health outcomes and equitable access to care.
- Demonstrate an in-depth understanding of health and healthcare needs of their patient populations and engage with equity-deserving communities in the service planning, design, and delivery.

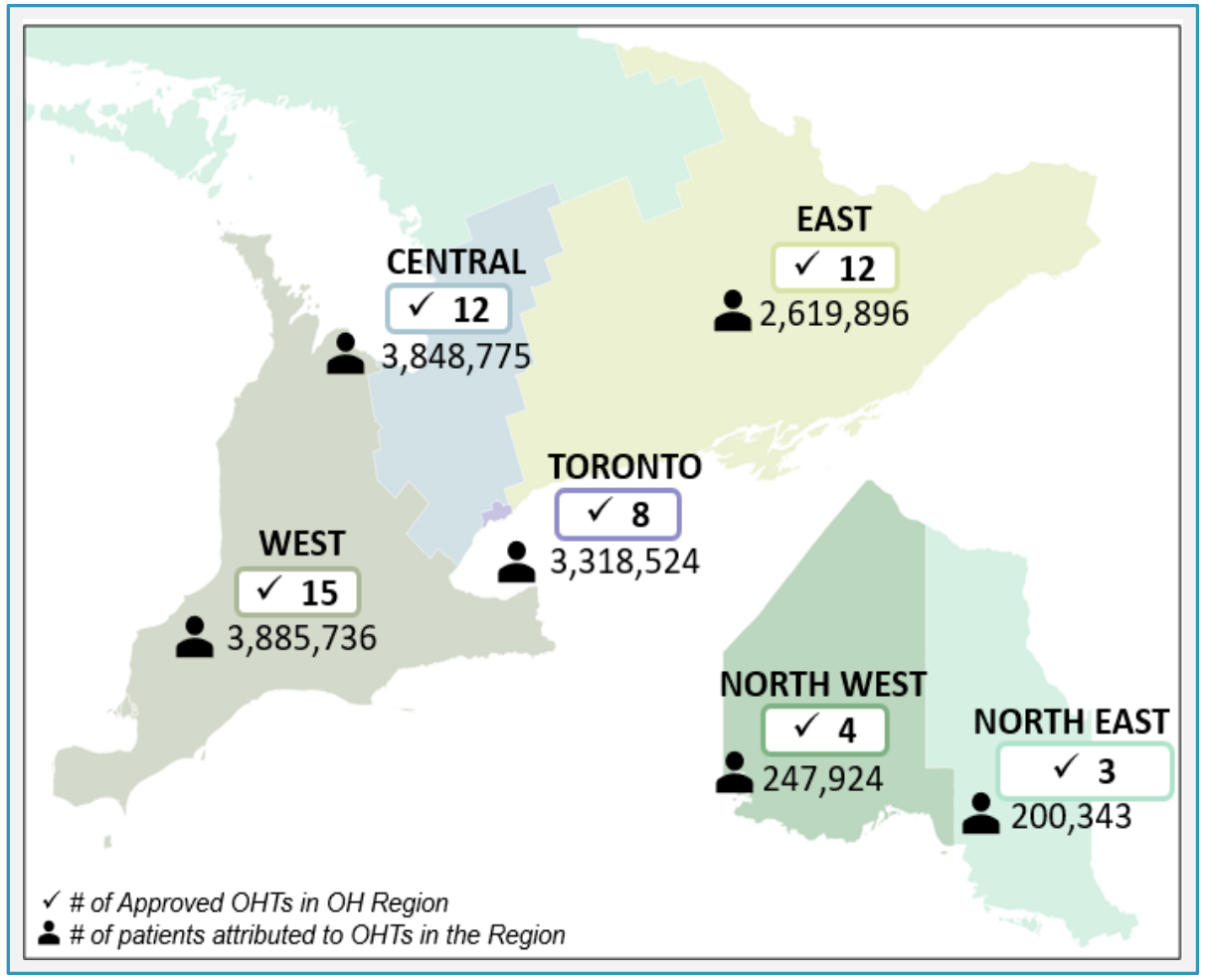
2. Leveraging Partnerships

- OHT model is foundation on leveraging partnerships from across the broader health system to provide care.
- Lead agencies leverage points of connections to make referrals and wraparound supports to HPCs.

Examples of partnerships in practice:

- Durham OHT and Carea CHC have worked together to increase access to wraparound supports utilizing a case management approach.
- Ottawa OHT and South-East Ottawa CHC worked together to support the referral pathway of patients.

HPC Strategy to Support Health System Transformation (Ontario Health Teams)



Ontario Health Teams (OHTs) that are collaborating with HPC lead agencies include:

- Mississauga OHT
- Central West OHT
- East Toronto Health Partners OHT
- Western York Region OHT
- Eastern York Region and North Durham OHT
- North Western Toronto OHT
- Durham OHT
- Scarborough OHT
- Ottawa OHT
- Windsor-Essex OHT

The majority of HPC lead agencies are members of their local Ontario Health Team (OHT).

Relationships and partnerships differ between lead agencies and OHTs; leading practices for strong collaboration are actively being spread.

Key Priorities for HPCS and OHTs: Discussion

- Exploring lessons learned and best practices that can be spread / scaled.
- Engagement and co-design approaches to link HPCS and OHTs.

Questions for discussion:

- What are the opportunities for strengthening partnerships between OHTs and lead agencies?
- What are the enablers or conditions required to support community-driven equity into OHT planning tables?
- How can OHT partnerships be further leveraged to help address gaps or barriers?