

Nipissing Wellness Ontario Health Team

2026-27 Annual Business Plan

Structured around the 2026-2029 Strategic Plan

A note on language

Through the development of the 2026-2029 Strategic Plan, NWOHT chose person- and people-centred language over patient-centred language to reflect that people are more than the care they receive. This Annual Business Plan follows that same convention. Where the words “patient” or “participant” appear, they are retained deliberately to align with mandated indicators, provincial measures, or funder directives (for example, Transfer Payment Agreement deliverables and reporting).

How This Plan Works

The **2026-2029 Strategic Plan** sets our direction for three years. This Annual Business Plan translates that direction into the specific goals, objectives and indicators for 2026-27, the first year of the strategic window. It has goals that reflect both expectations as set out in Nipissing Wellness OHT Transfer Payment Agreement, as well as strategic goals as developed in partnership with the Strategic Planning Working Group.

It is organized exactly as the Strategic Plan is: **three Foundations** (the cross-cutting and enabling priorities that shape everything we do) followed by **three Strategic Directions** (the co-designed priorities for the work itself). Under each, the Strategic Plan's commitments are carried into year-one initiatives.

Stages

Within each Foundation and Strategic Direction, initiatives are grouped into three stages:

- **Sustain** - work already underway that we continue with intention this year.
- **Implement** - new or expanded work being put in place in 2026-27.
- **Explore** - work we are scoping this year, with a view to potential implementation in future years.

The Strategic Plan holds the high-level commitments; this ABP holds the operational goals and objectives. The operating plan holds initiatives and activities to enact the objectives in the ABP.

PART 1**Our Foundations**

Foundations are the cross-cutting and enabling priorities that guide all NWOHT work.

Foundation A – People-Centred Care & Co-Design

Strategic Plan commitment A.1 · Involve people, families and caregivers in all initiatives and decision-making

Advances the Strategic Plan's commitment to a system shaped by the needs, preferences and lived realities of people, families and caregivers. In 2026-27 the anchor is completing Level 2 of the Creating Engagement Capable Environments Framework

SUSTAIN

Deliverable/Goal	Objectives
Ensure lived experience informs NWOHT planning, decision-making, and improvement.	Embed Patient, Family, Caregiver Council (PFCC) partners within all levels of NWOHT work (e.g. Working Groups, Collaboration Council, committees, etc.).
Demonstrate engagement capable environments with PFCC members.	Sustain ongoing engagement with the PFCC, including sharing data and performance information, where appropriate, to support partner-led improvement priorities.

IMPLEMENT

Deliverable/Goal	Objectives
Advance to a minimum of Level 2: Learning and Developing as outlined in the Creating Engagement Capable Environments Framework, building on the 2024-25 self-assessment and action plan.	Identify and complete the capability milestones required to reach Level 2.

Deliverable/Goal	Objectives
Advance people, family, and caregiver engagement and participation across the NWOHT.	Establish partnership with the Ontario Caregiver Organization (OCO) and incorporate the implementation of caregiver-inclusive practices into the PFCC work plan, leveraging the Essential Care Partners (ECPs) Support Hub

EXPLORE

Deliverable/Goal	Objectives
Strengthen people's understanding of available health and social services, where to go for support, and how to access care across Nipissing.	- Leverage the NWOHT Navigation Community of Practice (CoP) to build and expand on existing relational and operational channels of support. - Curate and promote information about local services, with a focus on primary care services, attachment pathways, interim care options, and resources for unattached and attached people, through Health811, the NWOHT website, and member organization channels. - Design and assess the feasibility of a bilingual "No Wrong Door" navigation approach, integrating digital supports and a single point of contact, where feasible. - Participate in the Regional Digital Health Advisory, providing input on gaps and opportunities and bringing findings back to inform NWOHT councils.
Explore community-accountable frameworks to inform how we will ensure decisions, initiatives, and programs are designed with, and accountable to, the diverse communities of Nipissing.	Review engagement-continuum frameworks (e.g., International Association for Public Participation (IAP2) and determine which level of engagement (Inform, Involve, or Co-design) applies to different types of NWOHT initiative design.

Foundation B – Health Equity, Cultural Safety & Trust

Strategic Plan commitments B.1 Co-design & partnerships · B.2 Data & determinants · B.3 Remove barriers

Advances the Strategic Plan's equity, cultural safety and trust commitments. The TPA Program Expectations require all OHTs to embed equity into planning and delivery, complete mandatory training, partner with Indigenous and Francophone communities on distinctions-based terms and use disaggregated data, where appropriate.

SUSTAIN

Deliverable/Goal	Objectives
Maintain a workforce that demonstrates competency and ongoing commitment to equity-based learning, Indigenous cultural safety, anti-racism, and French Language Services (FLS).	• Complete all required equity, Indigenous cultural safety, anti-racism, and FLS active-offer training. • Monitor training completion rates across NWOHT staff. • Support ongoing equity-related professional development.
Enable the PFCC and Primary Care Network (PCN) members to contribute to planning and decision-making using an equitable, culturally safe and community-responsive perspective.	• Out-source locally tailored orientation, education and learning opportunities in equity, Indigenous cultural safety, anti-racism training and FLS active offer training for the PFCC and PCN.
Sustain First Nations, Inuit, Métis, and urban Indigenous (FNIMUI) partnership work on distinctions-based, self-determined terms, grounded in OCAP® and the CARE principles for Indigenous data governance.	• Sustain distinctions-based, self-determined partnerships with Indigenous (FNIMUI) partners, grounded in OCAP® and the CARE principles for Indigenous data governance.
Sustain equitable access to French Language Health Services by meeting Active Offer requirements and maintaining meaningful engagement with the French Language Health Services Planning Centre and Francophone partners.	• Maintain compliance with Active Offer requirements by ensuring French Language Services considerations are embedded in NWOHT planning, communications and partner engagement activities. • Use the Regional Translation Network Program (RTNP) as the primary translation mechanism for French-language materials, preserving OHT funding for other priority activities, where appropriate.

IMPLEMENT

Deliverable/Goal	Objectives
Encourage health equity across OHT priorities through data-driven, evidence-informed initiatives that identify priority populations, address disparities, and guide targeted improvement.	• Apply an equity lens to OHT Performance and Improvement Program quarterly reports by reviewing equity data available through the OHT Data Dashboard, identifying priority populations and disparities, and using findings to inform targeted interventions.

EXPLORE

Deliverable/Goal	Objectives
Explore and encourage alignment with regional data governance principles, building toward a NWOHT process to adopt data governance principles (including OCAP® for Indigenous data) that builds interest-holder input and trust, and informs our own approach.	• Stay current on evolving regional data governance principles, including OCAP® for Indigenous data. • Share updates with partners to educate and encourage alignment, including risk mitigation as NWOHT develops its own approach.
Reduce barriers in access, experience, and health out-comes for vulnerable and marginalized populations across Nipissing.	• Work with community partners to identify barriers using social determinants of health, and co-design interventions to improve access.
Promote learning and training opportunities relating to equitable data-stewardship and collection (e.g. Indigenous Stewardship in OCAP® and CARE principles) and community-defined governance.	• Convene partners and advocate for shared learning, exploring a data collaborative or learning forum.

Foundation C – A Thriving and Supported Workforce

Strategic Plan commitments C.1 Recruitment, retention & pathways · C.2 Well-being, learning & culturally safe practice

Advances the Strategic Plan's workforce commitments. Workforce is a system-wide enabler rather than a stand-alone TPA deliverable – it is not directly TPA-funded, so the initiatives below are largely NWOHT-added, reflecting that workforce appeared in 100% of partner plans as a shared pressure. NWOHT's contribution is the connective infrastructure: shared tables, coordinated initiatives, and a recurring way of hearing from the workforce.

SUSTAIN

Deliverable/Goal	Objectives
Strengthen workforce retention and sustainability across the NWOHT member organizations while reducing duplication and helping member organizations make full use of resources already available.	Facilitate opportunities to connect partners to existing provincial workforce supports and programs, facilitating shared awareness and coordinated use of existing resources.
Strengthen provider well-being and professional growth across the OHT ecosystem.	Sustain communities of practice, peer learning, and collaborative professional development opportunities that strengthen relationships, share knowledge, and build leadership capacity.

IMPLEMENT

Deliverable/Goal	Objectives
Improve provider experience, strengthen practice sustainability, and support workforce recruitment and retention across the NWOHT ecosystem.	Establish a shared measurement and data structure that enables NWOHT partners to contribute data, collectively review to assess progress, identify improvement opportunities, and inform coordinated action.

EXPLORE

Deliverable/Goal	Objectives
Explore embedding Indigenous cultural safety, anti-racism, trauma-informed practice, and French-language services training and practices as foundational to workforce development and organizational culture across partners.	• Building on the equity training work in Foundation B. • Scope a shared sightline of mandated and optional training requirements across partners. • Identify a common, culturally safe workforce development approach.
Convene partners to understand workforce needs and pressures across the region, and explore a region-wide, coordinated approach to recruitment and retention, so member organizations work from a shared effort rather than competing for the same providers.	• Gather a sightline of existing recruitment and retention strategies across partner organizations and communities. • Convene fit-for-purpose working group(s) to determine the scope of a shared workforce approach.

PART 2**Our Strategic Directions**

The three co-designed priorities for the work itself. Each carries the Strategic Plan's commitments into 2026-27 initiatives.

Strategic Direction 1 – Improve Access & Attachment to Primary Care

Strategic Plan commitments 1.1 Attachment & access · 1.2 Team-based care & the PCN · 1.3 Prevention, chronic disease prevention and management (CDPM) & palliative care

Primary care is the foundation of a high-performing integrated system. This direction carries the Ministry's commitment to 100% attachment by 2029, the Supported Attachment (SA) and interim-care work, the PCN, cancer screening, and, because NWOHT is an I12 OHT, chronic disease prevention and management for Heart Failure and Chronic Obstructive Pulmonary Disease (COPD). CDPM is nested here to mirror the Strategic Plan; its links to patient flow are cross-referenced under Strategic Direction 2.

SUSTAIN

Deliverable/Goal	Objectives
Strengthen the PCN Clinical Lead/Leadership and ensure primary care perspectives are included in NWOHT planning, decision making and implementation of priorities.	Continue to fund and support PCN Clinical Lead(s) to advance PCN priorities, participate in OHT decision-making, and connect with regional PCN leadership tables.
Sustain and expand PCN participation and reach across Nipissing.	- Maintain an up-to-date PCN email distribution list, and sustain regular two-way engagement with family physicians, Nurse Practitioners (NPs), Interprofessional Primary Care Teams (IPCT), Indigenous providers, and administrators. - Ensure every clinician connected to the PCN is aware they are participating and understands its role and value.
Improve attachment to primary care by supporting the onboarding of people and strengthening primary care participation in Supported Attachment.	Continue to implement Supported Attachment services delivery in alignment with provincial guidance and local context, building on workflows established in 2025-26.

Deliverable/Goal	Objectives
Support 100% attachment of local population by 2029.	Continue to implement the joint workflow with Ontario Health atHome (OH atHome) Care Connectors to facilitate the matching and referral of Health Care Connect (HCC) waitlist registrants to primary care via Jan 1, 2025 cohort (priority) and post-Jan 1, 2025 cohort.
Improve access to timely, appropriate care for unattached people by strengthening awareness of interim primary care options, preventive services, and pathways to long-term attachment.	Maintain, update, and share clear information for unattached people about interim primary care options, preventive services, and pathways to long-term attachment through appropriate NWOHT and partner communication channels.
Improve outcomes for people living with heart failure and COPD by sustaining chronic disease prevention and management supports and strengthening access to Remote Care Monitoring (RCM) pathways.	- Sustain CDPM activities with heart failure and COPD as the core clinical focus. - Identify eligible people for OH atHome Remote Care Monitoring and other RCM programs. - Support timely referral to appropriate monitoring and care supports.

NOTE:

We acknowledge workforce capacity as a key enabler of attachment and chronic disease management outcomes. Many of the above objectives are dependent on recruitment, retention, and sustainability of primary care providers and teams.

IMPLEMENT

Deliverable/Goal	Objectives
Expand Supported Attachment beyond initial implementation: scale effective workflows, increase primary care partner engagement, and integrate SA with broader access work.	Scale effective SA workflows, grow primary care partner engagement, and integrate SA with broader access work.
With PCN, implement processes to support unattached people accessing cancer screening and follow-up after abnormal results, including a defined pathway to long-term attachment.	Implement processes, with the PCN, for unattached people to access cancer screening and abnormal result follow-up, including a defined pathway to long-term attachment.

Deliverable/Goal	Objectives
Through the PCN, run targeted communications and engagements with primary care providers to advance eReferral, Central Intake, including Mental Health and Addictions, and Online Appointment Booking (OAB) adoption working collaboratively with system partners (e.g. Ontario Health, Central Intake Lead Organization (CILO), Central Intake Ontario (CIO), North East Mental Health and Addictions (NE MHA) Hub, etc.)	Run targeted PCN communications and engagements with primary care providers to advance eReferral, Central Intake, including MHA, and Online Appointment Booking adoption, working with system partners.
Advance interprofessional team-based care: support development/expansion of IPCTs and champion maximizing scope of practice for NPs, pharmacists, social workers, allied health, and community health workers.	Support the development and expansion of IPCTs and champion maximizing scope of practice for NPs, pharmacists, social workers, allied health, and community health workers.
Build an inclusive, representative, and well-connected PCN that reflects the diversity of primary care providers, practice models, and communities across Nipissing.	Review and strengthen PCN governance structures, roles, and communication processes to support participation across provider and practice types, regional geographies, and health and care partner organizations.
Enable system-wide prevention and chronic disease management by supporting partners, where gaps exist, to coordinate cancer screening, immunization uptake, and early identification of chronic disease risk.	Support partners, where gaps exist, to coordinate cancer screening, immunization uptake, and early identification of chronic disease risk across the region.

EXPLORE

Deliverable/Goal	Objectives
Support primary care partners in securing new and expanded IPCT investments to improve access to team-based care.	Prepare NWOHT to support the 2027/2028 IPCT expansion by engaging primary care partners, assessing opportunities for investments, and aligning with Ministry of Health and Ontario Health guidance.
Expand access to palliative care by working with the Palliative Care and Primary Care Networks so people approaching end-of-life can access high-quality, culturally appropriate support.	In collaboration with the Palliative Care and Primary Care Networks, scope how people approaching end-of-life can access high-quality, culturally appropriate palliative support.

Strategic Direction 2 – Advance Integrated and Seamless Care Across the Continuum

Strategic Priority commitments 2.1 Home First · 2.2 Seamless transitions & no wrong door · 2.3 Cross-sector collaboration on SDOH

This direction carries the Alternate Level of Care (ALC) prevention and discharge-management work alongside NWOHT's commitments to seamless transitions, integrated clinical pathways, no-wrong-door navigation, and cross-sector collaboration on social determinants. Strong attachment (Strategic Direction 1) and proactive CDPM (Strategic Direction 1.3) are themselves ALC-prevention strategies; this is where they come together.

SUSTAIN

Deliverable/Goal	Objectives
Continue to implement the Home First Operational Direction and ALC Leading Practices, working with the OH Region on local focus areas.	Implement the Home First Operational Direction and ALC Leading Practices, working with the OH Region on local focus areas.
Advance the FY 2025-26 ALC action plan with hospital partners, OH atHome, Community Support Services (CSS), and other NWOHT partners, and participate in service resolution / complex case rounds.	Advance the FY 2025-26 ALC action plan with hospital partners, OH atHome, Community Support Services, and other NWOHT partners, and participate in service-resolution / complex-case rounds.
Sustain access to coordinated, evidence-based chronic disease management services that improve outcomes for people living with chronic conditions.	Maintain and build on established chronic disease prevention and management initiatives to support an integrated, patient-centred approach to care across primary and community care settings.

IMPLEMENT

Deliverable/Goal	Objectives
Strengthen transitions from hospital to community, and improve system readiness to support discharge, ALC prevention, and coordination care.	Engage Long-Term Care (LTC) homes as partners in transition planning, strengthening hospital to community handoffs and identifying shared priorities such as palliative care, transitions, and health human resources.
Ensure that integrated clinical care pathways take into account priority populations and equity-deserving populations (e.g. frail seniors, complex MHA)	Embed Health Equity Impact Assessments (HEIA) as a cross-cutting practice when developing or evaluating care pathways.

Deliverable/Goal	Objectives
needs, palliative/end-of-life, etc.), co-designed with affected communities and reflecting rural, Indigenous, and Francophone contexts.	

EXPLORE

Deliverable/Goal	Objectives
Explore cross-sector partnerships beyond the health system (e.g. housing, social services, municipalities, public health, etc.) to address social determinants of health.	Convene cross-sector partners to enable early identification of needs that affect flow and readmission risk, building on the relational foundation for upstream, collaborative action on social determinants of health.
Strengthen transitions across the full continuum of care by convening partners to reduce gaps and duplication at handoffs between acute, primary, home and community care, MHA, hospice, palliative, LTC, and social services.	Convene partners to map current handoffs, identify priority gaps and duplication, and agree on improvements that help people's information follow them across the continuum.

Strategic Direction 3 – Build a Connected, Learning and High-Performing System

Strategic Plan commitments 3.1 Connected & digitally enabled care · 3.2 Shared measurement, data stewardship & performance

This direction carries the provincial digital tools agenda, the OHT Performance and Improvement Program, and governance and membership. Under the 2026-27 amendment, the OHT Performance Framework and the Collaborative Quality Improvement Program (cQIP) are now integrated into a single OHT Performance and Improvement Program to reduce reporting burden.

SUSTAIN

Deliverable/Goal	Objectives
Sustain working relationships with existing NWOHT partners across sectors, monitoring membership composition.	- Deepen engagement with Indigenous communities and organizations. - Support meaningful participation of patients, families, and caregivers. - Strengthen 2-way communication between primary care, acute care, and community partners, and the NWOHT.

Deliverable/Goal	Objectives
Engage with the OHT Performance and Improvement Program Quarterly Performance Review meetings, standardized Provider Experience Survey distribution, and locally collected indicator reporting; including quarterly and annual performance reports with the Collaboration Council, PFCC, PCN, and Access and Flow (or equivalents).	• Utilize PCN communication pathways to increase provider survey participation. • Adopt and implement a process evaluation tool with the PFCC.
Increase adoption and utilization of streamlined digital pathways to advance provincial priorities.	• Continue to support eReferral and Central Intake adoption through PCN communications, with Regional Deployment Teams and Local Delivery Groups. • Participate in the Regional Digital Health Advisory Council to align efforts with partner priorities.

IMPLEMENT

Deliverable/Goal	Objectives
Conduct targeted outreach to expand NWOHT membership in optional sectors (e.g. community paramedicine, municipalities, LTC homes, public health units, emergency health services, etc.).	- Enhance collaboration with allied healthcare professionals, including pharmacists. - Increase participation and representation within the PCN.
Support Online Appointment Booking sustainment for participating primary care practitioners, aligned with OH Regional direction and any FY 2026-27 OAB maintenance funding agreements.	Increase overall OAB usage across OHT primary care partners.
Maintain a fit-for-purpose collaborative governance structure that enables NWOHT tables, councils and coalitions to remain effective and responsive to evolving priorities.	- Review the current Collaborative Decision-Making Agreement (CDMA) and Collaboration Council Terms of Reference against NWOHT's evolving governance and accountability needs. - Consult existing tables, councils, and coalitions to confirm continued purpose, right-size membership, and identify any that should be paused or made dormant. - Bring a refreshed CDMA and Collaboration Council Terms of Reference forward for endorsement.
Strengthen transparent, shared accountability for implementing the ABP and communicating progress to the community and Partners.	- Set a Collaboration Council reporting cadence that is more frequent than quarterly and confirm the format for progress updates. - Regularly report against ABP commitments, including where goals are not met and what is being done differently. - Publish an annual public report summarizing progress at year-end.
Strengthen a shared data and measurement culture that supports continuous improvement, equitable care, and collective accountability.	- Advance quality-improvement planning with partners as part of the unified OHT Performance and Improvement Program. - Support the responsibly governed collection of socio-demographic and race-based data to assess equity alongside system performance.

EXPLORE

Deliverable/Goal	Objectives
Advance digital health interoperability across NWOHT partners by promoting the adoption/integration of digital platforms so information flows without manual re-entry, and people have meaningful digital access.	Convene partners to identify priority interoperability gaps and align on common digital standards and platforms to adopt.

Deliverable/Goal	Objectives
	Support partner organizations to integrate selected platforms so referral and health information can flow between systems without manual re-entry.
Strengthen NWOHT and partner influence in shaping provincial digital tools and products being developed through Ontario Health's Digital Excellence in Health team.	- Review the Digital Assets Catalogue with the PCN and other partners to identify tools relevant to NWOHT priorities. - Share partner feedback on existing and planned products with the regional digital team.
Improve partner-facing transparency through shared NWOHT performance reporting, building on provincial OHT Performance Reports and incorporating disaggregated data where possible.	- Scope a shared NWOHT performance dashboard, building on provincial OHT Performance Reports. - Identify what disaggregated data could be included and confirm data-sharing and governance considerations with partners.
Enhance collaboration with neighbouring OHTs in the OH North East region on shared priorities.	- Connect with neighbouring OH North East OHTs to identify shared priorities and opportunities for joint work. - Scope the feasibility and value of collaborating on attachment, ALC, CDPM, or palliative care initiatives.

Glossary of Terms

Plain-language definitions for terms used throughout this Annual Business Plan that may not be familiar to all readers.

Active Offer - The proactive and visible offer of French-language services, so that people know those services are available and do not have to request them before they are offered.

ALC (Alternate Level of Care) – A designation for a hospital patient who no longer requires acute hospital care but remains in hospital while waiting for the appropriate next level of care (for example, home care or long-term care) to become available.

Annual Business Plan (ABP) - NWOHT's one-year plan describing the goals and objectives that will advance the 2026-2029 Strategic Plan during 2026-27.

Attachment / Attached / Unattached - Attachment means having an ongoing relationship with a regular primary care physician, nurse practitioner, or primary care team. An unattached person does not currently have this ongoing primary care relationship.

CARE Principles for Indigenous Data Governance - Principles that promote Collective Benefit, Authority to Control, Responsibility, and Ethics in the governance and use of Indigenous data.

Care Connector - An Ontario Health atHome role that helps match people registered with Health Care Connect to available primary care physicians, nurse practitioners, or teams.

Chronic Disease Prevention and Management (CDPM) - A coordinated approach to preventing chronic disease and supporting people living with chronic conditions through early identification, monitoring, self-management support, treatment, referral, and follow-up. NWOHT's required clinical focus includes heart failure and chronic obstructive pulmonary disease.

Collaborative Decision-Making Agreement (CDMA) - The formal agreement describing how NWOHT members work together, make decisions, share accountability, and govern the Ontario Health Team.

Collaboration Council - NWOHT's principal collaborative governance table, bringing partners together to provide direction, review progress, and support shared accountability for NWOHT priorities.

Collaborative Quality Improvement Plan or Program (cQIP) - A structured approach through which OHT partners identify shared quality-improvement priorities, measures, and actions. Beginning in 2026-27, cQIP activities are incorporated into the OHT Performance and Improvement Program.

Community of Practice (CoP) - A group of people or organizations that share a common area of work and meet regularly to exchange knowledge, solve problems, and improve practice. The NWOHT Navigation CoP focuses on access and navigation across local services.

Community Support Services (CSS) - Community-based services that help people remain safe, independent, and supported at home and reduce the need for hospital or institutional care.

Creating Engagement Capable Environments in OHTs Framework - A framework that helps OHTs assess and strengthen their ability to meaningfully partner with people, families, and caregivers. NWOHT is working toward Level 2: Learning and Developing in 2026-27.

Digital Assets Catalogue - An Ontario Health resource describing existing and planned provincial digital health products and how they relate to OHT and primary care priorities.

Digital health interoperability - The ability of different digital health systems to exchange, understand, and use information without requiring repeated manual entry.

Disaggregated data - Data separated into categories, such as geography, age, language, race, disability, or other characteristics, to identify differences in access, experience, or outcomes that may be hidden in overall results.

Distinctions-based approach - An approach that recognizes First Nations, Inuit, Métis, and urban Indigenous communities as distinct, with their own rights, histories, cultures, priorities, governance structures, and relationships.

Electronic Referral (eReferral) - A secure digital method of creating, sending, receiving, and tracking referrals between healthcare providers and services, reducing reliance on paper and fax-based processes.

Equity-deserving populations - Populations that experience systemic barriers, discrimination, or avoidable differences in access to services, care experiences, or health outcomes.

Equity lens - A way of reviewing a decision, policy, service, or result to understand how different populations may be affected and what action is needed to reduce inequities.

Essential Care Partner (ECP) - A family member, friend, caregiver, or other support person identified as an important partner in a person's care and included in care processes according to the person's wishes and applicable policies.

First Nations, Inuit, Métis, and urban Indigenous (FNIMUI) - The distinct Indigenous peoples, communities, and organizations with whom OHTs are expected to build respectful, self-determined, and distinctions-based partnerships.

French Language Health Services (FLS) - Health services that are available, accessible, and appropriately delivered in French, including through the Active Offer of French-language services.

French Language Health Services Planning Centre - A regional partner that supports planning, engagement, and system improvements intended to strengthen access to French-language health services.

Health811 - Ontario's provincial health information and navigation service, available online and by calling 811, which helps people find health advice, services, and local care options.

Health Care Connect (HCC) - Ontario's provincial program that helps people who do not have a family physician or nurse practitioner register for assistance finding primary care.

Health Equity Impact Assessment (HEIA) - A structured assessment used to identify how a policy, program, or initiative may affect different population groups and to prevent or reduce unintended inequitable impacts.

Home First - A care philosophy and provincial operational direction that prioritizes helping people recover and receive care at home or in the community whenever it is safe and appropriate.

Initial 12 Ontario Health Team (I12 OHT) - One of the first 12 OHTs designated by the province. As an I12 OHT, NWOHT has additional chronic disease prevention and management responsibilities, including requirements related to heart failure and COPD.

Integrated care - Care that is coordinated across providers, organizations, and settings so that services work together around the person's needs rather than operating separately.

Integrated clinical or care pathway - A coordinated, evidence-informed sequence of care that defines how people with a particular condition or need move between providers, services, and care settings.

International Association for Public Participation (IAP2) - An organization whose public-participation framework helps determine the appropriate level of community engagement for a decision or initiative, ranging from providing information to deeper forms of involvement and shared decision - making.

Interprofessional Primary Care Team (IPCT) - A primary care team that brings together physicians, nurse practitioners, and other professionals, such as nurses, pharmacists, social workers, dietitians, or allied health providers, to provide coordinated team-based care.

Learning health system - A health system that continually uses data, evidence, experience, and feedback to assess its performance and improve how care is planned and delivered.

Membership Reporting Template - The standardized Ontario Health template used to document and monitor the organizations, sectors, clinicians, and community representatives participating in an OHT.

Mental Health and Addictions (MHA) - Services and supports related to mental health, substance use, addictions, and associated health and social needs.

Nipissing - Used in this plan to refer to the NWOHT catchment area and attributed population, including communities geographically located in the Nipissing and East Parry Sound Districts.

Nipissing Wellness Ontario Health Team (NWOHT) - The local Ontario Health Team that brings health, community, primary care, and other partners together to improve the coordination, accessibility, and experience of care for people across its catchment area.

No Wrong Door - An approach in which a person seeking care or support is helped to reach an appropriate service regardless of which healthcare or community organization they contact first.

OCAP®: Ownership, Control, Access, and Possession - A First Nations data-governance framework asserting that First Nations collectively own information about their peoples and communities and have the right to control how that information is collected, accessed, used, and possessed.

Online Appointment Booking (OAB) - A digital service that allows people to view available appointment times and book appointments with participating healthcare providers online.

Ontario Caregiver Organization (OCO) - A provincial organization that supports unpaid caregivers and works with health system partners to strengthen caregiver-inclusive practices.

Ontario Health (OH) - The provincial agency responsible for coordinating and overseeing significant parts of Ontario's healthcare system, including Ontario Health Teams and their performance requirements.

Ontario Health atHome (OH atHome) - The provincial organization that coordinates publicly funded home and community care services and administers functions that include Health Care Connect and Care Connectors.

Ontario Health Team (OHT) - A group of healthcare providers, community organizations, clinicians, people, families, and caregivers working together to provide more coordinated care for a defined population.

OHT Data Dashboard - A provincial reporting and analytics resource that provides OHT-level information to support planning, performance review, population analysis, and identification of improvement opportunities.

OHT Performance and Improvement Program - Ontario Health's integrated approach to OHT performance measurement and improvement, including standardized measures, quarterly reports, provider-experience information, locally collected indicators, quality-improvement planning, and collaborative performance reviews.

Patient, Family, Caregiver Council (PFCC) - NWOHT's council of people with lived or living experience, family members, and caregivers who advise, participate in, and co-design NWOHT planning, initiatives, and improvement activities.

Primary Care Network (PCN) - A network that connects local family physicians, nurse practitioners, interprofessional teams, other primary care professionals, and administrators so they can communicate, coordinate, and participate collectively in OHT planning and implementation.

PCN Clinical Lead - A family physician or primary care nurse practitioner who provides clinical leadership to the PCN, represents primary care perspectives in OHT decision-making, and connects local clinicians with regional and provincial primary care leadership.

Provider Experience Survey - A standardized Ontario Health survey used to understand clinicians' and administrators' experiences with areas such as PCN participation, navigation, care coordination, digital tools, and chronic disease management.

Quarterly Performance Review (QPR) - A structured meeting in which Ontario Health, the OHT, PCN leadership, and other relevant partners review performance information and identify improvement priorities and actions.

Regional Digital Health Advisory Council - A regional forum through which OHTs, primary care partners, Ontario Health, and other organizations coordinate digital health priorities, identify implementation issues, and provide feedback on provincial digital tools.

Regional Translation Network Program (RTNP) - A shared regional service used to support the translation of OHT communications and materials into French.

Remote Care Monitoring (RCM) - The use of digital tools, remote clinical monitoring, coaching, and follow-up to help people manage their health at home and allow providers to identify and respond to changes in their condition.

Social Determinants of Health - The social, economic, and environmental conditions that influence health, including income, housing, education, employment, food security, transportation, geography, and social inclusion.

Supported Attachment (SA) - A provincially funded primary care service that prepares and supports unattached people as they transition into an ongoing relationship with a primary care physician, nurse practitioner, or team. It may include onboarding, health-information collection, initial clinical services, navigation, and administrative support.

Transfer Payment Agreement (TPA) - The formal funding agreement that establishes NWOHT's funded deliverables, eligible expenditures, performance expectations, reporting requirements, and accountability to Ontario Health.

TPA Program Expectations - Cross-cutting expectations that OHTs must incorporate into planning and delivery, including health equity, Indigenous health equity, cultural safety, anti-racism, French-language services, community engagement, and the use of relevant population data.

Working Group - A group established to complete a defined piece of work, develop recommendations, or implement an initiative. A working group may be time-limited and usually reports to a council, committee, or other governance table.

Closing

This Annual Business Plan is a living document.

It will be reviewed periodically during Collaboration Council meetings, refined as TPA guidance is confirmed, and updated to reflect what we learn from partners, people, families, caregivers, and the data we collect – consistent with our commitment to being a learning health system.