Practical Guidance for the IPCT Expansion EOI: Applying the Neighbourhood Health Home Model

October 9th 2025

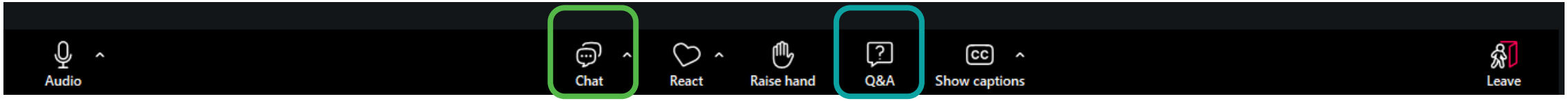
Alliance for Healthier Communities
Alliance pour des communautés en santé

ACKNOWLEDGEMENT OF TRADITIONAL INDIGENOUS TERRITORIES

We recognize that the work of the Alliance for Healthier Communities and Alliance members takes place across what is now called Ontario on traditional territories of the Indigenous people who have lived here since time immemorial and have deep connections to these lands. We further acknowledge that Ontario is covered by 46 treaties, agreements and land purchases, as well as unceded territories. We are grateful for the opportunity to live, meet and work on this territory.

Ontario continues to be home to vibrant, diverse Indigenous communities who have distinct and specific histories and needs, as well as constitutionally protected and treaty rights. We honour this diversity and respect the knowledge, leadership and governance frameworks within Indigenous communities. In recognition of this, we commit to building allyship relationships with First Nation, Inuit and Métis peoples in order to enhance our knowledge and appreciation of the many histories and voices within Ontario. We also commit to sharing and upholding responsibilities to all who now live on these lands, the land itself and the resources that make our lives possible.

Housekeeping



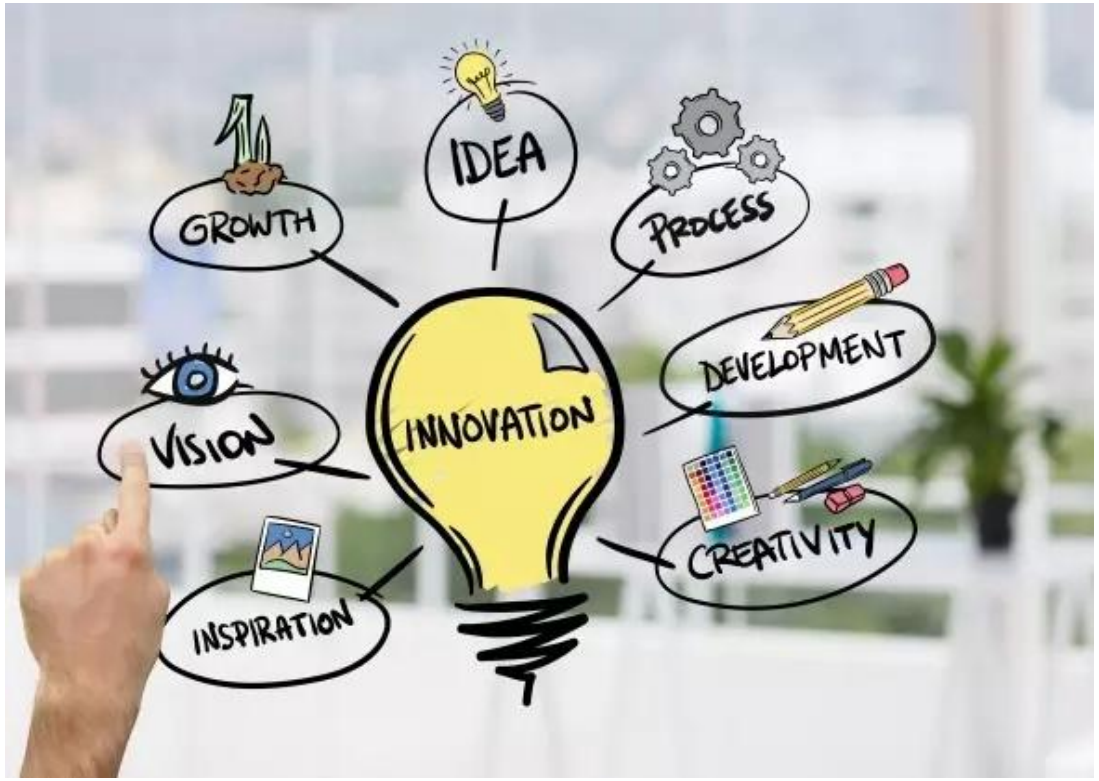
- Audience **microphones are muted** and will remain muted throughout.
- The webinar is being **recorded**. A link to the recording and slide deck will be shared by email next week.
- Please submit questions using the **Q&A panel**.
  - Questions may be answered **in writing within the Q&A panel**, **verbally during the Q&A period**, or in a **follow-up email** after the webinar
  - You can also upvote or comment on others' questions.
- Please use the **Chat window** **for technical assistance.**

Objectives for Today

Introduction	Review the problem we are trying to solve and introduce the Neighbourhood Health Home Model
Review	Learn from a Team that has implemented the Neighbourhood Health Home Model
Actions	Practical steps towards writing your EOI that will enable the Neighbourhood Health Home Model
Discussion	Discussion and Questions

Problem we are trying to support

- 2.3M people without a primary care provider --> 2.1 billion dollars will be spent over the next 4 years
- Primary care throughout Ontario being challenged to serve higher numbers of unattached people quickly
- New teams are being established, and goal is that all staff work to full scope
- Ambitious targets



If we continue to provide care in the same way we will not meet these targets

Big Questions we are grappling with…

How do we collectively build a primary care system that not only meets the needs of individuals but goes beyond basic primary care resulting in true health and wellbeing for people in Ontario?

How do serve communities and support 100% attachment and ensure access to the services individuals require to achieve the best possible health and wellbeing?

How do we reduce health disparities in our communities? How do we work collaboratively with existing and new resources?

Neighbourhood Health Home Model

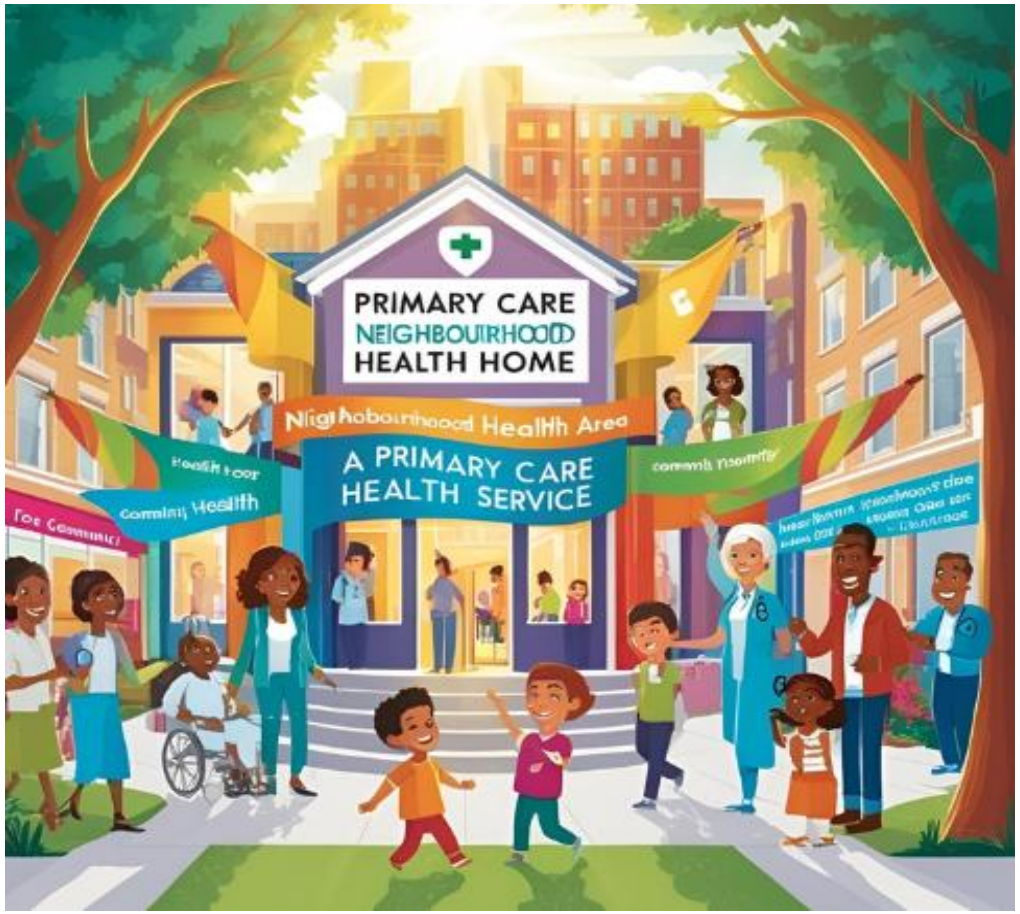
Model that may help teams and providers with their planning and ensures a community approach leveraging and supporting all primary care with attachment and more

Model built from evidence and research into what works for people, especially for people that have traditionally faced barriers in the health system.

The model is robust, and built on six pillars, including: Interprofessional, collaborative primary health care; Community governance and engagement; Population-based approach; A strong data foundation; A focus on equity and the determinants of health; Accountability and efficiency.

Key Principles: must have an equity lens and be grounded in community.

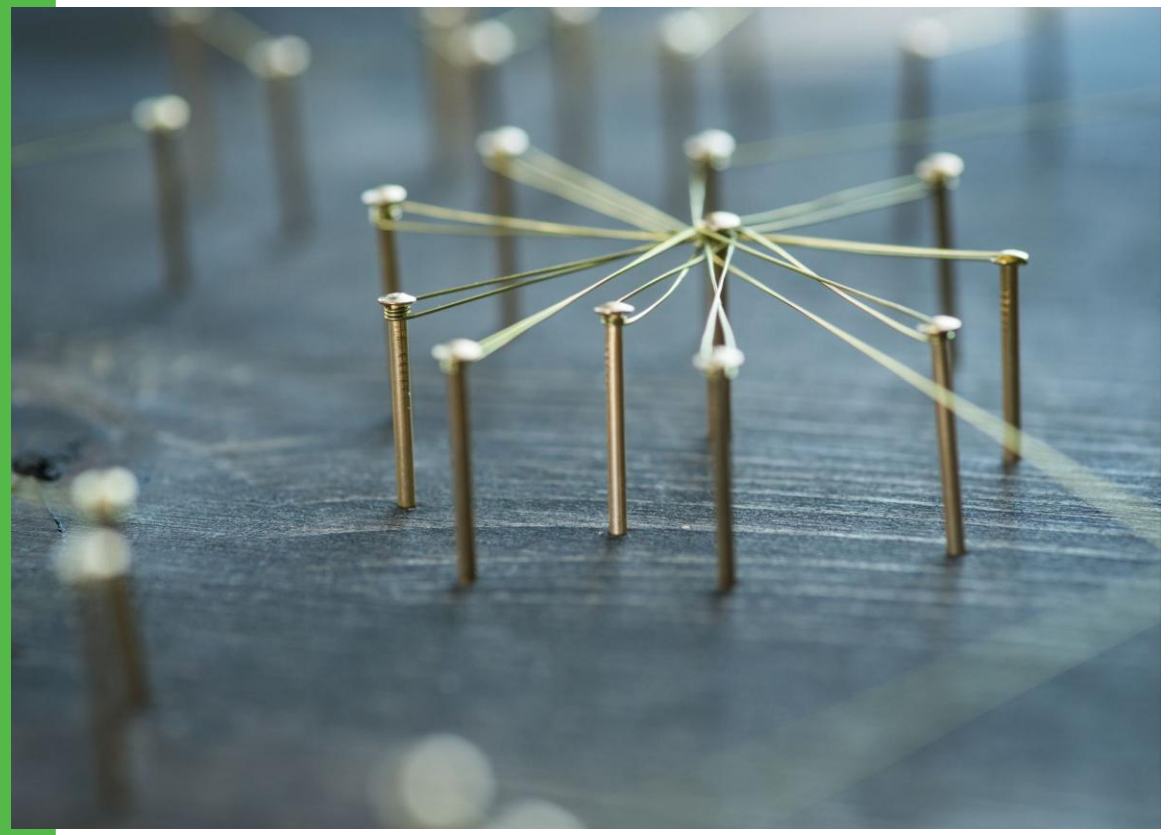
Vision: Neighbourhood Health Home that Centres Equity at the Core



- Health Homes nestled within neighbourhoods serving people from geographical areas or priority populations
- Every person will have barrier-free access to an interprofessional team, health promotion and community supports
- Community members involved with governance, decision-making and co-design
- Build on existing team-based primary care models (and establishing new ones where necessary) – hub and spoke model
- Primary Care Networks – essential to co-design and oversight

Hub and Spoke Model

- All primary care providers in the Neighbourhood Health Home will have access to the team, via a hub and spoke model
- The Hub (or a specific spoke) will provide equity-based care for the entire population
- The Hub will provide health promotion support and access to link workers to ensure seamless support between clinical and social and community
- Primary care providers and teams will collaborate to meet local needs



Pillars of a Neighbourhood Health Home

Interprofessional Collaborative PHC

Community Governance

Population Approach

Strong Data Foundation

Focus on Equity and Determinants of Health

Accountable and Efficient

Strong Primary Care Foundation

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Busting Some Myths

What the Model is:

- Set of core components that can be applied to your local context
- A way to reach attachment goals while also addressing health inequities
- It will make best use of resources including the skills, expertise and interests of the primary care clinicians, teams and organizations in a region

What the Model isn't:

- It is not a vision for the future – it is a tangible approach that can be used now
- It does not require a change in your governance or payment model
- The Hub is not a physical location – it is an organization that already exists that plays a specific role

The Neighbourhood Health Home in Action

WellFort

Community Health Services

Primary Care Neighbourhood Network

Interprofessional Primary Care in the Community

October 2025

WellFort
Community Health Services

1 Background of the IPCT Expansion Initiative

2 Neighbourhood Primary Care Network Model Overview

3 Impacts on the Ground

4 Enablers

Funding Goals and Principles

Ministry Initiative Name: 2023-2024 Interprofessional Primary Care Team Recipients from the May 2023 Expression of Interest and Ongoing Expansion in 2025

Funding Goals

Funds related to the Expanding and Enhancing Interprofessional Primary Care Teams initiative are intended to create new or expand existing inter-professional primary care teams (IPCTs) in Ontario. Grounded by the core mandate to build and expand a high-quality primary health care system that is centred on the person, Ontario Health's (OH) goals in proceeding with this investment include:

- Increasing access to comprehensive primary care for attached and unattached patients;
- Ensuring patients can connect with care where and when they need it;
- Removing barriers to care for people who are marginalized and/or have a poor health status;
- Improving patient experience; and
- Enhancing the experience of health professionals who work in primary care settings.

Principles to Guide the Work

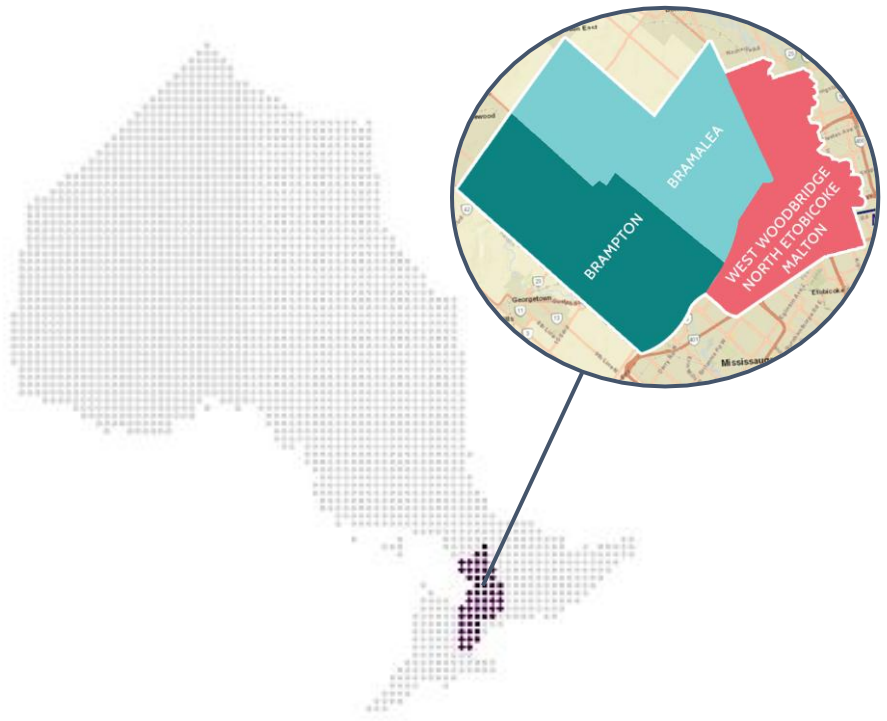
Funding recipients are expected to commit to the following principles for implementation and operation of new or expanded IPCTs that are enabled through this investment:

- Increasing access to care for unattached patients, patients with poorer health outcomes/health status;
- Ability to provide care to equity deserving populations with a demonstrated focus on reaching patients with poorer health outcomes;
- Efficient, effective and skills-based governance;
- Team-based models of interprofessional primary care that maximize efficacy, scope of practice and collaboration;
- Integration and collaboration with the broader health care system, including Ontario Health Teams (OHTs), as well as a commitment to participate in population-based planning for health services delivery;
- A commitment to using available data and evaluation for continuous quality improvement;
- The use of digital health to support care delivery and provide Ontarians with choice in how they interact with the health care system; and
- Support the training and education of IPCT health professionals, where possible.
- Maximize scopes of practice

Who We Serve

Our network is in the Central Region of Ontario Health. The populations we serve in this model span 3 municipalities: Toronto, Mississauga and Brampton.

Central West



Breakdown of Our Neighbourhood Population

500,000 Residents	**80%** Visible Minorities	**20%** Medium to High Comorbidity
18% Mental Health Diagnosis in Past 2 Years	**11-21%** Unattached to Primary Care	**<80** Family Physicians per 100k Residents

Getting started – CHC Model of Care

Model of Health and Wellbeing

WellFort Community Health Services is a CHC with two sites: Malton and Brampton (across Peel Region with mobile services and operating a 24/7 Homeless Medical Shelter)

- CHCs are interprofessional primary care teams that serve communities and populations who may have barriers to health services. They focus on addressing the underlying conditions that affect people's health, such as social determinants of health, and health literacy.
- The CHC employs a wide variety of interprofessional healthcare professionals such as nurse practitioners, nurses, physiotherapists, chiropodists, dieticians, social workers, outreach workers, midwives, health promoters, Diabetes Educators, Support and Care Navigators, Community Health Ambassadors, Dentists and Dental Assistants
- Regular and extended hours
- Physicians who work in a CHC setting are salaried employees.
- WellFort has a strong reliable history in these communities as a full service primary care and social support agency and is a leader in actionable transformative care with the Central West OHT at a population health level

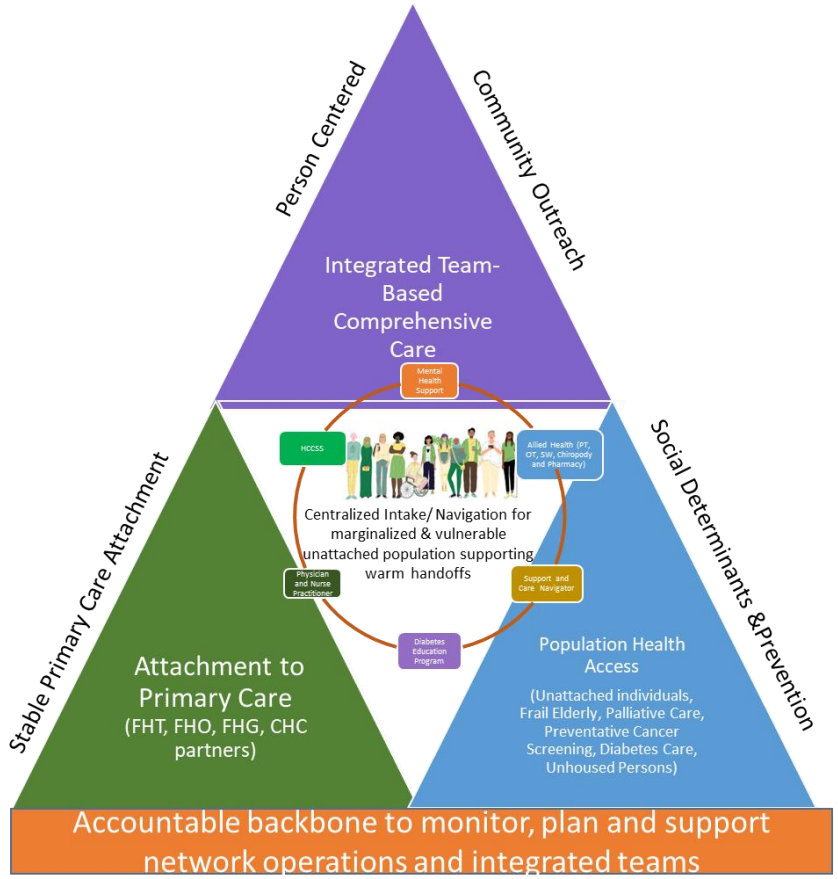
Network Model Overview

Primary Care Neighbourhood Network (Medical Home)

Over the past year, we have been building an exciting vision.

Together, we are achieving:

- Increased **primary care capacity** and increase **access** to interprofessional team-based primary care.
- Deliver person-centred care through a **population health approach** that ensures all individuals receive the care they need, when they need it.
- Leverage our **shared expertise and resources** to optimize patient experiences and outcomes.



This is funded through OH, as part of integrated interprofessional primary care network initiative

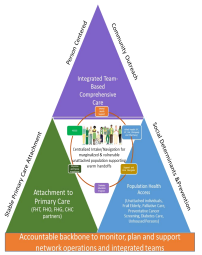
Our Partners:

WellFort CHS (Backbone Hub) | Rexdale Medical FHO | Malton United FHO | Central Brampton FHT | North Peel FHT | Main Street Medical FHO | Shopper's World Medical FHO | CMHA Peel Dufferin

Adding new FHG and 2 community agencies in 2025

Overview of Model

We have built a scalable model that helps local people who are unattached to primary care.



1. Increased interprofessional shared system resources

- Increase capacity of system to attach patients to primary care through partnerships and access to interprofessional care
- Resources and program expertise shared across practices

2. New Population Health Clinic for our unattached population

- Clinic embedded in the community focusing on population health programming and access to interprofessional resources
- Place for initial attachment and understanding needs to inform longitudinal primary care attachment

3. Set-up centralized intake and navigation function

- System-wide resource to create ease of access to primary care resources for unattached, marginalized and complex patients
- Includes single point of contact, initial assessment, personalized care planning and navigation to primary care
- Population health based assessment and data collection to identify care needs for unattached population in the neighbourhood network

4. Increased backbone support to enable the model and serve most complex patients

- Infrastructure investment to build WellFort as a central coordinating entity (administration, HR, finance, PM, IT, data, and QI)
- Digital enablement support locally among providers

Ontario's Primary Care Action Plan Pillars Alignment of Primary Care Neighbourhood Network

Connecting You to a Primary Care Team

- Equity focused approach to understand needs and match attachment to team best suited to meet needs within the neighbourhood
- Centralized intake with knowledge of primary care access within neighbourhood network
- Expanded attachment capability due to increased interprofessional team resources
- Creation of standardized pathways based on segmenting the population to meet the holistic and longitudinal needs

Making Primary Care More Connected and Convenient

- Digitally connected through Primary Care Digital Front door aligned with provincial digital assets for community
- Population health planning through coordinated data collection and digital systems
- Network operates as shared care model where resources are less duplicated based on expertise
- Improved referral methods to support primary care clinicians in shared care and adjustment of services due to patient care complexity

Supporting Primary Care Providers

- Back office supports
- Provider experience evaluation
- Interprofessional care education and supports to maximize scopes of practice
- Common vision with primary care driving planning and implementation (building coalition) and system transformation
- Mutual agreement of attachment volume targets and support of interprofessional resource support with clinical governance oversight
- Local leadership and expertise of community and connection to community supports is offered

Patient Co-Design

Personas

	Darshan	Hassan	Ayesha	Esther	John	Errol
						
DEMOGRAPHIC	• Elderly Female • South Asian • 65 – 80+	• Young adult male • African • 18 - 35	• Young female • Childbearing • South Asian • 18 – 40	• Middle aged female • Caribbean • 40 - 70	• Middle-aged white male • 40 - 50	• Middle-aged black male • 50 - 60
BACKGROUND	• Newcomer from India • Does not speak English (Punjabi) • Low-income multi-generational household	• Canadian, immigrated as child from Somalia • Supports siblings and mother • Precarious employment	• Canadian, immigrated from India • Young professional • Minimal family support (family in India)	• Canadian, immigrated from Jamaica • Settled and working	• Canadian, married with teenage kids • English speaking • Blue collar job • High debt – working poor	• Jamaican-Canadian • English speaking • Married, family in Jamaica • Incomplete high-school education, unemployed and on social assistance
HEALTH CONCERNS	• Uncontrolled diabetes • Arthritis • Frailty	• Mental health stress • Diagnosed PTSD, childhood trauma • Occasional substance use	• Healthy pregnancy • Ensuring baby is healthy	• Does not participate in cancer screening programs	• Life-long smoker • Shortness of breath • Arthritis	• Uncontrolled diabetes • Hypertension • Poor kidney function, • Retinopathy • Depression & anxiety
HEALTHCARE UTILIZATION	• Unattached • Frequent walk-in clinic and ED utilization	• Unattached • Attends walk-in clinics when necessary	• Unattached • Attends appointments related to pregnancy • Uses technology to navigate health concerns	• Unattached • Uses homeopathic/ traditional medicine as first choice • Uses online sources to find traditional remedies	• Attached to FHO • Visits hospital, if necessary • Does not complete follow-ups, routine tests & screenings	• Unattached • Experiences healthcare discrimination

Operational Approach

Stage 1: Intake

Stage 2: Assessment

Stage 3: Service Delivery

A Unattached Patient

Referral Sources:

- Primary Care Network Partner
- ED referral
- Healthcare Connect
- Self (email/phone/walk-in)
- OHT Primary Care Network

B Currently Attached Patient

Primary Care Network Partners:

- FHTs
- FHOs
- WellFort CHC
- CMHA Peel Dufferin
- HCCSS

Centralized Intake, Triage and Screening

Standardized clinical triage and intake process and population segmentation

Centralized Support and Care Navigation

Support connecting patients with interprofessional resources

Initial appointment booked with MRP or interprofessional resource

MRP Consultation and Assessment

Initial contact and comprehensive assessment with MRP

Network Attachment

Patient is formally attached after first visit with a provider

Care Plan Development and Management

Comprehensive care plan is developed, ongoing monitoring

Interprofessional Resources

- Social Worker
- Nurse
- Dietitian
- Clinical Counsellor
- Support and Care Navigator
- Physical Therapist
- Health Promoter
- Breastfeeding Services
- Mental Health Worker
- Health Education Services

Performance and Financial Reporting | Backbone Office Support (HR, IT, Finance, etc.) | Information Sharing

Population Health Clinic Site Partner Site

Stage 1: **Intake**

Stage 2: **Assessment**

Stage 3: **Network Attachment**

Target: Time to Attachment

CENTRAL INTAKE VISION

Unattached Patient

Referral Sources:

- Primary Care Neighbourhood Network
- ED referral
- Healthcare Connect
- Self (email/phone/walk-in)
- OHT Primary Care Network

Centralized Intake, Triage and Screening

Standardized clinical triage and intake process and population segmentation

Initial appointment booked with MRP identified as most appropriate for patient based on intake

Data Flow

Patient intake data flows from Orion to IPCT partner EMR

IPCT partner can update provider information and identify patient attachment status

MRP Consultation and Assessment

Initial contact and comprehensive assessment with MRP

Centralized Support and Care Navigation

OHT Navigator and WellFort IPCT Support connecting patients with community and interprofessional resources

Care Plan Development and Management

Comprehensive care plan is developed, ongoing monitoring

Attachment to IPCT partners

Rexdale CHC

WellFort CHS IPCT

North Peel FHT

TMU

Queen Square FHT

Key Assumptions

- Platform collects defined patient information
- Platform also includes in-network provider information to link patients to providers
- Managed by Clinical Intake Coordinators (WellFort CHC employees)

WellFort CHC

Central West OHT Navigator

Impact Across Primary Care Practices?

Resources for Primary Care Neighbourhood Group

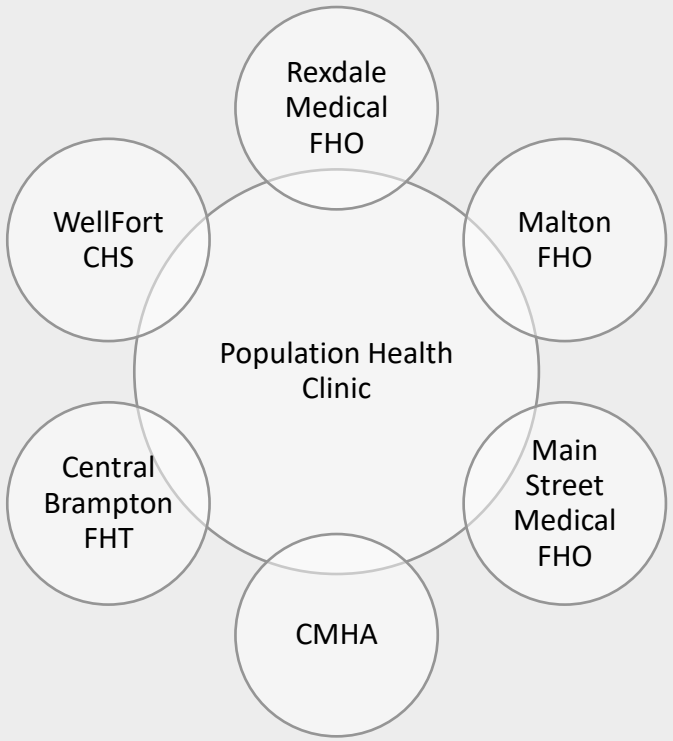
Below is a sample of how interprofessional resources are being distributed throughout our Network in year one: (Evolving Resourcing)

Population Health Clinic

- Nurse Practitioner
- Medical Office Assistant
- Chiropodist
- Physiotherapist
- Dietician
- Registered Nurse
- Clinical Aid
- Support and Care Navigator
- Intake Coordinator
- Clinical Counsellor
- Clinical Practice Lead

*** Partners Being Added as Model Grows**

Primary Care Neighbourhood



Rexdale Medical FHO

- Social Worker
- Dietician
- Nursing Supports
- Immediate Intervention Specialist
- EMR, IT and Data Support

Malton FHO

- Dietician
- Social Worker
- Medical Office Assistant
- Immediate Intervention Specialists

Main Street Medical FHO

- Dietician
- Social Worker/Clinical Counsellor
- Medical Office Assistant

Central Brampton FHT

- Registered Nurse for Specialized Program

How Will Clients be Assigned to a PCP?

Several criteria will be used to assign new clients to a PCP within our Network. Criteria below will be utilized to assign and triage clients.

Criteria to assign clients to PCP:

1. Availability (e.g., provider with soonest availability)
2. Provider Focus (e.g., providers' specialization and/or priority populations)
3. Patient Preferences (e.g., language, gender, location)
4. CPSO Criteria (i.e. first come first served, physician scope of practice, no discrimination against complex clients, family prioritization)
5. Equitable distribution of complex clients across partner practices

Triage Criteria:

- Clinical Urgency and Symptoms
- Greater Vulnerability (e.g., frailty, age, SDOH)
- Specific care needs (e.g., Mental Health Status, addictions, pregnancy)
- Population Health Clinic and Centralized Intake to complete initial assessments for real time access
- **Algorithm pathways being developed to support attachment within network and being shared across OHT IPCT partners**

- All primary care partners within the network provide information on participating clinicians, focus areas and languages to appropriately assign clients.

What does this mean for you and your practice?

Practice	Primary Care Providers	Interprofessional Resources	Patients
• Receive new resources (financial or FTE) in your practice to support you and your patients • Weekly reporting requirements to help us understand utilization	• Refer patients to a network of interprofessional resources, as deemed appropriate • Maximize scope of practice • Improve the provider experience • Able to attach more patients	• Able to provide the right support at the right time for patients	• Attaching* 9,915 patients in 2024/25 and 10,250 in 2025/2026 • Increased access to a network of interprofessional resources • Reduced wait times

Current State of the Model?

Model status?	• Interprofessional resources have and continue to be hired and onboarded across the network. • All primary care FHO practices have embraced the model and are serving patients in this model • FHT teams have increased access in their committed speciality • Population Health Clinic at WellFort CHS across both sites (Brampton and Malton) is in service • New partners joining model in IPCT phase 2 (2025)
What impact has been seen so far?	• Over 13000 patients attached and having increased interprofessional across the network • Trust building among partners • Pooling of resources has taken place
What is state of central intake?	• Our central intake is focused on our partners in the network and work underway for all IPCT team central intake that we will take on (WellFort is the HIC) • As additional maturity comes we will share with all other OHT partners and be implementation support to CW OHT Primary Care Network if asked • We intend to work closely with Health Care Connect and be ready meaningful partnership • Partnership with Central Region Urgent Care has been established and discussions about how both programs can collaborate to support • Central intake will be carefully matched with our OHT priorities of navigation and Integrated Care Hub Vision • Care pathways will be developed with local Urgent Care and ED
How will you measure success?	• Patient and provider experience (Joy In Work framework) • Expected deliverables from funders • Intake and segmentation advancement

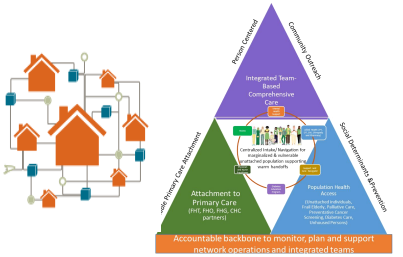
What do our primary care partners say?

Impact on My Day	"Today underscored the importance of having reliable support systems in place. During an already busy schedule, a patient presented unexpectedly with symptoms of depression for the first time. Thanks to the availability of appropriate backup resources and team support, I was able to respond to the patient's needs with care and attention, while also maintaining the flow of the rest of my clinical day. This experience reinforced how critical it is to have structures that allow for both patient-centered care and provider sustainability, especially during high-demand moments. It has been so helpful to know when you are having a busy day." Rexdale Medical FHO Physician
What difference has the model made on your practice?	After a physician left the large practice, there was worry on how the patient roster was going to be managed. The ability to describe this partnership model and the added team based supports within this network was the one feature that convinced a new physician to agree to join the practice and ensure no patients were left unsupported and nor where the remaining clinicians required to carry the load. Malton FHO practice
What makes this model successful to your practice?	• This model has brought services that our patients deserve through collaboration and partnership • Our clinicians are able to retain autonomy and help plan and close the gaps in care that are unique to our community needs • This model is bringing joy back to family medicine with less anxiety and more work life balance • "A happy doctor and happy patients" Main Street FHO

Alignment to OHT Priorities and Neighbourhood Health Home

Alignment to PCNN

We aim to test and build a scalable model that helps local people who are unattached to primary care and who are vulnerable/marginalized.



1. Improve access and attachment to comprehensive primary care with a focus on equity deserving populations.

2 Connect, integrate and support primary care through the improved delivery and coordination of primary care

3. Population health planning through coordinated data collection and digital systems

4. Common vision with primary care driving planning and implementation (building coalition) and system transformation through more neighbourhood model implementation

Pillars of a Neighbourhood Health Home and Enablers of Implementation

Interprofessional Collaborative PHC

Community Governance

Population Approach

Strong Data Foundation

Focus on Equity and Determinants of Health

Accountable and Efficient

Relationships

Autonomy and Shared Accountability

Commitment to Whole Community and Leverage Expertise

Support for Data Driven Approach

Sociodemo Data and Client Voice

Hub Leadership and Partner Approach

Alliance for Healthier Communities
Alliance pour des communautés en santé

Key Contacts

Executive Lead: Kimberley Floyd

kimberley.floyd@wellfort.ca

What to Include in your Expression of Interest

EOI Evaluation Criteria

1. Primary Care Attachment
2. Readiness to Implement
3. Meeting Primary Care Team Principles
    1. Province-wide
    2. Connected
    3. Convenient
    4. Inclusive
    5. Empowered
    6. Responsive

Primary Care Attachment

- 100% attachment within the region will be achieved through a Neighbourhood Health Home that is nestled within neighbourhoods working in a Hub and Spoke model
  - The Health Home will reflect the geographical areas and ensure that every member of the community has an interprofessional primary care team that they can access while working with primary care clinicians and/or teams throughout the area.
- Supportive and collaborative and is aligned to a population-based approach that is grounded in health equity.
- Describe how the hub can assist with facilitating attachment from Health Care Connect
- Population-based - the entire community (100% of the population) is part of this neighbourhood – not just the patients that walk through the clinic doors and that by building on existing team-based models as the HUB you will build **a collaborative group of providers that will work to full scope of practice** and ensure that all people can receive care when they need it that is seamlessly linked across providers, teams and settings

Readiness to Implement

- Describe how the Neighbourhood Health Model includes back-office support (outline supports – HR, Data, Improvement, etc)
- Describe hiring processes
- Describe all clinical, social and community partnerships
- Get letters of support/letters of collaboration
- The Alliance has templates for memorandums of understanding and other resources to help with readiness

Primary Care Team Principles: Connected and Convenient

Connected:

- Describe how you will ensure that staff are working to full scope
- Consider social prescribing and include a Link Worker into your team composition – SP has proven to increase capacity of physicians and nurse practitioners and can help advance attachment goals
- Centralized intake by the hub facilitates

Convenient:

- Include after-hours care and other access initiatives you have planned
- Discuss how virtual care is used
- Consider ongoing measurement of 3NAA and other access measures along with on-going improvement initiatives
- Hubs and spoke model allows for convenient care – ensuring care is closer to home

Primary Care Principles: Inclusive

- Discuss how you will embrace a population-based approach and be the home for people over their life course.
- Describe how the Hub will collect and use individual level sociodemographic and race-based data as well as community level data to support tailored service delivery and program planning as well as allowing for population segmentation.
- Describe how you use neighbourhood level data as well as community engagement to inform program and service planning.
- Describe how you have adopted population segmentation to ensure a proactive approach to service delivery that includes health promotion and prevention within the community.
- Describe how the Hub will promote health equity by addressing the social determinants of health.
- Consider training (FLS, Indigenous Cultural Safety, 2SLGBTQ+ etc) for all organizations involved with the Hub
- Talk about French Language Services – if you have a Francophone organization in your region, meaningfully engagement to determine what resources they need to expand services to all people in your region that speak French
- Consider other communities that require culturally safe care and determine if the Hub, or Spokes could be suited to serve them (i.e. Afrocentric models of care, gender affirming care etc)
- Discuss how Community Governance contributes to health equity

Primary Care Team Principles: Empowered

Empowered

- Discuss EMRs being used and demonstrate any shared data guidelines (or infrastructure)
- Describe how you are using e-consult and e-referral
- Describe how you plan on using data for continual monitoring and improvement that focused on the entire team and all patients (not just those that come through the door)
- Describe how you will use data to ensure populations get the care they need – including how data will inform decisions to address health inequities
- Describe any integration data tools you are using (OCEAN, Hospital Report Manager, Integrated Decision Support (IDS), etc.

Primary Care Team Principles: Responsive

- The Hub will be community governed - ensuring that patients, family and community have an explicit voice in decision making and accountability.
- Discuss community engagement strategies and how based on this involvement you tailor health services to meet the needs of the populations you are serving
- Ensure the patient and caregiver voice are included.
- Describe any programs or services that have been co-designed with community and/or clients.

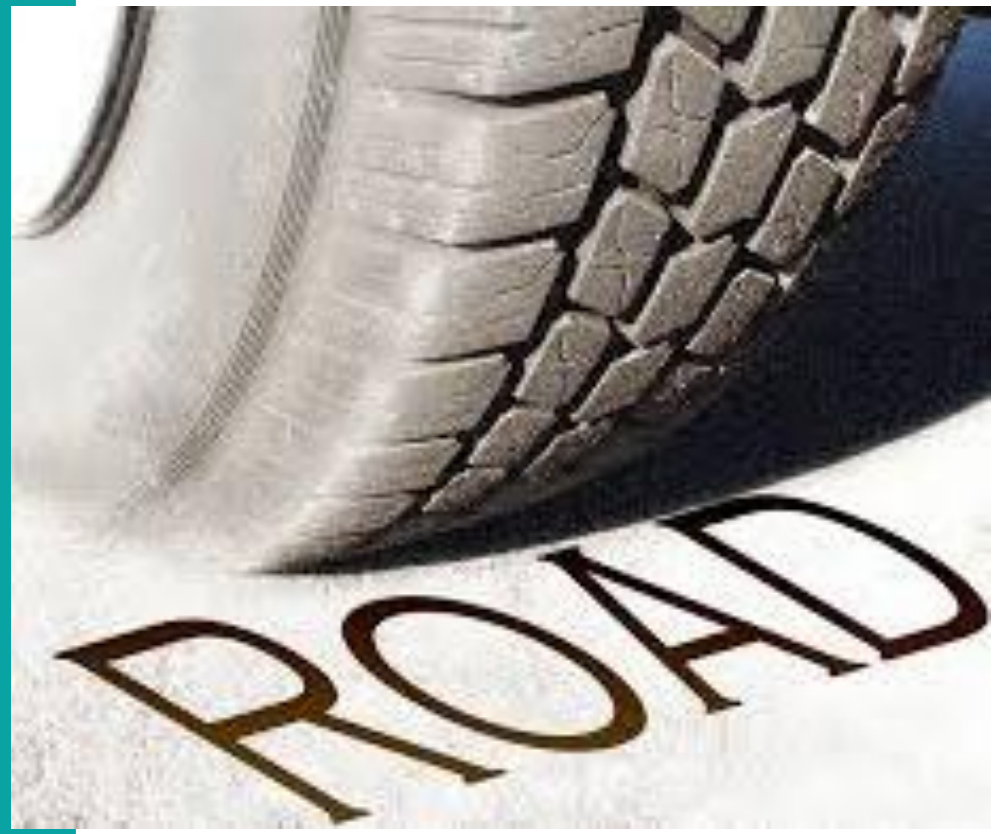
Resources

- Toolkit with case examples
- Vision for a Neighbourhood Home (video link and paper)
- https://www.allianceon.org/resource/IPCT-Expansion-EOI-toolkit-and-Neighbourhood-Health-Home-Case-Example
- OHT data
- Collaboration and Partnership letters

Massive opportunity to make a shift in the PHC landscape

Innovation, strategic leadership, primary care and community engagement is key to ensure that we can design systems to meet the need of our communities

Need to commit to interprofessional team-based data collection, ongoing improvement and facilitation/coaching to enable organizations to work differently



Discussion and Questions