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 *Please indicate an individual who the Ministry can contact with questions regarding this application and next steps*	Name: Georgia Whitehead
	Title: Director, Strategy Management and Major Projects
	Organization: Trillium Health Partners
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Contact for central program evaluation *Please indicate an individual who the Central Program Evaluation team can contact for follow up*	Name: Georgia Whitehead
	Title: Director, Strategy Management and Major Projects
	Organization: Trillium Health Partners
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	Phone: (647) 532-9531

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.

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

[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.

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

METHODOLOGICAL ALIGNMENT

We are highly aligned with the Ministry's attributed population of 878,424 people. While the population size has increased from our estimated 680,000 people living in Mississauga, we identified high alignment by:

- The majority of attributed people (~60%) in the Ministry's methodology reside within Mississauga, which reinforces engagement data that proximity is central to people's health care seeking behaviour.
- Approximately 29% reside in neighbouring regions. This reflects current service provider patterns.
- The majority of partners remain the same, given the local nature of the network (1).

We have updated our population approach to the Ministry's attribution method.

While the attributed population does not capture the uninsured or those not currently using services, the M-OHT will continue to plan for their anticipated care needs to support population health.

STRATEGIC OPPORTUNITIES

Our vision is to improve the health of people in the community by creating an interconnected system of care, from prenatal care to birth to end-of-life. Care will address physical, mental, and emotional well-being, and will be reliable, high-quality, grounded in exceptional experiences and sustainability.

We have identified important strategic opportunities that this OHT has in order to advance this vision:

1. Strength of Existing Partnerships with Aligned Vision

Our history of partnership and a shared aspiration to improve care and population health has enabled the M-OHT to come together quickly and successfully. With internal capacity including analytics, clinical and research expertise, and operational capabilities, we are prepared to delve into integrated system planning. Here are some examples of how we are already advancing a system centred on people and population health:

- The Institute for Better Health (IBH) - established to bring together experts in the community in health systems research, accountable and integrated care models, primary care and population health.
- CarePoint Health (CPH) - engaged with patients and families to design its health care space and to influence many aspects of the care to support health.
- Project N0W - an intersectoral collaboration to end child and youth suicide in the City of Mississauga and Peel Region, brings together health, education and community to support children and youth.

2. Local Health Care Design for Local Needs

Up to 80% of overall health outcomes are due to factors beyond clinical care, including social and economic factors, health behaviours and the physical environment (2). Our approach, which includes many local providers, means we can support prevention in clinical settings by also capitalizing on local supports (e.g. schools and municipalities) to impact health and wellness.

3. Building from a Strong Foundation

While the size of the M-OHT increases complexity, over 60% of individuals in the attributed population live within Mississauga and receive care here, and more than 30% travel in from surrounding communities to regularly seek care here (1). This allows us to more feasibly implement interventions, through connections to local primary care, and sets a strong foundation for future scale and spread. We recognize that over time there is an opportunity to increase the number of people receiving care close to home.

Despite the opportunities, we also identified challenges:

1. Highly Efficient Region with Growing Demand

The M-OHT attributed population is large and the region is rapidly growing and

densifying. Over the next two decades, the population in our general catchment area is expected to increase by approximately 45% (3). Each year, over 18,000 newcomers arrive, which impacts the numbers of uninsured people and rapid changes in the population (4). This continual evolution will require real-time funding to ensure sustainability of the system.

Further, in this region, we see lower than expected per-capita use of health care services, including in home care, mental health, acute care and LTC (See Supplementary Documentation). While investments have been made in services, they have not kept pace and the region is under-resourced. Improving population health and use of the system through the OHT model is a critical strategy in this region, in addition to strategies for growth.

2. Access to Modernized Primary Care

While there is a foundation of modernized primary care through the evidence-based Integrated Primary Care Centre (IPCC) model in Mississauga - through The Credit Valley Family Health Team (CVFHT), Summerville Family Health Team (SVFHT) and CarePoint Health (CPH) - a number of providers are solo fee-for-service not yet connected to an IPCC, and approximately 10,000 residents in Mississauga are not rostered (1).

The number of independent practices offers an opportunity to build in alignment with the OHT, but we recognize that will take time. Importantly, the OHT process has acted as a catalyst, and the creation of a primary care network is underway. The OHT is key to this momentum.

A number of Patient Enrollment Models (PEM) reside outside of Mississauga (1). We will work with these practices to discuss partnership and referral patterns.

We will engage with PEMs and fee-for-service practices not connected to an IPCC, and encourage people who are not rostered to enroll with a local primary care team.

3. Service Flow across OHT Boundaries

A feature of urban regions are providers that serve people across various boundaries (for instance, the Region of Peel). The M-OHT is committed to identifying opportunities to strengthen partnerships based on service flow patterns. Given OHT members provide many services across different boundaries, further understanding of how these services will be managed within the OHT model is needed, and we are committed to working with the Ministry on this and sharing learnings.

4. Gaps in Information and Care Management Infrastructure

We have to make assumptions about the attributed population, as patient-level linkages to survey data is not yet available. Similarly, other data sets are based on boundaries distinct from the attribution methodology.

We recognize that we will also need to establish additional infrastructure for population health management at the planning and care management levels. These challenges are significant operationally and will exist for other OHTs. The M-OHT is interested in engaging with other OHTs, the Ministry and communities of practice to support, learn from and share solutions.

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

The Year 1 population is based on the three IPCCs in Mississauga (CVFHT, SFHT, CPH). These have 50 physicians, with a roster of ~60,000 (7% of the attributed population). This number may increase over Year 1, with expansion at CPH.

For integrated pathways, we will focus on two subpopulations:
- people who would benefit from a palliative approach to care; and,
- people presenting with episodic, minor acute issues that could be managed effectively in the community if the right supports were available.

All 60,000 will have access to the two pathways based on need. We also expect that some improvements will have practice-wide application (e.g., health equity design, system navigation, virtual capability), benefiting many.

RATIONALE FOR INTEGRATED CARE SUBPOPULATIONS

We considered patterns of health status and health service use across the lifespan. Using an assessment framework, we considered several opportunities to improve outcomes, experiences and efficient system operations, accounting for feasibility, the opportunity to advance the OHT and support through engagement (See Supplementary Documentation for the framework and subpopulation size and characteristics listed).

SUBPOPULATION #1: PEOPLE WHO WOULD BENEFIT FROM A PALLIATIVE APPROACH TO CARE

At some point in their lifetime, most people will be diagnosed with a life-limiting illness and would benefit from a palliative approach (5). We estimate that as many as 5,500 people fall into this definition within the Year 1 population, with approximately 270 deaths anticipated.

This population has a high degree of multimorbidity, with 47% of individuals having 5+ chronic diseases, demonstrating a high need for care coordination and management, and a patient-centred pathway.

With early supports, we have the opportunity to improve quality of life at all stages of an illness, including end-of-life. Together, we can better support a person's autonomy and help people die in their place of choice, with psychosocial and bereavement supports, while improving system utilization.

A SUMMARY OF RATIONALE AGAINST OUR PRIORITIZATION FRAMEWORK FOR SUBPOPULATION #1:

Evidence suggesting there is opportunity for impact:
- Almost half (46%) of people who die in our region do so without receiving any palliative care (6).
- Research shows that about two thirds of Ontarians would prefer to die at home, yet 58% of palliative people in our region had one or more ED visits in the last 30 days of life and 65% of died in hospital (7, 6).
- Costs for those with a life-limiting illness in the attributed population are estimated at nearly $1B per year, with a high proportion at end-of-life (6).
- Only 38% of palliative people in the community received a physician home visit(s) in the last 30 days of life (7).
- A palliative approach to care has been shown to improve system utilization, and is

associated with a 50% reduction in the likelihood of dying in hospital (8).

Feasibility of introducing the required changes:
• This approach will build upon existing, evidence-based work, including the palliative pathway planning, and has support from partners including clinical leadership, primary care and hospice. This also aligns with this region's 2019/20 capacity project, designed to reduce ALC.

Opportunity to strengthen partnerships for OHT:
• This integrated care pathway crosses disease-states, building the foundation of a holistic, population health approach.
• It relies on a network of partners and therefore builds strong partnerships for future pathways.

SUBPOPULATION #2: PEOPLE PRESENTING WITH EPISODIC, MINOR ACUTE ISSUES THAT COULD BE MANAGED IN THE COMMUNITY

Minor acute issues are highly prevalent and can often be effectively managed in the community (9). However, due to a lack of access to timely diagnostics and specialist support for primary care, or access to primary care, people are often required to visit the ED and/or incur duplicate visits and tests.

To begin this work, our proposal is to focus on minor acute GI/GU issues, such as urinary tract infection, constipation and gastritis. We estimate demand of up to 13,000 in the Year 1 population, with 1,300 individuals anticipated to visit the ED (CTAS 3-5).

This population includes a higher proportion of women (65% vs. 52% in the maturity population). As this group also includes individuals with co-morbidities (52% with 2+ chronic conditions), some individuals will be appropriate for other integrated care pathways to-be-developed in the future.

A SUMMARY OF RATIONALE AGAINST OUR PRIORITIZATION FRAMEWORK FOR SUBPOPULATION #2:

Evidence suggesting there is opportunity for impact:
• Over 60% of the attributed population has at least one minor acute health care-related visit in a given year (6).
• In the Year 1 population, we anticipate up to 13,000 incidences of minor acute GI/GU issues across any setting, with nearly 1,300 ED visits (6).
• Per year, these individuals incur $800 on average in ED costs, resulting in millions of ED costs for the full attributed population (6).

Feasibility of introducing the required changes:
• By responding to challenges primary care is facing and motivated to address, there is a willingness for engagement and partnership.

• 99% of people visiting the ED are rostered or virtually rostered to a primary care provider (6).
• Change is less dependent on partners involved in the palliative pathway or the hospital, which is implementing a hospital information system in 2020.

Opportunity to strengthen partnerships for OHT:
• This presents an opportunity to strengthen partnerships with primary care and support primary care modernization. This lays the foundation for population health and the OHT model.

Of note, prevalence of mood disorders is high, supporting a medical psychiatry approach to care for all. Further, although less so than the maturity population, the Year 1 population is diverse, which points to the importance of a health-equity lens for design, including cultural appropriateness (See Supplementary Documentation).

Taken together, these integrated care pathways have the potential to benefit up to 2% or about 18,500 of the maturity population; a significant number in such a large OHT.

ALIGNMENT WITH READINESS SELF-ASSESSMENT

These areas are aligned with our readiness self-assessment. Palliative care was identified originally, which includes the benefits of a palliative approach for those with COPD and CHF. Minor acute issues represents a strategic opportunity to impact the quadruple aim and advance the OHT model. Seniors with dementia remains a future area of focus.

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

[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.

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

METHODOLOGICAL NOTE

In the absence of patient-level data for those attributed to us, census data for Mississauga is being used as a proxy for the attributed population (Mississauga represents over 60% of the attributed population; neighbouring regions account for an additional 29%) (1).

HIGHLY DIVERSE REGION

This region is one of the most ethnically diverse populations in Ontario and within it lies a wide variation of health needs (4). Cultural and language diversity is a key feature. This has implications for how care is delivered, including: cultural relevance and safety, language needs, provider training, and the need to work with newcomer organizations to support new residents on how and where to access care. For example:

• 32% of the attributed population are immigrants, with 4% recent immigrants (6). The numbers are higher in Mississauga, representing geographical differences that may be observed within the network. In Mississauga, 53% of residents are immigrants, with 56% identifying as a visible minority. Nearly 7% (49,305) of immigrants are recent immigrants, arriving between 2011 and 2016, while 39,995 are refugees. The majority of immigrants and refugees come from racialized communities, and the number of refugees continues to grow (4).
• Language diversity is an important feature. The top languages spoken at home in Mississauga include Urdu, Arabic, Polish and Mandarin (4). We will consider the availability of language translation services, particularly on sensitive issues that Year 1 populations may face (e.g., gynecological concerns).
• The country of origin for the largest proportion of recent immigrants is India, with Pakistan close behind (4).
• 2.3% of Mississauga's population identifies as a francophone (inclusive definition) (10).
• 0.7% of the Mississauga population identifies as Aboriginal (10).

HEALTH DISPARITIES

The region has wide differences in socioeconomic factors and health status. While educational attainment and employment status reflect Ontario, 96,475 (14.3%) of people in Mississauga live in a low-income household (4). Mississauga has growing income disparity with some of the most affluent and

deprived neighborhoods in the province. In 1980, only 2% of neighbourhoods were low income, while today, low- and very low-income neighbourhoods represent 51% of the community. Poverty has significantly increased in this region over time (11).

In Mississauga, premature mortality rates, widely considered the best single indicator of population health status and health system effectiveness, vary across the sub-regions. Significant disparities in premature mortality exist across the socioeconomic gradient. Persons residing in the most deprived neighborhoods of Mississauga are almost twice more likely to die at an early age than those living in the most affluent Mississauga neighborhoods, and this gap has been widening over time (12, 13).

Literature indicates certain groups experience health disparities, and a poorer quality of life than the general population, including: racialized populations, newcomers (immigrant, refugee, ethnocultural, racialized), Indigenous groups, Francophone and 2SLGBTQ+ communities. Intersectionality also compounds health inequities and contributes to the specific type of systemic oppression and discrimination experienced by marginalized populations (14-18).

Many of these groups do not access health care due to stigma, discrimination or other barriers (e.g., homeless, living in shelter). We need to leverage the opportunity to integrate across health services and with other partners to meet people where they are and lower barriers to accessing health services, including schools, religious places of worship, ethnic community centres and support groups. The M-OHT will design its services to account for the inequities in care design that can arise from these factors.

DESIGNING CARE TO SUPPORT DIVERSITY AND ADDRESS HEALTH DISPARITIES

In the Year 1 population, we will focus on the diverse needs of individuals to support health equity. Specifically, we will continue to create meaningful engagement opportunities with population sub-groups (e.g., Indigenous (~0.7% of population) and Francophone (~2.3% of population)) to better understand diverse realities, lived experience and respond to unique health and social needs (10). Throughout the development of the M-OHT approach, we will use the Health Equity Impact Assessment (HEIA) tool to continue re-designing care for our subpopulations, and identify any unintended impacts or gaps of our proposed approach.

We will focus on the development of high-trust partnerships among diverse patients, families, caregivers, providers and system partners to address issues that impact health (for instance, partnerships with the Region of Peel and community organizations working to address access to housing, poverty

reduction and food insecurity). Focus will be on the first two subpopulations and ensuring unique needs are met.

A particular focus for the M-OHT in Year 1 will be designing care to support individuals with cultural-specific and linguistic needs (e.g., English as a second language, newcomers). To address language barriers to health and social services, we will engage with multidisciplinary cross-sectoral partners to offer in-person or virtual multilingual services as appropriate or work with trained medical interpreters and translators (e.g., working with community organizations to leverage translation services provided in the community and sharing these costs amongst M-OHT partners). The M-OHT will support newcomer organizations on translation and digital distribution of the Newcomer Welcome Package, a navigation resource that provides users with valuable information on local health and social services. We will also leverage caregiver videos created by Heart House Hospice, produced in Punjabi, Urdu and Hindi.

The M-OHT will also support cultural training for provider organizations, working with community leaders and organizations on education tools and tactics to reduce bias, prejudice and stigma (e.g., Indigenous Cultural Competence Training has been made available for the M-OHT Interim Governing Council and other M-OHT team members). We will leverage work underway in our community to strengthen sociodemographic data collection and build capacity amongst M-OHT partners to collect and analyze this information.

We are already modelling this approach in our new IPCC (CPH). The design space and artwork were intentionally chosen to create a safe, inclusive environment, and information is available in various formats (digital, paper, in person) so people can access care in a way that is accessible and safe for them.

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**.* *Mixed or provider-led Family Health Teams and their associated physician practice(s) should be listed separately. Where a Family Health Team is a member but the associated physician practice(s) is/are not, or vice versa, please note this in the table.* *Physician **groups** should only be listed in this column if the entire group is a member. In the case where one or more physician(s) is a member, but the entire*	*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.* *Note here if a FHT is a member but not its associated physician practice(s) .* *Also note here if a physician practice is a member by not its associated FHT (as applicable).*

group practice is not, then provide the name of the participating physician(s and their associated incorporation name).					
See supplementary Excel spreadsheet					

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

Name of Organization	Type of Organization[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 M-OHT MEMBERSHIP AND MEMBER IDENTIFICATION

[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

Central to the M-OHT model are the foundational pillars of modernized primary care, home care, community care, and acute care, enabled by relationships across sectors to support population health (e.g. municipalities, public health, education, private sector). The Interim Governing Council (See Question 4.2), includes representatives from these foundational pillars and they have signed this submission. This includes primary care (CVFHT, SFHT, CPH), acute care (THP), home care (represented by the LHIN) and the Community Sector, represented by three members of the Metamorphosis Network Leadership Team.

We have taken, and will continue to take, an inclusive approach to member identification, which will be a strategic advantage for expansion to maturity (See Question 2.5). This includes service providers that will support Year 1 delivery and support future year population segments, including seniors with dementia, among others.

Considerations for member identification included:
- the desire to partner in order to support the M-OHT's vision,
- alignment to M-OHT patient care and referral networks,
- a track record of working together,
- commonalities in strategic plans and the principles of Quadruple Aim, and,
- commonalities in organizational values.

YEAR 1 MEMBERSHIP

In Year 1, signatories to the agreement will include those central to Year 1 service delivery in the foundational pillars, including: CVFHT, SFHT, CPH, THP, home care (represented by the LHIN), Heart House Hospice and Dorothy Ley Hospice.

Year 1 signatory members were identified based on their capacity to participate and deliver care, whether their delivery model met the identified health needs, practicality of geographic location, and support of this proposal. Partners have experience working together in this local system of care, which serves as a strong foundation, and are willing and able to build towards integrating functions over time.

EXPANDING MEMBERSHIP

For the Year 1 population segments, we will include additional service providers (including diagnostic services, supplies and home and community care) through appropriate procurement rules (as will apply to any agreements with members and affiliates). This will expand over time, for instance to LTC.

Others supporting the M-OHT are included as affiliate partners, including patient and family advisors, associations and contracted services. This includes Shifa Health, an "In Discovery" team who has since partnered with the M-OHT.

As new population segments are identified and pathways are developed, other partnerships with members identified in this application will be required to care for the maturity population. The M-OHT will also collaborate with other OHTs and innovative OHT models to align membership and expand capacity where appropriate (e.g. through virtual care).

CHALLENGES IN THIS COMMUNITY

Delivering integrated care to the population will be a challenge due to its large size and growth trajectory, combined with a lack of health and community service infrastructure (See Supplementary Documentation).

In primary care, we have the lowest rate of interprofessional care teams in Ontario (11%) (20), and there are many solo practice models, including walk-in clinics. The M-OHT has a large number of PEMs within our network, with several PEMs also aligned to other OHTs in the GTHA.

See Questions 2.5 and 2.9 for our plan to expand membership and address these challenges.

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

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

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

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

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

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

Max word count: 2000

The members of the M-OHT have a history of working together, within and across, primary care, home care, community care, acute care and social services, and with patients, families and caregivers. For the purposes of this question, we have focused on members involved in Year 1 along with examples across the foundations of primary care, home care, community care and acute care, as represented in the M-OHT Governance.

In addition to examples illustrated in our Readiness Self-Assessment, examples of integration within sectors include:

- A network of community support services, including mental health and addictions providers and health system partners (e.g., public health) has been established through the creation of Metamorphosis (a network of 45 agencies) and community planning tables.
- Home and community care has been strengthened by the geographic alignment of care coordination and contracted service provider organizations to sub-regions and neighbourhoods.
- A Primary Care Network is organizing in the Mississauga community to create a unified voice for primary care in the area including FFS, FHG, FHN and FHO physicians.
- The SFHT and the CVFHT family medicine teaching units were established, with support from THP to deliver comprehensive, primary care services with embedded medical education.
- The Mississauga Academy of Medicine (MAM) was established in 2011, with Trillium Health Partners and the University of Toronto, focused on offering medicine students clinical experiences in a wide range of health care settings at various clinical and academic sites.
- Acute care service delivery was integrated and strengthened for the region through a voluntary merger (Partnering for Patients) of the Credit Valley Hospital and Trillium

Health Centre to form Trillium Health Partners in 2011, providing all acute care services and specialties, with the exception of transplants and severe trauma.
• Cross-sectoral partnerships established through the Healthy Cities Stewardship Centre, which includes education, justice and other sectors, outlined below.

The success of the M-OHT will be founded not only on connectivity within sectors but on integration across sectors. Below we have outlined a number of examples that demonstrate the success of cross-sectoral teamwork:

PALLIATIVE CARE CONTINUOUS CARE PATHWAY

The Ontario Palliative Care Network has outlined a pathway for a palliative approach to care, based on best practice guidelines and Health Quality Ontario quality standards, which outlines the roles, responsibilities and accountabilities of providers. This has been leveraged at a local level, by the Mississauga Halton Palliative Care Network, established in 2016, which provides planning and strategic implementation of palliative care resources and services at the local level to ensure a system-wide approach to palliative care that is patient focused. This included work to: outline the phases of a palliative approach to care, create a plan to embed a palliative approach within primary care, and on palliative approaches within LTC. The Regional Mississauga Halton Palliative Care Network is supportive of this proposal, and the M-OHT members that have been involved in this work include primary care, THP (including specialists), Home and Community Care, Heart House Hospice and Dorothy Ley Hospice.

Embedding palliative care in primary care is already underway in our region through the Community Access to Palliative Care via Interprofessional Primary Care Teams Improvement Project (CAPACITI), a quality improvement program designed to operationalize an early palliative care approach within primary care team practice. This team is interprofessional, including physicians, nurse practitioners, social workers and pharmacists, among others.

Further, THP, Dorothy Ley Hospice, Heart House Hospice, the LHIN and MH Palliative Care Network worked together to recently submit a partnership proposal to reduce ALC through community-based palliative care. This work is complementary to this M-OHT proposal and is important for building much needed capacity.

PRIMARY CARE AND HOSPITALS – INTEGRATION OF MEDICAL EDUCATION

THP, CVFHT, and SFHT partnered with the University of Toronto, Department of Family and Community Medicine, to establish the Family Medicine Teaching Units (FMTUs) over a decade ago. THP in partnership with the FMTUs provide residents with postgraduate training in family medicine. In addition, medical students from the Mississauga Academy of Medicine are provided with training opportunities across

these organizations, supporting an annual total of 216 students.

This partnership has demonstrated success in sharing accountability and resources. For example, THP manages and distributes dedicated funding from the Department of Family and Community Medicine to each of the FMTUs to enable postgraduate program execution. There are service agreements between THP and FHTs related to THP providing back office supports (e.g., IT, human resources). There is an integrated Program Chief and Academic Lead who provides leadership and oversight for program effectiveness of Family Medicine education (including postgraduate and undergraduate medical education), delivered locally through the FMTUs, all hospital sites and community primary care providers.

Between the FMTUs, approximately 18 Mississauga-trained family medicine residents graduate annually and research demonstrates a trend for these residents to choose to remain and practice in Mississauga following graduation.

Health institutions across the province could benefit from the lessons learned from this model, as it is unique in demonstrating high-quality partnership, education and training for the workforce of the future.

SHARED RESOURCES (Heart House Hospice, Dorothy Ley Hospice and Acclaim Health)

Since 2010, Heart House Hospice, Dorothy Ley Hospice and Acclaim Health have shared a Coordinator of Recruitment and Training. This individual does training for hospice volunteers in Mississauga Halton to ensure consistency and achieve economies of scale, with 900 volunteers trained to date. A Coordinator of Outreach is also shared between organizations, who provides education about hospice services across the region and engages with the diverse members of our community to better understand needs.

SUPPORTING PERSONS USING OPIOIDS (Peel Addiction Assessment and Referral Centre (PAARC) and Primary Care)

PAARC has formal agreements with primary care providers to support persons using opioids, one beginning in 2006 and another in 2012. Physicians prescribe opiate agonist therapy and support clients with general physical health concerns, while PAARC provides the addiction and mental health counselling. To date, over 1000 patients have been treated through these models.

SUPPORTS FOR DAILY LIVING (Peel Senior Link, Nucleus Independent Living, Alzheimer Society of Peel, MHLHIN, THP and others)

This is an innovative program to support seniors who want and are able to continue living in their own homes. The program is intended to bridge the gap between scheduled home care visits and long-term care by providing high needs seniors with services in their own home through 24/7 access to supports with onsite PSWs or mobile patrol. The program served over 3000 seniors, and was a pioneering in reducing unnecessary hospital stays for seniors and reducing unnecessary ED visits. The project was awarded the Minister's Medal Honouring Excellence in Health Quality and Safety and the National 3M Award for Quality in Healthcare.

HEALTH LINKS (SFHT, CVFHT, THP, Home Care and Multiple Community Support Service Partners)

This initiative aims to provide complex patients with better coordinated care by bringing providers together around the patient, and improving the patient experience. Through the development of a coordinated care plan (CCP), patients, families and providers work together to meet the patient's needs. A key process measure included the percentage of complex patients with completed CCPs within 30 days. In the last three quarters, this reached above 90%, over the target of 80%.

BUNDLED CARE FROM HOSPITAL TO HOME: Putting Patients at the Heart (PPATH)

THP worked with Saint Elizabeth (SE) Health to develop a patient co-designed bundled care initiative that redesigned the journey for cardiac surgery patients from hospital to home. The initiative began in 2015 and used integrated funding and a cross-sectoral team approach to deliver efficient, high-quality care across traditional 'silos' and better meet patient needs. PPATH is now the standard of care at this regional cardiac surgical centre. The project resulted in a 15% reduction in post-operative hospital days; a 25% reduction in readmission to hospital within 30 days of discharge; a 33% reduction in ED visits within 30 days of discharge; and a total of 96% of patients were satisfied with their care. The initiative received a 3M Quality Improvement Initiative across a Health System Award, the 2018 Minister's Medal and has been used as a model to share and further develop across Ontario's health system.

MEDICAL PSYCHIATRY ALLIANCE – Hospital Partnerships in Mental Health

The Centre for Addiction and Mental Health, the Hospital for Sick Children, THP, the University of Toronto, and the Ministry partnered to develop the Medical Psychiatry Alliance in 2014. This partnership has focused on transforming the delivery of mental health services for patients who suffer from physical and psychiatric illness or medically unexplained symptoms. One of the examples demonstrating how this partnership has resulted in positive health outcomes for patents is the Seniors

Outpatient Project - a Collaborative Care Model designed to facilitate collaboration, communication, and navigation of the health care system for seniors with chronic health conditions and depressed mood and/or anxiety. The intervention included therapeutic care management of mental and physical health needs through evidence-based psychotherapy provided by care managers and allied health providers for up to 16 weeks. This work also included the completion of Systematic Case Reviews (SCRs) with the care team, including the primary care provider, care manager, allied health providers, and a geriatrician and geriatric psychiatrist. Finally, patients were provided with an integrated care plan with treatment and target goals.

BEST PRACTICE SPOTLIGHT ORGANIZATION (BPSO)

As of April 16, 2015, THP has been awarded the internationally recognized Best Practice Spotlight Organization (BPSO) designation through the Registered Nurses' Association of Ontario (RNAO). Achieving this designation recognizes THP has successfully implemented seven of RNAO's internationally recognized Best Practice Guidelines (BPGs), and is on track to sustain best practices within the organization with an additional three BPGs.

Implementation has resulted in better pain management, fewer falls and injuries, improved breastfeeding supports, fewer pressure ulcers, support for smoking cessation and improved diabetic foot care.

POPULATION HEALTH: Healthy City Stewardship Centre

The Healthy City Stewardship Centre (HCSC) is a long-standing volunteer initiative since 2004 that has brought together key decision-making organizations to collaboratively work toward the betterment of the health of the people of Mississauga.

The vision is for the City of Mississauga to be a Healthy City of people with optimal physical, mental and spiritual health. Key partners include University of Toronto Mississauga, City of Mississauga, Peel Regional Police, Dixie Bloor Neighbourhood Centre, YMCA, Region of Peel, Peel District School Board, and THP, among others. HCSC has had a successful track record over the past 15 years of working towards achieving its vision.

In its first decade, HCSC issued the Healthy Mississauga 2010 Plan and tracked the work of the collective organizations against the goals laid out in that plan, including initiatives such as "Walk Mississauga, Cycle Mississauga." In 2014, HCSC members participated in a facilitated session where the group determined it would move forward working collaboratively with a focus on a common theme that had an impact on the health of the City. Since then the group has advanced important work to address youth unemployment and has issued a forward focused report on the health of Mississauga coming out of the Better Health Matters Forum, endorsed by Peel

Regional Council in 2018. The City of Mississauga won the 2006 World Leadership Award for its HCSC initiative.

IDENTIFIED GAPS IN MEMBERS WORKING TOGETHER

Even though CarePoint Health services has more limited experience partnering with the other members of the M-OHT, CPH is expected to be a key member in delivering on the proposed outcomes of Year 1 and at maturity. Through the Board leadership at CPH, the organization has a history of working with M-OHT partners and with the signing members, and some members of CarePoint have been involved in the Boards of other M-OHT providers.

Our plan to expand membership includes focusing on building strong, trusted relationships between primary care practices, beyond the three IPCCs, and acute care. Focusing Year 1 efforts on addressing challenges faced by primary care is key to this, and is an important factor in selecting minor acute issues and palliative care.

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

Overall there is high alignment between current membership and the provider networks identified by the Ministry.

Our M-OHT is comprised of members who are already engaged and working together to deliver care within our geography, including building new capacity to deliver care. This enabled us to come together for this application.

Membership crosses all sectors and represents many providers in the region. For instance, it includes Metamorphosis, a network of 45 community agencies, THP for

acute care, LHIN as proxy for home care, and primary care, including 50 physicians and over 60 clinical providers, and 60,000 rostered people. The list of affiliates includes important providers and partners in the region, such as LTC, public health, cultural agencies and education, who will enable expansion and a population heath approach. With over 770 full-time active physicians, THP's membership enables the participation of many specialists providing care in the community, including care for our Year 1 populations – gynecology, urology, palliative care and emergency room physicians. This application also specifically includes the support of palliative care specialists.

For primary care, we understand from the Ministry that there are 31 PEMs to consider in our network. In Year 1, a key focus will be building a strong foundation across the three IPCCs. CVFHT and SFHT are two of the core PEMs that will make up the IPCC for Year 1. Family practices affiliated with CPH will also be a part of our OHT; these are affiliated regardless of payment model and numbers will rise over Year 1 with expansion of CPH.

The majority of the 31 PEMs primarily refer to the M-OHT and are located within the general vicinity, including Mississauga or Etobicoke - a strong foundation to build on.

IMPROVING ALIGNMENT GOING FORWARD

Our OHT has a large number of fee-for-service (FFS) practices compared to many other OHTs, including walk-in clinics. For example, 75% of providers are FFS, while 10% of belong to a FHT model in the LHIN (20). We are also a region without a stand-alone Community Health Centre. As the M-OHT grows over time, we will continue to grow our IPCC network and the number of family practices who are part of the M-OHT through IPCCs. This will include supporting organization of a primary care network.

We will use strong clinical leadership, robust engagement and attractive service offerings, including the IPCC model and Year 1 improvements, to support primary care involvement with the M-OHT. We will work with the Ministry, Ontario Medical Association (OMA) and primary care leadership to achieve this. The OHT model is a key accelerator for this work to continue.

This will include engaging with PEMs beyond the boundaries of Mississauga or those not currently in our attributed network based on the Ministry's methodology. The strategies to engage these providers may differ from those we deploy in our local community in Year 1, and we acknowledge it will be an ongoing process to reach these providers and will require collaboration with neighbouring OHTs. As the OHT's success grows, we may see a shift in referral patterns bringing more providers into the network over time.

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

Our Year 1 population includes the 60,000 people connected to the three IPCCs in the region, CVFHT, SFHT and CPH (See Question 1.2). This represents 7% of the attributed population (878,000). This is expected to grow over Year 1 with CPH

expansion.

Starting with this population allows us to build on existing patient-provider relationships, and working relationships between providers in the network, therefore focusing efforts on integrating care into seamless pathways.

The M-OHT strategy includes two subpopulations for integrated care in Year 1, as described earlier in this application: those who would benefit from a palliative approach to care and those presenting with minor acute issues (represented by a first target area of GI/GU needs).

All 60,000 patients (7% of maturity population) will have access to these services as needed. We anticipate that approximately 18,500 patients (2% of the maturity population and 30% of the Year 1 population) may need the integrated care pathway for palliative or minor acute:

- For palliative care, this represents approximately 5,500 people, 9% of the Year 1 population or 0.6% of the maturity population. This is estimated based on prevalence of key life-limiting illnesses in the attributed population. Based on historical data, it is expected that approximately 270 people will die within Year 1, representing 0.45% of the Year 1 population or 0.03% of the maturity population.

- For minor acute issues (GI/GU) this represents up to 13,000 patients, which is 22% of the Year 1 population or 1% of the maturity population. This is based on the incidence of any minor acute GI/GU issue in the attributed population. As described in Question 1.2, this is likely an upper-bound, and a key subpopulation is those presenting in ED with minor acute GI/GU, approximated at 1,300. This is 2% of the Year 1 population and 0.1% of the maturity population (See Supplementary Documentation).

IMPLEMENTATION ADVANTAGES OF YEAR 1 FOCUS

Focusing on these subpopulations means designing solutions for two different segments: high prevalence, low cost (minor acute) and low prevalence, high cost (palliative). This will help build strengths in different areas, enabling scale and spread to maturity.

In an OHT with such a large maturity population, this focus provides a measured approach to change. Starting clinical integration here allows us to learn, and set foundations, people and processes to support expansion.

Beginning these pathways with existing patient-provider relationships means anyone who requires these services will be able to access them. Further, our plan is for the integrated pathways to improve access and efficiency. For instance, we expect streamlining these pathways to reduce ED visits, reduce diagnostic repetition,

improve access through digital options and expand capacity through team-based approaches that maximize scopes of practice.

Once established, features of these services can be expanded to anyone connected to the IPCCs, not just those with palliative and GI/GU needs. For instance, hardwiring 24/7 navigation, virtual care access, community access to diagnostics and improved care coordination, will have positive benefits for patients and providers, outside of these two pathways.

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

The M-OHT will deliver the full continuum of care, including primary care, community care, home care, acute and specialist services, LTC and social supports. To get there, we need to partner widely to address a range of health needs for the community.

Membership expansion will follow two paths, aligned with our Year 1 subpopulations:

1. New Partners to Support Health Needs of Year 1 Populations

The M-OHT will expand services to the Year 1 population within and beyond the traditional health care sector, to support the population's physical, mental and emotional needs and to support health equity. This may include LTC, social services, private sector and agencies that provide culturally-appropriate services and professional translation services.

Primary care is key to expansion, and we will increase linkages of primary care to existing IPCC, expanding additional IPCCs within the region, and support people who are unattached. This may require satellite centres, or spokes, from the three IPCCs in the area, and a strong foundation of modernized primary care, which this region is building through the creation of IPCCs and a primary care network. This will require additional Ministry resources and support.

2. Expanding to New Population Segments in Year 2 and Beyond

Expansion of the M-OHT will also occur through new integrated care pathways targeted to new subpopulations over time, and we will develop new partnerships and deepen existing ones to form a complete system of care across sub-populations.

Scale and spread will accelerate over time, as the partnership foundations and integrated pathways are established and become hardwired into the M-OHT approach. For instance, minor acute will apply to relatively healthy populations requiring episodic care in the community, and palliative will be scalable for complex, multi-morbid pathways.

Integrated pathways will be population-based and data-driven, based on opportunities to influence the Quadruple Aim through upstream intervention and prioritized using our assessment framework (See Supplementary Documentation). In Year 2, we have already identified that we will build pathways for seniors with dementia, and other minor acute conditions (e.g., flu/respiratory illness). To do this, we will expand membership with community service agencies that support these new clinical integration streams (e.g., LTC homes, seniors support services).

As primary care involvement expands, this will expand the number of people that will benefit from these integrated care pathways.

MANAGING CHANGE AND EXPANSION

The introduction of the OHT model in Ontario represents a significant change in the health system. Success depends on trust among the partners and a managed approach to change (See Question 6.2). The core foundation of Year 1 members, and

planned expansion over time, is based on this philosophy.

To support Year 1 implementation, clarity is needed from the Ministry on partner accountability, decision-making and funding (including tracking service use outside the M-OHT network), as this may inform whether health service providers or organizations decide to partner with the M-OHT.

The M-OHT also acknowledges that the timing and pace of expanding membership depends on the provincial strategy to address labour relations and procurement rules, particularly with home and community care services, and infrastructure deficits.

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

The M-OHT membership in Year 1 will include three IPCCs, including 50 primary care physicians and over 60 interprofessional providers, who are a part of SFHT, CVFHT, and CPH.

CarePoint Health is a new IPCC and offers a unique model given the fee-for-service make-up in this region and other parts of Ontario. It uses affiliation agreements to bring together primary care practices, regardless of practice model, in order to access team-based care, learn together, and share in the provision of after-hours care. Since the readiness self-assessment submission, CPH has opened its doors with two primary care physicians and affiliation continues to expand. This number will increase over Year 1, primarily through those working in fee-for-service payment models. The learnings of establishing CarePoint Health in the region will be fundamental to expanding IPCC attachment for primary care providers throughout the network.

As noted earlier in the application, 31 Patient Enrollment Models (PEMs) have been identified by the Ministry as highly aligned to the M-OHT provider network (1). The majority of these PEMs are in Mississauga and Etobicoke. The M-OHT is actively engaging with the physician leadership of these PEMs, individually and collectively, to discuss alignment and partnership within the region. Given the number of PEMs, we are taking a measured approach to implementation and scale.

Specifically, we have begun to create a primary care council that is representative of physician leaders from all PEMs, with a particular focus on PEMs in Mississauga. M-OHT leaders have begun to connect FHG physicians in our area, interested physicians (including walk-in clinics) and primary care advisors, to a process to create a local, unified primary care voice that will have representation, and participation at all levels of OHT governance and planning. The group has set a plan to meet in late Fall 2019 to continue this important work.

An additional 14 PEMs have been identified by the Ministry as partially within our referral network, but that also align to other geographies. These are located in Brampton, Etobicoke, Toronto, Oakville and Mississauga (1). The M-OHT has reached out to collaborate with neighbouring OHTs, where they exist, to collectively support relationship development and partnership approaches.

Key to our strategy is strong engagement and linking physicians to IPCCs, phased over time, for community building, diversity, supportive networks, learning, practise facilitation, and back office consolidation. The M-OHT will: support the modernization of primary care and access to team-based care so physicians can work to their upper scope of practice; and, will bring resources to primary care from hospital for better community management and closer relationships.

The M-OHT is also working to stay abreast of work with the OMA, to ensure messaging and approaches are aligned across the province. This included ensuring this OHT had an established relationship with a Regional Manager at the OMA.

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.

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HISTORY OF OUR COMMITMENT TO ENGAGEMENT

The M-OHT has a strong history of working together, as outlined in our responses above. We are committed to the principles of co-design and active engagement, ensuring the needs of patients, families, caregivers and providers drive design. The creation of the M-OHT itself is in response to feedback gathered through continuous engagement with patients, families, caregivers, providers and the community.

OVERVIEW OF FULL APPLICATION DEVELOPMENT

Engagement continued as a driving force in the creation of this Full Application, along with population health analysis and evidence leveraged from IBH, RISE and the University of Toronto. We used the framework for patient and family engagement in health to inform our approach, following a continuum of engagement, and working with patients and families through consultation, involvement, and in governance structures.

This proposal has received resounding support from members of the community. To develop it, we engaged with over 300 people, including those involved in the first phase, including: patient and family advisors, health service providers, community agencies and organizations, front-line providers including primary care, and experts in population health and ethics.

The process was guided by a cross-sector Interim Governing Council that met regularly throughout the Readiness Self-Assessment and Full Application development (See Question 4.2). These founding members have support from their respective boards, bringing a diversity of talents and skills to help inform our work.

Here are the details on how we developed this application through engagement, co-design and decision-making with local stakeholders, providers, patients, families and caregivers.

CO-DESIGN SESSIONS THROUGH MULTI-STAKEHOLDER ENGAGEMENT

In August, the M-OHT held co-design sessions on the health care experience and delivery model for people with minor acute issues and people with palliative care

needs. These sessions focused on validating the M-OHT understanding of how care is delivered today and opportunities for change.

The M-OHT applied a user-centred, design thinking approach. Patient and provider stories helped identify issues, set priorities and identify solutions. Patient personas, journey maps, and service blueprints were developed for both priority populations with input and validation from evidence and subject matter experts across sectors.

Approximately 75 diverse stakeholders attended the sessions. Clinicians and patient and family advisors were key members, providing lived experience to ground this work. This, and feedback from all stakeholders, contributed directly to this Full Application. The findings were used by M-OHT partners to inform senior teams and Boards.

PATIENT, FAMILY, CAREGIVER AND COMMUNITY ENGAGEMENT

The voices of patients, families and caregivers are central to the M-OHT. Patients are represented at all levels of the interim governing structure established for this Full Application. This includes all decision making tables, and patient, family and caregiver engagement in co-design and advisory tables (See Question 4.2).

A targeted survey was sent to 80 patient and family advisors with questions about self-management tools and resources currently used, ideas to improve caregiver support in Mississauga, and how to incorporate digital health and virtual care, relevant to the subpopulations. We received feedback from 20 advisors. Five patient and family advisors were interviewed about their experiences with patient self-management and caregiver supports, eight participated in co-design sessions as above, and we received input on governance, what success looks like and the key risks to manage at a PFAC meeting. This input directly informed this proposal.

The M-OHT engaged with community leaders and organizations that represent the five identified communities: Indigenous, Francophone, racialized groups, newcomers and 2SLGBTQ+ (See Question 1.3). The M-OHT met with representatives from seven organizations and associations to discuss the vision of the OHT and develop this application (21). The M-OHT also has support of the Healthy City Stewardship Centre, including the City of Mississauga and Region of Peel.

Representatives were invited to all stakeholder and co-design sessions. Diverse perspectives were welcomed and incorporated to advance understanding and consideration of those with unique lived experience. We will continue to engage with diverse cross-sectoral stakeholders to challenge inequities and improve overall health and well-being of the community.

ENGAGEMENT WITH PROVIDERS, EXPERTS AND BOARDS

Engagement included physicians, nurses, social workers, home care workers and those with experience at the frontline of care delivery. Primary care engagement included OHT primary care sessions, weekly primary care meetings and engagement to begin a primary care network.

We have also engaged a number of experts, in population health, implementation science, patient experience, innovation and IT, and an ethicist to review our overall approach (See experts in Readiness Self-Assessment).

Founding members of the M-OHT have shared the OHT vision and areas of focus with their Board members, and have support to proceed with this Full Application. Materials have been prepared for participants to support sharing and transparency of information with organizations and Boards.

BROAD INFORMATION SHARING AND ENGAGEMENT

Continuous engagement and information sharing included existing Care Collaborative tables, and a series of M-OHT Stakeholder Sessions, which involved sharing the vision, detailed planning information and Q&A to support team building and alignment on the path forward. An average of 100 people across sectors, including patients and families, attended these sessions, in person and by webinar.

Written updates were shared with a broad stakeholder list, and a public website (moht.ca) was established to ensure transparency of planning, opportunities to be involved and access to tools and resources. The M-OHT has a publicly available email (info@moht.ca) for direct correspondence and engagement from the public with the M-OHT project team.

Information on the M-OHT was shared on social media and in late Fall 2019, we will host a tele-townhall with over 10,000 residents to build community support for change. Details on the tele-townhall will be available through the M-OHT website.

Copies of the application were made available at five partner locations, including community care agencies, primary care offices and at the hospital, for review. We had over 80 individuals review the document in detail.

These approaches enabled the M-OHT to be transparent with the community about the content of the application, and to incorporate community input at each stage.

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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VISION FOR IMPROVEMENT AT MATURITY

The vision of the M-OHT is to improve the health of people in this community by creating an interconnected system of care across the continuum, from prenatal care to birth to end-of-life. We will do this by re-designing how we work together, supporting the whole person, including mental, physical and emotional wellbeing, and promoting health. Our approach will involve an incremental build, starting with clinical integration processes with core members, prototyping of our Year 1 populations, and a commitment to establishing a culture and process for a rapid health learning system.

The prioritization of performance improvement opportunities is guided by:
- Principles of Quadruple Aim;
- Government Priorities; and,
- Local Population Needs and Preferences.

We have chosen our two subpopulations to achieve the following key overarching outcomes:
- Improved access to services to help reduce hallway medicine and wait times in the long-term;
- An exceptional experience achieved through a fully integrated system of care; and,
- Establishment of a model for implementation that can be standardized across the OHT as we expand.

RELEVANT MEASURES AND CURRENT STATE PERFORMANCE INCLUDES:

- ED wait times for an inpatient bed, for our population, are on average 3-4 hours longer than the province and is an area for improvement (22).
- The proportion of hallway beds in Ontario related to our population is rising, representing approximately 6% on average in 2018/19; representing on average 70 hallway beds (22).
- ALC is a contributor to flow issues and hallway bed use. While this region is on par with the province in terms of ALC rates, they remain high, at approximately 15%. At THP, 8% of patients in hospital with an ALC designation are palliative, and overall, 65% of palliative people in our region died in hospital (22, 7). We also observe that 58% of palliative people in our region had one or more ED visits in the last 30 days of life (7).
- EDs at THP are the second busiest in the province. Minor acute GI/GU issues (CTAS 3-5) are among the top reasons for an ED visit. These patients are often discharged home from ED, and show potential to be more appropriately managed in the community. Further, while ED wait times for non-admitted patients are near provincial targets, this means 90 percent of patients are still waiting 4 hours, when they could receive faster, more coordinated care in the community, improving patient experience and reducing total system costs (22).
- Through engagement with patients and providers, we know a top concern is system fragmentation. While cross-system patient and provider experience metrics are not yet in place, we will aim to measure and improve patient- and provider-reported

experience measures. The M-OHT will work to address provider burnout in primary care. While we know this is a complex issue, we intend to influence this by providing a voice through engagement and addressing challenges that relate to day-to-day effectiveness.

Taken together, targeting these opportunities has the potential to impact the quadruple aim, by creating better value, better experience for patients and providers, and better patient outcomes.

YEAR 1 IMPROVEMENT FOCUS

Impacting the measures at a system level will take time. It will require us to start small, using rapid learning to drive to success, and then hardwire features of the M-OHT during expansion to a larger array of populations with many, new integrated care pathways.

In Year 1, we will focus on improvement across these metrics at the subpopulation level, using both process and outcome measures.

For those that would benefit from a palliative approach to care:

• We will implement earlier end-of-life planning, early identification of palliative supports, a shared care plan so that patients, caregivers and care team members all understand the management steps and goals during an acute event, rapid and afterhours access to supports from a key contact within the care team and virtual access to care (See Question 3.2). Together, these improvements are aimed to improve PROMs, PREMs and enable patients to maintain their place of residence where preferred, reducing ED visits and hospital utilization.
• By providing these supports, including virtual care options, rapid access to afterhours support, a shared care plan and early bereavement and caregiver supports, we aim to improve the experience for caregivers.

Key process measures may include:

o Number of care team members and extended care team members with palliative care training
o Number of people with an advance care plan
o Number of people with documented assessment of palliative care needs and a documented care plan
o Adoption rate of palliative care shared care plan tool
o Number of days between first palliative care service and death

For those that require minor acute (GI/GU) care:

• We will create 24/7 access to navigation that promotes primary care as a first point of contact, including direction to after-hours care and virtual access. We will provide primary care with timely access to diagnostics that are reliable and offer rapid interpretation, and also rapid access to specialist consultation by phone or urgent e-consult. Through these means we anticipate a reduction in ED visits for minor acute GI/GU, better system value by maximizing utilization of lower cost community care, improved provider experience and patient reported experience and outcome measures (PREMs and PROMs).

Key process measures may include:

o Number of virtual consults between patients and primary care
o Wait time for primary care to receive diagnostic report
o Number of repetitions of diagnostic test or reinterpretation of test results ordered by primary care
o Wait time for primary care to receive consult with specialist (target would be same day)
o Number of virtual consults between primary care and specialists

For both subpopulations, we will select appropriate PROMs and PREMs, leveraging provincial supports, and in collaboration with patients, family members/caregivers and providers.

We are committed to rapid learning and continuous evaluation to enable our planning and pathways to adapt quickly so that we see measureable results, and over the long-term, deliver seamless, value-based health care.

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

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

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

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

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The M-OHT members are committed to working together and engaging the community to understand current challenges and re-designing services to address them.

Throughout this process, we engaged with leaders, community members, patients, families and caregivers, providers and experts.

We examined data that describes the significant number of people who die without palliative care and the high rates of caregiver burnout, and data that demonstrates the opportunity to improve access to services in the community for minor acute issues (See Question 1.2 and 3.5.2).

We heard from patients that OHT success needs to include improved communication between providers, and from primary care clinicians who told us that improved access to diagnostics in the community would allow them to better care for patients (See Question 1.2 and 2.10).

Through this process, we identified four key design principles for the M-OHT and the features that will enable them as described below.

FOUR DESIGN PRINCIPLES FOR THE M-OHT:

PRINCIPLE 1: Supporting the Health of the Whole Population

To address the health of the whole population, we will:
• Work towards a full and coordinated continuum of services for our population at all stages of life, building over time across subpopulations.
• Focus on prevention and anticipatory care to keep people well.
• Use a population health approach and apply a health equity lens to understand health needs and target interventions appropriately.
• Use data and evidence to inform decision-making and monitor emerging risks and needs in our community.
• Ensure team members have the appropriate competencies to deliver care that is sensitive to different cultures, languages and vulnerable populations.

PRINCIPLE 2: Creating One Seamless System

To provide clinically integrated care across the system, we will:
• Establish one vision, an overarching strategy and brand. Members will be asked to align to this. Each member will provide links to the M-OHT website.
• Develop structures focused on shared ownership and accountability, data sharing and privacy, with clear roles and responsibilities across teams and members.
• Design and implement evidence-based integrated care pathways for subpopulations across partners, including those outside traditional health care (detail

on Year 1 pathways below).
• Standardize and digitally automate processes within and across providers to hardwire evidence-based practice, build capacity for providers (e.g. through use of predictive statistical models) and support integration of systems.
• Connect partners across sectors to create a "Patient Medical Neighbourhood" that links health sector partners with other sectors (e.g. social services) (23).
• Create a culture of continuous improvement, providing change management supports and appropriate resources to enable providers in implementing change; we will draw on the lessons learned from our partners in family medicine education, including SFHT, CVFHT, and THP.

PRINCIPLE 3: Providing Holistic Care, with a Foundation in Primary Care

To ensure our population has access to care that considers physical, mental and emotional wellness, and is organized in ways that are patient-centred, we will:
• Set primary care as the foundation of the M-OHT. This includes establishing an evidence-based model of team-based care (an Integrated Primary Care Centre). This has home and community supports embedded and serves as the main hub connecting patients to system providers.
• Ensure access to IPCCs to achieve care continuity, regardless of primary care practice payment model.
• Create a seamless experience by embedding care navigation and coordination as functions within the IPCC, with clear accountabilities, roles and responsibilities to ensure success.
• Include shared after hours call access for care questions to allow for 24/7 care navigation (See Question 3.3.2).
• Link each medically and/or socially complex patient to a member of the core team who will serve as a key point of contact to support coordination on an ongoing basis (See Question 3.3.1).
• Through the IPCC model, streamline access to an extended team that includes all services needed to support patients, enabled by virtual care. This includes urgent access to specialists for consultation, professionals in community service agencies, home care, pharmacists, physiotherapists, psychologists, and social workers among others.
• Introduce solutions to enable a shared digital care plan for each patient that is accessible across all providers, and integrate digital communication and virtual care options for both patients and providers.

PRINCIPLE 4: Empowering Patients and Caregivers, and Delivering an Exceptional Experience

To design a system that provides an exceptional patient, family and caregiver experience, enables them to actively manage their care and provides access to the providers who know them best, we will:

- Provide 24/7 navigation through the IPCCs (See Question 3.3.2).
- Offer a clear point of access and a “front door” to find information about services. This will include a website where people can find navigation information, trusted medical information, a single telephone number for the OHT and over time, access to booking. People attached to a particular IPCC will have direct access to supports within their IPCC - especially important in an OHT of this size.
- Offer patients digital options for accessing care (if they prefer), including virtual access to primary care and specialists through video visits and secure messaging.
- Create a patient portal in future years, through which patients can access details of their medical record and view their shared care plan; this will include the ability to review and make changes as they interact with care providers and their care goals change.
- Design a standard experience that will be kept consistent across members of the OHT and embed mechanisms to collect and respond to feedback
- Establish a consistent patient relations process

IMPLEMENTING THE PRINCIPLES IN YEAR 1 SUBPOPULATIONS

Below is a description of changes proposed for Year 1 for our two priority populations: 1) those who would benefit from a palliative approach to care and 2) individuals presenting with minor acute issues (for example, GI/GU).

SUBPOPULATION 1: People who would Benefit from a Palliative Approach to Care

Based on consultation, challenges currently experienced by this population include:
- Transitions are difficult for people receiving palliative care. Their care providers may not always be able to share information with one another, and may not be aware of their goals or preferences for end-of-life.
- Identification of the need for palliative care is often delayed- ideally, it would occur at the time of diagnosis with a life-limiting condition so that palliative interventions can be considered early in the care journey, education can take place and plans can be made, improving quality of life and experiences for patients and their caregivers.
- Patients and caregivers are often not supported to manage their care in the community, including in setting goals for care, or managing their own care in the community.
- Many people have neither contemplated nor completed advance care plans. People at all life stages would benefit from having their wishes documented and understood by their care providers and their loved ones, in the event that they should not be able to communicate them. This kind of planning can prevent people from undergoing care experiences that are not in line with their wishes.

In light of these challenges, we propose the following change ideas in Year 1:

- Advance Care Planning: Use digital tools to prompt all individuals rostered with primary care, particularly those with chronic conditions, to engage in advance care

planning with their providers. This would include a prompt to: speak to loved ones and clinicians about wishes and values informing end-of-life care; identify a substitute-decision-maker.
• Early Identification: Work with primary care providers to implement standardized triggers within EMRs to enable early ID of potential palliative care needs. All members of the patient's core team would be expected to play a role in early ID.
• Integrated, Team-Based Care: Link patients in the Year 1 population who would benefit from a palliative approach to care to a core interdisciplinary team in primary care. Identify a member of the core team to serve as a key contact. The team would work with patients to develop goals of care and support end-of-life planning. Include extended services in the team, including palliative care specialists and a bundled approach to home care.
• Digitally-enabled Shared Care Plans and Communication: Ensure all patients with palliative care needs have care plans. These will be living documents that are standardized, cumulative and digitally modifiable and accessible by patients and care teams. Use a digital solution to enable information to be shared across the core and extended teams, including patients.
• Rapid Access: Ensure all patients rostered with primary care have access to 24/7 care navigation. For patients with medically complex needs (i.e. palliative population), provide a phone number to a designated member of the care team, who can be reached directly for rapid access.
• This will be knit together in an integrated care pathway with clear roles, responsibilities and warm hand-offs.
• See responses to question 3.3.1 and 3.3.2 for further detail.

SUBPOPULATION 2: People Presenting with Minor Acute Issues (e.g.GI/GU)

Based on consultation, challenges currently experienced by this population include:
• Limited access to primary care after-hours, on weekends, or on holidays, creating gaps in care and leading to higher utilization of emergency departments and longer wait times for patients.
• Primary care providers often lack of access to the diagnostics needed to care for these patients (i.e. laboratory testing, diagnostic imaging). Primary care providers may have to send patients to the emergency room to receive these tests.
• Access to timely and reliable interpretation of results is also limited, as is rapid access to specialist guidance or advice for primary care providers

In light of these challenges, we propose the following change ideas in Year 1:

• Access to Modernized Primary Care: Enable patients to quickly and easily schedule with primary care providers for urgent issues, including digital options for virtual visits. Identify designated after-hours primary care services and navigate patients there when their own providers' office is closed. Ensure warm handovers take place for patients visiting after-hour services to enable follow-up and documentation.
• Access to Timely, High Quality Diagnostics: Streamline access for primary care

providers to timely diagnostics through partners (i.e. acute care) or contracted services in the community. Develop agreements to ensure contracted service providers are accountable for timely results interpretation, quality standards, and accreditation. Over the long-term, diagnostic and lab records could be uploaded directly to the EMR to enable timely access to results in primary care and could include point of care diagnostics.
• Urgent Access to Specialist Advice (with Virtual Options): Enable primary care providers to access urgent advice from specialists through e-consults or phone for urgent situations. Explore the possibility of booking patients into ambulatory care clinics, when needed (e.g. when triaging is needed for acute diagnostics).

SUMMARY OF OUR APPROACH

To develop this application we engaged in an extensive co-design process, placing patients at the centre of our planning. This work included:
• Engagement of providers (including physicians, nurses and allied health professionals); health care organizations; patients, families and caregivers; and others from private industry and provincial and regional bodies.
• Development of patient personas, informed and validated by content experts.
• Application of design-thinking principles to identify pain points in the current system and develop a service blueprint to address them.
• Review evidence and work with subject matter experts to validate our proposal and support implementation planning, including identifying Year 1 change ideas that are achievable, meaningful and bold enough to disrupt the system in a move towards integration.

In Year 1, we will continue to engage with our community and across sectors and will work towards an OHT team with skills in design-thinking, change management, collaborative planning, and implementation. We will include patients with lived experience and caregivers and providers at every level. We will focus on improving Quadruple Aim indicators, and work with other OHTs focused on palliative care, to support alignment for patients and providers.

We will begin with the populations of focus above, ensuring that changes are hardwired and that standard approaches to implementation are designed to enable the rapid scale and spread of future integrated care pathways.

We will also focus on establishing core processes and foundations that will support a new way of working together as we expand into new clinical areas and learn from successes in other jurisdictions (for instance, work New Zealand has done on minor acute, and RISE resources for integrated care) (24).

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

CURRENT CHALLENGES AND OUR VISION TO ADDRESS THEM

Patients, families and caregivers currently experience a fragmented health system.

Transitions between services are difficult and the system lacks the infrastructure and processes needed to ensure health care is reliable and seamless. This is particularly true for people who have complex care needs and require support from multiple providers, for instance, palliative patients.

Effective care coordination is key to addressing this. We envision that the primary care team will undertake and be accountable for coordination of care. This would be for people with complex needs, or those deemed to require complex service coordination.

Within interdisciplinary primary care teams, medically or socially complex patients would have access to a core team working collaboratively to support care coordination. Each member - physicians, nurse practitioners, social workers, administrative staff and others - would work to the maximum scope of their practice, also leveraging supports of the extended team (e.g. hospice, specialists).

To ensure clear accountability, a member of the core team who is a regulated health professional (e.g. RN, RPN, social worker) would be assigned as the most responsible person for coordination and be designated as the point of contact for patients with complex needs. This person would have administrative support and would leverage the skills and capabilities of the entire team. This approach has been informed through numerous evidence-based publications.

Outside primary care, the care coordination function among discharge planners can also be enhanced to support patients as they transition home from hospital, including facilitating long-term care placement, ordering services and equipment and linking in primary care for regular updates.

We believe the vision proposed here will improve how patients, families and caregivers are able to move through the health system and access various services, including those beyond traditional health care.

CARE COORDINATION FUNCTION IN YEAR 1

With respect to our Year 1 subpopulations, we recognize that patients with palliative care needs and their caregivers, particularly those who are at more progressive stages of illness, will have significant needs for care coordination and management.

Supports such as ongoing access to a member of the primary care team, home care, and virtual care are particularly important for those who would prefer to remain at home as long as possible. Patients requiring other services from hospice or acute care will also benefit from a supported and coordinated journey through these transitions.

For patients with minor acute (GI/GU) needs, timely access to the right type of care in

the community is a priority. This includes timely diagnostics and specialist advice, to be coordinated in a seamless way through their IPCC team.

APPROACH TO EMBEDDING CARE COORDINATION FUNCTION IN PRIMARY CARE

As mentioned above, a key feature of our approach to care coordination is having one individual on the care team accountable to serve as a designated point of contact for those with complex medical and/or social needs.

This creates continuity of communication and rapid, simple access for patients, families and caregivers. It also centralizes accountability to ensure care is effectively coordinated.

This person will be a regulated health professional, depending on the needs of the patient. Individuals designated as points of contact may carry a sub-set roster of the teams' attributed population, for whom they will be expected to:

- Provide care within their scope practice;
- Provide follow-up, coaching and be available to support the patient on care plan goals;
- Ensure services, both internal and external, have been arranged and are in place;
- Communicate with other members of the care team when a change in patient needs has occurred, engaging the appropriate core team;
- Bring in extended team members as needed, such as palliative care expertise;
- Complete applications to long-term care and other social supports (e.g. Ontario Disability Support Program);
- Assist in providing patients information on private supports at home;
- Link with other team members about patient progress or needs, including: organizing care management conferences, arranging SPO services, and serving as the main point of contact for the patient and family about care needs on behalf of the team; and,
- Remain in place and stay connected to the patient throughout their journey (i.e. home, hospital, short-stay transitional supports, hospice).

Individuals designated as points of contacts will be part of an after-hours call group to ensure complex patients have 24/7 access to care coordination supports. These individuals will also be supported by a physician on-call system, including access to on-site, virtual or home care visits after hours, as appropriate.

In Year 1, a designated point of contact will be available for all patients with complex palliative care needs and, in some cases, patients with more service coordination needs for minor acute issues. The designated point of contact would hold the accountability for ensuring that the patient's needs are met, and would pull in members of the core or extended teams.

M-OHT members will offer many services; where services required are not available within the OHT, a member of the primary care team will help to coordinate smooth transitions for those patients who are medically and socially complex.

APPROACH TO RESOURCING CARE COORDINATION FUNCTION

We do not envision that this would be a new role in primary care, but rather would be a function performed by members of the patient's core interdisciplinary team. Primary care team members (e.g. nurses, social workers, physicians) would all share some responsibility for care coordination, with clarity on overall accountability.

This approach builds upon the services primary care already offers. To implement this function effectively, teams will require clarity on roles and responsibilities and a strong culture of teamwork. The M-OHT will ensure the appropriate administrative supports are in place to enable this role (through administrative staff or medical assistants).

Training staff in primary care will allow us to meet the needs of palliative patients in Year 1, although implementation of the model within the existing FTE complement of the IPCCs may require discussion of priorities with the Ministry to ensure feasibility. To achieve expansion beyond, existing home care infrastructure must be leveraged.

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

CURRENT CHALLENGES AND OUR VISION TO ADDRESS THEM

Patients and families in our system are not always sure where to go for their health care needs and who to call to help them navigate the system, for both information and

services. Navigation services exist in multiple organizations and roles across system today; they require rationalization and streamlining to improve the experience of patients.

The M-OHT believes that to improve navigation in the health system, not only do we need to design a simplified system but we also need to provide a mechanism that helps patients, families and caregivers access information easily to help them move through the system as smoothly as possible.

CARE NAVIGATION FUNCTION IN YEAR 1

At the start of Year 1, all patients attached to an IPCC (approximately 60,000) will receive an information pamphlet that provides basic navigation information for Year 1 populations. Information would include providers in the M-OHT network, services available, and general information about how to access services along integrated care pathways.

Throughout Year 1, the M-OHT will continue to build the M-OHT website, which can also be used to provide basic care navigation and information to all patients in Mississauga, should those patients be attached to the IPCC. In addition to these basic care navigation supports, the M-OHT will work with each of the IPCC locations and affiliated primary care providers to establish navigation functions within primary care teams.

Similar to the function of care coordination, care navigation will primarily be embedded in primary care, as the primary care team understands the patients' needs best, has access to their records as appropriate, and can communicate the patient's regularly changing needs to the core team easily and in real time. In such a large OHT, this approach enables local knowledge and a team based-approach, while also allowing for standardized training, processes and tools to ensure consistency and knowledge of the overall system.

APPROACH TO EMBEDDING CARE NAVIGATION FUNCTION IN PRIMARY CARE

Care navigation services will be available for all Year 1 priority populations 24/7 through on-call; and those providing care navigation would be a non-clinical member of the team in primary care. Navigation services will connect patients to the health services and providers that they need across the health and social services system, starting in primary care and beyond.

Individuals providing care navigation services would receive the appropriate skills training to understand and have knowledge of the health system. For example, these individuals would be responsible for resolving patient inquiries, providing information referrals to community resources and connecting with the care team if new concerns

arise. When deemed appropriate through decision tools or recommendation from the care team in the pathway, they will also administratively support referrals and tracking of referrals.

Individuals performing this function will manage a central intake and central bookings through primary care, and follow-up with patients, informing the core team of any updates based on care received in the extended team and ensuring warm handovers between the core team and the extended team (e.g. between primary care and specialists, primary care and diagnostics).

As a non-clinical function of the primary care team, individuals performing navigation would have access to a patient's medical chart and relevant medical information as appropriate in order to support referrals in the community.

In the case of providing after-hours care navigation (between approximately 8pm and 8am), an on-call group would be established from different primary care locations, which would facilitate the receipt of calls and need for navigation services for patients overnight.

For patients with minor and episodic GI/GU issues, these patients will be able to use navigation services to support them in understanding where and when to access care and to ensure warm handovers, particularly between accessing different types of health services, such as diagnostic imaging and labs.

Patients with palliative care needs may rely less on navigation services, as these patients will be supported largely by their designated point of contact on their core team to support their overall care management; however, these patients may still benefit from navigation and general information about health and social services, as required (e.g., through the M-OHT website, information pamphlet, interactions between care navigators and the designated point of contact).

In the long-term and at maturity, it is envisioned that care navigation services would include centralized scheduling and referral database that could be used across the M-OHT.

In addition, over time, the M-OHT would continue to build an effective website and application that can be used by patients to complete self-triaging and self-navigation, where appropriate.

RESOURCING APPROACH TO CARE NAVIGATION FUNCTION

As mentioned above, the care navigation function would be housed within IPCCs. Primary care practices already perform certain navigation functions; current volumes would suggest that a number of individuals would need to be placed in each of the primary care locations to manage taking on the additional navigation activities

proposed above.

Beyond the Year 1 population, this approach will require investment and would require leveraging the existing home care infrastructure. This would also require us to leverage existing assets such as information and referral specialists, home care access care team, health line and provincial tele-health resources.

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

A team-based approach to care is a central feature of the M-OHT, designed to improve patient transitions. This includes a core team in primary care that follows the patient throughout their care journey and connects as required with an extended team across the OHT. This is supported by a designated key contact for people with complex needs.

We will build on the initiatives and activities that M-OHT members currently have in place to improve transitions. Specifically, this includes building on the team-based care model within primary care, work to create seamless transitions and the work completed in the region on the palliative care pathway.

To understand the current state of transitions for patients in Mississauga, we created maps of the patient journey to identify the challenges in improving the patient experience and opportunities for improvement (See Supplementary Documentation). Key areas of focus include transitions between the core and extended teams, from hospital to home and within home and community care.

STRATEGY TO IMPROVE TRANSITIONS

Our goal is for as much patient care to remain in the IPCC as possible, to remove the need for patient transitions. Where transitions are required, the designated key contact will be accountable to ensure care is coordinated, leveraging the capacity and expertise of the team and administrative supports.

Simple access to the extended team, such as specialists or community supports, will

be key to smoother transitions. Creating these integrated care pathways with clear standards and accountabilities, supported by strong relationships and a team culture, will be a focus of OHT development. This work will build on the regional palliative care pathway development, which leverages work completed across the province.

Over time, our goal is to build in virtual support through the patient's core team and a designated point of contact. We see virtual care as a strategic opportunity to minimize transitions, where preferred by the patient, and where clinically appropriate. This would for instance allow for consults between patient and primary care provider together with a specialist. It would also include secure messaging and shareable and accessible care plans for patients.

The M-OHT will expect all members of the core team to embody this principle of minimizing transitions for the patient. As a member of the core team, the designated point of contact will play a major role in patient transitions, with a goal to minimize or eliminate transitions, and ensure a "warm handover" and a care plan when members from the extended team enter into the circle of care (e.g., the point of contact would support transitions to acute care, diagnostics, community supports). This is important as the key contact will have an understanding of the story and journey for each patient, providing an individualized experience. Patients, families and caregivers also play an important role, and the OHT will create an environment where patients and their families know what to expect and are able to be full partners.

In the case of patients with palliative care needs in Year 1, the point of contact would be responsible for working with the patient and family/caregiver, and team, to develop a care plan that is shareable with the core and extended teams as appropriate, and is used as a living document to guide care. For minor acute patients in Year 1, the point of contact would ensure diagnostics and follow-up are completed, and virtual options are anticipated, to reduce the need to see a specialist in a separate location at a separate time.

Since the point of contact is a member of the patient's core team, there is no need for additional intake or transition; rather, the services provided by the key contact would increase or decrease based on patient needs.

SPOTLIGHT ON SUPPORTING EXCELLENCE IN TRANSITIONS WITH THE EXTENDED TEAM

All M-OHT members will be involved in the design of pathways to create as few transitions as possible. On a day-to-day basis, the core and extended teams will seek to minimize transitions. When transitions to the patient's extended team are required, the expectation of the core team will be to ensure these transitions are streamlined with warm handovers and standards for follow-up.

Overall accountability to support a seamless patient journey will rest in the IPCC. The

M-OHT will support a team culture to ensure everyone on the core team, and extended team, understands their role in supporting the patient's journey. This includes information sharing across the extended team. For example, the M-OHT will ensure acute care providers validate the correct primary care provider information, along with the provision of hospital discharge summaries provided to primary care within 24 hours.

Where possible, we will provide virtual access to the extended team when needed. In particular for palliative patients, this will reduce the burden on patients and families by reducing travel, and will streamline care by enabling team discussions with the patient, family/caregivers, and core and extended care team members regardless of location. For GI/GU, it will also reduce travel to seek specialist input, with subsequent follow-up with primary care. This will also involve timely access to diagnostics and test results with rapid, reliable interpretation that is available digitally. This process will ensure a patient's designated key contact will have access to this information, can support any required follow-ups in primary care, and will support an up-to-date patient record and care plan.

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

The M-OHT envisions a system in which patients are empowered to manage their health journey and are provided with the tools to do so.

YEAR 1 APPROACH

The focus in Year 1 will be on both leveraging existing tools that promote patient self-management and health literacy, and introducing new patient health literacy activities, both for the Year 1 subpopulations. Supports will adhere to the following principles to enable access to timely advice and guidance, early planning and informed decision-making, including for acute events, and symptom management:

- Patients will be empowered to manage their own health care journey by support with access to tools that align with personal learning styles so that they feel supported and safe
- Patient, family and caregiver involvement in care planning will consider their needs, will use cultural and linguistic sensitivity, and respect choices in accordance with their values
- Communication content and materials will be inclusive of all patient groups
- Communication will occur early, frequently and through a variety of accessible formats (including virtual and digital)
- Shared care plans will be understood by all members of the care team

For patients who would benefit from a palliative approach, each patient will have a shared care plan, including an end-of-life plan, developed with the principles above. Education will help ensure patients and families know what to expect at end-of-life and have a plan for it. Support and engagement with families and caregivers are key for this population.

For patients with minor acute needs, the focus will be on supporting these patients to best navigate the health system, including providing triage and improved access.

For both of these populations, we have identified existing resources offered by our member organizations that we will promote in Year 1 as we implement the M-OHT. We will also leverage and promote a variety of patient self-management tools, and provider websites will link to the M-OHT website to provide centralized access. Examples of these resources can be found in the Supplementary Documentation.

M-OHT AT MATURITY

At maturity of the M-OHT, the plan for all M-OHT members will be to test the Patient Activation Measure (PAM) to support patient self-management and support patients in being experts in their own health condition(s). The PAM is a tool to assess a patient's knowledge, willingness and confidence to manage their condition and to determine the level of activation the patient can demonstrate in willingness to self-manage. The M-OHT envisions that all members of the core team would actively apply the PAM tool, including the PAM survey designed to assess how capable the patient is to self-manage.

The core team, through the point of contact if appropriate for that individual, will play a lead role in supporting patient self-management, in adherence to the principles above. This will include use of the PAM tool, acting as a behavioural coach and connecting the patient with peer supports.

The M-OHT will train all team members on motivational interviewing and goal setting with patients based on their values and beliefs to support this.

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

Caregiver distress is high in the Mississauga Halton region - among clients who received home care for six months or longer, nearly 28% of clients had a primary family or friend caregiver who experienced continued distress, anger or depression in relation to their caregiving role; above the Ontario average of 26.1% (25).

Our plan is that integrated care pathways be designed to lower the degree of caregiver distress, and ensure that caregivers within each pathway have access to age- and culturally-appropriate resources (e.g., information supports and access to services, mental health and emotional supports).

In Year 1, our focus will be on using existing supports for caregivers and identifying opportunities to expand on these supports as a part of the integrated care pathways.

SUPPORTS IN YEAR 1: Palliative Approach

The M-OHT will focus on hardwiring existing supports for caregivers, including those supported by the Mississauga Halton Palliative Care Network as well as grief, bereavement and community hospice supports from Dorothy Ley Hospice, Heart

House Hospice and the Canadian Virtual Hospice. The M-OHT will also make use of tools such as the Caregiver Distress Index (in use at Heart House Hospice) to identify those requiring more substantial support.

Early and ongoing education will be provided by the M-OHT, including local educational sessions for caregivers and families on: the palliative care approach; available resources (e.g. respite care such as the Caregiver ReCharge Service, social supports, bereavement supports); and opportunities to share their preferences. Sessions will be offered by M-OHT FHTs and other affiliate organizations, e.g., Mississauga Halton Regional Learning Centre.

Patients, families and caregivers will also be able to access 24/7 care navigation and coordination services for individualized support.

VISION FOR SUPPORTS AT MATURITY: Palliative Approach

At maturity, the M-OHT will provide access to hands-on skills training from health care professionals to equip caregivers to confidently provide care to their loved ones at home.

The M-OHT will implement an Advance Care Planning awareness initiative to provide education to patients, families and caregivers about why, when and how to do advance care planning.

A centralized information portal through the M-OHT website will have links to:
- Caregiver support organizations, including The Change Foundation, Ontario Caregiver Organization, Bereaved Families of Ontario and disease-specific support groups; and,
- Digital supports for caregivers, including virtual tours of services, online education and communication tools to interact with their personal support network and manage care for their loved one.

Over time, we will hardwire bereavement supports for families, including early identification of those at risk of complicated bereavement, and early referral to hospice supports.

We also plan to design an integrated in-home respite program with a centralized intake, waitlist, and eligibility/assessment process, and expand access to practical supports in a culturally, including spiritually, appropriate manner.

SUPPORTS IN YEAR 1: Patients with Minor Acute (e.g. GI/GU) Needs

Supporting caregivers for people with minor acute needs (especially children and vulnerable populations) will focus on education on where to go for care and how

follow-up will take place. Supports will be available through primary care offices, the core team, acute care settings and the M-OHT website.

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

The M-OHT members are committed to identifying and following patients throughout their care journey. Over the long-term, collective tracking of patients in the M-OHT will serve two purposes:

1. Enabling individual providers to actively manage care, including through transitions (e.g. ensuring care plans are shared across providers);
2. Allowing the OHT to carry out population health management.

ACTIVE PATIENT MANAGEMENT

The IPCC model positions primary care as the patient's medical home. Therefore, as a principle, the tracking and management of care for individual patients will be an important function to be housed within primary care. EMRs in each primary care practice will serve as patient registries that enable this.

As integrated care pathways are implemented, the information that must be shared between care providers to ensure high-quality care will be taken into account to support primary care providers in playing this role.

In Year 1, implementation will focus on putting in place a solution to support the sharing of care plans for palliative patients between necessary M-OHT team

members. The tool selected for this will be identified through an assessment process that takes into account assets currently in place in each organization. CHRIS and Care Connector are two tools being considered; a final determination will be made early in Year 1. See Appendix B1 for more detail.

Individual M-OHT members will continue to be responsible for holding and managing patient-level data to enable the provision of care and will be custodians of their own health information; however, over time, solutions will be implemented to enable further information sharing. This will focus in particular on ensuring primary care has the patient-level information needed from the extended team to develop sustained care relationships with patients, better enabling primary care to serve as a medical home (for example, timely information on diagnostics). Data sharing agreements will need to be in place among all OHT providers to enable this (see section 4.3.2. for more information).

In the long-term, with barriers addressed, we would envision a system with a common electronic medical record (EMR) across partners, or the fewest number of EMRs with integrating functions between them.

PLANNING, DECISION SUPPORT AND POPULATION HEALTH MANAGEMENT

A part of its longer-term vision, the M-OHT will work towards an integrated repository of aggregate information for population health management. This repository will be housed centrally, and will enable population health management for patients across the entire system of care, including identifying gaps in care and required follow-up. It will also support monitoring and reporting of outcomes and implementation of an integrated funding model. A provincial approach would be beneficial to support tracking of utilization across the province.

To build processes, best practices and experience across M-OHT members in sharing data for these purposes, Year 1 will focus on sharing for the purposes of implementing the integrated care pathways, with particular focus on palliative. The acute care member, THP, will serve as the holder of de-identified data for the OHT for the purposes of Year 1 implementation; this may shift in future to another entity. This is further described in Appendix B.

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 M-OHT has been actively engaged with Indigenous communities and organizations in the region. Our members are committed to responding to the history and great diversity of urban Indigenous communities, cultures and spiritualty in our region, drawing on the principles of the United Nations Declaration on the Rights of Indigenous Peoples, the Report and Calls to Action of the Truth and Reconciliation Commission, and other foundational documents.

In an effort to establish and implement strategies to build health care system capacity that better serves the diverse urban First Nations, Inuit and Métis populations (~0.7% of the population), the M-OHT will engage with local Indigenous leaders, organizations and partners including the Indigenous Network, (previously known as the Peel Aboriginal Network), Métis Nation of Ontario, and the Credit River Métis Council (10). The M-OHT work will build on the momentum of active engagement with Indigenous communities to date. In particular, building on two recent collaborative initiatives, The Indigenous Holistic Wellness Project and The Journey Together Project, and the collaborative Indigenous Cultural Training for Staff and leaders that has been completed to date.

In Year 1, the M-OHT will work with local Indigenous leaders, organizations and partners in the design of the integrated care pathways. The learnings within palliative and minor acute care will be standardized and applied across future integrated care pathways, and embedded into touchpoints across the Ontario Health Team. The M-OHT will look to adopt specific recommendations from the Ontario Palliative Care Network's Palliative Care Health Services Delivery Framework to support Indigenous approaches to care such as using trusting, participatory, culturally safe approaches, incorporating cultural knowledge into aspects of care and involving collaborative care

teams of conventional culturally competent providers as well as Indigenous Elders and/or Traditional Healers.

In future years, the M-OHT will work with local leaders to explore the establishment of an Indigenous Health Planning Circle that will facilitate linkages among culturally safe health and social care providers and services, and connect with members of the Dufferin-Peel Indigenous Education Advisory Council.

The M-OHT will continue to identify opportunities to meet the holistic health needs of Indigenous community members and seek to include Indigenous-led organizations as partners in service planning, design, delivery and evaluation. We will continue meaningful partnership development with Indigenous communities and organizations while respecting the right to Indigenous self-determination.

Our understanding is that Indigenous holistic health includes physical, mental, emotional, social and cultural aspects of life, and therefore places a great demand for culturally safe health and wellness programs and services in the region.

To support this work, the M-OHT governing council, leadership team and staff will benefit from cultural safety training, including training to increase knowledge, self-awareness and skills related to working effectively with Indigenous Peoples.

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

Mississauga is one of the 26 French language designated areas in Ontario (francophone population represents ~2.3% of population) (10). CVFHT, as a member of the M-OHT, is a bilingual site that provides primary care services to Francophones in the region. In addition, THP provides French language Sexual Assault and Domestic Violence Services, which is a program identified as a part of the French Language Services Act.

Building on the French language service practices of these organizations, the M-OHT will promote the principles of Active Offer and endorses obligations and

responsibilities to French Language Services by applying a Francophone lens when planning and integrating health services in order to improve Francophone access to appropriate health services.

The M-OHT will follow and align to the Guide to Requirements and Obligations Relating to French Language Health Services to better serve Francophones and improve access to linguistically and culturally appropriate services. We will continue to include the Francophone lens by enhancing the recently launched Francophone health promotion services in the region, partnering with the Interdisciplinary Primary Care Team at the bilingual CVFHT, and offering English language online Leadership Training on Active Offer for M-OHT members.

Together we strive to enhance access to linguistically and culturally appropriate health care services that focus on patient-centred care and improved health outcomes.

ENGAGEMENT AND RESOURCES

The M-OHT is committed to continuous engagement of the diverse Francophone communities in the region through the French Language Health Planning Entity, Reflet Salvéo, and the French Health Network of Central Southwestern Ontario (Réseau franco-santé du sud de l'Ontario). In addition, M-OHT will look to re-connect to the newly established Mississauga Site of Centre francophone.

The Mississauga Halton French Language Services Community of Practice, comprised of over 20 member organizations, will continue to work on the second year of its "Welcoming Community" initiative, which is a community approach to promote increased access to bilingual health professionals in official language minority communities and enhance French Language Services (FLS) in our region. The M-OHT is committed to staying connected to this Community of Practice as we work together to develop local collaborative welcoming practices with future bilingual professionals.

We are invested in strengthening relationships and collaborations between groups of health service providers that support FLS and bilingual health care students, colleges and universities by sharing information and collaborative opportunities, such as student placements, medical residencies, mentorships, volunteer positions and training programs.

We will look to adopt existing resources, particularly for the Year 1 populations, such as the Ontario Palliative Care Network's Palliative Care Health Services Delivery Framework, which includes alignment to the principles of Active Offer. Where bilingual human resources are limited, the M-OHT will identify opportunities to leverage translation services or other virtual care options.

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

The M-OHT members are committed to engagement and recognize that the community we serve is highly diverse. The M-OHT is committed to health equity and ensuring the inclusion of voices not typically heard. Our goal is to create integrated care pathways that improve the health and well-being of all people in the population, through:

- Building relationships with the full diversity of community groups in our area;
- Being explicit about the goal of any given community engagement initiative (e.g., whether the intent is to share information in a tailored and accessible way, consult with the community so they have the opportunity to weigh in, deliberate with the opportunity to identify issues/strategies for the OHT to focus on going forward, or to collaborate and share decision-making and implementation of a proposed solution); and,
- Being intentional in the design of community engagement initiatives, including recruiting for diversity, ensuring the appropriate supports to enable participation and ensuring the process, including follow-up and evaluation, are made clear from the outset.

The M-OHT WILL WORK WITH COMMUNITY PARTNERS TO FOSTER:

- Increased knowledge and understanding of the social determinants of health and the root causes of health inequities;
- Ongoing educational opportunities for health equity and cultural competence training;
- Increased contribution of diverse communities in system improvements that respond to their unique health and social needs;
- Enhanced ability of service providers to offer linguistically and culturally appropriate care that is informed by the diverse populations served;
- Culturally relevant system navigation; and,
- A health equity plan through engagement of multi-disciplinary, cross-sectoral partners and diverse and underserved communities.

In particular for Year 1, the M-OHT will focus on building relationships with representatives across the population subgroups identified earlier in this application (Racialized Communities, Francophone and Indigenous populations, Newcomers

(Immigrants, Refugee, Ethnocultural, Racialized populations) and 2SLGBTQ+ communities). These individuals will be invited to participate in the health equity assessment, co-design of the integrated care pathways and planning for future training and education for leaders and providers. The M-OHT will also be seeking partnerships to support engagement of individuals with disabilities and to ensure compliance with the Accessibility for Ontarians with Disabilities Act (AODA).

Finally, building on the momentum already established with the multi-year Enhancing Health Equity Capacity - Sociodemographic Data Collection Project, we will focus on improving health equity and providing high quality person-centered care within OHT member organizations by expanding use of the Health Equity Impact Assessment (HEIA) tool. Sociodemographic data serves as a valuable resource of information that identifies who is, and who is not, accessing services, the effects of social factors on health outcomes and increased awareness of potential barriers for marginalized and vulnerable populations.

As the M-OHT continues to mature and other underserved populations are identified through the sociodemographic data collection and engagement with providers, patients, families and caregivers, we will continue to expand opportunities to engage vulnerable populations, and consider opportunities to engage with other OHTs. All future engagement will ensure an ongoing culture of continuous improvement to meet the needs of our community.

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

Patients, families and caregivers have been embedded in M-OHT planning and decision making from the outset this spring, throughout Full Application development this summer, and will continue to be engaged throughout its evolution (See Question 2.10). This has built on the track record of meaningful engagement with patients, families and caregivers demonstrated by M-OHT members to date (See Questions 5.3 and 5.4).

The continued involvement of patients, families and caregivers will ensure lived experience drives priorities for improvement and design. Further, ongoing engagement will help us to build familiarity with the system from a user perspective that enables patients, families and caregivers to contribute meaningfully at all levels.

M-OHT APPROACH TO ENGAGEMENT WITH PATIENTS, FAMILIES & CAREGIVERS

Engagement will be guided by a best practice framework for engagement. This outlines the continuum of engagement, including: working with patients, families and caregivers to inform and share information as it becomes available; consulting to ensure mutual understanding of objectives and soliciting feedback; collaborating to problem-solve; and co-designing care to meet the needs of the community. The M-OHT will ensure engagement includes: a commitment to transparency, an openness to sharing stories and a willingness to adjust our approach throughout implementation based on feedback.

We are also committed to leveraging the Empowering Agents of Change: A Roadmap for Patient, Family, and Community Engagement developed by patients, families and caregivers, which has been recognized as a best practice model adopted by other regions in Ontario. This provides a roadmap that will help the M-OHT to establish the required infrastructure, training, partnerships and activities for continuous improvement and spread.

Importantly, we have adopted the Ontario Declaration of Patient Values and will apply this declaration to our practice.

M-OHT YEAR 1 AREAS OF FOCUS

The M-OHT will embed and engage people with lived experience throughout governance. This includes in care co-design working groups and at the M-OHT Governing Council, as equal members of these groups. This includes caregiver engagement in these pathways, particularly palliative, to address high levels of caregiver distress. We will share patient and family stories and embed diverse and unique patient experiences into leadership meetings, recognizing patients as partners in health care and providing insights into the patient experience to inform and impact decision-making.

The M-OHT will establish a PFAC that will report to the Governing Council. This will leverage existing PFACs across the partners to streamline engagement processes for ongoing feedback. Engagement and feedback will be critical across all changes outlined in Section 3 of this Application. In particular, navigation is a key challenge to solve and will require substantial engagement with patients, families and caregivers to ensure OHT access points (e.g. app, website, phone number) are designed to meet user needs, including format and content.

We will establish a centralized, transparent and accessible patient relations process for all in-scope services that is informed by patients, families, and caregivers,

including a process for timely response to patient complaints. All experiences matter and this process will ensure any concerns are reviewed with full transparency and fairness, and that the feedback is used to continually improve the care and services provided. This will be particularly important during early implementation for rapid-cycle improvement, and will include proactive communication with patients, families and caregivers about their experience to solicit feedback early and frequently. This will involve working with the Interim Governing Council and M-OHT membership to leverage processes already in place and build on them.

This will be supported by ongoing broad engagement with the community, patients, families and caregivers. For instance, through strategic planning, townhalls and regular surveys (See Questions 5.3 and 5.4).

MEASURING SUCCESS OF ENGAGEMENT

The M-OHT will hold itself accountable to engagement by measuring patient and family perceptions, and will tailor the measurement strategy to the type of engagement (inform, consult, collaborate or co-design).

We will assess overall satisfaction with involvement, perceived ease of sharing perspectives when being consulted, perceived level of impact and influence in decision-making when collaborating and co-designing, and any areas for improvement at all stages of the engagement continuum.

Where suited, we will leverage existing feedback mechanisms, such as patient experience surveys delivered by member organizations, and use evidence-based evaluation tools, such as the Public and Patient Engagement Evaluation Tool (PPEET) to measure engagement at the participation, project and organization levels.

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

M-OHT members include organizations providing services across the continuum including the pillars of primary, community, home and acute care. Through expansion, at maturity, the M-OHT will provide the full range of services, including prevention and health promotion, primary, home, community, acute, post-acute and long-term care.

M-OHT founding members have significant alignment between their goals, values and practices. All are committed to the principles of Quadruple Aim through their organization's mission, vision and strategic goals. They have demonstrated a commitment to ensuring user input informs practice, and regularly seek the advice of those who use their services. Due to the demand in health and social services in our region, the members are committed to working together and many have been involved in innovative integration activities. For example:

- PAARC has developed integrated care pathways with primary care to ensure that clients with mental health or addictions issues are able to access treatment and supports when released from prison;
- SFHT has developed a shared program with the Alzheimer's Society to implement a memory clinic and associated supports for seniors with dementia;
- Clinicians at Heart House Hospice regularly participate in integrated care planning conferences with palliative care physicians and practitioners to ensure care is coordinated and patient needs are met;
- Peel Senior Link has an integrated seniors team program that supports seniors with mental health concerns, which is a collaboration between Services and Housing in the Province (SHIP) and the Punjabi Community Health Services.

See question 2.4 for other initiatives undertaken by members to integrate within and across sectors, 1.2 for examples that demonstrate a commitment to advancing population health, and 5.3 and 5.4 for examples of member commitment to patient and community input driving service improvements.

SHARED STRATEGIC PLAN

Based on engagement and our past history of partnership, we have set a shared vision. Building on this, the M-OHT commits to a shared strategic plan in Year 1, through full engagement, that member organizations will align their strategies to.

LEARNING TOGETHER

Integrating care and standardizing practices is a journey that will be enabled by continuous improvement to address differences where they exist. For example:

• Boards of Directors of M-OHT members can learn together on a variety of topics, including population health, health equity and good governance.
• M-OHT leadership will learn together on the various sectors, health equity, change and communication, rapid learning systems and optimizing teams.
• Clinicians can learn together on best practice, health equity, working in teams and shared quality improvement (e.g., an opportunity for all family practice team members to receive medical psychiatry training and trauma-informed practice).

To support joint learning, we will build on existing learning infrastructure and events, such as THP's Learning Development Institute and staff development sessions (e.g., THP's Back to School event), approaches used in the Mississauga Halton LHIN in bringing Boards and leadership of various organizations together (i.e., Governance to Governance), and identifying new learning opportunities through existing resources.

Wherever possible, we will ensure partner representation in management and planning tables to support joint learning.

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

Key features of the interim governance structure used to develop this application have been outlined below. These features set the foundation for Year 1 governance, including shared decision-making, accountability, engagement and implementation.

GOVERNANCE APPROACH FOR FULL APPLICATION DEVELOPMENT

Three key levels of governance, used to guide the Full Application, are outlined below:

1. Strategy, Decision, and Oversight - M-OHT Interim Governing Council (IGC)

We established an Interim Governing Council to provide strategic direction and oversight to the M-OHT Full Application development. Membership included a patient and family advisor, primary care leads, community care leads, a home care lead and acute care lead (See Question 2.2). The IGC worked closely with other partners to bring in expert advice and education to inform and learn together.

This body will be leveraged for initial Year 1 implementation planning and agreement negotiations, and will lead transition to the Year 1 Governing Council. This will include being tasked to set the foundation for the governance structure for the M-OHT at full maturity.

To date, we have established processes that have enabled effective shared decision-making among the members at the table. These processes have included:
• Establishing the structure and team for development;

- Regular meetings over the course of application development;
- Discussions of governance and membership (both current and future);
- Engaging with working groups to solicit perspective and feedback from the full OHT membership;
- Providing endorsement or approval of key decisions, based on recommendations from working groups; and,
- Education sessions for the Council on areas requiring shared understanding.

Supporting the Interim Governing Council and all aspects of the project work is a small, internal Project Management Office. This would transition to an OHT Implementation Office in Year 1.

2. Design of Delivery - M-OHT Implementation Working Group

We established a cross-functional OHT Implementation Working Group. This brings together integrated planning across several work streams including: Population Health Analytics and Evaluation, Care Planning and Design (including Primary Care and Home Care), Digital Strategy, People Strategy, Financial Strategy and Quality Improvement. Each work stream has executive leadership, and includes engagement across partners and with subject matter experts as required. A seasoned patient & family advisor is a core part of the Working Group.

3. Engagement and Consultation on Delivery - Integrated Planning and Design Council

We established an Integrated Planning and Design Council to engage patients, families, caregivers, partners and health service providers throughout the M-OHT application development phase. This involved mapping the patient journey through the creation of patient personas, seeking feedback on current gaps or barriers to services for priority populations, and re-designing care alongside members, patients and families. We also identified a group of subject matter experts that we have engaged throughout the care design process, including the identification of care pathways, indicators and opportunities to address patient needs. We also engaged stakeholders broadly throughout the development of the full application through hosting information sessions, circulating information electronically, developing the M-OHT website, and ongoing discussions and engagement with partners (See Question 2.10). This governance structure has been supported by population health advisors from the Institute for Better Health (IBH).

APPROACH TO GOVERNANCE IN YEAR 1

As mentioned above, the interim governance structure will support the transition to the Year 1 structure. The IGC is currently developing a Memorandum of

Understanding (MOU) to enable this transition. This will include details for ratification of decisions and for resolving conflicts as they arise.

The Year 1 governance structure is designed to meet four key objectives: Strategy, Design, and Oversight; Management Decisions and Delivery of Services; Design and Implementation of Delivery by OHT Members, Patients, and Families; and, Engagement and Consultation on Delivery (See Supplementary Documentation). The structure will be supported by clear levels of authority, transparency and free flow of information. It will also include ongoing monitoring to ensure the structure is working effectively.

1. Strategy, Decision and Oversight: Governing Council (The Council):

In Year 1, we will refresh the Interim Governing Council to ensure the table has the right composition to provide oversight. The Council will reflect the founding pillars and initially be composed of 13 members: 2 patient and family advisors, 2 community care, 1 home care, 4 primary care and 4 acute care. The membership will be skills-based, using a best practice competency framework. Membership selection will include a transparent process, led by the interim Governing Council. We recognize this will be an important process to manage carefully, given the size and diverse membership of the M-OHT.

In addition, the Council will follow best practices for governance, including:

- It will establish clear Terms of Reference to define the scope of its decision-making powers, including for any Committees or Councils that report into it.
- Council membership will be selected based on a representative and skills-based matrix that takes into account the membership of the OHT, the services it will deliver in Year 1 and the expertise needed to meet Year 1 deliverables.
- The Council will be chaired by an individual from one of the OHT member organizations.
- Minutes will be taken for each meeting and key decisions will be documented.
- The Council will be no smaller than 12 individuals and no larger than 15 to enable successful decision-making in Year 1.
- Membership will be reviewed and refreshed at the end of Year 1, and ongoing through to maturity.

The Council will also explore how to address issues such as allowing observers, delegates, how members are selected and approved, and the frequency of meetings. The Council will develop a framework for shared decision-making and will agree on a set of principles to guide the work. Where conflicts arise, an external facilitator or neutral party will be brought on to enable dispute resolution. The Governing Council will be accountable for integrated funding and funding allocation.

The Year 1 Council will be responsible for establishing legal frameworks, a strategy,

central branding, overseeing the implementation of the integration of clinical service delivery and related infrastructure, and will be accountable for the multi-partite accountability agreement with the MOH.

This will include a Patient and Family Advisory Committee, which will be established and will report to the Council.

2. Management Decisions and Delivery of Services: Management Team

As the Ministry is aware, we have supported two rounds of OHT design and development with both financial and in kind resources at a time when we are experiencing unprecedented service pressures.

We believe strongly in this opportunity and need a sustained approach to resourcing further phases, moving beyond this concept stage.

If selected, the project office will transition to the Management Office. To support implementation this includes, in kind, an Executive Lead, project staff and key subject matter experts, including but not limited to: human resources, finance, decision support, IT, legal, project and change management, communications and engagement, including expertise in home care and primary care.

While continued in kind support will be necessary, it needs to be materially matched with dedicated support from the Ministry to realize the change envisioned. For digital, this includes $450,000 in initial digital seed funding to leverage existing assets as outlined in this proposal.

As we move forward, we are keen to work with government to identify existing regional and community based resources, including those in the LHIN and Home Care, that best align to advance the Ministry's model through our OHT approach.

We also welcome an opportunity to work in a coordinated way with other OHTs on funding models and strategies that would see us moving forward with consistency and adoption of best practices.

3. Design and Implementation of Service Delivery by OHT Members, Patients and Families – Integrated Planning and Design Teams

Care planning and design teams will be established, building from the work streams established during the Full Application. These will require executive leadership and teams to support implementation and design, using a co-design approach.

Teams will include patient and family advisors, expertise from across the member organizations and frontline provider expertise, in addition to functional workstream

expertise. Teams will leverage both the PFAC reporting to the Council and broad engagement, outlined below, to plan, implement and continuously improve.

4. Engagement and Consultation on Service Delivery

In the short-term, the M-OHT will leverage existing engagement tables, such as existing organization PFACs, primary care tables, Metamorphosis network meetings, acute care committees, and social service planning tables to continue to engage on the M-OHT approach.

Throughout Year 1, a full engagement and change management plan will be developed to lead design and recommendations on implementation. This will also include ongoing engagement to support continuous learning and feedback loops.

These stakeholders will include patients, families, caregivers, providers, including all clinicians, non-clinical staff, students, volunteers and Boards.

LONG-TERM VISION FOR GOVERNANCE

In this application we have outlined our plan to move closer to an interconnected system of care. For a fully integrated model and one OHT governor, fundamental changes are required to legislation, asset transfers and associated costs, existing delivery structures, funding and procurement models (See Risks Appendix). We are enthusiastic about the opportunity and look forward to working with the Ministry on this moving forward.

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

Patient information will be shared among the members of the M-OHT to support two core functions:

1. Decisions related to patient care management and the development of future integrated care pathways; and,
2. Decisions related to population health management and health care administration (e.g. analytics and decision support functions to understand patient flow, workforce planning, financial analysis and reporting).

HOW INFORMATION WILL BE SHARED IN YEAR 1

In Year 1, M-OHT members will continue to use existing patient health information data collection systems and will share data from these existing solutions (see appendix B1 for a current state assessment of each M-OHT members' data capabilities).

All members taking part in implementation planned for Year 1 are currently Health Information Custodians (HIC). The most significant gap is that members do not currently hold data sharing agreements. These will need to be defined prior to initiation.

To achieve information sharing required in Year 1, the following steps will be taken:

1. Striking an M-OHT Health Information Management Committee

o The M-OHT will begin by striking a Health Information Management Committee, which will support development of processes to facilitate the ongoing sharing of data, particularly under the current provincial personal health information legislative regime.
o The Committee will report to the M-OHT Governing Council, with appropriate representation and expertise from all OHT members implementing change in Year 1.
o This group will establish information management, privacy and security standards to be followed by all partners.
o The Committee will provide oversight and ensure adequate resources and processes are in place to monitor M-OHT partner adherence to standards and provide support, and would engage in shared decision-making based on OHT priorities.
o To ensure patient consent to collect and share information across M-OHT providers for health management, patient consent will be captured at the patient's point of entry into the OHT. This will permit sharing of information among the OHT providers within the circle of care. In Year 1, patients rostered in primary care will be provided with a standard consent form. Withdrawal of consent will be managed through documented procedures; it will be available to all patients and will be centrally managed by the

OHT.
o This Committee will ensure that all necessary privacy impact and threat risk assessments are conducted on behalf of the Health Information Network Provider, as outlined in PHIPA regulations O. Reg. 329/04.

2. Development of Sharing Agreements across M-OHT Members

o The specific data flows, processes, and uses of personal health information and other data among the OHT members will be rooted in PHIPA.
o The approach proposed will be tested through a privacy impact assessment and a security assessment.
o The approach will be outlined and agreed upon in a data sharing agreement to be developed for this purpose. The goal will be to develop a single data sharing agreement among all Year 1 members involved in implementation to prevent the need to negotiate multiple agreements between all parties.
o The agreement will also articulate the appropriate mechanisms to ensure that data-sharing is secure and compliant with PHIPA, and will ensure that patient consent processes can be managed.
o The M-OHT recommends that the Ministry consider making available draft data sharing agreements, Health Information Network Provider agreements, and privacy impact assessments to be used as resources by all OHTs.
o Please refer to the Supplementary Documentation for a data flow map and further details on the digital approach in Appendix B.

3. Design of Data Collection and Housing Approach

o In Year 1, partner organizations will maintain any medical record numbers (MRNs) currently in use for their own information management purposes.
o THP, as an agent of the M-OHT, will design an approach to integrate required datasets from different member organizations to enable monitoring and reporting on M-OHT patients and to support future planning.
o THP has the existing resources and capacity to house the data, and as a Health Information Custodian under PHIPA, THP has the legal authority to collect, use and disclose patient information.
o THP brings significant expertise and capacity in secure data management and has extensive experience in using, collecting and analyzing patient data through its established decision support and financial analysis functions, as well as its population heath management work as a part of the Institute for Better Health.
o As a holder of this data, THP will have the legal responsibility of ensuring compliance with PHIPA.

4. Data Sharing for Palliative Population: Design of Digital Coordination Solution

o For the population of patients with palliative care needs, data will be shared through a digital coordination solution. The solution will leverage existing tools - either CHRIS or Care Connector (to be determined early in Year 1).
o THP, as an agent of the M-OHT, will need to be enabled to extract and use aggregate, de-identified data in the digital coordination solution for the purpose of analysis. Analysis will be limited to agreed upon terms among partners, as well as based on consent from participating patients.

5. Data Sharing for Minor Acute Population

o For the population of people with minor acute GI/GU needs as well as all OHT patients, select data will need to be submitted to THP from partner electronic medical records to enable key quality performance metrics and reports.
o This will be accomplished at regular intervals, using agreed upon templates and secure data transfer processes.

6. Development of Long-Term Vision for Data Sharing

o In Year 1, the M-OHT will work to develop a digital strategy to inform work in Year 2 and beyond.
o This strategy will include approaches to information sharing across the members.
o In future, the goal will be to have either a single solution holding all M-OHT data or an ecosystem of integrated solutions that are able to communicate with one another to enable real-time integration.
o The M-OHT will work towards approaches that would allow one data sharing agreement to be reached among all joining members to reduce the need to negotiate hundreds of separate agreements among all providers.

SAFEGUARDS IN PLACE

THP, acting as an agent of the M-OHT in holding data, has an entire information security technology stack in place, with robust processes and procedures, to ensure the security and confidentiality of personal health information and confidential information.

Systems are in place which are designed to detect and alert on suspicious activity within the THP computer network and software applications.

THP regularly applies patches and updates to its computer systems to ensure vulnerabilities are remediated quickly.

SUMMARY OF BROADER GAPS OR BARRIERS IN INFORMATION FLOW

Existing gaps in information flow between members are due in part to privacy and information rules under the Personal Health Information Protection Act (PHIPA). Under existing legislation:

- Patient data can only be shared between two Health Information Custodians (HICs) if both are providing or have provided care to a patient, which limits the OHT from sharing data for the purposes of system and resource planning.
- Each HIC must continue to conduct separate reporting and tracking to registries, regulators and others, which increases reporting burden and redundancies.
- While members proposed for Year 1 implementation are all HICs, other M-OHT partners and future members who provide vital services within the continuum of care may not be. For these providers to participate, under the current model of PHIPA, it would require that they support the patient's journey as an agent as part of a defined relationship with a(n) HIC(s), where it is only those HICs that may share information with these providers. This generally creates inflexibility in the care model, where patient-community partner care paths only occur through a predefined path

Over time, as the M-OHT reaches maturity, it is recommended that the Ministry consider amendments to PHIPA to provide special designation to OHT teams in law, including providing a clear legal basis for sharing, collecting and retaining personal health information for the purposes of administering an OHT.

With these amendments, the M-OHT would have the legal authority to use personal health information from the respective OHT members for the purposes of system and resource planning, and would be able to share personal health information across members of the OHT. Each OHT member would be considered equally and independently a HIC.

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

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

5. How will your team learn & improve?

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

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

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

Max word count: 500

During member identification, the M-OHT asked that all members confirm that they do not have any issues to report in the areas of governance, financial management, compliance with contractual performance obligations, or compliance with applicable legislation or regulation.

This includes the founding members, who are signatories to this agreement, as well as Year 1 signatories (See Question 2.2).

Should we be selected as an OHT candidate and as more is understood regarding the accountability agreement for Year 1, a fulsome partnership due diligence process will be completed, guided by the Interim Governing Council.

In the future, a framework and process for partnership selection will be developed to support continuous onboarding of new members and affiliates. This will include processes for ongoing assessment of partnership status and accountability and processes for resolving issues.

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

Our team is committed to high quality care that is accessible, appropriate, effective, efficient, equitable, integrated, patient centred, population health focused and safe.

Throughout the development the readiness assessment and application, leadership of M-OHT membership and partners have engaged in ongoing briefings with staff teams and Boards, have sponsored webinars and information sessions, have been participating in Ministry-led OHT webinars, and have been utilizing existing partnerships and forums to support ongoing learning.

The M-OHT partners also have infrastructure and experience that informs our understanding of quality and performance, including:

- Our FHT, acute care and home care representation partners all produce Quality Improvement Plans (QIPs), which include meaningful evaluation measures from the patient and provider perspectives. These partners also make use of regularly reported scorecards and trended data to drive improvement.
- Our Regional Quality Table is a committed cross-sectoral coalition focused on improvement, and has established a Regional QIP focused on seamless transitions between hospital and home and the triaging and implementation of HQO's Quality Standards.
- Through the IDEAS program run jointly by HQO and the Institute for Health Policy, Management and Evaluation, QI teams in the region are driving improvement projects.

Our experience with collaborative QI planning and implementation has resulted in a number of successful initiatives:

PPATH INITIATIVE (THP and Saint Elizabeth Health)

This is a patient co-designed initiative that redesigned the journey for cardiac surgery patients from hospital to home. Patient and caregiver feedback has shaped the development, design and ongoing optimization of the model of care from the outset.

Feedback collected in years prior had highlighted gaps in community support following discharge, which served as the impetus for the pathway's development. Through patient involvement on the planning team, patient needs were validated and used to drive improvements. Patient feedback was collected continuously through a patient satisfaction phone survey and external review and incorporated into the PPATH processes. This included changes such as asking patient preference for timing of PSW visit, and adding staff to support a 24/7 call in line to ensure timely responses.

PPATH is now the standard of care at this regional cardiac surgical centre.
The initiative resulted in 15% reduction in post-operative hospital days, 25% reduction in readmission to hospital within 30 days of discharge, 33% reduction in ED visits within 30 days discharge and 96% of patient were satisfied with their care. This was selected as a 3M Quality Improvement Initiative(s) and was a 2018 Minister's Medal winner.

HEALTH LINKS (SFHT, CVFHT, THP, Home Care and Multiple Community Support Service Partners)

This initiative was aimed at providing complex patients with better coordinated care by bringing providers together around the patient, and improving the patient experience through the development of a coordinated care plan to meet the patient's needs. A key process measure included the percentage of complex patients with completed coordinated care plans within 30 days. In the last three quarters, this reached above 90%, over the target of 80%.

SEAMLESS TRANSITIONS (MH LHIN, Home Care, THP & Halton Healthcare)

Seamless Transitions was an innovative initiative to create a consistent, integrated, patient-centred approach to hospital transitions that improved patient experience. Patients were interviewed both in hospital and at home, and a patient and family advisory forum was leveraged, in order to ask about experiences with hospital to home transitions and opportunities for improvement. A patient and caregiver were also included on the core Design Team, which was established to design new processes and run PDSA cycles. The initiative resulted in a 52% reduction in

readmission rates in the THP (Credit Valley Hospital) initiative.

WEAVING A MOSAIC OF SUPPORT: Caregiver Respite (Nucleus Independent Living, Links2Care, Home Instead, Able Living)

This was a Caregiver Respite Program, developed by several partner organizations, and has transformed fragmented and siloed services into care that is coordinated and integrated for those caring for loved ones at home. The program was awarded the 3M Health Care Quality Team Award for Quality Improvement Initiative Across a Health System.

CAPACITY 99/BRIDGES2CARE (THP, West Park Healthcare, Home and Community Care)

This initiative created capacity of 99 beds in the community for post-acute transitional spaces and complex continuing care. Within the first year, THP reported the program had saved 18,557 patient days (freeing up one 50 bed unit for more than one year). The initiative was awarded as the winner of 2019 Patti Cochrane Partnership Award by THP.

COACHING AND MENTORSHIP

Members of our team have significant experience in coaching and mentoring others to support continuous learning and improvement. For example:
- Our Community Quality Table hosts QI workshops for the community sector to improve understanding of QI principles and increase standardization.
- The MH LHIN hosts an annual Quality Forum conference - a platform for peer-to-peer learning about collaborative local improvement initiatives - and an annual Quality Awards event focused on collaborative cross-sectoral QI projects.
- The LHIN along with a multi-stakeholder group that includes HQO has produced regional core competency training in QI, leading 10 organizations through online modules on care coordination and a HealthLinks approach to care.
- Clinical leaders with the LHIN have produced QIP workshops for community support services and mental health and addiction sector partners to support a LHIN requirement that these partners submit QIPs; more than 100 individuals participated.

We will bring this experience and knowledge to future OHT learning collaboratives and communities of practice (COPs). The M-OHT commits to leading a COP for other OHTs that are undertaking work in palliative care, and will also ensure that what we learn through this process is shared broadly. To enable this, we will complete a formal evaluation of the M-OHT Year 1 integrated care pathways.

We see opportunities to spread our expertise in QI and using data for improvement further to all members. In particular, we know that the majority of primary care providers in our region are solo fee-for-service clinicians and that they do not benefit from the infrastructure of a FHT to support improvement - through partnering with primary care, we see opportunities to extend infrastructure, knowledge and build capacity.

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

The M-OHT founding members have a strong history of using patient input to inform and change practice. Below are highlighted examples of our experience and learnings.

IMPROVING PRIMARY CARE ACCESS AND SERVICES

CVFHT, SVFHT and CPH have experience collecting patient feedback through survey mechanisms to inform practice. For example, SVFHT delivers an annual Patient Experience Survey, through a variety formats, with almost 1600 completed in 2019. As a result of feedback, SVFHT implemented online bookings across most sites, established same-day appointment spots and secure messaging with patients for the majority of physicians and nurse practitioners. Patient complaints are also processed and tracked. This information is used in strategic planning and operational improvements.

As mentioned in Question 1.1, CPH engaged with patients and families to directly inform the design of their new space.

IMPROVING PALLIATIVE SUPPORTS IN THE COMMUNITY

Heart House Hospice uses results from its client feedback surveys to inform topics of educational groups and workshops (e.g., nutrition, supporting children and youth to heal from grief), and to develop a library of resource videos in a number of languages including Punjabi, Urdu and Hindi (e.g., how to change a bed at home, nutrition, sexuality at end-of-life).

IMPROVING CARE COORDINATION

The MH LHIN worked with patients, families and health service providers to identify and define core competencies for anyone performing care coordination functions through the Care Coordination Capacity Project. This included strategies and techniques that can help service providers build rapport with patients and families, and improve the care experience.

IMPROVING ACUTE CARE SERVICES

Launched in 2014, THP's Patient and Family Partnership Council (PFPC) has improved patient experiences by assisting programs with operational changes as well as corporate initiatives such as the unrestricted visiting hours policy and parking ambassador program.

Patient, resident and family experience is measured through third-party and real-time surveys, and the question, "Would you recommend this hospital to your friends and family?" is reported on in THP's annual QIP. It is a priority indicator. THP has committed to improving this indicator through initiatives such as the AIDET method (Acknowledge, Identify, Duration, Explanation, Thank you) when communicating with patients and families.

THP's Patient Relations office was established in 2011. Feedback received is used to both improve the experience of the individual who provided this feedback and for quality improvement purposes. For example, complaints regarding the pre-surgical process led to parents being allowed to accompany their child into the operating room while their child is given anesthesia.

IMPROVING CARE THROUGH INTEGRATED PATHWAYS

The PPATH initiative was identified and designed to address what partners were

hearing through patient and provider engagement. Design focused on existing challenges and implementation relied on early and frequent patient feedback for continuous improvement (See Question 2.4 and 5.2.1).

COMMITMENT GOING FORWARD

Engaging patients, families and caregivers front-and-centre to care and system design will continue to be a cornerstone for the M-OHT, and we will continue to leverage the leading practices described above and in questions 2.10, 3.8, 4.2 and 6.2.

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

As described in Question 2.4, M-OHT members have a strong track record of working together and across sectors, engaging with the community and using this input to change services.

A selection of relevant examples that demonstrate how we incorporate community input include:

ACCESS TO HOSPICE CARE FOR THE SOUTH ASIAN COMMUNITY

The South Asian community is a large population in this region. Heart House Hospice, through the Ontario Trillium Foundation (OTF), conducted a study on access for South Asians. Together, with a diverse volunteer pool and client of Punjabi Community Health Services, they successfully increased their understanding and capacity to serve the end-of-life special considerations of the South Asian Community in Mississauga and Brampton. They also increased awareness in the South Asian Community about hospice palliative care programs and services. From this work, a second OTF grant was received to do outreach and a third was received to hire a South Asian language-speaking Counsellor.

HEALTHY CITY STEWARDSHIP CENTRE AND BETTER HEALTH MATTERS FORUM

The Healthy City Stewardship Centre (HCSC) is a cross-sectoral collaboration focused on building a healthy city (See Question 2.4). In 2017, HCSC organized a

community engagement forum called Better Health Matters, which identified a shared aspiration for health and priorities for improvement. This was unanimously endorsed by the Region of Peel, and was adopted by partner organizations as an input and driver for their strategies and services.

PROJECT N0W

Engagement with the community, including through the Better Health Matters Forum, Peel Public Health's 2019 report and a trend analysis of suicide occurrences from Peel Regional Police, made clear that despite best efforts, too many children and youth attempt suicide and die by suicide in our community (26).

Project Now is a community-wide child and youth suicide prevention initiative. United in the mission that no child or youth will die by suicide in our community, cross-sector core partners include the Dufferin-Peel Catholic District School Board, Government of Ontario, Peel Children's Centre, Peel District School Board, Peel Public Health and Trillium Health Partners.

The initiative aims to foster hope and resiliency, coordinate access to care options that meet the needs of children, youth, and families, and support healing by building connections that promote learning and understanding about suicide.

Project N0W will work in partnership with children, youth and families who have been impacted by suicide through its Youth and Family League. Their voices, experiences, and wisdom will guide the work of Project Now, providing feedback and advice and actively co-designing project initiatives.

COMMUNITY TOWNHALLS

THP hosts regular community telephone townhall meetings, where senior executives connect directly with over 10,000 community members and speak with them about the hospital and health system. During these meetings, participants have the opportunity to learn about services and raise issues and concerns, which enables THP to understand topics most important to the community it serves. The platform also allows THP to receive real-time input on patient satisfaction and public perspectives on organizational priorities which are used to direct and inform operational improvements.

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

We understand that current funding envelopes will remain whole and in place for at least Year 1. Some members, including primary care, have multi-year funding agreements in place. This has informed decision-making on the development of this application.

Per the guidance materials and Year 1 expectations, the M-OHT acknowledges that a fund holder will be required in order to receive, hold and administer funds. The fund holder will not unilaterally decide how to disburse funds, and will do so only by direction of the M-OHT Governing Council or delegated authority, or by direction from a legislative authority. The M-OHT Governing Council will also determine the funds to be held by the M-OHT fund holder and will engage in shared decision-making on priorities and funding decisions to support the M-OHT strategy (engaging M-OHT member boards, where necessary).

The M-OHT Governing Council will be representative and skills-based, with delegated authority from member boards to make decisions within the M-OHT scope.

The M-OHT Governing Council has identified that THP will act as the fund holder for the M-OHT and will have a fiduciary duty and be accountable to the M-OHT Governing Council for which it holds funds.

THP brings significant expertise and capacity in financial management and integrated funding approaches.

EXPERIENCE AS FUND HOLDER

THP was recently reviewed in detail through a successful debenture issuance process. It has a strong credit rating of Aa3, over $100M in savings reinvested in patient care as a result of its merger, and seven years of positive financial results. Despite unprecedented growth in demand, THP finished 2017/18 with a total margin (MOHLTC line) of 1.7% compared to the provincial average of 1.48%. THP finished at 2% in 2018/19 (27).

THP has demonstrated its extensive ability to work with partners on integrated funding models, acting as the Bundle Holder and Approved Agency for PPATH and

Hips/Knees Bundled Care. It is expected to lead future bundled care initiatives with partners (Surgical Spine, Thoracic, etc.). In collaboration, THP led decisions on scoping, populations, care, performance indicators, funding model and reconciliation of funding. Continuous advanced analytics to understand costs, patient pathways and volumes were used to identify innovation opportunities and ways to increase value for money.

Heart House Hospice, Dorothy Ley Hospice and Acclaim Health have shared a coordinator of recruitment and training together since 2010 (see Question 2.4). The CVFHT and SFHT also share a Quality Improvement Decision Support Specialist position.

THP has also demonstrated its ability to work with partners to pool financial/FTE resources across hospitals and diagnoses through the Medical Psychiatry Alliance.

KEY LEARNINGS

Experience with these different initiatives has led to learnings in:
- Sharing of patient-level information, outcomes assessment and use of outcomes to drive pathway evolution.
- Establishing a tiered risk-gain sharing incentive structure.
- Accounting for different costs such as supplies and care provided in the community, care navigation, and appropriate resourcing of similar projects (e.g. HR costs for finance, decision support).
- Developing partnership agreements, including pricing, timelines, indicators and risk-gain sharing, based on input from cross-sector clinical teams.

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 M-OHT will operationalize our plan to re-design care outlined in Section 3 through a phased approach, leveraging and expanding upon structures utilized to develop this full application. Our team's cross-functional expertise will guide the rollout of our implementation plan through to full operations which will be scaled to match funding available. Our commitment to rapid learning and improvement will enable us to be agile and responsive to changes through the development process while remaining focused on our shared values and goals.

IN THE FIRST 30 DAYS OF IMPLEMENTATION, WE WILL:

- Notify members and affiliates of successful candidacy; hold meeting of members to align on expectations moving forward.
- Negotiate a Year 1 Accountability Agreement with the Ministry that includes all intended Year 1 members; define reporting and conduct fulsome partnership due diligence process, guided by the Interim Governing Council.
- Establish Governing Council membership, Chair and Terms of Reference based on Year 1 membership and proposed services to be delivered; hold inaugural meeting.
- Establish OHT Management Steering Committee to carry out operational decision-making and advise on service delivery; hold inaugural meeting.
- Staff the OHT Implementation Office. Expertise to include: change management, project management, implementation and results management; finance; decision support; digital health and privacy/security; human resources; partnerships and engagement; communications.
- Establish leadership for primary care transformation; include accountability to establish a primary care network over Year 1 to ensure the voice and influence of primary care in the region can be more fully represented within the OHT.
- Establish leadership for home care; ensure lead works closely with the Ministry and Ontario Health to understand the provincial vision for home care and to plan for the eventual transition of home care services under the OHT.
- Establish structures under the Management Steering Committee to carry out the work or perform an advisory function. To include: Clinical Integration Working Groups for Year 1 populations of focus (GI/GU and palliative); Digital Health and Health Information Management Working Group, to include expertise in privacy and security and to advise on plans for information sharing, data workflows and data governance; Home Care Working Group to advise on approaches to transitioning home care under the OHT.
- Develop a communications plan and an engagement plan; both will contemplate

audiences that include patients and families, providers and community members.
• Send a communication to the M-OHT stakeholder distribution list, update the M-OHT website and hold a Tele-Townhall to share an update on candidacy and describe next steps for engagement and participation.
• Deploy clinical implementation team (from staff of Implementation Office) to initiate work on two Year 1 pathways. Work to include: engagement of partners and current/future state analysis for pathway implementation; analysis of financial and labour impacts prior to implementation.
• Define the OHT digital health plan for Year 1. To include: virtual care implementation, plan for patient registries and plan for IT bridging solution to enable integration of information in Year 1.

IN OUR FIRST 60 DAYS, WE WILL:

• Establish necessary agreements between Year 1 members involved in service delivery. This will include: data sharing agreements, financial agreements (for management of any funds that are pooled) and any service delivery targets or expectations already defined.
• Establish a decision-making framework for the Governing Council to enable decisions on issues that include: membership, management of shared funds and future areas of focus for clinical integration.
• Establish a Patient and Family Advisory Council to report into the Governing Council.
• Develop a change management plan to support implementation and design required training and education for interdisciplinary teams in primary care.
• Initiate planning for population health management approach, including defining process for patient tracking and identification.
• Develop plan for centralized intake of patient feedback and patient relations associated with Year 1 population.
• Begin evaluation planning. To include: defining baseline indicators and improvement targets; establishing analytic approach.

IN OUR FIRST 90 DAYS, WE WILL:

• Hold inaugural meeting of primary care network.
• Complete detailed plan for clinical implementation and receive approval through Governing Council prior to implementation. To include: detailed workflow design for care pathways; planning for intake teams in primary care to support 24/7 navigation; design of change management supports for clinicians and patients.
• Build out care model design (to be completed within 6 months).
• Complete assessment of home care current state to identify opportunities to reduce duplication and streamline care.
• Initiate development of digital solutions for information sharing (resource contingent)
• Initiate training in primary care offices on virtual care solutions to be deployed with

Year 1 populations; provide training on palliative care approach for interdisciplinary team (to leverage LEAP and others).
• Define plan to integrate new members into governance and operational structures, and develop a framework and process for partnership selection to support continuous onboarding of new members and affiliates that will include processes for ongoing assessment of partnership status and accountability and processes for resolving issues.
• Begin outreach for clinical partners related to Year 2 implementation (e.g. seniors).
• Define population segmentation approach for population health management.
• Initiate engagement strategies to enhance service offerings in Year 2 for populations impacted by sociodemographic factors (e.g. Indigenous, Francophone).
• Develop a health equity plan to support the M-OHT's population health strategy that will include engagement of multi-disciplinary, cross-sectoral partners and diverse and underserved communities; the Health Equity Impact Assessment (HEIA) tool will be core to our population health management strategy to continually inform how we re-design care and clinical integrated pathways, and identify any unintended impacts or gaps of our approach.
• Define process to test early changes through pathway prototypes and establish continuous learning strategy.
• Establish any service-level agreements needed to support implementation.
• Carry out communications plan and change management strategies to ensure public awareness of OHT and understanding of services.
• Begin planning for long-term digital health strategy following Year 1.

IN OUR FIRST SIX MONTHS, WE WILL:

• Begin prototyping new care model concepts through small tests of change, iteration and validation.
• Initiate community, patient and provider engagement to inform strategic planning and brand launch.
• Begin implementation of secure messaging tool for palliative population, including initiation of change management approach to support both patients and providers in using the tool.

To ensure we are on track for successful implementation, we will track the following milestones:

At the end of Year 1:
o Governance launched and committee, working group and leadership structures in place; review of membership and Terms of Reference of Governing Council to take place at the end of year to align to evolving membership and service delivery of the OHT and to also enable representation of evolving primary care networks in the community.
o Care pathways implemented, tested and iterated in palliative and minor acute

populations. Clinical implementation team redeployed to implement new pathways following a similar process; expanded service offerings available in Year 2.
o Population health management approach defined in detail, including process for tracking and identifying patients across providers and understanding of population segments at maturity.
o Costing of pathways understood in more detail to inform future integrated funding envelope.
o Evaluation of Year 1 implementation initiated to gather learnings and enable iterative improvements and sharing with other OHTs as a champion.
o Long-term strategy for digital health defined; procurement process initiated to enable implementation (resource contingent).
o Strategic plan defining integrated service offerings launched; shared brand established and launched.

Our iterative approach to implementation allows us to strengthen our foundation of partnerships to deliver integrated care for our Year 1 population so that we can incorporate learnings as we expand to service our full population at maturity.

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

The M-OHT recognizes that the level of change involved in the vision for Ontario Health Teams is substantial, and so is committed to continuous learning and embracing change. The foundation of the M-OHT partnership and most important component of our change management approach is the engagement of people in a compelling vision for a better future.

Our change management approach is strategy-driven, leader-led and builds on the capabilities for leading change that have been established in the partner organizations over time (See Question 2.4). It includes five key components, aligned to the mandatory elements of a best practice change model (28).

1. Vision/Leadership

The M-OHT leadership will be empowered with our vision, shared values and principles of change. Change will be leader-led, using existing networks and platforms to support change (e.g. clinical leadership, existing committees, tables, and engagement channels). We will ensure leaders have the competencies required to deliver, supported by strong project management and expert resources. Governing Council members will serve as sponsors for the OHT, critical to change management

success, and Boards will be engaged, including joint learning and strategy, to steward the change.

2. Structures

Structures will be designed to support strategy and purpose. We will use governance and delegation to ensure all members, including clinical providers, are leading the design and change, with decision making as close to patients and families as possible. Where changes impact the structure of partner operations and people, this will be supported by a transparent engagement and communications plan, with supportive and consistent key messaging.

3. Service Strategy & Systems

Change will be designed around patients, families and the health needs of the population. Everything we do will be patient-centred, focused on patient choice, with the ultimate goal of restoring and maintaining health. Our commitment to ongoing feedback, quality improvement and evaluation ensures there are mechanisms to stay true to this strategy. The M-OHT membership will work together to ensure all teams understand the OHT model and vision, and will work collectively on shared strategic priorities and brand to ensure alignment on vision.

4. People & Culture

Central to our change approach will be bringing teams and the community around a compelling vision for a better future. We will engage people in the design of the future, asking meaningful questions, using feedback to drive design, and being respectful of how change may impact how people work. Through this, a clear and trusted process to work through changes and make decisions will be used.

Where the M-OHT does not have the right complement of staff to support implementation, we will ensure a robust and transparent recruitment process is in place to draw on talent from the sectors impacted by integrated care pathways.

For the M-OHT, there are specific complexities related to labour relations and physician change that need to be front-and-centre in planning.

Engaging clinicians, including physicians, early to include their perspectives in the vision and change through co-design has been and will continue to be central. Our leader-led approach requires strong clinical champions as part of a clinical implementation team, who we will work with to build competencies for leading change, leveraging programs in place in existing member organizations.

Building off of the primary care engagement strategies used to date, the M-OHT will also support modernization and organization of primary care to serve as a foundation for all patient care. As a large proportion of primary care providers in this community are solo, and not linked into networks, we anticipate challenges in reaching, engaging and partnering with these clinicians. Therefore, we will launch a primary care network in the first phase, using a physician-champion model to help engage peers in change with consistent messaging to support clinicians in joining the M-OHT.

5. Processes

At Year 1 and through to maturity, we will make sure change takes place in an organized way to ensure appropriate engagement, due diligence and risk management. The M-OHT office will provide central change management tools to be used by members and partners to support local change management.

MANAGING RISK IN YEAR 1 AND TO MATURITY

The M-OHT will keep patients and families at the centre, providing safe, high quality care as we embark upon change. We will consider existing operational risks and how this impacts implementation plans and our capacity to effectively deliver on Year 1 and at maturity priorities. We will consistently and proactively monitor risks, adjusting our implementation of change continually to address challenges. See Appendix Table 6.6 for details.

KEY ACTIVITIES DURING CHANGE

The M-OHT will use the following plan and activities to manage specific changes outlined for Year 1 (29):

Phase 1: Preparing for Change

This will include:
- Conducting a more in-depth readiness assessment for implementation to assess the extent of change from current practice and time required.
- A risk assessment will supplement this to understand risk on an ongoing basis (See Question 6.6 for current assessment), along with an impact assessment to understand the groups impacted, the ways they are impacted, and unique challenges we may face.
- Early and frequent engagement, building trusted relationships, will continue to be central to the change management approach.

Phase 2: Managing Change

Using information collected in Phase 1, our change strategy involves five key plans (30):
• Tailored communications plans targeting different audiences impacted by change;
• Sponsor plans to support senior leaders to be active, visible and build awareness of the change;
• Training plan to ensure the necessary skills and competencies are established to implement the change;
• Coaching plan to help frontline supervisors and leaders build commitment and understanding; and,
• Resistance plan to support proactive resistance management, including anticipating causes through the risk assessment and working with subject matter experts to identify expected barriers and challenges.

Phase 3: Re-enforcing Change

Throughout the change process, we will:
• Adopt methods for a rapid learning system;
• Support a culture of continuous improvement and innovation;
• Support prototypes that show measurable success for scale-up and spread across the OHT region; and,
• Repeat phases 1 and 2, as we scale, spread and introduce new changes and members.

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

Central to the M-OHT strategy in Year 1 are the three evidence-based IPCCs, with 50 family medicine physicians, over 60 interprofessional providers, and the people currently rostered with them.

As these people are already connected to and receiving care from the IPCCs, and all rostered people are included in Year 1, this minimizes the level of change and potential risks. The M-OHT service changes can be focused on pathway improvements for those that require the particular services in the subpopulations.

Further, members identified are those already delivering care and working together in this region, and this further minimizes change for the provider organizations, and therefore people receiving care.

In terms of home care transformation, the M-OHT will work with the province and partner organizations to ensure a strong implementation and change management plan, with measured pace of change. Palliative care home care will be bundled with the OHT through a single provider, which builds on existing structures in this region, and will minimize the change for the Year 1 palliative population.

Throughout the implementation of the M-OHT in Year 1, M-OHT membership is committed to monitoring the service levels received by patients who are not a part of the initial Year 1 to ensure ongoing and high-standard quality of care.

As the approach involves focusing only on those patients that are rostered to the IPCC models, with the exception of home care, the M-OHT is confident that levels of care for patients and their families will be maintained for those who are not a part of the Year 1 population. As a result, these patients and their families will not experience service disruption.

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

System-wide change as significant as the one currently underway to implement OHTs will involve work to address structural and systemic barriers over time. If selected, the M-OHT envisions an ongoing dialogue that includes the Ministry, other OHT candidates and the patients, providers and community members in our region to understand these barriers and address them.

CAPACITY, INFRASTRUCTURE AND HUMAN RESOURCE PRESSURES

As addressed throughout this submission, our region is under-resourced across all sectors. We recognize that one of the Ministry's goals in introducing OHTs is to help address hallway health care; however, we also know that demand will only continue to grow.

Our model also involves expanding IPCC models within the region. This is expansion of capacity that would need support to be achievable.

We are also one of the largest potential OHTs in the province. Ensuring we have the capacity to manage our attributed population will be a significant challenge.

Engagement itself is a barrier - with more than 70 community agencies and hundreds of fee-for-service physicians, our OHT will be required to implement significant strategies and engagement infrastructure to effectively understand and work with our entire community.

LABOUR RELATIONS

We believe that our current health human resource complement in the community is sufficient to enable implementation of the M-OHT in Year 1, with some shifting of priorities. However, existing labour legislation will pose challenges in terms of implementing the level of integration the Ministry has articulated in its vision for OHTs.

If integrated care is to be realized, it will require legislative change. Otherwise, the vision can only be achieved on a much slower timeline or with significant financial investment.

PRIVACY AND INFORMATION SHARING

Current requirements under PHIPA create barriers in sharing patient data for the purposes of planning. Under PHIPA, patient data can only be shared between two HICs if they are providing or have provided care to a patient. It does not permit HICs to share patient data for health system planning.

While establishing a HINP could be contemplated, the administrative challenge this poses for Year 1 will slow timelines and impede full implementation of proposed digital and virtual solutions. It will also prevent sharing patient-level data for integrated decision support, human resource and financial planning functions.

DATA ACCESS AND METHODS

Access to the kind of data required to implement the OHT vision will also be a challenge in early years. The integration of data across sectors will necessarily be difficult to achieve - at the moment, data is available for certain sectors only and is cut based on LHIN geography. Data is also often not available in real time. The move to an approach that considers the Ministry's attribution model will take time and support from the Ministry.

The methodology that the Ministry has applied to population attribution model will also be a challenge for some OHTs, particularly where data is lacking. The CIHI Population Grouper is appropriate to estimate an overall capitated rate for patients, but is insufficient for planning purposes. Data definitions will also

need to be reconciled between local and provincial approaches.

It will also be necessary to consider the timeliness of data collected. Many provincial datasets involve significant time lags that will affect both population health management and funding models. It will take time for OHTs to build the infrastructure necessary to understand their populations fully. If referral networks shift rapidly, there will need to be a way to manage changes in the attribution model that are responsive to enable timely funding.

There is also currently an absence of patient and provider experience indicators and metrics that cross multiple sectors. To evaluate success of this work, OHTs will require support.

FUNDING AND INCENTIVE STRUCTURES

The vision for our M-OHT includes a model of primary care that we believe will enable clinicians to provide care to the full scope of their practice. However, the model also requires innovative approaches to providing care that are not always contemplated under existing payment structures, including increased virtual visits. The Ministry must ensure that programs that enable physician compensation, including OTN's Home Video Visit program, are appropriately resourced to manage demand.

The M-OHT also recognizes that clinician leadership will be fundamental to the changes required to the system, particularly leadership in primary care. However, for primary care practices who operate under fee-for-service models it can be difficult to engage in sessions that occur during office hours and can directly impact their earnings. Without additional resource for this work, these structures will present a barrier for engagement.

REPORTING AND ACCOUNTABILITY

The Ministry has indicated that existing accountability agreements and reporting requirements will remain in place through the transition to OHT status. This will necessarily create redundancy and place additional burden on all organizations participating in an OHT to deliver on both the current state as well as new accountabilities negotiated through this process. OHT-related agreements should be undertaken cautiously.

PROCUREMENT

The digital solutions required for the M-OHT will take multiple vendors and provincial service providers to coordinate and operate across multiple

organizations. Having a single entity to manage this, on behalf of OHT partners, establishes much more effective procurement relationships than having multiple provider groups arrange independently. However, there are barriers to this in current provincial procurement policy. The Ministry should undertake a process to address this.

This is similarly the case for the procurement of services through agencies. Clarity on expectations and process for this are required from the Ministry.

HOME CARE AND OTHER SYSTEM CHANGE

The system outside of OHTs is also undergoing significant transformation with the creation of Ontario Health and anticipated work on the part of the Ministry to address the structure of home care in the province. Each of the organizations involved in OHTs will be impacted as changes to accountability agreements, reporting relationships and others come online.

IMPACTS ON NOT-FOR-PROFIT AND CHARITABLE STATUS

Many of the organizations that are stepping forward to become members of OHTs are currently categorized as charities or not-for-profits. This status could potentially be impacted, should these organizations become more integrated over time with other corporate structures. The Ministry must ensure there is appropriate guidance on how to manage this.

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

Each of the barriers identified in Question 6.4 would benefit from the support of the Ministry to understand and appropriately manage if we were to move forward as an OHT.

We would also specifically highlight the following areas for support:

CLARITY ON SHARED ACCOUNTABILITY AND FINANCIAL INTEGRATION AND REPORTING

To support implementation in Year 1, further clarity will be needed from the Ministry

on accountability, decision-making, reporting (e.g. QIPs) and funding (including tracking service use outside the M-OHT network). This clarity will be needed both in terms of how existing structures, agreements and systems will be managed through the transition, as well as on how future OHT structures will be implemented.

Expectations of shared accountability will directly inform whether health service providers or organizations decide to partner with the M-OHT, so this information will be required early in the implementation process for Year 1.

INFRASTRUCTURE AND CAPACITY

Knowing the M-OHT is among the largest OHTs in the province, we will require supports from the Ministry if, over time, the M-OHT is expected to integrate and/or distribute funding to the many health service providers in our region. This is a function currently performed by the LHIN with a large team and significant infrastructure to support. The M-OHT would require human resource support to enable taking on elements of this role.

Should the M-OHT eventually be tasked with absorbing certain home care responsibilities, this would also need to be resourced appropriately and the accountability, reporting and integration with other responsible agencies (e.g. LHINs, Ontario Health) would need to be clear.

DATA AND PRIVACY

The M-OHT recommends that the Ministry amend PHIPA to provide special designation to OHTs as Health Information Custodians. This would facilitate a clear legal basis for sharing, collecting and retaining personal health information for the purposes of health system planning, which is integral to the population health management approach envisioned as part of OHTs.

Clarity is also required on the CIHI Population Grouper and its intended use. Will it drive expected costs within our funding model? Will we be given more information on how funding flows between HPGs? A great deal more information and engagement on this issue is needed to ensure that funding approaches built do not impact existing organizational funding.

COMMUNICATIONS AND ENGAGEMENT

This is one of the most significant changes to be undertaken in our health care system in decades, and it is likely to be confusing - both for those who work in health care and for members of the public. OHTs will require significant support from the Ministry to ensure that the change is appropriately communicated to the public.

The OHT will also need additional support for clinician engagement. Clinicians will need to be at the forefront of the change proposed; however, OHTs will need support to understand all the clinicians in their attributed network and help to communicate and engage with them.

DIGITAL HEALTH

As mentioned in Section 6.5, our proposed approach to virtual care intends to leverage the OTN Home Video Visits program. This has implications for physician compensation, and we would require clarity on this to ensure that physicians can be compensated for providing virtual home visits.

Given the Ministry's asks of OHT in Year 1, many of the digital health requirements proposed in Year 1 will need resources to enable. We suggest that the Ministry consider investing in building a Patient Access Channel that could be connected to the provincial clinical viewer (ConnectingOntario). Such a tool would positively impact all patients and OHTs across the province. It could serve as a single, patient-friendly access point for individuals to view their Electronic Health Records. A provincial approach could be more economical.

The Ministry should also consider whether a single unique identifier for all patients in the province could be achievable. Tracking of patients across the health care system within a single OHT will be a challenge, but inevitably patients will also move across OHTs. Information sharing will become exponentially more difficult in that case.

COLLABORATION AND LESSONS LEARNED

The M-OHT would value Ministry-led information sessions or best practice sharing on the approaches taken by other OHTs across the province and their early successes.

For example, if other OHTs have decided to focus on patients with palliative or minor acute needs in Year 1, it would be helpful to understand the approaches used by OHTs in integrating care pathways, particularly with respect to addressing some barriers (e.g. engaging specialist physicians, faster sharing of diagnostic imaging and laboratory results). This would also support improved standardization of work taking place across teams.

OTHER ONGOING IMPLEMENTATION SUPPORTS FROM THE MINISTRY

In addition to the broader categories indicated above, we would also like to share the following reflections:

• The M-OHT has valued having one Ministry contact throughout the development of the full application. This person has been helpful in providing clarity on Ministry expectations and areas to focus on. It would be helpful to have a Ministry contact in place on an ongoing basis to support implementation, particularly in sharing best practices, approaches to change management, and guidance on labour relations. • Potential toolkits that would be useful to inform implementation include: resources on how to work with partners through shared accountability agreements, data-sharing agreements, decision-making frameworks, issues management, and the integration of funding envelopes. • Given that we have chosen to focus on palliative care, we would appreciate ethics resources and supports for successful planning and implementation. Overall, the M-OHT would value ongoing support from the Ministry as we implement the OHT model. Particularly, recognizing the reality that while we implement, we will continue to deliver our current state services and address ongoing health system priorities. We ask for the Ministry's patience related to timing and pace of this large scale health system transformation.

6.6. Risk analysis

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

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

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

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

6.7. Additional comments

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

Max word count: 500

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)	

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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

This appendix is based on information available at the time of drafting. Notwithstanding that this application in non-binding, we submit this appendix without prejudice and acknowledge our reliance on the Ministry to work with all OHTs to

resolve the issues noted below in order to maximize our commitment to deliver population-based health care.

In developing new models, there are key issues for the Ministry of Health to take into consideration, providing both guidance and direction to OHT candidates. These include: labour relations strategy, including a plan to manage compensation equity issues across sectors (compensation includes total rewards (e.g. wages, benefits)); provincial standards that allow for local OHT delivery, but set consistency across the province; and procurement strategies that enable OHT agility for service design and delivery, removing historical barriers.

We look forward to working with the Ministry on the future model of home and community care, including alignment to a provincial framework to ensure equitable care for all Ontarians, and to implementing this next phase of transformation.

THE M-OHT VISION FOR HOME AND COMMUNITY CARE

Our vision retains the strengths of our current home and community care model with new solutions to address current state challenges. Today, the overall delivery of services can often feel transactional, task-driven and fragmented to patients, families and caregivers. To reduce and smooth transitions, we envision bringing home and community care closer to other parts of the system, increasing accountability and continuity. Recognizing the skilled people who deliver care and support to patients, families and caregivers, we envision retaining this workforce as we bring the system together.

THE ONE TEAM APPROACH

The overarching principal in our plan is for the OHT to be ‘one-team’, inclusive of home and community care within the Integrated Primary Care Centre (IPCC) model. In this model, the core and extended team will follow the person through their entire health care journey, to provide care and support. We believe that home and community care is part of the foundation of patient-centered, interdisciplinary, team-based health care.

Through this design, patients, families and caregivers will experience fewer transitions, more consistency and more anticipatory care, provided by a team that knows them well. Providers will have greater confidence that the system will support people at home and in the community, and will have closer working relationships when sharing care. Acute care will be less siloed, enabled by a tighter link to the primary, home and community team in the IPCC, which will facilitate safe and early discharges, promote care in the community and therefore, result in fewer long-stay patients. Patients, families and caregivers will be engaged as partners in care, empowered to manage their own health conditions, and will know what to expect at

every step along their health journey, with a key contact in their IPCC for when they need help or have questions.

To achieve a sustainable design and enable the one team approach, the functions and resources of home care should be integrated into OHTs as a whole, including specialized LHIN delivered services (e.g., rapid response nurses and wound care). This will preserve economies of scale, maximized purchasing power, effective human resource management and enable enhanced continuity and reduced transitions. We are prepared and willing to operate home and community care under the current model at status quo, but believe there are many opportunities to enhance services, efficiencies and, patient and provider experience. We have identified two potential paths forward:

Option #1:

The first path is a new service model that would require flexible work rules, procurement modernization, changes to current roles specifically addressed in legislation and wage parity on the part of the province. To allow for the functions to be absorbed by the OHT, this may require establishment of a new corporate structure on the part of the OHT. In this model:

- Home and community care services would be brought closer to where patients receive care, in primary care, the community and in hospitals;
- Its architecture would be designed around functions, rather than roles and would bring capacity for care coordination and navigation to teams that know the patient best; and
- It would include investment in our people to support and empower these functions within the OHT.

Option #2:

The second path allows for incremental change in recognition of the time and complexities involved in addressing provincial issues of this magnitude. This would help us advance integrated, population health-based care in Year 1, while time is provided to assess changes needed to funding, labour and procurement frameworks. In this path we propose to build and phase-in a series of bundled care packages for home care services, beginning with a palliative care bundle.

DESIGN AND DELIVERY PRINCIPLES

In either option, our vision for home and community care includes the following design and delivery principles:

1. Leveraging Care Coordination and Navigation Functions

- Care coordination supports the provision and organization of medical and social services for patients as appropriate based on need, including developing care plans, ensuring continuity of care and supporting transitions.

• Care coordination is a function delivered in conjunction with direct clinical care. While all providers have some level of coordination responsibility, for those with complex needs, key contacts are assigned from within the patient's primary care team. There is clear, well-articulated expectations related to oversight of the care plan and support to patients, families and caregivers.

• Individuals accountable for care navigation connect patients (in-person, by phone or virtually) to a myriad of services and supports across the OHT but do not provide direct care. They hold other clerical or administrative responsibilities within the team.

2. Increased Access to Services
• Care coordination functions would exist in primary care teams and within hospitals, accessible to the patient at the site of care.
• Information about resources and care access will be available 24/7 through an on-call telephone system and website, which support our large population.
• Additional investment in OHT community support services to increase capacity and flexibility for in-home care is required (e.g. PSW and respite care, activities of daily living).
• Model includes leveraging integrated partnerships with Community Support Services and Regional Program providers.

3. New & Stronger Partnerships with Service Provider Organizations (SPOs): Enabling the One Team Approach
• Dynamic partnerships and strong accountability will be established between SPOs and OHTs. Patients will receive and experience service provider organizations (SPO) services seamlessly as an extension of the OHT one team approach.
• Modernized contracts with meaningful KPIs that include clinical/quality measures are required enablers.
• SPOs services will be streamlined, procured based on value, and clustered according to the needs of the population through holistic 'packages' of care. Packages will be prevention-oriented and customizable. For example the following 'care packages' could be considered: services to keep frail seniors who are otherwise in good health at home longer; services for those with chronic care needs; and services for those requiring complex/post-acute care.
• There will be one standardized digital care plan: it will be a living document that is accessible to all providers, patients and caregivers as appropriate, and will include the patient's value-based goals.
• Common consent form among all providers working with patient, family and caregivers.
• Standardized assessments and consolidation of care variety from a single provider.
• Performance and quality dashboard monitoring, joint complaints and incident management process.

4. Enhanced Patient Experience • Simplified patient journey with as few handoffs as possible, with seamless transitions. All handoffs will be warm handoffs. • Digital interfaces to enable provider and patient communication. • Patient experience data will be collected in real-time for responsive performance management and quality improvement. • Increased options for self-management, education and caregiver support.

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

Our short-term action plan includes strategic partnership alignment into an OHT with sufficient agility for improved operations, while also building on modernized connections with SPOs. If operating within the current constraints of funding, labour and procurement as identified in Section A.1, in Year 1 we will focus on building and phasing-in a series of bundles, or packages, of home care services, beginning with a palliative care bundle (See Section A.1).

A comprehensive co-design process will be undertaken to build the palliative care bundle, including levels of care, service mapping, financial models and quality dashboards. The fundholder has substantial expertise with bundles, including a previous palliative bundle submission to government, on which to launch this work rapidly and meaningfully. Procurement of an SPO for care delivery in this bundle would follow.

This will set the stage for future bundles, including care delivery models, financial models and quality frameworks that can then be developed as part of the future clinical integration streams of work within the OHT.

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

In addition to our response in A.1., the M-OHT will work collaboratively with Ontario Health, its regional offices, SPOs and other OHTs where applicable, and will abide by the following guiding principles for transition:

1. Preserve continuity of patient care and experience
2. Support the government's goal to coordinate and connect the public health care system from top to bottom to make it more efficient and sustainable, so it is here for Ontarians today and for generations to come
3. Maintain and improve access to care based on need
4. Honor the spirit of collaborative partnerships in order to service the needs of the community
5. Maintain a holistic approach in service delivery that takes into account the social determinants of health and minimizes barriers to accessing care
6. Remain committed to responding to the needs of a changing population

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

As noted above, there are many challenges associated with home and community care modernization. We have identified the following five major barriers:

1. Lack of wage parity across sectors and lack of a health human resource strategy for home and community care
2. Labour relations and collective bargaining complexities due to 'related employer' provision in Labor Relations Act
3. Variations in scope of work and payment models for PSW services in the community sector versus SPOs

4. Current moratorium on competitive procurement for services; existing contracts incent transactional care, restrict innovation and limit service delivery that is aligned with our vision
5. Lack of transparency on SPO performance and quality
6. Workforce shortages in both PSW and nursing present challenges to the successful execution of OHT models. Stability of the current system needs to be thoughtfully managed during transition.

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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

OVERVIEW

In Year 1, the M-OHT will provide the following virtual services:
- All patients: online scheduling for in-person primary care visits
- Palliative care patients: secure messaging, video visits
- Minor acute (GI/GU) patients: video visits

Year 1 will focus on implementation leveraging existing assets and on planning for longer-term implementation.

It is reasonable to assume that 2-5% of patients will have a virtual encounter in Year 1. We estimate that in Year 1 this service could reach 9% of patients (5,250). To summarize:
- All 60,000 patients in the Year 1 population will have an opportunity to access online scheduling through primary care.
- Additional assumptions: only 70% of people visit their primary care provider in a given year (31); only 25% will decide to use online scheduling; due to implementation timing, the feature will be available for 50% of the year.

Up to 4.25% from the two priority populations will access more in depth virtual services (see below).

VIRTUAL SERVICES FOR ALL PATIENTS

Patients will be enabled to schedule an appointment with their primary care provider using the EMR. Currently, one primary care member of the M-OHT has implemented this technology; lessons learned and technical approaches will be extended to other practices.

Indicators of success:
- Number and percent of patients who booked, modified or canceled appointments online vs. over the phone;
- Average duration to complete booking;
- Impact on administration time allocated to scheduling;
- Patient satisfaction scores (e.g. survey response).

Implementation will require:
- An online booking solution deployed using primary care EMRs (where not currently in place).
- Business processes developed in each practice, establishing norms on visit types, durations and sharing of calendars.
- Minimal digital investments; change management resources within primary care to educate staff and teams will be needed.
- Resources from OntarioMD's peer support program as well as the MH LHIN's primary care advisory support network can be leveraged.

VIRTUAL SERVICES FOR PALLIATIVE CARE PATIENTS

All Year 1 palliative care patients and their caregivers will be able to:
1. Communicate with a member of their care team using secure messaging, and
2. Have the option of visiting their care teams through video visits, where appropriate.

In Year 1 the M-OHT will implement a single digital coordination solution to be used by palliative care teams. Its features will include secure messaging, visit scheduling (between providers and patients), and a link to OTN's videoconferencing technology (for virtual interdisciplinary video visits). A member of the care team will determine appropriateness of its use with patients and will be accountable to ensure services are scheduled.

We can anticipate that between 0.1% and 2.25% of our Year 1 population may use these services. To summarize:
- We assume (conservatively) only 50% of palliative care patients (135 of 270) will use at least one virtual care service (0.2% of Year 1 patients).
- This percentage could be as high as 4.5% (2,750 of 5,500) if it also includes everyone who would benefit from a palliative approach to care.
- Due to implementation timing, we assume the feature will be available for 50% of the year.

Indicators of success:
- Number and percent of patients who had a virtual encounter;
- Time to virtual video visit from date/time of request (by patient or care team member);
- Reduction of in-person visits as a result of virtual encounters;
- By specific virtual visit, estimation of ED visits avoided (e.g. through survey data or through correlation from baseline);
- Patient satisfaction feedback scores (e.g. survey response);
- Provider satisfaction feedback scores (e.g. survey response).

Implementation will require:
- Ensuring select providers have access to OTN technology and can participate in OTN's Home Video Visit or eVisit program to enable remuneration.
- Primary care practices and care teams to establish methods by which care interactions are scheduled.
- Virtual visits to leverage existing OTN technology; some investment in devices may be required, but the resources to implement will be largely associated with change management.
- The digital coordination solution (details in Appendix B 2.2) will need to be implemented among select M-OHT providers who are not already using it. This solution will allow access to virtual services; resources will be required to enable this.

VIRTUAL SERVICES FOR MINOR ACUTE (GI/GU) PATIENTS

All patients who present to their primary care practice with minor acute symptoms that suggest GI/GU conditions will be able to:
- Receive a virtual (video) option for visiting their care team;
- Receive education and self-management support resources.

Virtual visits will be enabled through OTN technology (see palliative above). The member of the care team will determine eligibility and appropriateness of a video visit, confirm the patient's ability to access a smart phone or tablet, and send the patient an email link. This will allow them to access the OTN Hub videoconferencing platform at a time when their primary care provider is available for a consult.

We can anticipate that between 0.2% and 2% of our Year 1 population may use these services. To summarize:
- We assume (conservatively) 20% of minor acute patients will use this service. Estimated demand is predicted to be as high as 13,000 patients (Section 1.2), with a possible subpopulation of 1,300 based on patients who currently visit the emergency department for services.
- Due to implementation timing, the feature will be available for 50% of the year.
- Therefore, between 1,300 and 130 patients are anticipated to have a virtual encounter in Year 1.

Indicators of success:
- Number and percent of GI/GU patients who had a virtual encounter;
- Time to virtual video visit from date/time of request (by patient or care team member);
- Reduction of in-person visits as a result of virtual encounters;
- Reduction in visits to urgent or emergency care as a result of virtual encounters;
- Patient satisfaction feedback scores (e.g. survey response);
- Provider satisfaction feedback scores (e.g. survey response).

Similar to work required for the palliative population, implementation will involve:
- Primary care practice team training to assess, screen and determine eligibility of patients and schedule a video visit.
- Use of primary care practice EMRs.
- Access to and adoption of OTN Hub technology.

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

OVERVIEW

In Year 1, the M-OHT intends to provide select patients with access to their personal health information:
- Palliative care patients: digital access to their shared care plans
- All M-OHT patients: appropriate access to their care record with their primary care provider

FOR ALL M-OHT PATIENTS

The M-OHT anticipates that as many as 18% of patients (10,500) who receive care from OHT members in Year 1 will have access to some form of their health information digitally. This assumes that 70% of patients access primary care in any given year, that 50% will want to access their information digitally, and assumes that this implementation timing will mean this feature is available for only 50% of the year.

M-OHT primary care provider member organizations will enable select information from their EMRs to be made available to patients in a “patient-friendly” and useful format (i.e. in a manner that supports the best care for patients).

In certain circumstances, information will not be shared electronically with the patient until a member of the care team has had the opportunity to discuss it and its implications with the individual. This will help to ensure that information is not inadvertently communicated with patients that could cause distress or anxiety without a discussion with a clinician to supplement.

Existing primary care practices in the M-OHT are already in the process of exploring tools that could facilitate access to their EMRs by patients. The tool will be made accessible in alignment with the online scheduling tool (described above).

One opportunity that will be explored relates to advance care planning. The intention is to enable patients who present in primary care to be prompted, through the use of digital tools, to both discuss an advance care plan with their loved ones as well as to document it with primary care providers. Patients may wish to review this information and provide updates over time. This information could potentially be documented in the same digital coordination solution used by palliative patients.

Investments will be required to enable this functionality, including in people resources (administrative, technical and professional support); processes (governance committee, policies, and procedures on information management, security, privacy and confidentiality); and technology (standardized technology hardware and software).

FOR PALLIATIVE CARE PATIENTS

The digital coordination solution will be used by all providers in each Year 1 palliative patient's circle of care. The tool will provide both patients and their caregivers access to a shared care plan that they will be able to review and contribute to (as appropriate), as well as planning tools and self-management supports.

We estimate that this digital coordination solution will most frequently be used by the percentage of the Year 1 population that is most likely to pass away over the course of the year: approximately 270 people. It may also be accessed by their caregivers, provided that consent is given. Assuming that implementation timing will mean the solution is only available for 50% of Year 1, and that only 50% of patients will choose to access their information digitally, this represents 0.1% of the Year 1 OHT patients receiving care.

SUMMARY

Notwithstanding the investments required to purchase and deploy needed technology (further outlined in subsequent sections), as well as the complexity involved in implementing these kinds of tools in primary care practices and across other OHT care provider organizations, we anticipate that the OHT will be able to meet the target of 10-15% of patients accessing some of their personal health information.

FUTURE YEARS

Year 1 implementation will be focused on developing interim solutions that leverage existing tools. As part of a broader digital health strategy for future years (described in Appendix B 2.5 - Other Digital Health Plans), the M-OHT will look to provide more comprehensive access to personal health information using a more sophisticated patient-facing digital tool.

This tool will be designed to provide services beyond scheduling and access to health information, and will extend beyond primary care electronic medical records, where it is currently planned to be situated.

Over the longer-term, the Ministry should consider investing in building a Patient Access Channel connected to the provincial clinical viewer (ConnectingOntario). Such a tool would positively impact all patients and OHTs across the province. It could serve as a single, patient-friendly access point for individuals to view their Electronic Health Records. It could be designed to contain the majority of patients' personal health information in a standardized format.

As part of the OHT application process, the Ministry should compare the investments that would be required from each OHT to implement and successfully achieve results equivalent to a Patient Access Channel to the investment that would be required to build a single provincial solution for all patients in Ontario.

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

OVERVIEW

Work to enable digital information sharing will focus initially on supporting the implementation of two integrated clinical pathways.

For palliative care patients, members of the primary care team will leverage existing EMRs as well as adopt a single digital coordination solution. For care pathways that require multiple providers from different organizations to collaborate, either single solutions or a digital coordination solution will be required. Such a tool will be particularly essential for organizations with little digital capability, and implementation may be a particular focus among the hospice partners in Year 1, many of which do not currently have access to tools being considered (i.e. CHRIS or Care Connector; see below).

For minor acute patients, their primary care teams will leverage existing tools (predominantly the primary care practice EMR) to share information.

PALLIATIVE CARE PATIENTS

M-OHT partners and their providers in palliative care teams will utilize their current record systems as well as adopt a single digital coordination solution. The solution will have the following capabilities:

- Providers can add patients and classify patients (e.g. non-palliative, palliative by needs assessment score).
- Providers can conduct shared care planning, care coordination and development of shared care plans.
- Providers can use common assessment and screening tools (and share results).
- Providers can securely message each other.
- Providers can access patient information from other M-OHT EMRs or provincial assets.
- Providers can access other provincial assets such as OLIS or Connecting Ontario.
- Patients (and their caregivers) can access self-management resources.
- Patients (and their caregivers) can review their shared care record, contribute to it (where appropriate) and contribute to care goals (e.g. end-of-life plans).
- Patients (and their caregivers) can communicate directly with a member of the care team through secure messaging, as appropriate.
- Members of the care teams and patients can schedule care interactions to be conducted in person and/or virtually (video).

The M-OHT is in the process of determining which digital coordination solution will best meet the needs of the providers who will be caring for palliative care patients. This assessment process will consider features necessary to achieve Year 1 goals; however, the team will concurrently be planning for the future needs of the M-OHT.

Existing candidates for a digital coordination solution include THP's in-house tool, Care Connector or HSSO's tool CHRIS. Which tool is used will be determined early in Year 1. Regardless of which technology is used, further development will be required.

The M-OHT would also be open to other solutions that may be adopted by other OHTs. The M-OHT is undertaking a review of options and will assess how well tools meet current and future needs as well as the cost implications (development, implementation, use).

Depending on the sophistication of the digital coordination solution, it may integrate (bi-directionally or read-only) with some M-OHT member EMRs or hospital information systems; however, it will likely exist as a stand-alone solution for many providers.

MINOR ACUTE (GI/GU) PATIENTS

Primary care providers, office admins and other members of the care team will use existing EMRs to manage these patients. These EMRs will also be required to accept information from hospital information systems through OntarioMD's hospital report manager (HRM) as well as OLIS, private labs and other community diagnostics in order for care teams to better manage their patient's care.

For the purposes of planning and population health management, the EMR systems will be used in conjunction with information pulled from other provider originations' datasets (e.g. acute care emergency department data, urgent care centre data).

FUTURE YEARS

This digital coordination solution will also collect data that will be shared in a de-identified, aggregate way with the M-OHT office in order to help conduct population health management, planning, financial management and other OHT management functions for palliative care patients.

The OHT will look to establish more consolidation and integration among electronic medical record systems used by M-OHT providers, which will make the collection of data for the purposes of planning and management much easier.

Further, the adoption of other central solutions for financial management, population health management, patient flow management and other central M-OHT functions will be explored. This will be adopted as early as late 2020 (pending partner agreement and available funding). In developing these solutions, a security assessment will be completed for each member that will have access to the data. The preference will be to leverage existing Ontario assets that members may already use (e.g. eHealth One ID).

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

CURRENT USE OF TOOLS

Each M-OHT member is experienced in using digital health tools and information to drive quality and performance. In home care, the LHIN uses an Events Tracking Management System to understand risk events, complaints and compliments. Data is trended quarterly and used for SPO performance indicators. Surveys are administered for client experience (including on discharge from hospital to home) and caregiver palliative care experience.

In acute care, THP has a robust incident management system to track and address issues. Performance is tracked and improved along a balanced scorecard. PAARC, Peel Senior Link and Heart House Hospice annually submit client satisfaction survey results to the LHIN for a Quality Report. They are also members of the Community Quality Network, which has a common indicator Scorecard for quality. The two FHTs members submit QIPs to the LHIN, and are experienced using data about their practices to drive improvement.

BUILDING EXPERIENCE AND CAPABILITY IN YEAR 1

At first, the role of QI across care pathways will be driven by Year 1 M-OHT primary care members whose existing solutions (e.g. EMRs) will be optimized for QI and data from these systems and other solutions will be consolidated.

PALLIATIVE CARE PATIENTS

The digital coordination solution will be used to extract data (and reports) for key performance metrics, and will also facilitate built-in decision support tools to more effectively manage patients. For example, every M-OHT patient over a specific age could be given a profile in the digital coordination solution and, at minimum, have an advance care plan (ACP) created and documented within. Patients will be prompted to complete an advance care plan through the digital tool that

will suggest speaking to loved ones about end-of-life wishes and values and will prompt to define a substitute decision-maker with one's clinician.

These patients will have a shared care plan and a section in the digital tool to outline shared care goals that will prompt providers if it is not completed.

Reports will also provide summary information about the M-OHT population group to help the team better understand their impact and the quality of care. HSSO's CHRIS solution has features that assist providers in identifying patients who would benefit from palliative care services. Some EMRs also have built in screening tools that automatically flag patients for further palliative care assessment that will be leveraged or built into the digital coordination solution.

MINOR ACUTE (GI/GU) PATIENTS

The EMR and select data from OHT partners' systems (e.g. HIS) will be used to extract data for key quality performance metrics and reports.

ALL OHT PRIMARY CARE PRACTICE PATIENTS

Primary care members of the M-OHT will be expected to optimize EMR use to better manage select patient populations and provide high-quality care, and in Year 1 will look to adopt an assessment tool (e.g. OntarioMD's "i4C Dashboard"), for individual- or practive-level use to enable proactive care, encourage data quality through standardization, and capture trends and indicators/measurements automatically.

The Waterloo Wellington eHealth Center of Excellence's best practices can be referenced to improve physician EMR data quality through coding standardization that will help set a more accurate data foundation for analysis and predictive purposes.

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

As outlined above, the M-OHT's initial approach will be to leverage the use of existing electronic medical record systems and look to implement a digital coordination solution to support integrated care pathway development. In Year 1, the M-OHT will also develop a more fulsome digital strategy to inform Year 2 and onwards. This will include detailed plans for information sharing, virtual care, patient access to information and population health management tools. The proposals contained within this application will require modest support and investment from the Ministry to advance, including $450,000 in digital start-up funding to leverage existing assets and support the first few years of digital results..

As described in Appendix B 2.3 above, the OHT will first look at the practicality of selecting existing digital coordination solutions (such as THP's in-house tool Care Connector, HSSO's tool CHRIS) or look to select a more sophisticated tool based on the outcomes of an evaluation that includes available investment and preferences of OHT members. The M-OHT welcomes the opportunity to consider other innovative provincial solutions.

At the outset of the OHT, the focus will be on developing process norms in caring for patients comprehensively and across organizations. Unfortunately, the digital tools selected will the meet needs of providers for Year 1 but may not be as seamless, easy to use or as integrated as desired.

To that effect, at initiation, the M-OHT will begin long-term planning for a comprehensive digital plan and approach. Improving ease of use, including integrating human-centred design, will be a focus of subsequent years of implementation.

To support the long-term, the M-OHT, through THP, has engaged in partnership with The University Health Network to help spearhead the province's vision to modernize the system through use of a single solution for Identity, Authentication, and Authorization (IAA). The goal is to challenge today's fragmented system and go beyond user names and passwords, inconvenient face-to-face authentication and siloed systems and data, through seamlessly integrating and managing digital identifies and PHI within and across organizations or sectors. We will apply lessons learned and potentially leverage the technologies created out of this engagement to the M-OHT digital strategy.

The M-OHT will also look to leverage opportunities created by through the enhanced digital integration across multiple system partners, which may include:

- Centralized planning, procurement, management and provisioning of digital tools;
- A common digital maturity framework across M-OHT partners;
- Consolidation and standard solutions (e.g. Single EMR, Epic) across all partners, where feasible;
- Collaborative and innovative procurement;
- Shared resources in privacy and security management, including use of standardized technology and software for security purposes;
- Shared resources in information technology support and management;
- Change management and practice facilitation, IT peer support, and education.

A comprehensive digital plan that outlines the needs of all providers, managers and administrators across multiple organizations will help the M-OHT chart a course for truly integrated digital solutions. Further, it will enable M-OHT partners to better understand and maximize their digital opportunities and the investment required to do so.

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.

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