Ontario Health Teams
Full Application Form

About Your Population

In this section, you are asked to provide rationale and demonstrate your understanding of the populations that your team intends to cover in Year 1[1] and at maturity.

Note: Based on patient access patterns and the end goal of achieving full provincial coverage with minimal overlap between Ontario Health Teams, the Ministry will work with Teams to finalize their Year 1 populations and populations at maturity.

1.1. Who will you be accountable for at maturity?

Recall, at maturity, each Ontario Health Teams will be responsible for delivering a full and coordinated continuum of care to a attributed population of Ontario residents, and will be accountable for the health outcomes and health care costs of that population.

Your team will be provided with information about its attributed population based on most recent patient access and flow data. These data will include attributed population size, demographics, mortality rates, prevalence of health conditions, utilization of health services by sector, health care spending data, etc.

Also, recall that in your Self-Assessment, your team proposed a population to care for at maturity.

Below, please rate the degree of alignment between the population and service area that your team originally proposed during the Self-Assessment and your team's attributed population (high, moderate, low). Where alignment is moderate or low, please explain why your initial proposed population may have differed.

Considering given information about your attributed population and any other data sources you may have, what opportunities and challenges (both in Year 1 and longer-term) does your team foresee in serving and being accountable for your attributed population as you work towards maturity? In your response, reflect on whether your team has experience implementing a population health approach or if this is a competency that will need to be developed. Note: If there is discrepancy between the given information about your attributed population and data that your team has, please comment on the difference below.

Maximum word count: 1000. *(998/1000)*

At maturity, our aim is to improve patient outcomes across all four quadrants of the Quadruple Aim. For Year 1, however, our priority populations are frail older adults (55+ years of age) and adults with mental health and addictions (MHA) issues who are not connected to primary care.

[1] 'Year 1' is unique to each Ontario Health Team and refers to the first twelve months of a team's operations, starting from when a team is selected to be an Ontario Health Team Candidate.

Alignment
There is a **high** degree of alignment between the population/service area originally proposed during our self-assessment and the attributed population defined by the Ministry of Health and Long-Term Care. According to the Ministry's data package:

- More than 90% of the attributed population resides in our proposed service area of Ottawa's city limits.[1]
- Our priority populations for Year 1 are well-aligned with the needs in our region. Specifically:
    - Frail older adults comprise the two highest-cost patient groups (palliative and dementia) in our attributed population.[1]
    - More than one-quarter (27%) of emergency department visits with a primary diagnosis that is MHA-related are from patients who are not connected to a primary care provider.[2]

Our team's population health experience
The OHT/ÉSO partners — which include Ottawa Public Health, the six Ottawa Community Health Centres (CHCs) and the Ottawa Community Resource Centres (CRCs) — have significant experience applying a population health approach to community health issues. They tailor services to specific populations including francophone and Indigenous communities and other health equity seeking groups.

Many of the partners have a strong history of responding collaboratively to population health crises. They have acted as the first line of response in mitigating the impacts of the opioid crisis; provided initial health assessments, healthcare and social supports for Syrian refugees arriving in Ottawa between 2015 and 2018; and enacted an emergency response plan to deal with the 2009 H1N1 flu pandemic.

Some partners are also highly proficient in health and community data analytics, and were involved in founding the Ottawa Neighbourhood Study (www.neighbourhoodstudy.ca), which publishes indicators of health and social wellbeing at a neighbourhood level.

Furthermore, Ottawa Public Health's connection to the City of Ottawa can be leveraged to inform municipal policies affecting population health, such as city planning, housing, transportation and social services.

Opportunities
At a high level, the opportunities related to our Year 1 priority populations include the following:

Adults with moderate to complex MHA not connected to primary care
The disproportionately high rates of people who visit the emergency department with alcohol-related disorders as a primary diagnosis among the unattached cohort (53% higher than the

attached cohort) [2] suggests such emergency department visits can be prevented through more regular contact with primary care and access to addictions medicine.

Given that the unattached cohort has a three to four times higher prevalence of homelessness than the attached group,[2] there is also an opportunity to improve these patients' long-term outcomes by connecting them with interdisciplinary Patient Enrolment Models (PEMs) such as CHCs and Aboriginal Health Access Centres (AHACs), which are well-positioned to connect people to services related to the social determinants of health (e.g., subsidized housing, income supports).

Frail older adults
The number of frail older adults (55 years or older) in alternate level of care (ALC) beds can be reduced. Older adults who are living on low incomes and/or have compromised or no formal supports are more likely to be in ALC due to the higher risk of unsafe discharges.[3] By wrapping appropriate services and supports around frail older adults, we can reduce avoidable hospitalizations and readmissions while also making earlier, safer discharges possible.

More frail older adults can also be supported with appropriate palliative care. Currently, only 32% of frail seniors and their caregivers have access to palliative care, compared to 88% of individuals diagnosed with a terminal illness.[4] By standardizing screening practices and assessment tools, and by developing protocols around the various stages of frailty, we can ensure families gain access to community and home care supports sooner, stay in their homes longer, and are engaged earlier in making informed decisions about dignified end-of-life care.

Finally, it is possible to reduce frail older adults' inappropriate use of the emergency department by creating more direct care pathways to sub-acute care. A frail older adult with an inoperable pelvic fracture, for example, does not benefit by going to the emergency department, where they can be exposed to hospital-acquired illness as they wait to be seen and referred to appropriate sub-acute care. In this case and many others, strengthening pathways from community care to inpatient geriatric rehabilitation for frail older adults will reduce inappropriate emergency department use, lead to better outcomes and improve the patient experience.

Challenges
The potential discrepancies between the Ministry's attributed population data and our own internal data are difficult to assess at this time, as we are aware that our CHC and AHAC clients may not be fully attributed to our OHT/ÉSO. This may or may not explain why repeat emergency department visit rates for adults with MHA issues are higher in Central Ottawa (19%) than the regional average (13%), but this same indicator is reported to be low in our OHT/ÉSO's performance relative to the province.[1],[3]

Given that the Ottawa CHCs serve more than 85,000 clients, this is a potentially significant data gap. CHC clients are disproportionately lower income, more racialized and more medically complex relative to the average Ontario patient — and CHCs themselves often act as neighbourhood sites for harm reduction and supervised consumption services. We anticipate that key performance indicators (KPIs), such as MHA-related emergency department

readmissions, could shift significantly once CHC clients are included in our attributed population.

References

1. Health Analytics and Insights Branch, Ontario Health. (2019). *Population, Performance and Utilization measures for Ottawa Health Team/Équipe Santé Ottawa* (R02 Data Package). Received Aug 15, 2019.
2. Inoue, J. (2019). ED data from The Ottawa Hospital (TOH) for MH&A-diagnosed patients (FY 2018-2019).
3. Champlain LHIN and partners. (2018). *Sub-Region Population Health Profiles Technical Report, October 2017* (Last update: April 2018). Retrieved from http://www.champlainlhin.on.ca/~/media/sites/champlain/Goals_Achvmnts/IHSP/SubRegions/Data/SRHlthPrflsTechRptEN.pdf?la=en
4. Seow, H., O'Leary, E., Perez, R., & Tanuseputro, P. (2018). Access to palliative care by disease trajectory: A population-based cohort of Ontario decedents. *BMJ Open*, *8*. e021147.10.1136/bmjopen-2017-021147.

1.2. Who will you focus on in Year 1?

Over time, Ontario Health Teams will work to provide care to their entire attributed population; however, to help focus initial implementation, it is recommended that teams identify a Year 1 population to focus care redesign and improvement efforts. This Year 1 population should be a subset of your attributed population.

To support the identification of Year 1 areas of focus, you will be provided with information about your attributed population including health status and health care spending data.

Describe the proposed population that your team would focus on in Year 1 and provide the rationale for why you've elected to focus on this population. Include any known data or estimates regarding the characteristics of this Year 1 population, including size and demographics, costs and cost drivers, specific health care needs, health status (e.g., disease prevalence, morbidity, mortality), and social determinants of health that contribute to the health status of the population.

If this Year 1 population differs from the one you proposed in your Self-Assessment, please provide an explanation.

Maximum word count: 1000. (931/1000)

In our self-assessment, we initially defined our Year 1 priority populations as **frail older adults (55+ years of age)** and **adults with MHA not connected to primary care**. These have not substantially changed; however, through our work with frontline care providers, healthcare leaders and data analysts from OHT/ÉSO partners, we have been able to identify sub-groups within these broad categories that appear to have the most acute unmet needs.

As a result, we have further refined the definitions for our Year 1 priority populations to be:

- **Adults with moderate to complex MHA not connected to primary care**

- **Frail older adults (55+ years of age)**

Adults with moderate to complex MHA not connected to primary care
Our first focus will be on adults with moderate to complex MHA issues who are not connected to primary care (i.e., are not rostered or, given that some prefer not to be rostered, are unable to connect with primary care on a regular basis).

The Ottawa Hospital (TOH) emergency department data suggest **one sub-population of potential focus** will be people with alcohol-related disorders, which is the most common MHA-related primary diagnosis made during emergency department visits. In fiscal year 2018–2019, alcohol-related disorders accounted for more than 2,300 visits to The Ottawa Hospital's emergency department. Interestingly, unattached patients had a 53% higher incidence of emergency department visits for alcohol-related disorders compared to attached patients.[1] They were also three to four times more likely to be homeless than attached patients.[1]

While our KPIs for patients with MHA issues indicate relatively good performance compared to the provincial average for repeat 30-day admissions and repeat visit rates,[2] we believe there is an opportunity to reduce the volume of emergency department visits by better managing the conditions of adults with moderate to complex MHA through interdisciplinary primary care attachment and improved access to addictions medicine.

Based on past-year data (2018–2019), the size of the cohort of unattached emergency department visitors with MHA is estimated to be approximately 2,350 individuals (with alcohol-related disorders affecting a smaller subset of some 620 individuals).

In terms of **cohort demographics**, among unattached emergency department visitors with MHA:[1]

- 58% are male (vs. 44% in the attached group)
- 75% are single (vs. 48% in the attached group)
- 7.2% are homeless (vs. 1.6% in the attached group)

As it relates to **cost drivers**:[1]

- 526 past-year emergency department visits were for acute intoxication (68.5% of past-year, alcohol disorder-related visits for unattached patients)
- 109 past-year emergency department visits were for harmful substance use (14.2% of past-year, alcohol disorder-related visits for unattached patients)
- 81 past-year emergency department visits were for alcohol withdrawal (10.5% of past-year, alcohol disorder-related visits for unattached patients)

Frail older adults (55+ years of age)
In 2008, falls became the leading cause of injury-related death in Ottawa, with the increase in fall-related deaths occurring primarily among adults 80 years of age and older[3]. In 2012,

dementia overtook heart disease as the leading cause of death among women aged 65 and older.[3] These trends illustrate how an aging population is increasingly becoming a public health priority.

Adults who are frail have a higher risk of poor health outcomes and an increased need for healthcare services. We are interested in developing a common understanding of frailty across the OHT/ÉSO partners.

We estimated frailty in the community using a method developed by Statistics Canada.[2] At least 19% of our attributed population aged 65 and older — some 20,000 people — would be considered "frail"[4] and could benefit from improved integrated care. An additional 28,000 people may be considered "pre-frail" and could benefit from preventative programming. Early intervention in the trajectory of frailty will support health, dignity and wellbeing as well as reduce avoidable health system use.

Using the Ontario-level proportion to estimate the group with highest morbidity and need, approximately 3,500 people in our attributable population aged 65 and older would be considered "most frail". This group cannot reliably be estimated directly for Ottawa, though, so we used the Ontario proportion estimate by age group.

Inclusion criteria for this priority population are as follows:

- At least one frailty-related diagnosis (e.g., senescence, falls, reduced mobility, dementia)
- Heightened risk due to lack of social support and/or low income

One sub-population for potential focus comprises those on the waitlist for Primary Care Outreach to Seniors (PCO) program or those currently being served but experiencing barriers to accessing key services (e.g., geriatric psychiatry, personal care, adult day programs). Based on the approximately 2,073 clients who are engaged in or on the PCO waitlist, we conservatively estimate that 56% have a frailty-related diagnostic code. Among those clients, 1,160 would match both inclusion criteria listed above.

Frail PCO clients tend to be among those with the lowest socioeconomic advantage. Looking at the **demographics** of frail PCO clients:[5]

- 76% have low income
- 87% have low social support
- 92% have low income and/or low social support
- 99% are over the age of 65
- 33% are over the age of 85
- 52% are male and 48% are female
- 7% are francophone

Male clients who are frail are, on average, younger than female clients.

References

1. Inoue, J. (2019). ED data from The Ottawa Hospital (TOH) for MH&A-diagnosed patients (FY 2018-2019).
2. Hoover, M., Rotermann, M., Sanmartin, C., & Bernier, J. (2013). Validation of an index to estimate the prevalence of frailty among community-dwelling seniors. *Health Reports*, *24*(9),10–17.
3. Ottawa Public Health. (2014). *State of Ottawa's Health, 2014.* Ottawa, ON: Author.
4. Statistics Canada. (2015). *Canadian Community Health Survey (2013-2014), Ottawa and Ontario estimates.*
5. Centretown CHC data sample of CCHC PCO clients enrolled during 2018-19 FY. Extracted Sep. 20, 2019.

1.3 Are there specific equity considerations within your population?

Certain population groups may experience poorer health outcomes due to socio-demographic factors (e.g., Indigenous peoples, Francophone Ontarians, newcomers, low income, other marginalized or vulnerable populations, etc.). Please describe whether there are any particular population sub-groups within your Year 1 and attributed populations whose relative health status would warrant specific focus.

Maximum word count: (886/1000)

Demographics and the social determinants of health

Given its population size (416,202) and alignment with our current service area, the census profile of the Champlain LHIN Central Ottawa sub-region[1] is likely the best proxy for assessing the size of population sub-groups that will be served by the OHT/ÉSO.

According to the Champlain LHIN's sub-region profile for 2018, Central Ottawa is composed of:

- 17.9% low-income individuals (15+ years of age), the highest among all Champlain LHIN sub-regions
- 15.3% Francophones (i.e., mother tongue is French), with proportions as high as 53% in the sub-region's easternmost areas like Vanier
- 27.1% racialized individuals, the highest among all sub-regions
- 4.6% recent immigrants, the highest among all sub-regions
- 1.5% Indigenous individuals, including the largest Inuit population south of the Arctic (approximately 3,300 residents)

Our team is well positioned to address to needs of population that experience barriers to accessing health services, including francophone and Indigenous populations, as well as other populations that experience barriers to health including people with low income, racialized populations and the LGBTQ2S+ population.

Frailty in seniors

Frailty increases with age, rising from 13% among those between the ages of 65 to 74 to 48% among those aged 85 and older. The proportion of seniors (aged 65 or older) in Ottawa has increased from 12% in 2006 to 15% in 2016. By 2035, it is estimated that seniors will account for more than 22% of the population.[3]

Older adults with the lowest education level[4], who live in deprived neighbourhoods[4] or who are living on a low income[5] are more likely to be frail.

In the Central Ottawa sub-region, 17.4% of the population is aged 65 or older, with one-third (33.5%) of these seniors living alone. Among those who live alone, 10.4% are also living on a low income, the highest proportion among the Champlain LHIN sub-regions.[1]

Emergency department visits for conditions that are best managed elsewhere, hospitalizations for ambulatory care sensitive conditions, and hospitalizations for chronic conditions all increase consistently as socioeconomic disadvantage increases.[1] People aged 65 or older who live in neighbourhoods with the lowest socioeconomic advantage had the highest emergency department visit rate for falls.[1] As mentioned in Section 1.2, frail PCO patients tend to be among those with the most socioeconomic disadvantage. Frailty is also much higher among the Indigenous population, with rates approaching 50% among those aged 65 or older.[6]. Frail older adults whose mother tongue is French depend on services to be delivered in that language, at this most vulnerable stage of their life when some also lose their capacity to speak in English.

The implications of these data are clear: frail older adults in our attributed population are likely to have a greater need for support due to the high number of individuals who live alone (without family caregivers in the home) and the higher rates of poverty compared to regional and provincial averages.

Mental health and addictions

The social and economic inequities a person experiences during their lifetime can lead to poor mental health and the risk of mental illness.[7] Stable income and employment, as well as access to education, quality housing, safe neighbourhoods and culturally appropriate services, provide people with the resources they need to reach their potential, leading to improved mental health outcomes. For example, while other population groups experience inequities, First Nations, Inuit and Métis peoples, as the original peoples of Canada, experience the cumulative effect of long-term social and health inequities combined with the ongoing impacts of colonization, systemic racism, discrimination and social exclusion.[8]

Mental health problems strongly correlate with socioeconomic factors such as employment and housing. A significant number of people living in homeless shelters have MHA problems, and the majority of individuals with severe mental illness are unemployed.[9] In Ottawa, emergency department visits for MHA conditions are almost three times higher among people from neighbourhoods with the least socioeconomic advantage compared to those with the most.[8] In Central Ottawa, an estimated 21.0% of the populations is affected by a mental health or addictions issue.[1] The Central Ottawa sub-region also has the lowest percentage of

individuals who report very good or excellent mental health at 68.2% as well as the lowest rate of primary care attachment at 82.6%.

References

1. Champlain LHIN and partners. (2018). *Sub-Region Population Health Profiles Technical Report, October 2017* (Last update: April 2018). Retrieved from http://www.champlainlhin.on.ca/~/media/sites/champlain/Goals_Achvmnts/IHSP/SubRegions/Data/SRHlthPrflsTechRptEN.pdf?la=en
2. Statistics Canada. (2015). *Canadian Community Health Survey 2013-2014, Ottawa estimates.*
3. Statistics Canada and Ontario Ministry of Finance. (2018). *Ontario Population Projections by County.* Extracted June 6, 2018.
4. Franse, C.B., van Grieken, A., Qin, L., Melis, R.J.F., Rietjens, J.A.C., & Raat, H. (2017). Socioeconomic inequalities in frailty and frailty components among community-dwelling older citizens. *PLoS One*, *12*(11). e0187946. doi: 10.1371/journal.pone.0187946. eCollection 2017.
5. Watts, P.N., Blane, D., & Netuveli, G. (2019). Minimum income for healthy living and frailty in adults over 65 years old in the English Longitudinal Study of Ageing: A population-based cohort study. *BMJ Open*, *9*(2). e025334. doi: 10.1136/bmjopen-2018-025334.
6. Walker, J. (2017). Aging and frailty in First Nations communities. *Canadian Journal on Aging*, *2017 Nov*., 1–12. doi: 10.1017/S0714980817000319.
7. World Health Organization and the Calouste Gulbenkian Foundation. (2014). *Social determinants of mental health.*
8. Ottawa Public Health. (2018). *Status of Mental Health in Ottawa, June 2018.* Ottawa, ON: Author.
9. Mental Health Commission of Canada. (2012). *The Facts.* Retrieved from http://strategy.mentalhealthcommission.ca/the-facts

2. About Your Team

In this section, you are asked to describe the composition of your team, what services you are able to provide, the nature of your working relationships, and the approach you used to develop this submission.

2.1. Who are the members of your proposed Ontario Health Team?

Please complete the tables below identifying the proposed physicians, health care organizations, and other organizations (e.g., social services) that would be members of the proposed Ontario Health Team.

Note:

- In Year 1, Ontario Health Team Candidates will have an agreement in place with the Ministry outlining their responsibilities as a team, including service delivery and performance obligations. Organizations and individuals listed as Ontario Health Team **members** in tables 2.1.1 and 2.1.2 would be party to this agreement and are expected to deliver services as part of their team. If there are organizations who intend to collaborate or be affiliated with the Ontario Health Team in some way but would not be party to an agreement with the Ministry (e.g., they will provide endorsement or advice), **they should be listed in section 2.5**. Note that a Year 1 agreement between an Ontario Health Team Candidate and the Ministry is distinct from any existing accountability agreements or contracts that individual members may have in place.
- *Generally*, physicians, health care organizations, and other organizations should only be **members of one Ontario Health Team**, unless a special circumstance applies (e.g., provincial organizations with local delivery arms, provincial and regional centres, specialist physicians who practice in multiple regions, etc.).

2.1.1. Indicate primary care physician or physician group members

Note: ***If*** your team includes any specialist (i.e., secondary care or GP-focused practice) physicians as **members**, please also list them and their specialty in this table. The information in this table will be used to assess primary care representation and capacity/coverage.

Name of Physician or Physician Group	Practice Model[2]	Number of Physicians	Number of Physician FTEs	Practice Size	Other
Provide the name of the participating physician or	*Please indicate which practice*	*For participating physician groups,*	*For participating physician groups,*	*For participating physicians, please*	*If the listed physician or physician*

[2] Physician practice models include: Solo Fee for Service (Solo FFS), Comprehensive Care Model (CCM), Family Health Group (FHG), Family Health Network (FHN), Family Health Organization (FHO), Blended Salary Model, Rural and Northern Physician Group (RNPG), Alternate Payment Plans. Family Health Teams may also be listed in Table 2.1.1. Community Health Centres, Aboriginal Health Access Centres, Nurse Practitioner Led Clinics, and Nursing Stations should be listed in Table 2.1.2. If you are unsure of where to list an organization, please contact the MOH.

*physician group, **as registered with the Ministry**.* *Mixed or provider-led Family Health Teams and their associated physician practice(s) should be listed separately. Where a Family Health Team is a member but the associated physician practice(s) is/are not, or vice versa, please note this in the table.* *Physician **groups** should only be listed in this column if the entire group is a member. In the case where one or more physician(s) is a member, but the entire group practice is not, then provide the name of the*	*model the physician(s) work in (see footnote for list of models)*	*please indicate the number of physicians who are part of the group*	*please indicate the number of physician FTEs*	*indicate current practice size (i.e., active patient base); participating physician groups should indicate the practice size for the entire group.*	*group works in a practice model that is not listed, please indicate the model type here.* *Note here if a FHT is a member but not its associated physician practice(s).* *Also note here if a physician practice is a member by not its associated FHT (as applicable).*

participating physician(s and their associated incorporation name).					
See supplementary Excel spreadsheet.					

2.1.2. Indicate member organizations (not including physician(s)/ physician groups)

Name of Organization	Type of Organization[3]	LHIN/Ministry Funding Relationship	Primary contact
Provide the legal name of the member organization		*Does the member organization have an existing contract or accountability agreement with a LHIN, MOH, or other ministry? If so, indicate which*	*Provide the primary contact for the organization (Name, Title, Email, Phone)*
See supplementary Excel spreadsheet.			

2.2. How did you identify and decide the members of your team?

Please describe the processes or strategies used to build your team's membership. Are there key members who are missing from your team at this point in time? Are there any challenges your team sees in moving forward with respect to membership?
In your response, please reflect on whether your team is well positioned to care for your Year 1 and maturity populations. Identify any strategic advantages your team has in relation to the health and health care needs of your Year 1 and maturity populations.

Max word count: 500. (448/500)

Building the team's membership

Leaders from the Ottawa Community Health Centre (CHC) Collaborative and partner community-based health and social service organizations had conversations to explore the feasibility of evolving a local OHT/ÉSO that would be grounded in a strong foundation of primary health care and social services with strong linkages to the rest of the health sector. The Ottawa Hospital also held a meeting with partners to explore interest.

[3] Indicate whether the organization is a Health Service Provider as defined under the *Local Health System Integration Act, 2006* (and if so what kind – hospital, long-term care home, etc.), Community Support Service Agency, Service Provider Organization, Public Health Unit, Independent Health Facility, Municipality, Provider of Private Health Care Services, Other: Please specify

In April 2019, the Ottawa CHC Collaborative hosted a meeting with leaders from a wide range of potential partner organizations, including primary care providers, mental health and addictions (MHA) agencies, hospitals, long-term and continuing care providers, community support services and home care providers. It was decided then that the Ottawa CHC Collaborative would facilitate the evolution of the OHT/ÉSO. All partners would endorse a set of commitments with a vision that people are healthy, well and supported to live in our community.

A group of convening partners that reflected the initial priorities of the Ministry of Health and Long-Term Care is responsible for advancing the OHT/ÉSO, including the effective engagement of many other partners throughout the community. The convening partners include the Ottawa CHC Collaborative, which includes the Carlington CHC, Centretown CHC, Pinecrest Queensway CHC, Sandy Hill CHC, Somerset West CHC and South East Ottawa CHC; Ottawa Inner City Health; Carefor Health & Community Services; The Ottawa Hospital; Ottawa Public Health; and Bruyère Continuing Care. The membership of this group will evolve over time.

Covering the continuum of care
When we submitted our self-assessment, the OHT/ÉSO had 44 partners. That number has since grown to 58 partners covering the entire continuum of care and support, including a broad scope of services and supports for the most marginalized and complex populations who experience barriers to access (as reflected in the sub-populations we will focus on in Year 1).

Our strategic advantage
The OHT/ÉSO's strategic advantage is the depth of collaboration across the community-based health and social service sector and with partners across the broader health system. The relationships are strong and the commitment to evolve a health system that truly works for the residents of our community is deep.

Strengths and challenges
Organizational leaders, primary care providers and client partners are all ready to engage and contribute. The appetite to influence the direction of change in a meaningful way is strong; the challenge lies in finding the time and capacity to engage people in the conversations that matter.

Moving forward, we are committed to evolving our engagement strategy so people can contribute and work together to advance our shared vision, including our commitment to the Quadruple Aim.

For more details on the responses above, see Sections 2.9, 4.1 and 4.2.

2.3. Did any of the members of your team also sign on or otherwise make a commitment to work with other teams that submitted a self-assessment?

Team Member	**Other Affiliated Team(s)** *List the other teams that the member has signed on to or agreed to work with*	**Form of affiliation** *Indicate whether the member is a signatory member of the other team(s) or another form of affiliation*	**Reason for affiliation** *Provide a rationale for why the member chose to affiliate itself with multiple teams (e.g., member provides services in multiple regions)*
See supplementary Excel spreadsheet.			

2.4. How have the members of your team worked together previously?

Please describe how the members of your team have previously worked **together** in a formal capacity to advance integrated care, shared accountability, value-based health care, or population health (e.g., development of shared clinical pathways or shared patient care, participation in Health Links, Bundled Care, Rural Health Hubs; shared back office, joint procurement; targeted initiatives to improve health on a population-level scale or reducing health disparities).

As part of your response, identify specific initiatives or projects that illustrate the **success** of your teamwork. Include detail about project scale and scope (e.g., patient reach), intended outcomes and results achieved (including metrics), **which** team members were involved, and length of partnership. Note: information provided should be verifiable through documentation by request.

Identify which members of your team have long-standing working relationships, and which relationships are more recent. Also identify whether there are any members of the team who have ***never*** previously worked with any other members of the team on initiatives related to integrated care, shared accountability, value-based health care, or improvement at the population health level.

Max word count: 2000. **(1943/2000)**

Ottawa's long history of successful collaboration can be leveraged to advance the vision of the OHT/ÉSO.

Meeting the needs of people facing barriers to health

Operating under a joint strategic plan, Ottawa's CHCs collaborate with each other to offer a wide range of services for people facing barriers to health, including comprehensive primary health care and specialized services for frail older adults, newcomers, people with MHA issues and other at-risk populations. With a combined panel of more than 80,000 people, many of

whom are hard to reach, CHCs serve a large number of low-income seniors (3.8 times higher than the community prevalence), clients with five or more chronic conditions (15% of the combined CHC panel) and clients who are racialized or newcomers (speaking a combined 170 different languages).

In collaboration with their sister Community Resource Centres (CRCs), the CHCs are able to offer city-wide services and initiatives to address the health inequities faced by some communities.

Serving people with MHA who are experiencing or have experienced homelessness
Ottawa Inner City Health, Inc. (OICHI) provides health care prioritizing people living with overwhelming substance use disorders, severe and persistent mental illness, and any combination of complex physical needs, as well as those who are experiencing or have experienced homelessness. It has integrated its services and formed partnerships with a variety of different organizations, including those that provide housing, social services, shelter services, hospital-based care, health promotion, disease prevention, specialized mental health treatment and support, substance use treatment, brain injury care, developmental services, geriatric care and primary care. It also works closely with homeless communities and people living with substance use problems.

The Ottawa Hospital and Ottawa Paramedic Service work with OICHI to reduce inappropriate or unnecessary emergency department use through an emergency diversion program, which ensures homeless people experiencing opiate overdose, sexual assault, wounds, chronic obstructive pulmonary disease (COPD), seizures and other health conditions can access quality care and customized treatment in the community without going through the emergency department.

Carefor Home & Community Care partners with OICHI to provide a unique model of housing, nursing services and personal care for people with complex mental health needs to ensure they are not institutionalized, even if community care can't address their mental health needs.

Serving frail older adults with compromised informal supports and living on a low income
The Ottawa CHC Collaborative, with leadership from the South East Ottawa CHC, offers the Primary Care Outreach to Seniors (PCO) program. A PCO team consisting of a community health worker and a registered nurse work with vulnerable seniors in their homes to provide support with their care and coordinate access to appropriate community resources, helping seniors maintain their health and independence. The team collaborates with a senior's primary care provider to develop and monitor a shared care plan. In the first quarter of fiscal year 2019–2020, PCO teams served a total of 1,378 seniors in Ottawa, 75% of whom are linked to non-CHC primary care models. Where needed, assistance is provided to attach seniors to a primary care practice.

Strong working relationships also exist with other seniors-serving agencies such as the Geriatric Outreach Assessment Teams and Geriatric Psychiatry Community Services of Ottawa, as well as organizations offering community support services to wrap services around

the clients, which helps reduce the number of avoidable emergency department visits and hospital admissions.

Providing post-discharge support
The Going Home program, operated by Carefor in partnership with other local community support service agencies, provides free in-home support services for seniors recently discharged from The Ottawa Hospital (and other hospitals in the region). Clients are assessed and referred by discharge planners or geriatric emergency management nurses located in the emergency department. Post-discharge, the 10-day program ensures a safe and organized transition back to the home by providing essential supports such as the delivery of frozen or hot meals, personal support services, homemaking services, and transportation to and from medical appointments and other outings.

Each year, Going Home serves more than 1,600 meals and provides more than 1,500 hours of personal support to nearly 500 people, 2,500 hours of homemaking services to nearly 800 people and about 2,500 rides for more than 1,400 people in Ottawa — all to keep people healthy and well in their homes as long as possible.

Aligning geriatric and sub-acute services
Building on their strong history of working together, Bruyère and The Ottawa Hospital have formed a partnership to facilitate admission to geriatric rehabilitation for orthopedic patients and those in palliative care and stroke rehabilitation programs. Bruyère has also reviewed and realigned its sub-acute clinical programs to meet the needs of acute care (e.g., for short-term, medically complex patients).

A partnership with the renal program of The Ottawa Hospital has allowed for a satellite dialysis unit at Bruyère's Saint-Vincent campus, allowing long-term renal patients to decant from acute care and the peritoneal dialysis program operating out of Residence Saint Louis — and ensuring long-term care residents have access to peritoneal dialysis. Bruyère has also partnered with Red Dot to support the use of tracking technology for dementia patients that allow to remain safely at home longer.

Taking a comprehensive approach to opioids
The Ottawa Community Action Plan is an opt-in, collaborative, network-based strategy that aims to make tangible improvements in mental health and reduce the harms associated with substance use, with a focus on opioids. Ottawa Public Health is working with partners to develop and implement the action plan — and in doing so, promote mental wellness, prevent problematic substance use and mental illness, reduce stigma, support emerging harm-reduction initiatives, and encourage collaboration and integration across the system.

Providing long-term support for people with severe and persistent mental illness
Some OHT/ÉSO partners collaborate to provide case-management services involving intensive, long-term support for individuals living with severe and persistent mental illness who are homeless or at risk of homelessness. These people may have a concurrent disorder (i.e., a mental health diagnosis *and* problematic substance use) or be in conflict with the criminal justice system. Community support workers and clients work together to develop

goals and plan for an eventual transition out of services. Approximately 1,300 clients receive case-management services through a collaboration between the Ottawa branch of the Canadian Mental Health Association, Upstream, Ottawa Salus Corporation, The Royal, Montfort Renaissance, and the Sandy Hill and Somerset West CHCs.

Other partners host Assertive Community Treatment Teams (ACTTs) for people with complex, long-term and serious mental illness involving multiple hospitalizations of a minimum of 50 days in the past year or 150 days over the past three years. A central intake team — a partnership between Montfort Hospital, The Royal, and the Pinecrest-Queensway and Carling CHCs — reviews referrals for all Ottawa area ACTTs, which collectively serve 400 clients annually.

Collaborating across the MHA sector
Significant planning and quality improvement work is underway in the MHA sector, including many OHT/ÉSO partner organizations as well as clients and families. Networks that will be tapped into to support the development of our goals include the:

- Addictions Mental Health Network Committee (AMHNC), a network of MHA service providers and community members
- Champlain Addictions Coordinating Body (CACB), a network of addictions/concurrent disorder service provider leaders that includes representation from the LHIN
- Harm Reduction Coalition and Safe Consumption Tables, a network of service providers and people with lived experienced that shares information and collaborates to advocate for and address access to services for people who use drugs

Offering non-urgent medical transportation
The Champlain Community Transportation Collaborative (CCTC) was established in 2010 to address a significant gap in the availability of non-urgent medical transportation services in the Champlain region. With Carefor designated by the LHIN as lead agency, 26 community support service (CSS) agencies from across the region have come together to help remove this barrier to accessing much needed healthcare services. The partnership has grown to include a fleet of more than 50 specialty transport vehicles and dozens of volunteer drivers delivering more than 150,000 units of service to people across the region, with nearly 6,500 units of service provided for nearly 800 Ottawa residents — easing the burden on hospitals, ambulances and other acute care transportation services.

Serving people with diabetes
The Community Diabetes Program of Ottawa (CDEPO) operated by Centretown CHC has collaborative relationships with many organizations and providers including OHT/ÉSO partners. Staff teams offering diabetes education and support are located at multiple CHC and Community Resource Centre (CRC) sites to offer accessible services at different locations and in multiple languages. Insulin starts and support for medication titration are done in partnership with primary care providers and specialists, either remotely or on-site. Weekly on-site clinics are also offered at four community endocrinology practices, a community heart failure clinic, two Family Health Teams and four CHC primary care clinics.

In addition to CHC referrals, more than 1,400 non-CHC providers referred clients to CDEPO, with 4,000 people served in last year. Carefor and other home care providers collaborate through the regional Foot Care Working Group, which brings together specialists, hospitals and home care to coordinate efforts in amputation prevention for people with diabetes. Centretown CHC manages Diabetes Central Ottawa, a one-access intake and referral service aimed at increasing referrals to the various community-based diabetes education programs operating in Ottawa. The service also provides central intake for lung health programs. In the past year, Diabetes Central Ottawa processed more than 4,000 referrals, including first-time referrals from 190 providers to diabetes education and 134 for lung health.

Serving people with lung health issues

Somerset West CHC works collaboratively with many organizations across the region including OHT/ÉSO partners to deliver a highly successful community-based population-health initiative that includes the:

- Primary Care Asthma Program to decrease health care utilization through prevention, education and self-management
- Ottawa Community Lung Health Program to support those living with COPD
- Complex Respiratory Care Program to improve transitions from hospital to home for those living with complex respiratory care needs

The initiative's partners include:

- The Wabano Centre for Aboriginal Health to provide asthma and COPD education to Indigenous clients
- Ottawa Public Health, the Ottawa Heart Institute and the Centre for Addiction and Mental Health to deliver smoking-cessation programs
- The Complex Respiratory Needs Sub-Committee, which includes The Ottawa Hospital, Bruyère (Saint-Vincent), and other home and community care agencies
- Hospice Care Ottawa to develop and implement care plans for long-term ventilated clients;
- Home care nursing agencies, including Carefor, to identify clients who require outreach respiratory therapist

Providing care coordination for people with complex health issues

With leadership from the Pinecrest-Queensway and South East Ottawa CHCs, OHT/ÉSO partners have worked together for the past four years to implement Health Links and ensure coordinated, patient-centred, integrated care is the standard for complex patients. More than 5,600 patients now have coordinated care plans within the region and thousands of care providers have been engaged in care teams. Key members of the OHT/ÉSO have been trained and coached in the approach and are supporting this transformation change. More than 54 agencies have collaborated to implement coordinated care plans and 85% of our unattached referrals are now connected to primary care.

Supporting aging in place
Champlain LHIN Home Care, Ottawa Community Housing and Ottawa West Community Support are working collaboratively with Ottawa Public Health, the Regional Geriatric Assessment Program, and Ottawa's CHCs and CSS agencies to provide integrated aging-in-place services in 11 low-income seniors buildings.

Outreach coordinators and case managers work in storefront offices in each building, providing and coordinating services that include crisis intervention, enhanced case management, nursing and therapy visits, homemaking, foot care, meals, transportation to medical appointments and health-related activities, and health promotion sessions. Emergency department visits and hospitalization rates have dropped as seniors are supported to live healthier lives and linked to key services and supports.

2.5. How well does your team's membership align to patient/provider referral networks?

Based on analysis of patient flow patterns and the natural connections between providers and patients revealed through this analysis, your team has been provided with information about which patient/provider referral networks the physician and hospital members of your team are part of.

How would you rate the degree of alignment between your current membership and the provider networks revealed through analysis of patient flow and care patterns (high, moderate, low)? Where alignment is moderate or low, please explain why your team membership may have differed. Given the provided data, have you updated your team membership since the Self-Assessment?

Max word count: 500. (177/500)

Degree of alignment
Alignment between our membership and patient/provider referral networks is high given the full span of OHT/ÉSO partners. All partners serve the patient population attributed, with some serving beyond that attributed population given the city-wide and or regional focus of their services.

The partnership includes:

- Interprofessional team-based care
- Mental health and addictions serving agencies
- Home care
- Community support services

- Acute care (in-patient and ambulatory)
- Hospital-based rehabilitation and complex care
- Long-term care
- Affordable and supportive housing
- Palliative and end-of-life care
- Emergency health services
- Health promotion
- Public health
- Other social and community services

Primary care capacity
Our base of primary care currently includes six Community Health Centres (CHCs), one Aboriginal Health Access Centre (AHAC), one Family Health Organization (FHO), and one Family Health Team (FHT) that is linked to The Ottawa Hospital and operates out of two sites. Other primary care provider teams are reaching out. The Community of Family Physician Practice is interested in further dialogue about how the OHTs will evolve. With time for further outreach and engagement, we are confident that our partnerships will evolve.

2.6. Who else will you collaborate with?

Please provide information on who else your team plans to collaborate or affiliate with. Describe the nature of your collaboration and include information on any plans to coordinate services with these providers or organizations. If your team has received endorsement from specialist physicians or clinical leaders/leadership structures (e.g., Chiefs of Service, Medical Directors, Medical Advisory Committees), please list them in table 2.6.1.

2.6.1. Collaborating Physicians

Name of Physician or Physician Group	Practice Model	Number of Physicians	Collaboration Objectives and Status of Collaboration
			Describe your team's collaboration objective (e.g., eventual partnership as part of team) and status (e.g., in discussion)
See supplementary Excel spreadsheet.			

Other Collaborating Organizations

Name of Non-Member Organization(s)	Type of Organization	Collaboration Objectives and Status of Collaboration
Provide the legal name of the collaborating organization	*Describe what services they provide*	*Describe your team's collaboration objective (e.g., eventual partnership as part of team) and status (e.g., in discussion)*
See supplementary Excel spreadsheet.		

2.7. What is your team's integrated care delivery capacity in Year 1?
Indicate what proportion of your Year 1 target population you expect to receive **integrated care (i.e., care that is fully and actively coordinated across the services that your team provides)** from your team in Year 1. Please provide a rationale for this estimate and describe what actions you will take to ensure as many Year 1 patients who require integrated care will receive it.

Max word count: 500 72/500

The OHT/ÉSO has identified possible sub-populations, care pathways and capacity to leverage. Given the large number of partners and the diversity of our population, we are choosing to engage in further dialogue to build our action plans, understand capacity and set targets.

Our team will submit an addendum by December 9, 2019 that will outline the number and proportion of the Year 1 target populations we could serve in an integrated manner.

2.8. What services does your team intend to provide in Year 1?
Provide a description of each service, indicate whether the service would be available to your entire Year 1 population or a subset (with rationale), and indicate which member of your team will provide the service.

Service	**Proposed for Year 1** (Yes/No)	**Capacity in Year 1** (how many patients can your team currently serve?)	**Predicted Demand in Year 1** (of your Year 1 population, how many patients are predicted to need this service)	**Description** (Indicate which member(s) of your team will provide the service. If a proposed service offering differs from your team's existing service scope, please provide an explanation as to how you will resource the new service. If there is a gap between capacity and predicted demand, identify if you have a plan for closing the gap.)

See supplementary Excel spreadsheet				
Interprofessional team-based primary care				
Physician primary care				
Acute care – inpatient				
Acute care-. ambulatory				
Home care				*Please complete Appendix A.*
Community support services				
Mental health and addictions				
Long-term care homes				
Other residential care				
Hospital-based rehabilitation and complex care				
Community-based rehabilitation				
Short-term transitional care				
Palliative care (including hospice)				
Emergency health services (including paramedic)				
Laboratory and diagnostic services				
Midwifery services				
Health promotion and disease prevention				
Other social and community services (including municipal services)				
Other health services (please list)				

2.9. How will you expand your membership and services over time?

Ontario Health Teams
Full Application Form

At maturity, Ontario Health Teams are responsible for offering a full and coordinated continuum of care. Teams are expected to expand the population they serve each year, working towards providing care for their entire attributed population.

Describe your plan for phasing in the remaining continuum of care for your population, including proposed timelines. Your plan should include explicit identification of further members, collaborators, and services for inclusion for Year 2. Include in your response commentary on whether your team anticipates any challenges in expanding the types of services your team provides or meeting demand for services beyond year 2, given your attributed population.

Max word count: 500. *(260/500)*

Current partners
OHT/ÉSO currently has 58 partners that together cover the entire continuum of care. As of the last review 15 of 55 are designated for French Language Services covering services from across the continuum of care including home care and support, mental health and addictions services, primary care, sub-acute and acute care.

Expanding partners
Other organizations committed to the vision of the OHT/ÉSO that offer care and support to the population base have expressed interest in partnering including but not limited to primary care providers, home care agencies, long-term care, brain injury services, supportive housing and shelters. Many of these organizations offer essential services and are a crucial component of a health system that enables people to live well and access the supports related to the social determinants of health.

The steps are being put in place to enable effective communication, engagement and relationship building with more partners. It is essential to establish the infrastructure that will support organizations to be informed and make their desired contribution while retaining focus on transforming the health system in alignment with the vision.

Work is currently being done to:

- Establish a website that will support effective communication in both official languages
- Establish an engagement process to include more partners while managing expectations
- Develop a repository of data, reports and consultation results that can support future planning.

The process of engagement with new partners is about developing relationships and building trust. Time is needed to have the necessary conversations, explore mutual interests, and ensure alignment to a common vision and set of commitments.

If you do not have all primary care providers in your network involved at this point, please describe what efforts have been made to date to involve these providers and your plan for how you will expand primary care partnerships to meet population need at maturity.

Max word count: 500. (405/500)

The effective engagement of primary care providers is crucial to evolving an OHT/ÉSO that is grounded in a strong base of primary health care, mental health and addictions and social services.

Steps taken
In the initial stages the OHT/ÉSO has:

- Consulted a representative group of CHC primary care providers about the challenges to provide care for the initial populations and their interest in engagement
- Met with the leadership of the TOH and Bruyère affiliated Academic Family Health Teams to explore how to engage primary care providers in the work of the OHT/ÉSO
- Met with the newly established Community of Family Medicine Practice to review: the vision and commitments of the OHT/ÉSO, initial results of action teams, and results of their Pain Points survey, which confirms the need to enhance the effectiveness of communication and shared care with specialists
- Engaged physician representatives in action teams
- Responded to queries from Primary Care Patient Enrollment Models (PEMs) about opportunities to engage in the work of the OHT/ÉSO
- Conducted a preliminary analysis of how many family physicians are referring clients to key CHC hosted services (Primary Care Outreach for Frail Seniors, Diabetes Education, Lung Health and Health Links), estimated to be 681 different family physicians in Ottawa

Proposed next steps
The next steps in the process are to:

- Consult with primary care providers and directors of affiliated practices to understand how they can contribute to advancing the action plans of the OHT/ÉSO in relation to the initial populations for focus (TOH and Bruyère affiliated Academic Family Health Teams, Greenboro Family Medicine Centre, Wabano Centre for Aboriginal Health)
- Reach out to the Primary Care Patient Enrollment Models (PEMs) linked to the OHT/ÉSO's attributed population to explore their interest in engagement, the issues/challenges they experience in providing care for the initial populations for focus, options for change and the contributions they can make to advancing the work of the OHT/ÉSO
- Establish a mechanism for communicating with and engaging primary care providers in planning (e.g., Reference Group)

- Clarify the relationship with the Community of Family Medicine Practice
- Determine what structure will best support engagement given practitioner time constraints
- Explore how to communicate and engage with more nurse practitioners

- Where possible, engage more primary care providers in OHT/ÉSO affiliated action teams
- Engage with representatives from primary care providers and hospital and community-based specialists to explore how to improve communications and care pathways, strengthening relationships and leveraging virtual care options wherever possible.

2.10. How did you develop your Full Application submission?

Describe the process you used to develop this submission. Indicate whether it was an participatory process across all members and if your submission reflects a consensus across the entire membership. If so, describe how consensus was achieved. Indicate whether any third parties external to your team were involved in the completion of this form (e.g., grant writers, consultants).

Also consider in your response:

- If patients, families, and caregivers partnered or were engaged or consulted in the design and planning of this submission, please describe any partnership, engagement, or consultation activities that took place and whether/how feedback was incorporated.
- If your team engaged with the local community in the design and planning of this submission, please describe any engagement activities that took place and whether and how feedback was incorporated. In particular, please indicate whether your team engaged with local Francophone communities (e.g., local French Language Planning Entities) or with Indigenous communities. Describe the nature of any engagement activities with these communities and whether/how feedback was incorporated.
- If you have community support for this application (e.g., support from a municipality), please provide a description and evidence of this support. If your team's attributed population/network map overlaps with one or more First Nation communities [https://www.ontario.ca/page/ontario-first-nations-maps], then support from those communities for your team's application is required. Where applicable, please indicate whether you have support from First Nation communities. Indicate the nature of the support (e.g., letter of support, band council resolution, etc.). If you do not have support at this time, provide detail on what steps your team is taking to work together with First Nations communities towards common purpose.

Max word count: 1000. (756/1000)

Building the foundation
A significant amount of work has been done to build the foundation for future collaboration while meeting the requirements of the application within a tight timeframe. Convening partners have held multiple meetings to plan the approach to advancing the OHT/ÉSO. The commitment is to evolve a collaborative leadership model and infrastructure.

Client engagement (See Section 3.8)
Client partners including family members and caregivers have been consulted to help design how clients will be effectively engaged and contribute to the work of the OHT/ÉSO. A model has been drafted which is continuing to evolve.

Client partners are active participants and equal voices in action teams, the key means for co-design. Their voice has been invaluable for identifying the vision for change.

Provider and client partner engagement
Providers are engaged through action teams, which are key to setting the direction for change. Current action teams include: Mental Health and Addictions and Primary Care; Frail Older Adult; and Home and Community Care. Staff of partner organizations self-identified interest in contributing to action teams and people were selected to ensure a cross representation. Between 10 and 14 people organizational leaders and front-line staff, primary care providers and client partners are engaged in each action team. Each action team participated in a 5 hour "deep dive" conversation to analyze issues/challenges, establish a common vision for change and identify options for initial action.

The results from those action team conversations, combined with our collective knowledge from existing collaborative initiatives, informed the initial direction outlined in this application. The teams will reconvene post application to determine the next best steps.

Primary Care Provider engagement
A number of steps have been taken to determine how to best engage primary care providers in a meaningful way. At this point we have:

- Consulted a representative group of CHC primary care providers about the challenges to provide care for the initial populations and their interest in engagement
- Met with the leadership of the TOH and Bruyère affiliated Academic Family Health Teams to explore how to engage primary care providers in the work of the OHT/ÉSO
- Met with the newly established Community of Family Medicine Practice to review: the vision and commitments of the OHT/ÉSO, initial results of action teams, and results of their Pain Points survey, which confirms the need to enhance the effectiveness of communication and shared care with specialists
- Engaged physician representatives in action teams

- Responded to queries from Primary Care Patient Enrollment Models (PEMs) about opportunities to engage in the work of the OHT/ÉSO
- Conducted a preliminary analysis of how many family physicians are referring clients to key CHC hosted services (Primary Care Outreach for Frail Seniors, Diabetes Education, Lung Health and Health Links), estimated to be 681 different family physicians in Ottawa. (see Section 4.2)

Francophone engagement
Le Réseau des services de santé en français de l'Est de l'Ontario (RSSFEO) has provided consultation expertise and gathered information about FLS designation of partners. They also organized two meetings with all FLS designated agencies which included partners from our OHT to share and collaborate on the planning of OHTs in our area. Leaders and staff of Francophone serving agencies who are members of the Coalition of Community Health and Resource Centres were consulted to explore the unique needs of Francophones in relation to year 1 populations and how best to plan with and for francophones to deliver culturally competent services from beginning to end. See Section 3.7.2

Indigenous engagement
A meeting was held with senior leaders and the Board of Directors of Wabano Centre for Aboriginal Health. Wabano staff will be involved in future work to plan interventions in relation to year 1 populations. See Section 3.7.1.

Data Analysis
Data analysts from convening partners have reviewed MOH provided data and analyzed data from individual organizations to understand and provide analysis that can support decision-making about where to focus initial efforts.

Digital health
A survey was conducted to gather information about the current state of digital health amongst convening partners. Staff from convening partners met to explore opportunities to leverage the current digital health capacity. These staff will be integrated into action teams going forward to ensure digital health options are considered in the re-design of care pathways.

Communication with partners
Two webinars have been held to update organizational partners on the status of the work, how to engage and respond to questions. A website has been developed to support future communications and engagement.

Third party support has been retained to support process design and facilitation. Assistance was provided to write the application.

3. How will you transform care?

In this section, you are asked to propose what your team will do differently.

By redesigning care for their patients, Ontario Health Teams are intended to improve patient and population health outcomes; patient, family, and caregiver experience; provider experience; and value. By working together as an integrated team, Ontario Health Teams are also expected to help improve performance on a number of important health system measures, including:

a) Number of people in hallway health care beds
b) Percentage of Ontarians who had a virtual health care encounter in the last 12 months
c) Percentage of Ontarians who digitally accessed their health information in the last 12 months
d) 30-day inpatient readmission rate
e) Rate of hospitalization for ambulatory care sensitive conditions
f) Alternate level of care (ALC rate)
g) Avoidable emergency department visits (ED visit rate for conditions best managed elsewhere)
h) Total health care expenditures
i) *Patient Reported Experience Measures, Provider Reported Experience Measures, and Patient Reported Outcome Measures are also under development*
j) Timely access to primary care
k) Wait time for first home care service from community
l) Frequent ED visits (4+ per year) for mental health and addictions
m) Time to inpatient bed
n) ED physician initial assessment
o) Median time to long-term care placement
p) 7-day physician follow up post-discharge
q) Hospital stay extended because the right home care services not ready
r) Caregiver distress

This is a non-exhaustive list of metrics that reflect integrated care delivery systems.

3.1. What opportunities exist for your team to improve care for your population and health system performance in Year 1 and at maturity?

Considering the measures listed above and the health status of your Year 1 and maturity populations, please identify and provide rationale for what your team considers to be your **most important (e.g., top three to five) performance improvement opportunities** both for Year 1 and longer term. In your response, consider your team's assets, the services you intend to provide, and the features of your Year 1 and attributed populations. Explain how you identified these priority improvement opportunities and any relevant baseline performance data you have for your Year 1 and/or attributed populations.

Max word count: 1000. (852/1000)

At maturity, our aim is to improve patient outcomes across all four quadrants of the Quadruple Aim. In Year 1, we will focus on the process indicators that affect access and transitions of care for our two priority populations: adults with moderate to complex mental health and addictions (MHA) issues not connected to primary care, and frail older adults (aged 55+). We expect that improving the process indicators will also improve patient outcomes for these two populations.

We have identified performance improvement opportunities that correspond to the assets available to us and the services we can offer to our priority populations. More dialogue will be needed among the OHT/ÉSO partners to establish baseline measures, assess capacity and identify priority improvement areas.

Adults with moderate to complex MHA not connected to primary care
For this population, we have identified the potential to:

- Decrease avoidable emergency department visits among adults with MHA issues by providing timely access to primary care within a team-based care model that includes MHA services
- Reduce the frequency of emergency department visits per year for adults with MHA issues

We have significant capacity to leverage:

- Interdisciplinary primary healthcare teams, including MHA services
- Existing supports within emergency departments tailored for adults with MHA issues
- Care coordination and case-management resources from multiple partner organizations
- Digital health platforms that can expand the use of e-health to support shared care
- Existing primary healthcare hubs already operating outside of traditional hours, which could expand access to both primary care and MHA services
- Current models of service help streamline access, such as single-session walk-in counselling and walk-in health clinics that are inclusive of social work and primary care
- Existing service models that are successfully offered in partnership through shared resources
- Willingness to shift resources outside of "organizational walls" for greater impact

The collective resources of the OHT/ÉSO partners can be leveraged to improve access to team-based care through primary health care hubs (with care coordination and MHA services included). This would:

- Provide timely, low-barrier primary care services, including access to addictions medicine, to MHA clients who are unattached to primary care
- Evolve the model of care coordination and case management to include social determinants of health
- Strengthen shared care — for example, through expanded use of e-health and on-site access speciality resources such as psychiatrists and other MHA professionals
- Increase access to primary health care hubs and services outside of traditional hours (e.g., single-session walk-in counselling services and walk-in health clinics that are inclusive of social work and primary care, rapid access to addictions medicine)
- Establish clear pathways to the full scope of MHA services available to adults with mild to moderate to serious MHA issues, including triage and assessment (e.g., by leveraging the proposed Centralized Access Service)

Frail older adults
For this population, we have identified the potential to:

- Reduce alternate level of care (ALC) rates
- Reduce hospitalization rates for ambulatory care-sensitive conditions
- Reduce avoidable emergency department visits for conditions best managed elsewhere
- Decrease the number of patients receiving care in unconventional spaces or hallways

We have significant capacity to leverage:

- Interdisciplinary primary health care teams, including those with expertise offering primary health care to vulnerable older adults
- Care coordination and case-management resources offered by multiple partner organizations
- Outreach services that are tailored to vulnerable older adults with low incomes and no or compromised supports, offered in shared care arrangements with primary care providers working in a wide range of models
- Complex continuing care, geriatric and stroke rehabilitation and memory care
- Strong, coordinated palliative care, including care consultation and hospice care
- Home care and a wide range of community support services, including personal care and adult day programs
- Residential care spaces, including long-term care and affordable and supportive housing for seniors
- Innovative transitional care programs for ALC patients

Similar to what was noted above, the collective resources of the OHT/ÉSO partners can be leveraged to improve access to team-based care through primary health care hubs (with care

coordination and an extensive array of services and supports customizable to the needs of older adults and their families). This would:

- Provide timely, low-barrier health services for frail older adults who are unattached to primary care
- Develop a more streamlined, integrated approach to assessment, care coordination and case management that is linked to primary care and includes a focus on the social determinants of health
- Embed standardized early assessment and identification of frailty, means and palliative care for patients
- Promote informed palliative care conversations (on topics such as advanced care planning, for example) to ensure patients have access to the right care at the right time, leveraging the Regional Palliative QI initiative
- Establish direct care pathways to rehabilitation and sub-acute services from primary care for older adults who require short-stay rehabilitation for acute non-operable conditions, allowing them to stay safely at home longer
- Transition ALC patients to home through enhanced team-based home and community care supports or the use of existing transition programs with demonstrated success
- Evolve and expand existing neighbourhood care and congregate care models to provide congregate care assisted living and support in buildings with high concentrations of vulnerable older adults while strengthening links to primary care

3.2. How do you plan to redesign care and change practice?

Members of an Ontario Health Team are expected to **actively work <u>together</u>** to improve care for their patients. Please describe how you will work together to redesign care and change current practices in your first 12 months of operations to address the performance improvement opportunities you identified in section 3.1.

In your response, please consider what specific outcomes you're aiming to achieve, as measured by one or more of the indicators listed above (or others, as relevant), and what targets, if any, you have set from baseline.

Note that detailed commentary on how you propose to provide care coordination and system navigation services, virtual care, and patient self-management are requested in subsequent sections.

Max word count: 2000. (1115/2000)

The foundation for our redesign

Our vision of redesigned care is grounded in the belief that primary health care and social services should be linked to the rest of the healthcare system — a fundamental reorientation toward supporting patients' overall health and well-being.

People should be connected to a team whose members are jointly responsible for caring for and supporting the *whole* person and their family, from cradle to grave. That team should be made up of providers from across the healthcare system, all collaborating in the best interests of the people who are accessing care.

Our vision is based on a set of commitments that include (but are not limited to):

- Providing timely and accessible care, including virtual access
- Providing comprehensive team-based care with contributions from multiple partners
- Addressing the social determinants of health and barriers to health equity

Accessing healthcare services has become too difficult for many Ontarians. The changes we are proposing are not about who *provides* the service; instead, they are about working seamlessly together so the patient experience is comfortable and makes sense. While there are many benefits to highly specialized services, the downside is that they have evolved in silos, each with their own unique mandates, areas of focus and access criteria. This makes navigating the system incredibly challenging — not just for patients and their families but for providers, too.

Moving forward, some services will need to be co-located for ease of access, to support communication and relationships among providers, and to reduce transportation requirements for people using multiple services. Other services will be better connected, like specialists providing on-site care in community-based primary care hubs.

While the number of physicians operating outside of group practices are decreasing, it is essential each family physician has access to an interdisciplinary team they can work with collaboratively to support their complex patients. In this regard, new models are evolving across the province that have been proven to be effective.

How we will redesign care

Our vision of redesigned care and the accompanying changes in practice reflect the complete scope of care and support required by our two priority populations. The OHT/ÉSO partners have expressed interest in and a capacity to shift their programs and services to align with our vision. However, further work with the partners will be needed to prioritize and solidify capacity options.

Adults with moderate to complex MHA not connected to primary care

We have identified the need and potential to evolve a more comprehensive approach to supporting adults with MHA issues. This approach includes:

- Expanding access to care coordination that is linked to team-based primary health care for adults with moderate to complex MHA issues (see Section 3.3.1 for more details)
- Establishing pathways for adults with MHA issues who present at emergency departments and/or are discharged from in-patient psychiatry so they can be connected/attached to primary care and have access to team-based care through community MHA services. This will require:
    - Identifying primary care providers willing and able to serve MHA clients with some complexity
    - Establishing a clear pathway for referrals
    - Implementing e-referrals
- Establishing clear and timely processes for shared-care referrals — for example, by expanding on-site and virtual care access to specialists and other clinicians and team members, and by working to ensure the availability of culturally appropriate supports
- Simplifying how people navigate and access MHA services by:
    - Engaging in implementation planning for the proposed Centralized Access Service for MHA (one portal for accessing MHA supports), matching level of need to appropriate intensity of service, and leveraging the navigation supports that already exist within the system
    - Leveraging multi-agency quality improvement initiatives (such as the Community Quality Improvement Project based on Ontario Perception of Care (OPOC) data) to improve seamless transitions of care
    - Sharing of standardized assessment and screening tools (e.g., Gain SS, GAIN Q3, OCAN) through the Integrated Assessment Record
    - Analyzing the potential for the expanded use of e-health
- Expanding supports for self-care management by:
    - Placing a greater focus on self-management and improving access to health literacy tools (e.g., self-directed tools such as Bounceback and Big White Wall, psychoeducation about MHA conditions, self-management modalities such as mindfulness and chronic disease self-management skills, peer-based group activities such as Smart Recovery)
    - Expanding the “social prescribing” approach, leveraging the capacity of OHT/ÉSO partners and community partners to support health and wellness through community connections to arts, culture, recreation, leisure, etc.
    - Increasing connections to existing peer supports and supporting the ongoing development of the peer sector

Frail older adults

We have have identified the need and potential to evolve a more comprehensive approach to supporting frail older adults. This approach includes:

- Increasing access to care coordination that is linked to a team-based care model (see Section 3.3.1 for more details)
- Expanding access to team-based care through primary health care hubs by:
    - Establishing virtual and on-site relationships with specialists and other allied professionals
    - Providing system navigation/linkages to care and social supports
    - Establishing a clear pathway for connection/attachment to primary care for those who need it
- Conducting systematic screening for frailty, standardizing and staging the clinical assessment of frailty to better anticipate care needs and mitigate health risks (e.g., falls). This will involve:
    - Screening and identifying older adults at risk
    - Conducting assessments
    - Designing and providing tailored interventions
- Expanding capacity to respond to the most complex and disconnected frail seniors, with a tailored approach to help them access care and supports. Includes:
    - Establishing a systematic approach to identification and response
    - Establishing a clear mechanism for rapid connection to support
    - Taking the time to build relationships and stagger access and level of care/support
- Targeting support for buildings/settings that are home to seniors with complex needs — for example, by increasing the number of buildings that can facilitate easy access to care and on-site supports, establishing clear links to primary care, and expanding care in response to seniors' individual needs
- Increasing access to sub-acute and transitional care by evolving the models for accessing rehabilitation services (which will enable successful transitions from hospital to home), and by better linking sub-acute and rehabilitation services with primary care
- Enhancing access to palliative and end-of-life care by:
    - Implementing practices to screen and identify people who require palliative care
    - Exploring the feasibility of having paramedics provide symptom management for people who prefer to remain at home (by leveraging the Ottawa Paramedic Service pilot project)
- Improving access to community supports for keeping people healthy and well at home by:

- Identifying essential supports available in the community and leveraging existing e-referral tools (e.g., Caredove)
- Moving to greater consistency of and equitable access to services
- Evolving standardized health promotion activities, including falls prevention

3.3. How do you propose to provide care coordination and system navigation services?

Seamless and effective transitions, 24/7 access to coordination of care, and system navigation services are key components of the Ontario Health Team model. Care coordination and system navigation are related concepts. Generally, care coordination refers to "deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care. This means that the patient's needs and preferences are known ahead of time and communicated at the right time to the right people, and that this information is used to provide safe, appropriate, and effective care to the patient" (Care Coordination. Agency for Health care Research and Quality (2018). System navigation activities can include helping people understand where to go for certain types of care and facilitating access to health and social services. Teams are expected to determine how best to implement 24/7 access to coordination of care and system navigation services based on the needs of their patients and which members of the team are best suited to play this role.

3.3.1. How do you propose to coordinate care?

Care coordination is a critical element of high-performing integrated care, particularly for patients who require higher-intensity care. Considering the needs of your Year 1 population, please propose how your team will coordinate care for these patients. In your proposal, describe whether any of the members of your team have experience coordinating care across multiple providers and care settings.

Describe what activities would be in and out of scope for your care coordination service in Year 1. Describe which patients will have access to care coordination services, how they will access the service, and whether care coordination resources will be organized differently from how they are currently deployed in order to better serve your population. Indicate whether your team will coordinate any care beyond the in-scope services provided by your immediate team.

Describe who (i.e., what type of staff, which organization) would provide care coordination, how many existing FTEs would be assigned to this service, and whether your team has sufficient existing capacity to meet the anticipated care coordination needs of your Year 1 population. Please specify if your plan involves the use of LHIN care coordination resources.

Describe how you will determine whether your care coordination is successful.

Max word count: 1000. (789/1000)

Simplifying the health system for everyone

We are committed to simplifying the healthcare system for everyone. That said, we know those with more complex needs will still require care coordination even in an easier-to-navigate future state. Specifically, they require a person who can work with them, their primary care provider and others across an interprofessional team to develop and implement a care and support plan. Care coordination goes beyond medical needs alone to consider the social determinants of health, including supports to connect and reduce isolation.

While our intent and approach to developing care coordination are mostly similar for each of our initial priority populations, there are some important variations to be noted.

Adults with moderate to complex MHA not connected to primary care

Best practices in MHA services have shown that access to care coordination and intensive case-management services (depending on the complexity of MHA symptoms and issues faced) lead to positive health outcomes and stabilization opportunities for individuals with MHA. Our goal is to ensure appropriate levels of support are offered along the health continuum (particularly where need is high) and that access to timely care coordination and case management is available. We will work to review current resources and capacity for care coordination, ensuring access to the right digital tools, training and competencies to eliminate duplication in data entry/reporting and enable the sharing of information for team-based care.

Intent

Every person with complex issues will have a care coordinator with whom they will establish a trusted relationship. Together they will:

- Develop a shared understanding of needs and goals
- Explore options for care and support
- Establish a plan of care and supports, including self-care
- Establish a crisis plan for when circumstances change
- Ensure connection/attachment to a primary care provider or team

Approach/model

There are many excellent resources and sources of expertise within the MHA and primary care sectors that can be mined to develop our core approach to care coordination. We will actively engage with and support existing leaders in this area.

The next steps will be to:

- Map the existing MHA-related human resources capacity among OHT/ÉSO partners
- Examine leading practices within the region and from other jurisdictions for linking or integrating care coordinators with primary care, looking closely at interprofessional

team-based care models designed to support all models of primary care, including solo practitioners

- Develop our model of care coordination as it relates to stepped care by:
    - Clarifying functions, scope of practice and competencies required
    - Developing a plan for training and competency-building (by leveraging information and mapping that already exists)
    - Implementing a change-management process

Frail older adults

Intent
Care coordination will be integrated with primary care, serving as the foundation and the focus of people's long-term relationship with the healthcare system. Every older adult with complex needs will have access to a care coordinator who operates within an interprofessional, team-based care model. The care coordinator will assume a lead role in partnering with clients and their family/caregivers to:

- Engage in strengths-, needs- and goals-based planning, rooted in primary care
- Establish a patient-centred, holistic plan of care that considers health and social needs and includes a "direction of care" discussion
- Provide support to access integrated care and social supports
- Provide flexibility by understanding what to do when a client's circumstances change
- Provide support to manage multiple appointments and relationships with healthcare providers
- Inform clients about steps in their care journey and how services will work
- Develop a plan that allows for 24/7 support when it is needed

People with less complex needs will have access to system navigation supports when required, specifically for transitions in care and access to essential social supports.

Approach/model
The current resources dedicated to care coordination among OHT/ÉSO partners and allied community health organizations can be streamlined to expand access, providing a more comprehensive and systematic approach to care coordination that includes a focus on the social determinants of health.

In Year 1, our aim is for frail older adults living on a low income with compromised or informal supports to have access to a care coordinator. This work will inform requirements for other sub-populations.

The next steps in designing our enhanced model of care coordination will include:

- Identifying existing resources with a mandate for assessment and care coordination
- Examining leading practices within the region and from other jurisdictions, including models for linking or integrating care coordinators to primary care, looking closely at interprofessional team-based care models that support all models of primary care, including solo practitioners (e.g., SCOPE)
- Engage partners to evolve the model into practice

The OHT/ÉSO partners are well positioned to take these steps. Working relationships already exist with multiple primary care providers and will be leveraged to provide a more integrated approach to care and support.

3.3.2. How will you help patients navigate the health care system?

Patients should never feel lost in the health care system. They should be able to easily understand their options for accessing care and know where to go for the services the need. Considering the needs of your Year 1 population, please propose how your team will provide system navigation services for your Year 1 population. Describe what activities are in and out of scope for your system navigation service in Year 1. Describe which patients will have access to system navigation and how they will access the service. Indicate whether system navigation will be personalized (e.g., will the system navigator have access to a patient's health information).

Describe how the system navigation service will be deployed and resourced, and whether your team has sufficient existing capacity to meet the anticipated navigation needs of you Year 1 population.

Describe how you will determine whether your system navigation service is successful.

Max word count: 1000 ***(571/1000)***

Enhancing system navigation in the short-term fits well with the planning initiatives already underway in the region.

Adults with moderate to complex MHA not connected to primary care
Community members and healthcare providers have long identified the challenges associated with accessing and navigating MHA services.

Research has been done to better understand the need for a regional coordinated access model for MHA services in the Champlain region. Led by the Royal Ottawa Hospital in partnership with the Champlain Mental Health and Addictions Coordinated Access Advisory Committee, this work included identifying population needs; an environmental scan; system mapping and consultations with service users, primary care physicians and stakeholders from psychiatry and MHA services; and a review of hospital- and community-based services.

The key areas of focus for a proposed coordinated access model for MHA services are closely aligned with our goals for systems improvement. They include:

- A centralized access point (i.e., one common number or online portal)
- A stepped-care approach to MHA supports (i.e., Level 1 MHA assessment and referral through to access to more specialized supports and care)
- Linkages to primary care, including for those who not already connected
- Screening and assessment and service matching
- Provision of supports to individuals on waitlists (for services with long wait times)
- Waitlist management for transparent information-sharing on wait times
- Feedback about the outcomes of the service match and service provision
- Skilled and appropriate staffing by a range of professionals (including regulated health professionals) whose skills and experience are consistent with their roles

The coordinated access model for MHA services is a conceptual model informed by research and consultation. It has the potential to simplify and improve access to MHA stepped care and supports through sector-wide competency development and simplified tele- and e-health points of access. This initiative has received some funding to continue next steps of development and work is now proceeding on implementation planning.

With the formation of the OHTs, planning will need to consider how the proposed regional coordinated access initiative will inform and align with local teams. This is an excellent opportunity to better understand and inform the interface with primary healthcare hubs that will facilitate access to intersectoral team-based care, particularly for those with complex needs.

Frail older adults
More work is needed to determine when care coordination is required — and how and when such coordination is distinct from shorter-term system navigation.

The OHT/ÉSO partners provide care across the continuum of prevention, primary care, acute and sub-acute care, home and community care. Together, they are committed to ensuring seamless navigation for frail older adults utilizing a range of services.

While there has been some discussion about a central intake for older adults, there is also significant caution regarding that approach. The broad continuum of unique services and supports available, each with their own criteria, is particularly challenging for older adults and those who support them. While much work has been done to support system navigation — including the creation of central access/intake phone numbers or websites for many services, and the establishment of care pathways — clients and organizational representatives indicate the system (or "lack of system") is confusing.

We see an opportunity to simplify the system and evolve coordinated supports through primary healthcare hubs and other places where older adults live or congregate to facilitate connections to key services. The intent is to build or leverage relationships between providers to facilitate integrated care.

See Section 3.3.3 that follows for more details.

3.3.3. How will you improve care transitions?

Patients should experience seamless transitions as they move from one care setting or provider to another. Beyond care coordination and system navigation, please identify any specific actions your team plans to take to improve care transitions and continuity of care for your Year 1 population. Describe what initiatives or activities the members of your team currently have in place to improve transitions and explain whether and how you will build off this work in your first year of implementation.

Describe how you will determine whether you have improved transitions of care.

Max word count: 1000. ***(908/1000)***

We will improve care transitions for our two priority populations as follows:

Adults with moderate to complex MHA not connected to primary care
Research has shown that poor care transitions can have significant consequences for individuals with MHA issues. They exacerbate symptoms and can lead to hospital readmissions and frequent emergency department visits. In contrast, an appropriate stay in hospital coupled with fulsome discharge planning and follow-up visits post-discharge (e.g., structured checklists of critical activities to empower patients before and after discharge) can lead to fewer hospital admissions.

The MHA service sector has established a sector-wide steering committee to address care transitions and gaps in discharge planning. This committee, comprised of people with lived experience (including family and caregivers), senior leadership from the MHA sector (including representation from the OHT/ÉSO), and planning and implementation support from the Centre for Addiction and Mental Health (CAMH), has been working for the last year to advance sector-wide quality improvement actions to address poor care transitions and discharges.

Priority areas of concern have been identified based on service user feedback from across the Champlain region through the provincially mandated Ontario Perception of Care Tool for Mental Health and Addictions (OPOC-MHA). A number of quality improvement initiatives related to care transitions are now being rolled out, including:

- Enhancing and standardizing discharge processes and planning inclusive of standards of care for post-discharge follow-up

- Mobilizing OHT/ÉSO resources to ensure seamless discharge planning and collaborative care planning for individuals moving between hospital- and community-based primary or mental health care (e.g., patient-centred health records and care plans, follow-up visits and phone calls, referrals and bridging to health hubs when needed)
- Simplifying referral processes and access for primary care providers to e-MHA resources for patients (e.g., embedding referrals within electronic charts)
- Addressing digital health barriers
- Ensuring clearer pathways for allied community partners who provide intensive case management and care coordination to ensure individuals with complex MHA issues have easy access to primary care (i.e., through primary healthcare hubs).

Frail older adults

Four key initiatives that have great potential to improve transitions for frail older adults are currently explored by the OHT/ÉSO partners — and will be considered in our Year 1 efforts.

1. With funding expected from the Ministry of Health and Long-Term Care, Ottawa@Home, and a partnership between hospital and home/community care agencies, we will **create a direct pathway to home for patients with complex needs currently living at The Ottawa Hospital and Bruyère Continuing Care**. These patients require enhanced support to live safely in their homes, which may include the support of caregivers or assist devices. Our program will focus primarily on patients who are designated as ALC and who have a discharge destination of a private home, assistive living or retirement home. The expected length of stay in the program is 112 days.

   The program would be supported by a navigation manager and a dedicated interdisciplinary community-based home care team. Support services will include personal care; therapy services including assistance with mobility (e.g., assessment, access to assist devices, strengthening); home safety assessment and modification; support to access ADP funding, financial aid, housing and food access assistance; monitoring of recovery from an acute illness; treatments that include but are not limited to infusion therapy, wound care, catheter care and enteral feedings; caregiver support; and direct access to a 24/7 phone line that can address any questions or concerns.

2. Bruyère Continuing Care will **create a pathway to allow for direct admissions to inpatient geriatric rehabilitation and complex continuing care** for acute, non-operable conditions such as pelvic fractures. As it stands, the flow into this type of care comes only from referrals from hospitals and specialists. A direct referral from a community-based primary care practice will enhance accessibility of this care, improving health outcomes while avoiding unnecessary emergency department visits.

3. Ottawa's Community Health Centres (CHCs) and potential family health teams will collaborate with partners to **establish a team-based care model for frail seniors that**

could integrate or facilitate access to a range of services and supports, including assessments, care coordination, primary care, home and community care, and various health professionals such geriatricians and other specialists as required. ttawa CHCs already offer an extensive array of services to patients of physicians in other primary care models, including diabetes education, primary care outreach, lung health and more. The CHCs collectively support more than 50% of the physicians operating in other practices in some way. A more formalized model could strengthen care pathways and working relationships. One such model, Team Care, provides interprofessional support to clients of primary care providers who cannot offer such support. Of the 5,000 family physicians in Ontario, 1,500 are referring their patients to one of the 30 participating interprofessional teams. Similarly, the SCOPE (Seamless Care Optimizing the Patient Experience) model enables seamless access to specialists and home and community care.

4. We will strengthen the patient experience **by establishing networks and community teams that include specialists. The use of** e-consults has already improved the patient experience by decreasing unnecessary long waitlists at specialists' offices. However, these could be better managed by primary care providers: the turnaround time for processing is two to seven days versus months of waiting to obtain an appointment in a traditional office setting. Research shows that using e-consult has avoided 32% of emergency visits and 60% of face-to-face specialist visits — meaning this change alone will help Ontarians avoid unnecessary trips to the emergency department and reduces costs to the healthcare system.

3.4. How will your team provide virtual care?

The provision of one or more virtual care services to patients is a key Year 1 service deliverable for Ontario Health Teams. Virtual care enables patients to have more choice in how they interact with the health care system, providing alternatives to face to face interactions. This includes virtual visits that allow patients to interact with their healthcare providers using telephone, video or electronic messaging; websites and apps that provide patients with easy access to their health records; innovative programs and apps that help patients manage their condition from their homes; and tools that allow patients to book appointments online and connect with the care they need. Ontario's approach to virtual care makes care more convenient for patients, provides patients with choices about how they receive and manage care, and ensures that virtual care is only used when clinically appropriate and preferred by the patient. At maturity, teams are expected to provide patients with a range of digital choices.

Please refer to *Appendix B – Digital Health* to provide your proposed plan for offering virtual care options to your patients.

3.5. How will you support patients (and caregivers) to be active participants in managing their own health and health care?

3.5.1. How will you improve patient self-management and health literacy?

Evidence from high-performing integrated systems shows that new approaches to care need to be flexible and adaptive to individual patient goals. Describe your proposed plan for helping patients manage their own health. Describe which of your Year 1 patients (e.g., which health conditions) will receive self-management and/or health literacy supports, and the nature of those supports. Include a description of your team's existing self-management and health literacy tools, processes and programs, and describe how you will build off this existing infrastructure to enhance these functions for your Year 1 population.

Max word count: 500. (485/500)

We have identified the following focus areas to improve patient self-management of health:

- Ensuring greater consistency and transparency about available services and supports in both official languages
- Providing access to health system navigation and, when needed, personalized strength-based care coordination
- Providing easy access to e-health resources and online tools when appropriate
- Ensuring culturally informed and culturally designed services and resources in both official languages
- Using evidenced-based communication tools as needed (e.g., braille, hearing aids, symbols, use of interpreters) to help establish open communication within the client's circle of care

Adults with moderate to complex MHA not connected to primary care
Access to resources that promote self-management of health and mental wellness is core to population health and wellness. Within a stepped care model for MHA, we will work to ensure:

- Primary care providers are equipped with the skills, resources and knowledge to efficiently provide resources on self-managed supports for mild MHA issues, including access to evidence based e-mental health services
- Culturally appropriate resources are easily accessible online
- Core health promotion activities are aligned with empowering individual self-management of MHA issues
- Tools that incorporate a holistic approach to health and wellness (such as social prescribing) are used to increase social connectivity, decreasing clients' perceptions of isolation and feelings of depression
- More people are aware of tools like Ottawa Public Health's "have THAT talk" video series, which discusses the importance of mental health in all areas of our lives and is available in both official languages and is tailored to different population groups including youth, adults, parents/caregivers, newcomers to Canada, workplaces and educators

Frail older adults
Support for self-management and health literacy is fundamental to the services offered by many of the OHT/ÉSO partners. By promoting self-directed and self-managed care among patients and their families, people become more confident and capable of living at home and in the communities much longer. We will leverage existing services and approaches available to support people in the community with complex illnesses, including:

- Living Healthy Champlain (hosted by Bruyère), an evidence-based peer-led program for people managing chronic disease and pain that includes in-person and online options
- Chronic disease education and management programs offered through Ottawa CHCs on lung health, diabetes education and management, and falls prevention
- Health education offerings that are integrated into the programs and services of community support service agencies
- An approach to health literacy that has been adapted by Ottawa Inner City Health for street culture, Inuit and First Nations culture — which effectively engages people living with MHA disorders to improve their capacity for chronic disease management, harm reduction and health promotion
- Ottawa Public Health's online and print resources on falls prevention, including a locally developed online course for older adults and their caregivers
- Devices that enable self-management of infusion therapy and other treatments with minimal clinical supports, along with virtual monitoring that reduces the need for in-person visits and offers clients greater comfort in their own home

3.5.2. How will you support caregivers?

Describe whether your team plans to support caregivers and if so how. In your response, include any known information about caregiver distress within your community or attributed population, and describe how your plan would address this issue.

Max word count: 500. (337/500)

To better support caregivers and care partners, genuine partnerships must be established to understand their situations and assess their care and support needs. Acknowledging and respecting the important role of family in health care, determining the desired degree of family involvement, and negotiating the roles of both the service provider and caregivers within the partnership will set the stage for developing a care plan to best support the person receiving care and the family involved.

An initial needs assessment and ongoing assessment of individuals in the context of the family (as they define it) is required to identify the degree of assistance desired and required. This is best achieved through dialogue, navigation of resources and connection to supports to best

meet their needs. Resources, both intrafamilial and extrafamilial, must be identified to get a clearer picture of both patient and caregiver needs.

We will leverage a number of partner-developed resources to support caregivers and care partners in our community, including:

- The five-week Practical Caregiver Training program offered by the Champlain Hospice Palliative Care Program (a partnership between Compassionate Ottawa, the Council on Aging, Hospice Care Ottawa and Hillel Lodge), which provides hands-on training on how to make the caregiving experience safer and less stressful for loved ones
- A national resource developed by Ottawa Public Health, in partnership with the Canadian Mental Health Association, Canadian Public Health Association, Military Family Services and the Mental Illness Caregivers Association, for caregivers of children, youth, adults and older adults experiencing mental health challenges
- Ottawa Public Health's resource guide for mental illness in the Champlain region, created specifically for caregivers
- Ottawa Public Health's comprehensive caregivers guide, which includes specific information for caring for older adults and those at end-of-life care

Other known resources for service providers can also be used, including best practice guidelines (*Supporting and Strengthening Families Through Expected and Unexpected Life Events*) and resources for caregivers such as the Caregiver Resource Hub (www.changefoundation.ca/caregiver-resource-hub/) that was developed by the Change Foundation and the newly formed Ontario Caregivers Organization.

3.5.3. How will you provide patients with digital access to their own health information?

Providing and expanding patients' digital access to health information is an important part of the Ontario Health Team model in Year 1 through to maturity.
Please refer to *Appendix B – Digital Health* to provide your proposed plan for providing patients with digital access to their health information.

3.6. How will you identify and follow your patients throughout their care journey?

The ability to identify, track, and develop sustained care relationships with patients is important for strengthening relationships and trust between patients and providers, implementing targeted care interventions, and supporting clinical follow up and patient outcome measurement.
Describe the mechanisms, processes, and/or tools that your team proposes to use to **collectively** identify, track, and follow up with Year 1 patients.

Max word count: 500. (484/500)

Identify, track and follow-up
Identifying, tracking and developing sustained care relationships can be a highly complex undertaking for any agency. The challenge is to achieve systematic tracking across the health system.

Our initial populations of focus have been collectively defined in general terms and also specifically within each dataset of the convening partners. In most cases, this will allow for ongoing individual tracking using the following systems:

- Nightingale, PSSuites (CHCs)
- OASIS, EPIC (The Ottawa Hospital)
- Meditech (Bruyère)
- Oscar (Ottawa Inner City Health)
- CHRIS, which includes Carefor (LHIN Home Care)

The approach used for Health Links could also be leveraged. Common identification criteria and forms are incorporated into various electronic medical records (EMRs), allowing for systematic identifications, flagging of identified clients and e-referrals.

The potential exists to link individual patients across EMRs, which would require shared understanding of consent and privacy, as well as data-sharing agreements (DSAs). Through DSAs and network-sharing agreements, the LHIN is able to track individual patient journeys by linking all hospital databases as well as home care services, resulting in a relatively robust overview of usage and cost impacts on those two sectors. This same methodology could be used for our initial priority populations.

Additionally, a dashboard has been developed through the LHIN that tracks identification agencies and patient progress, including time to initiate and complete care plans; partner targets and performance; and patient tracking, flow, access and confidence. Several other provincial indicators could be adapted to our Year 1 initial populations.

Link to care coordination
Another essential element in supporting the patient journey is having a single point of contact or lead care coordinator. Clearly identified in the care plan, this person supports alignment across the client care team as well as advocacy around client goals. While the ongoing relationship with the patient may ebb and flow in terms of intensity over time, ensuring the lead coordinator has the supports they need during the most intensive phases of activity will be key.

In addition, the Ministry of Health is currently piloting identity and access management (IAM) solutions within two OHTs in hopes that one of the products being tested will not only work locally but also scale provincially. We recommend that IAM be a provincial solution rather than a local one as most centres are not equipped to provide IAM support.

Another consideration is that if OHIP becomes the key identifier, uninsured people will be missed. ClinicalConnect and ConnectingOntario are provincial repositories that provide a view into the patient's journey within the health system. While it does not include primary care yet, it is a starting point — and we recommend that organizations participating in the OHTs gain access where applicable.

Once the minimum dataset is determined, OHTs, vendors and the government can work together on adding this data to the provincial repositories from primary care. Work will be needed to discern how to gather data across the broader partnership.

3.7. How will you address diverse population health needs?

Ontario Health Teams are intended to redesign care in ways that best meet the needs of the diverse populations they serve, which includes creating opportunities to improve care for Indigenous populations, Francophones, and other population groups in Ontario which may have distinct health service needs. In particular, Ontario Health Teams must demonstrate that they respect the role of Indigenous peoples and Francophones in the planning, design, delivery and evaluation of services for these communities.

Considering your response to question 1.3 and according to the health and health care needs of your attributed population, please describe below how you will equitably address and improve population health for Indigenous populations, Francophones, and other population groups who may experience differential health outcomes due to socio-demographic factors.

3.7.1. How will you work with Indigenous populations?

Describe whether the members of your team **currently** engage Indigenous peoples or address issues specific to Indigenous patients in service planning, design, delivery or evaluation. Considering the needs and demographics of your Year 1 and maturity populations, indicate whether you intend to expand or modify these activities or otherwise specifically seek to address Indigenous health or health care needs in Year 1 or longer-term.

How will members of your team provide culturally safe care? Does your team include Indigenous-led organizations as members or collaborators? Why or why not?

Max word count: 500. (496/500 words)

Indigenous population

According to the Wabano Centre for Aboriginal Health, there are 43,000 Indigenous people in Ottawa and the surrounding area.

A number of OHT/ÉSO partners serve Indigenous clients, including but not limited to the Wabano Centre for Aboriginal Health (Aboriginal Health Access Centre), Ottawa Community

Health Centres and Ottawa Inner City Health. The Ottawa Hospital is the tertiary care provider of healthcare services to Inuit patients from eastern Nunavut. Several convening partners participate in the Ottawa Indigenous Health Strategy Alliance (OIHSA), which works in partnership to collectively identify and address health priorities for First Nations, Inuit and Métis (FNIM) peoples living in Ottawa.

The Indigenous population experiences a disproportionate burden of ill health compared to their non-Indigenous counterparts, including higher rates of infant mortality, unintentional injury and death, tuberculosis, obesity and diabetes, mental illness and suicide, and exposure to environmental contaminants. A disproportionate number of FNIM individuals, families and communities live in poverty, experience food insecurity, and have inadequate access to healthcare and housing. Recognizing these health disparities and the importance of Indigenous leadership, we will be guided by the principles expressed in *The People's Health Care Act 2019*:

- Aim to reduce health disparities experienced by Indigenous peoples
- Redesign care to improve care for and meet diverse needs of Indigenous population
- Respect the role of Indigenous peoples in planning, design, delivery and evaluation of services
- Provide culturally safe (kind and competent care) for Indigenous people

Engagement
We are committed to fully engaging Indigenous partners in our process and structure. We support Indigenous-led organizations in provision of health services to their community members and Indigenous health leaders to direct the planning and implementation of Indigenous health services. We are also committed to the following relationship-building principles:

- Appropriate and meaningful consultation
- True and equal partnership
- Right of Indigenous organizations to self-governance
- Indigenous-governed health services (Indigenous health in Indigenous hands)

The participation of the Akausvik Inuit Family Health Team (FHT) is being explored. The Wabano Centre and the Akausvik Inuit FHT (if it joins our OHT/ÉSO) will be the primary care providers for Indigenous health, working with the principle of active offer of service. We have also begun a dialogue with Tungasuvvingat Inuit (TI) and invited them to participate. TI provides social and cultural services for Inuit.

We are committed to full engagement and consultation with these centres and other Indigenous-led health and social services in the first six months following acceptance of our proposal. The process for engaging client partners in care re-design is outlined in Section 3.8. Indigenous client partners were involved in the initial discussion about effective engagement of clients. That work and engagement will continue.

The process for engaging in planning and redesigning care for this application is outlined in Section 2.10. A recent study conducted by the Wabano Centre identified Indigenous-specific racism as a key issue/challenge affecting access to needed culturally safe health services. Key considerations for the redesign of services to ensure Indigenous populations are well-served will need to be developed.

3.7.2. How will you work with Francophone populations?

Does your team service a designated area or are any of your team members designated or identified under the French Language Services Act?

Describe whether the members of your team **currently** engage Francophone populations or address issues specific to your Francophone patients in service planning, design, delivery or evaluation. (This includes working towards implementing the principle of Active Offer). Considering the needs and demographics of your Year 1 and maturity populations, indicate whether you intend to expand or modify these activities or otherwise specifically seek to address Francophone health or health care needs in Year 1 or longer-term.

Max word count: 500 (408/500)

Designated area
The OHT/ÉSO is a designated area. Based on Champlain LHIN sub-regional data, an estimated 20% of the OHT/ÉSO's attributed population is Francophone.

We are well positioned to meet the needs of Francophones. At the latest review of the status of our partners' French Language Services (FLS) designation, 15 were designated agencies, five were identified agencies and 35 were non-identified agencies.

Engagement
We are committed to ensuring quality planning and delivery of services with and for the Francophone community in all its diversity. The unique needs of Francophones will be considered in every aspect of care planning and redesign. This will require Francophones to be represented in all capacities of the team's work, including its leadership. That said, all leaders will assume collective responsibility for working effectively with and on behalf of Francophones.

The French Language Services Network of Eastern Ontario / Réseau des services de santé en français de l'Est de l'Ontario has provided consultation expertise and gathered information about our partners' FLS designation. A consultation was conducted with leaders of Francophone-serving agencies (members of a coalition of CHCs and Community Resource Centres [CRCs]) to explore the unique needs of Francophones in relation to Year 1 populations.

The process for engaging client partners in care redesign is outlined in Section 3.8. The engagement strategy will be tailored to ensure Francophones can influence care redesign processes at the system level. They will also be engaged in tailoring services to ensure the full continuum of services meets the needs of Francophones. A Francophone Reference Group will be established to ensure the perspectives of Francophones are included and heard across all aspects of our work, including opportunities for people to speak in their language of choice. The commitments and practices that support effective Francophone engagement will be outlined.

Care redesign
To ensure Francophones have access to appropriate care and support, during the care planning and redesign process, we will:

- Proactively identify Francophone clients
- Ensure culturally appropriate service delivery, taking into account the diversity of the Francophone community, including new immigrants whose official language is French
- Work with the principle of active offer of service
- Establish a clear trajectory to serve Francophones across the continuum of health and social services, including transitions from youth to adult services, ensuring navigation services are offered/available in French
- Address inequities affecting the Francophone population
- Align with other OHTs to establish common practices for working with Francophones
- Evaluate performance metrics specific to Francophones (e.g. satisfaction, wait times)

3.7.3. Are there any other population groups you intend to work with or support?

Describe whether the members of your team currently engage in any activities that seek to include or address health or health care issues specific to any other specific population sub-groups (e.g., marginalized or vulnerable populations) who may have unique health status/needs due to socio-demographic factors. Considering the needs and demographics of your Year 1 and maturity populations, indicate whether you intend to expand or modify these activities in Year 1 or longer-term.

Max word count: 500. (500/500 words)

The attributed population of the OHT/ÉSO is diverse — and one of our strengths is our capacity and track record of addressing the unique health needs of equity-seeking groups.

We are committed to ensuring our work in this area continues. The perspectives of different sub-populations will be represented both through client partners and the organizations that have developed the working relationships and expertise to ensure the unique needs of the sub-

populations are being met. Service offerings and care pathways will be tailored to respond to those unique needs.

Examples of focus sub-populations and the potential assets we can leverage to meet their needs are identified below.

Racialized people
More than one-quarter (26.3%) of Ottawa's population is racialized. While the exact percentage within our attributed population is unknown, socio-demographic data will be gathered over time to better understand the proportion of racialized clients served by OHT/ÉSO partners. We do know that the clients of the combined CHC primary care panel speak 170 different languages, with higher proportions of individuals who are racialized and newcomers. The OHT/ÉSO is fortunate to include many partners with strong relationships, expertise and tailored services to support work with newcomers and immigrants.

One example is the Ottawa Newcomer Health Centre, hosted by Somerset West CHC. It includes a newcomers clinic, multicultural health navigator and Ottawa Language Access (a free interpretation service for healthcare providers who serve clients who don't speak English or French). Its services include coordinated medical assessments, preventative screening, urgent care, referrals to specialists, dental screening, immunizations, and mental health counselling and support. It also helps link newcomers to a primary health care provider in close proximity to their home.

LGBTQ2S+
Services and care need to be appropriate and welcoming for the LGBTQ2S+ population. One example is the Ottawa Seniors Pride Network, which is working to ensure care and services for older LGBTQ2S+ adults are safe and appropriate. OHT/ÉSO partners like the The Good Companions (Seniors Centre and Community Support Services) and Centretown CHC support the work of the Ottawa Seniors Pride Network. Partners like Ottawa Public Health and others are engaged in offering services by and for gay men through the Gay Zone Gaie program at Centretown CHC. Family Services Ottawa, Centretown CHC and other partners, including people with lived experience and family members, support the Regional Planning Table (RPT) for Trans, Two-Spirit, Intersex and and Gender Diverse Individuals.

Rural populations
With a focus and desire to age in place, rural seniors in particular face challenges related to isolation, transportation and access to services. OHT/ÉSO partners such as Rural Ottawa South Support Services and the CRCs are currently operating in the rural areas of our city.

People with physical disabilities
People with physical disabilities experience many barriers to service. For those with low or moderate income, the cost of and inability access to the necessary equipment can prevent them from transitioning between services in a timely way. There is a need for an equipment exchange service in the city similar to the one that existed previously.

3.8. How will you partner, engage, consult or otherwise involve patients, families, and caregivers in care redesign?

Describe the approaches and activities that your team plans to undertake to involve patients, families, and caregivers in your Year 1 care redesign efforts. Describe how you will determine whether these activities have been successful.

Max word count: 1000 (684/1000)

Engagement principles
The OHT/ÉSO endorses the Patient Declaration of Values. We have evolved a set of engagement principles that reflect our core commitments.

Our partnership with people** will be based on:

- **Meaningful engagement and equity:** We will ensure fair and equitable representation of people who will be recognized as members of the care team so they can express their needs, perspectives and concerns, and be included in the creation and design of healthcare policies and programs.
- **Learning:** We will encourage learning by sharing perspectives, experiences and facts about important issues and areas to improve.

It will be characterized by**:**

- **Respect and compassion:** We will be compassionate toward, and respectful of, each person's identity, beliefs, history, culture and ability. We will work together with people to provide care and support that meets their needs.

It will be measured by:

- **Accountability and transparency:** When people have questions or concerns, we will act upon them and make sure their voices are heard. We will be honest when we have limitations to the services we offer or don't have an answer to their question.

** ***People*** reflect various identities, including people with lived experiences, clients, patients, users, caregivers, families, peers and providers.

Developing the engagement strategy
A group of client partners, including family members and caregivers, has been consulted on the best ways to ensure effective engagement in our work. A model has been drafted and work is now underway to:

- Establish a model for reimbursement and potentially compensation
- Design recruitment processes that will be equitable and allow for engagement of people with a broad range of perspectives, representing the demographics of our community
- Establish mechanisms to solicit input from the broader community

- Document co-design practices to ensure consistency

Mechanisms for engagement
Action teams, which are already underway, are the key mechanism for co-designing and for offering perspectives and insights about specific improvements to be made to services/programs and the transitions/connections between services. People that use the services as well as the providers that offer the care/support have been engaged. The level of engagement will be scaled to the requirements of the situation. The action teams' responsibilities include:

- Analyzing the issues and opportunities for change
- Developing options or plans
- Making decisions at an operational level, where appropriate

Client partners are engaged in each of the three existing action teams: MHA and Primary Care, Frail Older Adult, and Home and Community Care. Their input has been invaluable as they provide real context for deliberation about how the system, ways of working and care pathways need to change.

Beyond the action teams, client partners have indicated that mechanisms are needed to solicit input from the community. Convening partners, particularly Ottawa Public Health, Ottawa CHCs and Ottawa CRCs, have well-established mechanisms and processes to engage with the broader community and at the neighbourhood level.

Leveraging relationships and existing mechanisms
Collectively, the partners have strong linkages with the Francophone community and its more marginalized sub-populations.

We also have strong links to Indigenous populations via the Ottawa Aboriginal Coalition as well as through partners like Wabano Centre for Aboriginal Health and agencies that serve the street-involved population such as Ottawa Inner City Health and the downtown CHCs.

Ottawa Public Health has collaborated extensively with people with lived experience of MHA issues on the development of the *Community Action Plan: Comprehensive Mental Health and Substance Use Strategy – Focus on Opioids*. It also maintains a partnership with the Community Addictions Peer Support Association (CAPSA), an organization of people with lived experience of addictions.

OHT/ÉSO partners have relationships and the demonstrated capacity to engage with populations and sub-populations that are marginalized and experience unique barriers to accessing healthcare services and supports. These include:

- People that are homeless or street-involved
- LGBTQ2S+ community
- New immigrants, refugees and racialized populations

- People living on a low income
- People living in rural areas
- People with physical disabilities

See Sections 3.7.1, 3.7.2, and 3.7.3 for more details.

The principles and approach for engagement are informed by:
Health Quality Ontario. *Patient Engagement Framework.*
Canadian Foundation for Healthcare Improvement. *10 Lessons Learned from Patient and Family Advisors.*
The Change Foundation. *Lessons from CHANGING CARE.*

4. How will your team work together?

4.1. Does your team share common goals, values, and practices?

The development of a strategic plan or strategic direction that is consistent with the vision and goals of the Ontario Health Team model (including the quadruple aim and the principles of integrated care, shared accountability, value-based care, and population health management) is a Year 1 expectation for Ontario Health Team Candidates. Describe the degree to which the members of your team already share common organizational goals, values, or operating practices and how these align with the Ontario Health Team model. Where there are differences, please describe whether they would need to be addressed as part of your partnership going forward.

Max word count: 500 **(463/500)**

Our vision, mission and commitments
We have a vision and mission that align with the aims of the Ontario Health Team and quadruple aim. Our commitments, rooted in evolving primary health care including mental health and addictions and social supports, as strong foundations of the health system will guide our work.

All of our current partners have endorsed the commitments. Future partners and collaborating organizations will also be expected to endorse the commitments, which are a fundamental reflection of the direction of our team. The commitments support the work of action teams with participants demonstrating alignment. Action team conversations are focused on understanding the full scope of client and family care and support needs, the current challenges and barriers to accessing the required care and support and the options for change.

At this point the OHT/ÉSO has 58 partners. Some organizations that are providing care to clients of the attributed population have expressed interest in the team but are not yet signed

on as partners. Every week organizations and individual providers are reaching out to convening partners to explore the potential for engagement. The challenge of this particular team is not how to attract the required partners but rather how to ensure capacity to support meaningful opportunities to contribute. We are now developing a more formalized engagement and communication strategy with associated tools and processes to support this effort. Some potential partners may not yet be signed on – either because they are not yet ready to engage in Ontario Health Teams or they are not aligned with the articulated vision and commitments.

Vision
People are healthy, well and supported to live in the community

Mission
OHT/ÉSO works to:

- ensure people have equitable access to high quality care and support when and where they need it
- ensure people have the best possible experience as they access and receive health care and supports
- improve the experience and work life of providers and staff striving to provide quality care and support
- establish the conditions that support health and create healthy communities

Commitments

1. Focus on keeping people, well and supported to live in the community
2. Focus on the whole person and family within their context
3. Address barriers to health (e.g., social determinants)
4. Evolve primary health care, as well as community and social services and supports, as strong foundations of the health system
5. Ensure coordinated care, seamless transitions for clients/patients and families
6. Expand access to inter-professional and inter-sectoral team-based care for clients with complex needs
7. Share leadership and advance collaborative governance relationships
8. Engage clients/patients, families and providers in our work
9. Work with and for Francophone and Indigenous populations to address health disparities and provide quality services, while working to address the unique health needs of all equity seeking groups.

4.2. What are the proposed governance and leadership structures for your team?

Ontario Health Teams are free to determine the governance structure(s) that work best for them, their patients, and their communities. Regardless of governance design, at maturity, each Ontario Health Team will operate under a single accountability framework.

Please describe below the governance and operational leadership structures for your

team in Year 1 and, if known, longer-term. In your response, please consider the following:

- ***How will your team be governed or make shared decisions?*** Please describe the planned Year 1 governance structure(s) for your proposed Ontario Health Team and whether these structure(s) are transitional. If your team hasn't decided on a governance structure(s) yet, please describe the how you plan to formalize the working relationships among members of the team, including but not limited to shared decision making, conflict resolution, performance management, information sharing, and resource allocation. To what extent will your governance arrangements or working relationships accommodate new team members?
- ***How will your team be managed?*** Please describe the planned operational leadership and management structure for your proposed Ontario Health Team. Include a description of roles and responsibilities, reporting relationships, and FTEs where applicable. If your team hasn't decided on an operational leadership and management structure, please describe your plan for putting structures in place, including timelines.
- ***What is your plan for incorporating patients, families and caregivers in the proposed leadership and/or governance structure(s)?***
- ***What is your plan for engaging physicians and clinicians/ clinical leads across your team's membership and for ensuring physician/provider leadership as part of the proposed leadership and/or governance structure(s)?*** For non-salaried physicians and clinicians, how do you plan to facilitate their meaningful participation? What approaches will your team use to engage community-based physicians and hospital-based physicians?

Max word count: 1500. **(1221/1500)**

Sharing decision-making

The governing model of our team is collaborative and oriented toward building on existing and evolving new relationships that will inspire and support action toward the vision. This collaborative approach is adapted from the constellation model (Centre for Social Innovation: The Constellation Collaborative) and is aligned with evolving models of Collective Impact.

Our team will create an ecosystem where people with lived experience (patients, clients, family members, caregivers), the providers and staff that provide care and supports, and organizational leaders come together to strategize, develop solutions and monitor progress.

The team's initial focus is to design the system and create the care pathways that make sense. Over time more structure will be developed to support decision-making. We believe that a premature focus on governance will detract from our engagement process. Instead, we are focusing on building shared understanding and energy for system change in line with the Ministry of Health transformation agenda and the OHT/ÉSO vision and commitments.

Facilitating engagement through convening partners

The convening partners steward the OHT/ÉSO's broader purpose and collective vision, facilitating the effective planning and engagement of the broader partnership. Their responsibilities include:

- Creating the conditions for effective engagement
- Collaborating to set strategic direction/intent
- Collaborating to inform the plan or broad framework to guide action and priorities for focus
- Aligning work of action teams with the partnership's purpose
- Monitoring progress and impact

Convening partners are currently represented by the organizations identified as priorities for engagement in Ontario Health Teams by the MOHLTC - primary care, home care and hospitals. The membership of this group is expected to evolve.

The proposed Client Partner Table would work in close alignment with the Convening Partners including cross representation.

Managing the team

Our team is evolving an infrastructure that leverages the resources of convening partners. That infrastructure can grow over time to include other partners. With leadership from the Ottawa CHC Collaborative, convening partners are sharing the infrastructure function/backbone support. It is anticipated that other partners will make similar contributions.

Resources are being shared to support the work including:

- Overall project coordination
- Communications including partner engagement, media relations and website development
- Data analysis and reporting
- Action team co-leadership and administrative support
- Administration including note taking, space booking, managing meetings

Our team's overall process design and facilitation is supported by a third-party independent consultant with experience in multi-stakeholder partnership engagement. This application was written as a collaborative effort between the consultant and staff of convening partners.

Our shared infrastructure approach is deliberate, with a view toward ensuring ownership of both the process and outcomes. While it would be easier to have one organization provide all backbone support, our research and experience suggests that in time the leadership and ownership could become increasingly vested in the backbone organization. This is a circumstance that our team wishes to avoid. A shared infrastructure will help to foster shared commitment to an ecosystem that will drive and nurture change across multiple partners toward the common vision.

Planning for implementation

Following the submission of this application, convening partners will develop an implementation plan and business case that will support the collaborative leadership model going forward. We intend to mitigate the common causes of unsuccessful collaboration including a lack of project planning (short and long-term) and inadequate involvement and support from all areas of collaborative leadership. We intend to develop a structure for our work while ensuring that our team is nimble, in line with a Learning Health System. **See Section 6.2**

Incorporating patient, families and caregivers in the leadership and/or governance structure
We have consulted client partners including families and caregivers about how they would like to contribute to the work of our team. While we have developed a model it requires further input to ensure a common understanding and agreement.

Client partners are already engaged in the action teams as outlined in section 2.10 and 3.8.

The proposed Client Partner Table is a mechanism to provide input into our team's broader purpose and collective vision and to monitor the progress and impact of our work. Client partners are expected to work in close alignment with the convening partners, including cross representation. Their responsibilities will include:

- Engaging with groups/organizations with lived experience.
- Collaborating to inform strategic direction/intent
- Collaborating to inform the plan or broad framework to guide action and priorities for focus
- Monitoring progress and impact
- Engaging in service design through action teams.

More work is needed to develop an engagement strategy that respects and supports client partners to make a meaningful contribution in both, system change and care re-design. This work includes:

- Establishing a model for reimbursement and potentially compensation
- Designing recruitment processes that will be equitable and allow for engagement of people with a broad range of perspectives, representing the demographics of our community
- Establishing mechanisms to solicit input from the broader community.

Engaging physicians and clinicians/clinical leads in the leadership and/or governance structure(s)

The effective engagement of primary care providers (PCPs) is crucial to evolving the OHT/ÉSO so that it is grounded in a strong base of primary health care, mental health and addictions and social services.

In the initial stages of our physician engagement we have:

- Consulted a representative group of CHC primary care providers (physicians and nurse practitioners) about the challenges of providing care for the initial populations, and how to engage providers in the process of care re-design

- Met with the leadership of the TOH and Bruyère affiliated Academic Family Health Teams to explore how to engage primary care providers in the work of the OHT/ÉSO
- Met with the newly established Community of Family Medicine Practice to review: the vision and commitments of the OHT/ÉSO, initial results of action teams, and results of their Pain Points survey, which confirms the need to enhance the effectiveness of communication and shared care with specialists
- Engaged physician representatives in action teams
- Responded to queries from Primary Care Patient Enrollment Models (PEMs) about opportunities to engage in the work of the OHT/ÉSO
- Conducted a preliminary analysis of how many family physicians are referring clients to key CHC hosted services (Primary Care Outreach for Frail Seniors, Diabetes Education, Lung Health and Health Links), estimated to be 681 different family physicians in Ottawa

The next steps in our process include:

- Consult with affiliated primary care providers and directors to understand how they can contribute to advancing the action plans of the OHT/ÉSO in relation to the initial populations for focus (TOH and Bruyère affiliated Academic Family Health Teams, Greenboro Family Medicine Centre, Wabano Centre for Aboriginal Health)
- Reach out to the Primary Care Patient Enrollment Models (PEMs) linked to the OHT/ÉSO's attributed population to explore their interest in engagement, the issues/challenges they experience in providing care for the initial populations for focus, options for change and the contributions they can make to advancing the work of the OHT/ÉSO
- Engage more primary care providers in OHT/ÉSO affiliated action teams
- Establish a mechanism for communicating with and engaging primary care providers in planning
    - Clarify the relationship with the Community of Family Medicine Practice
    - Explore how to communicate and engage with more nurse practitioners
    - Determine what structure will best support engagement given their time constraints
- Engage with representatives from primary care providers and hospital and community-based specialists to explore how to improve communications and care pathways, strengthening relationships and leveraging virtual care options wherever possible.

4.3. How will you share patient information within your team?

At maturity, Ontario Health Team will have the ability to efficiently and effectively communicate and to digitally and securely share information across the network, including shared patient records among all care providers within the system or network.

4.3.1. What is your plan for sharing information across the members of your team?

Describe how you will share patient information within your team. Identify any known gaps in information flows between member organizations/providers and what actions you plan to take to mitigate those gaps (e.g., are data sharing agreements or a Health

Information Network Provider agreement required?). Identify whether all participating providers and organizations within the team have the legal authority to collect, use and disclose personal health information for the purposes of providing health care and for any administrative or secondary use purposes. Outline the safeguards that will be in place to ensure the protection of personal health information. Append a data flow chart. Identify whether there are any barriers or challenges to your proposed information sharing plan.

(1447/1500)

Understanding the current situation
Currently, the majority of identified client information is analysed internally by each agency/sector. The team is interested in linking data across sectors, however the form of the data, coding used (e.g. ICD vs Code-FM) and lack of existing data sharing agreements (DSAs) limit our ability to do so. In Year 1 we will establish the necessary DSAs to allow us to link information within a shared data warehouse enabling more robust evaluation and tracking. In the meantime, we can leverage existing platforms such as CHRIS. The flow of data will be outlined as DSAs are established.

Sharing patient information
Patient information is shared in several ways within the OHT/ÉSO. One mechanism that was recently established is the eNotification which provides near-real time notification when active patients present at an emergency department, are admitted or discharged from an acute care facility, or are seen by EMS. This notification information is available to Home and Community Care staff and to primary care practices who have registered to use OntarioMD's Health Report Manager platform. Across Champlain, 15 hospitals have implemented eNotification including The Ottawa Hospital and Bruyère Continuing Care.

The eNotification about recent hospital visits enable home and community care agencies to avoid unnecessary home visits, rapidly follow-up with patients after an episode, or make alterations to the home care required by the patients after a return from an emergency department visit or hospital stay. Primary care clinicians receiving the notifications can use the information to plan appropriate ongoing care for their patients. Community support service agencies who participate in the Community Data Store and Summary reports can also receive daily hospital eNotification reports about their patients. These reports provide information about emergency department visits (registrations, discharges) and hospital in-patient admissions and discharges from the previous 24 hours.

Electronic Patient Referral (eReferral) is available through 2 platforms: Ocean & CareDove. This electronic communication supports referral through the transfer of patient information across providers. eReferral helps to address the challenges of fragmentation across a high number of disconnected systems that make it difficult to share information (Catalogue p. 37).

In the Champlain Region, the Ocean platform, which is used for primary care eReferral, is currently being deployed. The Ocean platform provides a referral 'toolbar' which integrates

into compatible primary care EMRs (Telus Practice Solutions, Accuro, OSCAR) that allows the EMR user to select the target referral service and pre-populate the appropriate referral form with the relevant patient information.

The Ocean toolbar is being used by 55 primary care clinics (as of 2019-07-19) with 135 staff enabled for Ocean eReferral. The Caredove eReferral platform has been adopted by 40 CSS agencies and the LHIN Home and Community Care (for limited programs) across the region. Through the online platform, users (patients/family, other community support service users, hospital discharge planners, primary care practices, etc.) can select a community service, determine the provider(s) of the service in a given region based on the patient's home address, and send a referral for the service including, if desired, booking the initial telephone intake appointment with the agency.

Simplified and consistent use of eReferral will provide more efficient, simplified and accurate transfers of patients and tracking of referrals and wait times. Use of the embedded Ocean toolbar with service-specific forms will ensure more appropriate information sharing and referrals. Identifying and linking people to available community services is important in the ongoing care of patients, particularly for frail seniors or those with chronic conditions. The Caredove software-as-a-service platform enables this in an easy to use visual style.

eConsult, the Champlain BASE Regional eConsult Service, is a secure web-based tool that allows physicians or nurse practitioners timely access to specialist advice for all patients, which can often eliminate the need for an in-person specialist visit. This service was established in 2010 in the Champlain Region, primarily supported by local specialists and resources in the region. It is part of the broader Ontario eConsult program (led by the provincial eConsult Centre of Excellence) which also includes the OTN-based eConsult service (Catalogue p. 49, 50). Currently the BASE eConsult service supports: 131 specialties; 251 specialists; and 1676 registered primary care physicians.

The use of eConsult services has been shown to improve the patient experience, reduce the time for consults and reduce the need for specialist visits. It has reduced the cost of the health care system through a demonstrated number of in-person specialty referrals required. The BASE eConsult platform continues to lead the province in both number of available specialties and volume of eConsults.

At this point, all eConsult/eReferral/OTN/ConnectingOntario/IDS/CHRIS/PrescribeIT data elements are tracked. Both high & low users can be tracked, and tailored solutions can be developed to meet provider needs. As the initial populations are more clearly defined, we have the capacity to track use. The tools inherently include quality assurance related to eligibility, provision of critical & timely information, and feedback loops which limit historic challenges related to lost information and inappropriate referrals. The primary aim will be to expand these eServices across providers.

Collecting, using and disclosing personal health information
All convening partners are health information custodians (HICs) which include health care practitioners, home and community care, hospitals and independent health facilities. HICs

may rely on assumed implied consent to collect, use and disclose personal health information for the purpose of providing health care or assisting in the provision of health care to an individual.

The personal health information that is collected or disclosed will be used for the purpose of providing health care or assisting in the provision of health care for the individual to whom that information relates.

HICs may assume implied consent to collect and use personal health information for most purposes. They may also imply consent to disclose personal health information to another HIC for the purpose of providing or assisting in the provision of health care to the individual.

HICs cannot rely on implied consent when disclosing personal health information to a person or organization that is not a HIC. Express consent will be obtained for the use and disclosure for any administrative or secondary use purposes. Information technology systems are protected by the use of personal accounts and passwords. Individual accounts are given access to information required by the account holder

Safeguards to ensure the protection of personal health information
Institutional policies compliant with PHIPA have been instituted across the OHT/ÉSO agencies with oversight through the privacy officer of each of the respective health information custodians.

Access to client information is provided on a need-to-know basis as appropriate to the Team Member's role and purpose for access. All access to the electronic medical record is logged and audited. Client information in paper format should be kept in a locked cabinet, container or room. Client information will only ever be removed from the premises by those Team Members who have a real need to do so to carry out their duties (for example, Team Members who provide care to clients off site such as home visits or community settings). This applies to electronic files, paper copies and information on laptops, smart phones, disks and memory sticks (USB keys) and any other formats. For electronic files, remote access to client information should be through secure server.

All electronic medical record logs user access. We can conduct random and targeted audits on our electronic medical records on a regular basis. Access audits can be performed on any client record at the request of the Privacy Officer or at the request of a client.

Failure by Team Members to adhere to the privacy safeguards and guidelines set out by their individual agency may result in corrective action being taken. Such corrective action may include, but is not limited to: retraining, loss of access to systems, suspension, reporting conduct to the Information and Privacy Commissioner of Ontario or a professional regulatory body or sponsoring agency, school or institution, termination of contract, restriction or revocation of privileges, and immediate dismissal. Additional consequences include notification of affected persons, fines, prosecutions or lawsuits

Reference:

CIRCLE OF CARE; Ann Cavoukian, Ph.D. Information and Privacy Commissioner, Ontario, Canada Sharing Personal Health Information

SWCHC Safeguard policy

4.3.2. How will you digitally enable information sharing across the members of your team?

Please refer to Appendix B – Digital Health to propose your plan for digital enablement of health information sharing.

5. How will your team learn & improve?

5.1. How will participation on an Ontario Health Team help improve individual member performance or compliance issues, if any?

Identify whether any of your team members have had issues with governance, financial management, compliance with contractual performance obligations, or compliance with applicable legislation or regulation.

Where there are issues, describe whether there is a plan in place to address them. Indicate whether participation on the team will help and why. Indicate whether there will be any formal accountability structures in place between individual team members and the team as a whole for ensuring that individual performance or compliance issues are addressed.

Max word count: 500 **(230/500)**

Identifying issues

Our team has not identified issues related to governance, financial management, compliance with contractual performance obligations or compliance with applicable legislation or regulation. At this point, it is assumed that each independent organization is working to address individual performance or compliance issues.

Using our collective resources effectively

Our commitment is to utilize our resources in the most effective and efficient way, aligning with the Quadruple AIM commitments. With an enhanced focus on strengthening primary health care and community, mental health and addictions and social services we intend to strengthen client/family care and support. We also intended to manage/contain costs of partner organizations dealing with avoidable health care utilization (e.g., alternative level care, emergency department visits).

We will move toward operating as one team across multiple organizations and providers with the intent to enhance client pathways, wrap the required care and support around clients and reduce transitions. Our commitments will be defined, and the performance and impact will be measured in relation to specific initiatives.

The convening partners have selected an approach to engagement with the broad partnership that is expected to unleash the energy and resources within the system toward common commitments. We will build the accountability structures and processes that we require to measure performance with an initial focus on specific initiatives to that improve client care and support. For more details, see Sections 4.1 and 4.2.

5.2. What is your team's approach to quality and performance improvement and continuous learning?

Ontario Health Teams are expected to pursue shared quality improvement initiatives

that help to improve integrated patient care and system performance.

5.2.1. What previous experience does your team have with quality and performance improvement and continuous learning?

Describe what experience each of the members of your team have had with quality and performance improvement, including participating in improvement activities or collaboratives and how each collects and/or uses data to manage care and to improve performance. Provide examples of recent quality and performance improvement successes related to integrated care (e.g., year over year improvement on target Quality Improvement Plan indicators).
Highlight whether any members of your team have had experience leading successful cross-sectoral or multi-organizational improvement initiatives.
Describe your members' approaches to continuous learning and improvement at all levels. Indicate whether any members of your team have had experience mentoring or coaching others at the organizational-level for quality or performance improvement or integrated care.
Identify which team members are most and least experienced in quality and performance improvement practices and whether there are any strategies planned to enhance quality focus across all member organizations/providers. Similarly, identify and describe which team members have the most and least data analytic capacity, and whether there are any strategies planned to enhance analytic capacity across all member organizations/providers.

Max word count: 1000 **(980/1000)**

Evolving as a Learning Health System
As a Learning Health System, our team will bring together experience and evidence to to make better decisions and provide better care. We are committed to:

- Developing standardized measures that are meaningful to clients, families, providers and the broader community (including socio-demographic data to guide equity informed QI initiatives)
  Establishing learning collaboratives to share best practices, increase competencies and build a culture of improvement
- Leveraging decision support resources, data standards, reporting and governance processes, research and timely evidence.

Integrating Quality Improvement Initiatives
We have identified many quality improvement (QI) initiatives that will help us advance our vision.

Emergency diversion for street involved adults
Ottawa Inner City Health has collaborated with The Ottawa Hospital, the Ottawa Paramedic Service, Ottawa Police and shelters to establish the targeted Engagement and Diversion Program, an alternative pathway to address the health needs of people that would previously have been directed to emergency departments. Substance use, mental health, wound care and minor ailments are now treated directly at Inner City Health. The methodology used to

measure emergency department diversions has informed the development and evaluation of a variety of interventions. OICHI has a robust data collection system and research capacity with data sharing arrangements in place with all key partners.

Palliative care
Earlier identification of people with palliative care needs is a significant success factor in positive patient/family and system outcomes. It ensures the beginning of care planning and facilitates access to appropriate resources and supports, minimizing unnecessary emergency department visits and hospital admissions. 'Early identification and documented assessment of needs for palliative care patients' has been selected by 65 health care organizations in Champlain as part of their QI annual plans including OHT/ÉSO partners: Bruyère, Perley and Rideau Veterans Health Centre; Centretown, Sandy Hill and Somerset West CHCs and Wabano Centre for Aboriginal Health. Standardized tools are under development.

Discharge planning and better transitions between care for MHA clients
The Champlain OPOC Quality Improvement Steering Committee, organizations responsible for delivering mental health and addictions care, are participating on a sector wide QI initiative based on data that has been compiled through the provincially mandated Ontario Perception of Care Tool (OPOC). Aggregate data from the OPOC has confirmed the need to address transitions in care. The OPOC QI steering committee (comprised of community leaders and people with lived experience of MHA) is identifying key focus areas for developing tools and training to share across the sector that will collectively enhance client/patient experience with discharge and care transitions.

Frailty initiative
The regional application for the "Advancing Frailty Care in the Community Collaborative" has just been approved. This is a QI initiative launched by the Canadian Foundation for Healthcare Improvement and the Canadian Frailty Network. It connects interprofessional teams to improve care for frail patients through a team-based QI project. This collaborative supports teams to strengthen the QI culture within their organization by providing seed funding, an evidence-informed QI model and coaching and advisory services. A number of OHT/ÉSO partners are involved.

Leveraging our capacity in quality and performance improvement
The convening partners have deep bench strength in this area. All are actively involved in quality improvement work and all are accredited, some with exemplary standing. Convening partners are affiliated with or have a strong history of academic research, partnering with hospital research institutes, universities, CIHI and other agencies. We can leverage this capacity to support the broader partnership and we will also assess the collective capacity in quality improvement as the engagement with partners deepens.

- Ottawa CHCs share the same electronic medical record (EMR) system and input client data into a shared business intelligence reporting tool (BIRT), allowing them to query their performance on many KPIs and benchmark themselves against regional comparators. There is a well-established sector-based governance for performance measurement activities through the Alliance for Healthier Communities.

- Ottawa Inner City Health was established as an academic non-governmental organization partnering with universities and colleges to support community-based research and evidence-based practice. Its robust data collection system and research capacity allows data to guide improvements to care.
- Carefor Home & Community Care has a demonstrated culture of performance monitoring and quality improvement, monitoring performance in key areas influencing client experience such as continuity of service providers, achievement of client service goals, involvement of client/family in care planning, efficiencies in referral processes, and timely and quality provision of services. Carefor participates in Canadian best practice networks to advance standards and skills development in wound management, palliative and dementia care.
- The Ottawa Hospital has a quality department that educates health providers in quality improvement techniques and supports them in quality improvement initiatives and is responsible for standardizing care based on best practices. To gather and use data to improve processes and systems and enable continuous quality improvement and better value (i.e., outcomes per dollar spent), TOH leverages a strong data analytics team, a data warehouse, an innovation centre, performance scorecards and dashboards and transparent performance reporting.
- Bruyère has a robust data-collection and research capacity and a comprehensive quality improvement program in place throughout the organization, including a number of staff trained in quality improvement and "lean" methodologies that support clinical teams to implement projects that improve quality of care. Bruyère runs a research institute whose investigators have gained reputations as innovators and problem solvers. They seek to understand and find solutions to health challenges facing people in our community, including for frail older adults. The research also explores the use of technological innovations that will allow people to re-envision their housing options in life's later years.
- Ottawa Public Health has capacity and experience in monitoring and surveillance to enable understanding of population health status and community need to ensure programs and services are continually improving and responding to emerging local needs. OPH also has a division for knowledge exchange, planning and quality improvement that can leverage its expertise in quality improvement for the OHT/ÉSO.

5.2.2. How does your team currently use digital health tools and information to drive quality and performance improvement?

Please refer to Appendix B – Digital Health to provide information on how your team will leverage digital health tools for improvement.

5.3. How does your team use patient input to change practice?

Ontario Health Teams must have a demonstrable track record of meaningful patient, family, and caregiver engagement and partnership activities. Describe the approaches the members of your team currently take to work with patient, family, and caregiver partners and explain how this information gets embedded into strategic, policy, or operational aspects of your care, with examples.

Do any members of your team have experience working with patients to redesign care pathways?

Identify which of your members have patient relations processes in place and provide examples of how feedback obtained from these processes have been used for quality improvement and practice change. Describe whether any members of the team measure patient experience and whether the resulting data is used to improve.

Max word count: 500. (424/500)

OHT/ÉSO partners have a rich history of using client/patient/family/caregiver input to change practice. We have provided some examples from convening partners.

CHCs are recognized for their effective engagement with equity-seeking groups offering tailored services where appropriate, such as LGBTQ2S+ health services, newcomer health services, and supervised consumption and addictions medicine. This work succeeds because it continuously leverages clients' lived experiences to improve care — for example, by involving them as committee members on the QI team, as subject matter experts at service planning roundtables, and as volunteers or staff. Client experience survey feedback is correlated to key performance indicators (KPIs), and rich sociodemographic client data is collected to flag inequities in access, client experience, care delivery and patient outcomes. Robust client feedback and resolution processes inform a culture of continuous quality improvement.

OICHI's organizational model, operating principles, programs and services were all based on extensive community consultation, including input from the homeless people who would eventually use the services. The management model supports the coordination of care across different service systems, shared accountability for outcomes, and patient and community involvement in all aspects of operations.

Carefor uses a range of approaches to meaningfully engage clients and families, including participation in program-specific improvement working groups such as safe mobility/falls prevention, and working with care partners and clients living with early onset dementia. The organization invites clients and families to contribute to policy and procedure revisions,

participate on regional program boards, inform/co-design nursing clinic and retirement home renovations, and participate in retirement home resident councils.

TOH has a formal approved patient engagement framework. Approximately 150 patients and family members participate in the hospital's patient experience, quality improvement and care redesign committees. The hospital has a well-established and responsive patient relations department that collects feedback about patient care services and a community engagement committee that meets regularly to discuss hospital/community relations.

Bruyère has a track record of meaningful engagement. Patients, residents, families and key stakeholders are engaged in developing plans, policies and service changes through patient and family advisory councils and the community advisory committee. All initiatives related to planning, quality and budgeting are brought to these groups to get their input and insight on the impacts.

OPH has a demonstrated track record of meaningful engagement and partnership activities with patients/clients and communities. OPH engages partners across the spectrum, from informing program and services to co-delivery (client advisory groups). OPH is revising a client/ community engagement framework informed by the City of Ottawa's public engagement strategy and the IAP2 framework developed by the international association for public participation.

5.4. How does your team use community input to change practice?

Describe whether the members of your team formally or informally engage with the broader community (including municipalities), and whether the outcome of engagement activities influence the strategic, policy, or operational aspects of your care.

Max word count: 500. (339/500)

Some partners have significant experience using community input to inform and change practice including strategic, policy or operational aspects of care. Examples are provided that focus primarily on population level change initiatives. Use of patient experience to change practice was described in section 5.3.

Ottawa Public Health (OPH) focuses on improving the overall health of Ottawa's population and reducing the burden on the health system. The services and programs provided by OPH are diverse and designed based on assessment of unique community needs. OPH consults across sectors, including the City of Ottawa's planning department, school boards and local health and social service agencies, to inform its mandate of health protection, health promotion and prevention.

OPH conducts population health assessment, monitoring and surveillance to understand the needs of the population and serve all residents of the City of Ottawa across the lifespan. OPH focuses on addressing disparities in health outcomes among certain groups, with its 2016

Health Status Report summarizing the relationships between income/neighbourhood socioeconomic advantage and 13 health-related measures. For example:

- People in low-income groups/low-advantage neighbourhoods are more likely to experience poor health outcomes, be inactive and smoke.
- These groups also have higher rates of hospitalization, premature death and diabetes.

Ottawa Community Health and Resource Centres address social determinants of health such as housing, income, food insecurity, education, employment, race, early life, social support networks and civic participation. Through extensive community development work, Centres are uniquely suited to address the health inequities faced by some communities. Working collaboratively through the Coalition, Centres have established trusting relationships with an extensive network of community-based health and social service partners to address gaps in service and influence system change.

The community governance model of Community Health and Resource Centres ensures that people from the local community have a voice in directing strategic choices and priorities for the evolution of services in neighbourhoods and engages clients and residents in the process of designing and tailoring programs and services. Board membership is diverse by design and reflects the diversity of their clients and communities.

5.5. What is your team's capacity to manage cross-provider funding and understand health care spending?

Please describe whether your team has any experience in managing cross-provider funding for integrated care (e.g., bundled care). Have any members of your team ever pooled financial resources to advance integrated care (e.g., jointly resourcing FTEs to support care coordination)? Does your team have any experience tracking patient costs or health care spending across different sectors?

Max word count: 500. (414/500)

Convening partners have a history of managing cross provider funding and understanding health care spending. Some of the convening partners offer back office support to other organizations or networks (e.g., human resources, finance, payroll).

The six Ottawa CHCs have a combined 2019 budget of $100,440,884. The majority of funding comes from the Ministry of Health (MOH). Other key sources of funding include different federal and provincial departments, the City of Ottawa, United Way of Ottawa and Ottawa Trillium Foundation. Ottawa CHCs manage a wide range of city and region-wide services and programs that are available through multiple CHC and partner sites. Examples include diabetes education, lung health, mental health and addictions services and primary care outreach for frail seniors.

Ottawa Inner City Health receives $9.8 million in direct funding from the MOHLTC and Champlain LHIN, and a further $2 million from three-way contracts with funders and other partners. Other funding sources include contractual agreements with partners for the purchase of services, third-party funding through partner foundations and fundraising.

Carefor has a global budget for fiscal year 2019–2020 of $64.7 million. It manages multiple sources of funding, including $37 million in fees for home-care service and $16 million in community support service funding from the Champlain LHIN, and $11.7 million from hospice, retirement homes and other private services.

The Ottawa Hospital (TOH) has a budget of approximately $1.2 billion, which comes mostly from the MOHLTC. TOH is committed to shared funding models and the principle that funding should follow the patient. It is a bundle care holder ensuring patients are cared for in the most appropriate setting that achieves the best outcome per dollar spent, and regularly transfers funds from the hospital to support patient care that is more efficient and effective in other settings (e.g. hospice beds, transitional care).

TOH is a case-costing hospital and is able to determine patient outcomes per dollar spent. TOH does many quality-based procedures, achieving savings in many procedures, which it reinvests to improve patient care. This has enabled TOH to achieve benchmark performance in its cost-per-weighted-case metrics.

Bruyère, is the dominant provider of sub-acute care in the region, providing 57% of all sub-acute care within the Champlain region. With a budget of approximately $160 million, mostly from the MOH, Bruyère offers sub-acute care, residential care (including long-term care and affordable supportive housing for seniors), and out-patient programs including a geriatric day hospital, a memory program and a palliative consultation service. It is also a case costing hospital.

6. Implementation Planning and Risk Analysis

6.1. What is your implementation plan?

How will you operationalize the care redesign priorities you identified in Section 3? Please describe your proposed 30, 60, 90 day and 6 month plans. Identify the milestones will you use to determine whether your implementation is on track.

Max word count: 1500. **(744/1500)**

Developing our business case and implementation plan

Following the submission of the application in October the OHT/ÉSO will develop a business case and associated implementation plan that will support the collaborative leadership model going forward.

The implementation plan will leverage the work done for this application and the next steps of engagement with action teams. It will include:

- The scope of our work for the first year, the populations for initial focus and the anticipated impact of that work
- The shifts in models and care pathways that will be developed, evaluated, and communicated to ensure we are achieving positive change
- The approach taken to engage providers and client/patient/family through action teams
- The ways partners will be interdependent on one another for data, client care, administration and governance to make this happen
- The infrastructure and how partners will work (what we will do, when, and by whom)
- The benefits and limitations of the collaborative governance model and shared infrastructure approach
- The risks of our approach and risk mitigation strategies as well as the consequences of a risk occurring, as well as plans to deal with these anticipated risks
- An assessment that discusses how the approach will add value (redirecting resources for the most effective and efficient use of resources)
- The budget and contributions to be made by partners to advance the work
- An evaluation plan for the collaborative.

The plan is intended to help mitigate the common causes of unsuccessful collaboration including a lack of project planning (short and long-term) and inadequate involvement and support from all areas of collaborative leadership. It will provide a structure for the work while ensuring that the OHT/ÉSO retains a nimble iterative orientation in line with a Learning Health System.

Our planned next steps

We have identified the work that we know we need to do. As we move forward we will identify other areas that require focus.

Client engagement

- Establish a model for reimbursement and potentially compensation

- Design recruitment processes that will be equitable and allow for a broad range of perspectives to reflect the demographics of our community
- Establish the Client Partner Table
- Design and establish ways to get input from specific populations and the broader community

Primary Care Provider Engagement

- Consult with affiliated primary care providers and directors to understand how they can contribute to serving the initial populations for focus
- Continue outreach to engage Primary Care Patient Enrollment Models (PEMs) linked to the OHT/ÉSO's attributed population
    - Clarify the relationship with the Community of Family Medicine Practice
    - Determine what structure will best support engagement given time constraints; consider a collaborative approach with other local OHTs
- Explore how to communicate and engage with more nurse practitioners
- Recruit more primary care providers to participate in OHT/ÉSO affiliated action teams
- Engage primary care providers and hospital and community-based specialists to identify ways to improve communications and care pathways, leveraging virtual care options

Frail Older Adults and the Mental Health and Addictions and Primary Care Action Teams

- Review the focus of each action team(s) and membership
- Identify how to effectively engage others that want to contribute (e.g. forums)
- Reconvene the action team(s) and draft a project charter
- Scope how to re-design services and care pathways in line with the vision
- Set priorities and develop an action plan
- Develop the care pathways/initiatives
- Establish benchmarks and identify the number of clients to be served
- Develop a monitoring plan

Home and Community Care Action Team

- Explore how to collaborate with local OHTs on system design and transition planning
- Review the membership
- Implement steps outlined in Appendix A: Home and Community Care

Partner Engagement

- Refine the process for signing on and contributing as an organizational partner
- Establish more opportunities to be engaged
- Engage with agencies serving specific populations including Indigenous and francophone communities
- Write regular bulletins and host regular webinars
- Further develop the website and associated repository of information
- Continue to work closely with other OHTs in the region to align and simplify communications and standardize processes and tools, where feasible and appropriate

Digital Health Strategy

- Engage physicians and develop a plan to expand use of digital health options for the attributed population overall
- Engage digital health experts to support the work of action teams in re-designing care pathways

Data Strategy
- Engage data analysts to support the work of action teams in redesigning care pathways
- Implement the plan to expand data sharing

Establish the collaborative infrastructure
- Identify requirements (human resources, financial, information technology)
- Define contributions
- Develop the structure and define working relationships

6.2. What is your change management plan?

Please describe your change management strategy. What change management processes and activities will you put in place before and during implementation? Include approaches for change management with primary care providers, and how you propose to leverage clinician leaders in helping their peers to embrace and embed change.

Max word count: 1000 **(836/1000)**

Our approach to engagement and change

Our change management planning is rooted in the approach and model for client and provider engagement. As noted in Section 4.2, the engagement strategy of the OHT/ÉSO is oriented toward building on existing relationships and evolving new relationships that will inspire and support action toward the vision. The approach is grounded in the constellation model and informed by evolving models of collective impact.

We are using a framework for multi-organizational collaboration to support our work toward a common outcome. It is a way of organizing a group of interested parties to meet a need without having to create a new organizational structure. The approach is focused on solving concrete problems and making change within a rapidly changing and complex system.

Moving forward together will require:

- A shared strategic purpose/intent (need/opportunity)
- A container that supports actions across multiple partners all working toward a common vision
- A stewardship group that serves the broader group of collaborating partners – our convening partners
- Third-party support to build capacity and focus on process

- Action focused teams made up of participants with converging interests and energy work to address specific issues or advance opportunities (coordinated mutual self-interest harnesses resources toward a common goal)
- Collaborative leadership (workload and leadership are shared)

Our work to date

This is a complex change process given the level of fragmentation in the current system.

On April 30th potential partners came together and decided to advance an OHT that was "grounded in primary health care and community services and integrated across the health system". Since that time, work has been done to build bridges and relationships with new partners while also engaging existing partners with deep relationships founded on trust. We have a community development orientation.

Convening partners established a framework that is intended to enable multiple partners across the continuum of care to contribute in a meaningful way. We have a lot of work ahead of us given the numbers of people that want to engage.

Multiple conversations have been held with individual stakeholders. Deep dive conversations have been held amongst action teams that are leading to shared understanding about the challenges and options for change while creating the foundation for a "one team" approach that is aligned with the commitments.

We know that more structure will be needed to support decision-making, however convening partners believe that a premature focus on structure will detract from the engagement process which is intended to build shared understanding and energy for system change in line with the Ministry of Health transformation agenda (Quadruple Aim) and the OHT/ÉSO vision and commitments.

Sources:

Tonya Surman, Centre for Social Innovation. Constellation Collaborative: A Model for multi-organizational partnership. June 2006

Tonya Surman and Mark Surman. Listening to the Stars: the Constellation Model of Collaborative Social Change.

John Kania and Mark Kramer. Collective Impact. Stanford Social Innovation Review. 2011.

Mark Cabaj and Liz Weaver. Tamarack Institute. Collective Impact 3.0 An Evolving Framework for Community Change

Our change management process post application

The partners chose to complete this application to demonstrate our progress and the tremendous capacity we have to leverage. We have made excellent progress to date, given the time and resources available. We have engaged as many people as possible. We are committed to continuing to evolve this engagement and change process.

Our team has a wonderful challenge. Many stakeholders are deeply committed to contributing to the work of this team. The team already includes partners from across the continuum of health and social services, all of whom want to be directly engaged in shaping the work. Each week organizational representatives and physicians are reaching out to explore how they can contribute. People want assurance that they can be actively engaged. We need to devote attention to maintaining and building relationships.

The challenge we face is to establish the necessary infrastructure and processes to support effective engagement toward the vision and commitments. A collaborative governance and shared infrastructure bring great promise as well as risk. The promise is that people hold the container of change together and are jointly accountable for its success. The risk is overcommitting to what is possible within the timeframe set.

Within a low rules' environment, the focus is to identify the key changes that can be implemented that will move us in the desired direction. We are already seeing evidence of the gains that have evolved from the trust established. One example is the recent move to facilitate access to The Ottawa Hospital (TOH) Electronic Health Records. When TOH moved to the new EPIC electronic health record this past spring, CHC practitioners without hospital privileges lost their capacity to view their clients' hospital clinical record when they had a hospital visit. Given the collaboration, TOH gave all CHC practitioner's access to EPIC so that they could view their clients' chart. Data sharing agreement documents were sent within 24 hours of the decision to grant access.

The status of the work to engage primary care providers is outlined in detail in Section 4.2.

6.3. How will you maintain care levels of care for patients who are not part of your Year 1 population?

Indicate how you will ensure continuity of care and maintain access and high-quality care for both your Year 1 patients and those patients who seek or receive care from members of your team but who may not be part of your Year 1 target population.

Max word count: 500. (42/500)

Each partner will be responsible for continuing to provide high quality care and services for their client base. Partners will adhere to existing mandated performance standards and quality measures.

The partners anticipate that the efforts directed at the two initial populations of focus will leverage gains in improved services for other clients.

6.4. Have you identified any systemic barriers or facilitators to change?

Identify existing structural or systemic barriers (e.g., legislative, regulatory, policy, funding) that may impede your team's ability to successfully implement your care redesign plans or the Ontario Health Team model more broadly. *This response is intended as information for the Ministry and is not evaluated.*

Max word count: 1000. (1000/1000)

Facilitators to change

Strong partnership base
Ottawa is a tight knit community with many strong partnerships. The community is pulling together to advance a common vision. The upswell of support suggests our team is on the right track. We will leverage the relationship capital that has been established over the years.

The collaboration with the other local OHTs is evidence of a willingness to partner for the benefit of the people we collectively serve.

Convening partners
Relationships have been strengthened and new relationships have been built. We understand what is required to ensure that the client/patient and their families are at the core of our work. We are committed to supporting change in a highly complex system with multiple stakeholders wanting to influence the direction of change.

We will evolve the necessary infrastructure to support the change effort. At this point, convening partners are contributing resources to advance the work without relying upon a single organization to provide the backbone support.

Collaborative governance
The number of existing governance structures stewarding health care services in this region, much like others in Ontario, is staggering. A collaborative governance approach is more likely to transform thinking to be less introspective and organizational focused and more population health and well-ness oriented. This will be key to designing a more people-centred, simple and accessible health care system.

Leveraging assets for health equity
The broad partnership has a strong equity lens. We understand the issues that create barriers for people to access key services and potential solutions and we know that social frailty is a major driver of costs to the health system.

Our partner network includes organizations funded by multiple levels of government and other sources to do important and complementary work. We can leverage all of these assets to fill gaps in service and supports while truly working to eliminate silos that are dictated by funding. We are working to establish a comprehensive suite of services, cradle-to-grave, equitably offered and accessible to all.

Population health approach
Partners have experience in using a population health approach to health promotion disease prevention and health equity, addressing the entire range of individual and collective factors that determine health. We are committed to maintaining and improving the health status of the entire population and to reduce inequities in health status between population groups.

Barriers to change

Illness-Based Model vs. Wellness-based Model
Today's health care system is largely resourced as an illness-based model rather than a wellness-based model. The majority of our health care dollars are spent at the acute care end of the continuum rather than investing in health promotion and illness-prevention to keep people healthy and well at home and in their communities longer. The impact of social determinants of health is a key factor in enabling people to be healthy and well. We need to shift this philosophy and model of health care funding in order to create greater health awareness, increase active living and prevent disease. Only then will we achieve greater cost savings with more appropriate investments in all parts of the health care system.

We need to shift to more upstream interventions, focusing on decreasing barriers to health and improving supports that allow people to achieve their full health potential.

Scope of Practice Culture
As the health care system has become more costly and complex, more provider roles have emerged with defined scopes of practice. While some cost containment has been achieved, the greater focus on specialization has had the perverse effect of limiting the flexibility of providers and their relationships with clients. The system is complex and confusing for people and their families receiving health care in their homes and communities.

The benefits of having increased scope of practice for nurse practitioners, nurses, pharmacists and other professionals are recognized.

Engaging Primary Care
The evolution of the OHT/ÉSO is predicated on evolving strong relationships with primary care providers. Non salaried providers are challenged to dedicate the time required to engage in care re-design processes. Funding has not been provided to compensate them for their time.

Engaging People with Lived Experience
At a minimum people need to be reimbursed for any costs associated with engagement. In some cases where significant amounts of time are dedicated compensation is appropriate. Organizations have different practices that guide this decision-making. Funding has not been provided to compensate them for their time.

Wage Inequity
In Ontario, service providers working in the home and community sector currently earn less compensation (per hour wage) than their acute and long-term care colleagues. This happens despite their working independently with no peer/mentor supports and increased safety risks due to exposure of environmental and behavioral challenges. This not only de-values the role of home care clinicians, it also creates major recruitment and retention challenges for home and community care agencies especially in times of depleted health human resources, particularly in a region where bilingual (English and French) capacity is essential. As the

OHT/ÉSO is located in a designated French Language Services region, recruitment and retention of human resources speaking both official languages are key.

An Environmental Scan of Working Conditions for PSWs in Ottawa conducted by Somerset West CHC (2019) found that low wages and inequities in wages across organizations was the primary driver for turnover and challenges in retention.

Innovation Limitation
Existing legislation and evergreen contracts with home care providers limits creativity, innovation and performance management in this sector. By lifting the provisions, agencies and think tanks will be more able to think outside the box and identify news ways of providing home and community care that is more personal, efficient and effective.

Privacy legislation and capacity
If the government and PHIPPA decide that all OHT partners will be considered Health Information Custodians (HICs), funding may be required for non-HICs to manage the change and to implement standards like creating audit processes and auditing. Smaller organizations that are HICs may be challenged to do this to the level required.

6.5. What non-financial resources or supports would your team find most helpful?

Please identify what centralized resources or supports would most help your team deliver on its Year 1 implementation plan and meet the Year 1 expectations set out in the Guidance Document. *This response is intended as information for the Ministry and is not evaluated.*

Max word count: 1000. (282/1000)

Establish reasonable timelines
The most significant challenge that the OHT/ÉSO faces is the implementation timelines. While the convening partners are committed to sustaining the momentum for change and advancing work, it is essential that timelines allow for appropriate levels of engagement. That engagement is multi-faceted and includes clients and their families and providers as well as specific population groups like francophone and Indigenous communities. This does not require additional supports or resources just consideration about what is feasible.

Provide access to comprehensive data in a timely way
If the MOH is providing data intended to support the work of teams, the data needs to be available within a timeframe that enables collaborative planning. At this point only a small part of the health sector is capturing socio-demographic data in a comprehensive way, making it challenging to plan for population health. We need socio-demographic data that reflects health inequity for different populations (i.e. Indigenous, francophones, racialized, LGBTQ, low income). Analysis of differences in service utilization for specific population groups will be helpful.

Offer streamlined supports
The current supports provided through RISE and through the Alliance for Healthier Communities and Community Health Ontario are useful. The digital playbook produced by the MOH has also been helpful.

Many stakeholders are currently working to influence the direction and/or support the evolution of OHTs and a streamlined approach is necessary.

Provide information about primary care providers
Despite the focus on engaging primary care providers, it is difficult to get a list with current contact information for individual family physicians and the practice models that they are associated with. Current lists held by the LHIN and other partners are considered confidential. A MOH provided list would be helpful.

6.6. Risk analysis

Please describe any risks and contingencies you have identified regarding the development and implementation of your proposed Ontario Health Team. Describe whether you foresee any potential issues in achieving your care redesign priorities/implementation plan or in meeting any of the Year 1 Expectations for Ontario Health Team Candidates set out in the Guidance Document. Please describe any mitigation strategies you plan to put in place to address identified risks.

As part of your response, please categorize the risks you've identified according to the following model of risk categories and sub-categories:

Patient Care Risks • Scope of practice/professional regulation • Quality/patient safety • Other	**Resource Risks** • Human resources • Financial • Information & technology • Other
Compliance Risks • Legislative (including privacy) • Regulatory • Other	**Partnership Risks** • Governance • Community support • Patient engagement • Other

Risk Category	Risk Sub-Category	Description of Risk	Risk Mitigation Plan
See supplementary Excel spreadsheet			

6.7. Additional comments

Is there any other information pertinent to this application that you would like to add?

Max word count: 500 No comment

7. Membership Approval

Please have every **member** of your team sign this application. For organizations, board chair sign-off is required.
By signing this section, you indicate that you have taken appropriate steps to ensure that the content of this application is accurate and complete.

Team Member	
Name	
Position	
Organization (where applicable)	
Signature	
Date	
Please repeat signature lines as necessary (See supplementary Excel spreadsheet)	

Ontario Health Teams
Full Application Form

APPENDIX A: Home & Community Care

Ontario Health Teams will help to modernize home and community care services, so patients can live at home longer, return home more quickly from hospital, or delay or avoid the need for admission to a hospital or a long-term care home.
In this section, you are asked to outline a long-term vision for re-designed home and community care model and a short-term action plan with immediate priorities. Your team is encouraged to consider how you will improve the patient and provider experience, better integrate home and community care with other parts of the health care system and improve the efficiency of home and community care delivery. For Year 1, you are asked to propose a plan for transition of home and community care responsibilities to your Ontario Health Team.
Your proposal should demonstrate how you plan to re-imagine and innovate in home and community care delivery, while ensuring efficient use of resources. Your team's proposal will help the Ministry understand how to better support innovative approaches to home care. The Ministry is exploring potential legislative, regulatory and policy changes to modernize the home care sector so that innovative care delivery models focused on quality can spread throughout the province.
Responses provided in this section will be evaluated based on how well your team understands the home care needs of your Year 1 and maturity populations and opportunities for improvement and how well your proposed plan aligns with the quadruple aim and the principles of integrated care, shared accountability, value-based care, and population health management.

A.1. What is your team's long-term vision for the design and delivery of home and community care?

Describe your long-term vision for how you will modernize and better integrate home and community care taking into consideration local population needs and local challenges in home and community care.
Highlight proposals to strengthen innovative service delivery, increase accountability for performance, and support efficient and integrated service delivery.

Max word count: 1500 (1004/1500)

This section outlines the emerging vision for home and community care. Further analysis is needed to outline how resources will be organized.

Our team imagines a future where:

- People can access the care and services they need, and if there are barriers, get the help required to guide them towards the required supports
- People (both clients and families/caregivers) have a better experience and are connected to the appropriate care and supports that match their strengths, goals and needs, including health and social services

- People feel connected to the staff that provide care and support, and continuity of care is facilitated wherever possible
- Care is less transactional, better coordinated and allows for seamless transitions when required.
- The health and social service providers/agencies wrapping services and supports around people are well-connected and working collaboratively to meet the needs and goals of people

Core components of this home and community care model include:

Open Team Philosophy

Home and community care will operate in partnership with care providers across the continuum of care and support. The intent is to:

- Establish and implement a shared care plan, reducing redundancy and inefficiency
- Identify and be responsive when a higher level of care, or social supports are required
- Reduce the number of transitions; where and when transitions are required, ensure transitions are warm, graduated and seamless (e.g. from community to sub-acute, from home to congregate assisted living)
- Be efficient and effective with collective resources.

Care Coordination and System Navigation

Care coordination will be embedded with primary care as the foundation of the health system and the locus of people's long-term relationship with the health system, and social supports. Every client with complex needs will have access to a care coordinator, operating within an inter-professional team-based care model. The care coordinator will assume a lead role in partnering with the client and family/caregiver to:

- Engage in strengths, needs and goals-based planning, rooted in primary care
- Establish a plan of care that is holistic and considers health and social needs
- Ensure that a care direction conversation has been held
- Provide support to access integrated care & social supports
- Provide flexibility, understanding what to do when circumstances shift or there is a change in health status
- Provide support to manage multiple appointments & relationships with providers
- Inform people about the steps in their care and how services will work.

People with fewer complexities will have access to system navigation support as required, supporting transitions in care and social supports.

Blended Supports
The care and support offered within the home and community care sector will be blended. With the support of streamlined information technology, care partners will collaborate to:

- Organize services to match people's strengths, goals and needs
- Standardize assessment tools
- Provide seamless support and care within the home and community (i.e. nursing care, personal care, therapies, respite, transportation, home making, accompaniment, opportunities for socialization, telephone assurance)
- Reduce transactional care and be more flexible to adjust to client needs.

Accessibility to Services for People with Low to No Income
People that require support but are unable to pay will have access to key services that enable them to continue to live at home. It will be important to:

- Clarify what is appropriate and feasible for clients to pay
- Identify the discretionary funding available within the system to offset co-pay requirements for essential services
- Establish a mechanism to facilitate access to subsidized co/low-cost supplies and equipment.

"Neighbourhoods of Care" and Congregate Care Models

Leveraging the success of existing models, a range of home and community care supports will be available to meet the service needs of seniors living at home and in congregate care settings. This will include:

- Providing greater consistency and continuity of care from providers in designated 'neighbourhoods' across the city
- Bundling care and support services for residents of senior's buildings, particularly those with large populations of higher need seniors
- Investing in more affordable congregate assisted living options for frail older adults who are no longer able to live independently, cannot afford retirement residences but do not require the level of care offered through long term care.
- Maximizing resources and efficiency, enabling more time for delivery of service, and less time traveling between people's homes

Valuing the Services and Jobs
Staff providing home and community care and supports often work alone and face greater risks when entering people's homes to provide essential services. These services include but are not limited to: getting people out of bed, bathing, feeding, and assistance with medications, nursing, therapies, and community supports.

The health system must recognize the value of this work and the complexity of the client base requiring these services. The system needs to be ensure that safety precautions are in place, and that workers are compensated appropriately for the work they do, and the risks they incur. The health care system also needs to organize itself to maximize the benefits for clients and families, while ensuring a quality work experience for staff. This requires:

- Organizing services to allow sufficient time for trusting relationships to develop between clients and providers so that holistic care is provided. This becomes increasingly relevant the more personal the care that is required (bathing, toileting etc.).
- Making greater use of technology for remote monitoring and risk management for staff
- Embracing 'windows of time to provide care' in order to meet client expectations and manage the complexity of scheduling.
- Building on informal support networks by exploring alternative approaches to meeting care needs including compensation (e.g. unregulated staff, attendant care, paramedic students, nursing students, unemployed care partners, remote technology options, and neighbours, etc.).
- Providing fair equitable wages.

Post-Acute Care Follow-Up & Monitoring

People requiring post-acute care who are functioning well upon discharge and without complex needs require a streamlined process to access the appropriate levels of care when required. This includes:

- Maintaining a simple process that prepares people for pre- and post-surgery
- Ensuring post-discharge follow-up is in place to monitor for complication(s) or further complexity
- Ensuring a clear and simple plan to activate intervention when and where required, directly linked to primary care.

A.2. What is your team's short-term action plan for improving home and community care in Year 1?

Identify your top priorities for home and community care in your first 12 months of operation.

- What proportion of your Year 1 population do you anticipate will require home care? For this proportion of patients, describe patient characteristics, needs and level of complexity.
- Describe how you will innovate in the delivery of care to improve the delivery of home and community care to achieve your Ontario Health Team quadruple aim objectives.

- Outline a proposed approach for how you will manage patient intake, assess patient need, and deliver services as part of an integrated model of care. If relevant use the **optional** table below to describe the delivery model.

Role/Function	**Organization**	**Delivery Model** (What type of provider (dedicated home care care coordinator, FHT allied health professional, contracted sevice provider nurse, etc) will be providing the service and how (in-person in a hospital, virtually, in the home, etc.)
Managing intake		
Developing clinical treatment/care plans		
Delivering services to patients		
Add functions where relevant		
See supplementary Excel spreadsheet		

Max word count: 1000. *(666/1000)*

Our team has identified six priorities for improving home and community care in the first 12 months of operation:

1. Understand existing resources and service utilization
2. Evolve the model of care coordination and system navigation
3. Pilot a blended care model offering holistic home and community supports that are linked to primary care
4. Re-design care pathways
5. Evolve neighbourhood and congregate care models
6. Examine and evolve approaches to cover costs of essential community and social supports

Action plan

The table outlines the actions OHT/ÉSO will take to evolve home and community care in Year 1.

Focus	Activities
Understand existing resources and service utilization	Conduct an asset inventory of home and community care resources • Health human resources • Information technology and virtual care • Successful programs and services with positive outcomes • Existing infrastructure
	Develop a shared understanding of existing systems and practices • Common assessments and tools utilized (RAI and InterRai) • Databases • Information systems • Infrastructure for ordering medications, supplies and equipment • Human resource practices • Contractual arrangements • Accountability oversight practices
	Analyze existing home care service utilization and demand (service and provider type) and project demand • Analyze supports (required by population groups) and level of care requirements • Analyze how resources are organized and leveraged
	Analyse existing community support service utilization and demand • Analyse the relationship between existing home care and community supports for gaps; underscoring those deemed essential to keeping people at home • Analyze existing referral pathways to such services
Care coordination and system navigation	Review asset inventory of care coordination and system navigation conducted for the Champlain LHIN (e.g., Home and Community Care, Health Links, Primary Care Outreach)
	Examine leading practices within the region and from other jurisdictions including models that: • Link to and/or integrate care coordinators with primary care, particularly the inter-professional team-based care models that can support all models of primary care, including solo practitioners (e.g., SCOPE) • Perform the system or patient navigator function through unregulated health professionals
	Examine the learnings from Health Links implementation and the key barriers to shared care planning and implementation • Develop a business case to retain Health Links resources in lead agencies to support the evolution of a care coordination model
	Develop and pilot a model of care coordination that is linked to an inter-professional primary care team-based model • Clarify the functions and scope of practice

	• Clarify the range of clinical function to be embedded and assessments to be led by the direct care nurse (e.g., assessment and medication reconciliation) • Identify the expertise and competencies required
	Develop a model of system navigation • Clarify the functions and scope of practice • Identify the expertise and competencies required
	Develop a plan to transition to an enhanced model of care coordination
Blended care model	Design and pilot a blended care model for home AND community care supports, leveraging the range of care and support services offered by partners • Leverage and standardize existing referral pathways • Standardize assessment tools across health and social supports, where possible (e.g,. frailty, means)
Re-design care pathways	Engage with staff and people with lived experience to co-design processes and care pathways that align with the vision and commitments
	Develop a plan for organization, allocation and management of services and the associated health human resources
Neighbourhood and congregate care models	Incorporate learnings from 'neighbourhoods of care' into redesign of services being provided in the OHT/ ÉSO
	Evolve 'Aging in Place' - a model currently operating in 11 buildings to serve seniors with high needs to strengthen linkages to primary care and social services and expand to serve more buildings with demonstrated need across the city
	Promote the development of more affordable congregate assisted living buildings, similar to existing models like Perley and Bruyère, for seniors who require higher level care, not long-term care
Creating affordable services	Examine leading practices in other jurisdictions for covering costs of critical community supports
	Identify discretionary funding available, within the system, to offset co-pay requirements for essential services
	Encourage organizations to collaborate to examine the feasibility of a model that will facilitate access to low or no cost supplies and equipment

A.3. How do you propose to transition home and community care responsibilities?

Please describe you proposed plan for transiting home and community care resources to your Ontario Health Team in Year 1, such as care coordination resources, digital assets, programs, and local knowledge and expertise.

Max word count: 1000. **(426/1000)**

In Year 1, the vast majority of home and community care will continue to be managed and operated by the Home and Community Care division of the Champlain Local Health Integration Network (LHIN). Providers will continue to deliver their contracted service volumes in nursing, allied health therapies and personal support services so care is not disrupted for our vulnerable population who depends on it to stay at home.

Working in close partnership with the LHIN, we will learn and analyze how the existing system operates to support planning for a future state for home and community care delivery within a transformed system.

For frail older adults with a low income and compromised informal supports, our partners will work closely with the LHIN to evolve a model that will transition selected individuals to an alternate method of case management/care coordination linked to primary health care teams. As proposed, their care will be managed in partnership with their primary care provider. Clients will have access to services that are wrapped around them to manage the full spectrum of their health care, including home and community care. The primary health care team will include mental health workers, care coordinators and system navigator and access to speciality services required for the population. Clear care pathways will be developed.

While this new care coordination model will be applied to select populations in Year 1, we will leverage other opportunities to help those living with complex health challenges return home from hospital and alleviate acute care system pressures. One example is the proposed *Ottawa@Home* initiative, a partnership between the The Ottawa Hospital (TOH), SE Health, Carefor Health and Community Services and CBI Home Health, which is designed to replicate the successful *Southlake@Home* model. This initiative, with funding provided by the Ministry of Health, aims to provide a 'bundled care' approach to seniors living with complex health needs living in Alternate Levels of Care (ALC) hospital beds and awaiting discharge. The model has the hospital and home care co-designing plans with patient/client and family input based on care and social needs. The care plan is designed for a smooth transition home, where clients and their family are supported with 24/7 services in nursing, allied health and personal support depending on their level of need. The 'bundled care' funding is for 16 weeks, with each client receiving appropriate levels of care when and where required. Community support services are included in the bundle.

The OHT/ÉSO will analyze other opportunities for change that align with the vision, set priorities and develop the associated action plans.

A.4. Have you identified any barriers to home and community care modernization?

Identify any legislative, regulatory, policy barriers that may impede your team's vision for modernizing home and community care with regards to improving health outcomes, enhancing the patient and provider experience, and ensuring system sustainability. *This response is intended as information for the Ministry and is not evaluated.*

*Max word count: 1000. (*530/1000)

We have identified barriers to modernizing home and community care including:

Home and Community Care Legislation
Existing legislation governing Ontario's home and community care system limits the way home and community care is both contracted to providers and managed. Providers are contracted by service volume in all areas of the city, which presents challenges for applying models such as 'neighbourhoods of care.' This highly systematic and transactional approach will make it challenging for OHTs to move forward to bring consistent and continuous care back to the home environment.

Innovation Limitation
Existing legislation and evergreen contracts with home care providers limits creativity, innovation and performance management in this sector. By lifting the provisions, agencies and think tanks will be more able to think outside the box and consider news ways of providing home and community care that is more personal, efficient and effective.

Wage Inequity
In Ontario, service providers working in the home and community sector currently earn less compensation (per hour wage) than their acute and long-term care colleagues. This happens despite their working independently with no peer/mentor supports and facing increased safety risks due to exposure to environmental and behavioral challenges. This not only de-values the role of home care clinicians, it also creates major recruitment and retention challenges for home and community care agencies especially in times of depleted health human resources.

Illness-Based Model vs. Wellness-based Model
Today's health care system is largely resourced by way of an illness-based model rather than a wellness-based model. The majority of our health care dollars are spent at the acute care end of the continuum rather than investing in health promotion and illness-prevention to keep people healthy and well at home and in their communities longer. The impact of social determinants of health is a key factor in enabling people to be healthy and well. We must shift this philosophy and model of health care funding in order to create greater health awareness, increase active living and prevent disease. Only then will we achieve greater cost savings with more appropriate investments in all parts of the health care system.

Scope of Practice Culture
As the health care system has become more costly and complex, more provider roles have emerged with defined scopes of practice. While some cost containment has been achieved, the

greater focus on specialization has had the perverse effect of limiting the flexibility of providers and their relationships with clients. This adds to the complexity and challenging experience of people and their families that receive health care in their homes and communities.

The benefits of having increased scope of practice for nurse practitioners, nurses, pharmacists, other professionals are recognized.

The Fragility of Personal Care Service Capacity
Approximately 70% of health care services that are delivered in people's home are related to personal support services. This encompasses bathing, feeding, toileting, dressing, etc. These services enable people to not only: stay in their homes, or stay in their homes longer, but also contributes directly to quality of life. Workers who go into homes to provide this care are facing pressures from many angles: pay only fractionally higher than minimum wage, increasing complexity of patients being discharged from hospital and wishing to stay in their homes, facing challenges and risks with: violence, physical injury, family members / friends, pets, infestations, and entering many private properties in a single shift.

Legislation protects equitable access for home care; lack of needs-based assessment.

APPENDIX B: Digital Health

Experience from other jurisdictions suggests that digital health is a powerful tool for advancing integrated care, shared accountability, value-based health care, and population health management approaches.
In this section your team is asked to assess its current digital health capabilities and propose plans for building off this existing capacity to meet the minimum readiness requirements and Year 1 expectations set out by the Ontario Health Team Guidance Document. Responses provided in this section will be evaluated based on the degree to which your team seeks to integrate already existing infrastructure and improve disparities in digital capacity across the members of your team. Responses will also help the Ministry understand what supports teams may need in the area of digital health.
By completing this section, the members of your team consent that the relevant delivery organizations (i.e., Cancer Care Ontario, Health Shared Services Ontario, Ontario MD, Ontario Telemedicine Network, and/or eHealth Ontario) may support the Ministry of Health's (Ministry) validation of claims made in the Current State Assessment by sharing validation information (e.g., the number of EMR instances, including the name and version of all EMRs used by applicants) with the Ministry for that purpose.

B.1 Current State Assessment

Please complete the following table to provide a current state assessment of each team member's digital health capabilities.

Member	**Hospital Information System Instances** *Identify vendor and version and presence of clustering*	**Electronic Medical Record Instances** *Identify vendor and version*	**Access to other clinical information systems** *E.g., Other provincial systems such as CHRIS, or other systems to digitally store patient information*	**Access to provincial clinical viewers** *ClinicalConnect or ConnectingOntario*	**Do you provide online appointment booking?**	**Use of virtual care** *Indicate type of virtual care and rate of use by patients where known*	**Patient Access Channels** *Indicate whether you have a patience access channel and if it is accessible by your proposed Year 1 target population*
See supplementary Excel spreadsheet							

B.2 Digital Health Plans

Where gaps are identified through the current state assessment, the plans below should include an approach for addressing these gaps. As you articulate your plans please identify what non-financial support and services you will require from the Ministry or delivery organizations.

2.1 Virtual Care

Describe your plan for how you will build off your team's existing digital capabilities to further expand virtual offerings in Year 1. If some or all of the members of your team do not have virtual care capacity, what steps will you take to ensure that by the end of Year 1 your team offers one or more virtual services? Provide an assessment of how difficult it will be for your team to meet the following target: 2-5% of Year 1 patients who received care from your team had a virtual encounter in Year 1. Describe how you will determine whether your provision of virtual care is successful or not (e.g., measures of efficacy or efficiency).

Max word count: 1000. *(681/1000)*

The OHT/ÉSO has a strong foundation of existing digital capabilities to build from in year 1.

One of the primary opportunities is the locally established eConsult service. The Champlain BASE Regional eConsult Service is a secure web-based tool that allows physicians or nurse practitioners timely access to specialist advice for all patients, often eliminating the need for an in-person specialist visit. This service was established in 2010 and has since evolved in the Champlain Region, primarily supported by local specialists and resources in the region. It is part of the broader Ontario eConsult program (led by the provincial eConsult Centre of Excellence), which also includes the OTN-based eConsult service.

Currently the BASE eConsult service supports: 131 specialties; 251 specialists; and 1676 registered primary care physicians. The current utilization by participating primary care clinics, and across various specialties can serve as a baseline, particularly for the initial populations of focus. Missing specialities will need to be identified (e.g. psychiatry, geriatrics), including both hospital-based (TOH, ROH, CHEO, etc.) and community-based specialities.

The Ontario Telemedicine Network (OTN) provides virtual visit services in the region, available extensively in a number of equipped telemedicine studios. Physicians are compensated when they use this service. The South East Ottawa CHC is a regional hub hosting approximately 4000 events a year including individual and group sessions with remote specialists hosted onsite and in home with

RN/RPN. More than 25 specialties are supported, however at this point only qualifying specialists can bill for in-home virtual visits. Champlain physicians are not yet (2019-09-01) approved to be compensated for these visits. The current home-based telemed visits are limited to 500 specialists, which should expand to more specialists, and allow for deployment with primary care remote visits.

An example of OTNinvite technology that is available is wound care. The TOH Limb Preservation Clinical wound specialists are using OTN Personal Video Conferencing to assess complex wounds in community nursing clinics, long-term care, and in-home care settings where there is a home care nurse present.

TOH is a leading partner provincially with respect to the adoption of telemedicine. In fiscal 18-19, TOH specialities completed a total of 9,966 appointments. This represented a growth of 7% over the last year and we are projecting a further growth of 8% this year.

TOH is currently piloting the use of e-visit: Home Virtual Visit (HVV) in a subset of medicine and surgical divisions and will evaluate the adoption of this technology with patients, families and providers, for continued rollout. A significant number of patients used their mobile devices during the HVV appointment, and on average saved almost 4 hours of time (commuting, arranging care for dependents, etc.). More than three quarters of patients indicated that they saved up to 100 km of travel and 81% of respondents indicated that the home video experience was the same as or better than an in-person visit. There is strong support for specialists to continue offering home video to their patients as over 86% of patients stated they would 'definitely' or 'probably' use home video again. TOH will continue its rollout and evaluation of HVV implementation in pilot locations this fiscal year.

Given the existing capacity & experience of OHT/ÉSO partners with virtual care, increasing access by 2-5% of Year 1 patients who received care should exceed general population growth projections. However, inherent initial population factors (i.e. homelessness, addiction issues plus other mental health issues, as well as generational elements within the frail population) may limit the virtual care options or adoption.

Success factors identified (demonstrated use and repeat use, satisfaction, reduced travel and associate costs) gives confidence that the general trend is towards increasing use and expanded capability of virtual technology. Additionally, there are several other active and potential options for virtual care (see Champlain Supplement attached). The OHT/ÉSO may work with OTN to select and standardize a videoconferencing technology for use by the OHT/ÉSO through their 'Partner Video Proof-of-Concept' project (see Catalogue p. 26).

2.2 Digital Access to Health Information

Describe your plan for how you will build off your team's existing digital capabilities to provide patients with at least some digital access to their health information. Provide an assessment of how difficult it will be for your team to meet the following target: 10-15% of Year 1 patients who received care from your team digitally accessed their health information in Year 1.

Max word count: 1000. (205/1000)

The OHT/ÉSO has some digital health capability to provide patients with digital access to their health information. One option is the TOH patient portal via Epic: MyChart. This portal could technically provide all year 1 initial population patients with access to their hospital record, however digital access issues (i.e. digital literacy) need to be considered. Currently TOH MyChart version is limited to hospital charts only.

There is interest to expand the use of TOH MyChart, currently available to about 30,000 hospital users, through an enrollment campaign focused on engagement and teaching around what can be done with digital access. The potential exists to allow OHT/ÉSO partners to have access to the portal through Epic CareLink (ECL), enabling home care & primary care to have some form of digital access to information. Access is already available through some partners.

CHEO and some of the OHT/ÉSO partners use another version of MyChart. Patient portals are also being planned by Ottawa Public Health, Bruyère, HCC CHRIS, and CHCs via Practice Solutions. The challenge will be to not overwhelm users with a plethora of access points, but to streamline options for local residents.

2.3 Digitally Enabled Information Sharing

Describe your plan for ensuring that patient information is shared securely and digitally across the providers in your team for the purposes of integrated care delivery, planning (e.g., pooling information to understand population health needs and cost drivers, population segmentation, integrated care pathway design).

Max word count: 1000. (754/1000)

Several provider facing tools, services and programs are available across healthcare sectors that ensure patient information is shared securely and digitally. One of the more recently established mechanisms is the eNotification which provides near-real time notification when active patients present at an emergency department, are admitted or discharged from an acute care facility, or are seen by EMS. This notification information is available to Home and Community Care staff and to primary care practices who have registered to use OntarioMD's Health Report Manager platform. Across Champlain, 15 hospitals have implemented eNotification including The Ottawa Hospital and Bruyère Continuing Care.

Information about recent hospital visits enable home and community care agencies to avoid unnecessary home visits, rapidly follow-up with patients after an episode, or make alternations to the home care required by the patients after a return from an emergency department visit or hospital stay. Primary care clinicians receiving the notifications can use the information to plan appropriate ongoing care for their patients. Community support service agencies who participate in the Community Data Store and Summary reports can also receive daily hospital eNotification reports about their patients. These reports provide information about emergency department visits (registrations, discharges) and hospital in-patient admissions and discharges from the previous 24 hours.

Electronic Patient Referral (eReferral) is available through 2 platforms: Ocean & CareDove. An eReferral in an electronic communication that supports the referral process through the transfer of patient information across providers. eReferral helps to address the challenges of fragmentation across a high number of disconnected systems that make it difficult to share information (Catalogue p. 37).

In the Champlain Region, the Ocean platform, which has been chosen for primary care eReferral, is currently being deployed. The Ocean platform provides a referral 'toolbar' which integrates into compatible primary care EMRs (Telus Practice Solutions, Accuro, OSCAR) that allows the EMR user to select the target referral service and pre-populate the appropriate referral form with the relevant patient information.

At this time (2019-09-01) Ocean eReferral has been deployed or is planned for the following care pathways:

- ISAEC low-back pain rapid access clinics
- Other MSK Central Intake - foot/ankle, shoulder, knee (non-replacement)
- Cognitive Behavioural Therapy through IASP (Increasing Access to Structured Psychotherapy) central intake based at The Royal Ottawa Hospital
- Hip/knee replacement central intake (in progress)
- The Royal Ottawa Mental Health Services Central Intake (in progress)
- Home and Community Care (in development)
- MRI Central Intake (planned)
- Other Diagnostic Imaging services (planned)

The Ocean toolbar has been deployed to 55 primary care clinics (as of 2019-07-19) with 135 staff enabled for Ocean eReferral, while the Caredove eReferral platform has been adopted by 40 community support service agencies and the LHIN Home and Community Care (for limited programs) to receive referrals across the region. Through the online platform, users (patients/family, other community support service users, hospital discharge planners, primary care practices, etc.) can select a community service, determine the provider(s) of the service in a given region based on the patient's home address, and send a referral for the service including, if desired, booking the initial telephone intake appointment with the agency.

Simplified and consistent eReferral will provide more efficient, simplified and accurate transfers of patients and tracking of referrals and wait times. Use of the embedded Ocean toolbar with service-specific forms will ensure more appropriate referrals and information. Identifying and linking people to available community services is important in the ongoing care of patients, particularly for frail seniors or those with chronic conditions. The Caredove software-as-a-service platform enables this in an easy to use visual style.

The next step for ensuring patient information is shared securely and digitally across providers is for the Ottawa CHC collaborative to complete the EMR conversion from Nightingale to Practice Solutions. Four CHCs have completed the process and the others will transition in spring 2020. Nightingale/Telus PS Suite EMR data from all CHCs in the province flows to a centralized data warehouse weekly and is accessible via a centrally-managed business intelligence tool (Cognos 11 Business Intelligence Reporting Tool –

"BIRT") administered by the CHCs' provincial association (Alliance for Healthier Communities - AHC). This includes a MSAA dashboard & Primary Care dashboard. BI dashboards/reports can be developed by individual CHCs, but the core data team and capacity are at the provincial level.
Using all of the available tools, services & programs (along with those found in the Supplement) will allow digitally enabled information sharing not only for the initial populations, but across Ottawa and even the province. As an example, all OHT/ÉSO convening partners have access to Connecting Ontario.

2.4 Digitally Enabled Quality Improvement

Describe how the members of your team currently use digital health tools and information to drive quality and performance improvement. How will your team build off this experience and capability so that it exists at the team-level?

Max word count: 500. (497/500)

A key resource for the OHT/ÉSO is the Champlain Business Intelligence Data Warehouse and Reporting tools. This business intelligence (BI) data warehouse has been established to capture and consolidate service usage and cost information from a range of health service providers across the Champlain region. Reporting tools & subscription reporting services are available. The data warehouse may be used for program evaluation and/or health service and program planning. To date the BI data warehouse has encompassed:

- Home and community care patient and service information
- Community support services information
- Acute care information from all regional hospitals for Health Links patients

All OHTs will require an integrated database of health care patient, service usage and performance information for ongoing program evaluation, OHT performance assessment, and quality improvement. Ideally this will be an integrated database of health data across all OHT service sectors. The current BI data warehouse may be used to form the core of an OHTs planning warehouse and extended to incorporate all OHT participating organizations and their data. It will be important for the OHT/ÉSO to collectively maintain this ability in partnership with other local OHTs.

For over 20 years OHT/ÉSO partners have captured and reported on data within their centres. All funded partners are required to submit statistics on the volume of service, quality of the service and the outcomes to funders.

Using a common data framework, primary & community staff are entering data in PS Suite EMR in a standardized way to better understand the care patients/clients receive at the centre. This data is reviewed by the team to ensure accuracy in the information and to benchmark against the Provincial targets. Processes are in place to assist team members improve on their performance and share best practices with others within the organization.

Each year OHT/ÉSO partners are responsible for creating quality improvement plans that are dependent on data captured within the digital health tools. Teams within each organization review historical numbers and determine areas for improvement. These targets are reviewed quarterly. Data management and decision support tools include:

- Practice profiles with linked performance data
- Dashboards and shared performance metrics
- Sharing and adoption of clinical best practices and EMR prompts
- Hospital Report Manager
- Regional supports (BI, IDS, etc)

Additionally, all eConsult/eReferral/OTN/ConnectingOntario/IDS/CHRIS/PrescribeIT data elements are tracked. These can be used to identify both high & low users and develop tailored solutions to meet provider needs. Further, as the initial populations are concretely defined, current use for these individuals could be used as the numerator to identify the gap and track progression towards these tools being used on behalf of priority patients. These tools also inherently include quality assurance in terms of eligibility, critical & timely information, and feedback loops which limit historic communication loops, lost information & inappropriate referrals. A primary aim will be to expand these eServices both across providers and within specialties/access points.

Continuous quality improvement will be a priority of the OHT/ÉSO.

2.5 Other digital health plans

Please describe any additional information on digital health plans that are not captured in the previous sections.

Max word count: 500. (497/500)

Client and related community service information may be contributed by community support service (CSS) agencies to the regional Community Data Store for assembly into a single summary report encompassing all community and home and community care (from the provincial CHRIS). These reports are updated and delivered to the participating agencies on a weekly basis using a secure file distribution mechanism to all participating agencies. Twenty-one agencies currently (2019-09-01) participate in the program as well as the LHIN Home and Community Care. The information is now available to Shared Service Operation (SSO) CSS agencies, but a pilot is underway to finalize an access mechanism for non-SSO community agencies. Additional information will be provided as this work progresses. CSS Agencies who participate in the Community Data Store and Summary reports may also receive daily hospital eNotification reports about their patients. These reports provide information about emergency department visits (registrations, discharges) and hospital in-patient admissions and discharges from the previous 24 hours. The ability to see a full, integrated view of all home care and community services for clients is important to the ongoing support for patients. Acute care and primary care decisions may be influenced by the availability of (or identified need for) ongoing service in the home.

Home Care On-line Self-Screener and eReferral - Patients, family members or clinicians can complete an InterRAI Preliminary Screener (with simplified wording for non-clinician use) to assess their eligibility for home care services. Patients, support family members or clinicians are empowered to self-assess and determine if the potential patients are likely to qualify for home care services. Those at lower acuity levels may be identified and referred to community support services agencies. In addition to the assessment, this information may be submitted on-line with patient contact information to begin the full home care of community services intake process. The on-line tool provides a more efficient mechanism for triaging incoming referrals between Home and Community Care services and community support services.

In-home tele-rehabilitation services are provided through in-home deployment of Jintronix software, supporting hardware and wireless internet services. Currently being used for post-stroke rehab (although exercise exist for other conditions), the installation walks patients through an assigned program of exercise designed by the Physiotherapist while tracking their progress using 3D sensor technology. Not only are the uses of the system tracked, but the results (patient uses, success rates) are provided to the remote PT who may increase the intensity of the exercise or assign additional exercises. The Jintronix software is a Health Canada approved therapy

rehab application. Use by participants in the post-stroke in-home rehab program have demonstrated increased compliance and frequency of use with their assigned exercise programs.

B.3 Who is the single point of contact for digital health on your team?

Please identify a single point of contact who will be the responsible for leading the implementation of digital health activities for your team.