HSPN Health System Performance Network

Co-Designing Health Solutions

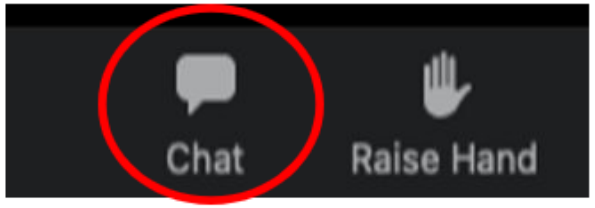
Learning Health System Series Part 4: Engaging Patients, Families, and Providers for Effective Implementation

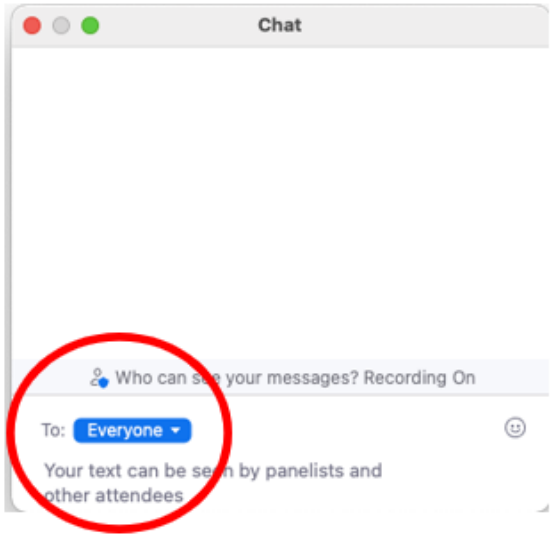
HSPN Monthly Webinar

July 23, 2024

Welcome & thank you for joining us!

Please let us know who you are by introducing yourself (name & OHT or other org)





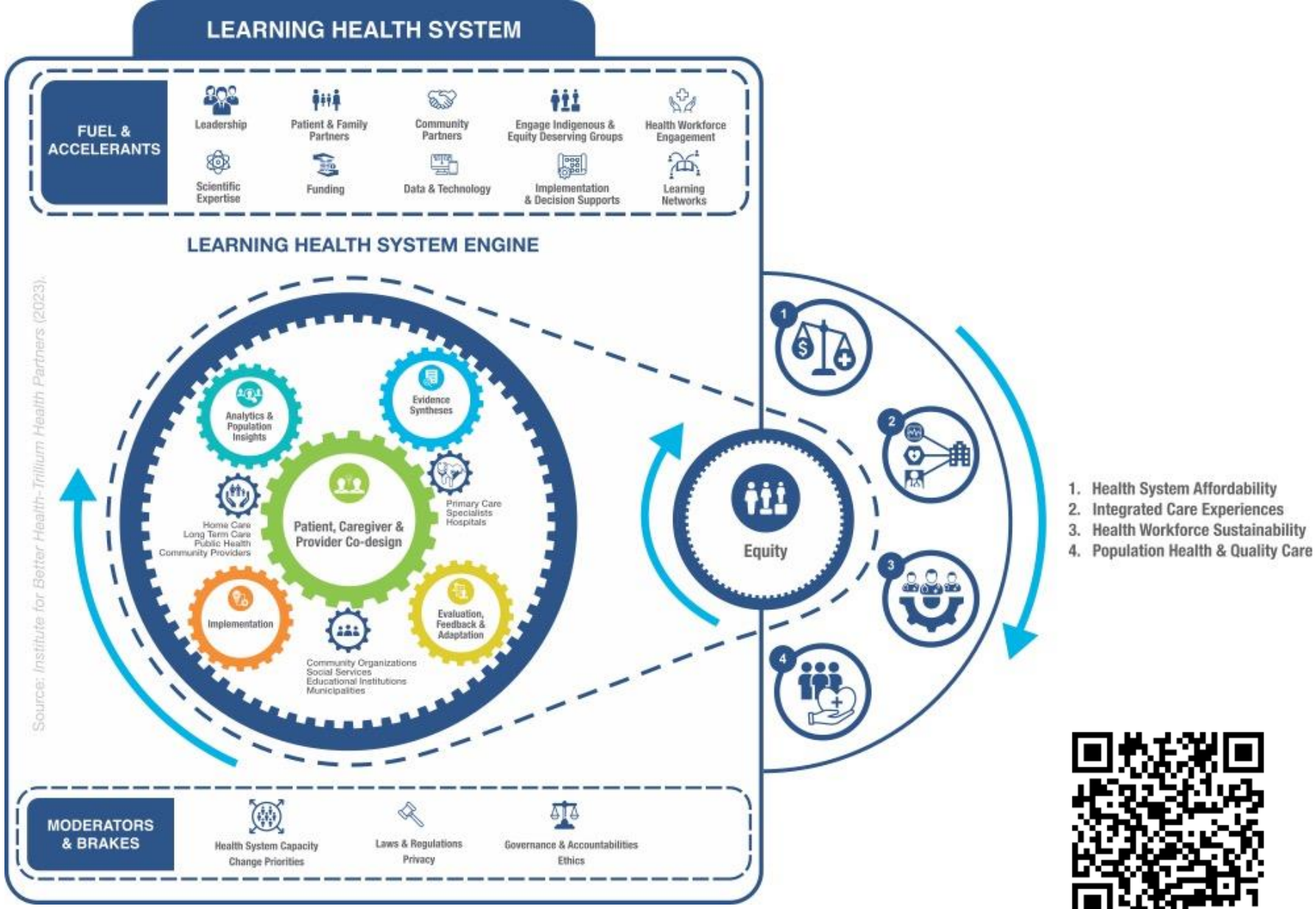
➢Open Chat

➢Set response to everyone in the chat box

Land Acknowledgement

We wish to acknowledge this land on which the University of Toronto operates. For thousands of years it has been the traditional land of the Huron-Wendat, the Seneca, and the Mississaugas of the Credit. Today, this meeting place is still the home to many Indigenous people from across Turtle Island and we are grateful to have the opportunity to work on this land.

LEARNING HEALTH SYSTEM ACTION FRAMEWORK



SOURCE*: Institute for Better Health-Trillium Health Partners* (2023).

Learning Gear 3: Patient, Caregiver and Provider Co-design

Description: Direct engagement and co-design with patients, caregivers, care providers and community members impacted by the health problem alongside those who can move co-designed services towards successful implementation.

Sample Questions: what are user centered design conditions (providers, patients, caregivers, community members)? What design considerations are most important? How can technology be used? How do requirements differ for equity deserving groups? What are the feasibility constraints?

Health System Affinities: innovation & user centered design experts/teams, clinical programs/networks, health informatics programs, patient & family experience councils, community groups, health system leaders/regulators etc.

Poll 1

1. Have you joined us for an HSPN webinar previously? (Single Choice)
*

53/53 (100%) answered

HSPN Health System Performance Network

Today's event: Learning Health System Co-design with Patients, Caregivers and Providers

Host

Dr. Walter Wodchis
Principal Investigator
HSPN

Presenters

Dr. Kerry Kuluski
Associate Professor at the Institute of Health Policy, Management and Evaluation, University of Toronto

Dipti Purbhoo
Executive Director at The Dorothy Ley Hospice
Mississauga Health OHT

Frances Henderson
Caregiver Advisor for Mississauga Health

Dr. Laura Harild
Clinical Co Lead for Ontario Health, Central Region, Division Head and Medical Director
Mississauga Health OHT

Yasmin Sheikhan
Vice Chair, Chair of Patient and Caregiver Advisory Council, Mid-West Toronto Ontario Health Team

Edward Aust
Director, Corporate Planning
Mid-West Toronto Ontario Health Team Secretariat

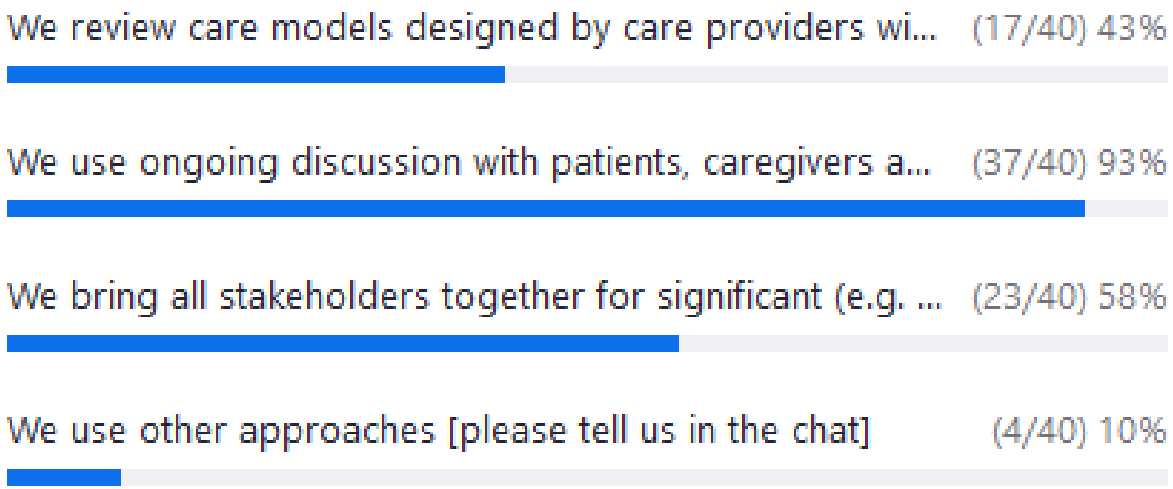
Poll 2


1. To what extent have you engaged in co-design? (Single Choice)
55/55 (100%) answered
We have not engaged in co-design
(12/55) 22%
A little (1-3 events in the past year)
(29/55) 53%
Moderately (4-7 events in the past year)
(10/55) 18%
A lot (more than 7 events in the past year)
(4/55) 7%

Poll 3

1. How do you approach co-design? [check all that apply] (Multiple Choice)

40/40 (100%) answered



CO-DESIGN
THE FUNDAMENTALS

KERRY KULUSKI, MSW, PHD
DR. MATHIAS GYSLER RESEARCH CHAIR IN PATIENT AND FAMILY CENTRED CARE
ASSOCIATE PROFESSOR

JULY 23, 2024

AGENDA

- What is Co-Design?
- Why Does Co-Design Matter?
- Co-Design in the Context of a Learning Health System

WHAT IS CO-DESIGN?

CO-DESIGN

1. a process for **developing solutions** to complex problems
2. **privileges lived expertise**, actively involves people affected by an issue as expert collaborators, along with other partners
3. a shift in healthcare improvement approaches **from consultation to more equitable involvement** and decision-making

Thorburn et al, 2024

3 APPROACHES TO INTERACTING WITH PEOPLE (SANDERS 2002)

Say- Listening to what someone says in an interview

Do- Watching how people use products and services

Make- In creative workshops, people exploring and *making* solutions

PATIENT ENGAGEMENT- WHERE DOES CO-DESIGN FIT?

Rowland and Johannesen (2020) point out that patient engagement is typically **instrumental** in nature- 'action focused' including committee work or co-design activities which strives for a tangible outcome

Engagement can also be framed in a **democratic form** (a patient and caregiver *have the right* to influence health care)

as well as a **narrative form** (with a focus on dialogic communication, sharing, learning, re-learning and influencing one another)

CO-DESIGN INVOLVES:

- PEOPLE AFFECTED BY THE PROBLEM
- THOSE IN A POSITION TO DO SOMETHING ABOUT THE PROBLEM

Bammer (2013)

Relationship Building Phase

Activity Phase

Looping Back/Ongoing Engagement Phase

STAGES OF CO-DESIGN

Engage- build relationships, take steps to understand the problem

Plan- stages of the work, logistics, assess needs, **goals**, **methods to use**, etc.

Explore- learn about experiences and priority areas

Develop- co-design/co-redesign improvement (intervention, process, product)

Decide- what to prioritize and refine/seek additional feedback

Change- turn improvement ideas into action

Adapted from Kiss et al (2024)- see Figure 2

THE ETHICS OF CO-DESIGN

Sendra (2024)

- Collective thinking
- Creation of partnerships
- Know the population/context
- Address power imbalances
- Empower people to participate (skill building)
- Inclusive events and language
- Collective benefits
- Transparency
- Timing and resources
- Start before decisions are made and continue after the activity is over

READINESS OF SELF AND CONTEXT

Moll et al (2020)

<u>Explore readiness of self and of organization/system</u>. Ask yourself:

1. **How does my position impact others?**

3. Am I creating a safe space?

2. How do I make others feel?

4. Is the organization ready to take on the change that we want to achieve?

WHY DOES CO-DESIGN MATTER?

BENEFITS

For the project- improving the creative process, developing better service definitions and organizing the project more effectively;

For the service's customers or users- better fit between the service offer and the person's needs, a better service experience;

For the organization(s) involved- fostering a learning culture, cooperation between different sectors, units, people, communities, enhance capability for innovation.

Steen et al (2011)

Helps us Move from Technical to Adaptive Solutions

"The single biggest failure in leadership is treating adaptive challenges like technical problems." Ron Heifetz

Technical Challenges	Adaptive Challenges
Easy to identify	Difficult to identify
Straightforward solution	Requires changes in ways of working
Solved by experts	People with the problem need to do the work of solving it
Requires a limited number of changes	Requires many changes
Typically bound by an organization	Typically crosses organizations
People generally receptive	People may resist the change(s)
Solutions implemented quickly	Solutions require a trial-and-error approach

A VEHICLE FOR COLLECTIVE IMPACT

“An intentional way of working together and sharing information for the purpose of solving a complex problem.”

- National Council of Nonprofits

“The complex nature of most social problems belies the idea that any single program or organization, however well managed and funded, can singlehandedly create lasting large scale change.”

-Fay Hanleybrown, John Kania, & Mark Kramer

A Tale of Two Co-Design Studies

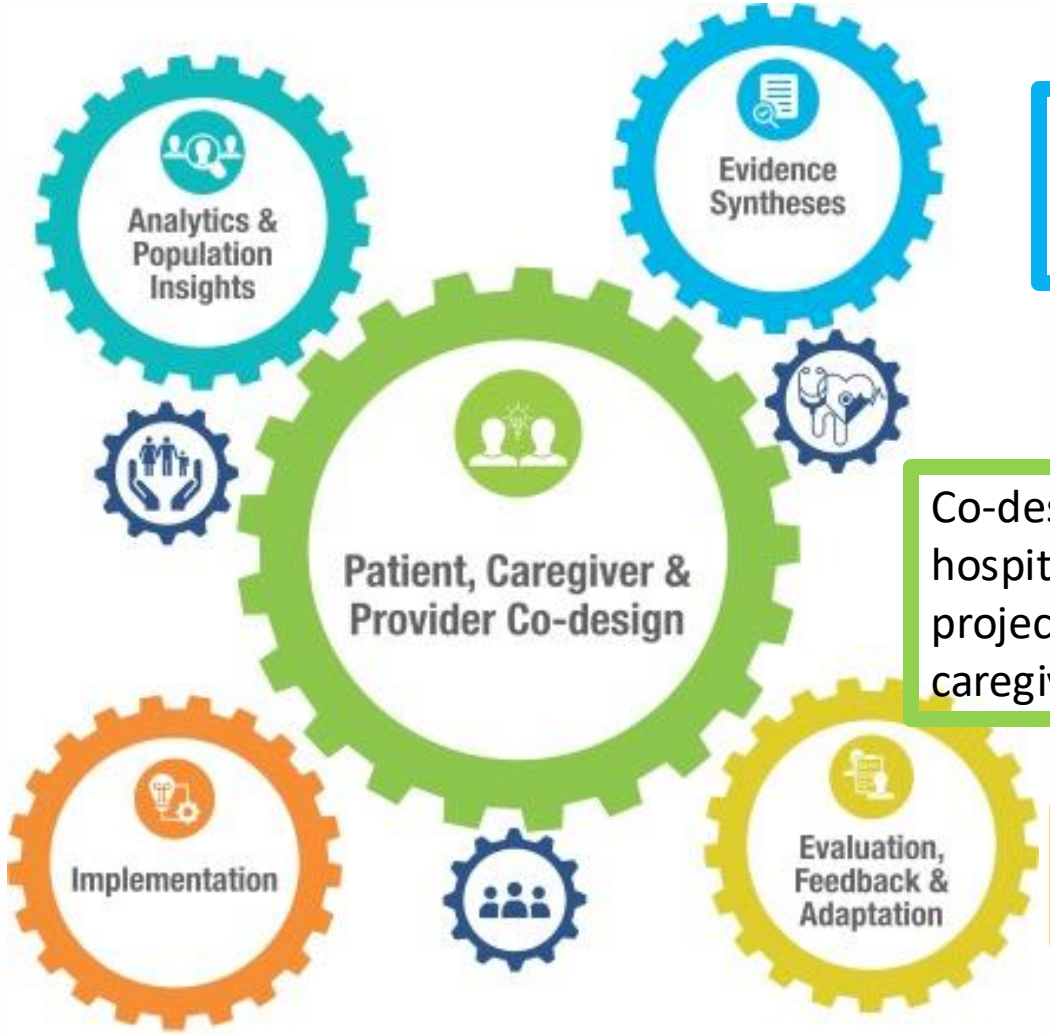
Example 1: Addressing Hallway Medicine

(Kuluski et al, 2020)

Example 2: Implementation of a new Patient Experience Data Strategy

EXAMPLE #1: HALLWAY MEDICINE

Analyzed local and provincial data of ALC patients. Conducted 1-1 interviews to learn about experiences



Source: *Institute for Better Health-Trillium Health Partners (2023).*

Scoping Review on strategies to address ALC

Co-designed a communication guide and in-hospital intervention and website with our project findings and materials with patients, caregivers and providers in different hospitals

Implemented into new hospital practice standards/ guidelines but not in hospital settings as planned

Feedback: integrate into existing processes in hospital

EXAMPLE #2: PATIENT EXPERIENCE STRATEGY

Trillium Health Partners | INSTITUTE FOR BETTER HEALTH

Analyzed previous survey data collected as well as other data sources to get a population snapshot

Source: *Institute for Better Health-Trillium Health Partners (2023).*

Scoping Review on how hospitals use Patient Experience data

Multi pronged Patient Experience strategy, including new short form patient experience surveys, co-design dashboards and tool-kit for clinical units

Rolled out new survey strategy, starting to share data dashboards with teams

Monitor use of patient experience data in practice (quality improvement uptake, patient outcomes, etc.), continuously adapt and track

CO-DESIGN LEARNINGS

- Ensure there are receptors for the work you are doing (who is invested? who will implement the changes?)
- Where possible, integrate changes and innovations within existing workflows
- Be explicit and intentional about the goals and scope of the work (e.g., go deep at a single site/in a single community to fully flesh out your proof of concept first)

CONCLUSIONS

- Relationship building is critical and ongoing
- Honor diversity of expertise and acknowledge differences in decision making power
- Involve people impacted by the problem as well as those who are invested in making the changes
- Think long-term (opportunity to build capacity and a learning culture)

CHECK OUT OUR TWO CO-DESIGN WEBINARS!

OHT learning series - Session #5: Preparing your Engagement Activities

https://www.youtube.com/watch?v=EA0A2QyK9rc

OHT Learning Series - Session #6: Engagement Methods

https://www.youtube.com/watch?v=FBk18YphCrY

To access the full 7-part series and workbooks:

https://www.instituteforbetterhealth.com/portfolio-items/patient-caregiver-and-community-engagement-learning-series/

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THANK YOU!

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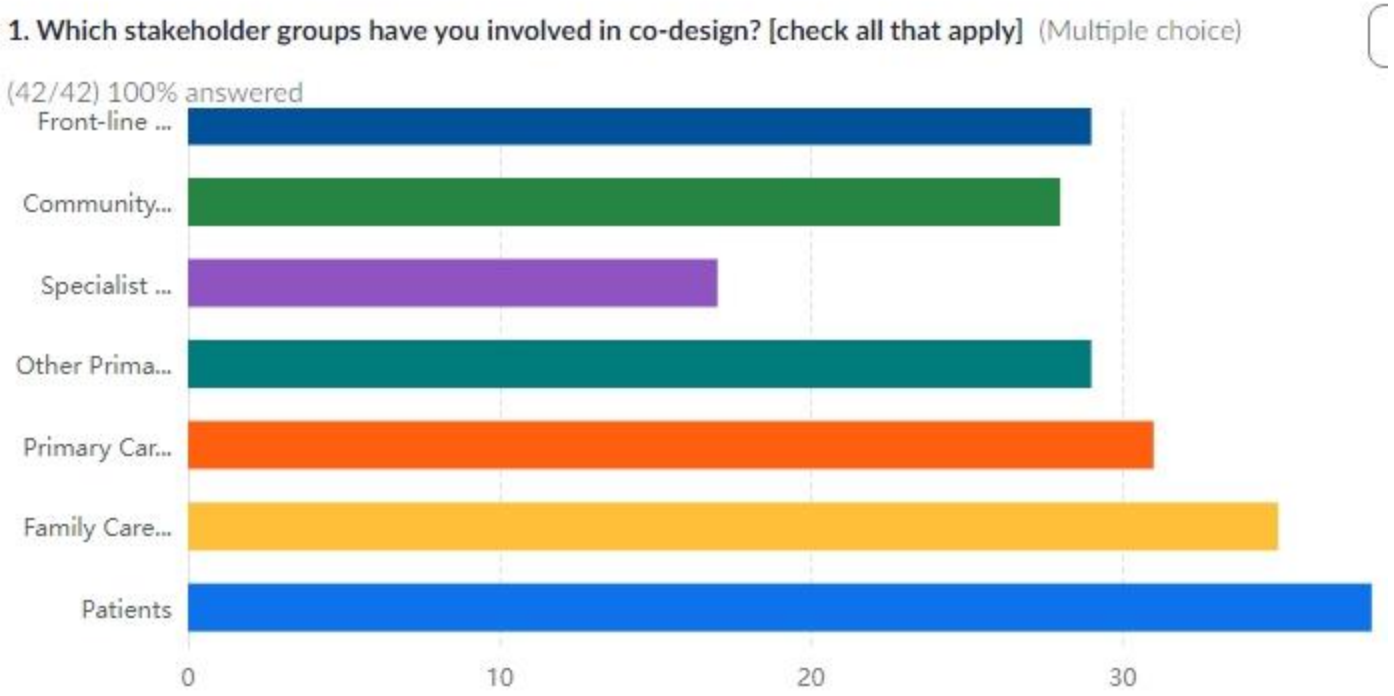
Poll 4



Options	Responses
Patients	38/42 (90%)
Family Caregivers	35/42 (83%)
Primary Care Physicians	31/42 (74%)
Other Primary Care (e.g Family Health Teams and Community/Aboriginal Health Centres)	29/42 (69%)
Specialist Physicians	17/42 (40%)
Community Care Agencies (Home care and community care Service providers)	28/42 (67%)
Front-line community care providers (nursing, PSW, etc)	29/42 (69%)
Community voluntary organizations	14/42 (33%)
Other (Tell us in the chat)	5/42 (12%)

Co-Designing an Integrated Model of Palliative Care

Experience of the Mississauga Health Ontario Health Team

July 23rd 2024

Dr. Laura Harild
Mrs. Dipti Purbhoo
Mrs. Frances Henderson

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Mississauga Health

Together, we will improve the health and wellness of all people in our communities by connecting their care across the system

900,000+ Attributable population

100,000+ Do not have a family physician

40% Live outside the Mississauga borders

Coming together to build an Integrated Model of Palliative Care to support palliative needs every step of the way

- In 2020, 62% of the people who died in our community did not receive palliative care[1]
- For those that had received palliative services, more than half are initiated in the last 2 months of life[1]
- Palliative care is a priority population in the Mississauga OHT (MOHT)
- There is an opportunity to build on the previous efforts to determine the best way to work in an integrated way to deliver exceptional palliative care along the continuum

[1] Population Health Indicators and Resource Utilization for End of Life and Palliative Population of Mississauga Ontario Health Team, Oct 14th 2022

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Palliative Care Collaborative

Together, we deliver exceptional and connected palliative care every step of the way because everyone's experience matters

OBJECTIVES

1. Advance the **Integrated Model of Palliative Care** for the MOHT
2. Build **capacity and competency** in palliative care locally

OUTCOMES

- Connect individuals earlier in their care journey and have a positive impact on patient and caregiver experience
- Improved provider experience, health system utilization and palliative care services
- Equitable access to palliative care services

PARTNERS

- ✓ Patients, Family, Caregivers, Community Members
- ✓ Hospice
- ✓ Hospital
- ✓ Primary Care
- ✓ Home Care
- ✓ Service Provider Organizations
- ✓ Equipment Suppliers
- ✓ Community Service Providers
- ✓ Long Term Care
- ✓ Community Paramedics
- ✓ Institute for Better Health
- ✓ Ontario Health

Palliative Planning Table provides oversight and guidance.

Designing the Integrated Model of Care Together

A roadmap for the future

START

FINISH

Current State:
Good care but limited access and poorly coordinated

Prep work for re-designing care:
Building on previous
- Co-design sessions
- Other frameworks including OPCN Health Service Delivery
- Population health management approach

Co-designing Future State:
- Multiple Co-design sessions
- Deeper dive with specific communities
- Synthesize possible model
- Review with Planning Table

Planning and Implementation:
Planning for implementation of integrated teams, digital tools and integration of home care (leading project)

Future State:
Multi-year implementation plan and ongoing engagement

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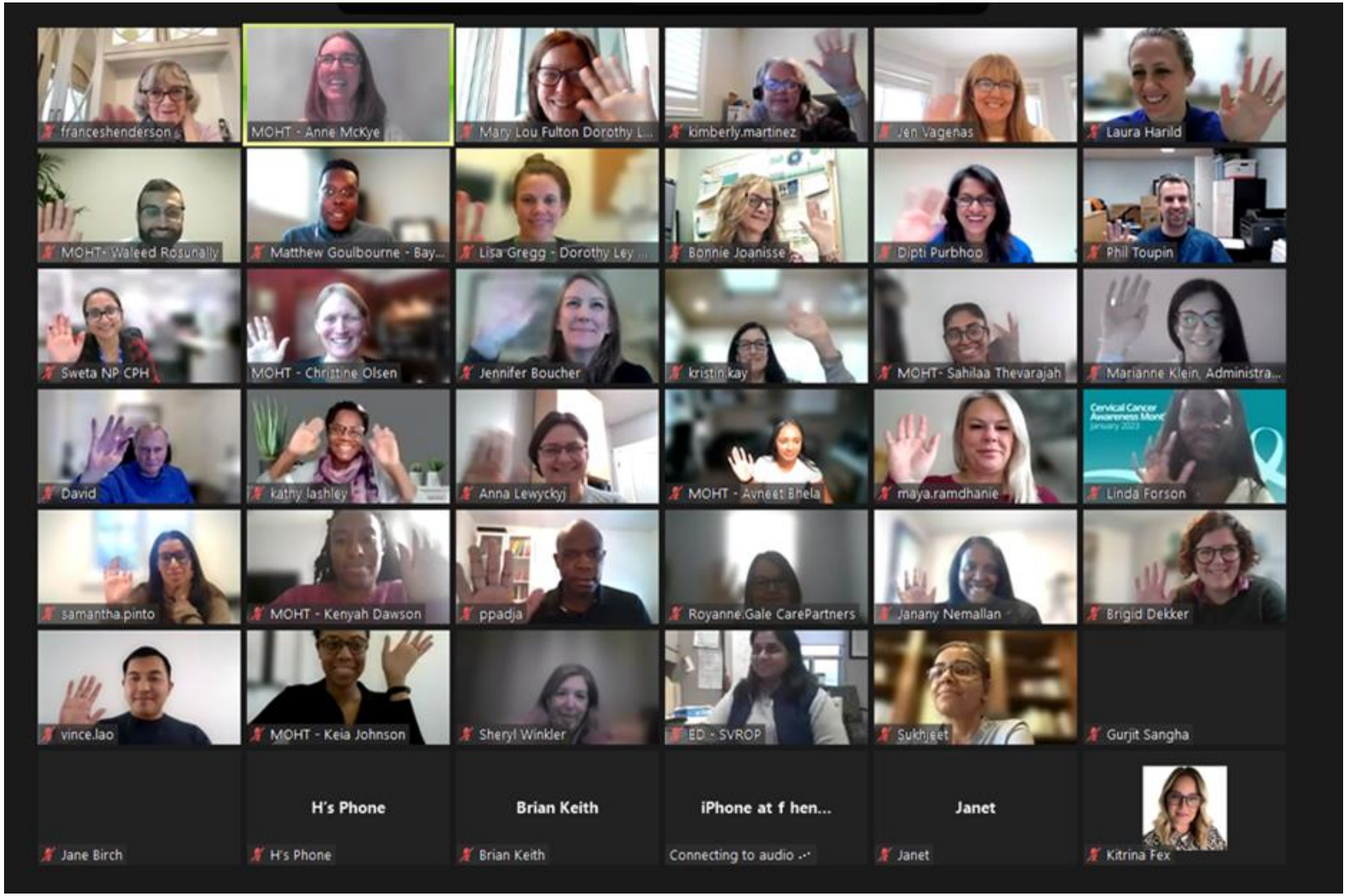
Co-Design Partnerships

Co-designing our future:

- 21 organizations
- 68 invited
- 52 attended (including 5 caregivers/ community members)



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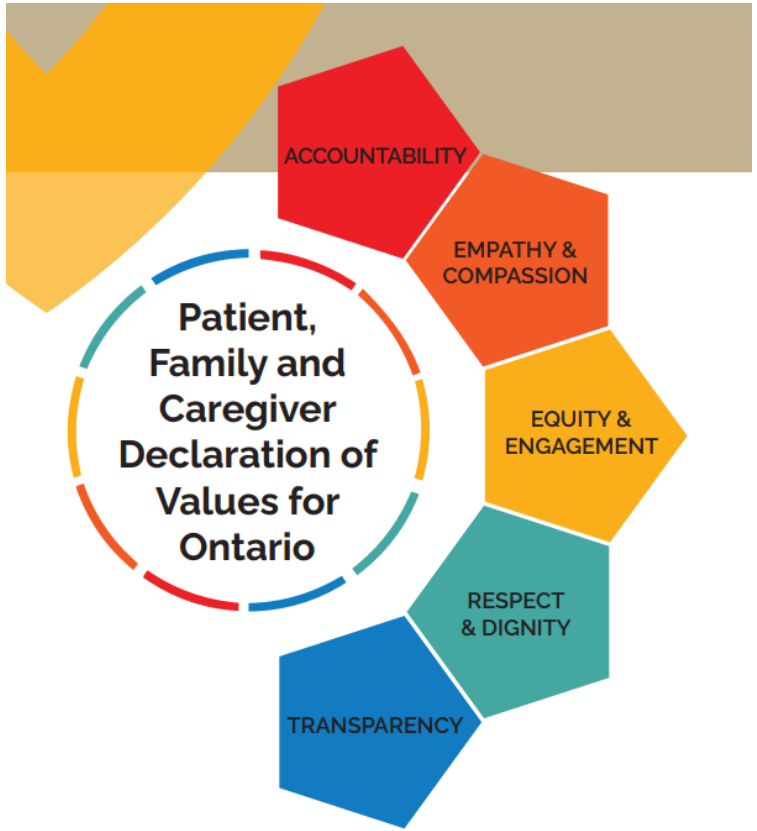
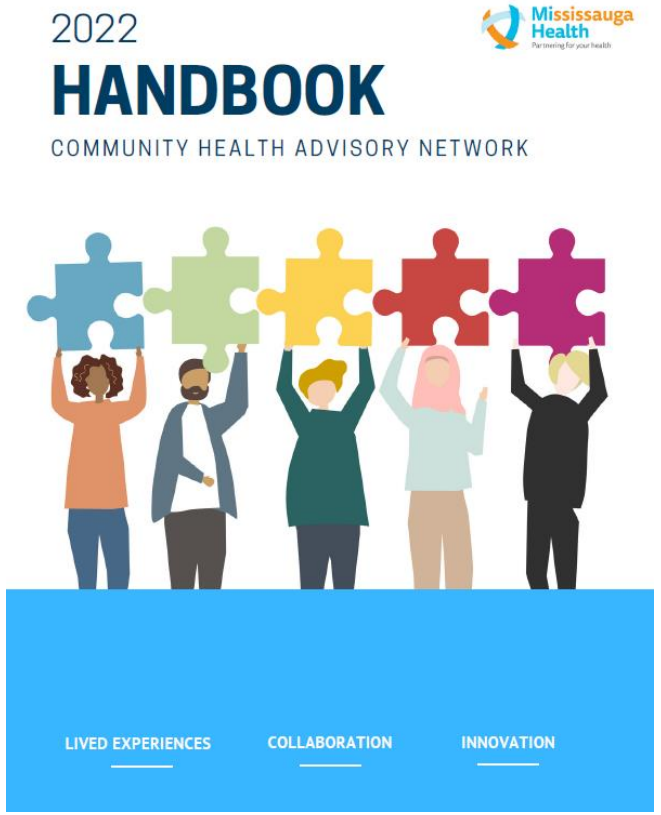
Guiding Principles

Ministry of Health Patient, Family and Caregiver Declaration of Values



Mississauga Health Community Health Advisory Network



Purpose

To create space for the diverse voices of patients, clients, and their support networks to provide guidance on our journey of creating an inclusive care system that we can all navigate.

Role of a Community Advisor

- Share experiences and those of their communities
- Participate and inform key decisions and health system solutions
- Make recommendations on help make our care system better for all
- Review or help create resources/ materials
- Help the Mississauga Ontario Health Team engage with diverse communities
- Encourage members of our local communities to get involved in opportunities

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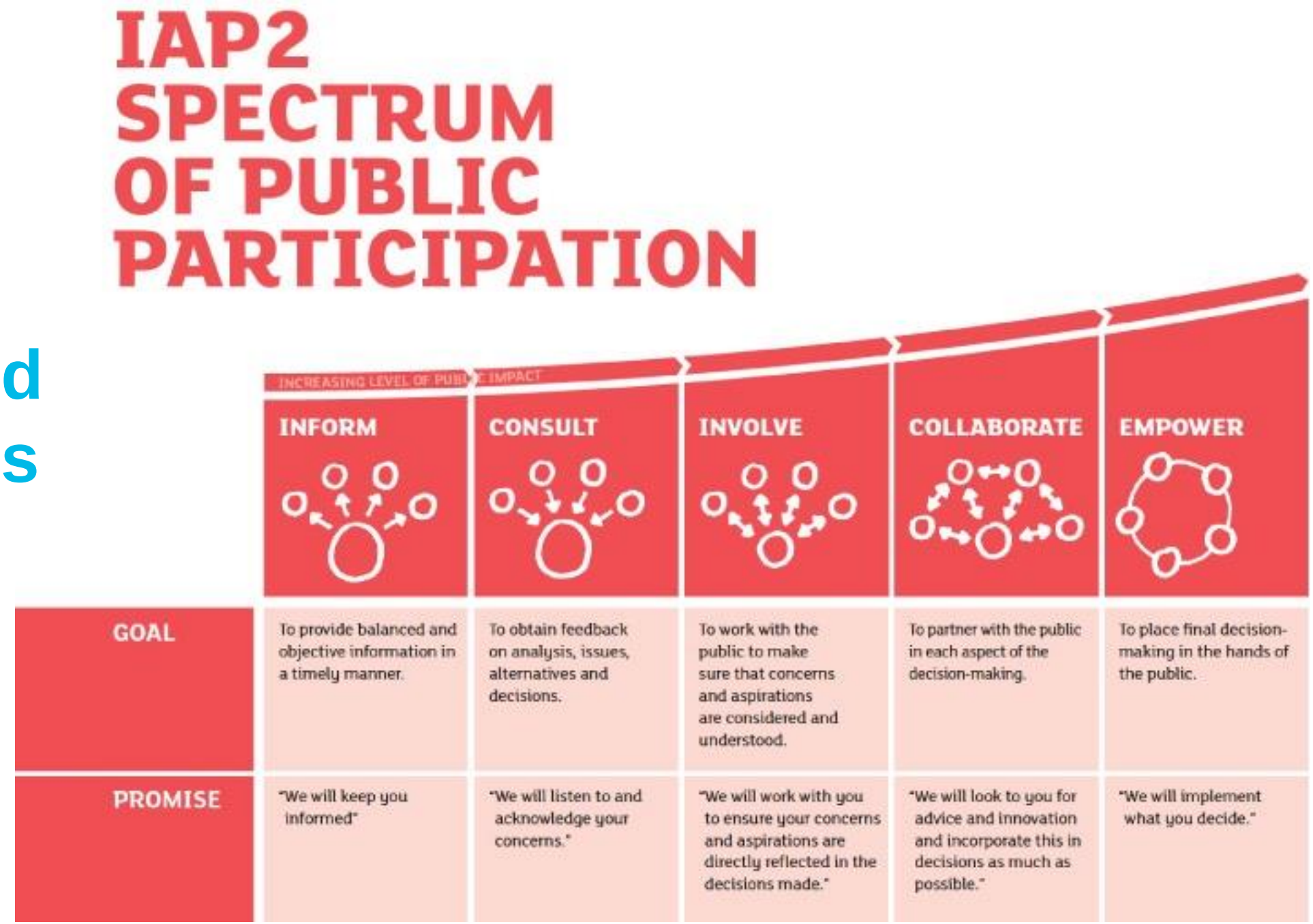
How we seek to include Patients, Family and Caregivers



Patient, Family, Caregiver Role in Palliative Care

Roles within the Work Stream

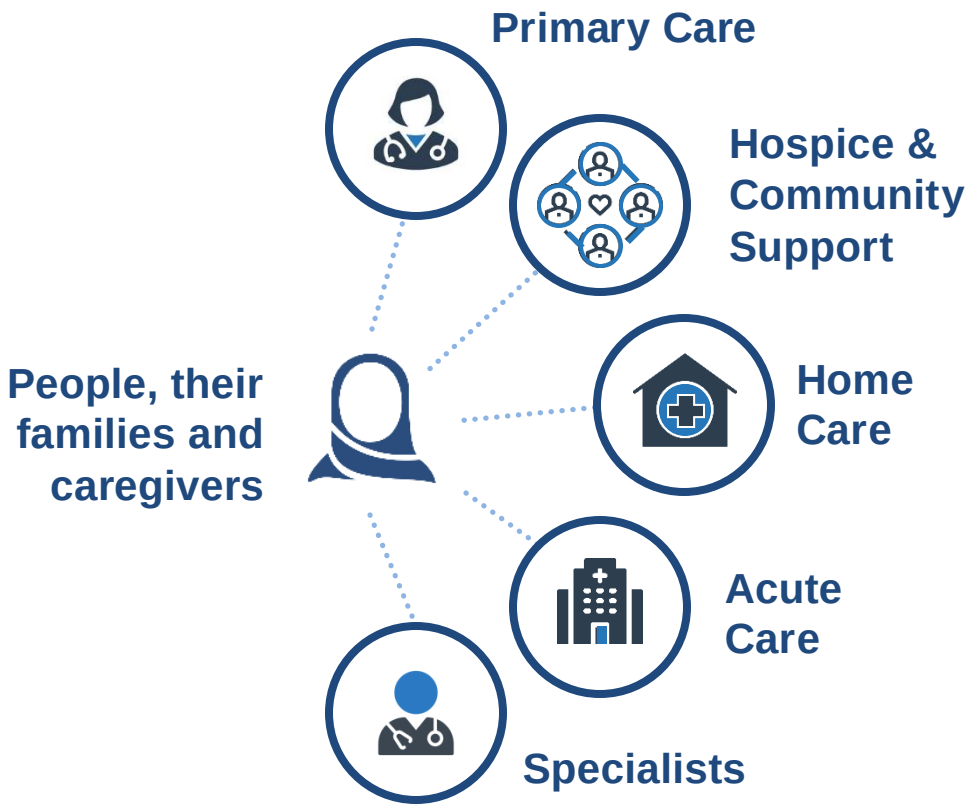
- Planning Table
- Working Groups
  - Integrated Model of Palliative Care
  - Integrated Technology Solution
  - Other
- Specific situations
  - Story telling
  - Focus groups
  - Interview for specific initiatives

Engagement Strategies

- Recruit interested persons from palliative care providers
  - hospices, hospital, home care, service providers
- Ensure equity perspective
  - specifically connect with communities under-represented or hard to reach
- Consider access and availability
  - offer evening participation as needed

Evolving Our Palliative Model: Shift From Individual to Collective

CURRENT FRAGMENTED CARE



Each organization/entity operates with its own goals, funding accountabilities, electronic health record, and service delivery models.

FUTURE INTEGRATED PALLIATIVE CARE MODEL

All organizations/entities shift to joint accountability, including performance management, integrated funding, integrated EMR/communications, shared outcome measures, and optimized Health Human Resources capacity planning in order to facilitate a One Team model of patient care.

Integrated Model of Palliative Care

Future Care Model

Early Identification

- **Earlier flagging system** of people in the community and hospital
- **Shift societal and provider thinking**
- Provide **better support earlier**

Intake

- Easy **single point of access**
- **Skilled navigators with 24/7 function**

Assessment by Core Team

- **Core team** assesses needs
- **Common tools with shared information**

Provision of Care

- **Navigator point person** to manage gaps and challenges with team
- **Enable one integrated interdisciplinary team (Navigator as point person)** - daily huddles & weekly rounds, shared communication platform
- **Improved 24/7access** to core team, providers and symptom management
- Proactive planning and Goals Of Care discussions
- Enable **smoother transition** between care settings

End of Life Care

- **Streamlined, centralized access** to End of Life beds

Grief & Bereavement

- **Establish standard of care and services**
- Right care and support at the right time

- **Develop Caregiver support model** to empower caregivers and **advance Compassionate Communities**
- **Build a Palliative Program across the Mississauga OHT** to build competency and capacity, address lack of resources with digital enablers, leverage digital tools to enable communications and common assessment
- **Collaborate with partners to build equity** within the future palliative care model – identify and address needs for the Francophone community, people living in Long Term Care, homeless and vulnerably housed people, and support First Nations Indigenous and Metis in designing a model for themselves

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The future Integrated Model of Palliative Care at Mississauga Health

Delivering exceptional palliative care across the continuum, from identification of a life-limiting illness to grief and bereavement

Connect people earlier for a supported experience

1 Early identification

- **Create a program for identifying**, serving and supporting people earlier
- **Centralized access** for patients, caregivers and providers to connect person to the right services and initiate services 24/7
- **Build pathways and models of earlier care and support** inclusive of all diagnoses and working together with primary care

Fully integrated care experience

2 Integrated Palliative Care Delivery Pathway

- **One integrated interdisciplinary team** with clear responsibilities enabled by **shared communications** and **24/7 centralized access**
- **Navigator point person** to connect with primary care and manage gaps
- Integrated **home care delivery**
- **Integration** of hospital and community palliative care

3 Foundational Building Blocks

- **Build a program across the OHT** with a process for capacity building and human health resources recruitment, structures for quality, performance and sustainability, and digital tools and enablers
- Develop model of care that supports an **equitable approach**

Deliver on what's important to people

4 Grief and Bereavement

- **Develop approach to provide grief and bereavement across the OHT** to those that need it and optimizing available resources

5 Caregiver Support

- **Develop a system for providing compassionate care for caregivers across the OHT** that includes educational, practical and emotional support

Core Elements for an Integrated Model of Palliative Care

An integrated model to drive positive outcomes for patients and providers

Initial Focus

- **Client and family centered** care
- **One integrated interdisciplinary team** with clear responsibilities
- **Navigator point person** to connect with primary care and manage gaps
- **One Care Plan** (Joint Assessments and visits)
- **Shared Communications** (One EMR, Daily Huddles)
- **24/7 Centralized access** to the team

- **Early identification Program**
- **Integration** of hospital and community palliative care
- **OHT grief and bereavement approach**
- **OHT Caregiver Support System**
- **OHT Foundational Building Blocks** (grounded in an **equitable approach**)

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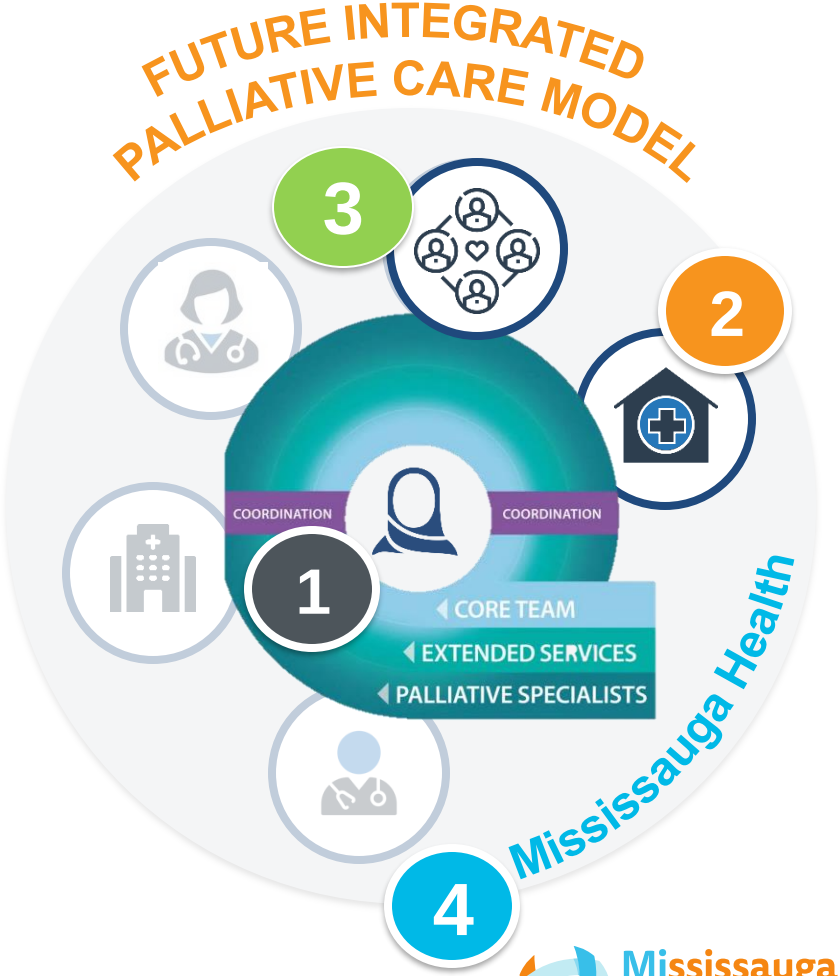
Designing and Implementing our Integrated Model

4 key innovations:

1. Integrated Care Team
2. Home Care Delivery Transformation
   *Leveraging Home Care Leading Project a key enabler
3. Digital Collaboration Tool
4. Governance Structure Development



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Lessons Learned in Co-Designing an Integrated Model of Care

1. Work with local priorities
2. Capitalize on relationships and previous work
3. Leverage other initiatives underway
4. Patient and caregiver partners are key to better outcomes
5. Lead collaboratively

The Voice of our Caregivers

Frances Henderson

Mississauga Health
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Together we will make care more accessible, equitable and patient, family, caregiver focused

If you want to go fast, go alone. If you want to go far, go together

African Proverb

Questions

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Appendix

Patient Family Caregiver Participation in Palliative Care

Increasing level of public impact

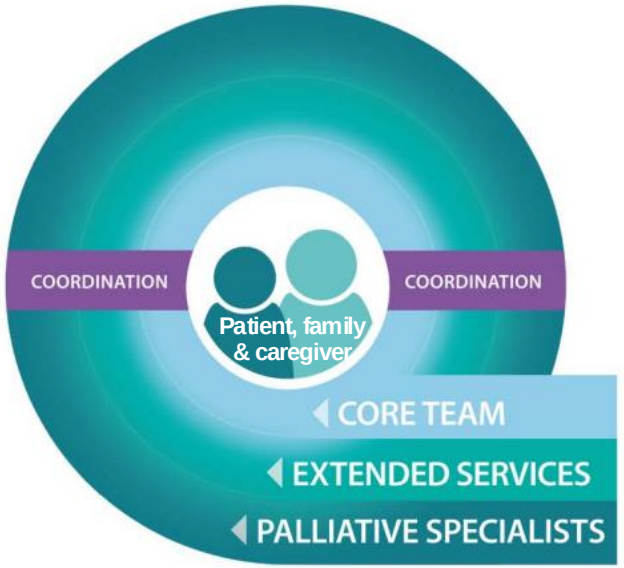
	Inform	Consult	Involve	Collaborate	Empower
Goal	To provide balanced and objective information in a timely manner	To obtain feedback on analysis, issues, alternatives and decisions	To work with the public to make sure that concerns and aspirations are considered and understood	To partner with the public in each aspect of the decision-making	To place final decision making in the hands of the public
Promise	"We will keep you informed"	"We will listen to and acknowledge your concerns"	"We will work with you to ensure your concerns and aspirations are directly reflected in the decisions made."	"We will look to you for advice and innovation and incorporate this in decisions as much as possible."	"We will implement what you decide"
Care Delivery	Inform the community on what is palliative care and how/ when to access it	Real time feedback from individuals and caregivers receiving care. Patient and caregiver surveys on care experience	Partnering for care delivery – working together to improve care experience	Patient, family, caregiver centred care - work together on decision making for care plan	Patient, family, caregiver managed care - patient, family, caregiver make decisions on care needed and received
Program and System Change	Inform caregiver partners regarding current and future plans for system	Feedback by survey, phone calls or other means for input on experience and improvements (eg. Caregiver Voices)	Routine 1:1 interviews, focus groups, surveys etc on specific initiatives. Develop process to respond to findings	Participation in planning and decision making on Planning Table, Working Groups, Co-design sessions	Self determination on program design, eg. First Nations building their own palliative care strategy with input from others

1 Integrated Interdisciplinary Palliative Care Team

COORDINATION

Core Neighbourhood Team - The patient/caregiver's core team will fluctuate over time and is made up of a geographically-based inter-professional teams including:

- **Integrated Palliative Care Coordinator**
- Person's primary care provider
- Palliative Care Team Assistant
- Nurse
- Personal Support Worker (PSW)
- Allied Health (OT/PT/SLP/RD)
- Community Palliative Care Physician / Nurse Practitioner
- Hospice Counsellor/Coordinator



Source: Ontario Palliative Care Network (OPCN) Service Delivery Framework

Community Services Team - interdisciplinary providers as needed, such as:

- Community Support Services
- Paramedicine Services
- Respiratory Therapy
- Community Pharmacy

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2 Home Care Delivery Transformation & Transferable Elements

CURRENT STATE	WORKING FUTURE STATE
Referral and intake access by Access Care Team via medical referral	**Centralized and integrated access** - One place to call but also no wrong door, access through other providers/organizations.
Assessment, care plan and service plan by HCCSS Care Coordinator (CC)	**Integrated team assessment and care plan** with CC oversight; service plan derived from care plan (goals of care) and **led by direct care provider.**
Organizational specific teams not aligned to similar geography	**Neighbourhood teams aligned to Hubs across** to improve collaborative care planning and information sharing by teams and patients.
Case management by HCCSS Care Coordinator	**Transform the care coordinator role and care coordination function.** Navigator is accountable but Integrated Care Team supports functions.
Equipment and supplies approved and ordered by HCCSS Care Coordinator	Shift responsibility to **Integrated Teams** for determining needs while HCCSS will retain equipment and supplies accountability.
Privacy and Confidentiality local responsibility and limits collaboration	Mechanisms that allow for consent to **one integrated program** and safe sharing at both organizational and program level
Digital Tools for each organization with limited sharing (some access to HPG)	Leverage **digital tools to facilitate sharing**, reduce duplicate data entry, and shared care delivery
Data management by Home & Community Care Services	Data accountability **shifts to the Operational Support Provider** (OSP) for the OHT with roles for HCCSS and other providers.
Funding model for SPO services based on a per-visit basis	**Bundled funding model** with cost-per-patient pathways that allow providers the flexibility to assess and deliver care in alignment with care goals and meet needs
Governance by organizations responsible to one another only by contract	**Integrated Governance and shared/distributed leadership** - Structure that enables and ensures collaboration and shared accountability

3

Co-designing a Digital Solution

Building on previous work to find the best way to implement a shared digital platform

- ✓ Identifying the problem space
- ✓ Refining the problem; identifying priorities
- ✓ Identify solutions

- ✓ Prototype solutions
- ✓ Refine solutions
- ✓ Patient journey and stakeholder mapping
- ✓ Develop implementation plan

- ❑ Pilot foundational elements with select providers (hospice/ physicians)
- ❑ Expand to initial LP neighborhoods

- ❑ Iterate for quality improvement
- ❑ Expand to full Mississauga & South Etobicoke geography

Awaiting OH atHome completion of PIA/TRA and approval for care coordinators to use the tool.

Health
Partnering for your health

4 Program Governance Structure

Mississauga Health

- OHT Collaboration Council
- OH TPA Partner (THP)
- OHT OSP (THP) to provide supports:
  - Data and Evaluation (IBH)
  - Privacy and Risk
  - Digital enablers
  - Community Health Advisory Network (CHAN)

Palliative Care Planning Table

- Advisory committee providing strategic alignment oversight and system-level guidance
- Identify and support operational lead(s) by setting direction, review performance, and regular improvement plan
- Making decisions and resolving system-level issues
- Family/Caregivers included

Integrated Model of Palliative Care

Operational Leadership Team (Model implementation and leadership)

- Led by Lead HSP Leadership
- Palliative service organization leadership (Hospital, Home Care, Hospice, SPO, Palliative Physicians
- Program implementation and clinical leadership
- Reporting requirements (progress, outcomes, KPIs)
- Participation in evaluation

Operational Management Group (Supervision)

- Operational managers making program-level decisions
- Provide oversight management of team
- Oversee and resolve team conflict resolution process, staffing and capacity issues
- Participation in the design of processes and systems

Palliative Care Partners & Boards

- Boards role to **support** the work of the Integrated model, raise community perspective
- **Escalate** conflicts and issues between organization and collaborative model

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Poll 5

What strategies are you aware of to address power imbalances in co-design work?

Use the Chat ("to Everyone") to enter your ideas

Poll 1

What strategies or practices have you implemented to create an inclusive environment where all patients/caregiver voices are heard and valued?

Use the Chat ("to Everyone") to enter your ideas

Mid-West Toronto Ontario Health Team

HSPN Presentation:

Commitment to Co-Design

July 22nd, 2024

MWT-OHT Context

- Approved in 2019, the Mid-West Toronto Ontario Health Team (MWT-OHT) consists of more than 50 partner organisations across social and health sectors, including:
  - 5 major tertiary hospitals, 5 community health centres, 5 family health teams
  - Several large community service organizations; range of small to mid-sized community service organizations
  - ~400 primary care community practitioners

- Serving over 550,000 people

- Patients and caregivers are at the heart of the MWT-OHT's growth and evolution

Early Commitment to Co-Design

- In 2019, the MWT-OHT made an early commitment to design health care in partnership with the people we serve – patients, families and caregivers
- We believe that we are are stronger when we bring people with lived experience of diverse backgrounds and experiences to the planning tables
- People with lived experience began serving at the OHT's highest decision-making table

MWT-OHT MHSU Work to Date

2019-2020

Consensus Decision-Making Process used to select MHSU as one of three priority populations;

2020-2021

MWT-OHT Partners complete co-design work with UHN OpenLab specifically focused on improving care experience and outcomes for individuals who experience structural, functional, and health impacts to varying degrees from substance use; **Closing Transition Gaps**

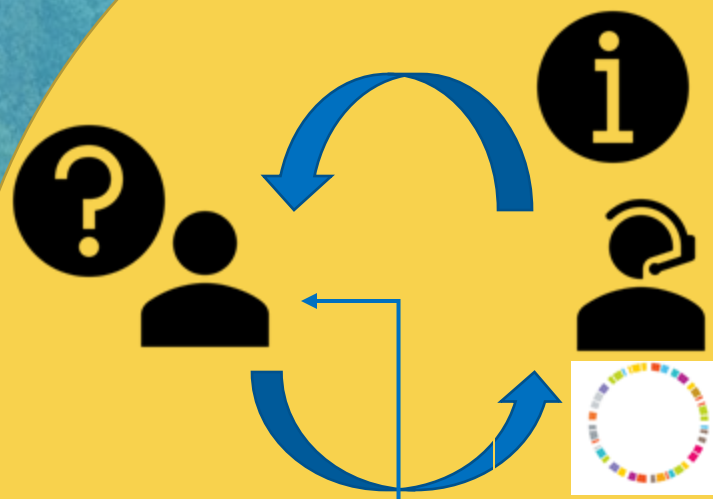
2021

Co-Design work creates framework for multi-partner Navigation Program;

2021-Present

Co-Designed program launched as ***In Your Corner*** 24/7 navigation service by 4 MWT-OHT partners through **5 months** Integrated Virtual care funding proposal + 3 months in-kind support from partners beyond funded period.

In Your Corner



In Your Corner Direct Line to Intake Counsellor for screening, information, referral and connection

The Access Point
The Toronto Mental Health and Addictions Access Point

Gerstein Crisis Centre

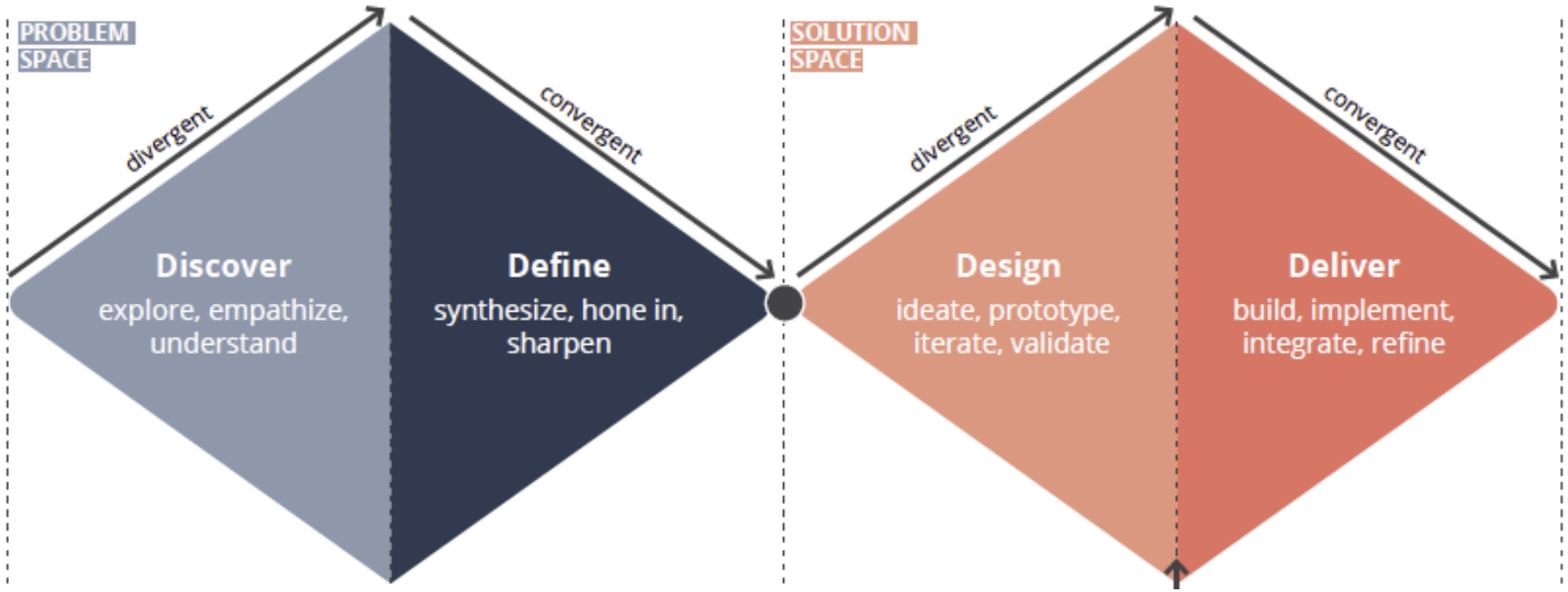
Evenings/Weekends Redirect to IYC Call Back

The Jean Tweed Centre
JTC
For Women & Their Families

St. Michael's HOMES

1 of 2 Service Navigation Support Counsellors for 6 to 8 Weeks of High Touch Support Navigation

Key Components of Co-Design

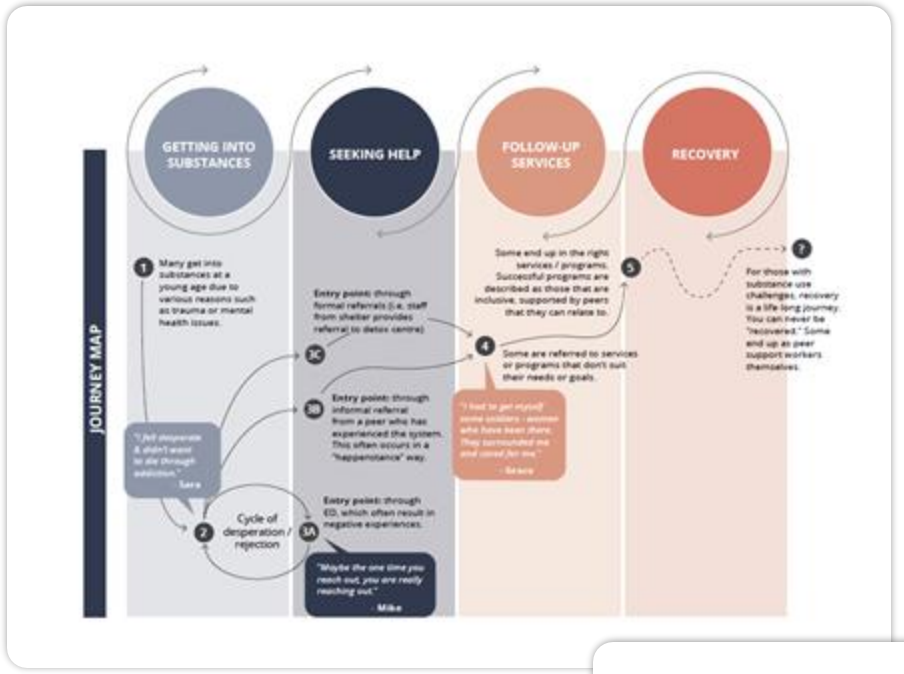


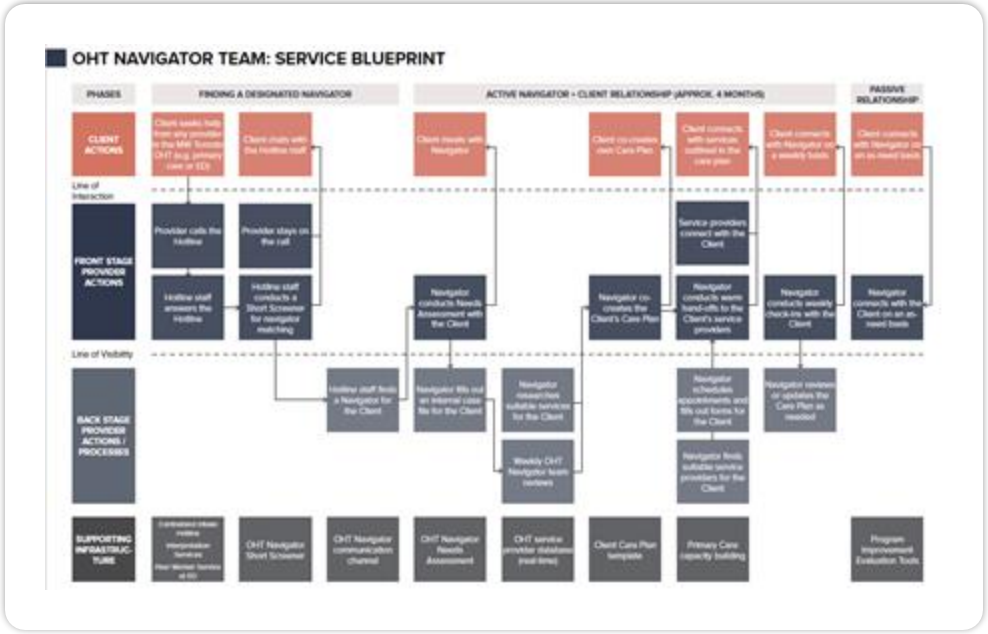
- Service asset mapping
- User engagement interviews
- Needs assessment review
- Literature and environmental scans
- Journey mapping

- Brainstorming
- Thematic analysis
- Visioning exercises
- Consultations
- Design brief

- Targeted user engagement interviews
- Team-based co-design activities
- User personas
- Navigator capacity survey
- Future state journey mapping
- Service blueprinting

Key Components of Co-Design





Design Phase: Interview Guide (Lived Experience)

Entering the System

1. Can you describe your attempts at entering the system?
2. Were there failed attempts?
   - What barriers were the hardest to overcome?
3. How did you successfully enter the system?
   - Who/which service referred you?
   - What was the most important support for your transition into the system?

Transitions within the system

General

1. What is the average wait time between services in your experience?
2. Were there any transitions that were particularly challenging?
   - Why?
   - How did you cope? What helped you?
3. Were there any services that were harder to access than others?

Detox - treatment

4. Did you experience a transition between detox and treatment?
   - How long did you wait?
   - Did you access services in the community while waiting? Which ones? How did they help?
   - Did you take part in a pre-treatment residential program?
   - Did you go back and forth between services during the

Key Components of Co-Design

Leadership and representation at every stage and level of process key to success

MWT-OHT All Partner Table

MHSU Service Design Working Group

Exploration Team

Peer-Led Interviews

Peer-Led Focus Groups

Peer-Led User Engagement and Feedback Sessions

Lesson Learned: Creativity and multiple options for engagement are required to ensure that all voices from this priority population are reflected in the work.

Deciding on an Engagement Model for MWT-OHT

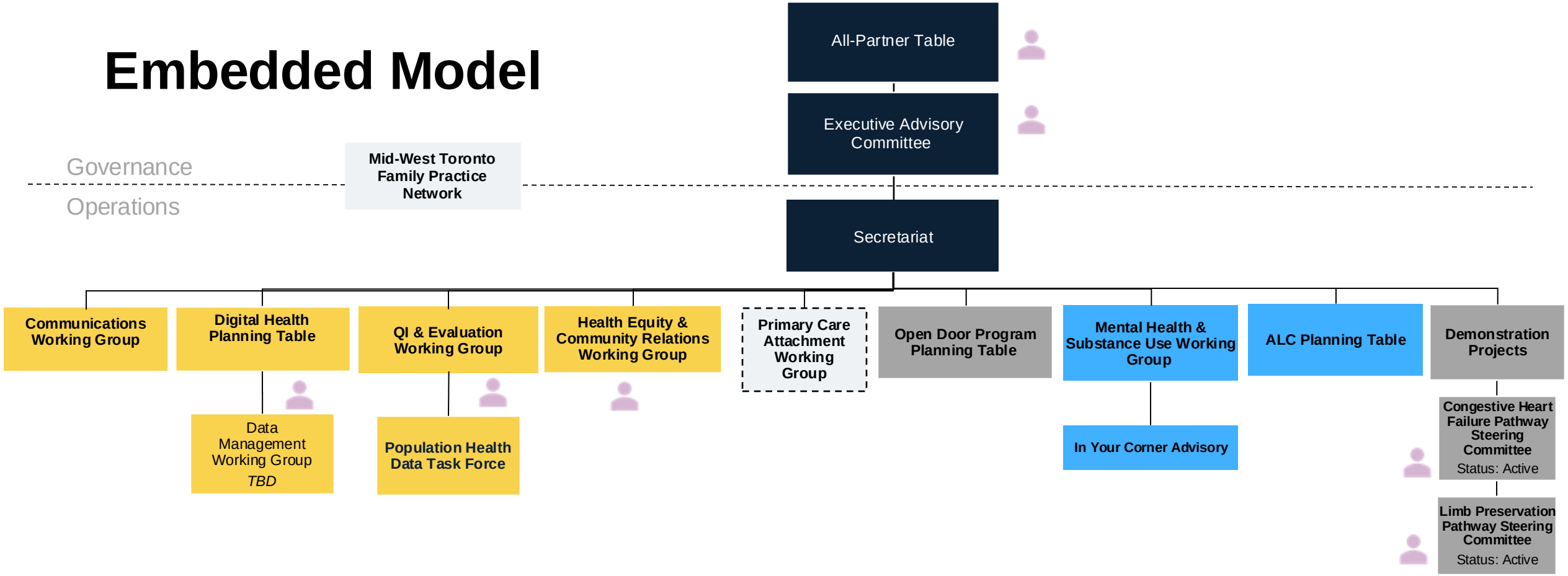
- Early decision to embed patients/caregivers into OHT instead of PFAC
- **Benefits of PFACs:** group discussion & collaboration with patients/caregivers; brings diverse perspectives to project discussed for feedback; builds trust among members & can learn from one another
- **Limitations of PFAC for our OHT:** input often made on projects that are near final; requires deep understanding of all OHT work; does not guide work (input limited to pre-determined intervals)
- **Benefits of embedding patients/caregivers:** patients/caregivers are partners in conceptualizing, planning and implementing OHT work; patients/caregivers gain deeper understand of OHT work → richer input

Benefits & limitations were identified in consultation with patients/caregivers in the context of MWT-OHT

Embedded Model for MWT-OHT

- Patients/caregivers sit at most working groups or planning tables to advise on and advance the work
- Patients/caregivers are **equal partners** in planning and implementing the work
- Meet as group to share experiences and lessons learned; however no collective decision-making power
- Some working groups/planning tables were on hold, and their patient/caregiver partners have stepped off

Embedded Model



Patient and Caregiver Partners

Evolving from Embedded Model

Why move from the embedded model?

- The embedded model served the OHT well — it strengthened the voices of patients/caregivers throughout OHT
- We felt that we could further amplify the patient/caregiver voice

Co-designing our new governance structure:

- Governance changes to create the best environment for co-design
- Decision to have a patient Vice Chair and implement a PFAC — seen as an enhancement to the embedded model (new **hybrid model**)

Decision to have a patient Vice Chair:

- New governance model creates environment to elevate patient/caregiver voice & set the stage for co-design work

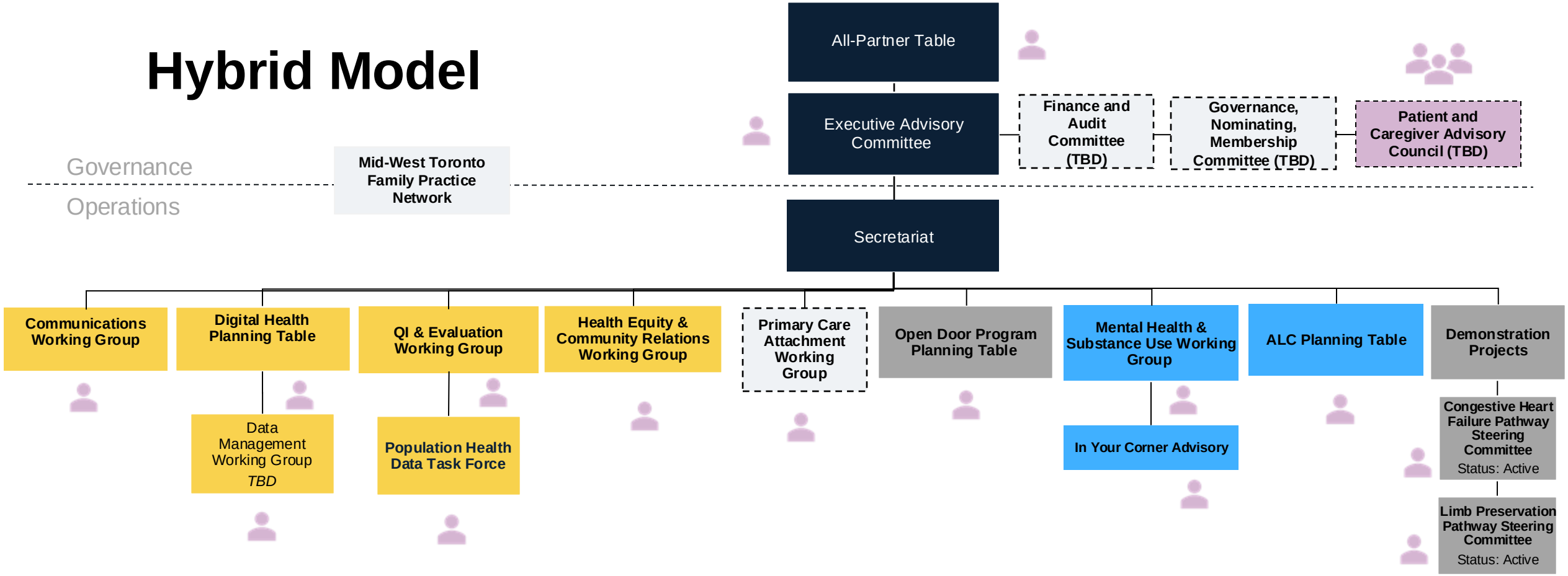
Hybrid Model for MWT-OHT

A hybrid model leverages the **benefits of the embedded model** with the **benefits of a PFAC**.

Structure:

- Embedded patients & caregivers remain at the working groups/planning tables
- A PFAC led by the patient Vice-Chair
- Tailored to patient/caregiver **skills & needs**
  - New patient/caregiver partners can choose one of two levels of engagement: 1) remain at the PFAC level only; or 2) be embedded in a working group/planning table *and* on the PFAC

Hybrid Model



Patient and Caregiver Partners

Conclusion

- At the core of the MWT-OHT, partnership is a shared value
- Through early co-design efforts like with IYC and recent governance changes, we legitimize the roles of patients and caregivers
  - The result: a democratized leadership space, with **shared power and decision-making**. A space for co-design to flourish.
- We encourage other OHTs to challenge the status quo and embed patients and caregivers into the highest levels of leadership


Thank You

Up Next

- HSPN webinar series
  - 4th Tuesday of the Month: 12:00 – 1:30 pm

Upcoming September + October 2024:

Advancing the Learning Health System in Ontario: Parts 4 & 5

Can you share some feedback? Scan here! (or click link in chat)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