# Ontario Health Teams
# Full Application Form

## Introduction

Thank you for your interest and effort to date in becoming an Ontario Health Team.

Ontario Health Teams will help to transform the provincial health care landscape. By building high-performing integrated care delivery systems across Ontario that provide seamless, fully coordinated care for patients, Ontario Health Teams will help achieve better outcomes for patients, improved population health, and better value for the province.

Based on the evaluation of Self-Assessment submissions, your team has been invited to submit a Full Application, which is the next stage of the Ontario Health Team Readiness Assessment process.

In the Self-Assessment stage, your team collectively assessed its ability to meet the minimum readiness criteria to become an Ontario Health Team, as set out in *'Ontario Health Teams: Guidance for Health Care Providers and Organizations'* (Guidance Document). This Full Application builds off the Self-Assessment. In this stage, your team is being asked to propose plans and provide detailed **evidence** of what you previously assessed that you could do.

This application form consists of seven sections and two appendices:

1. About your population
2. About your team
3. How will you transform care?
4. How will your team work together?
5. How will your team learn and improve?
6. Implementation planning and risk analysis
7. Membership Approval

Appendix A: Home & Community Care
Appendix B: Digital Health

The form is designed to provide reviewers with a complete and comprehensive understanding of your team and its capabilities and capacity. **The questions in this form are aligned to the eight components of the Ontario Health Team model and the corresponding minimum readiness criteria set out in the Guidance Document.** For any readiness criteria in the Guidance Document that referenced:

- your ability to propose a plan, you are now asked to **provide that plan**;
- a commitment, you are asked to **provide evidence** of past actions aligned with that commitment; and



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- a demonstrated track record or ability, you are asked to **provide evidence** of this ability.

Please read and fully respond to the questions. Clear, specific responses and the use of verifiable examples and evidence are encouraged.

Note that a core component of the Ontario Health Team model is alignment with the *Patient Declaration of Values for Ontario*, as well as comprehensive community engagement. This form includes discrete questions related to patient partnership and community engagement, but your team is also encouraged to consider patient, family and caregiver perspectives and opportunities for patient partnership and community engagement throughout your submission.

The Readiness Assessment process will be repeated until full provincial scale is achieved. The first group of Ontario Health Team Candidates will help set the course for the model's implementation across the rest of the province. Although the core components of the model will remain in place over time, lessons learned by these initial teams will help to refine the model and implementation approach and will provide valuable information on how best to support subsequent teams. The first Ontario Health Team Candidates will be selected not only on the basis of their readiness and capacity to successfully execute the model as set out in the Guidance Document, but also their willingness to champion the model for the rest of the province.

Applications will be evaluated by third-party reviewers and the Ministry of Health (the Ministry or MOH) according to standard criteria that reflect the readiness and ability of teams to successfully implement the model and meet Year 1 expectations for Ontario Health Team Candidates, as set out in the Guidance Document.

Following evaluation of the Full Application there are two possible outcomes. Teams will either: 1) be invited to move to the final stage of evaluation, or 2) continue to work towards readiness as a team 'In Development'. Those teams that are evaluated as being most ready to move to the final stage of evaluation may also be invited to participate in community visits, which will then further inform the final selection of the first cohort of Ontario Health Team Candidates.

## Information to Support the Application Completion

Strengthening the health care system through a transformational initiative of this size will take time, but at maturity, Ontario Health Teams will be responsible for delivering a full and coordinated continuum of care to a defined population of Ontario residents, and will be accountable for the health outcomes and health care costs of that population. Identifying the population for which an Ontario Health Team is responsible requires residents to be **attributed** to care providers and the method for doing so is based on

analytics conducted by ICES. ICES has identified naturally occurring networks of residents and providers in Ontario based on an analysis of existing patient flow patterns. These networks reflect and respect the health care-seeking-behaviour of residents and describe the linkages among residents, physicians, and hospitals. An Ontario Health Team does not have to take any action for residents to be attributed to their Team. As per the ICES methodology:[1]

- Every Ontario resident is linked to their usual primary care provider;
- Every primary care physician is linked to the hospital where most of their patients are admitted for non-maternal medical care; and
- Every specialist is linked to the hospital where he or she performs the most inpatient services.

Ontario residents are not attributed based on where they live, but rather on how they access care which is important to ensure current patient-provider partnerships are maintained. However, maps have been created to illustrate patient flow patterns and natural linkages between providers which will help inform discussions regarding ideal provider partnerships. While Ontario Health Teams will be responsible for the health outcomes and health care costs of the entire attributed population of one or more networks of care, there will be no restrictions on where residents can receive care. The resident profile attributed to an Ontario Health Team is dynamic and subject to change over time as residents move and potentially change where they access care.

To help you complete this application, your team will be provided information about your attributed population.

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

## Participation in Central Program Evaluation

To inform rapid cycle learning, model refinement, and ongoing implementation, an independent evaluator will conduct a **central program evaluation** of Ontario Health Teams on behalf of the Ministry. This evaluation will focus on the development and implementation activities and outcomes achieved by Ontario Health Team Candidates and a selection of teams In Development. Teams are asked to indicate a contact person for evaluation purposes.

[1] Stukel TA, Glazier RH, Schultz SE, Guan J, Zagorski BM, Gozdyra P, Henry DA. Multispecialty physician networks in Ontario. Open Med. 2013 May 14;7(2):e40-55.

## Additional Notes

- Details on how to submit your application will be provided by the Ministry.
- Word limits are noted for each section or question.
- Up to 20 pages of additional supplementary documentation are permitted; however, supplementary documentation is for informational purposes only and does not count towards the evaluation of applications.
- To access a central program of supports coordinated by the Ministry, please visit: http://health.gov.on.ca/en/pro/programs/connectedcare/oht/default.aspx or reach out to your Ministry point of contact.
- The costs of preparing and submitting a Self-Assessment and a Full Application or otherwise participating in this Ontario Health Team Readiness Assessment process (the "Application Process") are solely the responsibility of the applicant(s) (i.e., the proposed Ontario Health Team members who are signatory to this document).
- The Ministry will not be responsible for any expenses or liabilities related to the Application Process.
- This Application Process is not intended to create any contractual or other legally enforceable obligation on the Ministry (including the Minister and any other officer, employee or agency of the Government of Ontario), the applicant or anyone else.
- The Ministry is bound by the *Freedom of Information and Protection of Privacy Act (*FIPPA) and information in applications submitted to the Ministry may be subject to disclosure in accordance with that Act. If you believe that any of the information that you submit to the Ministry contains information referred to in s. 17(1) of FIPPA, you must clearly mark this information "confidential" and indicate why the information is confidential in accordance with s. 17 of FIPPA. The Ministry would not disclose information marked as "confidential" unless required by law.

  In addition, the Ministry may disclose the names of any applicants for the purposes of public communication and sector awareness of prospective teams.
- Applications are accepted by the Ministry only on condition that an applicant submitting an application thereby agrees to all of the above conditions and agrees that any information submitted may be shared with any agency of Ontario.

# Ontario Health Teams
# Full Application Form

## Key Contact Information

| | |
|---|---|
| **Primary contact for this application**<br>*Please indicate an individual who the Ministry can contact with questions regarding this application and next steps* | Name: Bill Davidson |
| | Title: Executive Director |
| | Organization: Langs Farm Village Community Health Centre |
| | Email: billd@langs.org |
| | Phone: 519-653-1470 ext. 236 |
| **Contact for central program evaluation**<br>*Please indicate an individual who the Central Program Evaluation team can contact for follow up* | Name: Bill Davidson |
| | Title: Executive Director |
| | Organization: Langs Farm Village Community Health Centre |
| | Email: billd@langs.org |
| | Phone: 519-653-1470 ext. 236 |

## 1. 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[2] 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.

[2] '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.

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*

Overview of Population at Maturity

The proposed geography of the Cambridge North Dumfries (CND) sub-region includes a total population of around 143,000, representing the urban community of Cambridge (~ 133,000) and the rural township of North Dumfries (~10,000). This geography aligns with existing municipal boundaries the healthcare utilization patterns as identified in the Ministry of Health (MOH) attribution model.
The demographic profile of CND mirrors Ontario overall: 14.5% of the population are over 65; 10.3% are below the low-income measure; 19.8% are immigrants; and 6.3% are unemployed. Seniors represent 14.5% of the total population in Cambridge, and 14.3% of the population in North Dumfries. The MOH data package indicates a slightly higher portion of our attributed population over the age 65 (15.9%). Seniors (people 65 and over) are a growing segment of the population with a 22.4% increase of seniors in Cambridge and a 21.3% increase in North Dumfries since 2011.
Most residents in Cambridge (79.1%) and North Dumfries (88.9%) identify English as their mother tongue - higher than the percentage in Waterloo Region (75%) and Canada (57.3%). 1.2% of Cambridge and 0.9% of North Dumfries residents report French as their mother tongue, which is lower than Ontario (3.8%) and Canada (23.9%). Although each group represents a small proportion of the total population, among the mother tongues reported most often by residents of Cambridge and North Dumfries are Portuguese, Punjabi, German, Spanish, and Dutch (Cambridge: Portuguese 4.5%, Gujarati 1.0%, Punjabi 1.2%, Spanish 1.1%, Urdu 0.9%. North Dumfries: Portuguese 2.6%, German 1.4%, Dutch 0.9%, Polish 0.8%, Italian 0.5%) (Cambridge North Dumfries Community Trends Report 2018, Social Planning Council of Cambridge North Dumfries).

Alignment of Geographic and Attributed Population

The demographic profile of the geographic CND population is largely consistent with the profile of our attributed population, provided in the MOH data package. Data on the CND attributed population from MOH indicates that about 71% of the attributed population live in Cambridge and North Dumfries, and another 10.3% live in nearby Kitchener-Waterloo, with the remaining 18.5% living in other surrounding communities. The distribution of patients in other communities can be accounted for by employment patterns (e.g. many people may choose to see a primary care provider close their work, but live in surrounding communities), migration patterns (e.g. individuals move from the CND sub-region, but wish to retain their relationship with their existing primary care provider or have not yet found a primary care provider in their new location), or are temporarily living in other locations (e.g. for school, temporary work, etc.), and have maintained their existing primary care provider.

Opportunities and Challenges

Our proposed primary care-based enrollment population methodology is highly aligned with MOH methodology for the Ontario Health Team (OHT) attribution model, as patient residence does not affect our ability to identify and serve our target population for our Year 1 target and maturity populations. Although about 97% of patients in CND are attached to a primary care provider (Primary Care Capacity Review, WWLHIN, 2015), unattached individuals will be able to receive OHT services through multiple entry points across Members and Affiliate Members and other partners across the community. The Langs Interprofessional Care (IPC) team will roster complex vulnerable patients that typically are not attached to other primary care providers. Our current slate of Members and Affiliate Member represents eleven health, community, social services, and municipal subsectors. This multi-sectoral network provides the opportunity to reach individuals that might not routinely seek care and services through a primary care provider.
Given that about 18.5% of our attributed population lives in other communities, and that 38% of acute separations occurred at hospital other than Cambridge Memorial Hospital (CMH) will be important for CND to establish formal relationships and aligned care pathways with other OHTs to ensure that, when attributed patients seek care and services through other OHTs, there is both continuity of care and services across OHTs, and also a degree of alignment and standardization to support seamless transitions. We will also need to work closely with other OHT's to identify mechanisms for population health planning and implementing mechanisms for shared accountabilities and resource allocation for our shared populations, particularly for OHT patients in North Dumfires, where residents access services in four other municipalities due to proximity.

Population Health Experience

Population health management uses aggregated, individual-level data to direct health resources and assess key population-level outcome indicators. We believe that the population health management approach is strengthened by also considering indicators for multiple determinants of health. The second key aspect of population health management approach is the strategic application of resources across an integrated health delivery system to maximize health outcomes and optimize the value of resource investments.
Collaboratively, the Member and Affiliate Members have several years of experience applying aspects of a population management approach, including our Member Family Health Teams (FHTs), the Waterloo Region Nurse Practitioner-Led Clinic (WRNPLC), Langs Community Health Centre (CHC) and CMH. Further our Members and Affiliate Members have worked on collaborative initiatives that have adopted a population health approach, including Health Links and the Connectivity Table. Section 2.4 demonstrates a number of these initiatives.
Our Members and Affiliate Members have adopted a Social Determinants of Health (SDOH) framework and routinely use population health data to understand the health status and outcomes of the populations they serve. These partnerships routinely leverage data from their own systems, CMH, Public Health, and the WWLHIN to identify populations needs and implement integrated services and programs designed to improve health outcomes and patient experience.
The members historically have been limited in our capacity to apply a full population health approach because of organizational, structural, and policy constraints that prevent the mobility of resources across organizational or sector boundaries. The OHT model provides an expanded opportunity for our current and future members to apply this experience across an integrated health delivery system to leverage population health data to mobilize resources more effectively across all our care and service delivery partners to better address population health needs and improve outcomes.

### 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*

Year 1 Base Target Population: Primary Care-based Model

The Year 1 base target population will be the rostered patients of five primary care practices within the network of healthcare providers identified through the attributed population model provided by MOH, including the WRNPLC, Langs CHC, the Two Rivers FHT and the Grandview Medial Centre FHTs and their associated Family Health Organizations (FHOs), and the Delta FHO. Together these primary care practices roster about 76,000 patients, or 51% of our attributed population. We have identified this approach for the Year 1 target population for several reasons:

i) A primary care-based target population provides the foundation for the primary care "home" that will be the basis for the proposed CND OHT model of care. The primary care-based target population will also enable CND OHT Members and Affiliate Members to re-design and evaluate an interdisciplinary, primary care-based model that could be scaled across the scope of the entire future CND OHT. Our Members and Affiliate Members have identified a significant portion of the clients are rostered within the five primary care practices comprise the Year 1 base population.

ii) Our Year 1 model will allow our OHT to reach individuals frequently not rostered in primary care services (e.g. vulnerable/at-risk populations) through our Members, Affiliate Members, and other community partners, as well as through our existing the Interprofessional Care Model (see Section 2.4).

iii) The Year 1 population covers a significant portion of the maturity population and provides a meaningful baseline to develop and apply a population health planning approach, while remaining a manageable size for learning, evaluating and adapting re-designed integrated care and service models. Leveraging primary care rosters will allow CND OHT to identify and track patients and enroll the Year 1 population to support a population health planning approach. Population health metrics for unattached individuals can also be monitored and evaluated through Affiliate Member and other partners, including the Interprofessional Care Model.

Year 1 Target Sub-Population Focus: Focus on Ending Hallway Healthcare

While the Year 1 target population base will include the rostered patients within the five Member primary care organizations, there will be a focus on re-designing care coordination, system navigation and integrated services targeted at frail/elderly and

medically complex individuals, and individuals that need patient-centred, wraparound mental health and addictions (MH&A) services to help address complex factors that contribute to hallway healthcare. Our Year 1 Members includes primary care, hospital, home and community care (H&CC), long-term care, palliative, community support services (CSSs), MH&A, and supports for individuals with acquired brain injury. The mix of Member organizations provides the opportunity to collaboratively address the complex factors that contribute to ALC.

1. Aging, Frail and Medically Complex Individuals

Like most communities in Ontario and Canada, the population of CND is aging. 15.9% of our attributed population is currently 65 years of age or older. The demand for services and care to meet the needs of aging individuals will continue to increase over the next 10 to 20 years. Since the previous census, the fastest growing age group Cambridge is 65-69 cohort with a 32.4% increase, followed by the 70-74 year-old cohort, which grew by 23.3%. It is expect that in CND, individuals over the age of 85 will account for 2.25% of the total population by 2026 (Shaping Waterloo Region's Urban Communities Report).

An aging population and their associated health conditions and service needs puts additional demand on hospital services, which increases ALC days and contributes to hallway healthcare and are a key cost driver for the CND local health system. Patients in the CND attributed population had an average of ALC length of stay of 9.4 days which, while considerably below the Ontario average ALC length of stay of 19.1 days, represents a significant cost driver for the system, with 4,846 ALC days in 2017/18. While CND continues to perform well against provincial averages, our sub-region has seen a trend toward fluctuating ALC percentage of total inpatient days consistent with the provincial trend, ranging from 6.2% to 10.6% in 2017/18. Increased ALC pressures have been experienced in 2019/20 – with the hospital experiencing record high demand in recent months.

Dementia and Palliative State (Acute) represent the two single largest cost categories by health profile group for our attributed population, representing $36.2M and $22.8M respectively. Expanding a palliative approach to care can not only facilitate individuals dying in a place of choice, but can also reduce costs associated with acute end-of-life care. Wait-times for long-term care also continue to increase, aligned with provincial trends. In Q4 2017/18 the median time to placement from community was 143 days and from hospital was 182 days. While the recently announced investments in long-term care beds will help reduce these wait-times in the future, our Members will address strategies to improve care and outcomes for individuals and their families/caregiver waiting for LTC beds.

2. Individuals with MH&A Conditions

Individuals with one or more mental health conditions are frequent users of the ED. Repeat ED visits within 30 days for mental health and substance abuse conditions was 24.1% in Q4 2017/18.

Individuals with MH&A issues face multiple challenges in accessing care and services in the community. We know that individuals with repeat ED visits for MH&A issues are frequently not connected to ongoing care. Many services, such as psychiatry, support

coordination and assertive community treatment, have long wait-times. There are currently 523 people waiting for ongoing care in NCD across 21 different services (Here24/7 Service Volumes Overview, Sept 2019). Our Members and Affiliate Members and other community partners will build on their previous experience working collaboratively together to improve access to integrated wraparound mental health and addictions services, including providing a primary care-based psychiatrist, increasing access to MH&A integrated services through collaboration among primary care and MH&A community partners, and creating community-based access to addictions specialist services through the Rapid Access Addiction Clinic. These services have historically not been available to our residents, or have been difficult for patients to access.

### 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: 1000*

*Where known, provide information (e.g., demographics, health status) about the following populations within your Year 1 and attributed populations. Note that this information is not provided in your data support package. LHIN Sub-Region data is an acceptable proxy.[3] Other information sources may also be used if cited.*

- Indigenous populations
- Francophone populations
- Where applicable, additional populations with unique health needs/status due to socio-demographic factors

The socio-economic status of the CND population is similar to that of other regions of South-Western Ontario. Despite having a relatively high average household income of $82,710, CND also has significant representation of populations who traditionally have experienced barriers of access to care such as:

- People with limited knowledge of English or French – 1.5%
- People who have French as the first language – 1.6%
- People who immigrated to Canada – 19.8%
- People who recently immigrated to Canada– 1.6%
- People who self-identify as Indigenous – 1.9%
- People without a high-school diploma – 14.9%

[3] Sub-region data was provided by the MOH to the LHINs in Fall 2018 as part of the Environmental Scan to support Integrated Health Service Plans. This data is available by request from your LHIN or from the MOH.

- People living below the low-income cut-off – 11.6%
- Seniors living below the low-income cut-off – 6.4%
- People whose households are in need of major repair – 6.0%

Although the demographics of our community suggests a high degree of people with barriers to access, we have nonetheless been able to achieve a high rate of attachment to primary care at about 97% as of 2015. The majority of our patients are already connected to and well serviced by their primary care providers. Information gathered from homeless shelters, food banks, addiction services, mobile safe kit vans, and other community-based health and social service agencies shows that users of these services have the least access to care. It is estimated that 50% to 70% of these health and social services users are not attached to a primary care provider. This estimate is aligned with a Health Analytics Branch sub-regional analysis which identified 1,650 complex and high-cost CND residents who were unattached to primary care.

Key Barriers for Vulnerable Populations Accessing Primary Care

Some of the key barriers that prevent patients from accessing or receiving primary care include:

- Poverty
- Lack of transportation to attend appointments
- Feelings of being judged
- Lack of formal identification (e.g. health cards)
- Mental health, addictions, or brain injury issues hindering ability to or interest in seeking care
- Mobility challenges

We anticipate the OHT model will continue to incorporate and build on existing initiatives targeted at vulnerable populations, such as the Inter-Professional Care model and the Hospice Palliative Community team that links patients at end-of life who are not able connect with a primary care provider. We believe that this model will be effective in closing the care gap for our residents with significant health inequities as it will enable strengthened connections between primary care providers and our social and community service providers.

Key Barriers for Indigenous Residents

The Indigenous community in Waterloo Wellington is comprised of a richly diverse group of people gathered from the north, south, east and west reaches of Canada. There is no single “Indigenous” Waterloo Wellington or the Cambridge North Dumfries Sub-Region. This estimate population figures above are believed to be a low representation of the true population, as many Indigenous people choose not to participate in the census. There are many factors contributing to the uncertainty of the Indigenous population including reluctance, fear, and caution of some Indigenous people to identify in surveys

and censuses; the tendency to move between urban settings and reserve; and, shared housing, homelessness or transient housing.
In spite of the lower average age of the Indigenous population, a 2011 study in the Waterloo Wellington Region indicated that the incidence of chronic health conditions was higher among Indigenous residents for all long-term health conditions for which comparative data were available. Estimated rates of asthma (17% vs. 7.9%), diabetes (7.5% vs. 3.9%) and chronic bronchitis (7% vs. 2%) were about twice as high for Indigenous residents as compared to the total population in the service area. There are several Indigenous-specific social determinants of health, including the experience of colonization; access to culture and traditional knowledge; connection to land; autonomy and self-determination; and holistic models of Indigenous health.
While there are some services specific to indigenous residents, there remains a significant gap in culturally-specific and safe services. A significant barrier to accessing mainstream services experienced by Indigenous community members is the lack of respect and understanding by service providers related to Indigenous healing and cleansing practices, including smudging, use of sweat lodges, and drumming. Many of the community members report having experienced discrimination when talking about the use of traditional medicines and spiritual practices to supplement mainstream treatments.
We know that current gaps include both access to Indigenous specific services and non-indigenous health care services. (Reference: Indigenous Wellness Services in Waterloo Wellington: Needs and Vision, Sustainable Societies Consulting Group, 2017).

Key Barriers for Francophones

In a geographical area like CND with a smaller Francophone community, recruitment and retention of bilingual health human resources can be challenging. As such, it is often difficult for Francophone or primarily French speaking populations to access services, particularly in communities like CND which have a smaller Francophone and French speaking population.

Key Barriers for LGBTQ+ Residents

Many LGBTQ+ people are unable to find services in their area, encounter discrimination or refusals of service in healthcare settings, or delay or forego care because of concerns of mistreatment. While many of our partners have implemented safe-spaces and programs for LGBTQ+ people, there are still barriers that need to be addressed.

Additional Opportunities for Improvement

Social Determinants of Health (SDOH) are foundational to our vision and model

because healthcare and SDOH are not independent of one another, particularly for our vulnerable patients. Our Planning Partners recognize that addressing SDOH is an essential strategy for improving the health and well-being our attributed population. In addition to improving attachment to primary care for our vulnerable patients, we also anticipate strengthening the wrap-around services that we are able to provide our vulnerable patients. Our OHT includes as Members and Affiliate Members a range of service providers providing mental health, brain injury support addictions support, and social and community services (such as housing support, foodbanks, etc.). We aim to provide our community members with improved access to community and social services by enhancing care integration through colocation, integrated intake and assessment, and warm transitions both within the community and social services sectors, and within healthcare settings. Through the inclusion of the range of social and community supports available in CND, as well as healthcare supports, we anticipate being better able to meet the continuum of needs of our vulnerable patients including their social determinants of health.

## 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[4] | Number of Physicians | Number of Physician FTEs | Practice Size | Other |
|---|---|---|---|---|---|

[4] 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.

| | | | | | |
|---|---|---|---|---|---|
| *Provide the name of the participating physician or physician group, **as registered with the Ministry**.*<br><br>*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.*<br><br>*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 participating* | *Please indicate which practice model the physician(s) work in (see footnote for list of models)* | *For participating physician groups, please indicate the number of physicians who are part of the group* | *For participating physician groups, please indicate the number of physician FTEs* | *For participating physicians, please indicate current practice size (i.e., active patient base); participating physician groups should indicate the practice size for the entire group.* | *If the listed physician or physician group works in a practice model that is not listed, please indicate the model type here.*<br><br>*Note here if a FHT is a member but not its associated physician practice(s) .*<br>*Also note here if a physician practice is a member by not its associated FHT (as applicable).* |

| | | | | | |
|---|---|---|---|---|---|
| *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[5] | 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*

Building on more than five years of experience with the Health Link/Sub-Region Planning Table, 31 health and community partner organizations (the "Planning Partners") representing 11 sub-subsectors in CND came together prior to the announcement of the government's OHT strategy to collaboratively plan and identify strategic priorities and opportunities to further the government's agenda of health system reform.

Following the announcement of the OHT strategy, the planning group was formalized as the Cambridge North Dumfries Ontario Health Team Planning Partners, and

[5] 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

focused on planning and designing the CND OHT. The Planning Partners agreed on the importance of a primary care-based model aligned with hospital, H&CC services, and long term care to respond to the government's priority of ending hallway healthcare, and to address the pressing health and social needs of the CND community which were identified through analysis of available population health data.

The composition of our Year 1 Members includes primary care, hospital, H&CC, long-term care, palliative, community support services (CSSs), MH&A, and supports for individuals with acquired brain injury. The mix of Member organizations provides the opportunity to collaboratively address the complex factors that contribute to ALC in Year 1, and also provide a strategic opportunity to integrate care coordination, and integrated services across a broad continuum of care.
In addition to the original 31 Planning Partners, we have engaged other interested physicians, specialists, health and social service organizations through a variety of consultation mechanisms, including nine on-site meetings with primary care practices, two clinician engagement sessions, a session for home and community care service providers, and digital health solutions providers, and a variety of one-on-one discussions led by members of a smaller Planning Partner leadership team.

The Planning Partners completed a series of meetings including five co-design workshops focused on a) governance, b) H&CC, c) care coordination and system navigation, and d) digital health to further design the integration and service priorities and tactics for a primary-care based model.

The Governance Co-Design Group developed the framework outlining Member and Affiliate Member roles, responsibilities, and commitments to help prospective members understand the specific roles and required commitments in Year 1.

Based on their organizational readiness and their relevance to Year 1 service transformation and integration priorities, Planning Partner organizations self-identified as Member or Affiliate organizations (see description of Member and Affiliate Member roles/accountabilities in Section 4.2), recognizing that many affiliate Members will transition to Members in Year 2 or future years.

Although Affiliate Members will not be party to the accountability agreement with MOH/Ontario Health (OH) and the joint Member agreement, they have indicated their commitment to be fully engaged in the ongoing design, planning, and implementation of the service delivery and transformation strategies, and to continue to build on existing integration initiatives. We expect that some Affiliate Members will be full participants in the re-design and delivery of integrated services within Year 1.

### 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)** | **Form of affiliation** *Indicate whether* | **Reason for affiliation** |
|---|---|---|---|

| | | | |
|---|---|---|---|
| | *List the other teams that the member has signed on to or agreed to work with* | *the member is a signatory member of the other team(s) or another form of 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*

All Year 1 Members and Affiliate Members of CND OHT have extensive experience working together in collaborative governance models, service integration and transformation, and collaborative quality improvement initiatives for three or more years. Examples include;

Collaborative Governance and Integration Planning Bodies

1. CND Sub-Region Planning Table (formerly the Health Link Steering Committee)
The CND Sub-Region Planning Table was established in 2013 to plan and direct Health Link initiatives. Eighteen member organizations identify priorities for collaborative

system planning, and form working groups to implement the change activities. Participation at the table requires commitment to coordinated care planning, the Connectivity Table, joint governors engagement sessions and other system transformation initiatives outlined below.
Partners: CND Health Link, Cambridge Self-Help Foodbank, , Dr. Chris Dissanayake, CMH, Community Support Connections (CSC), Dr. Kunuk Rhee, Dr. Russ Ashton, Dr. Diane Humphrey, Dr. Elaine Parker, Paula Carere (Nurse Practitioner, WRNPLC), Fairview Mennonite Homes, Hospice of Waterloo Region, House of Friendship, Langs CHC, Lutherwood, Regional Municipality of Waterloo, Stonehenge Therapeutic Community, Thresholds Supports, Two Rivers FHT, Waterloo Wellington Canadian Mental Health Association (CMHA WW), WWLHIN H&CC Services, and 5 others.

2. MH&A Leadership Advisory Group
Group of CEO's and Directors from partner MH&A organizations was established to provide strategic guidance, resource mobilization and organization commitment for the initiatives planned by the CND MH&A Working Group (see below). The CND MH&A Leadership Advisory Group developed a joint Plan of Action for 2018 – 2020 identifying four Lines of Action for MH&A services in CND. This document forms the basis of a shared accountability mechanism between partners, and is reviewed annually to gauge progress toward commitments.
Partners: Langs, CMH, CMHA WW, Stonehenge Therapeutic Community, House of Friendship

3. The MH&A Working Group
This working group of the CND Sub-Region Planning Table includes management and front-line staff from partner MH&A organizations. Established in 2016, their mandate is identifying and operationalizing opportunities MH&A service integration, particularly into primary care. The partners have leveraged the Working Group to adopt the Integrated Tiered Framework (Rush, 2010) across partner agencies and have mapped an inventory of MH&A services in CND, which was used expand access to MH&A services for FHO patients.
The MH&A Working Group has developed two annual Collaborative Quality Improvement Plans (QIPs) (2016-17; 2017-18). Partner organizations are accountable for these targets individually and in collaboration with partners through organizational board commitments, and the CND Sub-Region Planning Table.
Partners include: Langs CHC, CMH, CMHA WW, CMH, WWLHIN (H&CC), WRNPLC, Two Rivers FHT. Heritage FHO, Grandview Medical Centre FHT, Stonehenge Therapeutic Community, House of Friendship, Lutherwood.
Related Integration Initiatives:
• Children's Mental Health in Primary Care – Lutherwood/Front Door provides a children's mental health worker in 3 primary care setting in CND.
• Connectivity Cambridge (Situation Table) – Addresses acutely elevated risk within 24 to 48 hours by implementing wrap around services for individuals and families – Improves coordination between health and social service agencies to enhance access to services and share information and resources amongst healthcare providers. Approximately 25 health and social service agencies. Reduced police calls for service

by 74% and reduced ED visits by 41.5%.
• Integrated Acute Brain Injury (ABI) Services – Integrated ABI Services with single point of access designed by the ABI Steering Committee under the umbrella of the WWLHIN Rehab Council. Improves access to and coordination of brain injury services, caregiver support and primary care training on brain injury.
• Community Psychiatry Services – Pilot project providing CMH psychiatry services onsite at Langs CHC and WRNPLC to increase access to mental health supports.
• Health Connect Counselling partners – a network of six MH&A agencies and 52 physicians (7 physicians in CND) that increase access to services.

4. The Primary Care Collaborative Working Group

The Primary Care Collaborative was established in 2017 and includes physician and nurse practitioner representatives from six primary care practices in CND working together to strengthen cross-practice collaborations. The collaborative has identified several key priorities, including improving next day/same access to primary care, reducing inappropriate ED visits, and increasing access to MH&A primary care-based services. In 2018, the Primary Care collaborative developed an inventory of next/same access across primary care clinics in CND to identify potential opportunities for collaboration and alignment. This work will be leveraged in Year 1 to optimize after-hours primary care access.
Partners include: Langs, Grandview Medical Centre FHT, Two Rivers FHT, WRNPLC, Delta Coronation FHO, Heritage FHO
Related Initiatives
• Primary Care Memory Clinic initiative – Various CND practices are implementing memory clinics to build capacity for improved dementia care within primary care to help reduce ED visits, ALC and premature entry into LTC for patients with memory difficulties.
• CMHA WW and Two Rivers FHT initiated pilot in 2018 to enhance access for patients with complex MH&A needs and high socio-economic barriers, including access to FACTT, consults, case conferencing and system navigation support.

5. Discharge Planning Working Group

The Discharge Planning Working Group includes representatives from hospital, primary care, H&CC, and community pharmacies, and is focused on standardizing and strengthening discharge processes and patient experiences.
Partners include: Langs, CMH, WWLHIN (H&CC), WRNPLC, Two Rivers FHT, and 3 other groups
• Community-based medical reconciliation pilot – Pilot to identify recently discharged patients with complex medication needs and work with community-based pharmacists to provide medication reconciliation in the home. In the pilot cohort, 70% had medication errors or issues that required further review.
• CHF Management Working Group – Focus on integration of health failure management services and support in CND. Partners: CMH, Cambridge Cardiac Care Centre (CCCC), Two Rivers FHT, Grandview Medical Centre FHT.

Integration Initiatives to Improve Quality, Access, Transitions and the Patient Experience

1. Mental Health Integration Initiatives: Here24/7 Single Front Door to Mental Health, Addictions, and Crisis Services

Here24/7 provides centralized, coordinated intake and access for MH&A services in CND and across the Waterloo Wellington Region. It allows patients to easily access and navigate the services of 12 local agencies through common intake, assessment, referral, crisis management, waitlisting and appointment bookings for all partner programs. This service is available 24/7, and offers drop-in services at 5 sites across the region.

Partners include: Delivered by CMHA WW in partnership with all MH&A service providers in CND and across Waterloo Wellington.

Other MH&A Integration Initiatives:

• Lead Agency Advisory Council for Children's Mental Health – Collaborative planning body among children and youth mental health providers to improve access, quality and integration of services. Partners: Lutherwood, CMH, Carizon Family and Community Services, Waterloo Region Family and Children's Services, Langs, Lutherwood, and 5 others.

• Aligning Mental Health Resources with Primary Care Providers and their Patients – Increases access to mental health resources and counselling for Heritage FHO. Heritage physicians work with social workers on patient care planning, engagement and day-to-day patient progress. There have been over 4,321 appointments and with over 598 patients having received counselling. Partners: Heritage FHO and Langs.

• Rapid Access Addiction Clinic – Enables access to specialist medical care for those with substance use issues to reduce reliance on ED resources, and support capacity building for primary care providers for ongoing management of patients with substance use issues. Partners: House of Friendship, WRNPLC, Stonehenge Therapeutic Community.

• Specialized Outreach Services – Multidisciplinary outreach team providing MH&A supports to homeless and street-involved individuals disconnected from formal services. Works closely with Langs CHC IPC team; CMHA WW, Stonehenge Therapeutic Community.

• Peer2Peer Overdose Response Program – Modeled on an award-winning program from the United States, P2P places a peer with lived experience of opioid use/overdose and recovery in the emergency room to provide immediate support to those attending ED/admitted to hospital as a result of opioid overdose. Partners: Cambridge Memorial Hospital and Stonehenge Therapeutic Community.

• Shared primary care wellness, counselling and self-management support – Collaboration among FHT and non-FHT practices to open wellness, mental health and addiction counselling and self-management services to the community. Partners: Langs, Two Rivers, FHT, Grandview Medical Centre FHT, WRNPLC, Delta Coronation FHO, Heritage FHO.

• Community Responsive Behaviour Team – Jointly develops care plans to support patients and their caregivers. The Alzheimer's Society of Waterloo Wellington,

Specialized Geriatric Services.

2. Community Sector Integration Initiatives: The Hub@1145
The Langs Hub@1145 opened in 2011, and includes 25+ community partners who are co-located with the Hub@1145 with the Langs Community Health Centre, Diabetes Education Program and community programs. Designed to address the social determinants of health, the Hub@1145 serves over 13,000 people annually. This initiative involves the community in governance, setting priorities, program delivery and evaluation, and has improved access to a breadth of programs and services, enabling a larger impact on health and wellbeing of patients.
Partners include: Alzheimer Society of Waterloo Wellington, Carizon Family and Community Services, WWCMHA, CSC, Region of Waterloo Public Health, Hospice of Waterloo Region, House of Friendship, Lutherwood, CMH Psychiatry Services, WWLHIN H&CC, and 19 others.

3. Community Sector Integration Initiatives: The North Dumfries Hub@2958
This Hub@2958 operated by Langs in North Dumfries Township in the Village of Ayr includes co-location with the North Dumfries Township Community Recreation Complex and 8 community partners.
Partners Include: Born Midwives, Lutherwood, Family Counselling Centre, CSC, WWLHIN Home and Community Care, Public Health of Waterloo Region, Community Diabetes Program and House of Friendship.

4. Community Sector Integration Initiatives: Senior Active Living Centre
The Fairview Senior Active Living Centre (SALC) initiative provides fitness, therapy, social connection, entertainment, congregate dining and education to elderly Cambridge community members.
Partners Include: Fairview Mennonite Home, WWLHIN H&CC, Connections for the Healthy Aging and City of Cambridge.

5. Community Sector Integration Initiatives: Cambridge Self-Help Food Bank Service Hub
The Cambridge Self-Help Food Bank (CSHFB) plays a dual role in food procurement and distribution to partner agencies (supporting over 20 programs including shelters, meal programs, and community centre pantries, in CND with food support) as well as providing direct service. The CSHFB supports over 1,600 households in CND each month through two food security programs (emergency food, food co-operative), and serves approximately 5,000 meals annually through a weekly meal program. The CSHFB Street Outreach team made 3,039 contacts with people experiencing homelessness in 2018. The CSHFB Service Hub aligns social supports to provide wraparound health and social supports to people facing food insecurity.
Partners include: Cambridge Food Bank, Family Counselling Centre of Cambridge and North Dumfries, House of Friendship Family Outreach Program, Aids Committee of Cambridge, Kitchener, Waterloo, and Area, and 2 others.
Other Community Sector Integration Initiatives

• CSC shared intake with Waterloo Home Support to support patients in transitions – Shared intake processes to improve patient experience and reduce the number of times clients need to tell their stories. Partners: CSC, Waterloo Home Support.

6. Specialty Service Integration Initiatives: CHF/Atrial Fibrillation Community Management

The CCCC developed a nurse-led multi-disciplinary team-based program to better manage high-needs CHF and Atrial Fibrillation patients in the community through partnership with multiple local primary care providers and the WW LHIN. This initiative provides patients with rapid access to diagnostic testing and atrial fibrillation therapies to reduce hospital readmissions and improve patient outcomes.
Partners include: CCCC, CMH, Langs, Grandview Medical Centre FHT, Two Rivers FHT, Delta Coronation FHO, WRNPLC
Other specialty service integration initiatives:
• Cardiac Rehab – Partnership between cardiac rehab specialist and primary care practices to coordinate and provide access to self-management support, education and rehabilitation services close to home. To-date 44 visits have been completed. Partners: CCCC, Langs, Grandview Medical Centre FHT, Two Rivers FHT, Delta Coronation FHO.
• WW LHIN Community Stroke Program – Specialized community stoke rehab care plan for patients. Expert specialized community stroke rehab teams developed in partnership. Partners: CMD, WWLHIN (H&CC) and various outpatient rehab sites and CSSs.
• Health2Work initiative – Region of Waterloo, Ontario Chiropractor Association, Langs CHC, (with plans to expand). Provides MSK assessment and access to up to 10 visits to help enable Ontario Works and ODSP Clients to return to work.
• Low Back Pain Clinic – Volunteer chiropractors operating out of the Langs CHC. Reduction opioid use by 82% among participants.
• Hospice Palliative Care Community Team – Provides home visits for individuals that may benefit from hospice palliative care. Services are provided by Nurse Practitioners, Spiritual Care Providers, and Primary Care Palliative Expert Physicians who are regularly connected with the patient's Primary Care Clinician. Partners: WWLHIN, CMH, Lisaard and Innisfree, Hospice of Waterloo Region.

### 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*

The network analysis provided by MOH shows an extremely high alignment between our identified partner networks and our referral networks. The primary care provider enrollment models (PEMs), community health Centre, nurse practitioner-led clinic and hospital identified in the data package from MOH are the same as those included in our Planning Partners network and that were originally identified during our Self-Assessment. Since submitting our self-assessment, we have engaged all primary care practices in Cambridge through direct communications, on-site consultation visits and clinician engagement town halls. Our stakeholder engagement plan includes activities to continue engaging all primary care practices specialist during Year 1 (see Appendix C Figure 2 for details).

Of our original Planning Partners, 17 have signed on as OHT Members, including five primary care organizations, Cambridge Memorial Hospital (CMH), Home and Community Care, two long-term care facilities, two addictions organizations, a palliative care organization, community support services organizations, two housing and social service organizations, and a local digital health advancement centre.

Our Affiliate Members include community-based specialists, primary care, community support services, palliative care, mental health, public health, EMS, municipalities and social and housing services (see Sections 2.1.1, 2.1.2, 2.6.1 and 2.6.2).

### 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* | | | |

### *2.6.2. 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*

As described in Section 2.4, CND OHT Members and Affiliate Members have a strong history of working collaboratively to deliver integrated care. We anticipate expanding upon this foundation to increase our capacity to deliver high quality, integrated care to all CND OHT patients.

Integrated Care Delivery Capacity

Our OHT is a primary-care based model drawing on enrolled patients at five practices as well as unattached patients with complex needs. As such, our Year 1 population is about 51% of the attributed population, representing approximately 76,175 patients. Each of these patients will benefit from enhancements to integrated care as we are focused on improving functions (e.g. intake and assessment) across all services for all patients in Year 1. All of our OHT patients will have access to 24/7 system navigation supports, stronger relationships among team members, common intake and assessment where necessary, strengthened discharge planning, improved use of digital health tools, and any other functions we enhance during Year 1.

Additionally, we anticipate providing higher levels of integrated care through care coordination to patients who will benefit most: our frail elderly, complex patients, and those with MH&A conditions. H&CC care coordinators in CND currently receive about 5,000 referrals annually. 30% are short-term patients (e.g. wound care) and are unlikely

to require care coordination. Therefore, 1,750 patients in our Year 1 population would require care coordination. Based on the Canadian Community Health Survey, approximately 700 patients within our Year 1 population also likely have unmet homecare needs requiring coordination. Statistics from Canadian Frailty Network suggest that 757 frail and elderly seniors require care coordination. Finally, Mental Health Commission of Canada framework for severity of mental health issues, we anticipate 1900 MH&A patients require coordinated care. In total, we anticipate providing higher-level integrated care to 5,107 patients. This is in addition to other lower-level integrated care (e.g., system navigation, collaboration among care providers) that we would provide to all our Year 1 patients.

Identifying the Patients

To achieve these targets, we anticipate working with our LTC Members and community groups working with vulnerable populations, implementing Connectivity 2.0, and conducting analysis of existing populations to identify patients who may have fallen through the cracks. See Section 3.6 for a more detailed explanation of patient identification strategies.

Restructuring to Better Deliver Care Coordination

To increase capacity and ensure that we can meet the need, we anticipate:
•Rationalizing existing care coordination resources across organizations and sectors. Multiple organizations including H&CC have care coordination resources. Rationalizing the resources will help us identify where we have duplication and redeploy those resources into different settings or change their functions to align with the care coordination model we are developing.
•Focusing care coordinators on core competencies. Currently care coordinators, particularly those with H&CC, are required to complete administrative tasks such as ordering supplies. We anticipate focusing the scope of their duties on front-line care coordination and devolving administrative tasks to other resources within the OHT.

### 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?

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*

Our current cohort of Member and Affiliate organizations together deliver all services identified in the Table in Section 2.8. For purpose of clarity, we have only included services in this table that are offered by our Year 1 Members. However, it is important note that in our model Affiliate Members also may participate in the delivery of integrated services.

The Members and Affiliate Members, represented by their executive leadership, have been engaged in the planning and design of our OHT model and priorities for both the Self-Assessment and the Full Application. Further, the Governors of all our Members and Affiliate Members have been engaged through two targeted engagement sessions and have been routinely informed through briefing notes and updates from their executive leadership. We have established a highly participatory, informed and engaged slate of organizations who will become Members in Year 1 or in future years. Our governance model (see Section 4.2) provides opportunities for Affiliate Members in Year 1 to inform future priorities, strategies, performance measures and activities, and to be actively engaged in design and planning of service integration and transformation initiatives. We anticipate that most of our Affiliate Members will become Members in Year 2, depending the stage of OHT development.

We are already actively working to prepare and engage organizations, particularly community services, home and community support services, and health sector

services to join the CND OHT in future years. During Year 1, we will continue to build relationships with additional organizations that have not yet been involved in the planning process to-date. These organizations will continue to have the opportunity to become Affiliate Members in Year 1, and to participate in design and planning through co-design groups and reference groups.

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*

In Year 1, our Members include 5 primary care provider organizations which represent 51% of our attributed population. Our Year 2 priorities will focus on scaling the OHT across primary care members and adding additional services. Our Year 1 OHT model includes two FHT/FHOs, one FHO, one CHC and one NPLC, which together represents 51% of our attributed population. We anticipate adding at least three additional FHOs in Year 2, with the remaining three primary organizations and individual providers joining by Year 3. During our nine on-site consultations with the primary care groups in our network, providers identified several concerns that will need to be addressed and clarified in Year 2. These include the implications resource sharing (e.g. allied health resources), the impact of integrated OHT services on provider workload, maintaining the most responsible provider role of primary care providers in an interdisciplinary team, and the governance role of primary care and specialist physicians and other clinicians once the full continuum of services are included in the OHT.

### 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*

When the government identified its initial health system reform agenda, several planning bodies in CND including the CND Sub-Region Planning Table expressed the need to identify early the local needs and priorities. A group of interested community partners met in January to discuss opportunities and approaches to collaboratively plan and identify priorities for health sector reform. Following the announcement of OHTs, the initial partners invited other local organizations to join the planning process. In total, thirty-one organizations have joined the CND OHT planning process, representing 11 sub-sectors from health, community, municipal, and social sectors ("the Planning Partners"). Three municipalities (City of Cambridge, the Township of North Dumfries and the Region of Waterloo) have participated in the Planning Partners group, and all have signed on as Affiliate Members for Year 1. (See Letters of Support from Affiliate Members in Appendix E).

Building on five years' experience as a community highly engaged in Health Link, the Planning Partners developed a Planning and Engagement Framework early in the process to define roles of the various planning and design groups, direct ongoing stakeholder communication and engagement (see Appendix C Figure 2), and establish an effective planning process.

A series of 14 planning meetings held since January 2019 focused on identifying local health priorities and strategies, and reviewing and approving OHT models, designs and plans. The Planning Partners followed a collaborative decision-making approach that was built on a foundation of mutual trust and respect formed through their previous opportunities to work with one another and with other organizations on local, collaborative planning and service delivery initiatives (See Section 2.4). The Planning Partners were supported by a consulting firm with an established history of working with the local partners on various integration initiatives which facilitated meetings, prepared supporting materials, and drafted the Self-Assessment and Full Application.

The Planning Partners also created a smaller coordination group that includes the Year 1 primary care partner Members, CMH and H&CC (the “Small Planning Group”) to manage the logistics of the planning process. The Small Planning Group met weekly to establish meeting dates for the Planning Partners and co-design groups, develop agendas or topics for meetings, and identify planning and engagement strategies.

Three Co-Design Working Groups were established to focus on key aspects of OHT planning and design:

- Governance
- Service Delivery including H&CC, Transitions, Care Coordination and System Navigation
- Digital Health

The Planning Partners were asked to nominate representatives to the co-design groups. The representatives include:

- Patients/family/caregivers
- Primary care providers
- Specialist physicians
- Health system planners
- Front-line staff, managers and administrators; and
- Governors in the local community

Co-design group members did not need to be from the Planning Partners. Rather, Planning Partners were specifically asked to look beyond their own organizations and to nominate individuals that would adopt a “systems thinking” approach and not represent specific organization’s interests. In total, 45 individuals from a diverse range of perspectives, backgrounds and experiences participated in five half-day workshops across the three co-design groups. These and other co-design groups will continue to support OHT design and implementation planning through Year 1 and beyond.
In addition to the co-design groups, the Planning Partners also delivered a number of stakeholder engagement sessions to validate initial designs, models, and strategies:

- Two patient, family, and caregiver engagement sessions. The Planning Partners identified participants, including individuals with a variety of background, experiences, ages and needs.
- French-language PFC engagement session: The French Language Health Planning Entity for HNHB and WW reached out to the CND-HT to provide guidance and support with the engagement of the Francophone community, and with FLS planning. A specific Francophone session was held in French and facilitated by the French Language Health Planning Entity to identify the specific priorities and needs of this community.
- Nine primary-care engagement and information sessions. These peer-to-peer sessions were led by a community physician and held onsite in nine primary care practice locations. The sessions provided background information on the OHT model, the CND planning process, the potential benefits and risks for primary care providers, and provided an opportunity for primary care providers to share concerns,

opportunities, and ideas. The feedback from these sessions were used to refine the OHT design and plans for Year 1.
• Two clinician townhall sessions. These two sessions were attended by over 70 clinicians including primary care physicians, hospital and community-based specialist physicians, community and hospital-based nurse practitioners, midwives, and allied health professionals.
• Two governor engagement sessions. Board governors the Planning Partners were invited to participate in sessions in April and in September. Each session was attended by over 80 governors and executive leaders. The sessions were used to update governors on the OHT model, strategies, priorities and plans, and to get their input on strategic priorities and risks. The Year 1 governance model was reviewed and validated in these sessions.
• H&CC service providers – A session was held for service provider organizations that delivery H&CC services within CND. These providers were asked to review the proposed Year 1 vision and strategies, and identified opportunities to strengthen integration and collaboration for our sub-populations in Year 1.
• Digital Health solution providers – A session was held for vendor of digital health solutions to inform them of CND's OHT strategy and Year 1 priorities, and to identify opportunities for local digital health innovation. CND OHT will work within the provincial Innovation Procurement framework to engage digital health solution providers in Year 1, in alignment with BPS procurement guideline.

Planning Partners were supported with communication materials and key messages to engage their staff and stakeholders throughout the planning process. Several Planning Partner organizations have developed specific OHT board sub-committees to strengthen board knowledge and capacities to support the OHT process, and to ensure early alignment with OHT strategies and priorities. Finally, all Planning Partners were provided with the opportunity to review the draft Full Application and provide additional feedback, clarifications, or questions for incorporation into the final version submitted to MOH.

## 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.

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The Planning Partners have identified Year 1 priorities related to addressing the factors that contribute to hallway healthcare, including improving primary-cased based care coordination and system navigation to connect patient and increasing access to community-based MH&A services. We began our planning process by consulting with service provider organizations (SPOs), clinicians, patients, families and caregivers to understand key frustrations and challenges, and reviewed the demographic profiles, health profiles and performance metrics data of our attributed population. We then worked in co-design groups (see Section 2.10) to confirm priorities and identify solutions.

The data package provided by MOH shows that, in general, CND performs above provincial averages, against key performance measure. However, the OHT model provides an opportunity for partners in CND to collaborative more effectively to

strengthen performance, particularly against those domains that contribute to hallway healthcare.
Section 1.2 discusses our Year 1 sub-population and the associated health profile, cost drivers and performance measures. The Planning Partners have identified several key strategies and priorities to improve the patient experience and reduce the pressures that contribute to hallway healthcare, including how many of the partners have supported the design of a regional hospital surge strategy.These strategies will leverage existing assets, which include established collaborative planning forums and initiatives among our Members and Affiliate Member and existing integrated services and programs (specific planning forums, initiatives and actions identified below are further described in Section 3.2):

Key opportunities for ending hallway healthcare in Year 1:

1) Reduce avoidable use of Emergency Department (ED) services by providing coordinated access among primary care practices to same-day/next-day and after-hours primary care services in the community.
Key Assets:
• In 2016, Primary care providers in CND established the Primary Care Collaborative Working Group with support from the CND Health Links. These providers have been working to better understand primary care access issues and identify reasons for avoidable ED use. The working group conducted an inventory of same-day/next-day access approaches and after-hours services as a baseline to better coordinate access across primary care providers in the community. The working group also completed a study to identify reasons for avoidable ED use. This data will be used to coordinate access to primary care services across our five Year 1 primary care Members organizations, and possibly with other primary care provides in CND.
• Community Call is a voluntary call rostered staffed with primary care practitioners that respond to calls from LTC facilities, critical labs and to declare deaths in the community.
• The Department of Family Medicine and the Chief of Family Medicine are responsible for maintaining and promoting community involvement in the hospital. Quarterly Family Medicine meetings are held; this is an important channel for maintaining education and communication.

2) Reduce the avoidable use of Emergency Department services for individuals with mental health and addiction, or brain injury related services by providing improved access to integrated, wraparound MH&A services in the community.
Key Assets
• MH&A and primary care Members and Affiliate Members have designed, planned and implemented several integrated MH&A wraparound community services in collaboration with community partners, including Children's Mental Health in Primary Care, Community Psychiatry Services, Front Door Access, Primary Care Memory Clinics, Rapid Access Addictions Clinic, and the Community Response Behavior Team (See Section 2.4).
• Here24/7 (CHMA) is the integrated front door to addictions, mental health and crisis

services provided by 12 agencies across Waterloo Wellington Region. Here24/7 performs integrated intake, assessment, referral, crisis, waitlist and appointment booking for dozens of programs and services.
• Connectivity Table Cambridge (Langs) consists of 20+ agencies that have been meeting weekly for 5 years to address (number) situations of acutely elevated risk and provide a wraparound response within 24-28 hours
• CND MH&A Collaborative Quality Improvement Plan provides a foundation for collaborative performance measurement and management.
• The MH&A Working Group has mapped all available M&A services across CND across the 5 Tier Model. This provides an inventory of possible opportunities for integrating MH&A addictions services.

3) Identify individuals in the community earlier who need primary care, care coordination and H&CC services and other social and housing supports to keep people living healthier in their homes longer, or support them in dying in their location of choice. Leverage primary care-based care coordination and system navigation to more effective connect people to services, and to monitor their progress and needs
Key Assets
• H&CC Care Coordinators current performed both hospital and community-based care coordination functions. The Neighborhood model aligns care coordinators with local population and primary care providers. This model will be further reconfigured to establish primary care-base care coordination that strengthen the longer-term relationship between care coordinators, primary care providers and P/F/C.
• Health Guides are system navigator resources funded through H&CC with leadership provided by Health Link. These system navigation resources are currently deployed within 7 primary care settings throughout the community. These resources and the relationships with primary care providers can be leverage to expand system navigation functions and services in Year 1.

All the health system performance measures identified in the application form (among others) are important to our OHT and are relevant to our Year 1 and maturity priorities. However, in Year 1 – the key performance metrics below will support our capacity to measure performance improvement against our priorities will help us address these key performance questions:

Are we connecting people with H&CC and primary care services sooner?
1) Wait-time for first home service from community
2) Hospital stays extended because the right home care services not ready
3) 7-day physician follow post-discharge

Are we effectively providing integrated care and services in the community in or to keep people healthier and out of the Emergency Department (ED) and acute care?
4) Frequent ED visits (4+ per year) for MH&A
5) Avoidable emergency department visits
6) Rate of hospitalization for ambulatory sensitive conditions.

Are we effective in reducing “hallway healthcare?”
7) Time to inpatient bed
8) Number of people in hallway healthcare beds
9) Alternate Level of Care (ALC rate)

### 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.

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Plans and Outcomes for Redesigning Care and Changing Practice

1) Outcomes: Reduce the avoidable use of Emergency Department services by providing coordinated access among primary care practices to same-day/next-day and after hour primary care services in the community.
• Work collaboratively across Year 1 Primary Care Members to plan and schedule same day/next day and after-hours services. Patients within the Year 1 target populations (e.g. enrolled in a Member Primary Care practice) will be able to access these services through other Member providers and locations. The availability of same day/next day and after-hours services will be coordinated across the partner primary care practices to increase availability and make more effective use of primary care resources. Continuity of care will be provided through shared access to primary care records and through defined protocols/communication channels among primary care partners
• Expand Community Call program to support patients in long-term care, retirement residences and for frail/elderly/medical complex individuals.
• Expand the Fairview Campus program delivered by Fairview and H&CC which provides personal care and social services to seniors who live in congregate housing across Cambridge. This program continues to expand offering in-home care supports to seniors. This includes scheduled and unscheduled personal support, nursing, physiotherapy, social work, speech therapy and nutrition services.
• Leverage palliative approach to care framework and resources to help primary care providers identify patients, families and caregivers that would benefit from advance care planning and a palliative approach to care sooner. The strategy can reduce available ED use by better preparing patients, families and caregivers for end-of-life

care, improving their experiences during a difficult period. Scale the use of palliative approach to care EMR templates to guide primary care providers on identification and support of patients, families and caregivers.
• Expand bundled care models to promote more integrated care and seamless transitions, adoption of evidence-based care delivery, value-based health care, and efficiencies by reducing hospital length of stay and eliminating unnecessary hospital and emergency department visits. CMH has successfully implemented bundled care for unilateral hip and knee replacements and shoulder arthroplasty, in partnership with orthopedic surgeons, community physiotherapy clinics and H&CC.

2) Outcomes: Reduce the avoidable use of Emergency Department services for individuals with mental health and addiction services by providing improved access to integrated, wraparound MH&A services in the community.
• Expand/scale existing integrated, community-based MH&A services, including Children's Mental Health in Primary Care, Community Psychiatry Services, Front Door Access, Health Connect Counselling Partners, Heritage Social Work, FACT Team, Community Adult Mental Health inter-professional teams, Mental Health and Addictions Nurses in schools, Big White Wall, CMHA's Bounce Back services , Primary Care Memory Clinics, Rapid Access Addictions Clinic, and the Community Response Behavior Team.
• Leverage single front door access of Here24/7 to further streamline access to community-based MH&A services with common intake, assessment, referral and appointment booking.
• Develop Connectivity 2.0 Table model (protocols, pathways, agreements, relationships, etc.) to identify individuals that need MH&A services, but are not connected to care. Expand use of Health Link Coordinted Care Plans to this populations and strengthen integration with IPC model.
• Provide training and capacity building for the primary care providers in the treatment of individuals with complex MH&A issues to increase capacity for supports and treatment, and to increase provider comfort in provider care.

3) Outcome: Identify individuals in the community earlier who need primary care, care coordination and H&CC services and other social and housing supports to keep people living healthier in their homes longer. Leverage primary care-based care coordination and system navigation to more effective connect people to services, and to monitor their progress and needs.
• Establish primary care-based care coordination and system navigation, and rationalize care coordination functions, roles and responsibilities across Members and Affiliate Members (see Section 3.3.1 for further description of care coordination re-design and 3.3.2) to ensure most effective use of care coordination resources, and identify multiple entry points into integrated care coordination.
• Develop Connectivity 2.0 Table model (protocols, pathways, agreements, relationships, etc.) to identify individuals in the community with a need for early intervention and care co-ordination and connections to primary care and home and community care.
• Connect patients with brain or spinal injuries in acute care earlier with specialized

services, care coordination and system navigation.

Working Together to Resign Care and Change Practice

There is an opportunity to more effectively connect P/F/C to a broader range of health and CSSs, particularly from community, and to more effectively engage H&CC providers in the ongoing care of patients.
Redesigning care is about changing the way healthcare is delivered to a given population. Developing the 'right' care model for CND's population with complex needs is complex, multifaceted, and largely involves using the principles of human-centered design to develop an appropriate care model that aligns with the needs of CND's population.

Importance of the P/F/C perspective – Engaging patients in healthcare quality improvement and redesign has become a key component of redesigning the healthcare system to support patient-centered, high quality system in order to understanding their unique needs, values and perspectives CND OHT plans to incorporate P/F/C in the governance model through multiple avenues, including representation on the OHT Steering committee, P/F/C Advisory Groups, Reference Groups and General Stakeholders. Throughout these methods, P/F/C will have the opportunity to work with clinicians and other health service providers to address barriers to accessing care and services and streamline opportunities for addressing these barriers.

Develop common intake and assessment protocols – One of the key starting points for providing integrated care for patients is the ability to develop coordinated care/treatment plans for patients among a broad spectrum of providers. To effectively redesign care and change practice, CND OHT plans to work collaboratively amongst the providers in our team to develop common intake and assessment protocols ensure consistency across clinicians around decision making, care planning and treatment processes. Using co-design groups, stakeholders such as clinicians, managers, patients, etc. can work together to map current state workflows from referral to submission, screening and triage, to diagnosis and treatment and use existing guidelines and evidence to establish consensuses for the desired future state. Through this process, stakeholders can agree upon key performance indicators to measure and evaluate the effectiveness of the change process. For example, CND OHT partners can collaboratively agree upon the appropriate wait time for services, what information regarding resources and tools patients should receive upon diagnosis of a condition, etc.

Plan, Do, Study, Act – The co-design process is key to understanding different stakeholders' perspective in healthcare system change, however it is just one piece of the puzzle. To implement and redesign healthcare effectively in an iterative way, CND OHT partners plan to work with co-design groups to redesign services (e.g., coordinate care for complex MH&A patients), implement that change in practice, evaluate the change and learn from the change to eventually scale to a broader

initiative (e.g., coordinate care for all patients). This provides a framework for learning whether an intervention is effective and to adjust accordingly to support the expansion of integrated services, lead to improved patient and provider experience and enablers increased investment in information technology (IT) and performance management.

Learn from others – To encourage transformation change, it is necessary to not develop approaches in silos, but to learn from others around us, including other OHT and other models of care nationally. CND plans to engage other OHT and stakeholders outside of our OHT to continually understand lessons learned, challenges and opportunities for redesigning care.

Leverage Technologies – To support the collaboration and an effective integrated care model, utilize existing and emerging technologies where appropriate to the business and workflow and to provide information to clinicians and patients at the right place and time, and to minimize duplication of the story, the workflow, the documentation and reporting.

Evaluate Our Impact – focusing on the outcomes identified in 3.2 above, the CND OHT will commit resources to evaluate the effectiveness of the above strategies on hallway healthcare, service integration and home and community care reform

Knowledge Exchange – the CND will develop and implement strategies to share best practices, successes, challenge and evidence with local members, affiliates, non-affiliates and other OHTs to help spread and scale the model.

### 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*

In Year 1, we will focus on re-designing care coordination for frail/elderly and for people who are medically complex or have MH&A conditions and integrate specialized care coordinators for vulnerable populations. More specifically, we will undertake the following:

Align and Rationalize Care Coordination Function Across the OHT

Primary care – Embedding care coordinators in primary care facilitates long-term relationships between care coordinators, providers, and patients, improving outcomes and the patient experience through improved care continuity. Care coordinators will work closely with primary care providers to connect patients to the full complement of services required and monitor progress. Primary-care care coordinators will also be attached to the primary care providers of LTC residents to ensure they are effectively connected with services to reduce ED/hospital admissions.

Hospital Care Coordinator – Care coordinators will continue to work in acute settings ensuring seamless transitions and warm “hand-offs” to new care settings. Their roles will be aligned with primary care-based care coordinators, but focused on discharge planning, assessment and immediate service needs (up to 72 hours post-discharge) before connecting the patient to their primary-care care coordinator.

Specialized Care Coordinators – Patients and families with specialized needs (e.g., palliative, MH&A and pediatrics patients, acquired brain injury, etc.) will have specialized care coordinators with in-depth knowledge of the domain. This model builds on current models by Traverse Independence, CMHA WW, H&CC and other Members and Affiliate Members who provide intensive care coordination and system navigation to patients with specialized needs.

Optimize value-added care coordination functions – Home and Community Care has already implemented initiatives to optimize the value of care coordination functions, by implementing H&CC eReferrals using OCEAN platform and direct referrals from primary care to services (e.g. home safety assessments) and shifting administrative functions to other resources. We will continue to build on these initiatives in Years 1.

Care Coordination Model

Expansion of care coordinator responsibilities – Care coordinators will be responsible for coordinating all health, social, and community services required by patients. Specific functions include:
• Identifying patients that need care coordination – Working with PCPs and other organizations to identify individuals that would benefit from care coordination.
• Developing care plans - Collaborating with PCPs and other team members to support comprehensive care plans for patients with complex needs or multiple providers.
• Broader assessment of need - Ensuring that patient care includes social determinants of health in addition to patients' clinical needs.
• Planning and mobilizing resources - Planning and mobilizing resources across the continuum of care including H&CC, SPOs, CSSs, and other required services.
• Supporting patients with transfers of care - Ensuring smooth transitions by scheduling appointments as necessary (e.g. where transfers are complex and self-management tools do not meet needs), addressing problems in information transfer, coordinating multiple appointments.
• Engaging the required interdisciplinary team and other care coordinators– Communicating with the interdisciplinary team to ensure that care providers have a clear and shared understanding of the roles and responsibilities of each provider and care coordinator (e.g. specialized) involved in the patient's care, and to keep others informed of updates to changes on the patients care plan.

24/7 access – Care coordination will be available 24/7 for patients. Patients in community requiring after-hours support will have a single after-hours call-in line, staffed by a care coordinator with clinical experience (e.g., nurse).

Multiple entry points – Although care coordination will be embedded in primary care, we anticipate that our patients will be able to connect with care coordination support through any of our Members and Affiliate Members.

Care coordination for vulnerable populations – CND's Inter-Professional Primary Care

(IPC) will connect vulnerable individuals (See Section 3.8 for details on the program) until they choose to be connected with a primary care provider in a mode which will best meet their needs.

Care Coordination Resources

Currently 26.5 FTE WWLHIN H&CC care coordinators provide services in CND across community, hospital and specialized domains. We propose leveraging approximately 13.5 FTE of the WWLHIN H&CC resources to meet the needs of our Year 1 population, which represents of 51% of our attributed population. In addition, several of our Members (e.g., Langs, Fairview, CSC, Traverse Independence) and Affiliates (e.g., ACKWWA, Alzheimer's Society) also perform care coordination functions that we would leverage in our re-designed model. We are continuing to work across Members and Affiliates to develop a model to align and optimize care coordination functions to support our targets for our Year 1 sub-population.
H&CC care coordinators in CND currently receive approximately 5,000 referrals annually from hospital, primary care, and other sources. 30% (1,500) of these are short-stay patients with specific service needs (e.g., post-surgical care) and are unlikely to require ongoing care coordination. Because CND OHT will include about 51% of the attributed population within Year 1, we estimate 1,750 individuals will require care coordination as a baseline. However, based on the Canadian Community Health Survey, we estimate that up to 700 patients within our Year 1 population may have unmet home care needs requiring care coordination. Finally, using the Mental Health Commission of Canada framework for severity of mental health issues estimates, we anticipate another 2,660 mental health patients (Tier 3) could benefit from coordinated care. In total, we estimate approximately 5,110 patients could require care coordination in Year 1. The specific workload demand of this new proposed care coordination model is difficult to determine at this stage our planning. Recent research from the United States show that interdisciplinary care coordination teams spent a mean of 30 hours per year with a patient with complex medical and socio-economic need. These teams included nurses, community health workers, social workers and clinical psychologists, which aligns with our proposed interdisciplinary team models. If we are able to leverage 13.5 FTE care coordinators from H&CC to meet the needs of our year 1 population, as well as augment this resource complement through aligning functions and existing resources across the system – we will likely still not be able to fully meet demand in Year 1. Our Members and Affiliate Members are continuing to develop and refine models and resource requirements, but additional investments in care coordination will be likely be required to implement a sustainable primary care-based care coordination model, particularly one that can meet the ongoing growing demand created by demographic and morbidity trends. In the longer term, the shift to an effective and proactive care coordination model holds the potential to reduce costs elsewhere across the system and could be reinvested in front line care.

### *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*

System navigation is a key element of providing integrated care and improving access to care for patients within an OHT, as individuals seeking care can frequently get lost as they move among different healthcare providers. At times, this can have a serious effect on clinical outcomes, as it frequently duplications efforts, requires substantial time, and increases costs.

Partners in our CND OHT have some new experience with programs to improve system navigations for P/F/C. System navigators called 'health guides' are currently in place at seven primary care settings across CND and could be expanded and revised to match the role of the system navigator. Below is a description of the program.

• Participating primary care settings – Waterloo Region Nurse Practitioner Led Clinic (Member), Grandview FHT (Member), Two Rivers FHT (Member), Delta FHO (Member), Coronation FHO, Langs, North Dumfries Satellite CHC

• Benefits to providers and patients – Health guides have already improved the morale of primary care providers and patients by acting as an alternative source of system navigation for patients. Providers have described the use of health guides as a 'sense of relief for patients' and are pleased to incorporate them into their practice as they believe this model has a high impact and is successful at reducing acuity of patients.

Expanding this Model to CND OHT

CND OHT plans to leverage and scale this model to provide system navigation services for CND OHT; however, it is expected that this model will require additional investment and resources in order to scale to provide 24/7 access for our Year 1 patients, and eventually all patients at maturity.

Therefore, we propose to have dedicated system navigator roles which will be available to patients during regular practice hours, and after hours. These system navigator roles will also allow us to address the lack of French-language services by collecting

additional data on the needs of Francophones in the region to support French-language services planning and navigation in the future. We will measure the success of the system navigator role by measuring changes in health outcomes, improved patient experience and more efficient use of health services.
During regular hours – This role will be attached to a primary care practice, and will be available as a point of contact for all patients who need information/system navigation services. The system navigator role during practice hours will likely be filled by a non-clinical who has met the appropriate training obligations (determined during Year 1) and will be clearly defined in relation to the care coordinators to delineate their responsibilities. The navigator would have authority to access some personal health information (PHI, to be determined), provide information and referral services, and book appointments as needed.
After hours – All patients belonging to CND OHT will have one point of contact to call after hours. This role will be filled by a care coordinator with a clinical background (e.g., nurse) to determine the patients needs and triage accordingly. The goal of 24/7 access to care coordination and system navigation is to strengthen and enhance feelings of security to patients and their caregivers and reduce ED admissions.
In addition to having dedicated system navigator roles, the following plans are in place to help patients and their family members navigate the healthcare system:
Improving patient's health literacy – Health literacy is essential for successful access to care and use of services, self-care of chronic conditions, and overall maintenance of health and wellness. By improving a patient's health literacy and ability to understand and act on health information, patients will be better equipped to support themselves in navigating the healthcare system in CND (see Section 3.5.1 for details on plans to improve patient health literacy). CND will explore leveraging the consumer digital health framework, utilizing emerging consumer facing frameworks and leveraging tools for the patient to increase understanding and self-management capabilities.

### *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*

Enhancing care coordination and system navigation as described in Sections 3.3.1 and 3.3.2 respectively are key mechanisms by which we intend to improve care transitions. Having a role accountable within the system to support a patient in coordinating complex care amongst multiple providers or to support the patient in navigating the services available to them is a critical step to improving transitions in

care. The care coordinator and system navigators help to ensure that the patient is not “handed-off” between providers, but rather has a guide to provide them with a smooth and warm transition between providers.

In addition to strengthening care coordination and system navigation, we anticipate implementing the following features or mechanisms to improve care transitions:

• Colocation of services – A key barrier of our Year 1 target group is mobility amongst services. Our frail elderly population has difficulty getting to the services that they require. Our MH&A population, and those with brain injury also experiences challenges in getting to appointments due to a variety of issues. CND already has an urban and rural community hub that collocates health, social, and community services to make them more accessible to our patients. We plan to further leverage the Hub model to make warm hand-offs between OHT members, by taking the patient “down the hall”. Similarly for our population in long-term care homes, we plan to increase co-location of services and providers onsite at the home to enable smooth transitions.

• Streamlined intake and assessment – A common challenge that patients experience during transitions is telling their story multiple times. CND OHT anticipates expanding the current initiatives we have taken to further streamline intake and assessment so that multiple providers can leverage the same intake and assessment process. The Members and Affiliate Members have already made progress in this area, such as Lutherwood’s offering streamlined intake and assessment to programs from multiple other service providers for children, youth, and their families experiencing mental health challenges, Here24/7 which provides people experiencing mental health issues or crises a 24/7 helpline that provides them with access to services of 12 different organizations, and Connectivity which provides common intake, assessment, and service planning across health, social, and community services for people at acutely-elevated risk of harm. We also leverage use of and share the interRAI across organizations to eliminate where possible duplicated effort. Year 1 will include understanding where gaps exist and how we can leverage our existing initiatives or implement new ones to fill those gaps.

• Discharge Planning – CND has established a Discharge Planning Group comprising Members including CMH, Langs CHC, and the FHTs as well as representatives from H&CC and retail pharmacies to enhance patient education and care collaboration during transition back into community. The group has worked on redesigning discharge planning, patient materials, and medication reconciliation processes for patients with CHF, COPD, and the frail elderly. During Year 1 we anticipate expanding this to our other high-priority populations. In addition, CMH uses the CoHealth App for enabling patients to document their discharge instructions and information on available services to support their smooth re-entry into the community.

• Clearly-defined roles and responsibilities in the transition processes – Working in a team strengthens collective accountability for the patient’s health and wellbeing. No single provider is accountable for providing all the care that the patient needs, but the

team as a whole is accountable. CND anticipates establishing clear processes, roles, and responsibilities with respect to the transition function. This will help OHT Members and Affiliate Members understand what the ideal transition process looks like, and what their role in effecting a smooth transition for the patient is. It will also provide the patient with information about what they can expect during transitions, and what supports are available to them during transitions of care.

• Strengthened relationships – A key benefit of an OHT is strengthening the relationships among the providers. Providers are often challenged when transitioning a patient to appropriate care services because the provider is unaware of the services available to the patient or the primary function of other health, social, and community organizations. Strengthening the relationship among the providers and clearly mapping the responsibilities among them will improve the transitions. CND has many examples of previous collaborations demonstrating the strength of our existing relationships and we look forward to further enhancing our Member and Affiliate Member network (Section 2.4).

• Expanded access to eReferral solutions – Both Ocean eReferral and Caredove allow the Members to identify the health, social, and community services appropriate for the patient and their condition, and electronically refer to the relevant service provider. They also provide the referring provider with a feedback loop that lets them know that the referral has been received and the patient has been connected to the service they require. The patient can additionally subscribe to updates in the Ocean eReferral tool. Expanding provider access and patient subscriptions to the tools will provide more patients with a smoother transition from one provider to another.

• Robotics Process Automation (RPA) – The Members and Affiliate Members also anticipate expanding use of RPA to extract patient information from EMRs and share it with CHRIS. This will further support streamlined sharing of patient information amongst the care providers by enabling them to more easily create a shared care plan. A shared care plan will reduce the “transitions” among providers by promoting their working together as a team.

### 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*

CND's strategy for supporting patients' ability to self-manage is by expanding patient access to their own health information, providing them with tools to support effectively engaging with their health information, and enhancing their health literacy to use the information effectively.

Expanding Access to Health Information

As discussed in Appendix B.2, CND has a variety of mechanisms by which we make health information available to patients, including:
• MyChart – Patients with access to MyChart can view their acute care information in Clinical Connect
• Ocean eReferral – Patients can subscribe to email updates on referrals that their providers create using the Ocean eReferral tool
• CMH CoHealth Application – Patients discharged from hospital can use the app to document discharge instructions and view the services available to them in the community

CND intends to increase the number of patients accessing their information via these channels by strengthening promotion of services and removing barriers to enrollment. CND also anticipates working with regional and provincial digital health delivery partners to identify mechanisms to provide patients with a greater scope of their own information such as primary care information.

Enhancing Health Literacy

In addition to providing patients with their information to support self-management, CND has identified two other specific activities to be undertaken in Year 1 to increase health literacy.
• CND currently has the Waterloo Wellington Self-Management Program, based out of Langs CHC, which supports people living with chronic disease to manage their own care. The program includes a central intake and referral function as well as self-management education for patients. The Planning Partners anticipate growing this program by offering it to patients enrolled at the other Year 1 primary care providers. Expanding this program will enable to us to meet the needs of one of our priority populations in Year 1 and, through the lessons learned during Year 1, expand the program to include other populations in the future.

• CND proposes developing a standardized process to onboard patients to the OHT. A key component of the onboarding process would be educating patients about the OHT, how their care and services are enhanced by the OHT, and the services available to them. Providing this information is expected to support all patients with managing their services, particularly low-acuity patients who are less likely to need care coordination services.

CND already provides its patients with access to referral and acute care information through eReferral and MyChart initiatives respectively. We currently have eReferral information on 8,388 patients from CND (5.9% of the attributed population) of which 2,151 have subscribed to email updates on their referrals. Patients also have access to MyChart via CMH which gives them access to information available in ClinicalConnect including acute care, home and community care information, and provincial repository information such as lab and diagnostic testing results. Finally, with the CMH CoHealth App, patients are able to document discharge instructions and view information on accessible community services and supports.

### *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*

The Members and Affiliate Members of CND OHT offer a multitude of resources and programs to support caregivers both in providing and supporting care for patients, and in supporting the caregiver's health needs to reduce caregiver burnout and distress. CND OHT plans to undertake the following initiatives or developments to ensure that caregivers are fully supported both in providing informal care, and in maintaining their health and wellbeing:

Increasing availability and awareness of respite services – CND OHT aims to provide

access to emergency respite, short stay respite, and adult day respite programs to meet the varying needs of CND's population and their caregivers. CND also aims to ensure that caregivers are aware of the programs available within the region, for example:
• Grief and bereavement supports available through Family Circle, and follow up outreach calls through Lisaard and Innisfree Hospice
• Volunteer respite, caregiver support groups, and educational workshops for caregivers to improve knowledge and build capacity for providing care at home offered by Hospice of Waterloo Region

Improving peer support accessibility – in order to reduce the perceived isolation experienced by many caregivers, CND OHT intends to provide access to online peer support resources as well as increasing awareness, accessibility, and enablement of current peer support groups and networks.

Reducing the need for caregiver administration – many caregivers are currently burdened by the need to obtain and maintain records of care received or needed by the patient, the need to share information with care team members as the patient transitions between service providers, or the need to manage the scheduling and referral statuses of the patient. Through the involvement of the system navigator and care coordinator, the caregiver will be relieved of these activities while gaining access to a resource to support both the patient and themselves as they access the services of CND OHT.

#### *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*

Identifying Our Patients

The foundation of our OHT target population will be the patients already enrolled in the five primary care groups who are full OHT members beginning in year 1, as we will draw the majority of our year 1 patient population from patients already enrolled to our Member providers. Using the RPA tool from eHealth Centre for Excellence, we will identify complex patients by identifying their Standardized ACG Morbidity Index (SAMI Score). RPA searches through the EMRs and runs algorithms to assign patients a SAMI score. Patients with complex needs who are not currently and actively in care will be contacted and invited to see their provider to follow up and ensure a care plan is in place.
In addition to patients who are already enrolled in our primary care groups, we anticipate identifying complex patients who are not currently in care through the following mechanisms:

1. Identification by affiliate members – We anticipate that our affiliate members, particularly those providing MH&A, and brain injury services, will identify patients with complex needs who are not currently attached to a primary care provider. We expect the affiliate members to refer these people to a primary care provider.

2. Identification by community groups – Our members have relationships with a number of community, social service, and justice organizations who are not directly connected to the OHT. For example, our members participate in Connectivity Tables (i.e., Situation Tables) with Waterloo Regional Police Service and others to support people with elevated risk of harm. We anticipate receiving referrals from the police and other community, social service, and justice organizations of people who would benefit from care.

3. Identification through Connectivity 2.0 - As noted above, CND has a Connectivity Table that connects people at acutely-elevated risk of harm with care. Our Members and Affiliate Members are interested in replicating the Connectivity Table model and process for other groups, particularly our priority populations such as frail elderly or MH&A, to get them into care. Members and Affiliate Members would meet on a regular basis to identify high-needs, complex users who require a coordinated, cross-sectoral intervention by a number of our Members and Affiliate Members.

Following our Patients

Our OHT model is a primary care centric model, where each patient enrolled in our model will have primary care as a home. The patient will receive services from a primary care provider who is the focal point of their care, and patients with complex needs will receive additional supports from a care coordinator to ensure that the patient is receiving the appropriate services and that their care providers are coordinating and collaborating in their care. These roles will be responsible for tracking the patient through their journey.

### 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*

The CND OHT members and affiliates are committed to ensuring that the plans and strategies created during the ongoing redesign of the healthcare system in Cambridge and North Dumfries are culturally safe, particularly for Indigenous peoples. We recognize that this population may have certain, specialized needs for their care, both due to specific healthcare concerns, and socio-culturally.

Engagement of the Indigenous Population To-Date – Our Members and Affiliate Members have historically engaged the Indigenous perspective in health system planning, through initiatives including the Hospice of Waterloo Region's Indigenous Palliative Care Needs Assessment, the results of which will be used to inform Indigenous in CND's OHT planning. CND OHT development and design thus far has included Indigenous perspectives in our co-design sessions. Our members have actively sought to include Indigenous perspectives wherever possible throughout the OHT design process, and we intend to continue and expand this effort moving forwards. Many of our clinicians and partner organizations have completed the Indigenous Cultural Safety (ICS) training program, and we are committed to continuing to leverage this training opportunity as an OHT.

The WWLHIN Indigenous /Health and Wellness initiative is based at the Guelph CHC serves the entire WWLHIN. We will continue to engage the support and advice of the Wellness Initiative as we plan and design OHT services.

### *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*

We recognize that it is often difficult for Francophone or primarily French speaking populations to access services, particularly in communities like CND which have a smaller Francophone and French speaking population. In order to ensure that our OHT will adequately support the needs of these patients, we intend to build on our existing foundation of French-language friendly services, and continue to engage the Francophone and French speaking population as our OHT is further designed and matures.

Building on a Foundation of French-Language Friendliness – We are committed to ensuring that our OHT and its services are accessible by French speakers, and intend to leverage the existing French language services offered by our providers, particularly our Primary Care Members, and Fairview Mennonite Home. Expanding on this foundation, we intend to collaborate with the local French Language Health Planning Entity, the WWLHIN, and local French language associations to ensure that over time all services offered within CND OHT are available and accessible in French, or with interpretation services.

Ongoing Involvement of the Francophone Population – providing Francophone and French language-friendly services is a feature of all intended and planned services in CND OHT. Throughout the CND OHT design process thus far, the Francophone and French speaking population has been engaged to validate the current OHT plans. The Francophone population will continue to be engaged on an ongoing basis through the involvement of Francophone representatives such as FLHPE staff or board members, community members and other stakeholders in service planning at the workgroup level in order to be consulted and collaborate on ongoing design initiatives in the OHT.

Recruitment and Retention of Francophone Human Resources - Physicians, nurses,

allied health, personal support workers (PSWs), and other allied health professions will be critically important to the successful implementation of OHTs. In a geographical area like CND with a smaller Francophone community, recruitment and retention of bilingual health human resources can be challenging. WWLHIN H&CC team has bilingual staff at reception, Information and Referral and within the community and hospice palliative care team. Current number of bilingual H&CC SPO staff is low and therefore H&CC is looking to innovative approaches to provide a more focused and patient centered approach to care provision in French by creating a more integrated care team with other bilingual community services. CND OHT will look into partnering with the francophone roundtable for WWG that have launched an initiative to attract and retain francophone health human resources. In addition, the CND-OHT will partner with the FLHPE and other stakeholders to provide member organizations with education, resources and tools related to bilingual human resources recruitment and retention.

### *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*

In addition to focusing on our year 1 target population, CND OHT plans to support and work with groups with distinct health service needs such as marginalized and vulnerable populations (e.g., unattached patients, patients with chronic diseases, mental health or addictions issues, elderly, newcomers and refugees, young families, socioeconomically disadvantaged groups, Indigenous or Francophone communities and people in supportive care/long-term care, etc.).
Currently in CND, even though attachment rates suggest close to 97% residents have a primary care provider, recent information gathered from homeless shelters, food banks, addiction services, mobile safe kit vans and other community-based health and social service agencies show close to 50-70% of the residents they serve are not attached to primary care, nor do they have access to primary care services. This represents approximately 1650 patients in Cambridge. CND is already working to address these populations through the use of the Interprofessional Primary Care (IPC) program which is a team of Vulnerable Complex Outreach Primary Care providers supporting complex-vulnerable patients.

About the Program – The IPC program lead by Langs for the Cambridge community aims to improve attachment and access to team-based primary healthcare for those who need care the most and has been an effective way to meet the needs of the complex and vulnerable population. These residents face the double disadvantage of

both health inequality and barriers to accessing traditional primary care services. This model includes a blend of the creation of a new interprofessional care team anchored in social service settings with the goal of creating primary care attachment. A forthcoming Primary Care Bus being implemented by Sanguen with resources from the IPC program will reach transient populations that reside in tent cities, on the street or in local rooming housings.

Organizations Involved – Langs (Member), Cambridge Library, Women's Crisis Services, The Cambridge Shelter Corporation, Monica Place, Argus Residence for Young People, Sanguen Health Centre, Delta Coronation FHO.

### 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*

P/F/C are a core stakeholder group for our OHT, and have been engaged in a variety of ways to assist in establishing the vision, strategy, and priorities for the OHT. P/F/C will continue to play an important role in redesigning care as we develop our OHT in Year 1 and continue toward maturity.
We anticipate engaging P/F/C in the following ways:

• Steering Committee – The steering committee will include representation from P/F/C. The steering committee, as can be seen in the governance model in Appendix C Figure 1, will be the OHT's governance body with authority to make binding decisions among the members according to the terms of their agreements. Sitting on this steering committee will provide P/F/C with a formal voice on the body that oversees the OHT.

• Co-design groups – We anticipate the continuation of our current process of engaging representatives from different stakeholder groups on co-design groups to redevelop and redesign care. Representatives of P/F/C will continue to sit on the co-design groups in the next phase. They will extend the work of redesigning and planning the governance, service delivery, and digital health functions of the OHT that has been completed to date. The co-design groups in the next phase will focus on developing plans for the detailed governance structure, establishing the mechanisms for embedding care coordinators in primary care, transforming how we support patients on their journey within the OHT, developing the digital health plan, and more. As we have included P/F/C in the current co-design groups, we anticipate them

continuing in the next phase and beyond to work with us in the co-design groups.

• Patient engagement sessions – CND OHT has also already begun engaging broader representation of P/F/C through open consultation sessions. We have engaged the existing patient, family, and caregiver advisory groups that the Members maintain to solicit their perspective on the care priorities and needs for CND. We have also invited other P/F/C to these groups to ensure that we are soliciting a broader perspective of input. CND anticipates continuing to engage members of the P/F/C to provide advice and guidance throughout OHT development and beyond.

• Patient surveys – Using the Ocean-enabled tablets, we are able to record Patient Reported Outcome Measures (PROM) and Patient Reported Experience Measures (PREM) at point of service. This allows us to further explore the patient experiences and outcomes at points of care and feed this information into engagement sessions and co-design groups for further discussion. The Members anticipate that we will expand the number of tablets at point of service to solicit PROMs and PREMs from a larger group of P/F/C than we are not reaching.

# 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*

As described in Section 2.4, the Planning Partners have extensive experience working together on multiple collaborative governance and planning forums, and delivering collaborative quality improvement and service integration initiatives in addition to our current work of OHT planning. This history of collaboration provides a strong foundation of trust, based on a common vision, values, and priorities.

All of our Planning Partners fully support the values and principles embodied in the provincial Patient Declaration of Values and have relevant experience to offer. In 2011, local hospitals and the Community Care Access Centre at the time developed a joint Declaration of Values. This process and experience helped inform the development of the WWLHIN joint Declaration of Patient Values in 2018 that was designed with patient and provider input and signed by nine of our Planning Partners. Other Planning Partners have developed their own declarations of patient values that are fully aligned with both the provincial and WWLHIN statements.

During the initial Planning Partner Meetings in January and February 2019, the Planning Partners began their journey by identifying common goals and values. The group noted the opportunity to preserve and advocate for these values as one of the key reasons to be an early adopter of the OHT model. The common values and goals identified during the planning sessions included:

- Primary care as the foundation of quality, integrated, coordinated care
- Equitable, accessible, and culturally-safe care and services
- The importance of addressing social determinants of health in the care model
- Focus on prevention and wellness
- Value, enable, and encourage care directed by P/F/C
- Interdisciplinary teams based on respect
- Strong accountability to funders and partners and the efficient use of resources
- Collaborative governance and community engagement
- Population health planning – driven by data

These values, goals, and priorities are reflected in the proposed future state vision.

The future vision was developed collaboratively by all 31 Planning Partners, not just the Members involved in Year 1 service delivery, and is therefore shared by a significant portion of current and future Members. The vision was also informed by engagement with clinicians, P/F/C, governors and community stakeholders, and is reflective of the community at large. This broadly shared vision will be a critical success factor for the OHT as it expands its membership and scales services in years to come.

### 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*

The CND OHT Planning Partners have designed a collaborative governance framework for Year 1 that includes representation from physicians/clinician, patients, and member organizations. The governance model was developed based on key principles for collaborative governance, and leverages frameworks and resources provided through RISE. The governance model was developed by a Governance Co-Design Working Group that included governance subject matter experts, patients/caregivers, primary care physicians, nurse practitioners, sector leaders, and experts from long-term care, MH&A, hospital, palliative and CSSs. The model was reviewed and validated with our Planning Partner representatives and governor representatives during a consultation session with approximately 80 governors and executive leadership.

The Year 1 governance model reflects a "collaborative or joint venture" agreement structure (Reference: Ontario Health Teams Governance Options: Getting Started and Evolving Toward Maturity, BLG 2019; RISE Brief 2: Leadership Infrastructure and Work Plan; Rise Brief 3: Collaborative Governance). Members will continue to maintain their own legal structures and will enter into an agreement to co-manage a defined set of services. This model provides a minimally disruptive governance structure that allows OHT Members to leverage existing trust relationships to collaboratively design, implement, and oversee Year 1 commitments.

Joint Board Committee of Member Organizations
In addition to the Steering Committee, the Planning Partners anticipate striking a Joint Board Committee, comprising governor representatives of the Members. The role of this body will be to ensure alignment between the strategic priorities and plans of the OHT and the Members, to provide oversight on OHT and joint Member accountability commitments, and to establish a framework for future state governance structures at OHT Maturity. The Joint Board Committee also provides a mechanism to effectively integrate and align Member boards to the OHT, and to strengthen board-to-board relationships and communications.

OHT Steering Committee
The OHT Steering Committee in Year 1 will set strategic and tactical priorities, develop agreements and plans (see Accountability Agreements below), set and monitor performance targets, report to the Joint Board Committee and organizational boards, and provide management oversight of design, implementation and operational activities of the OHT.
Steering Committee representation for Year 1 will include:
• Executive or clinician leadership from each Member organization
• Local physician leadership repsentation (e.g. Chief of Staff and Chief of Family Medicine)
• Primary care provider representation selected by the Primary Care Collaboration Working Group
• Non-physician clinician repesentation
• Patient/Family/Caregiver representation elected by the Patient/Family/Caregiver

Advisory Group

Accountability Agreements
Our planning partners understand that their existing accountability agreements will continue during Year 1 and during maturation, and that MOH/OH will also establish an accountability agreement with Year 1 Members for specific services and performance outcomes. In Year 1, the Planning Partners will also have Members sign a collaborative accountability agreement amongst themselves. The collaborative accountability agreement will define governance roles and responsibilities, the specific basket of services for transformation and integration, and an agreement to share and mobilize financial and human resources among member to support the delivery of integrated and transformed services. In addition, the Members will develop and commit to the following:

- Shared Integration Principles
- Integrated Strategic Plan for the OHT
- Resource Allocation for Year 1 activities/services
- Shared Performance Measurement Framework
- Integrated Quality Improvement Plans
- Data Sharing Agreements for service delivery and population health analysis
- Conflict Resolution Plan

Affiliate Members
Planning Partners not directly involved in caring for the Year 1 population or the delivery of transformed/integrated services in Year 1 may choose to identify as Affiliate Members. While Affiliate Members will not be party to the OHT Accountability Agreement with MOH/OH or the joint accountability agreement between Members, they will be signatories to an Affiliate Agreement defining their roles and responsibilities including:

- Participation in an Affiliate Member Forum, co-design working groups and ongoing stakeholder engagement
- Committing to a joint vision statement and the shared integration principles for the OHT
- Signing a data share agreement to support service delivery and population health analysis purposes for the OHT.

The Steering Committee will develop mechanisms for onboarding new Members and Affiliate Members in Year 1 to ensure that individual physicians and organizations can participate fully in supporting Year 1 commitments.
Other potential future Member physicians or organizations that are not yet ready to participate as a Members or Affiliate Members will continue to be engaged as stakeholders to ensure they are informed of OHT progress and have an opportunity to provide input.

Primary Care Representation
The Primary Care Collaborative an initiative of Health Link was established three years ago to provide a forum and mechanism for primary care clinicians in CND to identify shared priorities and implement integrated services where possible. The group meets 8 to 10 times per year and includes representation from different patient enrollment

models including CHCs, NPLC, FHT, and FHOs. Membership in the collaborative will also be refreshed to ensure effective representation from other primary care groups in CND including physicians in fee-for-service (FFS) models. During Year 1, this group will be leveraged to provide advisory input to the OHT Steering Committee including having a representative on the Steering Committee.

Patient/Family/Caregiver and Community Representation
All Planning Partners currently have some form of Patient/Family/Caregiver advisory bodies. A new advisory body specific to the CND OHT will be established in Year 1, and members of this group will select a representative to sit on the Steering Committee.

Management
An OHT Operational Team will be responsible for coordinating and supporting the strategic and tactical priorities, plans and performance measures established by the Steering Committee in Year 1. Members have committed to supporting these resources through financial resource sharing and/or secondments. The Planning Partners currently anticipate requiring an operational team comprising 1 FTE coordinator, 0.5 FTE decision support, 1 FTE administrator, and 1 FTE communications and change management resource. As Year 1 tactical plans are further developed, other operational resources may be required.

Design, Planning and Implementation
- Co-Design Working Groups

The Steering Committee will establish topic-based sub-committees to define the strategic and technical priorities across a number of specific domains, such as H&CC transformation, service delivery integration, care coordination/system navigation, digital health, and health information privacy. The sub-committees will be supported by Co-Design Working Groups that comprising participants from not only Member organizations, but also from Affiliate Members and other community stakeholders. Co-Design groups will include physicians, P/F/C, subject matter experts, front-line staff, and other community representatives. They will focus re-designing care and services and developing integration mechanisms such as common assessment and intake processes, common data standards, common patient pathways, and common care/service protocols.

- Reference Groups

Reference groups are formally established bodies to provide periodic but ongoing feedback and advice to the Sub-Committees and the Co-Design Groups. It is anticipated that these groups will be organized around professional disciplines and patient/family/caregiver representatives, but other configurations (e.g. interdisciplinary/patient groups focused on specific patient pathways) might also be established as needed. The purpose of these groups is to leverage informed and engaged subject matter experts and patients/family/caregivers to advise and guide technical design and implementation plans such as common assessment forms or models for integrated services.

Ongoing Governance Planning and Design
The Planning Partners recognize that this structure is not optimal to support accountability and funding structures at Maturity. The governance structure will evolve to reflect representation from a much larger group of Members as Year 1 Affiliate Members and other stakeholder organizations transition into full Members in future years. The future state governance structure will also need to robustly support the single-fund holder structure across the full continuum of services at Maturity.
As such, the Members will continue to evaluate and evolve the governance model and have identified a "next phase" governance model as a key deliverable by the end of Year 1. The next-stage model will strengthen the decision-making role of the Steering Community by transitioning it into a community board with independent decision-making authority over a designated basket of services. The community board will be supported by a robust management team that can drive change and manage operations for a larger portion of the attributed patient population.

### 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.

*Max word count: 1500*

Information Flows

Our Members and Affiliate Members use a variety of electronic tools to share information for service and population health purposes (see Appendix C Figure 3 for diagram):

Enabling Mechanisms

In addition to the solutions identified above, we will also put in place the following administrative mechanisms to ensure that information can be exchanged:
• Harmonized Information Management Plan – An information governance and information plan outlining information govrnance mechanisms, the core data set across the sectors, sector-specific core data sets, data entry protols and standards, and information sharing mechanisms amongst the CND OHT Members and Affiliate Members
• Data sharing agreements – The governance agreements of Members and Affiliate Members include data sharing clauses or reference separate data sharing agreements. The data sharing agreements will describe the information to be disclosed with one another, the purposes and PHIPA authorities of the disclosures, and the safeguards that must be in place to protect privacy and security. The data sharing agreement that defines information sharing framework and privacy policies of the Connectivity Table can be leveraged as an practicel example of an existing agreement among our Members and Affiliate Members that have been effective.
• Privacy Policy Manual – CND OHT will develop and distribute a privacy policy manual that defines the detailed privacy processes that the Members need to follow when interacting with one another, and which will establish standards that each Member and Affiliate Member must meet with respect to the safeguards they are required to deploy to protect patient privacy.
• Exploring Single Health Information Custodian (HIC) Status – CND OHT will also explore the possibility of becoming a single HIC as permitted by Minister order under PHIPA, s 3 (7). Being designated a single HIC may provide the Members and Affiliate Members with opportunity to share Personal Health Information (PHI) amongst each other for a broader set of purposes related to population health management and performance management. We will examine during Year 1 whether acting as a single HIC will better support achieving the OHT goals – recognizing that only organizations that are currently HICs can be included under the umbrella of a single, designated HIC.
• Core data set and data entry standards – CND OHT will establish core data sets of health information that need to be captured on patients depending on the nature of the service they are receiving and common data entry standards to enable effective exchange and interpretation of health information.

Status under PHIPA

Most of our Members and Affiliate Members involved during Year 1 of the CND OHT are HIC under PHIPA. However, we will also need to accommodate the organizations are not HICs under our model:

• Acute Care - Relevant PHIPA Section Establishing Sector as a HIC: 3 (1) 4. i. A hospital within the meaning of the Public Hospitals Act
• Primary and Specialty Care - Relevant PHIPA Section Establishing Sector as a HIC: 3 (1) 1. A healthcare practitioner or a person who operates a group practice of healthcare practitioners

• CHCs - Relevant PHIPA Section Establishing Sector as a HIC: 3 (1) 4. vii. A centre, program, or service for community health or mental health whose primary purpose is the provision of healthcare

• MH&A - Relevant PHIPA Section Establishing Sector as a HIC: 3 (1) 4. vii. A centre, program, or service for community health or mental health whose primary purpose is the provision of healthcare

• H&CC - Relevant PHIPA Section Establishing Sector as a HIC: O. Reg. 329/04, (8) (a) Every local health integration network is prescribed as a HIC

• LTC Homes - Relevant PHIPA Section Establishing Sector as a HIC: 3 (1) 4. ii. A long term care home within the meaning of the Long-Term Care Homes Act

• CSSs - Relevant PHIPA Section Establishing Sector as a HIC: 3 (1) 2. A service provider within the meaning of the Home Care and Community Services Act

• Hospice - Relevant PHIPA Section Establishing Sector as a HIC: 3 (1) 2. A service provider within the meaning of the Home Care and Community Services Act (but may differ depending on the nature of the hospice services provided)

Authority for Collection and Disclosure

As such, PHIPA allows for disclosure and collection amongst the Members and Affiliate Members who are HICs for the following relevant purposes:
• To provide or support the provision of healthcare – Implied Consent - See PHIPA, ss 18 (1), 29, 36 (1)
• To improve or maintain the quality of care to the individual or similar individuals where both custodians provide care to the individual – See PHIPA, s39 (1) (d)
• To determine eligibility for provincially-funded services – See PHIPA, 39 (1) (a)
• For other administrative purposes such as billing – See PHIPA ss38 to 50

Obtaining Express Consent

Additionally, the Members and Affiliate Members anticipate identifying mechanisms for obtaining express consent during our Year 1 planning when create the privacy manual. Obtaining express consent from patients will enable sharing information for a broader set of purposes as well as with organizations who are not HICs.

Key Safeguards

The key safeguards that the Planning Partners anticipate deploying to protect privacy

are:
• Privacy manual – A privacy manual establishing policies and procedures guiding information sharing among the Members and Affiliate Members so that it is conducted in a privacy-protective way
• Common training – Standardized training materials related to privacy in an OHT
• Data Sharing Agreements – Standardized agreements among the Members and Affiliate Members
• Codes of Conduct – Codes of conduct to be signed by staff members obtaining agreement to meeting their privacy obligations
• Harmonized Privacy Policies – Harmonized privacy policies among the Members and Affiliate Members where possible
Secure Transfer of PHI – Secure electronic transfer of information amongst the systems
• Privacy Lead – Identification of a privacy lead to support development of the privacy program and provide guidance to the Members and Affiliate Members
• Privacy Working Group – Formalized Terms of Reference for a working group representing the partners to align policies and procedures
• Cyber Insurance – Securing cyber insurance for privacy and security breaches such as snooping or ransomware

Gaps

The key gaps that CND faces with respect to information exchange is the technical ability to extract and share primary care data and CSS data. Although some primary care data can be extracted and shared through Ocean eReferral and through CHRIS, it is not the full scope of data required for all modalities of care. CSS data cannot be electronically shared with the other providers. The Planning Partners would be interested in investigating provincial solutions to enable sharing this information including expanding the Primary Care Database beyond pilot to full implementation. Additionally, while the Members and Affiliate Members will establish data sharing agreements to clarify authorities for collection, use, and disclosure amongst themselves, the agreements are unable to authorize disclosures of PHI not already authorized by PHIPA. The Planning Partners would like to work with the Ministry in identifying potential changes to PHIPA including enabling disclosure of PHI (where the patient is shared or is expected to be shared) for the same purposes for which it can be used specifically for the purposes of health system and service planning. This would help enable us to disclose PHI to one another for key OHT purposes that we can currently only use PHI for internally.

#### *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.

# Ontario Health Teams
# Full Application Form

## 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*

None of our Members or Affiliate Members have issues with governance, financial management, or compliance with contractual or legislative obligations. However, the Members and Affiliate Members are also interested in improving performance and anticipate deploying the following mechanisms:

• Joint Board Governance Committee – One of the committee's key roles is ensuring that Members and Affiliate Members are meeting the accountability obligations established in their accountability agreements with one another and their accountability agreements with MOH/OH. The committee will provide ongoing oversight to identify, support, and resolve performance issues.

• Accountability Agreements – The Accountability Agreements will outline the obligations and performance benchmarks that the Members and Affiliate Members must meet individually and as an OHT to achieve shared strategies. It will further define corrective measures that Members must take to improve performance should they fall short.

• Accountability Agreement with MOH/OH – The Members recognize that they will be required to sign accountability agreements with MOH/OH defining the benchmarks that they need to meet, and are committed to meeting these benchmarks.

• Integrated Quality Improvement Plans – CND already has and will continue to use Integrated Quality Improvement Plans to establish common performance metrics for Members in the OHT. Affiliate Members will also have the option of being included in the Integrated Quality Improvement Plans. The plans are another tool used in addition to the agreements to inform interventions that we need to make across the system and with individual providers where performance does not meet the benchmarks.

• Peer mentoring – CND OHT anticipates rolling out peer mentoring opportunities to the Members and Affiliate Members. Peer mentoring will enable Members and

Affiliate Members learning from one another about effective care and service mechanisms to improve outcomes.

• Strengthening connection to the OHT's mission and vision – A core aspect of our OHT will be changing the culture among the Members and Affiliate Members to focus on the shared mission and vision for the CND OHT, rather than only organizational goals. We intend to establish and promote a common brand not just to patients but to our staff as well. A key performance challenge in the healthcare system currently is individual organizations or providers failing to take accountability for the whole patient rather than the particular service that the organization or provider offers the patient. Increasing staff connection to and affinity for the OHT will enable us to strengthen individual accountability for the whole patient and minimize siloistic attitudes undermining care performance.

• Conflict Resolution Plan – The Members and Affiliate Members have included in their workplan the development of a conflict resolution plan to address any conflicts amongst the Members and Affiliate Members. Conflicts that are not resolvable at the lower levels are expected to be escalated to the Joint Board Governance Committee for discussion and resolution according to a formalized process.

### 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*

Provincial OHT Championship

Our Members and Affiliate Members are committed to championing the OHT vision and model across Ontario. As the only region participating in collaborative QIPS, we have demonstrated a willingness to lead transformative change for the system. We are excited about the transformative potential of OHTs and would support provincial messaging and resource sharing. We have experience in sharing lessons, evaluation results and resources, and championing innovative models with other regions and jurisdictions, for example, with our Health Links model, the Connectivity Table and the Hub@1145 model. In the case of Connectivity Table and Hub@1145 we have been recipients of awards for the work and/or presentations/site visits by organizations interested in adopting these models in their environment. We look forward to the opportunity support the scale and spread of OHTs across Ontario.

Performance Improvement and Continuous Learning

Our Members and Affiliate Members have a demonstrated history of quality and performance improvement and continuous learning both as individual organizations and collectively as a team.

We have previously established baseline metrics for integration among our Members by using the data that the Members and Affiliate Members collect and through support of WWLHIN Integrated Decision Support System. We understand the impact that changes in one sector has on the others. Both Members and Affiliate Members currently collect and report on a range of key performance metrics related to integration, patient experience, utilization, and outcomes. We use this data to establish local priorities, monitor performance against local and provincial priorities and benchmarks, and learn as organizations.

Most of our Members already have accountability agreements in place with the LHIN and similar with MOH. These include WRNPLC, Two Rivers FHT, Grandview Medical Centre FHT, Langs CHC, CMHA, CMH, WWLHIN (Ministry-LHIN Accountability Agreement), House of Friendship, Stonehenge Therapeutic Community, Fairview Mennonite Home, St. Luke's Place, CSC, and Traverse Independence. Additionally, many of our Affiliate Members have also signed accountability agreements with the LHIN which require them to meet and report on performance benchmarks.

Other examples of continuous learning and performance management include:

• In collaboration with HQO, eight of our Members and Affiliate Members already

report on key patient experience, quality and performance metrics as part of their mandatory quality improvement plans (QIPS).
• Our Members and some of our Affiliate Members have also been early adopters of Collaborative Quality Improvement Plans (C-QIPS) and are now in our third year of driving system-level change through a MH&A and a discharge planning C-QIP across multiple organizations and sectors.
• Our FHTs and CHC have in place Quality Improvement Decision Support Specialists (QIDSS) who support the Members in using their data to drive performance improvement and decisions.
• Most of our Members and many of our Affiliate Members are accredited through Accreditation Canada.
• Independent Living Centre of Waterloo participates in a continuous learning initiative in which performance indicators are developed based on Board-established strategy and priorities, and used to monitor and govern organizational performance. Independent Living Centre of Waterloo's innovative performance in this area has made them a showcase site in performance management and have visitors locally, provincially, and internationally come to learn from their performance management success.
• Our Members and Affiliate Members participate in a variety of workshops and training sessions to support continuous learning and growth. Examples of workshops that our primary care Members have attended include Indigenous Cultural Training, Rainbow Positive Space Training, Challenges in Care of the Elderly, Self-Compassion and Emotional Resilience, Positive Psychology, Grief-focused Counselling Skills, Safer Opioid Prescribing, and Effective Pain Management.
• Traverse Independence provides Acquired Brain Injury training to over 300 other healthcare providers in the region to support their continuous learning, and provides ongoing mentoring and support as necessary.
• H&CC provides continuous learning opportunities to staff and service providers both locally and regionally (e.g. wound care pathways, advance care planning, coordinated care planning, actively offering French-language services, palliative approach to care, ASIST training). As well, H&CC has supported staff to participate in Health Innovation Basecamp to help develop, grow and spread a culture of innovation and quality improvement.

Process Improvement
Through our work on C-QIPs, as well as other collaborative initiatives, our Members and Affiliate Members have identified numerous opportunities to align clinical standards and processes. For example, the Discharge Planning Working Group has standardized discharge processes and information flow between hospital, primary care, speciality care, H&CC, rehab services and long-term care providers, and is working with community pharmacists to streamline and standardize medication reconciliation processes across these sectors.

As the Members transition to greater team integration and resource mobilization in Year 1, we will leverage the experience and capacity of our Members to support the

our FHO partner that currently does not have access to decision support and data analytics resources.

Our Members and Affiliate Members have been involved in multiple innovative models (e.g., Health Links, Community Hub, Situation (Connectivity) Tables, System Coordinated Access, Here24/7) and have championed these models through a variety of collaborative learning forums. If we are chosen to proceed, we are committed to continuing to champion a model of continuous improvement by monitoring performance, mentoring other organizations, and being mentored by our peers in other regions.

#### *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*

Previous Examples of Patient Input

Our Members and Affiliate Members have existing advisory groups to solicit P/F/C input:

• Langs CHC Community Services Committee and North Dumfries Program Committee comprise patient and community representatives to provide input on improvement plans, user experience and partnership opportunities

• CMH Patient and Family Council provides input into various operational and strategic decisions and is engaged in design of programs and services. The Patient-to-Patient Program solicits feedback on key decisions and plans.

• CMH Mental Health Family Advisors provide the family perspective on decision-

making processes and services
• The CMHA WW Family Council makes recommendations for improving or enhancing programs, initiatives, policies, processes and P/F/C experience
• WWLHIN Patient Family Advisory Council engages patients across the entire LHIN region and has launched a new Patient Declaration of Values developed by 20 patient and family groups and endorsed by all partners
• WWLHIN H&CC Voices Survey gathers P/F/C experience feedback
• Hospice Residences “Point of Care” program gathers P/F/C real-time experience feedback

Additional Patient Engagements Completed to Date

The Planning Partners also conducted specific engagement sessions with P/F/C in relation to the OHT. These include:

• P/F/C have participated in co-design groups to plan service changes (i.e. transitions, H&CC, system navigation, and care collaboration)
• CND Primary Care Collaborative held P/F/C Focus Groups from primary care practices across CND on priorities for an CND OHT, and on same/next day/after-hours access.
• The Planning Partners held focus groups with P/F/C comprising a variety of backgrounds, experiences, ages and needs. A specific Francophone session was held in French to identify the specific priorities and needs of this community

During our engagement, P/F/C questions and concerns were:
• Privacy concerns such as breadth of access to their PHI, consent model, and data localization
• Interest in understanding whether the OHT funding envelope could be used to procure private services (e.g., counselling) and greater transparency into how providers are paid
• Concerns related to the potential impact of a change in government on the OHT model
• Worries that the process is moving too quickly
• Questions about accessing services external to the OHT
• Interest in the accountability mechanisms required to ensure care coordination and seamless transitions
• Suggestions to improve integration of PSWs into the care team
• Worries that the care team will be too large, and they will lose a personal connection with their primary care provider

Ongoing Patient Input during Year 1 and Beyond

We anticipate continuing to engage P/F/C to obtain their perspectives on the priorities and needs for practice and service changes – particularly through P/F/C's continued participation in co-design groups. Each group is responsible for designing and planning how a service needs to change to improve transitions, coordination, and

care.

In addition to the co-design groups, we will engage P/F/C by:
• Developing a P/F/C advisory group responsible for providing ongoing feedback and guidance to the OHT;
• Appointing a P/F/C representative to the CND OHT Steering Committee; and
• Delivering surveys via tablets at point of care to measure PROMs and PREMs.

### 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*

Previous Examples of Community Input

Members and Affiliate Members currently use a variety of mechanisms to solicit and incorporate community feedback into practice and service changes. Connectivity tables (i.e., situation tables) are a good example of community input driving change. CND has a successful Connectivity Table that identifies people at acutely-elevated risk of harm and provides them urgent health, social service, and community supports. In addition to health and social service providers, we also have police, schools, and other community partners at the table. The Connectivity Table has driven changes to intake and assessment for people at acutely-elevated risk of harm in collaboration and in response to the recommendations of our community partners such as the police.

CND also built a community hub (Hub@1145) which houses community services along with health and social services under one roof. The community hub model enables service providers to work alongside one another to provide wrap-around service to patients and residents of CND. The hub involves patients and community members in governance, setting priorities, program delivery and evaluation, and drives both informal and formal changes in our practice models.

Community Representation on Our OHT

In addition to previous examples of participation by and partnerships with community, community members are also actively represented at our planning table and comprise some of the 31 Planning Partners. These community representatives have participated alongside health service providers in developing and designing the vision, strategy, and plans for our OHT.

Ongoing Community Input during Year 1 and Beyond

In addition to sitting at the planning table, community representatives have also been

part of the co-design groups to design and plan for the OHT. Members and Affiliate Members anticipate continuing to seek community input into practice change through their ongoing participation at the planning table and in co-design groups.

CND OHT is also interested in expanding our mechanisms for collaborating with community. As noted above, we currently collaborate through opportunities such as Connectivity Tables. We expect to continue these tables and grow our work together by expanding their focus and applying similar principles and processes to a broader population (i.e., Connectivity 2.0). CND has a strong collaborative relationship amongst health and social service providers and community, and look forward to continuing to strengthen and explore new opportunities for growth.

### 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*

All Members and Affiliate Members have a strong track-record of financial management and have robust governance structures in place. The partners understand that OHTs will have an integrated funding envelope delivered through a single fund holder at maturity.

Several Members and Affiliate Members have experience with integrated funding models such as bundled care and acting as transfer payment agencies. For example:

- CMH is working with WWLHIN H&CC on a bundled care model and pathways for hip and knee surgery, and shoulder arthroplasty
- Langs CHC is a transfer payment agent for community midwifery practices
- Lutherwood as a lead agency for children's mental health has held funds for many joint ventures
- CND Health Link works with several of our Members and Affiliate Members to plan for and meet priority needs in the region. The Health Link commonly moves and mobilizes resources around the region as the needs or care evolves

Using the population health metrics available through our partners and the WWLHIN, we have identified local health system cost drivers related to ALC, unnecessary ED visits, avoidable hospital admissions and re-admissions and inefficiencies in patient

transitions. These cost drivers have informed our proposed Year 1 target population, integration strategies, and scope of services discussed elsewhere in this application. In addition to the mechanisms that we have already deployed, we intend to add the following mechanisms during Year 1 of our OHT to manage resources across the Members:

• Integrated Quality Improvement Plans – Collaborative plans that establish strategic priorities and performance benchmarks for the Members and which are used to guide service planning including a collective commitment to mobilizing financial and human resources as necessary to meet our community's needs

• Accountability Agreements – The Accountability Agreements will outline the accountability obligations and performance benchmarks that the Members and Affiliate Members must meet individually but also as an OHT to meet the shared strategy. It will further establish mechanisms to move resources around the system as required to meet the care needs or innovate in care

• Joint Board Governance Committee – The committee is intended to provide oversight to the accountability agreements including mobilizing the resources as required in their own organizations as well as across the system to ensure that resources are being effectively deployed

• Colocation of services – Where the Members are unable to reallocate spending for various reasons, the Members intend to move and collocate human resources in different settings such as primary care to support the evolving needs. Affiliate Members will also be extended this opportunity.

# 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*

The implementation plan focuses on three workstreams: 1) Governance; 2) Service Integration and Transformation; and 3) Digital Health and Information Sharing.

Workstream 1: Governance

Days 1 to 30
1. Establish governance bodies – Identify and initiate governance bodies to oversee development, implementation and oversight of the OHT
2. Draft integration principles and confirm governance structure – Extending the current governance work to develop detailed Terms of Reference, decision-making structures and principles
Outcomes: a) Steering Committee; b) Defined Decision-making Structure; b) Terms of Reference for Committees and Working Groups; c) Guiding principles

Days 31 to 60
1. Develop supporting governance tools and mechanisms – Create mechanisms such agendas, reporting templates, and tools and templates to support effective decision making and communication
2. Draft agreement framework – Negotiate table of contents and key concepts for the agreement's governing members and affiliates
3. Initiate strategic plan development – Extend previous work to begin formalizing the integrated strategic plan for the OHT
4. Initiate OHT Brand Identity development – Explore OHT brand principles
Outcomes: a) Governance tools and templates; b) Draft agreement frameworks

Days 60 to 90
1. Sign agreements – Finalize negotiations and sign agreements among Members and with Affiliates
2. Develop Integrated Strategic Plan – Continue consultations and engagement towards developing the integrated strategic plan
3. Develop brand identity – Develop the OHT brand
Outcomes: a) CND OHT Member Accountability Agreement; b) CND OHT Affiliate Accountability Agreement; c) Vision, Mission, and Goals; d) CND brand identity

Day 91 to Six-months
1. Finalize integrated strategic plan – Finalize the integrated strategic plan including confirmation of performance metrics and benchmarks
2. Develop OHT Brand assets – Create brand assets including logo, letterhead,

website, and patient-facing materials
Outcomes: a) Integrated Strategic Plan; b) Integrated Performance Metrics; c) CND brand assets

Six Months to Year 1
1. Monitor – Ongoing monitoring to confirm performance
2. Prepare for maturity – Establishing target governance structure to accommodate changes required to achieve maturity
3. Optimize – Changes in the governance structure from lessons learned during the initial six months of operation
Outcomes: a) Optimized Governance Structure

Workstream 2: Service Integration and Transformation

Days 1 to 30
1. Identify transition, service coordination, and system navigation priorities – Confirm priorities for improvement based on self-assessment and full application work
2. Finalize current state map – Develop a detailed map of those involved in transitions, coordination, and system navigation and the specific services they provide
3. Confirm co-design groups – Identifying participants and initiating co-design groups based on the transition, service coordination, and system navigation priorities
Outcomes: a) Current State; b) Terms of Reference for Co-Design Groups

Days 31 to 60
1. Redesign transitions, service coordination, and system navigation functions – Develop a detailed future state model outlining refreshed service integration functions based on priority services or sectors; the redesign is expected to examine the detailed process, the people involved, the required information and supporting technology
Note that there are expected to be several co-design groups each examining a different aspect of service integration (e.g. expansion of care coordination to include coordination of other services, reviewing integration between primary care to mental health)
Outcomes: a) Redesigned transitions, service coordination, and system navigation

Days 60 to 90
1. Finalize collaborative quality improvement plan and other plans to support collective ownership over the success of care delivery
2. Develop protocols and supporting materials – Creating protocols and supporting tools and templates to guide transition, coordination, and system navigation (e.g. training materials)
3. Establish change management plan – Create a change management plan to guide transformation of healthcare services
Outcomes: a) Collaborative Quality Improvement Plan; b) Service Transformation Supports; c) Detailed Change Management Plan

Day 91 to Six-months
1. Execute change management plan – Implement the activities required to transform the coordination and integration of services. Specific activities will be developed in the change management plan, this may include relocation of services or human resources, establishing team-based care groups, training on care protocols, etc.
Outcomes: a) Integrated Care Team providing system navigation, care coordination, and better transitions

Six Months to Year 1
1. Monitor – Ongoing monitoring to confirm performance against quality; monitoring is expected to involve soliciting feedback from patients and providers as well as monitoring performance metrics
2. Optimize – Incremental changes in care delivery to enhance transitions, coordination, and system navigation, and identification of the next set of transformation priorities
Outcomes: a) Optimized Service Integration

Workstream 3: Digital Health

Days 1 to 30
1. Confirm digital health priorities – Confirm priorities for enabling information exchange amongst the partners and with patients (e.g. access to information, virtual visits)
2. Confirm co-design groups – Identifying participants and initiating co-design groups to focus on key areas (e.g. information management, technical integration, change management)
Outcomes: a) Terms of Reference for Co-Design Groups

Days 31 to 60
1. Develop digital health delivery model – Create the digital health strategy and roadmap for the OHT
Outcomes: a) Digital Health Strategy including governance model, digital health services to be deployed, support models, and required supports

Days 60 to 90
1. Develop digital health workplans – Plans to implement the digital health strategy
Outcomes: a) Digital Health Work Plans to deliver on the strategy such as data standardization, technical integrations, change management, and technology governance

Day 91 to Six-months
1. Execute on the digital health work plans – Specific activities to be determined but will generally include establishing a governance structure for technology, identifying and executing on training and change management needs, securing necessary licenses, enrolling patients for access, developing patient-facing training materials for

virtual visits, and so forth
2. Develop Harmonized Information Management Plan – Plan to govern health information amongst the CMD OHT Members and Affiliate Members including information governance, protocols and so forth
3. Develop Privacy Manual – Development of a privacy manual to safeguard patient information across the CND OHT Members and Affiliate Members
Outcomes: a) Digital health in place; b) Harmonized Information Management Plan; and c) Privacy Manual in place

Six Months to Year 1
3. Monitor – Ongoing monitoring to identify pain points and gaps in digital health needs
4. Optimize – Incremental changes in digital health services and support
Outcomes: a) Optimized digital health

### 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*

Effective change management will be a critical success factor for implementing the Year 1 governance structure, service transformations, and digital health enablers. System transformation is both time-consuming and expensive and will require significant change to the Members' and Affiliate Members' current practices and workflow. The Planning Partners will develop a change management plan to guide design and implementation of changes to governance, services and digital health, and to better understand how individuals, teams and partner organizations change from their current practices to those required at maturity.
We have identified 6 core elements which must be accounted for in a change management plan. Each element helps to ensure that a key component of the change process is considered carefully and thoroughly, and that change is successfully implemented and adopted with minimal organizational or individual resistance.

The core elements include:

1. Governance – Our governance structure includes highly informed and engaged organizations who are either Members, Affiliates, or engaged stakeholders and provides a clear accountability structure for Year 1. Our governance structure has clearly defined principles, roles, and responsibilities which will ensure that CND partners are actively aligned and engaged throughout OHT maturation. We provide the opportunity for each Planning Partner and stakeholder to participate in developing or to be informed of CND OHT's priorities, strategies, mechanisms and activities and the design process. As we

work towards becoming an OHT, policies for operationalizing our governance model will be documented and formalized.

2. Stakeholder Engagement – As part of the planning process to become an OHT, we have identified a range of stakeholders, from patients to health service providers to community organizations to service vendors, who will be affected by the changing landscape. We have begun consultations with these groups to help understand their perspectives in planning for change, and will continue to identify and engage stakeholders who would benefit from and benefit with OHT with engagement. We have collectively considered different forms of engagement that would be best suited for each group. For example, the Planning Partners agreed that collaboration and co-creation of integrated services would best achieve through co-design groups to gain perspectives from a variety of system users (i.e., clinicians, administrators, patients, etc.). CND OHT plans to continue to engage stakeholders to ensure minimal resistance to change, and that everyone's voice is heard.

3. Communications – In order for change to be effective within our OHT, communication and messaging must be proactive, consistent and repeated. Communication in this context refers not only to the information that is disseminated, but also for building the organizational understanding of the value of the upcoming changes, and for generating commitment to change at any and all levels within the Members, Affiliate Members, and broader community. The Planning Partners have developed a communications plan considering the various stakeholders included in our governance model, and the best method of communication at each stage of change.

4. Workflow Analysis – The Planning Partners have developed co-design groups where a variety of system stakeholders will have the opportunity to iteratively work together and map current state care and services flows to gain an understanding of gaps, allowing groups to introduce and design future state programs and services that best suits the needs of all health system stakeholders.

5. Training and Education – As new workflows are identified through co-design groups, we will select clinician and end-user champions to support employees in building the skills required for change. Understanding that training and education is different for differing roles in the healthcare system, we will tailor education and training opportunities to specific roles, whether this be P/F/C, clinicians, administrators, and others.

6. Evaluation and Monitoring – The Planning Partners have identified several key priorities to evaluate and strengthen performance, particularly against domains that contribute to hallway healthcare. In the first 6 months, the Planning Partners anticipate developing a formalized collaborative QIP plan to track these identified key performance indicators to gauge the status of the desired change. By iteratively monitoring and evaluating performance and change management, CND partners will identify and course-correct where initiatives are not meeting specific goals and targets.

### 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*

Our Year 1 patient population has been selected because they are currently enrolled in the Year 1 primary care practices that have signed to be initial Members of our OHT or because they are complex and currently unattached to primary care providers. Patients from other primary care practices will continue to receive the same level of service that they have in past from their primary care providers and the other health, social, and community organizations that provide them with services.
The patients in our Year 1 population will benefit from the changes that we introduce through increased care collaboration, improved transitions, better information sharing among their providers, and easier access to their own health information. This is particularly true for our complex patients such as our frail elderly, people in long-term care, people with MH&A issues, and those with significant barriers to access.
However, many of these functions or services will also be improved for patients who are not enrolled in our Year 1 primary care practices because the functions will be strengthened for all patients in CND. The enhancements that will be made available to all patients in CND include:

• Strengthened relationships among health, social, and community service providers to enable easier transitions between providers
• Integrated intake and assessment protocols when accessing services of our Members or Affiliate Members
• Streamlined intake and assessment for H&CC services
• Access to expanded care coordination functions for patients with complex illnesses or chronic disease particularly at hospital discharge
• Access to their own health information through increased adoption of MyChart, eReferral, and other digital health tools that have consumer-facing functions

### 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*

OHT planning participants have identified various systemic barriers that will hinder the progress that we are able to make towards ending hallway healthcare

Labour

• Resource mobilization – Often due to collective bargaining agreements, we are unable to shift human resources from one setting to another such as moving a nurse from one care setting to another. Similarly, we are not readily able to change the scope of their work to meet community demand. This will be a challenge when we move human resources around the system to better serve the patients needs (e.g., moving a care coordinator from LHIN office to primary care office to enable stronger collaboration with the primary care team).
• Clinician compensation for OHT development – Clinicians are expected to have a significant role in developing and overseeing the OHT but do not receive financial compensation for doing so. Fee-for-service clinicians in particular are extremely challenged in devoting the time required to plan for the OHT because it directly impacts their revenue.

Policy

• Virtual care remuneration models – Virtual visits are only reimbursed if Ontario Telemedicine Network (OTN) technology is used and there is a cap on the reimbursement available. This impedes our ability to provide virtual care services to a broader population without immediate access to OTN technology and limits the ability for FFS physicians to use the service because their remuneration may be capped. Remunerating care should be based on the service provided rather than by the mode by which the service is provided. This would enable us to innovate more with other avenues such as text, consumer-based technologies such as FaceTime, and so forth.
• Existing Home & Community Care Contracts – SPOs have assigned market share and estimated volume awards that limit ability to create new H&CC interprofessional care teams. More flexibility should be offered for the development of contracts for H&CC SPOs, including the ability to leverage outcomes-based remuneration, and other value-based contracting mechanisms.
• Penalties against access bonuses – Physicians receiving the access bonus are penalized if their patient goes to a walk-in clinic. Penalizing a physician within the OHT for having their patient see another provider disincentivizes providers asking patients to call after hours and instead has the negative impact of incentivizing physicians to encourage patients to go to the ED. This undermines the key principle of team-based care in the OHT and may reinforce hallway healthcare

Privacy

• Circle of care – Some types of service providers (e.g., PSWs) are not HICs and therefore the providers cannot rely on implied consent to disclose PHI to

them. PHIPA should be amended to enable disclosure of PHI with implied consent to any service provider within the OHT, assuming that the service is for the benefit of the patient. Note that prescribing the OHT as a single HIC would not address this issue, because some of the OHT members are likely to not be HICs on their own and therefore cannot be designated as part of the single HIC.
• Disclosure of information – Similarly, there are purposes such as service planning for which providers can use PHI but cannot disclose it for the same purpose. This limits ability to transfer PHI across providers in the OHT. PHIPA should be amended to enable disclosure of information for similar purposes for which it can be used.

Technology

• Access to CHRIS – CHRIS has care coordination tools that could be used to support broader care coordination but is only available to certain sectors and users. Allowing for expediated and expanded access would benefit care collaboration.
• Interoperability – Providers are reliant on their point of service vendors to deliver on the interoperability requirements in the Digital Health Playbook, and lack control over when and how these are implemented. While there does exist some interoperable systems implemented provincially and regionally (e.g., Ocean eReferral, Clinical Connect), they do not address the scope of information required such as sharing patient records amongst primary care organizations to facilitate collective care. Similarly, they do not address flows of information with CSSs. Developing a provincial solution to enable greater interoperability would reduce our reliance on the vendors to deliver interoperability requirements and would enable us to exchange information with other OHTs.
• Technical support – Several of the smaller providers do not have the financial capacity to procure the technology and supporting services required to effectively utilize or implement digital health tools. This impedes their ability to participate fully in the digital health strategy. Technology and expert support would enable these providers to participate more fully.
• Cost to use regional and provincial solutions – The regional and provincial delivery organizations do not charge for their solutions or services. However, the EMR vendors often charge a monthly fee to integrate with those solutions which is an impediment for providers with constrained budgets. Vendors should be reimbursed directly by government to interoperate with provincial or regional systems to remove the financial burden from the providers.
• Change Management support for Clinical Connect – With a reduction in the Change Management resources in the region, there is a concern to maintain and increase adoption of the Electronic Health Record use.

Other

• Long-term care – Increasing community supports will enable us to transition more ALC patients back to their homes but there will continue to be high acuity patients that require long term care. There continues to be shortages in long-term care beds compared to the high acuity patient population that requires them.

### 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*

Remove legislative barriers – Members of the OHT are challenged in sharing PHI with non-HIC Members despite their being critical service delivery partner. MOH should enable disclosure based on implied consent through PHIPA change. MOH should work with IPC/Ontario to clarify the status of LHIN-funded CSS providers under PHIPA.

Establish a provincial communications strategy – OHTs fundamentally shift Ontario's healthcare system and raise significant concern among stakeholders. CND has done its best to address concerns and fill in knowledge gaps where the stakeholder is unclear on the overall strategy. However, MOH executing a comprehensive communications strategy to educate the public and providers would alleviate this burden on CND, allowing focus on engagement and care redesign.

Reduce barriers to digital health tools – Obtaining access to provincial digital health tools is challenging. They have differing participation and enrollment processes which are difficult to navigate. For example, consuming OLIS data into systems requires eHealth Ontario to conduct a time-consuming PIA. Additionally, access requirements do not mirror how organizations use the tools. ConnectingOntario can be used by clinicians but not assistants, despite their key role. Reducing barriers to access would allow us to use the tools.

Standardize privacy and security frameworks across regional and provincial assets – Regional and provincial solutions do not have consistent privacy frameworks. Privacy-related issues for OLIS are handled generally by ServiceOntario. Privacy-related issues for ConnectingOntario are handled by eHealth Ontario. Privacy-related issues for regional diagnostic imaging repositories are handled by the delivery partner. These patchwork privacy requirements make it difficult to participate.

Streamline data sharing agreements – Providers sign agreements for each sharing initiative in which they participate. The agreements are costly to develop and have

differing commercial terms and conditions (e.g., indemnity, insurance) requiring the providers to engage their own legal counsel for review. Streamlining agreements would reduce the administrative and legal requirements required to sign them.

Support cost sharing models for sharing patients between OHTs – Although we will provide the full range of health, community, and social services in our OHT, patients have a choice in healthcare providers and may seek services from providers attached to other OHTs. Obtaining supporting from MOH in developing the cost sharing models when patients move amongst the OHTs would benefit us to ensure that we are not required to negotiate them on a case by case basis with each different OHT.

Provide health analytics and decision support resources – CND previously had a resource at CMH who was responsible for health analytics and supported the hospital and other partners in decision support and performance management. This role was moved to the LHIN. We would benefit from this role transitioning back into the OHT and being given access to the Integrated Decision Support (IDS) tools so that we are able to extract our own data as possible.

Access to expanded data sets – The data package provided by MOH was useful, but highly focused on hospital data. OHTs would benefit from a wider scope of data to support decision-making, including primary care, long-term care, H&CC, and community-based palliative care. MOH would need to coordinate across and within ministries to develop policy, technical guidance and standards to increase the scope and quality of data available.

Aligned reporting requirements – Currently OHT Members and Affiliates are required to report to a variety of funders on differing metrics, requiring considerable data collection and analytical work. Aligning the reporting requirements would significantly reduce the effort required.

Ability to reinvest – LHIN and Ministry-funded organizations must return unspent funds at year-end. These organizations should be allowed to re-invest into the OHT to enhance other areas of care. Key to this change would be ensuring flexibility with budget lines so that the OHT can move money around as needs arise.

Financial Resources or Supports

Financial support for OHT planning – Local and regional planning is currently performed by the LHIN. OHTs shift planning roles to the OHT requiring resources already committed to overseeing, managing, and supporting care delivery. However, this does not come with commensurate supports, making it difficult for team members to manage their own organizations while redesigning healthcare across the local community. Supporting OHT planning would relieve the burden on providers and enable them to focus on care delivery. For example, with the reasonable investments in Health Links, CND has had a considerable impact of system change demonstrated

by the breadth and success of our integration initiatives to-date.

Consulting supports – Facilitating stakeholder engagement, developing plans to design and build the OHT, and redesigning governance, service delivery, and digital health require specialized expertise. The OHTs require this expertise to support developing the OHT but do not require it on an ongoing basis. Obtaining consulting support would enable the OHTs to develop an effective structure and re-design care without having to sustain these resources in the long-term.

Investment in allied health professionals – CND has fewer allied health professionals than other sub-regions, resulting in patients being seen by higher-cost resources such as physicians rather than the provider most relevant to the service required. CND requires investment in social workers, occupational therapists, physical therapists and pharmacy to improve access to services in the community that will contribute to ending hallway healthcare. In some cases, there existing filled and vacant funded roles. Shifting these roles to CND OHT would enable us to serve more clients and reach performance targets sooner.

Support for clinician leadership – Clinicians are expected to play a significant leadership role in developing and overseeing the OHT which represents significant effort. Providing clinicians with compensation for time out of their practices would enable clinicians to provide the time required to support planning, development, and oversight of the OHT.

Ongoing support from the LHIN for the Sub-Region Primary Care Lead – Currently the LHIN has a funded role for a primary care physician to engage physicians in health system planning and strengthen physician leadership. This role has been tremendously successful in obtaining physician support in CND. We would benefit significantly were this role to continue to be funded in CND.

### 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** | **Resource Risks** |
|---|---|
| • Scope of practice/professional regulation<br>• Quality/patient safety | • Human resources<br>• Financial<br>• Information & technology |

| | |
|---|---|
| • Other | • Other |
| **Compliance Risks**<br>• Legislative (including privacy)<br>• Regulatory<br>• Other | **Partnership Risks**<br>• Governance<br>• Community support<br>• Patient engagement<br>• 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* |

## 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*

The long-term vision for H&CC introduces additional resources for patients, new roles and functions, and an expanded scope of coordinated services to ensure the full and efficient use of H&CC services. Ultimately, the H&CC vision is intended to improve performance and outcomes associated with the 'Quadruple Aim' and reinforce the

overarching aim of supporting patients to live at home longer, address hallway healthcare (i.e., lower ALC rate) and ensure patients receive appropriate care for their needs in the right setting.

Innovative and Efficient Service Delivery

• H&CC Care coordinators embedded in primary care – As a means to ensuring that care is well coordinated around the patients needs, our plan is to move care coordination out of a centralized location and 'embed' these roles in primary care. This allows care coordinators to work alongside the clinicians and their patients with more complex care needs. In addition to clinicians building strong relationships with patients, the care coordinators can play a vital role and extension to clinicians in having a more holistic view of the patient, ensuring all their clinical and social needs are met and address any gaps in receiving appropriate services.

• Building capacity and improving efficiency – There are many opportunities to build H&CC capacity and increase efficiency by removing redundancies in roles, functions and processes across the system and by strengthening linkages across agencies and roles in the H&CC sector. These include:
-Enhancing the use of care coordinators – In addition to embedding H&CC care coordinators in primary care, we will expand the scope of coordination services currently provided. In addition to the existing services that the care coordinators coordinate, they will also be responsible for coordinating services such as CSS, public health, MH&A, speciality services, or any service that the patient requires. By expanding the scope of care coordination, we are introducing efficiencies across the system.
-Strengthen linkages with SPOs – There is a need to strengthen H&CC relationship with SPOs, to more fully integrate these providers within the patient's care team.
-Uncoupling care coordination from administrative duties – In the future OHT, we envision the care coordinators' role to be focused solely around care coordination. Therefore, we expect to transfer administrative tasks such as ordering of supplies and equipment, billing management, monitoring of SPOs, and other similar tasks to an administrative role.
-Build on connectivity model to meet needs of vulnerable and complex population – To improve access and service delivery to complex patients requiring H&CC services, CND OHT plans to expand on the connectivity tables (described in Section X.X) to proactively identity patients at elevated risk and support their accessing the services they need.

H&CC Resources

We anticipate the following roles to change or be added to H&CC:
• H&CC Care coordinators – As noted above, H&CC coordinators will be embedded in primary care and be dedicated to complex patients. Care coordinators will maintain

relationships with patients and the care team to ensure that the appropriate services are delivered, referrals are made, and patient goals are met. Below are examples of the care coordinators responsibilities.

Engagement and Assessment:
- Building relationships with patients
- Performing comprehensive intake assessments

Organization and Provision of Care/Services and Care Planning:
- Building care plans in collaboration with providers on the team
- Coordinating the necessary services/programs (H&CC and all other services the patient requires)
- Engaging and communicating with other care providers and other, specialized care coordinators where the patient has a specialized need (e.g., MH&A)
- Reconciling interventions and medications
- Patient/family/caregiver advocacy

Ongoing Monitoring and Evaluation:
- Monitoring and evaluating the patient objectives and system-level targets
- Managing or liaising during care transitions and facilitating continuity of care
- Acting as a point of contact for the patient with regards to care coordination
- Providing patient education for various health conditions, with a focus on medically complex, frail and elderly, and MH&A (e.g., diabetes, CHF, COPD, etc.)

• Dedicated system navigator role- As described more fully in Section 3.3.2, a dedicated system navigator will be attached to a primary care practice and be available as a point of contact for all patients who need information/system navigation services. A key enabler of this role includes the support IT systems to provide access to relevant patient information and facilitate communications between providers in the team.

• After hours system navigator – As described more fully in Section 3.3.2, P/F/C will be provided with 24/7 access to system navigation or care coordination services. We anticipate that patients will primarily require after hours access to care coordination in the hospital during the discharge process. Hospital care coordinators will be available 24/7 to provide necessary care coordination activities as part of the discharge planning process. For those patients not receiving care in hospital, we anticipate having care coordinators available by telephone. All patients belonging to CND OHT will have one point of contact for after hours calling. This role will be filled by a care coordinator with a clinical background (e.g., nurse) to determine the patients needs and triage accordingly. The goal of 24/7 access to care coordination and system navigation is to strengthen and enhance feelings of security to patients and their caregivers and reduce unnecessary ED admissions.

The P/F/C Experience

• Dedicated and Consistent Care Team - At maturity, every patient/family/caregiver who needs one will have access to a dedicated and consistent care team responsible for services are available, coordinated, and appropriate.

• Single point of contact - Every patient/family/caregiver will be better supported by having a single point of contact for any care coordination, system navigation issue or any concern. By having one point of contact, CND OHT aims to reduce current challenges patients face with navigating the healthcare system and receiving timely access to care.

• Support during transitions of care - Patients will be better supported during transitions of care by standardizing common intake and assessments, care plans upon admission and discharge

• Training for caregivers – Family and friend caregivers have an integral role in care but commonly experience stress and burnout while caring for patients. CND OHT plans to build opportunities to train existing caregivers on practical and problem-solving skills unique to specific health conditions (i.e., Dementia, CHF, MH&A, etc.) to reduce caregiver burnout and improve patient outcomes.

Increasing Accountability for Performance

• Population Health Outcomes – To proactively identify high-needs patients, CND OHT plans to use RPA tools to identify patients with high SAMI scores – indicating significant need or risk. Particular attention can be provided to these patients, ensuring they receive appropriate and timely access to services to prevent escalation of acuity.

• Programs funded based on patient outcomes and not the number of visits ¬– There have been several challenges with the current service delivery model for H&CC which is FFS. We envision changing this mechanism to allow for enrollment-based funding, with a consideration for complex patients to ensure that patient outcomes are considered.

### 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*

Population requiring home care
In CND OHT, approximately 2500 (3.2%) of our Year 1 population will require home care services. This number is based on 51% (Year 1 Population) of the average number of home care services per year the LHIN currently provides in CND, which is 5000.
However, we anticipate that the proportion of Year 1 population requiring home care services will increase to meet unmet needs. Using the Canadian Community Health Survey (CCHS) 2015/2016, approximately 3% of people reporting unmet homecare needs, which includes either home healthcare or personal support services. This survey provides a breakdown of the average unmet need per age distribution, which we have used to calculate the anticipated unmet need of home care services for CND OHT attributed population. Based on this data, we anticipate that an additional 1000 patients will require home care services based on unmet need. The breakdown on anticipated demand by age for our attributed population for year 1 is listed below.

- Age 0 to 24 – 175 people
- Age 25 to 49 – 293 people
- Age 50 to 74 – 352 people
- Age 75 + – 220 people

Short Term Action Plan
The short-term action plan for improving H&CC services in Year 1 revolves around the mobilization of H&CC care coordinators, expanding the scope of H&CC services, and building capacity and improving efficiencies. Below is a list of CND OHT short term action plan.

Attach care coordinators to primary care – One of the first steps as described in question A.1 above, is to embed care coordinators in primary care to ensure that care is well coordinated around the needs of the patient. This will allow care coordinators to build strong relationships with clinicians and patients and ensure that our year 1 population which are medically complex, frail and elderly, and MH&A patients are receiving care in a timely and appropriate manner. These patients are high cost users of the system and typically face challenges around navigating the complex healthcare system, and would benefit for improved collaboration and communication from care coordinators and their primary care clinicians.

Expanding scope of services coordinated by care coordinators - Expand scope of H&CC coordination to all services, including CSS and others in broader ecosystem. Our year 1 patients are complex and high needs and typically require support acquiring community supports in addition to clinical services. Care coordinators may be better equipped and have a better understanding of what services are available in the community to support a patient's psychosocial needs, attitudes and beliefs and preferences in accessing services.

Align and streamline responsibilities to reduce redundancy – CND OHT partners plan to align and streamline care coordinators roles and responsibilities across service providers (e.g., hospital, community, MH&A) as we plan to encourage care coordination across multiple sectors. This will enable the team to collaborate and identify best practices, processes and procedures and general roles and responsibilities for the various coordinators across the system.
Align and streamline assessment/care pathways across broader ecosystem – One of the foundational elements of providing integrated care starts with collaborating with the OHT to formalize roles and responsibilities, accountabilities and lines of communication among the broader team. This includes developing common intake and assessment protocols to ensure consistency across clinicians around decision making, care planning and treatment processes. Within year 1, stakeholders such as

clinicians, managers, patients, etc. can work together in co-design groups to map current state workflows from referral to submission, screening and triage, to diagnosis and treatment and use existing guidelines and evidence to establish consensuses for the desired future state.

Identify what H&CC initiatives can be expanded or scaled – The planning partners have identified potential models during co-design sessions that can potentially be expanded or scaled in Year 1. Examples of these initiatives include the retirement home model, direct referrals to H&CC services, City Call, Children's mental health in PC community, Medication Reconciliation, etc. Partners will identify which initiatives to expand for Year 1 patients, evaluate the change and eventually support the expansion of H&CC services, leading to improved patient/family/caregiver and provider experience.

Build a strategy for advancing alternate SPO models – Due to challenges in current service delivery models for H&CC, CND OHT plans to work collaboratively with the Members and Affiliates, H&CC, the Ministry and other relevant stakeholders to identify a model for funding of H&CC services that is more aligned with patient care and outcomes rather than FFSs.

### 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*

Transitioning Care Coordination Resources

In alignment with CND OHT change management strategy, H&CC responsibilities will be transitioned in alignment with evidence-based practice and research to guide the development of integrated care teams, which will include H&CC roles. Key principles of CND OHT change management strategy including governance, stakeholder engagement, communication, workflow analysis, education and evaluation will support and guide the transitioning of H&CC functions.

There are currently 26.5 FTE H&CC care coordinators in the CND region. We anticipate leveraging approximately 13.5 FTE care coordinators and as well as well a 3.0 FTE team assistant supports (1 FTE hospital-based Team Assistant and 2 community-based Team Assistance) from H&CC to meet the needs of our year 1 population, as well as the current 1 CMH/LHIN Integrated Manager (0.5 FTE WWLHIN funded and 0.5 FTE CMH funded). As described in Section X.X, we anticipate that additional care coordination and management resources would be required meet our Year 1 anticipated demand effectively.

Within CND this is past evidence of collaborating on the integration of functions across health services which can be leveraged in the OHT planning and implementation. For example, MOU between H&CC and CMH to co-fund Hospital/LHIN Integrated Discharge Planning/Care Coordinator roles. These types of collaboration and integration will support a more streamline and positive patient experience (e.g. reducing duplication of assessments for patients), improve value for money and supports better patient outcomes through a quality based and more integrated care delivery, which has also been shown to improve staff experience and job satisfaction.

Digital Assets

We plan to increase use of digital assets such as CHRIS and interRAI, enable the use of these systems to Member and Affiliate organizations that do not have access to it.

Knowledge Transfer

The CND OHT will leverage the H&CC knowledge and experience of WWLHIN teams, including H&CC staff, leadership and support functions, to build a stronger and more robust local health care team which supports patients to receive the care in their

community and home, when appropriate and prevents and/or delays the need to access higher cost institutional services e.g. Long Term Care and Hospital.

Programs

We plan to expand programs such as the SALC initiative (see details in Section 2.4) to include coordinating services for long term care patients. Additional plans to transition H&CC programs will be evaluated by the Member organizations and during co-design sessions to determine additional programs that can be leveraged. Examples include, Campus Model of Care, Neighbourhood Model, wound care leading practices, joint care coordination/clinician roles, Telehomecare Plus (remote patient monitoring partnership with community paramedicine), Integrated Assisted Living Program, community pharmacy to support medication reconciliation, electronic care coordinator appointment bookings using Caredove, and virtual visits.

### 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*
Key barriers to H&CC modernization include:

• Inflexibility of MOH agreements with service providers – Contracts with service providers define the specific scope of services that the service provider will deliver and continue to be evergreened with limited the ability to change or update them unless performance issues are identified. This makes it extremely difficult to be flexible and responsive to the needs of patients as the healthcare needs and priorities of the population evolve. Similarly, service providers are guaranteed a particular market share and estimated volume awards for delivering services. This barrier could be addressed by either moving to a more competitive procurement model or transferring responsibility for delivering and managing the basket of H&CC services to the OHT to deliver.

• SPO remuneration agreements – Contracted service providers are paid on a unit basis, based on the tasks they are assigned to perform for the patient due to their assessment scores. This limits the ability of the service provider to tailor their services to the patient as their needs evolve. This barrier could be addressed through other payment models, for example the service based on the acuity, patient rostering or outcomes.

• Recruitment – Service providers have significant challenges recruiting and retaining

PSWs, physiotherapists, and occupational therapists. A major challenge is the recruitment and retention of PSWs which provide a large portion of home care services to CND OHT. This is due to poor wages and benefits, insufficient reimbursement policies for travel, and few incentives to enter and stay in the field. In addition, PSW's shifts are often piecemeal and the service providers are unable to guarantee a minimum amount of work. A PSW for example might be required to do a split shift with a couple of hours in the morning preparing a person for the day and a couple of hours in the evening putting them to bed. The lack of consistent and minimum hours results in a high turnover among service provider staff. This barrier could be addressed by allowing the OHT to manage the resources so that they could be redeployed as necessary to meet other OHT needs and which would provide them with income stability.

• Inflexibility of the H&CC Budget – The H&CC budget includes separate budget lines for direct services, management, and service provider payments. H&CC is unable to move money around within the budget to meet patient and population priorities. This barrier could be addressed by providing greater flexibility with budget allocations.

• Lack of integration with the broader care team – Because the service provider and H&CC staff are not embedded within primary care or another setting where other members of the patient's care team are located, there is often a lack of information exchange with and integration between the service provider or H&CC staff and the broader care team. This barrier could be addressed by providing H&CC resources with a home base in a primary care or other clinical setting (i.e., Long Term Care)

• Barriers to Information Sharing – CHRIS has care coordination tools that could be used to support broader care coordination but is only available to certain sectors and users. Allowing for expediated and expanded access would benefit care collaboration.

# 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*

CND is confident that we can increase the number of virtual visits to 2% to 5% per year. Our Members and Affiliate Members already deliver virtual care to patients with a wide variety of conditions. For example, thirteen CND primary care providers provided a virtual visit to 0.68% of our patients (3,054 visits with 1,016 patients from CND) in the past year. Additionally, other Affiliated Members in such as MH&A use virtual care tools to deliver or augment patient care. Currently, our Members and Affiliate Members provide virtual care within the following programs:

Primary Care Virtual Visits
- As above

Cardiac Rehab Virtual Visits
- Cambridge Cardiac Care Centre offers virtual visits to patients with barriers attending appointments in person through secure video platform.

Rapid Access CHF Virtual Visits
- Cambridge Cardiac Care Centre offers remote home monitoring and interactive patient self-management support in the home for moderately stable patients

Ontario Telehealth Network
- Used for virtual patient and provider consultants by various primary care, hospital, H&CC and specialist providers
- Many sites supported with OTN nurses

Telehomecare Plus
- Home monitoring and virtual support COPD/CHF patients by H&CC nurses in collaboration with community paramedicine.

eShift
- Used to support H&CC patients requiring daytime and overnight palliative care with a PSW in the home. Off-site nurses manage care of multiple patients and provide care direction to on-site PSW

Woebot
- Artificial Intelligence Chatbot that provides Cognitive Behaviour Therapy to patients

GeriMedRisk
- Interdisciplinary telemedicine consultation and education service for healthcare providers, that connects them with Geriatric specialists and pharmacists to provide responses to questions of medication optimization, mental health concerns, or other comorbidities

Despite our confidence in achieving the target of 2% to 5% virtual visits, we have identified a number of barriers to expanding access that need to be addressed in the near term to properly enable our transition serving our population at maturity:
•Remuneration to physicians providing virtual care is capped by OTN
•Limited primary care licensing inhibits significant growth
•Clinicians and organizations require change management support to effectively incorporate virtual care tools into care delivery
•Integration between virtual care and EMRs through a launch bar is on the OMD roadmap, but we lack control over when it will be delivered

To expand virtual care including overcoming the above barriers we expect to:
•Reallocate licensing – Licenses currently used by FFS physicians who are less active on the primary care platform will be

reallocated to other clinicians including salaried primary care providers (e.g., salaried physicians, nurse practitioners) as well as other types of salaried clinicians (e.g., H&CC Nurses, addictions counsellors).
•Raise awareness of virtual care options – We propose planning and undertaking a communications campaign with our patients to make them more aware of our virtual visit services and provide them with a better understanding of which conditions virtual visits would be appropriate for.
•Expand virtual care use cases –Reallocating licensing to other clinician types (e.g., H&CC Nurses) will also enable us to expand the scope of services offered through virtual care to meet the needs of our other high-priority populations such as frail elderly.
•Establish virtual care protocols – Leveraging good practices and the lessons learned from the current providers using virtual care tools, CND will develop protocols and standards for virtual care that guide providers in using the technology, appropriate situations in which to provide virtual care, and documentation requirements. The protocols will be used to standardize the patient care experience across providers and to educate new providers on effectively using the tools.
•Provide increased change management support – eHealth Centre for Excellence will be engaged to provide change management services for organizations.
•Leverage other initiatives – In addition to the tools that our Members and Affiliate Members already use, we explore other provincial tools that we have not begun to leverage. An example of a tool that would be particularly valuable to support the needs of our priority population includes Big White Wall to support patients with low-acuity mental health issues to receive peer support.

Measuring success of virtual care will involve the following:
•Increased choice and uptake – A key performance indicator benchmark is the uptake of virtual care as well as the services being provided through it. We will monitor the rate of adoption of the service to ensure that it is increasing and to confirm that the nature of the issues being treated through the service are expanding.
•Patient experience surveys – We will deliver Patient Reported Experience Measure (PREMs) surveys to P/F/C using the virtual care services to monitor their satisfaction and recommendations for improvement. We anticipate delivering these surveys routinely in year 1 and beyond to ensure that we are continuously improving the service we deliver.
•Population health – We will also randomly select patients from our high-priority populations (e.g. frail elderly) who have used the service and compare their health status against patients who have not used the service to identify correlations between virtual care and health status.
•Ending hallway healthcare – We propose comparing the rate of ED use between the patients accessing virtual care and those who do not to determine whether there is a reduction in unnecessary ED visits.

### *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*

CND already provides its patients with access to referral and acute care information through the eReferral and MyChart initiatives respectively. We currently have eReferral information on 8,388 patients from CND (5.9% of the attributed population) of which 2,151 have subscribed to email updates on their referrals. Patients also have access to MyChart via Cambridge Memorial Hospital which gives them access to acute care information available in ClinicalConnect. Finally, with the CMH CoHealth App, patients can integrate their discharge instructions and information on accessible community services.

Expanding Access to the Currently-Available Information

The key barriers with expanding access to 10% or 15% of the population are that user provisioning for MyChart is centralized at CMH and that there has been limited uptake of the number of people receiving referral information via email. We propose to close the gap and increase the number of patients to which we offer digital access to their information by:
•Improving awareness of MyChart and eReferral - Increasing the uptake of MyChart and eReferral would enable CND to meet our 10% to 15% target for patients with access to their PHI by offering access to acute care and referral information.
•Decentralizing user provisioning for MyChart – Currently only CMH is authorized to provision patients with access to MyChart in the CND region which causes a bottleneck in getting patients registered. Sharing responsibility for provisioning with primary care and other providers would help distribute the load and increase our through-put of patients registered to the portal.

Expanding the Scope of Information Available

In addition to increasing the volume of patients with access to their health information, we would also like to work towards expanding the scope of information to which they have access.
Currently, not all information types are available to Clinical Connect. For example, only 4 primary care practices in the southwest contribute to Clinical Connect as a proof of concept – none of which are CND partners. Similarly, other data

types such as Integrated Assessment Record and social or community service information is not available to Clinical Connect. MyChart also does not show all of the information that currently exists in Clinical Connect. For example, it does not deliver CHRIS data to patients.

CND proposes working with digital health delivery partners in the region to examine the scope of information made available to patients and identify opportunities for expanding access through MyChart. This would provide patients with richer information and support their becoming more active partners in their care.

Providing Access to Other Data Repositories

Finally, CND proposes working with other digital health organizations that have patient-facing applications such as CanImmunize which is expected to make immunization information available to patients in spring 2020. Working with these organizations will allow us to leverage existing digital health tools to provide our patients with access to their information. We would also like to work with government on a standard approach to sharing data with patients that provides one front door and integrates solutions in the background.

### *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*

The province and LHIN have already made significant investments in digital health solutions and services that can be leveraged to promote digital information exchange among the partners. Our plan for enabling digital information sharing leverages existing, regional solutions such as the Ocean eReferral Network and provincial solutions such as ClinicalConnect or Hospital Report Manager.

Increasing adoption of regional and provincial solutions
CND would work towards increasing adoption of each of the regional and provincial tools to extend our capacity to exchange information electronically but the key solutions on which we would focus include:

- ClinicalConnect – ClinicalConnect has a relatively wide penetration amongst organizations in CND with 16 organizations

and several solo family clinics with access to ClinicalConnect. Approximately 900 end-users have access to ClinicalConnect in CND. However, adoption by primary care is only at about 31%. Increasing adoption of ClinicalConnect in all sectors but particularly primary care through change management support would improve our ability to exchange acute and homecare information about patients.

- Ocean eReferral – eReferral is also a key tool in our digital health toolkit because it allows us to send and manage referrals electronically. A key benefit of eReferral is that the patient can sign up for updates in addition to providers being able to use it to refer to one another. It can allow us to exchange information about and collaborate on care for our patients regardless of the nature of the service they require.

- HRM and eNotifications – CND has a relatively low uptake of OntarioMD's HRM and eNotifications. Only about 45% of our primary care providers are enrolled to receive reports from CMH using HRM. Many primary care providers do not yet ADT information electronically and there is significant room for growth and improvement.

- Standardized Care Plans in CHRIS – CHRIS is another tool that will enable us to better exchange information about our patients because it has care planning functionality that will allow us to better collaborate developing and carrying out collaborative treatment plans for our patients. We hope to work with the LHIN and HSSO to make it more available to other providers.

- Robotic Process Automation (RPA) – Developed by eHealth Centre of Excellence, RPA enables secure sharing of coordinated care plan elements between different point of care systems. An automated process reviews the charts, extracts key data elements, and inserts them in another care provider's system to allow for a shared understanding of the patient status and action plans. We think additional support for this functionality would allow us to share care plans across the continuum.

Supports to increase adoption

CND recognizes that there have been significant barriers in the past in adopting these tools. The barriers generally are associated with uncertainty around how to incorporate the tools into their practices and the perceived privacy and security concerns.

CND proposes to support the providers in adopting these information sharing tools by:

• Aligning digital workflows across providers – Providers are uncertain about how to use the tools and there is not a common approach for using the tools in their practices. This creates challenges with a seamless flow of information. CND will leverage the skills of eHealth Centre for Excellence to work with the partners to map out and establish an aligned digital health workflow. This will help both the existing providers but also those we onboard in the future.

• Increase pathways in Ocean eReferral – Ocean eReferral enables electronic referrals to various health and community-based organizations. Increasing the pathways to include other destinations (i.e., different types of specialists, different types of services) will be an important step towards enabling information exchange among all of our members and affiliate members.

• Expand use of CareDove – Similar to Ocean eReferral, CareDove enables electronic referral to community support and rehabilitation services. Expanding adoption of the tool within CND and further integrating it with Ocean will enable easier exchange of referral information amongst the organizations.

• Establish an information sharing and privacy model – Developing an information sharing model will involve mapping out the information that each member collects on patients and understanding which information needs to be shared with others to support healthcare purposes, quality of care purposes, and population health management purposes. This will allow CND to confirm the existing authorities in PHIPA for use and disclosure of the PHI as well as to establish a common privacy framework to ensure that health information is appropriately safeguarded when shared and that patients have a consistent level of privacy protection afforded by each member of the OHT.
In addition to the steps that CND can take, we would also want to understand whether and how we can work with the province to move the Primary Care Data Sharing beyond the pilot phase into full rollout. This project is critical to extracting information from our primary care EMRs and sharing it with other sectors and patients.

### *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*

CND providers currently makes use of the following digitally-enabled quality improvement tools:

• Quality Based Improvements in Care (QBIC) EMR Templates – The care templates developed by eHealth Centre for

Excellence help drive standardization of data entry but also care decisions based on clinical guidelines. The templates include a range of conditions such as depression, heart failure, COPD, and more. In addition to supporting clinicians in providing evidence-based care, standardizing the data entry also allows the clinicians to better use the information for population health management and service planning.

• Robotic Process Automation – RPA standardizes data in EMRs to identify complex patients and is able to trigger actions in the EMR such as alerts to the clinician to prompt them to recall or intervene with the patient. This standardization will be aligned with acute care and home care to allow for cross-sector assessment of quality of care in the future.

• OntarioMD Dashboards – Similarly, OMD dashboards are integrated with the EMRs and help clinicians in identifying high-needs patients and profiling their patient population for the purpose of identifying necessary interventions at the patient and population levels.

• eConsult – Through the use of eConsult tools, primary care providers are able to get support and improve the care they provide to patients by addressing questions and getting advice from medical specialists.

CND will rely on existing resources from eHealth Centre for Excellence to establish the detailed implementation and change management plan to expand adoption and optimize use of these tools. However, the approach will generally involve:

• Increasing tool adoption – Actively working with providers that do not currently have the tools to support them in engaging the appropriate delivery partner to obtain and implement the tool in their clinic. Adoption will also include supporting the clinics in configuring the tool to meet their needs.

• Enhancing data entry practices – Extending the work of the information sharing model and other data activities intended to define the core data set, we expect to work with the providers to ensure alignment of data entry protocols so that all providers are following a common data standard.

• Optimizing use of the tools – Similarly, we anticipate working with the providers in managing changes to their workflows to maximize the clinical benefit they receive from the tools.

• Interpreting performance – eHealth Centre of Excellence currently works with providers through their QBIC services to support clinicians in understanding how to extract reports from their systems and interpret the information those reports provide. eHealth Centre for Excellence will work with the team members to identify options for how to best compare provider data against good practice benchmarks established by Health Quality Ontario as well as how they compare against the collaborative quality improvement plans that the team establishes and provide them guidance on potential areas for improvement.

### *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*

CND OHT will leverage current digital health plans in the region and establish our own digital health plan in alignment with MOH in Year 1. In addition to the plans above, CND OHT will use self-management tools to improve patients' and providers' experience within the system. We feel strongly that we can collaboratively develop digital health plans to reduce clinician burnout and improve patients' self management resulting in improved experience navigating the healthcare system.

Improving Patient Self Management – CND OHT will leverage digital tools empowering patients to self manage conditions, appointments and general tasks related to their health. This includes but is not limited to expanding online booking to primary care, access to communication platforms and messaging.

Tablets – Integrating tablets into patient intake workflows supports managing and assessing health concerns by enabling patients to complete validated health assessments, privately and by themselves, while waiting to see their PCP. By using tablets, patients can answer assessment questions, including mental health screening, sending their answers automatically into EMRs before their appointment. This results in improved accuracy, time savings for clinicians, and enhanced patient experiences. eHealth Centre of Excellence is supporting PCPs in the region in partnership with the Canadian Mental Health Association WW to deliver mental health assessments and management using tablets and email. To date, 54 clinicians in in 5 clinics in CND have adopted tablets that incorporate the tool into their workflows, supporting efficient mental health screening while improving the patient experience.

Hypercare – A PHIPA compliant group messaging, group management platform that allows for multiple users to create

groups and instant message, photoshare, send urgent flags, and manage joint patient tasks lists. WWLHIN is piloting this platform with KW and Cambridge Inter Professional Care teams to manage care coordination. It is difficult to coordinate care for this patient population because the transient and unpredictable nature of how patients currently access care. Communication between team members has been particularly difficult due to the lack of a truly mobile, secure, and user-friendly platform to facilitate the transfer of messages and multimedia that contains PHI. Pre-emptive is a mobile app available for existing addictions patients at Stonehenge and has been expanded to other partners to support remote management of patients going through withdrawal. Case workers are able to track and deter a crisis escalation by providing information to the patient to manage withdrawal symptoms.

Reducing Provider Burnout – Provider burnout has been recognized as a significant problem in recent years, and digital tools have been identified as a contributing factor to this burnout. CND OHT plans to introduce the use of the eHealth Centre of Excellences form completion robots to help reduce the often-duplicative processes of documentation, and to optimize the use of clinical digital health tools to improve the provider and patient experiences. The Members and Affiliate Members have recognized the risks of implementing or changing digital health tool use in clinical settings, as related to provider burnout, and is committed to working collaboratively with providers throughout design and implementation to mitigate these risks.

### 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.

| | |
|---|---|
| **Name:** | Dr. Mohamed Alarakhia BSc(Hons), MD, CCFP, MSc |
| **Title & Organization:** | Managing Director, The eHealth Centre of Excellence |
| **Email:** | mohamed.alarakhia@ehealthce.ca |
| **Phone:** | 519-580-3070 |