

Nipissing Wellness Ontario Health Team

Strategic Plan 2026 - 2029

Our Shared Purpose (Vision)

Together, we create an equitable, accessible and connected health and care continuum for the people and communities of Nipissing.

Our Role (Mission)

Facilitate collaboration and enable integrated health and care across the continuum to advance population health and wellbeing for all in Nipissing.

Our Values

These values guide every decision, partnership and initiative:

- **Equity, Cultural Safety and Trust** – We ground every action in equity, cultural safety and trust, including through the lens of Indigenous, Francophone, rural, and other equity-deserving communities.
- **People-Centred Care and Co-Design** – We ensure people, families, and caregivers shape design and decision-making, not just receive the results of it.
- **Community-Focused and Socially Responsive** – We honour the strengths, needs, and lived realities of the communities we serve, recognizing that health is shaped by social, economic, cultural, and environmental conditions.
- **Collaboration** – We work across professional, sectoral, and geographic boundaries to advance shared priorities, convening and connecting rather than acting alone.
- **Accountability** – We measure what matters and report transparently, including when we fall short.
- **Innovation and Learning** – We build a digitally enabled, data-driven learning system that adapts and improves.

Our Guiding Principles

Communicate – to grow understandings

- Connect, collaborate and engage with partners across the NW OHT to inform, share progress, receive feedback and ensure that communication is open and transparent.

Grow – on successes

- Continually refine, leverage and build upon evidence-based skills, expertise and resources across our communities in health care and social services.

Build Relationships – through meaningful and purposeful solution-oriented processes

- Create a collaborative culture that fosters flexible and innovative thinking and respects the cultural and language diversity of our partners and community.
- Keep all partners engaged, working together and supporting one-another to achieve shared goals.
- Measure success toward agreed-upon outcomes and report results regularly.

Create – person-centred care

- Include people, families, and caregivers in the planning, and co-design of care plans supporting a seamless, holistic health care experience.

Work as a Team – to remove barriers to care

- Work as a cohesive team, to provide effective and timely access to health care and social services across our communities.

Our Strategic Framework

Our Strategic Framework outlines what we will achieve in the next 3 years to create a caring, equitable, accessible and connected health and care continuum for the people and communities of Nipissing.

This Strategic Framework is structured into the following two sections:

- **Our Foundations** – these are cross-cutting priorities that will guide all strategic directions.
- **Our Strategic Directions** – these are co-designed priorities that will inform activities to achieve our shared purpose.

Our Foundations

- A. People-Centred Care and Co-design
- B. Health Equity, Cultural Safety and Trust
- C. A Thriving and Supported Workforce

Our Strategic Directions

1. Improve Access & Attachment to Primary Care
2. Advance Integrated and Seamless Care Across the Continuum
3. Build a Connected and High Performing Learning Health System

Our Foundations

Foundation A: People-Centred Care and Design

WHAT SUCCESS LOOKS LIKE IN 2029

- **People and Caregiver Centred Design:** People, families, and caregivers report experiencing a system that is shaped by their needs, preferences, and lived realities, with care that adapts to them.
- **Trusted, Culturally Safe Experiences:** People, families, and caregivers report feeling respected, culturally safe, and supported throughout their care journey, with their voices shaping decisions, service design, and system improvements through trusted relationships.

HOW NWOHT WILL GET THERE

A.1 Involve people, families and caregivers in all initiatives and decision making

- **Community-accountable decision-making** by ensuring all decisions, initiatives, and programs are designed with, and accountable to, the diverse communities of Nipissing.
- **Embedded voice of people with lived and living experience (including people, families and caregivers)** through active participation in NWOHT governance, planning, evaluation and quality improvement.
- **Clear communication and navigation supports** that strengthen people's understanding of where to go and how to access care.

Foundation B: Health Equity, Cultural Safety and Trust

WHAT SUCCESS LOOKS LIKE IN 2029

- **Equity-driven Decision Making:** Health equity is visible in how every decision is made, who is at the table, and how every initiative is designed, including through the lens of Indigenous, Francophone, rural and other equity-deserving communities shaping how the system is designed and how care is delivered.
- **Culturally Safe, Trauma-Informed, Equitable Care:** People report experiencing greater culturally safe, trauma-informed, linguistically appropriate care experiences across the system.
- **Community Trust in the System:** Communities of Nipissing experience NWOHT as a trusted, equity-deserving, reliable partner – one that is strategic, responsive and demonstrates accountability through transparent action and measurable improvement.

HOW NWOHT WILL GET THERE

B.1 Strengthen equity-driven co-design & partnerships

- **Equity-driven co-design** with equity deserving communities, including Indigenous, Francophone, rural, remote, 2slgbtq+, racialized, low income, disability, and underhoused populations, to shape priorities, pathways and improvements, recognizing that those closest to the barriers are best placed to design the solutions.
- **Indigenous Health in Indigenous Hands** as foundational to how we partner with Indigenous organizations and communities, including supporting Indigenous ways of knowing and being, Indigenous-led health models, and culturally safe care pathways.
- **Equity-informed decision-making** across all NWOHT structures (including funding decisions) and ensuring the people and processes shaping the system reflect the communities we serve.

B.2 Advance shared data, determinants-based planning and accountability.

- **Equity-Relevant Data Stewardship** that supports responsible use of equity-relevant data, grounded in OCAP® (Ownership, Control, Access, and Possession) principles and community-defined data governance to ensure disparities can be identified through data segmentation where possible and in order to be collectively acted upon.
- **Advance action on the social determinants of health** by applying a determinants-based lens to how priorities are set and initiatives are designed, recognizing that health is shaped by housing, income, food security, transportation, and other conditions beyond the health system.

B.3 Remove barriers for equity-deserving populations

- **Identify and Support Removal of Barriers** faced by vulnerable and equity-deserving populations through community partnership.

Foundation C: A Thriving and Supported Workforce

WHAT SUCCESS LOOKS LIKE IN 2029

- **A Coordinated Regional Workforce Approach:** Recruitment and retention across Nipissing is approached as a shared regional effort that supports member organizations. *NWOHT convenes partners to create an integrated sightline of the workforce so the system can see its own collective workforce trends and experience and act on them collectively.*
- **Enabling Conditions for a Thriving Workforce:** NWOHT members and partners are working together on concrete, jointly identified pressures (incl. administrative burden, onboarding, team-based models), and possibilities (shared learning, policy alignment). *NWOHT's contribution is the connective infrastructure – convened tables, coordinated initiatives, and supporting the measurement of workforce and provider experience – that makes these improvements possible.*

HOW NWOHT WILL GET THERE

C.1 Build a sustainable workforce through recruitment, retention & career pathways

- **Shared Workforce Strategy** by convening partners to develop a district-wide, regionally coordinated approach to recruitment and retention so member organizations are working from a shared effort rather than competing for the same providers.
- **Integrated Workforce Sightline** that enables a district level understanding of workforce that partners contribute to and review together, so the system can see its own collective trends, and experiences in order act on them.
- **Leverage Existing Resources** by connecting partners to provincial workforce supports and programs, reducing duplication and helping member organizations make full use of resources already available.
- **Reduce Administrative Burden to Enable Providers to Focus on Care** by advocating for and exploring opportunities to reduce administrative burden – aligning workflows, automating processes, reducing duplication – and supporting partner participation in regional initiatives such as central intake.

C.2 Promote provider well-being, shared learning and culturally safe practice

- **Provider Well-being and Professional Growth** enabled through communities of practice, and collaborative professional development across the OHT ecosystem.
- **Culturally Safe and Anti-Racist Workforce Development** that promotes Indigenous cultural safety, anti-racism, trauma-informed practice and French-language services as foundational to workforce development and organizational culture.

Our Strategic Directions

Strategic Direction 1: Improve Access & Attachment to Primary Care

WHAT SUCCESS LOOKS LIKE IN 2029

- **Primary Care Attachment Pathways:** Every person in Nipissing has either a consistent primary care provider and/or team, or for those who are unattached or have barriers to care, have a clear pathway to access appropriate services.
- **Interprofessional Team-Based Care:** Interprofessional team-based care is the norm across the district, with more people receiving care from coordinated teams that work to their full scope.
- **A Strong, Unified Primary Care Network:** The Primary Care Network is strengthened and functioning as a unified, district-wide structure that supports coordination, communication, and shared planning across all primary care models.
- **Prevention and Chronic Disease Management at Scale:** System-wide prevention and chronic disease management are prioritized and enabled, with partners working together to improve early identification, screening, and ongoing management – keeping people healthier and helping people stay well in their communities.

HOW NWOHT WILL GET THERE

1.1 Work toward primary care attachment and access for every resident across the Nipissing

- **Attachment pathways for every resident** by building on the Primary Care Network and Supported Attachment model to facilitate connection of unattached eligible people in Nipissing to a consistent provider or team. This includes but is not limited to a focus on unattached people (patients) in rural and remote areas.
- **Reliable Interim Care Access**, supporting partners to maintain and expand access to interim care options for those without access to a primary care provider who are waiting to be attached.
- **Advocating for clear pathways for those with barriers to access.**

1.2 Strengthen Interprofessional Team-Based Care & the Primary Care Network collaboration

- **Advance interprofessional team-based care as the model** by supporting the development and expansion of Inter-Professional Care Teams (IPCTs), and championing maximizing the scope of practice of nurse practitioners, pharmacists, social workers, allied health providers, and community health workers.
- **Strengthen the Primary Care Network** by supporting the PCN's governance to be inclusive across all provider and practice types across all regions of the district. Ensure bi-directional communication between PCN and all health and care partners. Coordinate planning so that primary care is genuinely connected to the rest of the system.

1.3 Shift focus to Prevention, Chronic Disease Management & Palliative Care

- **Enable system-wide prevention and chronic disease management** where there are gaps by supporting partners in the coordination of cancer screening, immunization uptake, and early identification of chronic disease risk across the district.
- **Advance proactive, upstream prevention** by convening partners where appropriate to coordinate cancer screening, immunization, and early identification of chronic disease risk across the district – recognizing that proactive prevention and strong primary care attachment are themselves strategies that reduce avoidable emergency visits, hospitalizations, and time spent in hospital beyond clinical need.
- **Enable coordinated chronic disease management** by connecting primary care partners to chronic disease programs and pathways, leveraging provincial CDPM funding where available to support capacity building and peer leadership.
- **Expand access to palliative care** by working with the NWOHT Palliative Care Network and Primary Care Networks so people approaching end of life can access high-quality, culturally appropriate palliative support.

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

WHAT SUCCESS LOOKS LIKE IN 2029

- **Integrated Care Experience:** People in Nipissing feel that their care is integrated, and that their information follows them across the health and care continuum.
- **Coordinated Transitions:** Transitions between hospital, home, primary care, mental health, palliative, and long-term care are coordinated and decisions are made with people, their families and caregivers.
- **Right Care, Right Place:** More people receive care in the most appropriate setting, with Home First embedded as the working philosophy across sectors.

HOW NWOHT WILL GET THERE

2.1 Focus on Home First & Providing Care in the Most Appropriate Setting

- **Champion Home First and support people receiving care in the most appropriate setting** as foundational for NWOHT decisions so that people spend less time in hospital beyond their clinical need. Support partners so that regionally, hospital care used only when truly needed and community-based organizations are able to provide services in the most appropriate settings.

2.2 Enable Seamless Transitions, Integrated Pathways & No Wrong Door Navigation

- **Strengthen transitions across the full continuum** by convening partners to reduce gaps and duplication at the handoffs between acute care, primary care, home and community care, mental health and addictions, hospice and palliative care, long-term care, and social services. Work toward a system where people's information follows them across the care continuum; providers know what the other team is doing, and no one falls through the cracks in a transition.
- **Co-develop and maintain integrated clinical pathways** for priority populations including frail seniors, people living with chronic conditions, those with complex mental health and addictions needs, and people requiring palliative and end-of-life care. Ensure pathways are co-designed with impacted communities, services providers, and reflect the realities of rural, Indigenous, Francophone, and other equity-deserving service contexts.
- **Champion and enable no wrong door for people, families, and caregivers**, including care coordinators embedded in the system, accessible digital and phone tools, a single point of contact where possible, and navigation services available in both official languages. People in Nipissing know where to go and who to call while we build a more seamless system.

2.3 Advance Cross-Sector Collaboration to Address Social Determinants of Health

- **Enable cross-sector collaboration beyond health** by convening partners across health, social services, public health and community sectors (including Indigenous and Francophone service providers) around shared priorities, building the relational foundation through which social determinants can be addressed through collaborative and upstream approaches.

Strategic Direction 3: Build A Connected and High Performing Learning Health System

WHAT SUCCESS LOOKS LIKE IN 2029

- **Digital Tools as System Enablers:** Digital tools function as enablers across all strategic priorities, supporting smoother transitions, clearer communication, and reduced administrative burden for providers.
- **Seamless Information Flow:** Providers across NWOHT share information, refer patients, and coordinate care without fax machines or duplicate data entry.
- **A Clear Digital Front Door:** People have a clear, consistent digital front door where they can access their own health information and navigate the system with confidence.
- **Transparent, Shared Performance:** NWOHT publishes a shared performance dashboard with segmented data where possible, and reports transparently on progress, gaps, and what is changing as a result.
- **Fit-for-Purpose Governance:** NWOHT governance and working groups are fit for purpose, enabling timely decisions, clear roles, and effective partner relationships and accountability.

HOW NWOHT WILL GET THERE

3.1 Enable connected, Interoperable & Digitally Enabled Care

- **Advance digital health connectivity across NWOHT partners** by promoting the adoption, integration, and interoperability of digital platforms across NWOHT member organizations. Work toward a provider-centred experience where information flows without manual re-entry, and a person-centred experience where digital access to care and health information is real.
- **Support partners with alignment** by convening partners, identifying duplication, and helping coordinate adoption efforts.
- **Leverage provincial digital tools and supports** by promoting the use and integration of virtual system navigation tools such as Health 811 and virtual urgent care to all residents of Nipissing. Champion the adoption of eReferral Ontario and Central Intake adoption across all NWOHT partners where appropriate. Participate in Ontario Health's digital health capacity-building initiatives.

3.2 Strengthen Shared Measurement, Data Stewardship & System Performance

- **Build a shared data and measurement culture** by developing the Collaborative Quality Improvement Plan (cQIP); establishing a shared performance dashboard; and supporting partners in collecting socio-demographic and race-based data so that equity commitments can be tracked alongside system performance commitments.
- **Strengthen shared accountability for outcomes** by establishing clear, partner-owned accountability structures. Report progress to the Collaboration Council regularly – more frequently than quarterly. Publish an annual public report. Acknowledge when goals are not met and explain what we are doing differently.